# UCLPartners Proactive Care Framework:

## Type 2 Diabetes – Managing Diabetes and Cardiovascular Risk

Version 7

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**The Proactive Care Frameworks (PCF) can be used independently or in conjunction with CVDACTION**

**To request the PCF search tools please visit:**
**UCLPartners Proactive Care Frameworks - UCLPartners**

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# Background to the Frameworks

# The Challenge of Long-Term Condition Management in Primary Care

**Historical challenge in long term condition care**

- Late diagnosis, suboptimal treatment, unwarranted variation
- Focus on reactive rather than proactive care
- Limited support for self-management

**Real World Primary Care**

- Complexity, multimorbidity and time pressures
- Often asymptomatic conditions
- Soaring demand and shifting priorities

**This is a wicked problem**

- Despite decades of QOF incentives, NICE guidance and myriad quality schemes, improvement has been marginal at best
- Primary care needs support to do things differently and at scale

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# UCLPartners Proactive Care Frameworks Address Core Challenges in Primary Care

**Aim**

Help people with long term conditions to stay well longer

**Objectives**

1. Mobilise data - Identify patients whose care needs optimising and prioritise those at highest risk
2. Harness wider workforce - standardise delivery of holistic proactive care by wider primary care team
3. Support GPs to safely manage workflow, improve care and outcomes by releasing capacity

**Framework components**

- ✓ Risk stratification & prioritisation tools
- ✓ Locally adaptable resources to support real world management
- ✓ Systematic use of wider primary care team (eg ARRS* roles) to deliver structured support for education, self-management and behaviour change

**Framework Development**

- Led by primary care clinicians
- Based on NICE guidelines and clinical consensus
- Patient and public support

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*Additional Roles Reimbursement Scheme

# Stratification and Management of Type 2 Diabetes


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# Type 2 Diabetes Stratification and Management

## 1 Identify & 2 Stratify

**This search identifies all patients with T2 Diabetes. These patients are then stratified into priority groups based on HbA1c levels, complications, co-morbidity, social factors and ethnicity**

| High risk | | Medium risk | | Low risk |
|---|---|---|---|---|
| **Priority One**<br><br>**HbA1c >90 OR**<br><br>**HbA1c >75 WITH any of the following:**<br><br>• BAME<br>• Social complexity**<br>• Severe frailty<br>• Insulin or other injectables<br>• Heart failure<br><br>** Social complexity includes Learning disability, homeless, housebound, alcohol or drug misuse | **Priority Two**<br><br>**HbA1c >75 OR**<br><br>**Any HbA1c WITH any of the following:**<br><br>• Foot ulcer in last 3 years<br>• MI or stroke/TIA in last 12 months<br>• Community diabetes team codes<br>• eGFR < 45<br>• Metabolic syndrome<br><br>(Except patients included in Priority 1 group) | **Priority Three**<br><br>**HbA1c 58-75 WITH any of the following:**<br><br>• BAME<br>• Mild to moderate frailty<br>• Previous coronary heart disease or stroke/TIA >12 months previously<br>• BP≥140/90<br>• Proteinuria or Albuminuria<br><br>(Except patients included in Priority 1 and 2 groups) | **Priority Four**<br><br>**HbA1c 58-75 OR**<br><br>**Any HbA1c WITH any of the following:**<br><br>• eGFR 45-60<br>• BP≥140/90<br>• Higher risk foot disease or PAD or neuropathy<br>• Erectile Dysfunction<br>• Diabetic retinopathy<br>• BMI >35<br>• Social complexity<br>• Severe frailty<br>• insulin or other injectables<br>• Heart failure<br><br>(Except patients included in Priority 1, 2 or 3 groups) | **Priority Five**<br><br>**All others**<br><br>(Except patients included in Priority 1-4 groups) |

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# Type 2 Diabetes Stratification and Management

## ❸ Manage

**Healthcare Assistants** undertake initial contact for all risk groups; check blood tests*, urine tests** and blood pressure up to date; provide trusted information on lifestyle risk factors, e.g. smoking cessation, diet and physical activity, alcohol

| High risk | Medium risk | Low risk |
|---|---|---|
| **GP/Diabetes Specialist/ Nurse** | **Clinical pharmacist/ Nurse/ Physician Associate** | **Healthcare Assistant/ other appropriately trained staff** |
| **Medication:**<br>• Adherence<br>• Titration & intensification as appropriate<br><br>**Monitoring**<br>• Medicines optimisation and blood sugar control<br>• Agree HbA1c targets<br>• Lipids/lipid lowering therapy<br>• BP optimisation<br>• Screen and manage Diabetic Foot Disease and Diabetic Kidney Disease<br><br>**Education (including online tools)**<br>• Sick day rules<br>• DVLA guidance<br>• Flu jab<br><br>**Review & Discuss Red flags**<br>• Vision: floaters/flashing lights<br>• Blood sugar control: hypos<br>• Infections<br>• Signposting and Escalation<br>• Diabetes community +- secondary care team/advice<br>**Recall & Code** | **Medication:**<br>• Adherence<br>• Titrate as appropriate<br><br>**Monitoring**<br>• Blood sugar control<br>• Lipids/lipid lowering therapy<br>• BP optimisation<br>• Screen and manage Diabetic Foot Disease and Diabetic Kidney Disease<br><br>**Education**<br>• Sick day rules<br>• Signpost online resources<br>• DVLA guidance<br>• Flu jab<br><br>**Review & Discuss Red flags**<br>• Vision: floaters/flashing lights<br>• Blood sugar control: hypos<br>• Infections<br>• Signposting and Escalation<br><br>**Recall & Code** | **Medication:**<br>• Adherence<br>• Explore/ check understanding<br>• Confirm supply and delivery<br><br>**Education**<br>• Signpost online resources<br>• Risk factors – diet/lifestyle/smoking cessation<br>• DVLA guidance<br>• Flu jab<br>• Advise and signpost re Diabetic Foot Disease<br><br>**Review & Discuss Red flags**<br>• Vision: floaters/flashing lights<br>• Blood sugar control<br>• Infections<br>• Signposting and Escalation<br><br>**Recall & Code** |

