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CARE EXCELLENCE

Quality standards

Consultation summary report: Type 2 diabetes in adults

Quality Standards Advisory Committee post-consultation meeting: 23 November 2022

1. Introduction

The draft quality standard for type 2 diabetes in adults was made available on the NICE website for a 4-week public consultation period between 20 September and 18 October 2022. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 15 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 to 3.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

* Stakeholders supported the areas contained within the quality standard.
* Suggestion that the statements should include behaviour science interventions.
* Suggestion that the statements should focus on people aged under 70.

### Consultation comments on equality and diversity considerations

* The equality and diversity considerations should reference the legal duty to consider reasonable adjustments.
* Ensuring the availability of translators or interpreters may be challenging and may need financial support to implement.

### Consultation comments on data collection

* Stakeholders felt that systems and structures are in place to collect data for the proposed quality measures. They highlighted the data collection for the National Diabetes Audit.
* They noted that foot assessments can be difficult to measure unless electronic data collection has been used.
* Stakeholders highlighted that the SCI-diabetes system is an effective tool to gather information collected and operate as a clinical management system.

### Consultation comments on resource impact

* Most stakeholders felt that the quality statements are achievable.
* Stakeholders noted that use of electronic notes in hospital can be used to measure key performance indicators and reduce adverse events. There are potential cost savings through unnecessary delays in discharge or potential litigation.
* Stakeholders highlighted staff shortages as a challenge that mean the implementation of the quality statements could be expensive.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

Adults at high risk of type 2 diabetes are offered a referral to an NHS Diabetes Prevention Programme. **[2016, updated 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

* Most stakeholders welcomed this statement and thought that prevention was a priority area of improvement. Some stakeholders proposed additional areas that apply to people currently living with type 2 diabetes are more of a priority for quality improvement.
* The pathway and outcomes are part of the National Diabetes Audit.

Statement

* The statement should include timeframes between diagnosis and referral to guide clinicians.
* The statement reflects the key areas of providing different venues for the education sessions, evidence-based programmes, communication needs and allows for flexibility and a patient centred approach. There should be a greater focus on cultural needs and delivery options.

Definitions

* The definition of high risk of type 2 diabetes should include patients with non-alcoholic fatty liver disease and non-alcoholic steatohepatitis.

### Issues for consideration

#### For discussion:

* Is the area of priority referral to a programme, or timely referral?
* Do we need to include a timeframe for referral?
* Should we update the definition of intensive lifestyle-change programme to highlight the need to include behavioural science approaches?

#### For decision:

* Should this statement remain in the quality standard?
* If we include a timeframe in the statement or measures, what should this be?
* Should the definition of intensive lifestyle change programme be amended, and if so, what should be added?
  1. Draft statement 2

Adults with type 2 diabetes are offered a structured education programme at diagnosis. **[2011, updated 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

* Stakeholders supported this quality statement. The NHS Long Term Plan has a focus on prevention of illness by supporting patients to adopt improved healthy behaviours.
* The statement is covered by the National Diabetes Audit and data quality is good.

Statement

* The statement should include a timeframe. Stakeholders suggested referral as soon as possible after diagnosis to ensure patients are activated to participate.
* Structured education programmes should include information on common co-morbidities.
* It would be useful to understand who is responsible for setting and delivering the programme and the expected outcomes.
* The statement should include programme duration and frequency of access for users.

### Issues for consideration

#### For discussion:

* The timeframe for referral. Is the timeframe of ‘at diagnosis’ appropriate for the statement?
* The definition of structured education. Should we update the definition to highlight the need to include behavioural science approaches and information on common comorbidities?

#### For decision:

* Should the statement remain in the quality standard?
* Should the timeframe in the statement be amended, and if so, what should this be?
* Should the definition of structured education be amended, and if so, what should be added?
  1. Draft statement 3

Adults with type 2 diabetes and a learning disability or cognitive impairment who have multiple daily insulin injections, and adults with insulin-treated type 2 diabetes who need help from a care worker or healthcare professional to monitor their blood glucose, are offered intermittently scanned continuous glucose monitoring. **[new 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

* Stakeholders supported this quality statement. It will help to address health inequalities.

Statement

* The statement does not include all people eligible for intermittently scanned continuous glucose monitoring (isCGM).

Measures

* The statement and measures include elements that are not included in routinely collected data sets.
* It would be useful to understand how this would be assessed across healthcare boundaries and who would take responsibility for it.

### Issues for consideration

#### For discussion:

* The focus on a subpopulation of adults eligible for isCGM.
* The difficulties in defining and extracting data for this population from routinely collected data sets.

#### For decision:

* Should this quality statement remain in the quality standard?
* Confirm the population to be covered by the statement.
  1. Draft statement 4

Adults with type 2 diabetes and chronic heart failure or established atherosclerotic cardiovascular disease, or chronic kidney disease (CKD) with an albumin to creatinine ratio (ACR) over 30 mg/mmol on optimised standard care, are offered an appropriate SGLT2 inhibitor. **[new 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

* Stakeholders supported this quality statement.
* Stakeholders noted the update of the medicines section of NICE’s guideline on type 2 diabetes in adults and suggested this should be considered during development of the quality standard.

Statement

* The statement does not align with NICE’s technology appraisal guidance on dapagliflozin. Dapagliflozin does not require a minimum level of ACR before it can be prescribed.

Measures

* There should be a definition of CKD and guidance on how optimised standard care with ACE inhibitors or angiotensin receptor blockers (ARBs) is defined, recorded and measured.
* Measurement of ACR is poor in general practice.
* The National Diabetes Audit can measure who has been prescribed SGLT2 inhibitors but not the offer.
* Is there another source that could be considered for the outcomes measure? The National Diabetes Audit report on complications and mortality includes data on renal replacement therapy which is the final stage of CKD progression.

### Issues for consideration

#### For discussion:

* The use of dapagliflozin in this population and impact of [NICE’s technology appraisal on dapagliflozin for treating chronic kidney disease](https://www.nice.org.uk/guidance/ta775).
* The inclusion of ACR measurement and reference to optimised standard care in the statement. Can this be defined and extracted from routinely collected datasets?
* Are there alternative outcome measures that could be used?

