NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE

Quality standards

Consultation summary report: Type 1 diabetes in adults

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

1. Introduction

The draft quality standard for type 1 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 14 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 appendix 1.

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? Should annual health checks for adults with type 1 diabetes be added as a new quality improvement area, either replacing one of the existing statements or as an additional statement? (see Section 5 for details)

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.

* support for the areas contained within the quality standard
* suggestion to highlight legal duties to consider reasonable adjustments in the relevant equality and diversity considerations sections.

### Consultation comments on data collection

Stakeholders commented that:

* the National Diabetes Audit (NDA) collects national data. Local level data is available through the Quality and Outcomes Framework
* suggestion for further data sets to be added to NDA to capture data such as numbers completing structured education
* local systems and structures may not be in place to collect data on patient satisfaction and quality of life
* in primary care the systems are generally in place but coding needs to be clear in SystmOne and Emis etc
* this should be measurable where electronic patients record and systems exist
* the SCI-diabetes system is an effective tool to gather information collected and operates as a clinical management system.

### Consultation comments on resource impact

Stakeholders commented that:

* not currently achievable so funding should be made available at local level
* these statements are desirable but may be expensive
* locally the quality statements should be achievable with net resources available
* all recommendations are being delivered to some extent by most localities so any deficits are due to resource allocation
* for primary care it is achievable but this is additional workload
* delivery of the statements within current resources is possible but reporting will be challenging without simple processes for data collection and reporting.

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

Adults with type 1 diabetes are offered a structured education programme 6 to 12 months after diagnosis. [2011, updated 2016]

### Consultation comments

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

Statement

* support for the inclusion of this statement
* suggestion to remove the timescale, with a couple of stakeholders querying why this is 6 months following diagnosis.

Measures

* process measures b and c need to have time limits for measurement purposes
* suggestion to measure the number who have not been offered structured education in their lifetime but are more than 12 months since diagnosis
* suggestion to use a 6 - 18 month window as the initiatives to improve quality and hit QOF targets are often done on an annual basis in primary care
* outcome measures should include better glycaemic control, reducing complications and people’s experience of care.

Definitions

* suggestion to clarify the age people are classed as adults and therefore when they would need to be offered a structured education programme.

Data collection

* data may be difficult to collect as the majority of type 1 diabetes care is delivered by specialist services, especially in the years after diagnosis.

Resource impact

* additional specialist staff and specialist staff training required
* potential cost savings as people will be more confident to self-manage, reducing clinician time and potential savings on drug costs and managing complications.

### Issues for consideration

#### For discussion:

* note: the guideline recommendation supporting this quality statement was based on Guideline Development Group (GDG) consensus. The GDG felt that the first few months post diagnosis are a period of considerable adjustment and that trying intensive education at this stage would be less worthwhile and even counter-productive. The consensus was that for most people it would be worthwhile enrolling in DAFNE (or similar) from a time point of 6-12 months post diagnosis
* the evidence for the type 2 diabetes education statement is different. The statement in that quality standard is currently: Adults with type 2 diabetes are offered a structured education programme at diagnosis
* the quality standard covers adults aged 18 and over. This can be added to the overview at the beginning of the quality standard

#### For decision:

* should this quality statement remain in the quality standard?
  1. Draft statement 2

Adults with type 1 diabetes in hospital are offered advice from a multidisciplinary team with expertise in diabetes. [2011, updated 2016]

### Consultation comments

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

Statement

* support for this statement
* one stakeholder was unclear whether this would be annual, or done every time a person with type 1 diabetes is in contact with the health system.

Measures

* this statement is positive but there is currently no way to measure it
* the patient satisfaction outcome measure is not in the National Diabetes Audit
* suggestion to include the following outcome measures:
  + - patient’s experience of care
    - supported self-care / able to self-manage

Resource impact

* additional specialist staff and specialist staff training required.
* may be challenging, information is needed on how this would be funded.

### Issues for consideration

#### For discussion:

* does the committee think that the statement wording makes it clear when the advice should be given as one stakeholder found this confusing.

#### For decision:

* should this quality statement remain in the quality standard?
* should the outcome measure on supported self-care / ability to self-manage whilst an inpatient be included?
  1. Draft statement 3

Adults with type 1 diabetes are offered a choice of real-time continuous glucose monitoring (rtCGM) or intermittently scanned continuous glucose monitoring (isCGM). [2022]

### Consultation comments

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

Statement

* this is largely done in secondary care for people with type 1 diabetes.

Measures

* it is difficult to measure the impact of CGM on health-related quality of life
* outcomes are better glycaemic control, overall experience of care and patient empowerment.

Equality and diversity considerations

* people from deprived communities are likely to be managed in primary care. Funding and training in primary care is needed to reduce inequality in this area.

Data collection

* the National Diabetes Audit measures isCGM use at individual patient level and, as prescribing of rtCGM increases, a complementary measure will be included
* mechanisms to record the activity are available in primary and community care, subject to consistent coding
* data collection should be straight forward once coding is clear.

Resource impact

* funding is needed to deliver this and provide the relevant education if this is done in primary care where many people with type 1 diabetes are managed
* achieving this while addressing inequality in access is difficult without additional education resource directed at primary care
* significant workload in primary and secondary care could be caused if all patients accept CGM
* some technologies offer the opportunity for virtual training and give potential for more efficient care delivery and resource use.

### Issues for consideration

#### For discussion:

* stakeholders commented there could be a resource impact if all people with type 1 diabetes accept CGM
* stakeholder commented that people from deprived communities are likely to be managed in primary care. Is this the case?

