UCLPartners Proactive Care Framework:

Type 2 Diabetes – Managing Diabetes and Cardiovascular Risk

Version 5.1

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The Proactive Care Frameworks can be used independently. To request the search tools please visit: UCLPartners Proactive Care Frameworks - UCLPartners

They can also be used in conjunction with CVDACTION

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Background to the Frameworks

The Challenge of Long-Term Condition Management in Primary Care

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Historical challenge in long term condition care:

- Late diagnosis, suboptimal treatment, unwarranted variation
- Lack of self-management support
- Holistic care not always provided

Real world primary care:

- Complexity, multimorbidity and time pressures
- Soaring demand and shifting priorities
- Winter pressures

Pandemic impact:

- Disruption of routine care in long term conditions
- Risk of poorer outcomes for patients and health inequalities
- An increase in health care demand

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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

Cardiovascular Disease (CVD) Conditions – Stratification and Management

ARRS[$] roles/ other appropriately trained staff

Gather information e.g. Up to date bloods, BP, weight, smoking status, run risk scores: QRISK*, CHA_2DS_2VASc, HASBLED.

Self management e.g. Education (condition specific, CVD risk reduction), self care (eg red flags, BP measurement, foot checks), signpost shared decision making.

Behaviour change e.g. Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol.

Risk Stratification & Prioritisation

Atrial Fibrillation

Blood Pressure

Cholesterol

Diabetes

Prescribing Clinician

Optimise therapy and mitigate risk
Review blood results, risk scores & symptoms.
Initiate or optimise therapy.
Check adherence and adverse effects.
Review complications and co-morbidities.
CVD risk – BP, cholesterol, pre-diabetes, smoking, obesity.

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*QRISK 3 score is recommended to assess CV risk for patients with Severe Mental Illness, Rheumatoid Arthritis , Systemic Lupus Erythematosus, those taking antipsychotics or oral steroids

[$]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 **Hba1c >90 OR** **Hba1c >75 WITH any of the following:** • BAME • Social complexity** • Severe frailty • Insulin or other injectables • Heart failure ** Social complexity includes Learning disability, homeless, housebound, alcohol or drug misuse	**Priority Two** **Hba1c >75 OR** **Any HbA1c WITH any of the following:** • Foot ulcer in last 3 years • MI or stroke/TIA in last 12 months • Community diabetes team codes • eGFR < 45 • Metabolic syndrome (Except patients included in Priority 1 group)	**Priority Three** **Hba1c 58-75 WITH any of the following:** • BAME • Mild to moderate frailty • Previous coronary heart disease or stroke/TIA >12 months previously • BP≥140/90 • Proteinuria or Albuminuria (Except patients included in Priority 1 and 2 groups)	**Priority Four** **Hba1c 58-75 OR** **Any HbA1c WITH any of the following:** • eGFR 45-60 • BP≥140/90 • Higher risk foot disease or PAD or neuropathy • Erectile Dysfunction • Diabetic retinopathy • BMI >35 • Social complexity • Severe frailty • insulin or other injectables • Heart failure (Except patients included in Priority 1, 2 or 3 groups)	**Priority Five** **All others** (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 to provide; check HBA1C up to date, provide information on risk factors, eg smoking cessation, diet and exercise, waist circumference

High risk	Medium risk	Low risk
GP/Diabetes Specialist/ Nurse	**Clinical pharmacist/ Nurse/ Physician Associate**	**Healthcare Assistant/ other appropriately trained staff**
Medication: • Adherence • Titration & intensification as appropriate **Monitoring** • Blood sugar control & personal targets • Agree HBA1C targets • Lipids/lipid lowering therapy • BP optimisation • Screen and manage Diabetic Foot Disease and Diabetic Kidney Disease **Education (inc online tools)** • Sick day rules • DVLA guidance • Flu jab **Review & Discuss Red flags** • Vision: floaters/flashing lights • Blood sugar control: hypos • Infections • Signposting and Escalation • Diabetes community +- secondary care team/advice **Recall & Code**	**Medication:** • Adherence • Titrate as appropriate **Monitoring** • Blood sugar control • Lipids/lipid lowering therapy • BP optimisation • Screen and manage Diabetic Foot Disease and Diabetic Kidney Disease **Education** • Sick day rules • Signpost online resources • DVLA guidance • Flu jab **Review & Discuss Red flags** • Vision: floaters/flashing lights • Blood sugar control: hypos • Infections • Signposting and Escalation **Recall & Code**	**Medication:** • Adherence • Explore/ check understanding • Confirm supply and delivery **Education** • Signpost online resources • Risk factors – diet/lifestyle/smoking cessation • DVLA guidance • Flu jab • Advise and signpost re Diabetic Foot Disease **Review & Discuss Red flags** • Vision: floaters/flashing lights • Blood sugar control • Infections • Signposting and Escalation **Recall & Code**