#### For decision:

* Should this quality statement remain in the quality standard?
* Should the statement be amended to include reference to ACE inhibitors and ARBs?
  1. Draft statement 5

Adults with type 2 diabetes have key care processes completed every 12 months. **[new 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

* Stakeholders supported this quality statement.
* This statement is a core part of the National Diabetes Audit.
* Stakeholders particularly highlighted poor performance of ACR to detect proteinuria and performance of foot assessments as a key area for quality improvement. They suggest that retinal screening should be kept as a priority to maintain the improvements in this area.

Statement

* The statement should be reworded to emphasise the need for completion of all key care processes.

Measures

* How would this be measured in different healthcare environments?

Definitions

* The definition of key care processes should include other diagnostic tests to evaluate comorbidities in the liver and heart.

### Issues for consideration

#### For discussion:

* Are amendments needed to the definition of key care processes?

#### For decision:

* Should the quality statement remain in the quality standard?
  1. Draft statement 6

Adults with type 2 diabetes who are admitted to hospital are assessed for their risk of developing a diabetic foot problem. **[new 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

* Stakeholders were supportive of a quality statement on diabetic foot problems. Some felt that that inpatient assessment is not the priority for quality improvement in this area.
* Stakeholders suggested that a statement on diabetic foot problems should be consistent with quality statements in NICE’s quality standard on type 1 diabetes in adults.

Statement

* The statement should include foot assessments in all settings to ensure prompt referral to specialist services.
* Statement needs to clarify what criteria would be met for assessment on admission. Adults with diabetes could be admitted for reasons other than diabetes.
* There is a current quality and outcomes framework indicator that measures annual foot examination and risk classification. Would this be shared with secondary care to provide a full history?

Measures

* There is no way of measuring at present. It would be dependent on universal hospital electronic patient records and structured admission records.

### Issues for consideration

#### For discussion:

* The inconsistency in the priority area of quality improvement for diabetic foot care with the NICE quality standard on type 1 diabetes in adults.
* Is the focus on inpatient foot assessments appropriate or should the statement be widened to cover additional settings?

#### For decision:

* Should this quality statement remain in the quality standard?
* Should the focus remain on inpatient admission?

1. Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

* improving access and experience of diabetes care and support. This should include training to enable reasonable adjustments for people with a learning disability.
* Offer of multi-organ imaging at diagnosis to assess for potential comorbidities.
* Offer of GLP-1 RAs to people with type 2 diabetes and non-alcoholic steatohepatitis.
* Promotion of fitness and activity for patients with type 2 diabetes.
* Foot ulcers.
* Support for coexistent mental disorder.
* Inpatient care, including dedicated multidisciplinary teams of specialist diabetes practitioners.

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# Appendix 1: Quality standard consultation comments table – registered stakeholders