#### For decision:

* should this quality statement remain in the quality standard?
  1. Draft statement 4

Adults with type 1 diabetes who are over 40 or who have had type 1 diabetes for more than 10 years are offered statins for the primary prevention of cardiovascular disease (CVD). [2022]

### Consultation comments

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

Statement

* support for the statement
* agreement with the section of the statement for people over 40 years
* one stakeholder interpreted this as stating they have to wait ten years before prescribing a statin to someone over the age of 40 if their QRISK3 > 10%
* there should be a risk evaluation. There is little evidence to start statins for all 18yr olds who have diabetes since childhood
* as statins are contraindicated in pregnancy this should not apply to the young female population as risks outweigh the benefits
* many patients who have hospital follow ups are not routinely offered statins
* the statement is achievable in primary care if the patient is seen there.

Measures

* non-HDL cholesterol is a more relevant outcome measure than total cholesterol in response to statin therapy.

Data collection

* the National Diabetes Audit reports on the prescription of statins. It does not report on statins in people with type 1 diabetes for over 10 years aged under 40 but that could be added
* data collection in primary care is routinely done in many areas already.

Resource impact

* potential cost savings if people have access to statins at an earlier age and at a reduced length of time since diagnosis
* this statement could be used on the principle of no further regular lipid monitoring being required to minimise use of resources.

### Issues for consideration

#### For discussion and decision:

* should this quality statement remain in the quality standard in its current form?
* some stakeholders were uncomfortable with including the under 40s population. Should this remain in the statement?
  1. Draft statement 5

Adults with type 1 diabetes who have a limb-threatening or life-threatening diabetic foot problem are referred immediately for specialist assessment and treatment. [2011, updated 2022]

### Consultation comments

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

Statement

* support for quality statement
* the quality issue is that clinical staff may not realise the problem is life or limb threatening, not the pathway once recognised
* many limb or life-threatening problems start with active foot disease which was not seen by the correct team in a timely manner
* the prevention of foot ulcers is critical and when ulcers develop it is often too late
* suggestion to focus on primary care and all active foot problems
* suggestion to reword to:
  + adults with type 1 diabetes who have an active foot problem should be referred immediately to a multidisciplinary diabetic foot care service
  + adults with limb or life-threatening foot problem should be referred immediately to a centre with the surgical, radiological and technological infrastructure necessary to try and avoid amputation
* suggestion to ensure the quality statements in the type 1 and type 2 diabetes quality standards on foot care are the same

Measures

* to measure ‘referred immediately’ would require comprehensive primary, community and hospital electronic patient records and structured records for diabetic foot disease referrals
* the statement is achievable but difficult to measure.

Definitions

* suggestion to clarify what is meant by ‘immediate’ (for example, referred the same day and assessed within 24/48 hours) and ‘specialist assessment’.

Resource impact

* centres with an active vascular centre with orthopaedic input and an active interventional radiology centre are not adequately resourced or staffed
* foot assessment is often completed by health care assistants and general nurses meaning training is needed to assess appropriately and make urgent referrals

### Issues for consideration

#### For discussion:

* annual checks, which include annual foot reviews, are included under section 5 for discussion for inclusion in the quality standard
* statement in type 2 diabetes quality standard relates to inpatients being assessed for their risk of developing a diabetic foot problem.
* should the statements in the quality standards align and, if so, what should the focus be?

#### For decision:

* should this quality statement remain in the quality standard?
* should this statement be replaced by a statement on annual checks (section 5 of this paper) which includes annual foot reviews?
  1. Draft statement 6

Adults with type 1 diabetes are referred to specialist services if mental health problems interfere significantly with their wellbeing or diabetes self management. [2022]

### Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

Statement

* support for this statement
* there is no evidence base to determine the treatment pathway for people with these conditions or with the mental disorders mentioned
* an assessment should be done to determine the support needed, for example peer support, a diabetes-specialist psychologist or in-patient admission
* at every diabetes appointment people should be asked how they feel
* suggestion to include more information on the emotional and psychological support that can be provided by non-specialist healthcare professional
* as diabetes distress is part of diabetes management, it should be addressed by a diabetes health professional, or GP if they are the main health professional
* suggestion to include a timescale in the statement.

Rationale

* this includes a mixture of mental health disorders and circumstances that, whilst burdensome for patients, are not recognised mental disorders.

Measures

* process measure is hard to measure as ‘mental health problems that interfere significantly with their wellbeing or diabetes self management’ is not clear.

Definitions

* define ‘interfere significantly’
* it is not clear which specialist service the person should be referred to so this should be defined.

Data collection

* the National Diabetes Audit separately reports on people with diabetes and severe mental illness and includes data on referrals to psychology services.

Resource impact

* specialist mental health services with skills in supporting people with diabetes is needed to deliver this.

### Issues for consideration

#### For discussion:

* several stakeholders asked for clarity around this quality statement: who is making the referral, when should the referral be made, where is the referral being made to, who is completing an assessment etc.

#### For decision:

* should this quality statement remain in the quality standard? if so, significant levels of clarity need to be added that are not in the guideline.

1. Suggestions for additional statements

### Consultation comments on question 1

Should annual health checks for adults with type 1 diabetes be added as a new quality improvement area, either replacing one of the existing statements or as an additional statement?

Stakeholder feedback:

* support for this to be included as a quality statement
* suggestion to include review of treatment regime and potential further treatment options
* suggestion to include the same annual care processes as for type 2 diabetes
* statement supporting information will need to identify the specific checks to be carried out
* it is the responsibility of primary or acute clinicians to ensure that the processes are undertaken.

#### Selected recommendations

NICE’s guideline on type 1 diabetes (NG17):

1.2.7 Use population, practice‑based and clinic diabetes registers (as specified by the [Department of Health and Social Care's national service framework for diabetes](https://www.gov.uk/government/publications/national-service-framework-diabetes)) to assist programmed recall for annual reviews and assessments of complications and cardiovascular risk.

