South West London Clinical Commissioning Group

Central London Community Healthcare NHS Trust

Prescribing Guidelines for Type 2 Diabetes & Frailty

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EXPIRES: **May 2023**

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Policy reference and description of where held.	*To be provided by Quality and Learning Division*
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Approved by originating committee, executive or departmental management group	*The Clinical Effectiveness Group*
Ratified by Policy Ratification Group:	*Insert date ratified by Policy Ratification Group.*
Review date: 2 years maximum for clinical guidelines 3 years maximum for other documents	*May 2023*
Target audience	*General Practitioners, Community Nurses, Diabetes Specialist Nurses, Diabetes Dieticians, Consultants and any health care professionals involved in Diabetes Care within South West London*

Version Control Sheet

Version	Date	Author	Status	Comments
1	April 2019	D Strain, S Saha, S Kelly & D Sivakumaran	New	Developed to be in line with in keeping with new GMS contract
1	March 2020	S Kelly & R Dhir	update	Table 1 overview on page 6 updated to reflect all common frailty scores
2	May 2021	S Kelly & R Dhir	update	SWL CCG Logo added. Valid from and Review dates for guideline updated. Lead Authors section updated. Drugs added to reflect formulary updates. Consultation process & engagement and consultation section updated as comments have now been received by all Boroughs/Trusts across SW London. Diabetes flowchart – removed all commissioning & provider logo. In addition, removed advice box to refer to prescribing guidelines for type 2 diabetes & frailty for full guidance and further advice.

CONTENTS:

1. Introduction

Over the last 20 years there has been a dramatic shift in the epidemiology of diabetes towards old age, particularly among those aged 60-79 years[1]. Both ageing and diabetes are recognised as important risk factors for the development of functional decline and disability[2] which are often compounded with impaired quality of life[3]. In addition, diabetes has a high associated economic, social and health burden[4]. Traditional macrovascular and microvascular complications of diabetes appear to account for less than half of the diabetes-related disability observed in older people[5]. It is now acknowledged that frailty and muscle loss (sarcopenia) are emerging as important new complications of diabetes and are major risk factors for disability. Their importance lies in the observation that they are 'pre-disabling' conditions capable of therapeutic intervention[6].

This evidence is reflected in NICE guidance (NM157)[7] and the 2019 General Medical Services (GMS) contract[8] includes the identification and management of patients with frailty followed by establishing frailty specific targets[9.] Elderly and frail individuals with diabetes are at marked increased risk of adverse effects of treatments for diabetes, including admissions to hospital and hypoglycaemia. They are less likely to benefit from the long-term protective effects of good glycaemia control. There is a need for local guidance to establish a mechanism by which to achieve these individualised goals.

2. Aims and objectives

We propose these guidelines to help identify diabetic adults affected by frailty and manage them in a more appropriate way to minimise the risk of adverse health events/ outcomes.

We examined assessment methods that can be used to recognise frailty and suggest more individualised targets for glycaemic control including medication choices, blood pressure, lipids and physical training goals.