| ID | Stakeholder | Section | Comments |
| --- | --- | --- | --- |
| 1 | Diabetes UK | General | Diabetes UK broadly welcome this draft quality standard and the inclusion of key improvement areas for type 2 diabetes reflecting the new recommendations on Flash (isCGM), medications and importance of recovering routine services like annual health checks.  We also welcome the updated statements regarding referral to the National Diabetes Prevention Programme to prevent those at high risk developing the condition, and on the need for structured education following diagnosis. |
| 2 | Diabetes UK | General | The legal duty services have to consider reasonable adjustments should be referenced in the relevant ‘Equality and Diversity Considerations’ sections of these quality standards.  Reference: https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/11/rightcare-pathway-diabetes-reasonable-adjustments-learning-disability-2.pdf |
| 3 | Healthcare Quality Improvement Partnership (HQIP) | General | No comments to make. |
| 4 | Royal College of Physicians of Edinburgh | General | The Royal College of Physicians of Edinburgh (RCPE) welcomes this opportunity to comment on the new draft quality standard and generally welcomes the updates contained within it. Fellows of the Royal College of Physicians of Edinburgh welcome references to retinal screening rates. The RCPE considers that a generally first-class retinal screening services exists across the UK which has reduced the need for laser treatment and reduced blindness. The RCPE further considers that this must be kept as a priority in order to maintain and continue the excellent improvements in this area. |
| 5 | Association of British HealthTech Industries (ABHI) | Question 1 | Question 1 - Does this draft quality standard accurately reflect the key areas for quality improvement?  Yes, the draft quality standard accurately reflects the key areas for quality improvement. |
| 6 | Diabetic Foot Network Wales | Question 1 | Would like to have seen behaviour science interventions being identified to support some of the statements |
| 7 | Healthy.io | Question 1 | Yes, this draft quality standard accurately reflects the key areas for quality improvement. |
| 8 | National Diabetes Audit | Question 1 | As for type 1 diabetes NDA has shown that younger people have the least complete routine care, the most adverse treatment target achievement rates and the greatest socioeconomic and ethnic inequalities. The population of people under age 40yr with T2DM has been growing rapidly and is now numerically equal to people age <40 with T1DM. Developing T2DM over the age of 70 has little adverse effect on cardiovascular risk or mortality but NDA data shows large effects in people of working age with T2DM. |
| 9 | Association of British HealthTech Industries (ABHI) | Question 2 | Question 2 - Are local systems and structures in place to collect data for the proposed quality measures?  Yes |
| 10 | Diabetic Foot Network Wales | Question 2 | Foot assessments when admitted to hospital will be difficult to measure unless electronic notes are used and a data set can be used to capture performance otherwise its based on trawling through notes |
| 11 | Healthy.io | Question 2 | Yes, local systems and structures are in place to collect data on the proposed quality measures.  For instance, these data to support QS5 are already collected and reported on a quarterly basis through the NHS National Diabetes Audit. |
| 12 | National Diabetes Audit | Question 2 | Please see answers to statements below |
| 13 | Royal College of Physicians of Edinburgh | Question 2 | Fellows wished to highlight the SCI-diabetes system as a highly effective tool which gathers information collected and operates as a clinical management system. While Covid has negatively impacted on the ability to collect simple but important information, the RCPE considers that such data is vital for good clinical care and that new ways of collecting this information must be developed. |
| 14 | Association of British HealthTech Industries (ABHI) | Question 3 | Question 3 - Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them?  Yes |
| 15 | Diabetic Foot Network Wales | Question 3 | Use of electronic notes in hospital will lead to measurable key performance indictors and support service improvement and reduce adverse events with potential cost savings through unnecessary delays in discharge or potential litigation. |
| 16 | Healthy.io | Question 3 | Yes, each of the statements in the draft quality standard would be achievable by local services given the net resources to deliver them. |
| 17 | National Diabetes Audit | Question 3 | Can see no reason why the recommendations would not be achievable |
| 18 | Royal College of Physicians of Edinburgh | Question 3 | The RCPE considers that these statements are desirable but may be expensive. Fellows are concerned that staff shortages, with a significant number of vacancies existing in many areas, are a major challenge. Specialist nurses, doctors and podiatrists must be made use of as efficiently as possible and to the benefit of the maximum number of patients, with their time spent where it makes most difference. Efficiency and effectiveness could be improved with additional support staff, such as administrative support staff, and by aiming to use more junior staff to collect more basic clinical information- as referred to above- to free more senior staff to concentrate on more specialist work. |
| 19 | Association of British Clinical Diabetologists (comments endorsed by Royal College of Physicians) | Statement 1 | ABCD would like to question the inclusion of a quality standard pertaining to people at risk of developing type 2 diabetes rather than already living with the condition. Whilst these are absolutely an important group of people with much to gain from the DPP this quality standard takes away the opportunity to include a further standard more relevant to those living with type 2 diabetes e.g., access to specialist diabetes care in hospital or indeed, support for co-existent mental disorder. |
| 20 | National Diabetes Audit | Statement 1 | Good standard, though would restrict to age <70yr. Whole pathway and outcomes already part of NDA portfolio |
| 21 | Perspectum Ltd | Statement 1 | The definition of “At High Risk of Type 2 diabetes” in this statement should be amended to include patients with clinically diagnosed non-alcoholic fatty liver disease (NAFLD) and its more advanced subgroup, non-alcoholic steatohepatitis (NASH), for the following reasons:  Patients with NAFLD/NASH have been shown to be at high risk of developing type 2 diabetes (T2D). Research exploring the UK Biobank population showed that higher liver fat levels directly increases the risk of T2D, with an increase of 5% in liver fat corresponding to a 27% increase in risk of diabetes onset ([Diabetes UK](https://www.diabetes.org.uk/about_us/news/liver-fat-risk-type-2-diabetes)). Additional studies have shown that NAFLD increases the risk of T2D by 1.6 to 6.8 times in meta-analyses (Adams et al. 2009, Ballestri et al. 2016).  The global prevalence of NAFLD and NASH amongst individuals with T2D is estimated to be 60% and ~37%, respectively (Younossi et al. 2019) (Dai et al. 2017; Friedman et al. 2018). This is supported in the NAFLD: assessment and management NICE guideline; Recommendation 1.1.1. states that NAFLD is more common in people who have T2D or metabolic syndrome. In support, we recommend that the T2D in adults quality standard is appropriately aligned and linked to the NICE guidance NAFLD: assessment and management (NG49) to ensure the cross referral is current.  Meta-analyses have also shown that patients with co-prevalent NAFLD and T2DM are also at higher risk of both liver-related (Wang et al 2012; Bazick et al 2015 ) and non-liver comorbidities, mainly cardiovascular (Targher et al 2016, Khalid et al 2020) and renal (Musso et al 2014; Mantovani et al 2018).  