1.6.1 Measure HbA1c levels every 3 to 6 months in adults with type 1 diabetes.

1.13.2 Assess cardiovascular risk factors annually, including:

* estimated glomerular filtration rate (eGFR) and urine albumin:creatinine ratio (ACR)
* smoking
* blood glucose control
* blood pressure
* full lipid profile (including high-density lipoprotein [HDL] and low-density lipoprotein [LDL] cholesterol, and triglycerides)
* age
* family history of cardiovascular disease
* abdominal adiposity.

1.13.5 Give adults with type 1 diabetes who smoke advice on stopping smoking and stop smoking services, including NICE guidance‑recommended therapies (see the NICE webpage on smoking and tobacco). Reinforce these messages annually for people who currently do not plan to stop smoking, and at all clinical contacts if there is a prospect of the person stopping.

1.15.6 Encourage adults to attend eye screening, and explain that it will help them to keep their eyes healthy and help to prevent problems with their vision. Explain that the screening service is effective at identifying problems so that they can be treated early.

1.15.10 Ask all adults with type 1 diabetes, with or without detected nephropathy, to bring in the first urine sample of the day ('early morning urine') once a year. Send this for estimation of albumin:creatinine ratio (estimating urine albumin concentration alone is a poor alternative) and measure eGFR at the same time. See [NICE's guideline on chronic kidney disease](https://www.nice.org.uk/guidance/ng203).

1.15.39 Measure blood thyroid‑stimulating hormone (TSH) levels in adults with type 1 diabetes at their annual review.

NICE guideline on diabetic foot problems (NG19):

1.3.3 For adults with diabetes, assess their risk of developing a diabetic foot problem at the following times:

* When diabetes is diagnosed, and at least annually thereafter (see the recommendation on carrying out reassessments at intervals, depending on the person's risk of developing a diabetic foot problem).

1.3.7 For people who are at low risk of developing a diabetic foot problem, continue to carry out annual foot assessments, emphasise the importance of foot care, and advise them that they could progress to moderate or high risk.

1.3.11 Depending on the person's risk of developing a diabetic foot problem, carry out reassessments at the following intervals:

* Annually for people who are at low risk.
* Frequently (for example, every 3 to 6 months) for people who are at moderate risk.
* More frequently (for example, every 1 to 2 months) for people who are at high risk, if there is no immediate concern.
* Very frequently (for example, every 1 to 2 weeks) for people who are at high risk, if there is immediate concern.

Consider more frequent reassessments for people who are at moderate or high risk, and for people who are unable to check their own feet.

### Issues for consideration

#### For discussion:

* This was discussed and not prioritised in the first QSAC. Whilst the committee felt this is fundamental to diabetes care, they considered that it is addressed by the national diabetes audit and the Quality and Outcomes Framework (QOF).
* The question was asked at consultation as there is a quality statement in the type 2 diabetes quality standard in this area.
* Statement in the type 2 diabetes quality standard is: Adults with type 2 diabetes have key care processes completed every 12 months.
* The key care processes are taken from the [National Diabetes Audit](https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-audit/core):
  + urine ACR measurement
  + HbA1c measurement
  + blood pressure measurement
  + foot surveillance
  + serum creatinine measurement
  + cholesterol measurement
  + BMI measurement
  + smoking status
  + retinal screening.
* Note that similarly to the type 2 diabetes guideline, the 12-month timeframe for recording of serum creatinine, BMI and retinal screening is not derived from NICE guidance. It can be used as a practical timeframe to enable stakeholders to measure performance. The timeframe is used in the [National Diabetes Audit](https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-audit/core) and the [NHS diabetic eye screening programme](https://www.gov.uk/guidance/diabetic-eye-screening-programme-overview).

#### For decision:

* Should a statement in this area be included? If so, should it match the wording of the statement in the type 2 diabetes quality standard?

### Other additional areas suggested by stakeholders

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

* offer a choice of a continuous subcutaneous insulin infusion (CSII) device or insulin pump therapy
* equalities
  + equity in access and choice for people living with T1D
  + less successful care and outcomes in younger people
  + improving access and experience of diabetes care and support for people with a learning disability.
* retinal screening
* one third of people have sustained high-risk hyperglycaemia.

