|  |  |
| --- | --- |
| **Service**  | Early Onset Type 2 Diabetes Service |
| **Delivery Point** | Primary Care Networks or Integrated Neighborhood Teams |
| **Date of Review** | 4/10/2023 |
| **Version control** | v0.1 Tony Willis and the MDT Level 2 Service Specification Task and Finish Group v0.2 Updated ARRS referral code setv0.3 Hyperlinks added to appendices |

|  |
| --- |
| 1. **National context and evidence base**
 |
| Early onset Type 2 diabetes (EOT2D) is defined as the development of Type 2 diabetes below the age of 40 years. It is more common in people from ethnic minorities (particularity in people with South Asian ethnicity) and people living in the most socio-economically deprived areas. A high proportion of people with EOT2D are living with obesity and may also have concurrent unmet psychological and social needs. The National Diabetes Audit (NDA) shows that prevalence is increasing yearly, with 137,260 people with Type 2 diabetes aged 18-39 in England in the latest report (21/22). In North West London specifically, there are approximately 8235 people with EOT2D, the majority of whom are cared for exclusively in General Practice, with an average of ~180 adults with EOT2D per Primary Care Network (PCN). EOT2D is associated with a more aggressive diabetes phenotype than older-onset Type 2 diabetes, including more rapid progression of glycaemia and early development of complications with significant reduction in life expectancy. Despite this, people with EOT2D are less likely to receive all NICE-recommended care processes and tend to have higher HbA1c than older people with Type 2 diabetes1[[1]](#footnote-2). 54% of pregnancies in people with diabetes in 2020 related to those affected by Type 2 diabetes, representing a doubling in proportion since 2002. Attaining HbA1c < 48 mmol/mol is associated with better neonatal outcomes; however, in 2020 only 11% of women with Type 2 diabetes who became pregnant had evidence of adequate preparation for pregnancy[[2]](#footnote-3), reducing to only 6% of those living in the most deprived areas[[3]](#footnote-4). National funding is being made available to all ICBs for the T2Day: Type 2 Diabetes in the Young Programme, a 2-year initiative (for 23/24 and 24/25) aiming to improve care for people with EOT2D. In North West London, the aim is to integrate the Early Onset Type 2 Service within the MDT Level 2 Service Specification in April 2024, once the MDT Level 2 Service is rolled out universally to all PCNs. |
| 1. **Aims and objectives of service**
 |
| 1.) to work with people with EOT2D to provide high quality care and optimise glycaemia, cardiovascular risk and weight, aiming to reduce long-term complications and morbidity 2.) to support better preparation for pregnancy in women[[4]](#footnote-5) with Type 2 diabetes, including supporting access to contraception for those not trying for pregnancy 3.) to help address unmet psychological and social needs and support overall wellbeing  |
| 1. **Service Description/Care Pathway**
 |
| This Early Onset Type 2 Diabetes service specification fits within a wider pathway for people living with diabetes, which operates to allow people to move between levels seamlessly and as their needs dictate and where more experienced clinicians are required to manage their care.* **Non Diabetic Hyperglycaemia (NDH):** This largely primary care service will be responsible for proactive identification of NDH and referral into nationally commissioned NHS Diabetes Prevention Programme to support the prevention of Type 2 Diabetes.
* **Diabetes (Level 1):** The primary care service at Level 1 will have primary responsibility for the person with Type 2 Diabetes
* **Diabetes (MDT Level 2):** The MDT level 2 service is a PCN/INT-based service which integrates level 1 primary care services and specialist support and uses methodologies including an MDT approach to optimise patient care. The objectives of the MDT include to integrate complex decision making inter-professionally and bring levels 2,3 and 4 together rapidly, improving patient outcomes and reducing the need for direct F2F Level 4 contact as well as to initiate insulin and GLP-1 agents. The MDT will also integrate mental health and social prescribing input in order to help direct the clinical team towards the most appropriate support pathways for patients with more complex mental health and social care needs. Lastly, the MDT Level 2 service will provide more intensive support for people with EOT2D.
* **Diabetes (Level 3):** The consultant-led community-based diabetes team acts as the link between generalist clinicians and specialists. Specialists who provide the Level 3 diabetes service should spend a proportion of their time leading, advising and facilitating the work of the primary care based Level 1 and Level 2 diabetes teams. Staff will fast-track people with diabetes safely back to primary care or to Level 4 (where clinically appropriate) and allow the Level 3, 2 and 1 teams to provide care closer to the patient’s home.
* **Diabetes (Level 4):** Specialist diabetes services have primary responsibility for those with Type 1 and rarer forms of diabetes. All people with Type 1 Diabetes and other forms of diabetes, such as monogenic diabetes e.g. maturity-onset diabetes of the young (MODY), mitochondrial diabetes, diabetes due to chronic pancreatitis or total pancreatectomy, should have access to specialist diabetes services including those commissioned by NHS England. Provision needs to be made in the community for people with Type 1 Diabetes who refuse to be seen in secondary care or on end of life pathways.