Given that the primary goal of disease management is prevention, this is being recognised in international guidelines (AACE) that have called for people with NASH and co-existing obesity to be offered not only lifestyle intervention as part of preventing onset of T2D, but also pharmacotherapy:  “*Clinicians must consider obesity pharmacotherapy (with preference to semaglutide 2.4 mg/week [best evidence] or liraglutide 3 mg/day) as adjunctive therapy to lifestyle modification for individuals with obesity and NAFLD or NASH to promote cardiometabolic health and treat or prevent T2D, CVD, and other end-stage manifestations of obesity*” (Cusi et al. 2022).  *References*  Adams et al. (2009) NAFLD as a risk factor for the development of diabetes and the metabolic syndrome: an eleven-year follow-up study. Am J Gastroenterol; 104(4): 861-7  Ballestri S. et al. (2016) Nonalcoholic fatty liver disease is associated with an almost twofold increased risk of incident type 2 diabetes and metabolic syndrome. Evidence from a systematic review and meta-analysis: J Gastroenterol Hepatol; 31: 936-944.  Bazick et al. (2015) Clinical Model for NASH and Advanced Fibrosis in Adult Patients With Diabetes and NAFLD: Guidelines for Referral in NAFLD. Diabetes Care 2015;38:1347–1355.  Cusi K. et al. (2022) American Association of Clinical Endocrinology Clinical Practice Guideline for the Diagnosis and Management of Nonalcoholic Fatty Liver Disease in Primary Care and Endocrinology Clinical Settings. Endocrine Practice; 28: 528-562  Dai W. et al. (2017). Prevalence of nonalcoholic fatty liver disease in patients with type 2 diabetes mellitus: A meta-analysis. Medicine, 96(39), e8179–e8179.  Friedman S. Neuschwander-Tetri B. Rinella M. and Sanyal A. (2018). Mechanisms of NAFLD development and therapeutic strategies. Nature Medicine, 24(7), 908–922.  Wang et al. (2012) Increased risk of hepatocellular carcinoma in patients with diabetes mellitus: a systematic review and meta-analysis of cohort studies. Int J Cancer 2012;130:1639–1648.  Bazick et al. (2015) Clinical Model for NASH and Advanced Fibrosis in Adult Patients With Diabetes and NAFLD: Guidelines for Referral in NAFLD. Diabetes Care 2015;38:1347–1355.  Targher et al. (2016) Non-alcoholic fatty liver disease and risk of incident cardiovascular disease: A meta-analysis. J Hepatol 2016;65:589–600.  Khalid et al. (2020) Increased cardiovascular events and mortality in females with NAFLD: a meta-analysis. Am J Cardiovasc Dis 2020;10:258–271.  Musso et al. (2014) Association of non-alcoholic fatty liver disease with chronic kidney disease: a systematic review and meta-analysis. PLoS Med 2014;11:e1001680–e1001680.  Mantovani et al. (2018) Nonalcoholic fatty liver disease increases risk of incident chronic kidney disease: A systematic review and meta-analysis. Metab - Clin Exp 2018;79:64–76.  Martin et al. (2022) Estimating the effect of Liver and Pancreas Volume and Fat Content on Risk of Diabetes: A Mendelian Randomization Study. Diabetes Care; 45(2): 460-468  Younossi et al. (2019) The Global epidemiology of NAFLD and NASH in patients with Type 2 diabetes: a systematic review and met-analysis: JHepatology; 71(4) P793-801.  Targher et al. (2016) Non-alcoholic fatty liver disease and risk of incident cardiovascular disease: A meta-analysis. J Hepatol 2016;65:589–600.  Wang et al. (2012) Increased risk of hepatocellular carcinoma in patients with diabetes mellitus: a systematic review and meta-analysis of cohort studies. Int J Cancer 2012;130:1639–1648. |
| 22 | Royal College of General Practitioners | Statement 1 | [Statement 1](#_Quality_statement_1:) Adults at high risk of type 2 diabetes are offered a referral to an NHS Diabetes Prevention Programme. **[2016, updated 2022]**  We would recommend that this statement includes some timeframes between diagnosis and referral to better guide clinicians. This would help to explain expectations on clinicians on whether this statement is one of urgency and whether the referral and intervention should be immediate or rather within a certain period after diagnosis. |
| 23 | Royal College of Physicians of Edinburgh | Statement 1 | The RCPE very much welcomes the focus on prevention here and considers that it is critically important that systems are in place for all adults at high risk of type 2 diabetes to be offered a referral to an NHS Diabetes Prevention Programme. |
| 24 | Xyla health and wellbeing | Statement 1 | This quality statement well reflects the key areas for quality improvement, for example, providing different venues, local/evidence based/quality assured sessions, and allowing for flexibility and a patient cantered approach. |
| 25 | Xyla health and wellbeing | Statement 1 | There is a focus on communication needs within statement 1, which is appropriate and necessary. I would also recommend a greater focus on cultural needs e.g., through content (in-session food examples/recipes etc) and delivery options (language/interpreter available). |
| 26 | Xyla health and wellbeing | Statement 1 | Regarding the resource required to ensure a translator or interpreter is available for all delivery of diabetes prevention and structured diabetes programmes, I feel this is a challenging request and would need sufficient financial support to implement. |
| 27 | Xyla health and wellbeing | Statement 1 | If appropriate please add comment around when outcomes are to be measured and by whom, e.g. repeat HbA1c tests post programme completed by primary care/providers. |
| 28 | Diabetic Foot Network Wales | Statement 2 | Education programme is extremely important but are we setting ourselves and patients to fail if we don’t know their activation to participate and should it be referral as soon as possible after diagnosis when activated to participate |
| 29 | National Diabetes Audit | Statement 2 | Good standard and covered by NDA. Because most care is in General Practice and electronic records are universal data quality is good. |
| 30 | Perspectum Ltd | Statement 2 | The NHS Long Term Plan has a strong focus on the prevention of illness by supporting patients to adopt improved healthy behaviours. In line with the focus of the NHS long term plan, we propose that the structured education programme described in this statement should include information on common type 2 diabetes co-morbidities. This will support patients to adopt improved lifestyle behaviours and provide patients with information to adopt healthy lifestyle behaviours and increase awareness of symptoms to support earlier detection or prevention of co-morbidities. These include cardiovascular disease, chronic kidney disease, non-alcoholic fatty liver disease, which are highly co-prevalent in type 2 diabetes: prevalent in 32.2% (Einarson et al. 2018), 34-51% (Lou et al. 2010) and 60% (Dai et al., 2017; Freidman et al. 2018) of T2D patients, respectively.  Whilst it is important to educate patients on the comorbidities associated with onset of T2D, outlined above, it is imperative that early diagnoses of these comorbidities be made since there are medicines that can improve these patients’ prognoses. Given the multifactorial nature of these comorbidities, patients should be offered multi-organ imaging at diagnosis to assess their potential comorbidities – See our response to Statement 5.  *References*   1. Dai W. et al. (2017). Prevalence of nonalcoholic fatty liver disease in patients with type 2 diabetes mellitus: A meta-analysis. *Medicine*, 96(39), e8179–e8179. 2. Einarson, T.R. Acs, A. Ludwig, C. and Panton, U.H. (2018). Prevalence of cardiovascular disease in type 2 diabetes: a systematic literature review of scientific evidence from across the world in 2007–2017. Cardiovascular diabetology, 17(1), 1-19. 3. Friedman S. Neuschwander-Tetri B. Rinella M. and Sanyal A. (2018). Mechanisms of NAFLD development and therapeutic strategies. *Nature Medicine*, 24(7), 908–922. 4. Lou A.L. et al. (2010). Prevalence of chronic kidney disease in patients with type 2 diabetes mellitus treated in primary care. Nefrologia, 30(5), 552–556. |