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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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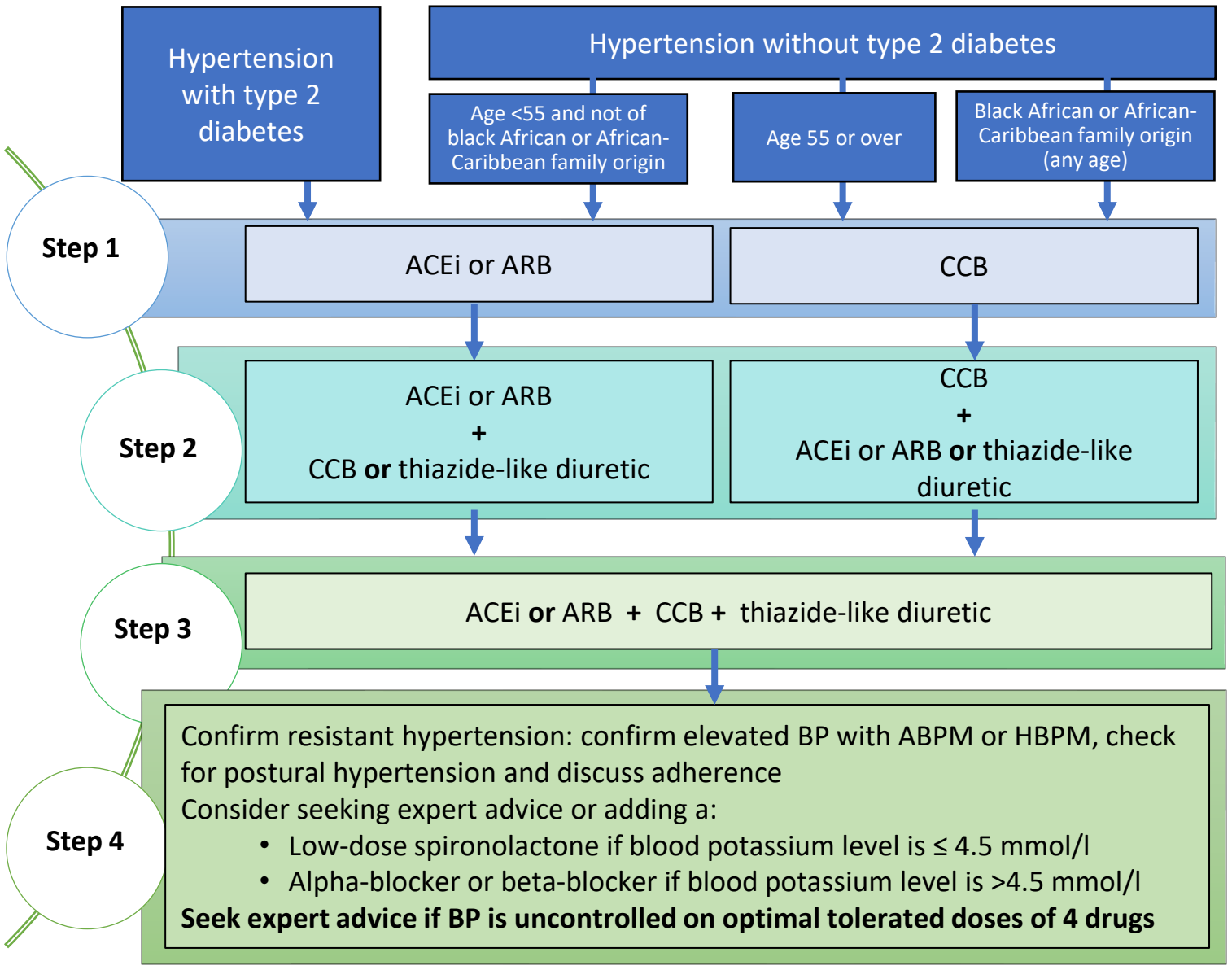
NICE Hypertension Treatment Pathway (NG136)