The ultimate aim is to integrate pathways and funding further, particularly for level 2 and 3 services, in order to provide a more seamless experience for patients.

|  |
| --- |
| ***All people with Type 2 diabetes (particularly those with EOT2D) should be offered, where appropriate, the opportunity to participate in a diabetes remission or intensive weight management support programme, whether through a low calorie total diet replacement (TDR) programme, through other education programmes such as X-PERT, or through bariatric surgery.*** |

People with diabetes (seen at any level) should have access to the Know Diabetes Service, structured education, social prescribing and emotional and mental health support according to need, commissioned services available and choice.Accountability for the incidence of onset of complications and incidence of hard clinical endpoints such as amputation and blindness lies across the health economy, and responsibility will be shared by all providers of diabetes care as well as by the wider integrated care system.Care planning, care delivery, plan review and adjustment and operational improvement should underpin the approach to all service delivery.[[5]](#footnote-6)**Additional Support for Early Onset Type 2 Diabetes**All people with EOT2D should be encouraged to attend an extended (at least 30 minute) face to face review and where appropriate, discussed at an MDT meeting.1. **Data gathering to support reviews / opportunistic care process delivery**
* For clarity, it is expected that completion of all 9 NICE recommended annual care processes should occur in all people with diabetes, independent of this intervention
* Prior to a review, appropriately up-to-date values of relevant clinical markers should be obtained to guide shared decision-making and therapeutic approach (e.g., re-checking HbA1c prior to review, particularly if there has been an intervening change to glucose-lowering medication or last HbA1c was recorded more than 6 months ago)
* The additional contact / review(s) funded by this intervention also present an opportunity to ensure completion of any care processes that were previously missed
1. **Consideration of potential misclassification of diabetes type**
* During reviews, consideration should be given to any features suggesting that diabetes type may be other than Type 2 diabetes, taking into account any prior correspondence from specialist services
* If there is suspicion that misclassification may have occurred, local pathways for further assessment should be followed (this is likely to include a referral to specialist services)
1. **Contraception and planning for possibility of pregnancy**

For all women with EOT2D and potential to become pregnant, discuss contraception, the importance of pre-pregnancy planning and what to do if they have a positive pregnancy test. For women with potential to become pregnant, who are not trying for pregnancy, encourage use of contraception:* Offer initiation of contraception or signpost/refer as appropriate

For women with potential to become pregnant who are trying for pregnancy / likely to become pregnant (including those who are sexually active and not using contraception):* Prescribe folic acid supplementation of 5mg daily
* Avoid use of medications which are not suitable in pregnancy. This includes many glucose-lowering medications (except metformin and insulin) as well as other medications which are not used for glucose-lowering (e.g., statins, ACE-i etc)
* Emphasise the importance of intensive glycaemic control in reducing the risk of adverse maternal and foetal outcomes in pregnancy. Referral to specialist services for insulin initiation may be indicated