*Blood tests: HbA1c and U+E's
**Urine test: microalbuminuria

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# Overview of Type 2 Diabetes Management

**Information / signposting to support education and self management**

**Tailored advice on lifestyle**

| Smoking cessation | Weight management | Diet | Physical Activity | Alcohol |
|---|---|---|---|---|

**Optimise medicines – NICE NG28**

## Optimise diabetes medicines

**Medicines**: offer Metformin SR and SGLT2i as first line therapy unless contraindicated / frailty, with further medicines dependent on co-morbidities

**Agree personalised HbA1c targets** taking account of age, frailty and risk of hypoglycaemia

- ≤48mmol/mol (6.5%) OR
- ≤53mmol/mol (7%) if on a medicine associated with hypoglycaemia

## Optimise blood pressure

BP treatment to target following NICE guidance for hypertension:

**Less than 80 yrs old aim for**

- BP<140/90mmHg OR
- BP < 130/80mmHg if CKD with ACR ≥ 70 mg/mmol

**80 yrs or more aim for:**

- BP<150/90mmHg OR
- BP <140/90mmHg CKD with ACR < 70 mg/mmol
- BP < 130/80mmHg if CKD with ACR ≥ 70 mg/mmol

## Optimise lipid management

**If CVD:** offer high dose high intensity statin
**If CKD:** offer high intensity statin

**For primary prevention:** offer high intensity statin if QRISk ≥10%.

**For CKD and primary prevention :** aim for 40% drop in non-HDL cholesterol

**If CVD (Secondary prevention**): aim for LDL < 2mmol/L

**Embed the 9 care processes**

| | | |
|---|---|---|
| HbA1c – treat to target | BMI - consider eligibility for GLP1s | Smoking – signpost to stop smoking |
| Blood pressure – treat to target | Renal - uACR | Foot check |
| Cholesterol – treat to target | Renal – serum creatinine | Eye check |

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**References:** NICE guideline [NG28] Type 2 diabetes in adults: management
NICE guideline [NG203] Chronic kidney disease: assessment and management
NICE guideline (NG136) Hypertension in adults: diagnosis and management
NICE guidance [NG238] Cardiovascular disease: risk assessment and reduction, including lipid modification

# Hypertension in Patients with Type 2 Diabetes

# Detection and Management of Hypertension in Patients with Type 2 Diabetes

Blood pressure should be checked in patients with Type 2 diabetes to identify undiagnosed hypertension. If hypertension is suspected due to a high BP reading, the diagnosis should be confirmed using ABPM or home BP checks over 7 days.

Checking BP in patients with established hypertension:

- Patients **without** AF:
  - Submit lowest of 3 Home BP readings
- Patients **with** AF:
  - Submit 2 BP readings each morning and evening over 4 days. Calculate the average systolic and diastolic values.

- Please refer to UCLP hypertension pathway for detailed guidance:

https://uclpartners.com/our-priorities/cardiovascular/proactive-care/cvd-resources/