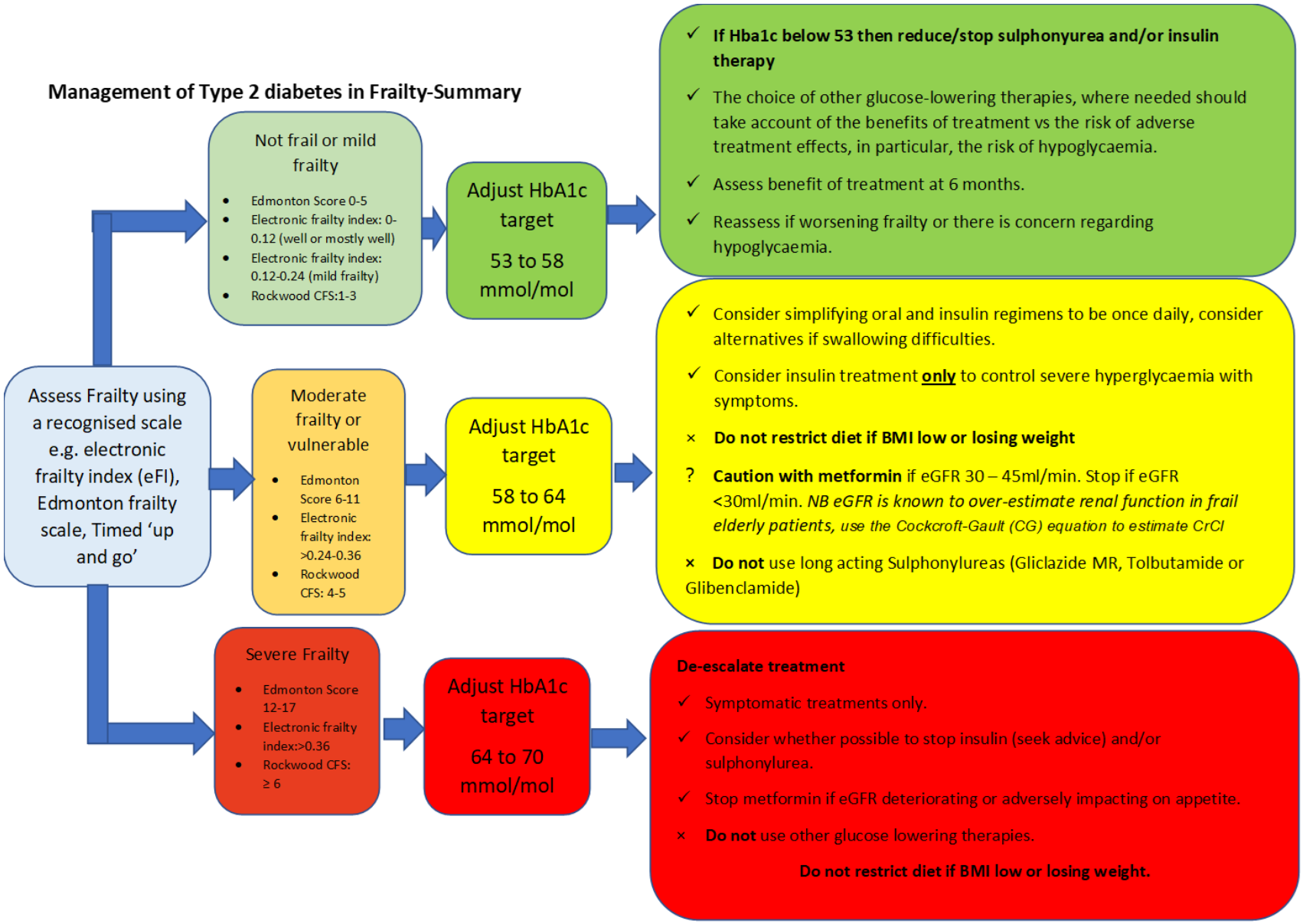
3. Definitions and explanation of any terms used.

- Estimated Glomerular Filtration Rate (kidney function) - eGFR
- Dipeptidyl Peptidase-4 inhibitors - DPP-4
- Glucagon-Like Peptide-1 analogues - GLP-1
- Gastro-Intestinal - GI
- Sodium-Glucose Co-transporter 2 inhibitors- SGLT2
- Thiazolidinedione e.g. Pioglitazone - TZD

4. Target audience

For General Practitioners, Community Nurses, Diabetes Specialist Nurses, Diabetes Dieticians, Consultants and any health care professionals involved in Diabetes Care within South West London who are considering treatment changes to improve clinical targets e.g. HbA1c.