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

| ID | Stakeholder | Section | Comments |
| --- | --- | --- | --- |
| Question 1 – General | | | |
| 1 | Association of HealthTech Industries (ABHI) | Question 1 | **Question 1 - Does this draft quality standard accurately reflect the key areas for quality improvement?**  The key areas identified for improvement accurately reflect the areas that require quality improvement.  We believe that all technologies which can enable effective diabetes management should be available for people with type 1 diabetes  An additional statement: ‘Adults with type 1 diabetes are offered a choice of a Continuous subcutaneous insulin infusion (CSII) device or 'insulin pump' therapy as recommended by NICE TA151’, should be added as a quality improvement area.  Efforts have been made to increase the uptake of CSII with the uptake in adults in England doubling since 2012, but the rate of uptake is still below that in the Nordic countries, Germany or the US.  2018 - BP\_DTN\_v13 FINAL.pdf (abcd.care)  There should also be a standard aimed at driving the need for equity in access and choice for people living with T1D. |
| 2 | Addenbrookes Hospital Cambridge University Hospitals NHS FT | Question 1 | Use of pump therapy is not included in the draft quality standard. This is a key area for quality improvement, especially given the significant variation across regions |
| 3 | 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 |
| 4 | National Diabetes Audit (NDA) | Question 1 | NDA analyses have identified: less successful care and outcomes in younger people; and the one third of people with sustained high-risk hyperglycaemia as priorities for improvement. |
| 5 | NHS England | General | 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 1 care and treatment for people with a learning disability.  Evidence:   * 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] |
| 6 | NHS England | Question 1 | Does this draft quality standard accurately reflect the key areas for quality improvement?  Yes: See comments on specific statements |
| 7 | Royal College of Nursing | General | Agree the need to split the quality standard for type 1 and type 2, albeit there will be significant overlap |
| 8 | 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 have some concerns that the draft quality standard does not make sufficient mention of retinal screening. 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. |
| Question 1 – annual reviews | | | |
| 9 | Association of HealthTech Industries (ABHI) | Question 1 | Annual health checks for adults with type 1 diabetes should be added as a new quality improvement area as an additional statement. It should also include review of treatment regime and potential further treatment options. |
| 10 | Diabetes UK | Question 1 | We think that this draft standard reflects the key areas for improvement but strongly feel that annual health checks for people with type 1 diabetes should be included in an additional quality statement.  Annual checks are essential for ensuring people with diabetes receive consistent care to improve their health and reduce complications, and there has been a marked drop-off in the completion of annual checks according to data from the latest National Diabetes Audit. The 2020-21 audit reported 27% of people in England with type 1 diabetes received all their recommended checks, compared with 42% in 2019-2020.  Furthermore, a recent study investigating the link between poor care process completion and non-Covid related mortality has found an increased risk of mortality in those who did not receive all eight care processes in one or both of the previous two years.  This data showing a significant drop in care process completion and emerging evidence on the impact this has on mortality clearly demonstrates the need for this to be a key area for improvement in this quality standard, as it is in the corresponding draft quality standard for adults with type 2.  Reference: <https://www.thelancet.com/journals/landia/article/PIIS2213-8587(22)00131-0/fulltext> |
| 11 | Diabetic Foot Network Wales | Question 1 | Would suggest same annual care processes included as in type 2 |
| 12 | Greater Manchester and Eastern Cheshire Strategic Clinical Networks | Question 1 | Annual health checks for adults with type 1 should be included as a standard and it is the responsibility of clinicians primary or acute to ensure that the processes are undertaken. |
| 13 | NHS England | Question 1 | Health checks – this is a separate question. We need to define exactly what this is – there are already the nine care processes which is a burden on the patient already and the activity of a health check is already included. – drop this comment. It is about getting the existing checks done properly to start. |
| 14 | Royal College of Nursing | Question 1 | Standard reflects key areas but minimal requirements for annual checks should be added as an additional statement |
| 15 | Royal College of Physicians of Edinburgh | Question 1 | 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. |
| 16 | Sheffield Teaching Hospitals NHS Foundation Trust | Question 1 | We suggest you add this as an additional statement. The highest risk individuals are those where the system has failed to engage people with routine screening. |
| Question 2 | | | |
| 17 | Association of HealthTech Industries (ABHI) | Question 2 | The level of information that has been presented within the National Diabetes Audit points to this not being the case currently in both the quality of data in the NDA and the number of centers contributing. Therefore, additional resource and guidance regarding collection of data would be welcomed. |
| 18 | Addenbrookes Hospital Cambridge University Hospitals NHS FT | Question 2 | Local systems and structures may not be in place to collect data on patient satisfaction and quality of life. |
| 19 | Diabetic Foot Network Wales | Question 2 | Should be measurable where electronic patients record/ systems exist |
| 20 | Greater Manchester and Eastern Cheshire Strategic Clinical Networks | Question 2 | In Greater Manchester it is expected that in time we can collect data centrally. |
| 21 | National Diabetes Audit (NDA) | Question 2 | Please see comments on statements |
| 22 | NHS England | Question 2 | In primary care the systems are generally in place, but as with any new target, coding needs to be precise and clear -- this is important.  See comments on specific statements. |
| 23 | Royal College of Nursing | Question 2 | NDA will collect data from a national perspective. Local level implementation data via QoF. Additional data sets should be added to NDA to capture data which is currently reliant on variable sources, such as numbers completing structured education |
| 24 | 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. |
| 25 | Sheffield Teaching Hospitals NHS Foundation Trust | Question 2 | Some of these questions will be easier to answer than others, but by making them part of the quality standard it will help us gain more data analytic time from within our trust to help improve the quality of the service we provide. In addition, some of these statements would be easier to report on, if read codes within SystmOne / Emis existed, eg., offered rtCGM. A request from NICE for these read codes to be created would greatly facilitate data collection and reporting. |
| Question 3 | | | |