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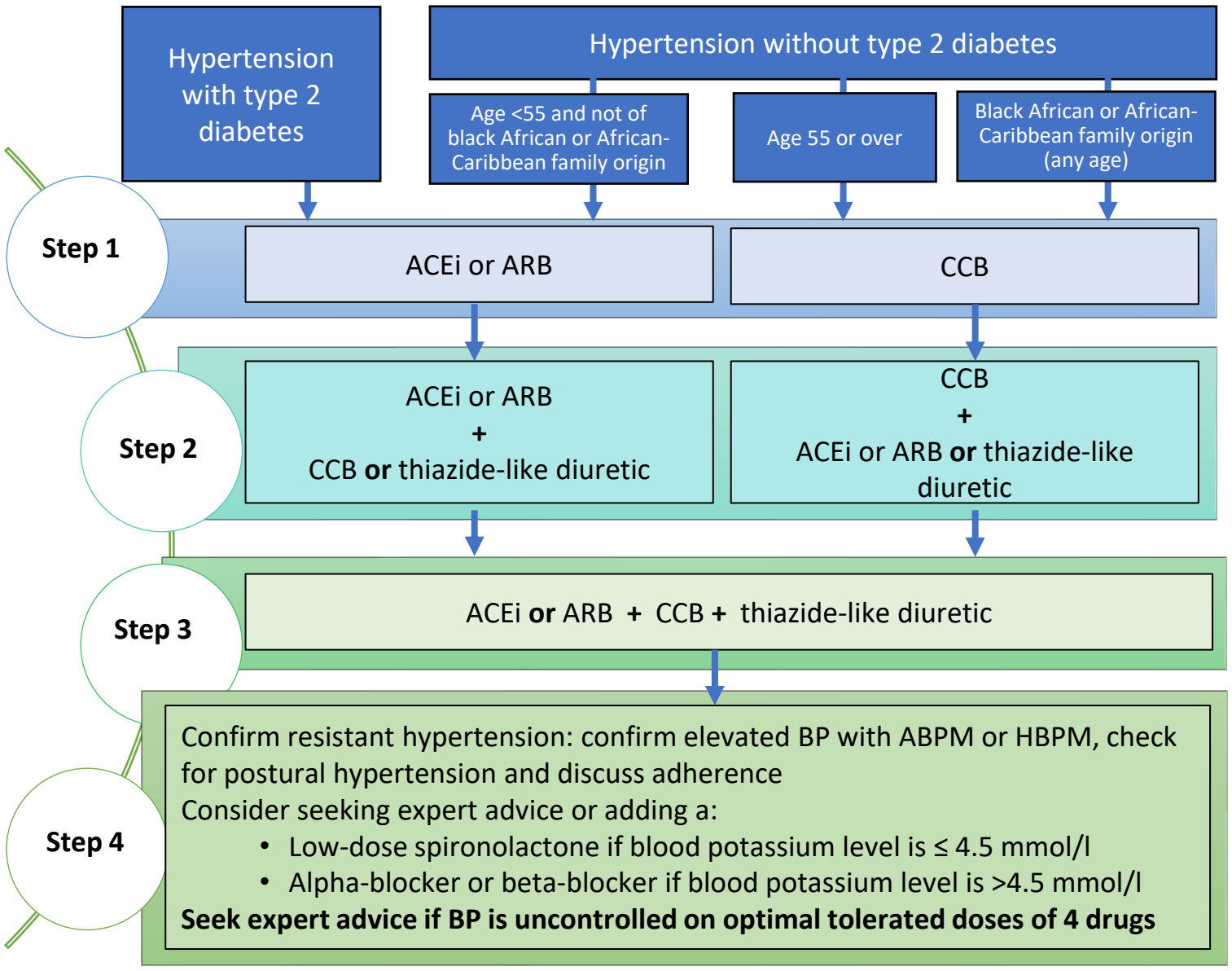
# NICE Hypertension Treatment Pathway (NG136)




Use clinical judgement for people with frailty or multimorbidity

Offer lifestyle advice and continue to offer it periodically

**Monitoring treatment**

Use clinic BP to monitor treatment

Measure standing and sitting BP in people with:

- Type 2 diabetes or
- Symptoms of postural hypotension or
- Aged 80 and over

Advice people who want to self monitor to use HBPM. Provide training and advice

Consider AMPM or HBPM, in addition to clinic BP, for people with white-coat effect or masked hypertension

**BP targets**

Reduce and maintain BP to the following targets:

Age <80 years:

- Clinic BP <140/90 mmHg
- ABPM/HBPM <135/85mmHg

**Postural hypotension:**

- Base target on standing BP

**Frailty or multimorbidity:**

- Use clinical judgement

Pathway adapted from NICE Guidelines (NG136) Visual Summary
https://www.nice.org.uk/guidance/ng136/resources/visual-summary-pdf-6899919517
Abbreviations: ACEi: ACE inhibitor, ARB: Angiotensin II Receptor Blocker, CCB: Calcium Channel Blocker, ABPM: Ambulatory Blood Pressure Monitoring, HBPM: Home Blood Pressure Monitoring