Women with EOT2D should be informed that they should urgently notify their GP practice (or diabetes team if applicable) if they have a positive pregnancy test so that they can be urgently referred to the Diabetes in Pregnancy team (for antenatal clinic review within a week to reduce pregnancy risks).1. **Optimisation of glycaemia and cardiovascular risk and weight**

It is recommended that clinicians follow NICE guidance on management of glucose, cardiometabolic risk factors and weight, with the avoidance of therapeutic inertia and undue delay in intensification.This includes use of non-pharmacological treatments, with particular consideration of suitability for the NHS Type 2 Diabetes Path to Remission Programme (which is currently available in most of England and will be available nationwide by the end of 23/24).***Glycaemia:**** In accordance with NICE NG28, individualised targets should be discussed and agreed. These should take into account the more aggressive nature of EOT2D and the high lifetime risk of complications
* Targets are therefore likely to be more intensive than those which may be typically used in people developing Type 2 diabetes at more advanced age
* NICE Patient Decision Aid may support discussions on HbA1c
* It is important to avoid therapeutic inertia and discuss treatment escalation promptly if individualised targets are not met
* Offer referral to Structured Education, taking into account individual needs and preferences (note the availability of nationally commissioned digital structured education)

***Cardiovascular risk:**** Lipid-lowering therapies (e.g., statins) should be offered in line with NICE CG1816
* SGLT2 inhibitors should be offered in line with NICE NG286 for addressing cardiovascular risk (and renal protection in CKD)
* NICE NG1368 recommendations for the diagnosis, treatment and monitoring of hypertension should be followed[[6]](#footnote-7)
* Offer support with smoking cessation including referral / signposting as appropriate

***Weight:**** Weight management support is likely to be indicated in the majority of people with EOT2D. This may include pharmacological interventions (in line with NICE guidance) and/or appropriate referral to weight management services
* Given the high prevalence of obesity in people with EOT2D, a high proportion may be eligible for GLP-1 receptor agonist treatment, in line with NICE guidance. This may be as an intensification of glucose-lowering therapy in accordance with NICE NG28, or as a treatment for weight management in line with relevant NICE guidance and technology appraisals.
1. **Psychological wellbeing unmet and social needs**

Assess unmet psychological needs and manage accordinglyExplore unmet social needs and consider social prescribing and other support servicesConsider availability and opportunities for peer support**Funding and commissioning:** Funding allocations for systems have been based on the number of people with EOT2D in each system (NDA quarterly data – 2022/23 Q3). These are the minimum allocations (initially £52 per adult with EOT2D) which may increase depending on take-up of the offer across all ICBs. All systems receiving funding in 2023/24 will receive the same level of funding in 2024/25 (subject to annual confirmation). There will be no future opportunities for expressing interest beyond August 2023. Although systems should consider sustainability from the outset, there is no specific requirement for systems to commit to sustaining the service following the period of national funding. **Reporting:** Evaluation of the service will be supported by the National Diabetes Audit as well as data from nationally commissioned services (e.g., NHS Type 2 Diabetes Path to Remission Programme). It is recommended that systems also monitor applicable metrics (such as those listed in the section above, in addition to others considered relevant) to assess performance, identify need and inform ongoing quality improvement. This may also support local service sustainability. Systems participating must confirm mobilisation but no further reporting will be required. **Equity**: Service providers should make sure systems are in place to address health inequalities and ensure equity of access to the enhanced support and any treatment interventions. They should deliver the service in a culturally sensitive way to meet the needs of their local, diverse populations. **Supporting resources**: The following documents are enclosed: • **Appendix IV:** Example of Supporting Information for Clinical Reviews • **Appendix V:** [Prevalence Data and Minimum ICB Funding Allocations.](https://nhs.sharepoint.com/%3Ax%3A/r/sites/msteams_22ccb5/Shared%20Documents/Virtual%20Group%20Consultations/Enhanced%20Service%20Specifications/Level%202-3/Diabetes%20Level%202%20Service%20-PCN%20Contract%20Variation%20Values%202023-24%20v0.4.xlsx?d=wa50d0f930d314c8fa5813ad5ba4da641&csf=1&web=1&e=LIccPC) • **Appendix VI:** National Webinar Slide pack. A recording of the national webinar is also available at EOT2D Webinar Appendix IV: Example of Supporting Information for Clinical Reviews is a resource to support clinicians carrying out reviews of people with EOT2D. It should be adapted by systems according to local needs, pathways, processes, services, formulary etc., signed off by local clinical leads and ‘owned’ by the ICB. Systems are therefore encouraged to modify sections, add elements to suit local need and change presentation / formatting, providing the key elements of the service remain.**Outcomes****Metrics used to evaluate impact include:** - Completion of all NICE recommended care processes - Improvements in treatment target achievement - Proportion with HbA1c ≤ 48 mmol/mol - Proportion achieving > 5% weight loss - Prescribing data relating to management of diabetes, weight, and cardiovascular risk - Referral / uptake of NHS Type 2 Diabetes Path to Remission Programme (once available) - Use of other services, e.g., Digital Weight Management, NHS Talking Therapies etc. - Proportion of women with potential to become pregnant with preparation for pregnancy (preconception advice and folic acid)- Rates of maternal and neonatal adverse outcomes at NWL or national level- Across relevant metrics, inequality including by ethnicity and socioeconomic deprivation  |
| 1. **Any Acceptance and exclusion criteria and thresholds**
 |
| Inclusions:* Patients aged 18-39 with assumed Type 2 Diabetes