5. Management of Type 2 Diabetes in Frailty – Table 1: Overview

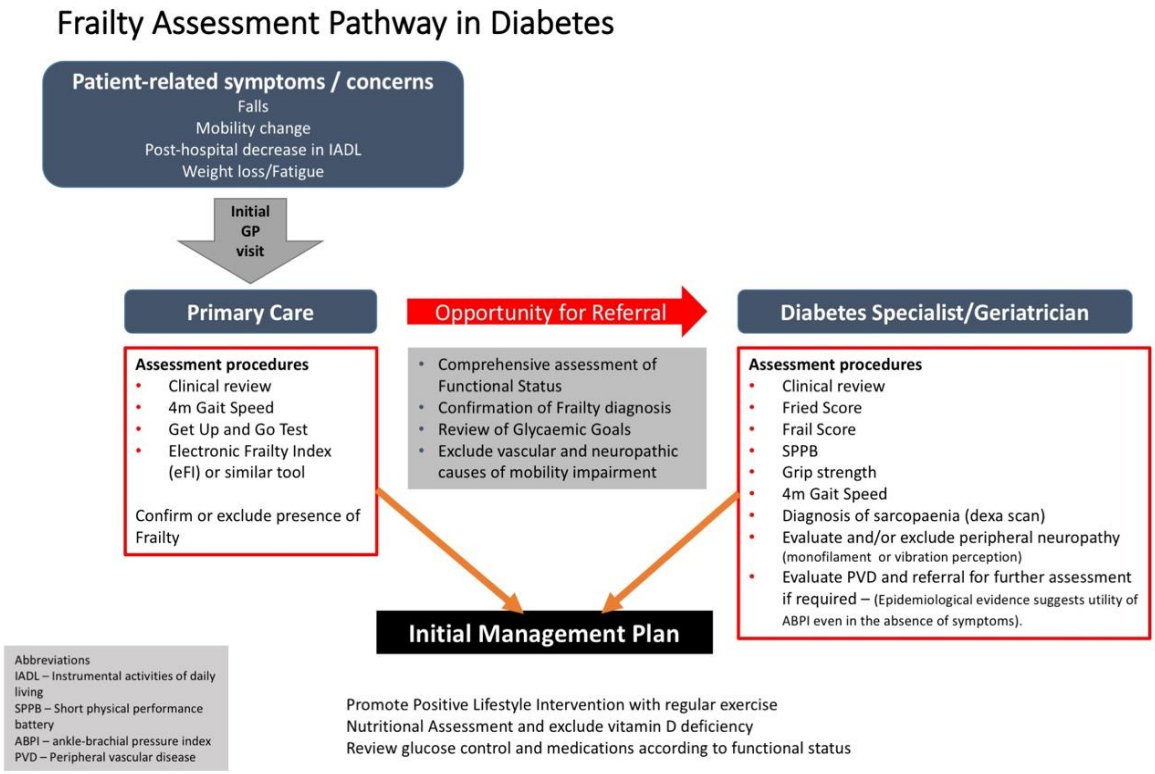


5. Management of Type 2 Diabetes in Frailty

a) Identifying Frailty[9]:

A number of approaches are available to detect the presence of frailty in community-dwelling older adults which are applicable to adults with diabetes[10]. These have been subject to feasibility and validity reviews[11-14]. A general frailty assessment pathway for people diabetes is presented in Figure 1 (below). The importance of detecting frailty lies with the opportunity to consider targeted interventions that reduce functional decline and the risk of disability.

Figure 1:



Consider frailty in any acute presentations suggestive of a frailty syndrome

- Falls (e.g. 'collapse', 'legs gave way', 'found lying on floor)'
- Immobility (e.g. sudden change in mobility, 'gone off legs' 'stuck on toilet')
- Delirium (e.g. acute confusion, worsening of pre-existing confusion/short term memory loss)
- Incontinence (e.g. new onset or worsening of urinary or faecal incontinence)
- Susceptibility to side effects of medications (e.g. confusion with codeine, hypotension with antidepressants).
- Gait speed - taking more than five seconds to cover four metres

- Timed up-and-go test - time taken to get up from a chair, walk three meters, turn around and sit down.

- Frail if >8 secs under age of 70, >9 seconds if 70-80, >10 seconds if 80-90 years

N.B. Assess for the presence of frailty in any individual of or above the age of 65 years with Type 2 Diabetes at non-acute clinic encounters using a screening tool recommended by the British Geriatric Society Prisma 7 questionnaire[15] (Appendix 1).

b) Grading Frailty:

Although there are many complex grading scales for frailty; use the Edmonton frail scale[16] (Appendix 2) or Rockwood Clinical Frailty Scale[19] (appendix 3) to identify the degree of frailty. Pragmatically however there are only three grades worth identifying, namely "healthy elderly", "moderate frailty" and "Severely Frail" (Table 2).