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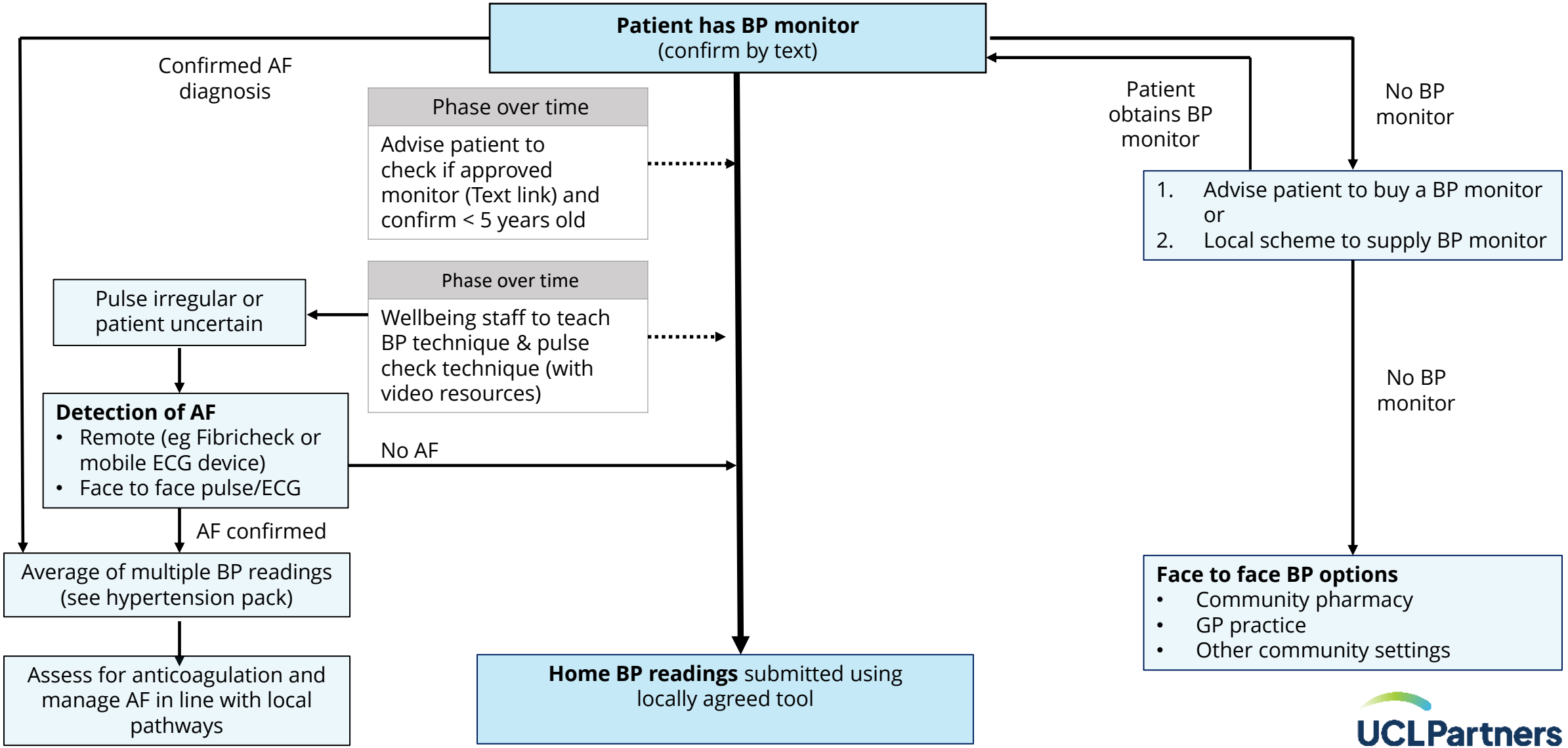
# Home Blood Pressure Monitoring Pathway

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# Atrial Fibrillation in Patients with Type 2 Diabetes

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# Detection and Management of AF in Patients with Type 2 Diabetes

- Palpate pulse and if irregular or patient uncertain:
- Assess for AF using ECG or remote devices:
  - Fibricheck (needs smartphone) www.fibricheck.com and ask them to monitor morning and evening for 7 days
  - Kardia by AliveCor (needs smartphone): www.alivecor.co.uk/kardiamobile
  - MyDiagnostick: www.mydiagnostick.com/
  - Zenicor: https://zenicor.com/
- If AF is confirmed, undertake stroke and bleeding risk assessment and anticoagulate as appropriate.
- **Please refer to UCLP AF pathway for detailed guidance:**

https://uclpartners.com/our-priorities/cardiovascular/proactive-care/cvd-resources/

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# Management of Broader Cardiovascular Risk in Type 2 Diabetes: Cholesterol

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# Managing High Cholesterol and Cardiovascular Risk in People with Type 2 Diabetes

**The following slides will help clinicians manage the broader cardiovascular risk in people with diabetes:**

- **Pre-existing cardiovascular disease**
  - Optimise lifestyle
  - Use of high intensity statins at maximal appropriate dose
- **No pre-existing cardiovascular disease**
  - Optimise lifestyle and lipid lowering therapy as primary prevention in people with:
    - QRisk >10% in ten years
    - CKD 3-5
- **All patients:**
  - Responding to possible statin intolerance
  - Managing muscle symptoms and abnormal LFTs in people taking statins

- Please refer to UCLP lipid pathway for detailed guidance:

https://uclpartners.com/our-priorities/cardiovascular/proactive-care/cvd-resources/