Exclusions:* People with known Type 1 Diabetes or MODY
* Patients aged under 18 or 40 or above
 |
| 1. **Training, Skills and Experience**
 |
| Diabetes Clinician:* Minimum Grade:
* Agenda for Change Band 7 or equivalent.
* Education, Qualifications &Training
* Minimum competencies in line with Training Research and Education for Nurses in Diabetes (TREND) recommendations [www.trend-uk.org/documents/TREND\_3rd.pdf](http://www.trend-uk.org/documents/TREND_3rd.pdf) for “competent nurse” and working towards competencies for “experienced or proficient nurse”.
* PITSTOP or similar training for insulin and GLP-1 initiation / optimisation

Add in other qualifiers  |
| 1. **Equipment**
 |
| There is no specialist equipment required for the delivery of this service. |

**APPENDIX I - CONTRACTUAL REQUIREMENTS**

|  |  |
| --- | --- |
| EARLY ONSET TYPE 2 DIABETES |  |
| **Unit Price** |

|  |  |  |
| --- | --- | --- |
| **Activity** | **Target Thresholds** | **Price per patient** |
| DL202: Review of patients with EOT2D | 100% of EOTD patients | £52 |

 |
| **Service Type** | Package | No Pop-Up |
| **Referral Criteria** | Patients aged 18 years and above are Mandatory under this contract |

**APPENDIX II – EOT2D REVIEW**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Ref.** | **Description** | **SNOMED Code** | **Measurement** | **Target****achievement** | **% of total payable for achieving target** | **Frequency of Monitoring** |
| **DL202** | Number of patients receiving EOT2D review | Diabetes self-management plan review (**810961000000103**) | **Numerator:**Number of patients with EOT2D (coded as T2DM and aged 18-39) with diabetes self-management plan review | **Denominator:**Number of patients with EOT2D (coded as T2DM and aged 18-39) |  |  | Monthly via dashboard |

|  |
| --- |
| **PAYMENT/KPI RULES:** |
| **To Achieve Payment for EOT2D DL202*** Patient must be Aged 18-39 **AND**
* Has a SNOMED code of Type 2 Diabetes Mellitus without being resolved **AND**
* Has a SNOMED code of Diabetes self-management plan review (**810961000000103**)
 |