| 26 | Association of HealthTech Industries (ABHI) | 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?**  No. Therefore, adequate funding should be made available at local service level to ensure the quality standards are achieved.  **Please describe any resource requirements that you think would be necessary for any statement.**  See statements 1, 2, 3, and 6 for specific comments.  **Please describe any potential cost savings or opportunities for disinvestment.**  See statement 3 for specific comments. |
| 27 | Association of HealthTech Industries (ABHI) | Question 3 | **Please describe any resource requirements that you think would be necessary for any statement.**  Additional Statement outlined in Q1 – specialist trained staff to implement and support use of CSII therapy. |
| 28 | Addenbrookes Hospital Cambridge University Hospitals NHS FT | Question 3 | Difficult to comment on this nationally. In our region the quality statements should be achievable with net resources available. |
| 29 | National Diabetes Audit (NDA) | Question 3 | All recommendations are being delivered to some extent by most localities so I would conclude that if there are deficits it is down to resource allocation |
| 30 | NHS England | Question 3 | For primary care, as in all cases, it is achievable but this it is a further a creeping of workload for primary care. Should be included in the quality frameworks but the discussion with statin for example needs to be resourced – It is more work for primary care and as such should be funded specifically --i.e. attach adequate QOF points to the activity.  See comments on specific statements |
| 31 | 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. |
| 32 | Sheffield Teaching Hospitals NHS Foundation Trust | Question 3 | Delivery of the statements within current resources is possible but reporting on them will be challenging without simple processes in place around data collection and reporting, see answer to Q2. |
| Question 4 | | | |
| 33 | National Diabetes Audit (NDA) | Question 4 | I would use the T2 care processes standard for T1 as well. |
| 34 | NHS England | Question 4 | Questions about the individual quality statements  See below for comments on the statements. |
| Statement 1 | | | |
| 35 | Addenbrookes Hospital  Cambridge University Hospitals NHS FT | Statement 1 | Suggest that the duration is not specified – “Adults with Type 1 diabetes should complete a structured education program”. |
| 36 | Association of HealthTech Industries (ABHI) | Question 3 – Statement 1 | **Please describe any resource requirements that you think would be necessary for any statement.**  With reference to statement 1 Broad training and regular updates for all clinical service staff on options and innovation for treatments of T1D.  Additional specialist staff and specialist staff training required. |
| 37 | Diabetic Foot Network Wales | Statement 1 | Agree with supported education but when person with diabetes is activated to participate otherwise we could be setting them and us to fail |
| 38 | Greater Manchester and Eastern Cheshire Strategic Clinical Networks | Statement 1 | Why should structured education have to be at least 6 months after diagnosis? |
| 39 | Greater Manchester and Eastern Cheshire Strategic Clinical Networks | Question 3 | Statement 1 if amended as per below could have potential cost savings longer term as people will be more confident to self-manage reducing clinician time and savings on future drug costs and management of complications. |
| 40 | National Diabetes Audit (NDA) | Statement 1 | This is sensible. The NDA has a measurement system in place. It is reliable for primary care data but patchy for specialist care data because a large number of specialist services still do not have electronic records. Because the majority of Type 1 care is delivered by specialist services, especially in the years after diagnosis, data quality is imperfect. |
| 41 | NHS England | Question 1 – Statement 1 | Does this draft quality standard accurately reflect the key areas for quality improvement?  Yes: -- Quality Standard 1 – Absolutely—regarding Structured Education (SE) . However in the text there are three sections to the “process” and “b” and “c” have no time limits… need to be specific that they related to those referred in part “a”. The monitoring of part b and c should be by the provider of the SE and commissioned as part of the SE. Sections “b” and “c” should not be included in primary care quality targets but yes included in overall quality.  We could also measure the number who have been offered SE attended in their lifetime, as a separate measure and it will pick up those you have not had SE as yet but are more than 12 months since diagnosis.  Regarding SE – I would recommend an interval be changed to 6-18 month window, and the initiatives to improve quality and hit QOF targets are often done on an annual basis in primary care in preparation for QOF. Many patients will miss out as they will fall outside the time window when the practices do the annual data improvement activity and search for eligible patients. |
| 42 | NHS England | Question 2 - Statement 1 | In primary care the systems are generally in place, but as with any new target, coding needs to be precise and clear -- this is important.  Quality Standard 1 as above |
| 43 | NHS England | Question 3 – Statement 1 | For primary care, as in all cases, it is achievable but this it is a further a creeping of workload for primary care. Should be included in the quality frameworks but the discussion with statin for example needs to be resourced – It is more work for primary care and as such should be funded specifically --i.e. attach adequate QOF points to the activity.  QS1 – see comments above – I would change guidance to 6-18 months to allow primary care to pick up on an annual basis. |
| 44 | NHS England | Statement 1 | As above regarding SE. – Outcome should include better glycaemic control reducing complications as well as their experience of care. |
| 45 | Royal College of General Practitioners | Statement 1 | It would be good to clarify when a patient with T1DM becomes adult and therefore when they would first need to be offered a structured education programme.  Would waiting 6-12 months for an education programme a bit too late for a person newly diagnosed with T1DM? |
| 46 | Royal College of Nursing | Statement 1 | Where data is not available (i.e.: proportion of adults who attend structured education) – can this be added to NDA audit? |
| 47 | Royal College of Nursing | Question 3 – Statement 1 | Variables is present across different localities as to the type of structured education provided – so deriving a true comparison in uptake etc. is difficult because of this.  Resources, cost savings etc |
| 48 | Royal College of Physicians of Edinburgh | Statement 1 | Fellows generally welcome the emphasis on structured education programmes, recognising they are an effective and cost efficient way of improving both short and long term outcomes. In addition consideration of adoption of the newer app technology integrating education and patient engagement should be considered. |
| 49 | Sheffield Teaching Hospitals NHS Foundation Trust | Statement 1 | Whilst this is an important measure it only captures a fraction of the population living with type 1 diabetes, as most people have had the condition for over 12 months. Therefore, we suggest that either the time frame be removed entirely, or that another statement be added to say all adults should be offered structured education. We also need to recognise that offered is not the same thing as attendance, so we need to measure this within the first year and beyond as well. A blanket letter to all could for instance give 100% offered, but if it is not follow-up by 1:1 conversations then the conversion to attendance is likely to be very low. |