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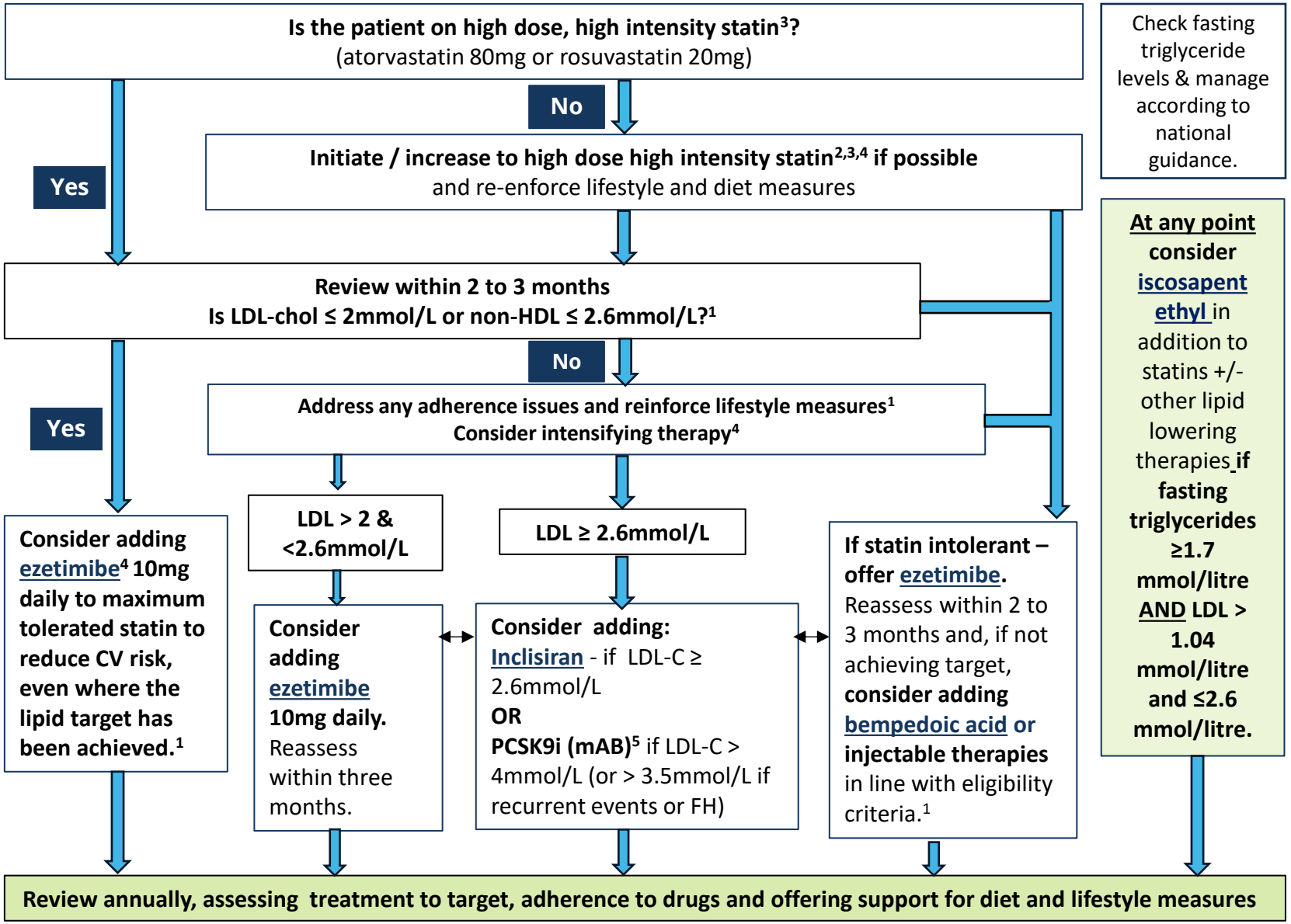
# Lipid Optimisation Pathway for Secondary Prevention[1]




Check fasting triglyceride levels & manage according to national guidance.

**At any point consider iscosapent ethyl in addition to statins +/- other lipid lowering therapies if fasting triglycerides ≥1.7 mmol/litre AND LDL > 1.04 mmol/litre and ≤2.6 mmol/litre.**

**Lipid lowering therapy should be offered to all patients with established CVD[1]**

1. NICE NG238: Cardiovascular disease: risk assessment and reduction, including lipid modification
2. Dose may be limited, for example if:
   - CKD: eGFR<60ml/min – recommended starting dose - atorvastatin 20mg
   - Drug interactions
   - Drug intolerance
   - Older age / frailty
3. See statin intensity table.
4. Use shared-decision making and incorporate patient preference in treatment and care decisions.
5. NICE Guidance: Evolocumab, Alirocumab