Table 2: Grade of Frailty

Patient type	Examples of patient features
Healthy Elderly	• Few coexisting chronic illnesses • Cognitive and functional status intact
Mild - Moderate Frailty	• Multiple coexisting chronic illnesses • >2 activities of daily living impairments • Mild-to-moderate cognitive impairment
Severely Frail	• Long-term condition • End-stage chronic illnesses • Moderate-to-severe cognitive impairment • >2 activities of daily living dependencies

N.B. Where there is physical or cognitive impairment, or functional loss, referral to geriatricians or other skilled clinicians for a comprehensive assessment should be considered/ sought. Identifying frailty is more important than age itself.

c) Glycaemic Targets

Many patients with HbA1c levels indicative of "good" control may be at significant risk. This is, in part, because as patients age red cell longevity increases and cell membranes become more friable, therefore the same glycaemic exposure results in higher HbA1c[9]. Conversely similar HbA_1c can only be achieved with lower glycaemic exposure increasing the risk of hypoglycaemia It is good practice to review all frail, older people and those with dementia who have type 2 diabetes. The aim should be for the best glycaemic control that can be achieved without increasing the risk of hypoglycaemia and without lowering quality of life through additional treatment burdens. The goals have been outlined in the stakeholder's document that informed the 2019 GMS contract review[9].

- Fit older adults - aim for a HbA1c of 53mmol/mol to 58mmol/mol.

- Moderate frailty – aim for a HbA1c of 58mmol/mol to 64mmol/mol.

- Severe frailty – aim for a HbA1c of 64mmol/mol to 70mmol/mol, but up to 75 mmol/mol is acceptable.

- In end-of-life care (life expectancy <1 year) – primary goal should be avoidance of symptomatic hyperglycaemia.

- In individuals with comorbidities that make HbA1c measurements inappropriate - aim for random blood glucose levels of 6.7 - 11.5 mmol/L in mild to moderate frailty and up to 13 mmol/L in more severe frailty.

d) Choosing Medications

Frailty presents an opportunity in reducing the medication burden for these patients. Consider simplifying oral and insulin regimens to once daily regimes, considering cost effective alternatives for patients with swallowing difficulties.

- When insulin is needed, consider the physical and cognitive abilities of the patient. Consider using once daily basal analogue insulin with the lowest risk of hypoglycaemia wherever possible with other non-insulin agents. Ensure patients and carers are aware of hypoglycaemia including the atypical presentation in older adults and its treatment.

- Consider Metformin as first line treatment as long as there are no contraindications e.g. declining eGFR below 30 ml/min. Monitor for GI side effects and weight loss.

- DPP-4 inhibitors (Gliptins) e.g. Sitagliptin or Linagliptin may be considered next as these have lower hypoglycaemia risk compared to other options

- **Do not <u>initiate</u> longer acting sulfonylureas e.g. Glibenclamide, Tolbutamide or Gliclazide modified release (MR)** in frail patients and/or over the age of 70. This group of agents have an action from 18-24 hours at least. They can be the cause of severe and prolonged hypoglycaemia at any time of day or night. Once the most popular sulfonylureas, Glibenclamide 2.5mg and 5mg tablets are now declining in use. Glibenclamide is liable to cause hypos, especially, if given in the evening because its duration of action is over 20 hours.

- Although the long acting sulfonylureas are not recommended in the elderly, this is not the same as being contraindicated. If elderly patients are well controlled and there is certainty that they are not suffering from hypos, then the long acting sulfonylureas may be continued. Hypoglycaemia does not present with typical adrenergic symptoms in older adults but rather with non-specific neuroglycopeanic symptoms. E.g. weakness, fatigue, difficulty in thinking, confusion, behavioural changes.