**APPENDIX III - QUALITY METRICS – EOT2D REVIEW**

|  |
| --- |
| **QUALITY METRICS** |
| **Ref.** | **Description** | **SNOMED Code** | **Measurement** | **Target****achievement** | **% of total payable for achieving target** | **Frequency of Monitoring** |
| **DL207a** | Average change in HbA1c 3m, 6m, 12m following EOT2D review | Haemoglobin A1c level – IFCC standardized (**999791000000106**) **OR**Haemoglobin A1c level (monitoring ranges) - International Federation of Clinical Chemistry and Laboratory Medicine standardised (**1049321000000109**) | **Numerator:** | **Denominator:** |  | NA | Monthly – via the WSIC Tier 2 Dashboard |
| **DL207b** | Average change in BP 3m, 6m, 12m following EOT2D review | O/E - Systolic BP reading**(72313002)**O/E - Diastolic BP reading**(1091811000000102)** |  |  |  |  | Monthly – via the WSIC Tier 2 Dashboard |
| **DL207c** | Average change in lipids 3m, 6m, 12m following EOT2D review | Non high density lipoprotein cholesterol level (**1030411000000101**) |  |  |  |  | Monthly – via the WSIC Tier 2 Dashboard |
| **DL207d** | Average change in weight 3m, 6m, 12m following EOT2D review | On examination - weight (**162763007**) |  |  |  |  | Monthly – via the WSIC Tier 2 Dashboard |
| **DL207e** | Average change in BMI 3m, 6m, 12m following EOT2D review | Body Mass Index - observation **(60621009)** |  |  |  |  | Monthly – via the WSIC Tier 2 Dashboard |
| **DL207f** | % of people with EOT2D referred to weight management programmes | Any of the following:* Referral to NHS Digital Weight Management Programme (**1402911000000108**)
* Referral to weight management service (**1326201000000101**)
* Referral to National Health Service Tier 3 specialist weight management service (**1403011000000103**)
* Referral to NHS Tier 4 specialist weight management service (**1402991000000104**)
* Referral to total diet replacement programme (**1239571000000105**)
* Referral to bariatric surgeon (**698563003**)
* Referral for pre-bariatric surgery assessment (**907731000000102**)
 | **Numerator:**Number of patients with EOT2D (coded as T2DM and aged 18-39) with weight management referral | **Denominator:**Number of patients with EOT2D (coded as T2DM and aged 18-39) |  |  | Monthly – via the WSIC Tier 2 Dashboard |
| **DL207g** | % of patients with EOT2D referred to ARRS team | Any of the following:* Referral to social prescribing service (**871731000000106**)
* Referral for health coaching (**276221000000100**)
* Referral to mental health link worker (**1362951000000104**)
 | **Numerator:**Number of patients with EOT2D (coded as T2DM and aged 18-39) with ARRS referral | **Denominator:**Number of patients with EOT2D (coded as T2DM and aged 18-39) |  |  |  |
| **DL207h** | % of female patients with EOT2D with record of preconception advice  | Pre-conception advice (**171012002**) | **Numerator:**Number of female patients with EOT2D (coded as T2DM and aged 18-39) with preconception counseling code | **Denominator:**Number of female patients with EOT2D (coded as T2DM and aged 18-39) |  |  |  |
| **DL208i** | % of female patients with EOT2D with record of folic acid prescription  | Folic acid prescribed in last 6m | **Numerator:**Number of female patients with EOT2D (coded as T2DM and aged 18-39) with folic acid prescription in last 6m | **Denominator:**Number of female patients with EOT2D (coded as T2DM and aged 18-39) |  |  |  |
|  |  |  |  |  |  |  |  |

**APPENDIX IV: T2Day: Type 2 Diabetes in the Young –Supporting Information for Reviews**

Early onset Type 2 diabetes (EOT2D) is defined as the development of Type 2 diabetes below the age of 40 years. It is more common in people from ethnic minorities (particularity in people with South Asian ethnicity) and people living in the most socio-economically deprived areas. A high proportion of people with EOT2D are living with obesity and may also have concurrent unmet psychological and social needs.

