Type 1 diabetes in adults: diagnosis and management (update)

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 19 May 2021 email: t1diabetesadults@nice.nhs.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. The recommendations in this guideline were largely developed before the coronavirus pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication. See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	[UKCPA Diabetes and Endocrinology Committee] Endorsed by ROYAL PHARMACEUTICAL SOCIETY

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Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	**n/a**
Name of commentator person completing form:	[**Victoria Ruszala**]
Type	[office use only]

Comment number	Document [guideline, evidence review A, B, C etc., methods or other (please specify which)]	Page number Or 'general' for comments on whole document	Line number Or 'general' for comments on whole document	Comments Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
1	Guideline	11	21	1.4.3 Dietary and lifestyle advice has altered and there is increased focus on low CHO diet in diabetes, albeit less so for those with T1DM. If specific diets are being highlighted then this should be expanded to include these or the recommendation should be removed to prevent confusion.
2	Guideline	16	23	1.6.12 Patients testing as often as 10 times a day are now switched to use Libre to provide better data. It seems astonishing that Libre and its use to support patients with hypoglycaemia and labile CBG has not been mentioned throughout this section. NHSE have put in place recommendations and support for its use – these should have been included in this guidance with a review of the latest evidence. This omission will lead to misunderstanding of best practice and what we are encouraging our patients to achieve.

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3	Guideline	17	1	1.6.13 There has been no acknowledgement of the target for 'time in range' which is increasingly the preferred measure for patients with T1DM. Although not all patient will have access to Libre and CGMS, it should be included to ensure education of less specialist practitioners and a clear standard for those who have been given access. HbA1c and blood glucose targets - although they have stated about individual targets for HbA1c there is no specific mention of frail/older patients where these tight targets would not be appropriate. There is no alternative NICE guidance in which these are specified / stated.
4	Guideline	19	20	1.7.4 Toujeo (glargine 300units/ml) should be considered alongside degludec if there is a particular concern about nocturnal hypoglycaemia. The BRIGHT study compared insulin glargine 300 units/ml vs. insulin degludec 100 units/ml in a head-to-head RCT, results showed non-inferior HbA1c reduction for Toujeo vs degludec. Hypoglycaemia rates were lower for degludec compared to Toujeo in the initial phase (0 - 12 weeks), but hypoglycaemia event rates were similar in the maintenance phase (13 - 24 weeks). Toujeo has a slightly lower per unit cost than degludec. Toujeo could also be considered where assistance is required, as it also gives flexibillity in dosing time. When needed, Toujeo can be given up to 3 hours before or after their usual time of administration. In the evidence summary and economic model there was virtually no difference between the two. Given that alternatives to detemir have been listed for the specific circumstances listed it seems very odd to have excluded an insulin that performs well against all other alternatives, especially in the population of patients that require significant insulin doses (such as obesity), where Toujeo often outperforms the others listed.
5	Guideline	20	11	1.7.6 We strongly endorse the consideration of biosimilars for use in T1DM in order to reduce costs without altering efficacy.

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6	Guideline	24	17	1.10.6 This needs to be adjusted for frail / elderly patients. We would fully expect targets to be relaxed in an older patient where they would no longer see the benefits of tight control and are more likely to adverse outcomes secondary to hypos particularly those with cognitive impairment.
7	Guideline	29	15	1.13 The section on cardiovascular risk only considers ischaemic heart disease and has not mentioned nor considered heart failure. Given the high population of patients with diabetes and heart failure there is likely to be an increasingly elderly population where both need assessment and practitioners understand the difference between T1DM and T2DM. New data considers the use of adjunctive therapies such as SGLT2-inhibitors in T1DM and it seems remiss to not review the current data and make recommendations. Diabetes is not considered well in cardiovascular guidelines with only a recommendation to control blood glucose.

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a **Word document (not a PDF)**.
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **page and line number (not section number)** of the text each comment is about.
- Combine all comments from your organisation into 1 response. **We cannot accept more than 1 response from each organisation**.
- Do not paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; do not cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use
- For copyright reasons, **do not include attachments** such as research articles, letters or leaflets. We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

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- **We have not reviewed the evidence for the recommendations shaded in grey. Therefore, please do not submit comments relating to these recommendations as we cannot accept comments on them.**
- **We do not accept comments submitted after the deadline stated for close of consultation.**

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

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