- De-escalation of therapies should be considered for any individual with frailty with an HbA1c lower than the target range. Specific considerations include
    - discontinuing any sulfonylurea and short-acting insulins due to risk of hypoglycaemia
    - avoiding TZDs (e.g. Pioglitazone) due to risk of heart failure
    - Cautious use of insulin and metformin mindful of renal function.

- When de-prescribing; medications reviews should be undertaken as appropriate according to individual need.
- Therapies that promote weight loss (GLP-1 analogues) e.g. Liraglutide, Dulaglutide, Semaglutide and SGLT-2 inhibitors e.g. Empagliflozin, Dapagliflozin, Canagliflozin & Ertugliflozin) may exacerbate sarcopenia (muscle wasting).
- Patient leaflet 'Living with Diabetes and Dementia'[17] may also be of use for family and/or carers. See link in reference list below
- Consider the role of self-monitoring i.e. home glucose testing in patients when altering medication and whether this needs to continue, reduce in frequency or is safe to stop.

e) Hypertension

- Aim for a target BP of 140/90mmHg. If adverse effects develop whilst aiming for this BP considers risks and benefits and modify targets
- In older adults, isolated systolic hypertension is common due to increased arterial stiffness. In these patients, targeting systolic control risks diastolic hypotension which is associated with increased falls and dementia risk. De-escalation of blood pressure therapies should be considered if diastolic blood pressure is consistently below 70mmHg[18].

f) Hyperlipidaemia

- Statins can be added to manage/improve cardiovascular risk in dyslipidaemia in appropriate patients (life expectancy > 3years). There is no detrimental impact upon life expectancy for 80+ year-olds commencing statins, it is more that the benefit will not likely be realised for primary prevention in that cohort unless they will live longer than 3 years.

g) Physical Training

- There are established benefits from physical training including resistance and endurance training in older adults with frailty. Consider physiotherapy input or refer to a local exercise programme for the elderly if available for appropriate patients.

6. Consultation Process

The following stakeholders were consulted in the creation of this policy and comments incorporated as appropriate.

Organisation	Role
CLCH	Diabetes Specialist teams in Merton, Wandsworth, Barnet, Harrow, Chelsea & Westminster, Hammersmith & Fulham, Medicines Management, Medical Director
Merton & Wandsworth CCG	Chief Pharmacist, CCG Medicines Optimisation team Pharmacists, GP leads
Wandsworth GP Federation	Frailty consultation exercise with Drs S Saha and D Strain (January 2019).
Borough & Acute Trust diabetes teams	Comments received from all Borough & acute Trusts across SW London (March 2021)

7. Approval and Ratification Process

Final approval was given by xxx Group on x date

8. Dissemination and Implementation

This document will be placed on the intranet by the QLD team. The QLD team will provide a reference number for the policy.

It will therefore be available to all staff via the CLCH NHS Trust intranet. Furthermore, the document will be circulated to all managers who will be required to cascade the information to members of their teams and to confirm receipt of the procedure and destruction of previous procedures/policies which this supersedes. Managers will ensure that all staff are briefed on its contents and on what it means for them. It will be circulated to all GP practices within South West London via CCG's Medicines Optimisation newsletter, be available on GP team.net, SWL Medicines Optimisation Group website and promoted at local Borough based education events.

9. Archiving - The QLD team will undertake the archiving arrangements.

10. Training requirements - Guideline promotion with Primary Care and Community Nurses

11. Monitoring and Auditing Compliance with the Procedural Document

11.1 Element to be monitored – appendix 3. To ensure Frailty has been assessed and appropriate target HbA1c documented and relevant diabetes treatments adopted. Usage of long acting sulfonylureas in the moderate to severe frailty patients

11.2 Lead – Consultant & Diabetes Service Lead

11.3 How will you ensure that the policy is being implemented? Level of referral or enquiry to CLCH Diabetes Service for advice on individual case. EMIS/Eclipse deep dive search at GP practice for at risk patients