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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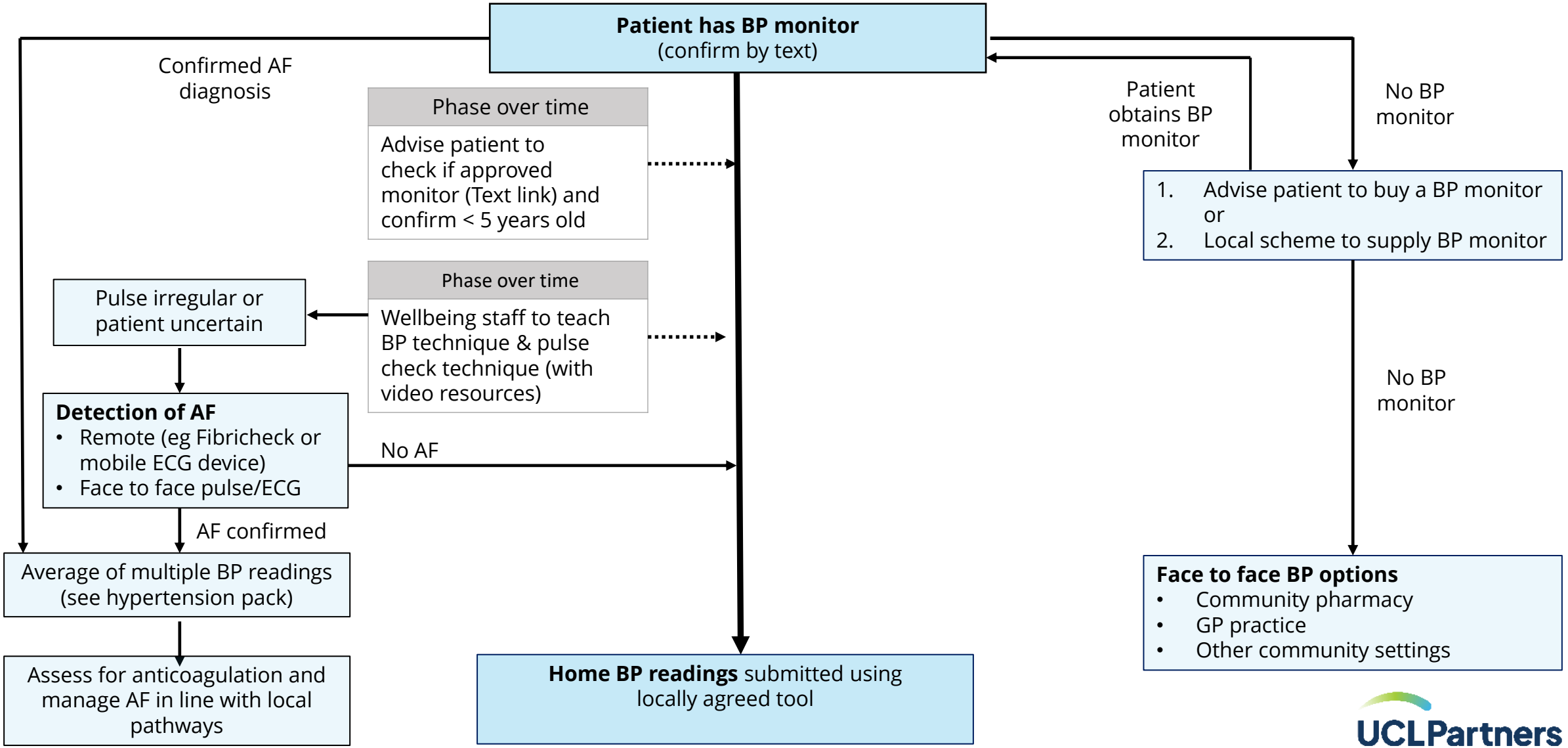
Home Blood Pressure Monitoring Pathway



