TYPE 2 DIABETES – HbA1c TARGETS

NHS

Hull and East Riding Diabetes Network

Check HbA1c 6mthly in patients with stable control who have achieved their target. Consider 3mthly monitoring when adjusting treatment to assess effectiveness.

INDIVIDUALISING HbA1c TARGETS **Document the agreed target**

HBA1C TARGET RECOMMENDATIONS

Clinicians should aim to involve people in decisions about their individual HbA1c target level with 48-58mmol/mol being the standard target.

An HbA1c of below 48mmol/mol should be encouraged in younger patients where this can be achieved without polypharmacy or exposure to repeated hypoglycaemia.

Target HbA1c level should be informed by a number of factors including life expectancy, hypoglycaemia risk related to insulin or sulphonylurea use, co-morbidities especially vascular complications and frailty.

Tighter targets (42-48mmol/mol or even below 42)
Younger, healthier individuals with low risk of hypoglycaemia

Looser targets (58-70mmol/mol)
Older individuals, co-morbidities, high risk of hypoglycaemia, etc.

Encourage the person to maintain their individual target unless the resulting side effects (including hypoglycaemia) or their efforts to achieve this impair their quality of life or impact on their occupation eg Class 2 licence holders

Offer therapy (structured education, lifestyle and medication) to help achieve and maintain their HbA1c target level.

Inform a person with a higher HbA1c that any reduction in HbA1c towards the agreed target is advantageous to future health.

Avoid pursuing highly-intensive management particularly in the elderly and frail patients in whom the risk of hypoglycaemia is high.

International Diabetes Federation (IDF) guidance below should be used for the elderly and frail patients. Where this conflicts with QOF targets for HbA1c, it may be appropriate to exclude older patients.

Functional capacity	General HbA1c target
Functionally independent	53-59 mmol/mol
Functionally dependent	53-64 mmol/mol
Frail	Up to 70 mmol/mol
Dementia	Up to 70 mmol/mol
End of life	Avoid symptomatic hyperglycaemia

APPROACH TO MANAGEMENT OF HYPERGLYCAEMIA

Most intensive **Least intensive**

	Most intensive	Least intensive
Risk of hypoglycaemia Insulin, sulphonylureas	Diet controlled Metformin, gliptins, SGLT2	High risk medication combined with other factors eg CKD,
Life expectancy	Long	Short
Established vascular complications	Absent	Severe
Significant co-morbidities, frailty	None	Multiple, severe
Patient goals, engagement	Highly motivated, adherent	Not engaged despite Multiple attempts by HCPs

HERPC **Hull & East Riding Prescribing Committee**

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Further local diabetes guidelines are available on the HERPC website: https://www.hey.nhs.uk/herpc/prescribing-guidelines/

Adapted from Ismail-Beigi, et al. Individualizing glycemic targets in type 2 diabetes mellitus: implications of recent clinical trials. Ann Intern Med. 2011 Apr 19;154(8):554-9