| Statement 2 | | | |
| 50 | Addenbrookes Hospital  Cambridge University Hospitals NHS FT | Statement 2 | Outcome – Patient satisfaction. The National Diabetes Inpatient Safety Audit does not collect data on these domains. The NaDIA audit which did has not been conducted for some time. Even then it was a resource intensive mechanism. Local surveys may the only current mechanism but experience from NaDIA suggests that return rates are about 50% or less and less well patients who need the most input are less likely to be able to participate. Besides this is resource intensive especially for smaller inpatient teams who struggle meeting demands of provision of care. Suggest a metric around empowering those able to self-manage and having policies in place to support this – this was still not being met as per last NaDIA audit. This may be more measurable as for eg number of patient on “self-administered medication” may be auditable by electronic means. |
| 51 | Association of HealthTech Industries (ABHI) | Question 3 – Statement 2 | Broad training and regular updates for all clinical service staff on options and innovation for treatments of T1D.  Additional specialist staff and specialist staff training required. |
| 52 | National Diabetes Audit (NDA) | Statement 2 | This is desirable. But there is no way presently of measuring it. Until there are universal enterprise wide hospital EPRs I cannot envisage a practicable way of measuring compliance. |
| 53 | NHS England | Question 1 – Statement 2 | Does this draft quality standard accurately reflect the key areas for quality improvement?  Quality Standard 2 – difficult to comment as this is for secondary care. |
| 54 | NHS England | Question 2 - Statement 2 | Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  Quality Standard 2 – N/A to primary care |
| 55 | NHS England | Question 3 – Statement 2 | 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.  QS2 – N/A in primary care |
| 56 | NHS England | Statement 2 | Outcome should include Patient’s experience of care enhanced.  Supported self-care should be a goal and included in the headline of the standard  Unable to comment on data collection as this is secondary care. |
| 57 | Royal College of General Practitioners | Statement 2 | We would welcome clarification on the specifics of this statement, including whether it should be undertaken annually, or every single time a patient with T1D comes into contact with the health system regardless of the reason. Additionally, how would this be assessed as it may not always be needed and what would the scope of definition for a multidisciplinary team be. We feel that this statement may end up being quite challenging for our hospital colleagues and would welcome more information on how this sort of service would be funded. |
| Statement 3 | | | |
| 58 | Addenbrookes Hospital  Cambridge University Hospitals NHS FT | Statement 3 | “Health related quality of life in adults with Type 1 diabetes” as a quality measure for CGM provision will be hard to measure as QoL is multifactorial and will be difficult to measure the impact of CGM alone. |
| 59 | Association of HealthTech Industries (ABHI) | Question 3 – Statement 3 | **Please describe any resource requirements that you think would be necessary for any statement.**  With reference to statement 3: Broad training and regular updates for all clinical service staff on options and innovation for treatments of T1D.  Additional specialist staff and specialist staff training required.  **Please describe any potential cost savings or opportunities for disinvestment.**  Technologies that offer the opportunity for remote/virtual training and more efficient onboarding for all users should be prioritised as they offer the potential for more efficient care delivery and resource use.  Statement 3 – The use of algorithms to support CGM use, where CGM and CSII criteria is fulfilled the use of an algorithm to increase Time In Range (TIR) should be encouraged.  As well as TIR being increased relating to better long-term outcomes, the training required is reduced significantly with certain algorithms since there is little intervention required. |
| 60 | National Diabetes Audit (NDA) | Statement 3 | In my opinion this is an important standard. The NDA does not measure offers of CGMS, other than for pregnant women, but it does have a comprehensive system for measuring isCGMS use at individual patient level and, as prescribing of rtCGMS gathers pace, there will be a complementary system for measuring usage of that modality as well. |
| 61 | NHS England | Question 1 – Statement 3 | Does this draft quality standard accurately reflect the key areas for quality improvement?  Quality Standard 3. – Provision of CGM. For patients with Type 1 this is largely done in 2nd care. However a significant number of patients with Type1 are managed in the community. For the community, this is a development area (due to recent NICE guidance for type 2 on insulin) and this activity needs to be resourced. It is a new service and gradually coming online and very sporadic as currently the support required is not funded. This is another example of increasing primary care service delivery. Mechanisms to record the activity are there (subject to consistent coding) but the activity if provided for patients with Type 1 in primary care must be funded. |
| 62 | NHS England | Question 2 – Statement 3 | Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  In primary care the systems are generally in place, but as with any new target, coding needs to be precise and clear -- this is important.  Quality Standard 3 – as above, as the service develops in primary care for type 2 diabetes, we will offer it to type 1, but, as stated above, coding needs to be clarified and additional funding is needed as this activity is resource hungry. |
| 63 | NHS England | Question 3 – Statement 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.  QS3 – CGM – Yes but more investment is needed as the education(for patient and professional) is resource intensive. Achieving this while addressing inequality in access is difficult without additional education resource directed at primary care. Data collection should be straight forward once coding is clear. |
| 64 | NHS England | Statement 3 | Outcome is better glycaemic control and patient empowerment. Better overall experience of care. The outcomes are giver here as the metrics – needs to be updated.  In primary care this will be creeping work and needs funding. Many patient with Type 1 are managed in primary care.  Patient from deprived communities are more likely to be managed in primary care. To address the inequality agenda here will require more funding and training in primary care. |
| 65 | Royal College of Nursing | Question 4 – Statement 3 | Statement 3: At local centre, dietitians run sensor start clinics to free DSN time and are well placed as can tie in with CHO counting |
| 66 | Royal College of Nursing | Statement 3 | Depending on preference / clinical need in addition, at lowest acquisition cost. ? add metrics no routinely collected nationally to NDA |
| 67 | Royal College of Physicians of Edinburgh | Statement 3 | The RCPE welcomes the proposal to expand the use of real-time continuous glucose monitoring (rtCGM) which will increase choice and allow many individuals to respond more quickly to changes in blood glucose levels. It is also to be welcomed that there is a recognition of the equality and diversity considerations in relation to access to this technology and the need to address inequalities in CGM access and uptake. |