The National Diabetes Audit (NDA) shows that prevalence is increasing yearly, with 137,260 people with Type 2 diabetes aged 18-39 in England in the latest report (2021/22). It is associated with a more aggressive phenotype than older-onset Type 2 diabetes, including more rapid progression of glycaemia, and earlier complications with significant reduction in life expectancy. Despite this, people with EOT2D are less likely to receive all recommended care processes and tend to have higher HbA1c levels than people with older-onset Type 2 diabetes[[7]](#footnote-8)1. Preparation for pregnancy and pregnancy outcomes are also poorer than in people with Type 1 diabetes; during 2018-2020, only 11% of women with Type 2 diabetes who became pregnant had evidence of adequate preparation for pregnancy[[8]](#footnote-9) reducing to only 6% of those living in the most deprived areas3.

Please note that although this document relates to the reviews of adults with early onset Type 2 diabetes, the process for identifying this group is likely to involve system searches for all people aged under 40 years who are recorded as having Type 2 diabetes. If any people aged under 18 years are identified, they should be supported to access specialist care for management, as recommended in NICE NG18 (2023) guidance.

**Before the reviews:**

* NICE-recommended annual care processes should be completed, and up-to-date values of relevant measures obtained (e.g., re-checking HbA1c prior to review, particularly if there has been an intervening change to glucose-lowering medication or last HbA1c was checked > 6 months ago)
* Please note these reviews are additional to the usual routine care provided for people with EOT2D

**During the reviews:**

As well as opportunistically addressing any missed care processes, the four key elements of reviews are:

1) Classification of diabetes type – is this Type 2 diabetes?