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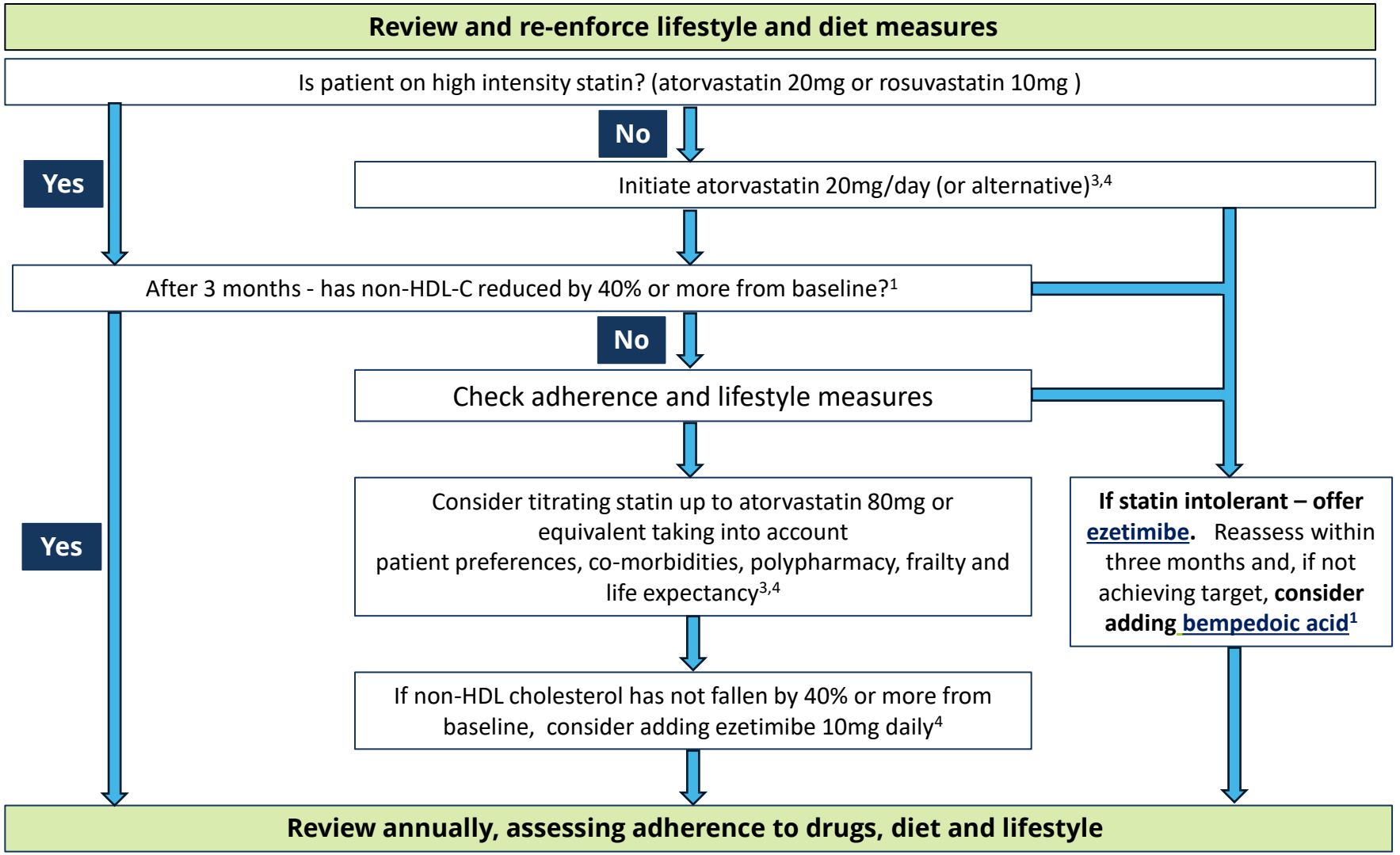
# Optimisation Pathway for Patients with High Cardiovascular Risk – Primary Prevention[1,2]




**Lipid lowering therapy should be offered to all patients at high CV risk[2] . (It may also be considered in individuals with QRIsk < 10% )[1]**

**People living with HIV should be offered statin therapy regardless of QRisk score [5]**

1. NICE NG238: Cardiovascular disease: risk assessment and reduction, including lipid modification
2. High cardiovascular risk:
   - QRisk ≥ 10% in ten years
   - CKD: eGFR<60ml/min or albuminuria
   - Type 1 Diabetes for >10 years or over age 40, nephropathy or other CV risk factors
3. See statin intensity table.
4. Use shared-decision making and incorporate patient preference in treatment and care decisions.
5. BHIVA rapid guidance on the use of statins for primary prevention of cardiovascular disease in people living with HIV v2