| 68 | Royal College of General Practitioners | Statement 3 | This statement has the potential to cause a significant workload referral in both primary and secondary care if all patients were to accept this. Would the expectation be that this question would be asked at all primary and secondary care reviews with an expectation of coded documentation? |
| Statement 4 | | | |
| 69 | Addenbrookes Hospital Cambridge University Hospitals NHS FT | Statement 4 | Non-HDL cholesterol is a more relevant outcome measure than total cholesterol in response to statin therapy. |
| 70 | Greater Manchester and Eastern Cheshire Strategic Clinical Networks | Statement 4 | Why should one wait ten years before prescribing a statin to someone over the age of 40 if their QRISK3 > 10%? |
| 71 | Greater Manchester and Eastern Cheshire Strategic Clinical Networks | Question 3 | Statement 4 also if people could have access to statins at an earlier age and reduced length of time since diagnosis. |
| 72 | National Diabetes Audit (NDA) | Statement 4 | This is a good QS. Prescriptions of statins, but not offers of statins, have been routinely recorded and reported by the NDA for several years. Presently NDA does not report statins in people with 10yr duration and age under 40 but that could easily be added. |
| 73 | NHS England | Question 1 – Statement 4 | Does this draft quality standard accurately reflect the key areas for quality improvement?  Quality Standard 4 – Statins  For the over 40s agree completely and is in line with other guidance. I would highlight the caveat regarding pregnancy.  Part of this guidance remains controversial (the >10 duration) and should be reviewed – see comments below. |
| 74 | NHS England | Question 2 - Statement 4 | Quality Standard 4 – Statins Data collection in primary care here should not be an issue. Routinely done in many areas already. |
| 75 | NHS England | Question 3 – Statement 4 | QS4 – Statins – Data should be easy to collect and it is achievable. |
| 76 | NHS England | Statement 4 | (Statins) Agree for those over 40 yrs old. No issues. Should be straight forward to measure in routine systems.  For the cohort greater than 10yrs of diabetes, this is controversial. It may include 18 yr old with a very low CVD 10yr risk where statins would be inappropriate (compare with Q Risk evaluation for the non-diabetic population – NICE CG181 guidelines 1.3.18 – and also look at the Steno Type1 risk engine). In addition, as they are contraindicated in pregnancy, thus for the young female population I think the guidelines are inappropriate, as risks outweighs the benefits.  There should be a risk evaluation. There is also little or no evidence to get all 18yr olds who have diabetes since childhood to start statins. Better guidance is needed on this point. For the purposes of the quality statements I would omit the >10 yr duration of diabetes cohort. |
| 77 | Royal College of General Practitioners | Statement 4 | We believe the outcomes for this statement could be effective, however, how would it be evaluated? Would the expectation be that every health care contact the patient receives should include the offer of statins as many patients who have hospital follow ups are not routinely offered statins. We believe that this would be possible in primary care though if the patient was seen there. |
| 78 | Royal College of Physicians of Edinburgh | Statement 4 | We welcome the introduction of statins for primary prevention of future cardiovascular disease and would use on the principle of no further requirement of regular lipid monitoring as with other guidelines to minimise use of resources. |
| Statement 5 | | | |
| 79 | Addenbrookes Hospital  Cambridge University Hospitals NHS FT | Statement 5 | The quality statement and rationale as written have potential to support poor practice.  Many of these limb or life-threatening problems have started with “active foot disease” which did not see the correct team in a timely manner, therefore this QS does not address the gap that was apparent even in previous versions (QS5 speaking to at “risk foot” and QS6 speaking to “limb threatening foot”). The gap is the foot with an “active lesion” at a stage where it can be turned back into “at risk” without progression to” limb threatening.”  Therefore this statement would be more impactful if it read “adults with type 1 diabetes who have an active foot problem should be referred immediately to a multidisciplinary diabetic foot care service.” |
| 80 | Addenbrookes Hospital  Cambridge University Hospitals NHS FT | Statement 5 | There are also resource and system issue highlighted by this statement. There too many patient are held in an inadvertent “holding pattern” environment where timely corrective intervention can be undertaken.  This would mean sending such people on immediately to a centre that had an allied to an active vascular centre with meaningful orthopaedic input and an active interventional radiology centre. These centres are not adequately resourced or staffed.  If you wished to quantify existing statement further with the acute extreme limb or life-threatening issues then a statement would also be more impactful if were frames as “Adults with limb or life-threatening foot problem should be referred immediately to a centre with the surgical, radiological and technological infrastructure necessary to try and avoid amputation”. |
| 81 | Diabetic Foot Network Wales | Statement 5 | Totally agree |
| 82 | National Diabetes Audit (NDA) | Statement 5 | NDFA has repeatedly demonstrated worse outcomes if delay from first seeing a HCP to first expert assessment is >14d. NDFA measures ulcer severity (SINBAD scoring system). And those who self-refer to specialist teams invariably do best. The standard says ‘referred immediately’ but to measure that would require comprehensive primary, community and hospital EPRs and structured records for Diabetic Foot disease referrals. |
| 83 | NHS England | Question 2 - Statement 5 | Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  Quality Standard 5 – Urgent Foot – see comments below. Measurement may be difficult and meaningless in current form. |
| 84 | NHS England | Question 3 – Statement 5 | 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.  QS5 – Urgent feet – Yes achievable but difficult to meaningfully measure. See comments below. |
| 85 | NHS England | Statement 5 | No issues with the guidance. However, the difficulty will be measuring it. For primary care, if you code life- or limb-threatening then you are aware of the serious need, so you will admit to secondary care anyhow. It would be negligent not too unless good reason. It is the awareness that it is life- or limb-threatening that is missed by clinical staff which is the quality issue, not the pathway once recognised  For primary care a better quality statement may be – derived from NG19, 1.4.2, “for the management of all active foot problems, other than the life- or limb-threatening, i.e. “ requiring 1-day referral for review by specialist MDFT”. By promoting this quality standard you will drive up the recognition of the former regarding life- and limb-threatening admissions. It is this area that the biggest improvement are to be made. |
| 86 | NHS England National Diabetes Programme | Statement 5 | The foot quality standard needs to be the same for Type 1 and Type 2 - there is no rationale (or evidence) for them being different.  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. |