2) Contraception and planning for possibility of pregnancy

3) Optimisation of glycaemia, cardiovascular risk, and weight

4) Psychological wellbeing and unmet social needs

1. **Classification of diabetes type – is this Type 2 diabetes?**
* Young people may have subtypes of diabetes other than Type 2 diabetes such as Type 1 diabetes or monogenic diabetes (e.g., maturity onset diabetes of the young, MODY)
* Although it can be difficult to distinguish Type 2 diabetes from other types of diabetes based on clinical features, it is worth considering ‘are there features here that don’t fit with early onset Type 2 diabetes?’
	+ For example, they have a relatively lean BMI, they do not have any features of insulin resistance or metabolic syndrome, there is no family history of Type 2 diabetes. Note that in people of South Asian ethnicity, EOT2D may develop at lower levels of BMI than people of white ethnicity, although they would usually still have a BMI falling within the overweight or obese category
	+ NICE NG17 (2022) states that people with Type 1 diabetes typically (but not always) have 1 or more of: ketosis, rapid weight loss, age of onset < 50 years, BMI < 25 kg/m2, personal and/or family history of autoimmune disease. Do not use age, BMI, or ethnicity alone to exclude Type 1 diabetes
	+ MODY is usually characterised by a strong family history of which may have been identified in multiple generations at young ages (50% chance of being passed to the next generation). Bear in mind that a parent may have been misclassified as having Type 1 or Type 2 diabetes
	+ The agreed national guidelines for eligibility for testing for MODY (R141 guidelines) are available at <https://www.diabetesgenes.org/tests-for-diabetes-subtypes/guidelines-for-genetic-testing-in-mody/>
* Although classification of diabetes type should be considered at time of diagnosis, it should also be regularly reviewed as features may develop that indicate an alternative diabetes subtype
* If there is concern that this may not be Type 2 diabetes, follow the local pathway for further assessment. In most areas, this is likely to include a referral to specialist teams. If Type 1 diabetes is strongly suspected, urgently discuss with specialist care, and do not delay starting treatment
1. **Contraception and planning for possibility of pregnancy**
* Women with EOT2D have an increased risk of stillbirth and neonatal morbidity. The major modifiable risk factor for this is glucose control at the start of pregnancy (this may be before the woman is aware she is pregnant). HbA1c > 48 mmol/mol is associated with poor pregnancy outcomes
	+ According to NPID data (2014 to 2020), only 11% of pregnant women with Type 2 diabetes had received adequate pre-pregnancy care
* Note that many of the medicines used to manage glucose and cardiovascular risk are not advised in pregnancy. Contraception should be used if taking these drugs. If not wishing to use contraception, consider likelihood of pregnancy occurring (it may be reasonable to assume that pregnancy is likely – almost half of all pregnancies are unplanned)
* If not trying for pregnancy, contraception should be offered and initiated / arranged as appropriate
* Women trying for pregnancy or likely to become pregnant should be prescribed folic acid 5mg daily and have their medication reviewed
	+ The only safe glucose-lowering drugs in pregnancy are metformin and insulin. If insulin initiation is needed, this should be commenced in line with local pathways
	+ If actively trying for pregnancy, an HbA1c target of < 43 mmol/mol may be suggested
	+ Follow local pathways for pre-conception support / review
* Women with EOT2D should be informed that they should urgently notify their GP practice (or diabetes team if applicable) if they have a positive pregnancy test so that they can be urgently referred to the Diabetes in Pregnancy team (for antenatal clinic review within a week to reduce pregnancy risks)
1. **Optimisation of glycaemia, cardiovascular risk, and weight**
* Consider referral to the NHS Type 2 Diabetes Path to Remission Programme (T2DR; will be available nationwide by April 2024) or other intensive lifestyle change interventions
* Early outcomes from the NHS T2DR programme show mean weight loss of 11kg at 12 months. It is expected to improve glycaemia, blood pressure and cardiovascular risk (data on remission rates is awaited). See your local referral form for full eligibility requirements
1. **Glycaemia:**
* NICE NG28 recommends discussing and agreeing an individual HbA1c target. One factor the accompanying NICE decision aid specifies is ‘thinking about my age and my health overall, my quality of life in the long term is important.’ The decision aid is found at
* https://www.nice.org.uk/guidance/ng28/resources/patient-decision-aid-pdf-2187281198
* People with EOT2D are at higher risk of complications that those who develop Type 2 diabetes later in life. There is therefore rationale for agreeing more intensive glycaemic targets in people with EOT2D than typically used. Given the higher risk profile, the QOF-incentivised HbA1c target of ≤ 58 mmol/mol is unlikely to be suitable; a target of ≤ 48 mmol/mol may be more appropriate
* Note that people with EOT2D may have faster progression with increasing HbA1c than is typically seen with onset at older ages. NICE recommend rechecking HbA1c every 3-6 months until HbA1c is stable on unchanging therapy and then 6 monthly. It is important to avoid therapeutic inertia and to escalate treatment promptly if individualised targets are not met