11.4 How often will you monitor that the policy is being implemented? 2 yearly

11.5 Reporting arrangements – ***to be agreed locally***

12. Expiry and review dates- This procedural document will be reviewed in 2 years' time in 2023.

13. References

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2. Wong, E., et al., *Diabetes and risk of physical disability in adults: a systematic review and meta-analysis.* The Lancet Diabetes & Endocrinology, 2013. **1**(2): p. 106-114.
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7. National Institute for Health and Care Excellence (NICE) 2018 – Type 2 diabetes in adults: management
8. NHS England: Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan 2019 https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf (accessed 13/03/2019)
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14. Woo, J., et al., *Frailty Screening in the Community Using the FRAIL Scale.* Journal of the American Medical Directors Association.2015 May; **16**(5): p. 412-419.
15. British Geriatric Society . Recognising Frailty 2014 https://www.bgs.org.uk/resources/recognising-frailty (accessed 13/03/2019)
16. The Edmonton Frailty Scale. Cited in Rolfson, D et al; *Validity & Reliability of the Edmonton Frail Scale.* Age & Ageing 2006. **35** (5): p526 - 529 Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5955195/ (accessed 13/03/2019)
17. TREND UK & Institute of Diabetes for Older People patient leaflet https://diabetes-resources-production.s3-eu-west-1.amazonaws.com/diabetes-storage/2017-08/DL_Dementia_leaflet_Final.pdf (accessed 13/03/2019)
18. Ruth Peters, et al. Treating hypertension in the very elderly—benefits, risks, and future directions, a focus on the hypertension in the very elderly trial Eur Heart J. 2014 Jul 7; **35**(26): 1712–1718.
19. Rockwood Clinical Frailty Scale https://www.cgakit.com/fr-1-rockwood-clinical-frailty-scale

14. Appendices

Appendix 1: Identifying frailty [15]

The following outcomes could be suggestive of frailty and should prompt consideration of this diagnosis. Consider referral to a geriatrician or other skilled specialist for further assessment and/or management where appropriate.

1. **Prisma 7 questionnaire** - answering 'Yes' to three or more of the 7 questions below:

1] Are you more than 85 years?
2] Male?
3] In general do you have any health problems that require you to limit your activities?
4] Do you need someone to help you on a regular basis?
5] In general do you have any health problems that require you to stay at home?
6] In case of need; can you count on someone close to you?
7] Do you regularly use a stick, walker or wheelchair to get about?

Appendix 2: Grading Frailty[16]

The Edmonton Frail Scale

NAME : _____

d.o.b. : _____ **DATE :** _____

Frailty domain	Item	0 point	1 point	2 points
Cognition	Please imagine that this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions then place the hands to indicate a time of 'ten after eleven'	No errors	Minor spacing errors	Other errors
General health status	In the past year, how many times have you been admitted to a hospital?	0	1–2	≥2
	In general, how would you describe your health?	'Excellent', 'Very good', 'Good'	'Fair'	'Poor'
Functional independence	With how many of the following activities do you require help? (meal preparation, shopping, transportation, telephone, housekeeping, laundry, managing money, taking medications)	0–1	2–4	5–8
Social support	When you need help, can you count on someone who is willing and able to meet your needs?	Always	Sometimes	Never
Medication use	Do you use five or more different prescription medications on a regular basis?	No	Yes	
	At times, do you forget to take your prescription medications?	No	Yes	
Nutrition	Have you recently lost weight such that your clothing has become looser?	No	Yes	
Mood	Do you often feel sad or depressed?	No	Yes	
Continence	Do you have a problem with losing control of urine when you don't want to?	No	Yes	
Functional performance	I would like you to sit in this chair with your back and arms resting. Then, when I say 'GO', please stand up and walk at a safe and comfortable pace to the mark on the floor (approximately 3 m away), return to the chair and sit down'	0–10 s	11–20 s	One of : >20 s , or patient unwilling , or requires assistance
Totals	Final score is the sum of column totals			

Scoring :
0 - 5 = Not Frail
6 - 7 = Vulnerable
8 - 9 = Mild Frailty
10-11 = Moderate Frailty
12-17 = Severe Frailty

TOTAL /17

Administered by : _____

Appendix 3: Rockwood Clinical Frailty Scale[19]

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

Appendix 4: Compliance monitoring table

- Suggested action/audit: review elderly patients on long acting sulfonylureas avoid as these have higher risk of hypoglycaemia.