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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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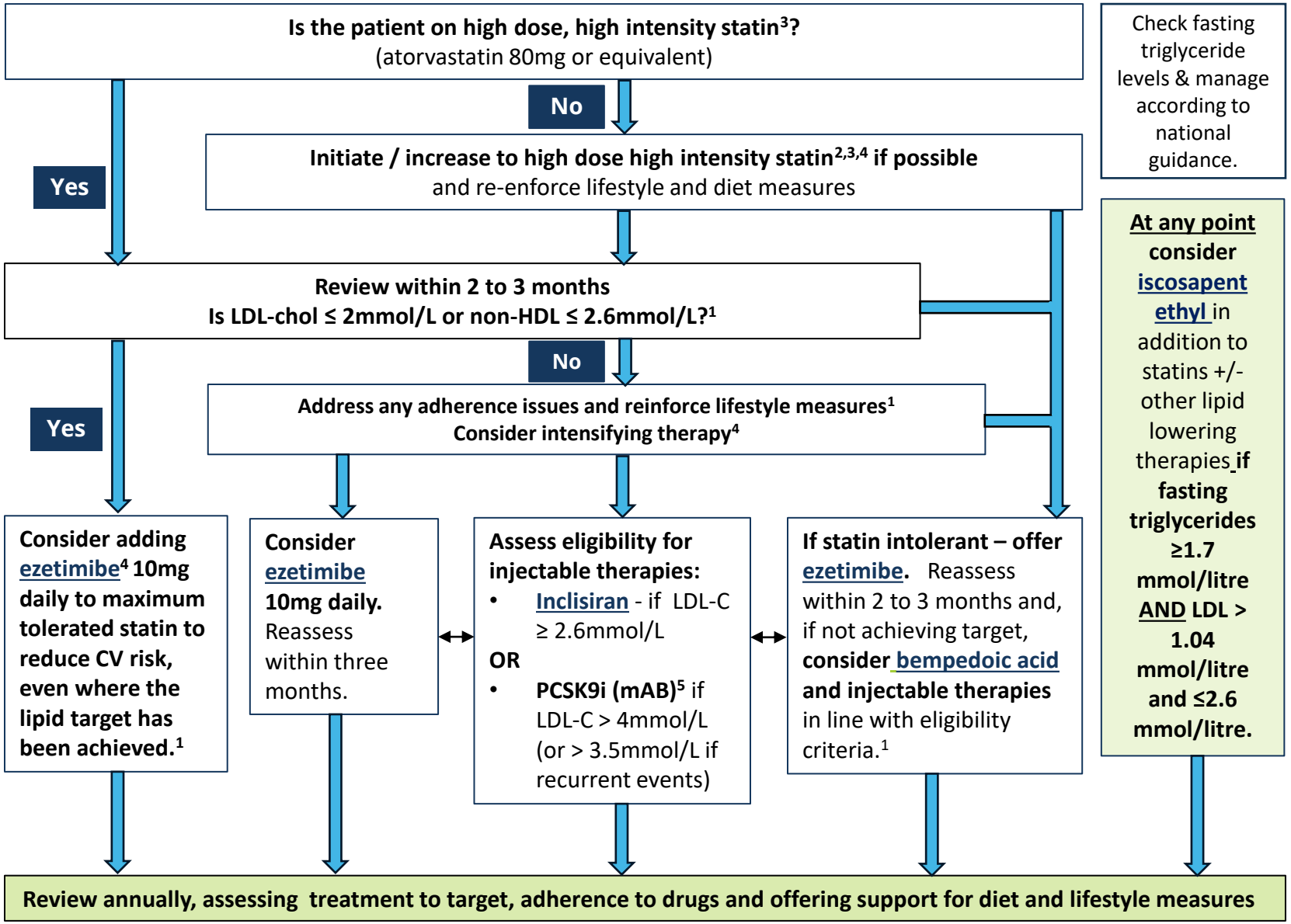
Lipid Optimisation Pathway for Secondary Prevention[1]



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.

