

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality impact assessment

Type 2 diabetes in adults: management

The impact on equality has been assessed during guidance development according to the principles of the NICE equality policy.

1.0 Scope: before consultation (To be completed by the developer and submitted with the draft scope for consultation)

1.1 Have any potential equality issues been identified during the development of the draft scope, before consultation, and, if so, what are they?

(Please specify if the issue has been highlighted by a stakeholder)

1.2 What is the preliminary view on the extent to which these potential equality issues need addressing by the Committee? For example, if population groups, treatments or settings are excluded from the scope, are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

Completed by Developer _____

Date _____

Approved by NICE quality assurance lead _____

Date _____

2.0 Scope: after consultation (To be completed by the developer and submitted with the final scope)

2.1 Have any potential equality issues been identified during consultation, and, if so, what are they?

2.2 Have any changes to the scope been made as a result of consultation to highlight potential equality issues?

2.3 Is the primary focus of the guideline a population with a specific disability-related communication need?

If so, is an alternative version of the 'Information for the Public' document recommended?

If so, which alternative version is recommended?

The alternative versions available are:

- large font or audio versions for a population with sight loss;
- British Sign Language videos for a population who are deaf from birth;
- 'Easy read' versions for people with learning disabilities or cognitive impairment.

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Updated by Developer _____

Date _____

Approved by NICE quality assurance lead _____

Date _____

3.0 Guideline development: before consultation (to be completed by the developer before draft guideline consultation)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

People aged 60 years and above were identified as a population subgroup within the guideline scope because it was considered that the treatment of people with type 2 diabetes in this group may vary.

In the recommendations about target values for HbA1c, the guideline development group (GDG) recognised that a target value higher than 53 mmol/mol (7.0%) might be more appropriate in people who are older or frail. The GDG felt it was important to highlight this because they wanted to ensure that people with type 2 diabetes are managed holistically, in accordance with their clinical and personal circumstances. Older people may have other co-morbidities or differing levels of social support which might mean that pursuit of a lower HbA1c target would not offer additional benefit in terms of managing the person's clinical condition and supporting the person in their activities of daily living.

Throughout the update of the guideline, the GDG discussed how the recommendations generated may impact on older people or those with significant co-morbidities.

People with renal impairment were identified as a population subgroup within the guideline scope because it was considered that the treatment of people with type 2 diabetes in this group may vary.

People with renal impairment are not mentioned specifically within the recommendations in the guideline because no evidence was found to support specific recommendations for this subgroup, but people with significant co-morbidities are highlighted in the recommendations on target values for HbA1c. The GDG felt strongly that in some circumstances, pursuit of a lower HbA1c target may not be appropriate for people who have significant co-morbidities and that clinical judgement should be applied in these situations.

The scope highlighted that specific ethnic groups may need to be considered further in development of the guideline as the treatment of type 2 diabetes in these populations may vary.

Throughout development of the guideline, the evidence reviews did not highlight that treatment of type 2 diabetes in specific ethnic groups may differ. For this reason the GDG did not think it was appropriate to make any recommendations on specific ethnic groups. The GDG were persuaded more that management would differ by

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

clinical condition.

The scope highlighted people in specific cardiovascular risk groups may need to be considered further during development of the guideline as the treatment of type 2 diabetes in these populations may vary.

The GDG felt that all people with type 2 diabetes were at high risk of cardiovascular disease and therefore did not make additional recommendations/ comments about this subgroup.

3.2 Have any **other** potential equality issues (in addition to those identified during the scoping process) been identified, and, if so, how has the Committee addressed them?

In conducting the updated evidence review on erectile dysfunction in people with type 2 diabetes the technical analyst and the guideline development group (GDG) recognised that sexual dysfunction in women with type 2 diabetes may be a pertinent issue. The evidence base which underpinned this review also only considered sexual dysfunction in men with type 2 diabetes in the context of heterosexual relationships. These particular issues did not impact on the recommendations but the committee felt it was important that any future update of the guideline to consider them.

Throughout the development of the guideline, the GDG gave consideration to how treatment of people with obesity may differ to other population subgroups.

The committee felt it was important to give further consideration to people with obesity and type 2 diabetes. Diabetes is a disease which has significant cardiovascular implications. A cross referral to NICE guidance on obesity was also added to the recommendations to emphasise the importance of ensuring obesity is addressed by healthcare professionals and there is access to services. The GDG also chose to make lifestyle advice and support around nutrition and physical activity prominent within the key priorities for implementation.

In addition, the committee made a separate recommendation which enables healthcare professionals to consider adding a GLP-1 mimetic for second intensification of therapy in people with obesity to control HbA1c levels. The

3.2 Have any **other** potential equality issues (in addition to those identified during the scoping process) been identified, and, if so, how has the Committee addressed them?

committee thought this was important because it may not be appropriate for some people with obesity to go onto insulin or to add a sulphonylurea to their existing treatment regimen.

3.3 Were the Committee's considerations of equality issues described in the consultation document, and, if so, where?

Equality considerations were explained in the linking evidence to recommendations sections of the guideline.