Policy lead	**Element(s) to be monitored**	**How will you ensure that the policy is being implemented** (E.g. via an audit, KPIs)	**How often will you monitor that the policy is being implemented**	**Reporting arrangements** (Which committee or group will the monitoring of the policy be reported to?)
Samantha Kelly Dr Sharvanu Saha Dr Darshi Sivakumaran Dr David Strain	Appendix 3. To ensure Frailty has been assessed and appropriate target Hba1c documented. With relevant diabetes treatments adopted.	Level of referral or enquiry to CLCH Diabetes Service for advice on individual case. EMIS/ Eclipse deep dive search at GP practice for at risk patients	Annual	To be agreed
Dr Sharvanu Saha Dr David Strain	Usage of long acting sulfonylureas in the moderate to severe frailty patients	Eclipse/EMIS audit	Annual	To be agreed

Explanatory notes

1. **Lead** Who is the overarching lead for monitoring the policy's implementation?

2. **Element to be monitored** which bits of the policy will you be monitoring to ensure they are implemented or is it the entire thing?

3. **How will you ensure that the policy is being implemented?** For example, will you audit that it is being implemented, will you question staff or service users, use KPIs or if there any other method you will use to ensure it is being implemented.

4. **How often will you monitor that the policy is being implemented?** How often will you check to see if the policy is being implemented e.g. annually, six monthly, quarterly?

5. **Reporting arrangements** where will you report the results of **3.** Which committee or working group or whatever will you be informing as to progress of the policy being implemented.

Appendix 5: EQUALITIES IMPACT ASSESSMENT PRO FORMA

NAME OF POLICY: Prescribing Guidelines for Type 2 Diabetes & Frailty

Manager's name	Samantha Kelly
Division	South West
Date	17th May 2021
Function, policy or service	CLCH Diabetes Specialist Community Services
Main aims, purpose and outcomes of the function, policy, service or work	Tier 3 Community Service
How will these aims affect our statutory duty to: Advance equality of opportunity? Eliminate unlawful discrimination, harassment and victimisation? Foster good relations between different groups?	Ensures that frail vulnerable patients at risk of unscheduled admission are not medically over treated with hypo inducing medications to lower their Hba1c in order to meet QoF targets.
Associated frameworks/NHS Operating Framework mention e.g. national targets NSFs	GMS Contract 2019
Who does it affect? *e.g. staff, patients, carers*	People with diabetes. Carers of older adults living with diabetes, Staff managing people living with diabetes.
Engagement and consultation process carried out *(state who was involved, how and when they were engaged and the key feedback)*	Wandsworth GP Federation frailty consultation exercise. 24th January 2019 CLCH Head of Medicines Management, CLCH Lead Pharmacist CLCH Diabetes Service Leads, CLCH CBU Managers, SWL CCG Medicines Optimisation Team Pharmacists, SWL Borough based Diabetes Steering Groups, GP leads, Senior Prescribing Pharmacist, Nurse Consultant Primary care
What aspects of the policy, including how it is delivered, or accessed, could contribute to inequality?	N/A
What different needs, experiences or attitudes are particular communities or groups likely to have in relation to this policy?	N/A

Please complete the screening assessment grid below for equality groups listed within the Equality Act (2010) and highlight the evidence underlying your assessment.

Equality group	**Positive impact**	**Neutral impact**	**Negative impact**	**Reason/comment/evidence/ necessary action planning following equality analysis screening**
Age *Consider across age ranges on old and younger people.*	x			
Disability *Consider physical and social barriers.*	x			
Gender Reassignment *Consider impact on transgender and transsexual people.*		x		
Marriage and civil partnership		x		
Pregnancy and maternity		x		
Race		x		
Religion/belief (including lack of belief)		x		
Sex (i.e. gender)		x		.
Sexual Orientation *(heterosexual people as well as lesbian, gay and bi-sexual people*		x		
Others *(e.g. carers, homeless people*	x			