| 87 | Royal College of General Practitioners | Statement 5 | We would welcome clarification on what ‘immediate’ would equate to (eg would this be within 24 hours similar to a 2 week-wait referral) and would this standard be the same across healthcare boundaries? Additionally, what equates to a specialist assessment and how would this be assessed if the patient presents in ED, out of hours, or diabetes outpatient clinics? |
| 88 | Royal College of Nursing | Statement 5 | Should immediate be replaced with urgent or added in addition to? Need for additional metrics not routinely collected nationally to be added to NDA in regard to diabetic foot problems. As foot assessment is, in the first instance often completed by HCA / general nursing, quality standards should indicate the need for appropriate training to make appropriate assessment and urgent referral |
| 89 | 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, leading to a hugely negative impact on patients. We consider that prevention of foot ulcers requires risk stratification and first class podiatric services for those at high risk. |
| 90 | Sheffield Teaching Hospitals NHS Foundation Trust | Statement 5 | A time frame here would be helpful, for example referred the same day, and assessed within 24/48 hours |
| Statement 6 | | | |
| 91 | Addenbrookes Hospital  Cambridge University Hospitals NHS FT | Statement 6 | Mental health assessment should precede referral – the QS my first need to reflect that assessment/screening is occurring in specialist services. Referral is also restricted by patient choice and access. As currently stated for the this standard, the quality measure has “number of adults with T1DM who have mental health problems that interfere……” in the denominator. This will make this hard to measure as the denominator in itself is not clear currently till mechanisms for systematic assessment are in place making it hard to measure if appropriate referral has taken place. |
| 92 | Association of HealthTech Industries (ABHI) | Question 2 – Statement 6 | The level of information that has been presented within the National Diabetes Audit points to this not being the case currently in both the quality of data in the NDA and the number of centers contributing. Therefore, additional resource and guidance regarding collection of data would be welcomed.  Statement 6 for example, is ambiguous. Clarity will be needed to accurately measure the quality statement. What is meant by ‘Interfere significantly’? How would this be identified and measured? As stated, it is too subjective. |
| 93 | Association of HealthTech Industries (ABHI) | Question 3 – Statement 6 | **Please describe any resource requirements that you think would be necessary for any statement.**  Regarding Statement 6, specialist mental health services with skills in supporting people with diabetes is needed to deliver the quality standards. |
| 94 | Association of British Clinical Diabetologists (ABCD)  Comments endorsed by Royal College of Physicians | Statement 6 | ABCD welcomes the new quality standard for people living with type 1 diabetes but have concerns regarding quality standard 6:  Statement 6 Adults with type 1 diabetes are referred to specialist services if mental health problems interfere significantly with their wellbeing or diabetes self management. [new 2022]  Rationale  Some adults with type 1 diabetes may experience distress, depression and anxiety. In addition, adults with type 1 diabetes are at an increased risk of eating disorder behaviours including omitting or under-dosing insulin. Referral to a specialist service if mental health problems interfere significantly with their wellbeing or diabetes self-management will ensure adults with type 1 diabetes are supported to manage these issues.  The rational includes a mixture of mental health disorders (depression and anxiety) and circumstances that whilst burdensome for patients, are not recognised mental disorders. In addition, there is no current evidence base to determine the treatment pathway for patients with these conditions or with the mental disorders mentioned. The rationale is not clear as to which “specialist service” the person should be referred to. Is this a diabetes service or a mental health service? Additionally, in order for services to be utilised most effectively an assessment is required to determine the level of support an individual requires-be this peer support, IAPT, a diabetes-specialist psychologist or CMHT or even in-patient admission. |
| 95 | Diabetes UK | Statement 6 | Diabetes UK agree with the inclusion of this statement addressing referral to specialist mental services for people with diabetes who require it. However, we believe this quality standard should also include more information or an additional statement focused on the emotional and psychological support that can be provided by non-specialist healthcare professionals.  We recommend everyone is asked how they are feeling as part of every diabetes appointment and a mental health professional with knowledge of diabetes is part of every diabetes care team. People with diabetes who experience psychological problems often prefer to talk about this with their diabetes health professionals or their general practitioner (GP) rather than with a mental health specialist. As diabetes distress is so common and intertwined with diabetes management, it is best addressed by a diabetes health professional (or the GP if they are the main health professional).  Reference: <https://www.diabetes.org.uk/professionals/resources/shared-practice/psychological-care/emotional-health-professionals-guide> |
| 96 | Diabetic Foot Network Wales | Statement 6 | Very pleased to see this within the Quality Standards |
| 97 | National Diabetes Audit (NDA) | Statement 6 | What is meant by ‘specialist services’ - specialist type 1, psychology, psychiatry, social work? NDA does identify and separately report on people with SMI and has started to include data on referrals to psychology services. |
| 98 | Royal College of Physicians of Edinburgh | Statement 6 | The RCPE considers that the introduction of a quality statement on adults with type 1 diabetes being referred to specialist services if mental health problems interfere significantly with their wellbeing or diabetes self‑management is appropriate and a positive development. |
| 99 | Royal College of General Practitioners | Statement 6 | We welcome this statement, though we would welcome a timeframe to be included. Additionally, are there any preferred methods of assessment for those patients suspected of experiencing mental health problems as most practitioners who manage patients with diabetes are more experienced in single disease care and may require guidance with this. |
| No comments | | | |
| 100 | HQIP | N/A | I can confirm that we don’t have any comments. |
| 101 | InDependent Diabetes Trust | N/A | I confirm that we will not be responding. |

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.

## Registered stakeholders who submitted comments at consultation

* Addenbrookes Hospital Cambridge University Hospitals NHS Foundation Trust
* Association of British Clinical Diabetologists
* Association of HealthTech Industries
* Diabetes UK
* Diabetic Foot Network Wales
* Greater Manchester and Eastern Cheshire Strategic Clinical Networks
* National Diabetes Audit
* NHS England
* NHS England National Diabetes Programme
* Royal College of General Practitioners
* Royal College of Nursing
* Royal College of Physicians (endorsed comments from Association of British Clinical Diabetologists)
* Royal College of Physicians of Edinburgh
* Sheffield Teaching Hospitals NHS Foundation Trust