| 31 | Royal College of General Practitioners | Statement 2 | This statement could also use a timeframe to help guide care. It would be also helpful to understand who is responsible for setting and delivering this structured education programme and what the expected outcomes would be. |
| 32 | Royal College of Physicians of Edinburgh | Statement 2 | Fellows generally welcome the emphasis on structured education programmes, recognising they are an effective and cost efficient way of improving outcomes. |
| 33 | Xyla health and wellbeing | Statement 2 | This is a comprehensive statement, which has captured the vast majority of key areas for quality improvement. I would suggest that a comment on programme duration and duration service users have access to course content/other resources is added to the statement, to ensure long term sustainability of diabetes management. |
| 34 | Xyla health and wellbeing | Statement 2 | If appropriate please add comment around when outcomes are to be measured and by whom, e.g., repeat HbA1c tests post programme completed by primary care/providers. |
| 35 | Xyla health and wellbeing | Statement 2 | Can we please add clarity as to how many times a service user can be enrolled into a structured diabetes education programme? I.e., if they have completed the course in the last year, can they be re-referred? |
| 36 | Xyla health and wellbeing | Statement 2 | Regarding the resource required to ensure a translator or interpreter is available for all delivery of diabetes prevention and structured diabetes programmes, I feel this is a challenging request and would need sufficient financial support to implement. |
| 37 | Abbott Diabetes Care | Statement 3 | It is great to see the inclusion of intermittently scanned continuous glucose monitoring in this statement, supporting the recent changes to NG28 in regard to continuous glucose monitoring. However the eligibility descriptor does not reflect fully the defined patient cohort as per NG28 (1.6.17). The quality standard for Type 1 has a similar statement (3) around CGM being offered however it is reflecting the full cohort defined in NG17, could consistency here please be considered. |
| 38 | National Diabetes Audit | Statement 3 | This complex standard has several elements that are not presently part of any routine dataset e.g., ‘cognitive impairment’, ‘care worker dependence’, ‘healthcare worker BG monitoring dependence’ |
| 39 | Royal College of General Practitioners | Statement 3 | We welcome this statement as it will help address health inequalities experienced by those who have learning disabilities or cognitive impairment and ensure they receive high quality care. It would be helpful to understand how this statement would be assessed across healthcare boundaries and who would be expected to take responsibility for it. |
| 40 | Royal College of Physicians of Edinburgh | Statement 3 | The offer of intermittently scanned CGM to adults with type 2 diabetes and a learning disability or cognitive impairment who have multiple daily insulin injections, and adults with insulin-treated type 2 diabetes who need help from a care worker or healthcare professional to monitor their blood glucose, is welcome. |
| 41 | Diabetes UK | Statement 4 | We support this statement but note the update of the ‘Type 2 diabetes in adults’ [NG17] medicines section currently in progress, and the need for updates to the guideline to be considered within this quality standard in due time. |
| 42 | National Diabetes Audit | Statement 4 | Reasonable standard. NDA can measure who has been prescribed SGLT2s but not who has been offered SGLT2s. ACR is poorly performed in General Practice ~50% |
| 43 | NHS England, Diabetes Programme | Statement 4 | The point about SGLT2 inhibitors for people with chronic heart failure or established ASCVD is fine. The element about use in CKD is more problematic simply because it implies that an ACR over 30mg/mmol is needed before an SGLT2 inhibitor would be indicated for renal protection in people with type 2 diabetes. The SGLT2 inhibitor which is used in CKD is generally dapagliflozin - as it can be initiated down to an eGFR of 15 (and is also licensed for treatment of CKD). This has a NICE TA which does not require a minimum level of ACR before the agent is recommended in CKD in people with type 2 diabetes.  So essentially, the threshold stated in the draft quality standard, in relation to SGLT2i use in CKD, does not align with the TA for what is considered to be the most commonly used agent for this purpose.  It would be better if the quality standard did not state an ACR threshold but simply said 'Adults with type 2 diabetes and chronic heart failure or established atherosclerotic cardiovascular disease, or chronic kidney disease (CKD) on optimised standard care, are offered an appropriate SGLT2 inhibitor'. The use of the word ‘appropriate’ covers the point about different SGLT2s having different thresholds for use in T2DM and CKD in relation to ACR levels. |
| 44 | Perspectum Ltd | Statement 4 | This statement should be amended to include offering people with overlapping type 2 diabetes (T2D) and non-alcoholic steatohepatitis (NASH) certain pharmacological therapies and to highlight how such patients should be identified for eligibility:    Whilst the draft quality standards are right to highlight the importance of offering people living with T2D chronic heart failure or established atherosclerotic cardiovascular disease, or chronic kidney disease (CKD) with an albumin to creatinine ratio (ACR) over 30 mg/mmol on optimised standard care; this section appears to omit any recommendations for patients with overlapping T2D and NASH, the importance of which is highlighted in detail in our previous comments.  NICE should consider recommending GLP-1 RAs in people with overlapping T2D and NASH. Evidence suggests that patients living with these comorbid conditions respond well to medicines of this mechanism of action (MoA) (Newsome et al. 2021).Indeed, the most recent updates to clinical guidelines using evidence-based recommendations regarding the diagnosis and management of NAFLD and NASH to endocrinologists recommends (R3.31b): *“Clinicians must consider treating diabetes with pioglitazone and/or GLP-1 RAs when there is an elevated probability of having NASH based on elevated plasma aminotransferase levels and noninvasive tests”* This recommendation was supported by evidence graded Grade A, with best level of evidence Level 1. (Cusi et al. 2022)  Given the large numbers of patients expected to be assessed in clinic for this indication, it would be both unfeasible and unethical to identify / stratify NASH & T2D patients by liver biopsy. Liver corrected T1 (cT1) is the best non-invasive biomarker to accurately identify patients with NASH & F2-F3 fibrosis (Imajo et al.), an endpoint that aligns with the criteria of many clinical trials of potential NASH therapies.  Liver cT1 as part of a multiparametric MRI assessment should, therefore, be measured to non-invasively identify T2D patients with comorbid NASH that would benefit from GLP-1 RAs. Liver cT1 can predict clinical outcomes (Bradley et al. 2018; Pavlides et al. 2016; Jayaswal et al. 2020) and has shown diagnostic accuracy in identifying NASH in patients with T2D (Brown et al. 2020; Levelt et al. 2016; Waddell et al. 2020).  *References*  Bradley C et al. (2018) Multi-organ assessment of compensated cirrhosis patients using quantitative magnetic resonance imaging. Journal of hepatology, 69(5), 1015-1024.  Brown et al. (2020) Multiparametric magnetic resonance imaging of the liver demonstrates prevalence of steatohepatitis in patients with type 2 diabetes. Diabetologia, 63:876.  Cusi K et al. (2022) American Association of Clinical Endocrinology Clinical Practice Guideline for the Diagnosis and Management of Nonalcoholic Fatty Liver Disease in Primary Care and Endocrinology Clinical Settings. Endocrine Practice; 28: 528-56  Imajo K et al. (2020) Quantitative multiparametric magnetic resonance imaging can aid non-alcoholic steatohepatitis diagnosis in a Japanese cohort. World Journal of Gastroenterology, 27(7), 609–623.  Jayaswal A.N. et al. (2020) Prognostic value of multiparametric MRI, transient elastography and blood-based fibrosis markers in patients with chronic liver disease. Liver Int, 40:3071–3082.  Levelt et al. (2016) Ectopic and Visceral Fat Deposition in Lean and Obese Patients with Type 2 Diabetes. Journal of the American College of Cardiology, 68, 53–63.  Newsome et al. (2021) A Placebo-Controlled Trial of Subcutaneous Semaglutide in Nonalcoholic Steatohepatitis. N Engl J Med; 384:1113-1124  Pavlides M et al. (2016) Multiparametric magnetic resonance imaging predicts clinical outcomes in patients with chronic liver disease. J Hepatol, 64:308–315.  Waddell T et al. (2020) Multiparametric magnetic resonance imaging of the pancreas and liver in patients with type-2 diabetes mellitus. Diabetologia, 63:877. |