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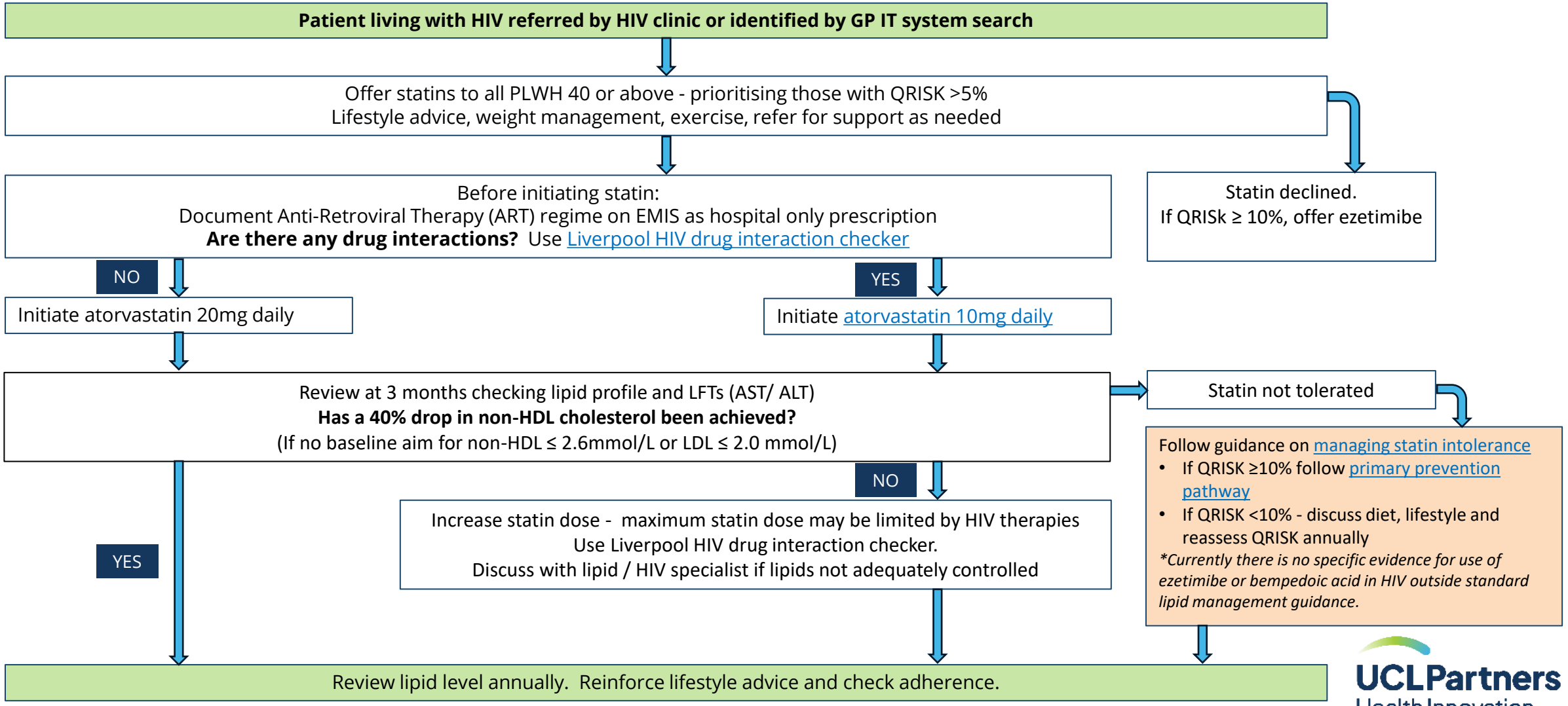
# Statin Initiation for Primary Prevention for People Living with HIV (PLWH) 40 years and above*

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Adapted from a pathway initially developed by SE London ICB; Based on BHIVA rapid guidance on the use of statins for primary prevention of cardiovascular disease in people living with HIV v2

# Common Statin/ARV Interactions and Recommended Doses for PLWH

| ARV Regimen | Effect on Statins | Recommended atorvastatin starting dose | Maximum atorvastatin dose | Recommended rosuvastatin starting dose | Maximum rosuvastatin dose |
|---|---|---|---|---|---|
| **Ritonavir- or cobicistat-boosted darunavir** | Increased atorvastatin and rosuvastatin concentrations. | 10mg | 40mg | 5mg | 20mg |
| **Ritonavir- or cobicistat-boosted elvitegravir** | Increased atorvastatin and rosuvastatin concentrations. | 10mg | 40mg | 5mg | 20mg |
| **Ritonavir- or cobicistat-boosted atazanavir** | Significantly higher atorvastatin and rosuvastatin levels. | 10mg | 10mg | 5mg | 10mg |
| **Lopinavir/ritonavir** | Significantly higher atorvastatin and rosuvastatin levels. | 10mg | 20mg | 5mg | 10mg |
| **Efavirenz** | Variable reductions in atorvastatin. Rosuvastatin preferred first line. | 20mg | 80mg | 10mg | 40mg |
| **Other ARV regimens** | See resources below or seek advice from a lipid / HIV specialist | | | | |

**Standard dosing of Ezetimibe is advised for all ARV regimes**

Please note some antiretrovirals, such as boosted protease inhibitors (e.g. darunavir/ritonavir/cobicistat/atazanavir) and efavirenz can increase lipids, while others are more lipid-friendly. Consider referring patients with persistently elevated lipids to their HIV clinic for optimisation of their antiretroviral regimen.

For further information and advice about interactions: https://www.hiv-druginteractions.org/checker

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Adapted from a pathway initially developed by SE London ICB

# Statin Intolerance Pathway

## Important considerations

- Most adverse events attributed to statins are no more common than placebo[1]
- Consider food and drug interactions which may be contributing to adverse effects – see Summary of Product Characteristics (SmPC)[2,3]
- Stopping statin therapy is associated with an increased risk of major CV events. It is important not to label patients as 'statin intolerant' without structured assessment
- If a person is not able to tolerate a high-intensity statin, aim to treat with the maximum tolerated dose
- A statin at any dose reduces CVD risk – consider annual review for patients not taking statins to review cardiovascular risk and interventions

**A structured approach to reported adverse effects of statins**

- Stop for 4-6 weeks.
- If symptoms persist, they are unlikely to be due to statin
- Restart and consider lower initial dose
- If symptoms recur, consider trial with alternative statin
- If symptoms persist, consider ezetimibe +/- bempedoic acid


1. Reith C et al Metanalysis, Lancet 2025
2. SmPC: Atorvastatin https://www.medicines.org.uk/emc/product/5274/smpc#gref
3. SmPC: Rosuvastatin https://www.medicines.org.uk/emc/product/4366/smpc#gref