* NICE NG28 sets out guidance on use of glucose-lowering therapies, including recommendations for each step of intensification. Note that, in addition to glucose-lowering impact, SGLT2 inhibitors and GLP-1 receptor agonists have additional benefits in supporting weight loss and reducing CV risk and may therefore be particularly appropriate for people with EOT2D at applicable steps of intensification, in line with NICE guidance (not suitable if trying for pregnancy / likely to become pregnant)
* Offer diabetes structured education, even if previously attended. Take into account individual needs and preference and discuss options available. Note that Healthy Living is a nationally commissioned, digital structured education service which can be accessed at [www.healthyliving.nhs.uk](http://www.healthyliving.nhs.uk)
1. **Cardiovascular risk:**
* Statins and SGLT2 inhibitors may be indicated for reducing cardiovascular risk
* Anyone with EOT2D and known CVD / HF should be offered a statin as well as an SGLT2 inhibitor
* Due to particularly elevated lifetime risk of CVD, NICE recommends consideration of the use of SGLT2 inhibitors in people with EOT2D and any of hypertension, dyslipidaemia, smoking, obesity, and family history (in a first-degree relative) of premature cardiovascular disease
* While setting the threshold to offer statins for primary prevention at a 10-year QRISK3 score of ≥ 10%, NICE CG181 states ’do not rule out treatment with atorvastatin 20 mg for the primary prevention of CVD just because the person's 10‑year QRISK3 score is less than 10% if they have an informed preference for taking a statin or there is concern that risk may be underestimated’
* Note that the 10-year QRISK3 score will not reflect lifetime CVD risk for people with EO2TD and therefore consideration for statin therapy, in line with the criteria set out for considering use of SGLT2 inhibitors, may be appropriate
* Statins are also recommended if there is co-existent CKD, as are SGLT2 inhibitors. Note that the guidance for each SGLT2 inhibitor varies for this indication. Follow your local pathway and formulary
* SGLT2 inhibitors and statins are not suitable if trying for pregnancy / likely to become pregnant
* Blood pressure should be managed in line with NICE NG136, with a clinic BP target of < 140/90 mmHg (or average home BP of < 135/85 mmHg) for people with EOT2D and hypertension
* NICE recommends that an ACE-inhibitor or Angiotensin Receptor Blocker (ARB) is used preferentially as the first-line medication for managing high blood pressure in people with Type 2 diabetes, with an ARB more suitable in people of Black ethnicity. Note that these medicines are not suitable in women if trying for pregnancy / likely to become pregnant
* Offer support with smoking cessation in line with local pathways
1. **Weight:**
* If not referring to the NHS Type 2 Diabetes Path to Remission Programme, consider other appropriate weight management support, including local service offers
* The NHS Digital Weight Management Programme is available for people with diabetes and BMI ≥ 30 (adjusted to BMI ≥ 27.5 in ethnic minorities)
* Also consider referring to specialist obesity services in line with local pathways
1. **Psychological wellbeing and unmet social needs**
* People with EOT2D may have concurrent psychological needs. These should be assessed, and appropriate support offered in accordance with relevant NICE guidance and local pathways
* Explore unmet social needs and consider if social prescribing and/or other support may be indicated
* Consider local opportunities for peer support
1. For completion of all 8 care processes - 22.8% of 19-25 year olds and 33.6% of 26-39 year olds compared to 46.6% and 58.5% of 40-59 and 60-79 year olds respectively; for HbA1c ≤ 58 mmol/mol - 51.6% of 19-25 year olds and 54.5% of 26-39 year olds compared to 57.1% and 68.4% of 40-59 and 60-79 year olds respectively - National Diabetes Audit, Young People with Type 2 Diabetes, 2019-20 [↑](#footnote-ref-2)
2. Defined as achieving HbA1c target of < 48 mmol/mol, taking 5mg folic acid and avoiding potentially teratogenic medications. [↑](#footnote-ref-3)
3. National Pregnancy in Diabetes Audit Report 2020 - NDRS (digital.nhs.uk) [↑](#footnote-ref-4)
4. The specification and other supporting material uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant. [↑](#footnote-ref-5)
5. A small number of specialised services are commissioned nationally by NHS England directly as part of NHS England’s specialised commissioning role. These services include islet cell transplantation, pancreas transplantation, insulin-resistant diabetes, congenital hyperinsulinism, Alstrom Syndrome, Bardet-Biedl Syndromes and Wolfram Syndrome, and are delivered by tertiary centres that specialise in these specific conditions. Service specifications for these specialised services will not be covered here, but are included in the work streams of the Diabetes Specialised Commissioning Clinical Reference Group at NHS England. [↑](#footnote-ref-6)
6. And any updates to the guidance during the lifetime of the service [↑](#footnote-ref-7)
7. For completion of all 8 care processes - 22.8% of 19–25-year-olds and 33.6% of 26–39-year-olds compared to 46.6% and 58.5% of 40-59- and 60–79-year-olds respectively; for HbA1c ≤ 58 mmol/mol - 51.6% of 19-25 year olds and 54.5% of 26-39 year olds compared to 57.1% and 68.4% of 40-59 and 60-79 year olds respectively - National Diabetes Audit, Young People with Type 2 Diabetes, 2019-20 [↑](#footnote-ref-8)
8. Defined as achieving HbA1c target of < 48 mmol/mol, taking 5mg folic acid and avoiding potentially teratogenic medications. [↑](#footnote-ref-9)