| 45 | Royal College of General Practitioners | Statement 4 | We welcome this statement as part of this quality standard. Many patients who would fall into this category are likely to be quite frail and so many have many contacts with both primary and secondary care. Because of this, it would be helpful for computer systems to track whether or not the patient has been offered an SGLT2 inhibitor to prevent repetition and wasted time. |
| 46 | Diabetic Foot Network Wales | Statement 5 | Would agree until sufficient evidence to increase frequency within foot screening is evident – link with NG19 |
| 47 | Healthy.io | Statement 5 | Regarding Quality Statement 5, urine albumin to creatinine ratio (ACR) testing is consistently the worst performing of the diabetes key care processes and is a key area for quality improvement, as detection of proteinuria is a key indicator for chronic kidney disease (CKD) and cardiovascular risk. |
| 48 | Healthy.io | Statement 5 | Regarding Quality Statement 5, further means and methods of encouraging greater levels of adherence to ACR testing will be important, as it is the worst performing key care process currently. While system incentives have been used previously to encourage greater adherence through the Quality Outcomes Framework (QOF), Healthy.io offers an alternative method of testing intended to improve uptake among previously untested/nonadherent patients. The CE-approved Minuteful Kidney test has demonstrated an average adherence of 54% to date among diabetes patients in England who had previously not completed a urine ACR test via the standard method in general practice for >12 months. Minuteful Kidney was awarded the AI in Health and Care Award and has been commissioned for c.640,000 across England as part of a programme via the Accelerated Access Collaborative. |
| 49 | National Diabetes Audit | Statement 5 | Core diabetes care. And a core part of NDA |
| 50 | Perspectum Ltd | Statement 5 | Statement 5 is accurate, but the care process is incomplete and would benefit from the inclusion of other diagnostics to evaluate comorbidities in the liver and heart too. Currently the care process comprises evaluation for risk factors of metabolic syndrome and eye and foot disease. However, as mentioned above:   1. There is a 60% co-prevalence of NAFLD and T2D (Dai et al., 2017; Friedman et al. 2018). Meta-analyses have also shown that patients with co-prevalent NAFLD and T2DM are also at higher risk of both liver-related (Wang et al. 2012; Bazick et al. 2015) and non-liver comorbidities, mainly cardiovascular (Targher et al. 2016, Khalid et al. 2020) and renal (Musso et al. 2014; Mantovani et al. 2018). 2. Recent evidence from >30,000 UK Biobank individuals suggests that chronic liver disease activity (measured by MRI metric cT1 but not when measured by blood-based scores FIB4 or AST/ALT ratio) is a strong risk factor independently associated with cardiovascular events (atrial fibrillation, heart failure, any major adverse cardiovascular event, cardiovascular hospitalisation) (Roca-Fernandez et al. 2022). The association to risk of cardiovascular hospitalisation was observed even in the absence of metabolic syndrome and indicated that the association with liver disease activity is independent from traditional cardiovascular risk factors such as obesity, hypertension, and even type 2 diabetes. These results highlight the prognostic relevance of a comprehensive evaluation of liver health in populations at risk of cardiovascular and/or liver disease, even in the absence of clinical manifestations or metabolic syndrome, when there is an opportunity to modify/address risk factors and prevent disease progression. This is in line with the NICE guideline NG49, which proposes that investigations for NAFLD and NASH should be performed for adults with T2D. Iron-corrected T1 mapping (cT1) is a marker of CLD activity, which has been shown to correlate with parenchymal ballooning, inflammation and fibrosis (Dennis 2020) and has been associated with histological disease activity in steatohepatitis (Andersson et al. 2021). cT1 has been shown to predict liver-related outcomes in patients with chronic liver disease (Jayaswal et al. 2020). cT1 has since been recognised by gastroenterology and endocrinology guidelines in the assessment of patients with NAFLD (Cusi 2022, Long 2022). cT1 can predict clinical outcomes (Pavlides et al. 2016; Jayaswal et al. 2020) and has diagnostic accuracy in identifying NASH in patients with T2D (Brown et al. 2020; Levelt et al. 2016; Waddell et al. 2020, 2021). 3. Additional evaluation of comorbidities can also be achieved by multi-organ MRI, to comprehensively assess abnormalities in the liver, kidney, pancreas, spleen, heart and lungs in a single 40-minute scan. Multi-organ MRI in patients with type 2 diabetes has demonstrated a high prevalence of both single organ abnormality including fatty infiltration and/or fibroinflammatory changes in the liver (73% of patients), pancreas (34%), spleen (44%), kidney (64%), aorta (67%) (Eichert et al., 2022). In addition, 86% of the same patients had abnormality in at least 2 organs. The high prevalence of co-morbidities in these organs in patients with type 2 diabetes is already established (Einarson et al. 2018; Lou et al. 2010; Dai et al., 2017; Freidman et al. 2018) and this technology could provide clinical information on these comorbidities efficiently and before clinical symptoms are apparent. As argued by the Chief Medical Officer for England, the high prevalence of co-morbidities in patients with T2D highlights the need to a multi-specialty approach to the monitoring of the disease (Whitty et al. 2020) and these should include multi-organ MRI technologies. Multi-organ MRI provides quantitative tissue characterisation of multiple organs as well as functional and structural information (Bradley et al. 2018; Chouhan et al 2018). Multi-organ MRI techniques have the potential to complement existing diagnostics by allowing clinicians to diagnose, monitor and stratify co-prevalent diseases in patients with T2D. 4. There is increasing evidence of licensed type 2 diabetes treatments that have beneficial effects in reducing the risk of comorbidities in the kidneys or heart (Kristensen et al. 2019; McGuire et al. 2020; Sattar et al. 2021) and reversing disease course in the liver (Newsome et al. 2021). Similarly, beneficial effects on the liver and pancreas have been observed with lifestyle management. The ReTUNE trial measured the impact of body weight loss on ectopic fat via MRI in T2D patients with a healthy weight (McCall 2021). Weight loss was able to induce remission in 67% of this patient population and correlated with a reduction in fat in the liver and pancreas (McCall 2021). In the DiRECT trial weight loss and fat reduction in liver and pancreas induced remission in obese T2D patients (McCall 2021).   Therefore, we recommend that tests to assess co-prevalent diseases including CVD and NASH are included in addition to the existing care processes for adults with T2D to enable earlier detection of complications and prevention or reversal of comorbidities.  *References*   1. Andersson, A. et al. (2021). Clinical Utility of Magnetic Resonance Imaging Biomarkers for Identifying Nonalcoholic Steatohepatitis Patients at High Risk of Progression: A Multicenter Pooled Data and Meta-Analysis. Clinical Gastroenterology and Hepatology, S1542-3565(21), 01056-9 2. Bazick et al. (2015) Clinical Model for NASH and Advanced Fibrosis in Adult Patients With Diabetes and NAFLD: Guidelines for Referral in NAFLD. 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| 51 | Royal College of General Practitioners | Statement 5 | We would welcome the promotion of fitness and activity for patients with T2D as international data shows that those who are deconditioned have poorer health outcomes than those who are fitter. Additionally, how will the key care processes be measured in different healthcare environments as many patients with T2D are seen in secondary care. If the expectation would be that this work would take place in primary care, how would it be funded? |