Secondary prevention should be offered to all patients with established CVD[1]

High Intensity Statin for secondary prevention[3]	
Atorvastatin	80mg
Rosuvastatin	20mg

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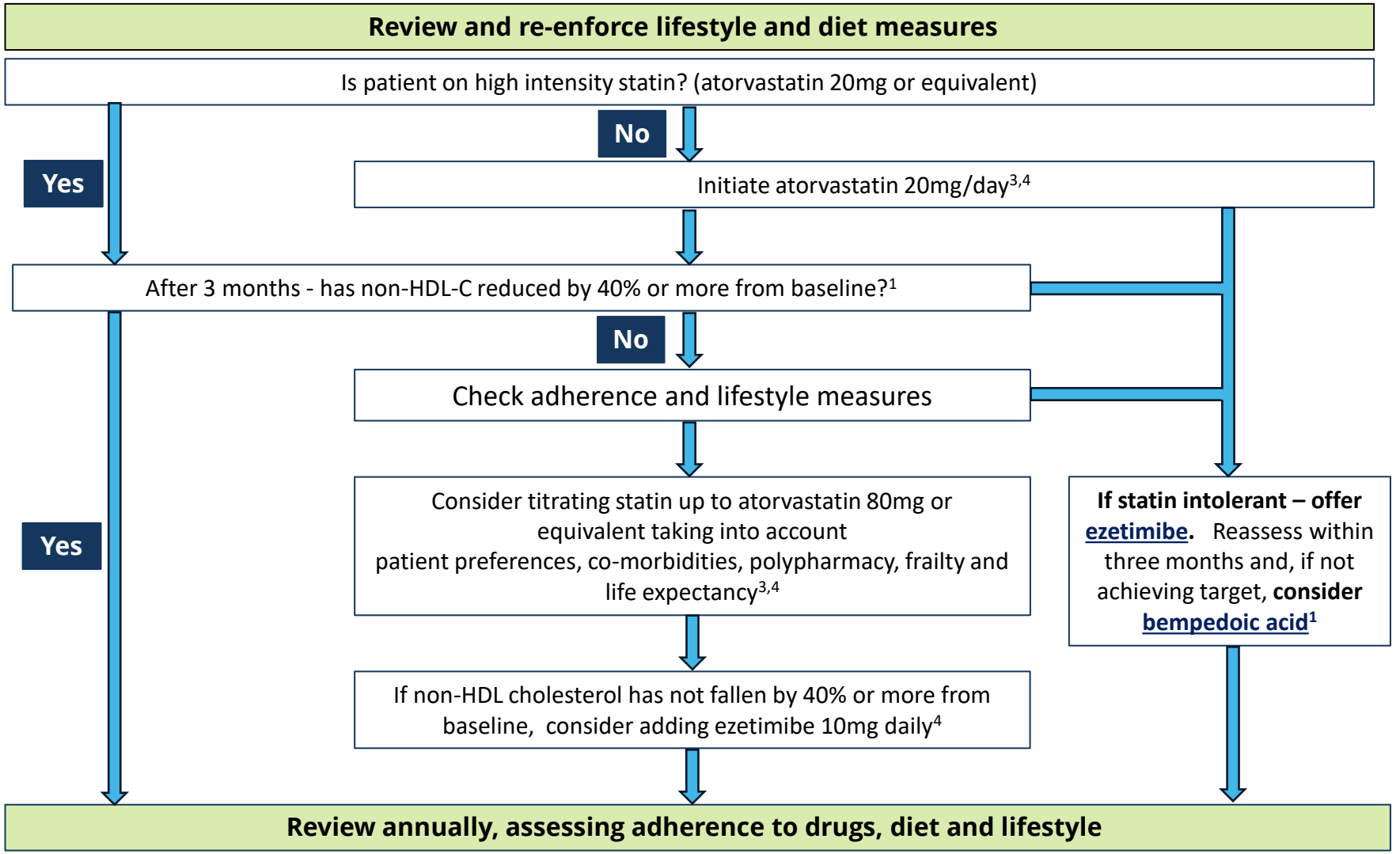
Optimisation Pathway for Patients with High Cardiovascular Risk – Primary Prevention[1,2]