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# Digital Resources

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# Resources for Patients

**Diabetes – the basics**

**Living with Type 2 Diabetes Video**
Living with diabetes
https://player.vimeo.com/video/215821359

**What health checks do you need when you have Diabetes**
NHS UK video library
https://player.vimeo.com/video/215816727

**Blood sugar – how to test**
Checking your blood sugar levels

**Healthy eating with Diabetes**
NHS advice on eating well
What is cholesterol and how do I lower it?

**Type 2 Diabetes and exercise**
How to get active while living with a health condition
Get active
Dance to health

**Foot care**
How to look after your feet

**Support from others living with Type 2 Diabetes**:
https://healthunlocked.com/

**Mental Well-being**
Every Mind Matters - NHS (www.nhs.uk)

**Managing blood pressure**
Managing blood pressure at home
Remote blood pressure monitoring video (in English and other languages)

**Confidential diabetes helpline:** 0345 123 2399
Monday to Friday, 9am to 6pm

**Smoking cessation**
NHS support, stop smoking aids, tools and practical tips

**Alcohol**
Heart UK alcohol guidance & NHS Drink Less guidance

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# Digital Resources to Support Healthcare Professionals: Type 2 Diabetes

**Diabetic Foot Disease**:
www.diabetes.org.uk/guide-to-diabetes/complications/feet/taking-care-of-your-feet

**Sick day rules:**
www.england.nhs.uk/london/wp-content/uploads/sites/8/2020/04/3.-Covid-19-Type-2-Sick-Day-Rules-Crib-Sheet-06042020.pdf

**NICE Guidance NG28: Type 2 Diabetes in Adults:** www.nice.org.uk/guidance/ng28

**Locally commissioned digital tools:**
Healthy.io: Albumin-creatinine ratio (ACR) home urine test kits utilising the smartphone camera
My Diabetes My Way: structured education integrating with the GP record
Oviva Diabetes Support: Digital structured education and behaviour change programme including 1:1 remote dietician support
Low Carb Program: Digital support for people with type 2 diabetes to achieve a lower carbohydrate lifestyle

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# Implementation Support

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# Proactive Care Frameworks: Implementation & Support Package

Implementation Support is critical to enable sustainable and consistent spread. UCLPartners has developed a support package for the Integrated Care Systems within our geography covering the following components. The resources below can be accessed via the UCLP website: **Proactive care frameworks – UCLPartners**.

UCLPartners is one of 15 **Health Innovation Networks** (HINs) across England and all 15 have a priority around CVD. Please reach out to your local HIN to understand what support they might be able to provide. Please note each varies in its approach and offer.

| | |
|---|---|
| **Search and stratify** | **Comprehensive search tools** for EMIS and SystmOne to stratify patients<br>• Pre-recorded webinar as to how to use the searches.<br>• Online FAQs to troubleshoot challenges with delivery of the search tools. |
| **Workforce training and support** | **Training tailored to each staff grouping (e.g. some ARRS* roles) and level of experience**<br>• **Delivery:** Scripts provided as well as training on how to use these underpinned with motivational interviewing/ health coaching training to enable adult-to-adult conversations.<br>• **Practical support**: **Recommended training** e.g. correct inhaler technique; correct BP technique, Very Brief Advice for smoking cessation, physical activity etc.<br>• **Digital implementation** support: how to get patients set up with appropriate digital.<br>• **Education** sessions on conditions.<br>• **Communities of Practice.** |
| **Digital support tools** | **Digital resources** to support remote management and self-management in each condition.<br>Support available from UCLP's commercial and innovation team for implementation. |

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# Thank you

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UCLPartners.com/newsletter

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# Version Tracker

| Version | Edition | Changes Made | Date amended | Review due |
|---|---|---|---|---|
| 2 | 2.0 | • Incorporated blood pressure and cholesterol management content for patients with multi-morbidity<br>• Updated slide 3 to highlight a focus on virtual delivery where appropriate | | |
| 3 | 3.0 | • Added option of bempedoic acid<br>• Added slides on Atrial Fibrillation | August 2021 | February 2022 |
| 4 | 4.0 | • Introduction slides updated<br>• HCA roles amended to ARRS roles<br>• Lipid pathway treatment targets updated to align with NICE and AAC guidance<br>• Website links checked and updated | December 2022 | December 2023 |
| 4 | 4.1 | • Updated cholesterol pathway slides<br>• Amended introduction slides and updated resources links | September 2023 | September 2024 |
| 5 | 5.0 | • Updated cholesterol pathway slides to align with NICE<br>• Updated implementation slide | January 2024 | January 2025 |
| 5 | 5.1 | • New UCLP branding applied | April 2024 | April 2025 |
| 6 | 6 | • Secondary care pathway slide amended to included statin monitoring info and high intensity statin examples incorporated within pathway. | June 2024 | January 2025 |
| 7 | 7 | • Updated in line with NICE guidance NG28 Type 2 diabetes, added overarching management slide, guidance on drug choice and alignment with updated lipid and hypertension PCFs | June 2026 | June 2027 |