| 52 | Royal College of Physicians of Edinburgh | Statement 5 | The RCPE considers that annual screening for various blood tests, microalbuminuria, blood pressure, weight, and foot risk assessment are essential for early identification. Many of these tests have been simplified and do not necessarily need highly skilled personnel to perform them as before but the results are critical for optimal care and early warning of problems. |
| 53 | Royal College of Physicians of Edinburgh | Statement 5 | The RCPE believes that the prevention of foot ulcers is absolutely critical and that when ulcers develop it is often too late. We consider that prevention of foot ulcers requires risk stratification and first class podiatric services for those at high risk. |
| 54 | Diabetes UK | Statement 6 | We feel that the quality standard should highlight the importance of foot assessments in all settings in order to ensure prompt referral to specialist services.  This is because despite improvements in the proportion of severe and active ulcers being treated, which is linked to an increase in prompt referrals to specialist footcare teams, the NDFA Interval Review 2014-2021 found that 18% of people presenting with a severe ulcer either underwent a major amputation or died within one year. |
| 55 | Diabetic Foot Network Wales | Statement 6 | Would agree to support identification of existing problem and referral on appropriately and reduce risks to hospital acquired wounds |
| 56 | National Diabetes Audit | Statement 6 | Why has this one hospital harm been selected? There is no evidence that risk assessment leads to lower incidence. There is no way of measuring at present – would be dependent on universal hospital EPRs and structured admission records. |
| 57 | NHS England, Diabetes Programme | Statement 6 | We do not feel it is appropriate to have the foot quality statement for Type 1 diabetes to focus on limb and life threatening issues, whilst the foot quality statement for Type 2 diabetes focuses on when a person is admitted to hospital. Whilst we accept that different areas were prioritised for different quality standards, this nuance could be missed, undermining the message that the management across the foot pathway is the same for all types of diabetes. |
| 58 | Royal College of General Practitioners | Statement 6 | We would welcome clarification regarding the circumstances where this statement would be expected to take place. Patients with T2D could be admitted to hospital for a whole host of reasons that may have nothing to do with their diabetes and therefore what are the criteria needed for this statement to take place. There is also a QOF indicator already in place which seeks for diabetics to have a foot examination and risk classification every 12 months within primary care and would these assessments be shareable with secondary care to provide a full history if this assessment were to take place? |
| 59 | National Diabetes Audit | Additional areas | I would use the T1 foot ulcer referral standard in T2 as well |
| 60 | NHS England, Learning Disability and Autism Programme | Additional areas | We strongly recommend a Quality Standard on improving access and experience of diabetes care and support, ensuring that staff are supported with training to enable reasonable adjustments to be made to improve diabetes type 2 care and treatment for people with a learning disability.   * The Kings College London LeDeR report highlights that diabetes is a significant cause of avoidable death as identified by the LeDeR annual report 2021, with 17% of avoidable deaths being linked to diabetes ([KCL LeDeR main report](https://www.kcl.ac.uk/ioppn/assets/fans-dept/leder-main-report-hyperlinked.pdf) page 64 accessed on 18/10/2022). * Research shows that diabetes is more prevalent in people with learning disabilities than in the general population and that for those with a learning disability, the estimated prevalence is between 9 and 11% (compared with 4%–5% in the general population (research from: Holden & Lee, 2021 “Barriers and enablers to optimal diabetes care for adults with learning disabilities: A systematic review” available from: <https://onlinelibrary.wiley.com/doi/full/10.1111/bld.12393> [accessed on 18/10/2022]). * Research also shows that individuals with learning disabilities have a higher rate of hospital admission resulting from diabetes-related conditions that are usually managed in an outpatient or community setting (research from: Holden & Lee, 2021 “Barriers and enablers to optimal diabetes care for adults with learning disabilities: A systematic review” available from: <https://onlinelibrary.wiley.com/doi/full/10.1111/bld.12393> [accessed on 18/10/2022]). * See also: [NHS RightCare Pathway: Diabetes](https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/11/rightcare-pathway-diabetes-reasonable-adjustments-learning-disability-2.pdf)  2017 [accessed on 18/10/2022] : “Addressing reasonable adjustments for those with diabetes and a learning disability will not only improve diagnosis and detection of the condition but has other benefits including reductions in: * Complications arising from diabetes, e.g. amputations * Diabetes related A&E attendances * Missed appointments   Reasonable adjustments are seen to be particularly essential at the following:   * Tests and investigations * Structured support programmes * Weight management programmes * Supported self-management of diabetes * Personalised care planning” (NHS Rightcare Pathway, 2017:4)   See also:   * How to make reasonable adjustments to diabetes care for adults with a learning disability, available from: <https://www.diabetes.org.uk/professionals/resources/shared-practice/for-people-with-learning-disability> [accessed on 18/10/2022] * Why is improving diabetes care for people with a learning disability important? Available from:   <https://www.diabetes.org.uk/resources-s3/2018-02/Improving%20care%20for%20peeople%20with%20diabetes%20and%20a%20learning%20disability%20-%20Fact%20sheet%201.pdf> [accessed on 18/10/2022] |
| 61 | Diabetes UK | Additional areas | We feel that it is important that inpatient care is included as a stand-alone area of improvement in this guidance, as it is in the Type 1 diabetes draft standard.  The 2020 GIRFT report on diabetes notes the high incidence of medication errors in people with diabetes in hospital, as well as higher infection rates, longer lengths of stay and higher mortality than people without diabetes.  The National Diabetes Inpatient Audit also continues to make the long-standing recommendation that every unit should have a dedicated multidisciplinary team of specialist diabetes practitioners, in line with the NHS Long Term Plan, for inpatients with all types of diabetes.  Reference: [www.gettingitrightfirsttime.co.uk/wp-content/uploads/2020/11/GIRFT-diabetes-report.pdf](http://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2020/11/GIRFT-diabetes-report.pdf) |
| 63 | Royal College of Physicians of Edinburgh | Additional areas | Some Fellows wished to see reference to GLP1 Agonists which have been shown to have major benefit in patients with Cardiovascular disease. |