Primary prevention should be offered to all patients with a QRisk ≥ 10% after addressing lifestyle modification (It may also be considered in individuals with QRIsk < 10%)[1]

Optimal High Intensity Statin for Primary Prevention	
Atorvastatin	20mg
Rosuvastatin	10mg

1. NICE NG238: Cardiovascular disease: risk assessment and reduction, including lipid modification
2. High cardiovascular risk:
   - QRisk >10% in ten years
   - CKD 3-5
   - Type 1 Diabetes for >10 years or over age 40
3. See statin intensity table.
4. Use shared-decision making and incorporate patient preference in treatment and care decisions.

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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. (Collins et al systematic review, Lancet 2016)
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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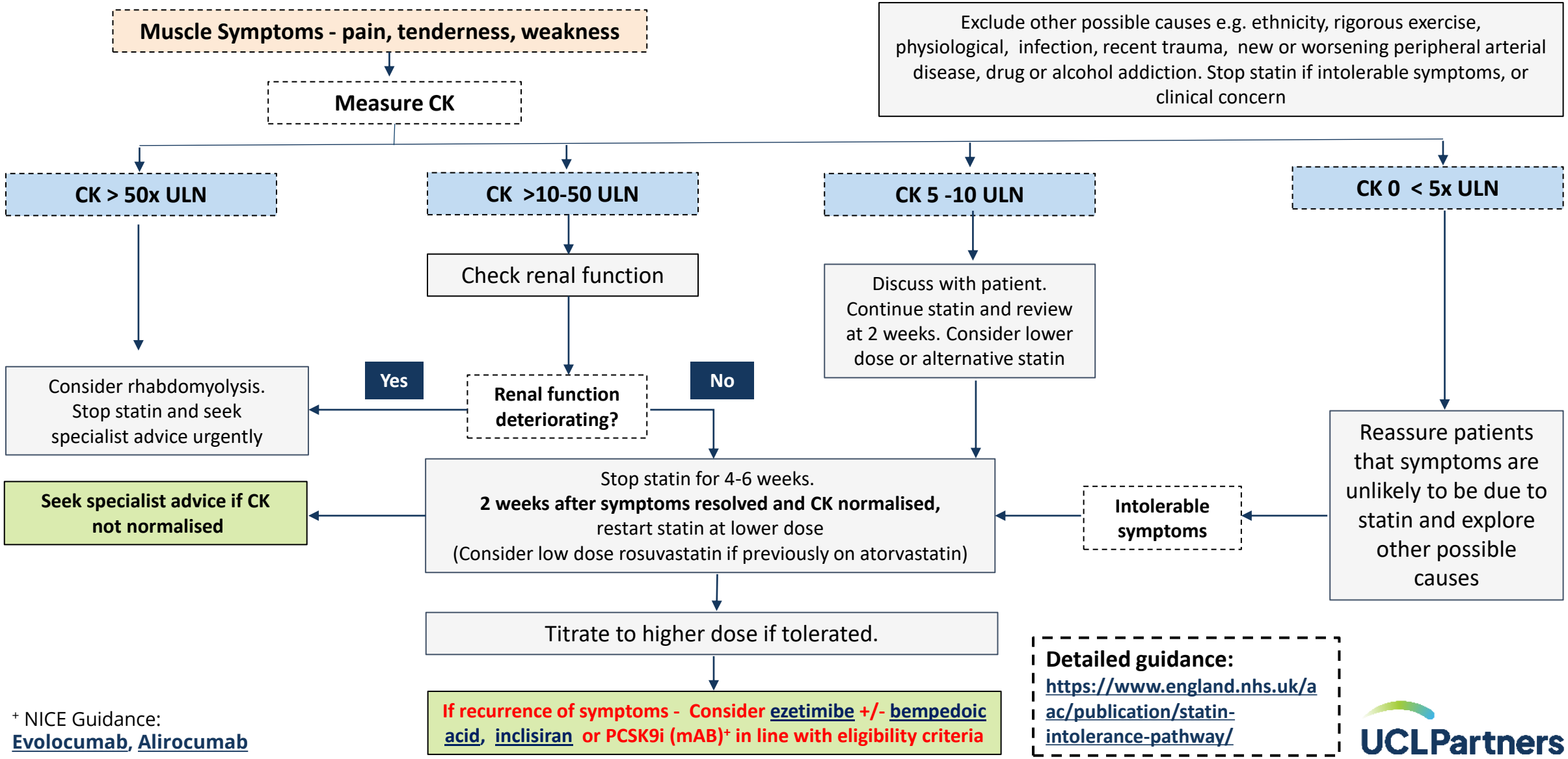
Muscle Symptoms Pathway