3.4 Do the preliminary recommendations make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

Based on consideration of the evidence and committee expertise, the guideline development group (GDG) have only chosen to recommend self-monitoring for those who are:

- on insulin or
- there is evidence of hypoglycaemic episodes or
- on oral medication that may increase risk of hypoglycaemia while driving or operating machinery or
- pregnant or are planning to become pregnant or

The GDG recognised that if implemented, this may result in a substantial change in clinical practice. The committee recognised that this recommendation could affect people who are not in the above subgroups but who have been self-monitoring or

3.4 Do the preliminary recommendations make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

even people who for other reasons, such as anxiety, currently self-monitor. For this reason, the recommendations in this section is prefaced by a recommendation which states the guidance from the DVLA is taken into account when a healthcare professional discusses the issue of self-monitoring with the person. The GDG also felt that individual clinical judgement should be applied in situations outside of those listed in the recommendation. The committee based this recommendation on the evidence that self-monitoring in people with type 2 diabetes on oral therapy did not demonstrate an additional benefit in the management of blood glucose levels.

3.5 Is there potential for the preliminary recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No preliminary recommendations have been identified as likely to have an adverse impact on people with disabilities.

3.6 Are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 3.1, 3.2 or 3.3, or otherwise fulfil NICE's obligation to advance equality?

A recommendation on individualised care has been crafted which now prefaces all the recommendations in the guideline. It reads:

1.1.1 Adopt an individualised approach to diabetes care that is tailored to the person's needs and circumstances, taking into account their personal preferences, comorbidities, risks from polypharmacy, and their ability to benefit from long-term interventions because of reduced life expectancy. Such an approach is especially important in the context of multimorbidity. Reassess the person's needs and circumstances at each review and think about whether to stop any medicines that

3.6 Are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 3.1, 3.2 or 3.3, or otherwise fulfil NICE's obligation to advance equality?

are not effective.

The hope is that this recommendation will encourage patient-centred care and alleviate barriers or difficulties with service access.

Completed by Developer 

Date 7 May 2018

Approved by NICE quality assurance lead _____

Date _____

4.0 Final guideline (to be completed by the Developer before GE consideration of final guideline)

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?

Stakeholder consultation feedback from the Royal National Institute for the Blind raised issues with the NICE website compliance to standards for access of material for people with sight loss. It was not within the influence of the committee to do anything directly. These issues have been highlighted to the NICE web team and Public Involvement Programme.

Other stakeholders raised issues around access to self-monitoring for people with type 2 diabetes and provided comment on certain situations when self-monitoring may be appropriate. The committee took these comments into account but still felt that advice not to routinely offer self-monitoring was appropriate. However, they did recognise the need for short term monitoring in people starting treatment with oral or intravenous corticosteroids or to confirm suspected hypoglycaemia.

Although separate recommendations for people with renal impairment were not made, renal function was reflected in a new recommendation, to remind healthcare professionals that a low HbA1c level could be due to deteriorating renal function. Aside from this, no evidence was found to support specific recommendations for this subgroup, but people with significant co-morbidities are highlighted in the recommendations on target values for HbA1c, which would include people with renal impairment. The guideline development group were also aware of the recently published NICE Chronic Kidney Disease guideline and were keen not to duplicate any recommendations in the guideline which may pertain to people with diabetes.

4.2 If the recommendations have changed after consultation, are there any recommendations that make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

No amendments to the recommendations have been identified as making it more difficult in practice for a specific group to access services compared with other groups.

4.2 If the recommendations have changed after consultation, are there any recommendations that make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

4.3 If the recommendations have changed after consultation, is there potential for the recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No changes to recommendations have been identified to have an adverse impact on people with disabilities.

4.4 If the recommendations have changed after consultation, are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 4.2, 4.3 and 4.4, or otherwise fulfil NICE's obligations to advance equality?

Changes have been made to the recommendations for initial pharmacological management for type 2 diabetes so that repaglinide is not as prominent and so that extended release metformin is now an option for those people who are contraindicated to or cannot tolerate standard release metformin. The committee did this following significant feedback from the stakeholder community that this could lead to barriers to selecting and continuing treatment for people with type 2 diabetes. The very limited use of repaglinide in current clinical practice also brought the 'Do not routinely offer self-monitoring' recommendation into conflict with the initial pharmacological therapy recommendations which were put out for consultation. Stakeholders felt that if repaglinide was given, self-monitoring would certainly be needed to ensure safe prescribing of this drug as there is a distinct lack of experiential evidence on repaglinide amongst the clinical community.

The reasons for amended recommendations for initial therapy are detailed in the linking evidence to recommendations tables in the full guideline. It is hoped that these amendments will alleviate any barriers to treatment.

4.5 Have the Committee's considerations of equality issues been described in the final guideline document, and, if so, where?

Equality considerations are explained in the linking evidence to recommendations sections of the guideline.

Updated by Developer Se Spen

Date 7 May 2015

Approved by NICE quality assurance lead _____

Date _____

5.0 After Guidance Executive amendments – if applicable (To be completed by appropriate NICE staff member after Guidance Executive)

5.1 Outline amendments agreed by Guidance Executive below, if applicable:

Approved by Developer _____

Date _____

Approved by NICE quality assurance lead _____

Date _____