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## Registered stakeholders who submitted comments at consultation

* Abbott Diabetes Care
* Association of British Clinical Diabetologists (ABCD)
* Association of British HealthTech Industries (ABHI)
* Bayer
* Diabetes UK
* Diabetic Foot Network Wales
* Healthy.io
* National Diabetes Audit
* NHS England, Learning Disability and Autism Programme
* NHS England, Diabetes Programme
* Perspectum Ltd
* Royal College of General Practitioners
* Royal College of Physicians
* Royal College of Physicians of Edinburgh
* Xyla Health and Wellbeing

# Appendix 2: Quality standard consultation comments table – respondents with links to the tobacco industry

Bayer PLC declared that:

Current Situation

* Bayer does not have direct or indirect links with, or funding from, manufacturers, distributors or sellers of smoking products but Bayer provides pesticides for crops, which would therefore include tobacco crops.
* Bayer is a member of the Cooperation Centre for Scientific Research Relative to Tobacco (CORESTA) (http://www.coresta.org/) within the scope of recommendations of pesticides used for protection of tobacco plants.
* It is also a member of country and EU business federations such as the Confederation of British Industry (CBI) and ‘Business Europe’, which include tobacco companies.

Past Situation

In 2006, Bayer and its subsidiary Icon Genetics piloted a new process for producing biotech drugs in tobacco plants. Icon Genetics was acquired by Nomad Bioscience GmbH from Bayer in 2012.

| ID | Stakeholder | Section | Comments |
| --- | --- | --- | --- |
| 01 | Bayer PLC | Statement 4 | In order to consistently measure the denominator for this statement i.e., “the number of adults with type 2 diabetes and CKD with an ACR over 30 mg/mmol on optimised standard care”, there will need to be:  (1) A clear definition of CKD i.e., will it be defined by coded CKD or biochemical measures indicative of CKD?  Guidance on how optimised standard of care with ACE inhibitors/ ARB is defined, recorded and measured. |
| 02 | Bayer PLC | Statement 4 | It is proposed that the outcome “Progression of CKD in adults with type 2 diabetes and CKD” is measured using the following data source:  • The National Diabetes Audit’s report on complications and mortality, which includes data on the number of people with type 2 diabetes who have renal replacement therapy (end-stage kidney disease).  Whilst renal replacement therapy (RRT) is an important outcome measure, it is the “final stage” of CKD progression. As such, using RRT as a measure is not capturing disease progression but rather focusing on the “ultimate” endpoint. Is there another source that could be considered which would give a better measure of CKD progression? |
| 03 | Bayer PLC | Statement 5 | In order to drive clinical practice such that all key care processes are completed, we suggest that the statement be reworded:  “Adults with type 2 diabetes have all key care processes completed every 12 months”.  Historically, there has been mixed uptake of the care processes. As an example, the National Diabetes Audit 2019-20. Report 1: Care Processes and Treatment Targets. England and Wales (1), reports on the uptake of NICE recommended care processes and found that in 2019/20, for those with type 2 diabetes in England, 92.3% of patients had an annual check of serum creatinine, but only 68.6% had an annual check of urine albumin/creatine ratio (UACR). The values for Wales were similar for serum creatinine, but the testing of UACR was even lower at 55%. In addition, the marked variation in UACR measurement between CCGs was highlighted as a key finding of the report.  1. NHS Digital. National Diabetes Audit, 2019-20. Report 1: Care Processes and Treatment Targets. England and Wales. August 2021 |

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# Appendix 3: Quality standard consultation comments table – additional comments

| ID | Stakeholder | Section | Comments |
| --- | --- | --- | --- |
| 01 | Cumbria, Northumberland Tyne and Wear NHS Trust | Statement 3 | Intermittent scanned glucose monitoring would we ideal for this group of patient’s. However we have a patient on the autism ward who cannot tolerate these devices as they require a sensor on the skin that is in place 24/7. |
| 02 | Cumbria, Northumberland Tyne and Wear NHS Trust | Statement 4 | The BNF states that SGLT-2 Inhibitors cannot be used in patients with an eGFR of less than 60-also there is a risk of norm glycaemic ketoacidosis which would be difficult to detect in a learning disability patient group |
| 03 | Cumbria, Northumberland Tyne and Wear NHS Trust | Statement 6 | Assessment for diabetic foot problems-this would be brilliant, but the availability of podiatry is very poor in our area and we find it very difficult to source a professional who can even cut the toenails of our diabetic patients |

Note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.