+ NICE Guidance:
Evolocumab, Alirocumab

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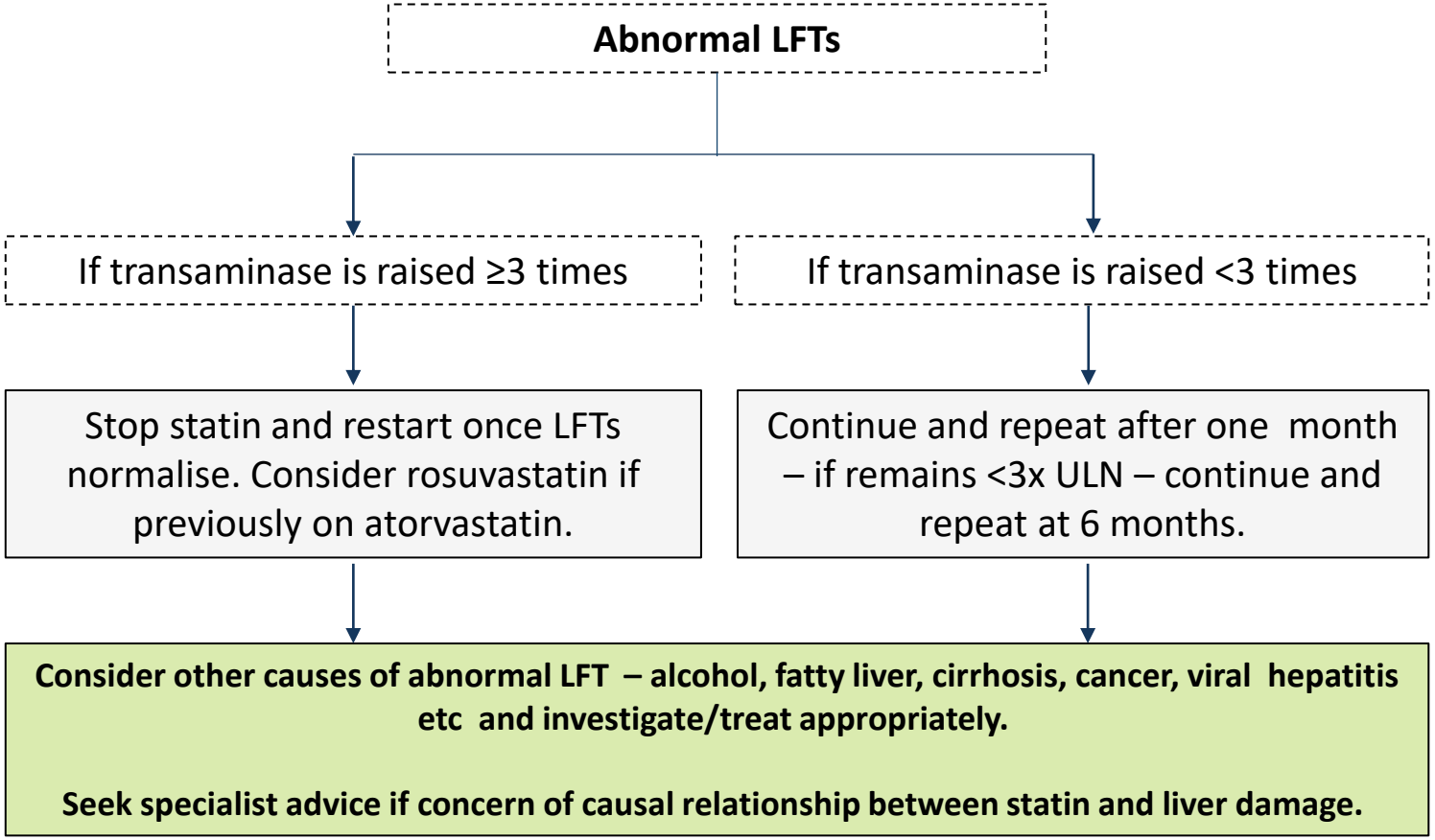
Abnormal Liver Function Test (LFT) Pathway



Check liver function at baseline, within 3 months and at 12 months after initiation of statin therapy.

- Do not routinely exclude from statin therapy people who have liver transaminase levels that are raised but are less than 3 times the upper limit of normal.
- Most adults with fatty livers are likely to benefit from statins and this is not a contraindication.

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Shared Decision-Making Resources

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Shared Decision-Making Resources

Benefits per 10,000 people taking statin for 5 years	Events avoided
Secondary Prevention: Major CV events* avoided in patients with pre-existing CVD & a 2mmol/l reduction in LDL	1,000
Primary Prevention: Major CV events* avoided in patients with no pre-existing CVD & a 2mmol/l reduction in LDL	500

Adverse events per 10,000 people taking statin for 5 years	Adverse events
Myopathy	5
Haemorrhagic Strokes	5-10
Diabetes Cases	50-100

**Major CV events = CV death, non-fatal myocardial infarction and non-fatal stroke*

Shared decision-making resources:

- **BHF information on statins**
- **Heart UK: Information on statins**
- **NICE shared decision-making guide**

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Ref: Collins et al 2016 Lancet Systematic Review Lancet 2016; 388: 2532–61

Statin Intensity Table – NICE recommends Atorvastatin and Rosuvastatin as First Line

Approximate Reduction in LDL-C					
Statin dose mg/day	5	10	20	40	80
Fluvastatin			21%	27%	33%
Pravastatin		20%	24%	29%	
Simvastatin		27%	32%	37%	42%
Atorvastatin		37%	43%	49%	55%
Rosuvastatin	38%	43%	48%	53%	
Atorvastatin + Ezetimibe 10mg		52%	54%	57%	61%

Low/moderate intensity statins will produce an LDL-C reduction of 20-30%

Medium intensity statins will produce an LDL-C reduction of 31-40%

High intensity statins will produce an LDL-C reduction above 40%

Simvastatin 80mg is not recommended due to risk of muscle toxicity

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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
10 Tips for healthy eating if you are at risk of Type 2 diabetes
NHS advice on eating well
What is cholesterol and how do I lower it?

Type 2 Diabetes and exercise
Moving more to reduce your risk of type 2 diabetes
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

ACR - home urine testing : Healthy.io https://healthy.io/urinalysis-products/

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 • Pre-recorded webinar as to how to use the searches. • 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** • **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. • **Practical support**: **Recommended training** e.g. correct inhaler technique; correct BP technique, Very Brief Advice for smoking cessation, physical activity etc. • **Digital implementation** support: how to get patients set up with appropriate digital. • **Education** sessions on conditions. • **Communities of Practice.**
Digital support tools	**Digital resources** to support remote management and self-management in each condition. **Implementation** toolkits available where required, e.g. MyCOPD. Support available from UCLP's commercial and innovation team for implementation.

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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 • Updated slide 3 to highlight a focus on virtual delivery where appropriate		
3	3.0	• Added option of bempedoic acid • Added slides on Atrial Fibrillation	August 2021	February 2022
4	4.0	• Introduction slides updated • HCA roles amended to ARRS roles • Lipid pathway treatment targets updated to align with NICE and AAC guidance • Website links checked and updated	December 2022	December 2023
4	4.1	• Updated cholesterol pathway slides • Amended introduction slides and updated resources links	September 2023	September 2024
5	5.0	• Updated cholesterol pathway slides to align with NICE • Updated implementation slide	January 2024	January 2025
5	5.1	• New UCLP branding applied	April 2024	April 2025