



**Cornwall and
Isles of Scilly**

Type 2 Diabetes and Frailty Guidance

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NHS Cornwall and Isles of Scilly Integrated Care Board

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1. Introduction

This local guidance provides healthcare professionals with further advice to promote the appropriate management of Type 2 diabetes in this more vulnerable and complex cohort of patients. Once established, apart from age and gender, frailty is the single biggest predictor of mortality in older adults (1). Elderly and frail individuals with diabetes are at an increased risk of adverse effects from treatments for diabetes, including admissions to hospital, and are less likely to benefit from the long-term protective effects of good glycaemia control. The aim is to balance the benefits of tight glycaemic control with the associated increased risks.

NICE guidance Type 2 Diabetes in adults: management (NG28) recommends clinicians:

“Consider relaxing the target HbA1c level on a case by-case basis, with particular consideration for people who are older or frail, for adults with type 2 diabetes.

Consider reviewing the person's overall diabetes treatment plan to ensure that they are taking the smallest effective number of medications, at the lowest effective dosage.”

For adults with type 2 diabetes and frailty:

- Offer modified-release metformin.
- Only offer an SGLT2 inhibitor if the person's level of frailty does not place them at risk of adverse events from such a medicine (for example, volume depletion or hypotension).

If metformin is contraindicated or not tolerated, assess whether their level of frailty places the person at risk of adverse events from SGLT-2 inhibitors:

- if it does not, consider monotherapy with a SGLT-2 inhibitor
- if it does, consider monotherapy with a DPP-4 inhibitor.

For adults with frailty who need further medicines to manage their hyperglycaemia symptoms and reach their individualised glycaemic targets:

- consider adding a DPP-4 inhibitor to their current treatment or
- if they are already taking a DPP-4 inhibitor or if a DPP-4 inhibitor is contraindicated, not tolerated or is not effective, consider adding 1 of the following to their current treatment:

- pioglitazone or
- a sulfonylurea or
- an insulin-based treatment

When choosing a treatment with the person, take into account that sulfonylureas and insulin-based treatments can increase the risk of hypoglycaemia and falls.

See Appendix 1 for NICE 2 page visual summary on factors to take into account when reviewing medicines.

2. Assessment of Frailty

If frailty is a concern, assess for it before starting medicines. The [Rockwood Clinical Frailty scale](#) (2) can be used to assess for frailty and the frailty categorisation should be coded on the patient record. There is also a [Top Tips](#) resource which may be helpful for clinicians. It is recommended that this is considered as part of the patient's annual review but may also be required more regularly.

3. Frailty and Type 2 Diabetes – suggested changes in approach to treatment

Mildly Frail – Rockwood CFS 1-5

Treatment Goals – Reverse frailty or limit its progression; Maintain functional status, independence and quality of life; Prevent or delay macro/microvascular complications

Status	Recommended targets	Recommended interventions
Functional and independent and Life expectancy likely to be over 10 years	- HbA1c 53 - 58 mmol/mol - Avoid low levels of HbA1c <53 if on insulin or SU (no evidence of benefit and increased risk of hypo)	- Offer modified-release metformin as first-line treatment. - Appropriate to consider DPP-4, GLP1, Pioglitazone or SGLT2i (gliflozins) and insulin if HbA1c above target or symptoms of hyperglycaemia. - Caution with sulphonylureas (SU) e.g gliclazide as increased risk of hypoglycaemia. Reassess/reduce if worsening frailty or hypos

Moderately Frail – Rockwood CFS 6

Treatment Goals – Limit progress of microvascular complications; Prevent decline in quality of life; Avoid emergencies such as hypoglycaemia

Status	Recommended targets	Recommended interventions
Some impairment in activities of daily living and Life expectancy likely to be less than 10 years	- HbA1c 53 - 64 mmol/mol - Avoid low levels of HbA1c < 59 if on insulin or SU	- Do not use GLP1, Pioglitazone or SGLT2i unless to control symptoms or to avoid insulin (A DPP-4 inhibitor may be useful here) - Consider insulin treatment to control severe hyperglycaemia with symptoms (Isophane or Analogue once daily)

Severely Frail or Very Severely Frail – Rockwood CFS 7-8

Treatment Goals – Improve quality of life by reducing symptoms or hospitalisations; Maintain functional status, preventing further lower limb dysfunction, prevention significant disability

Status	Recommended targets	Recommended interventions
Reduced life expectancy and Especially: Multiple co-morbidities ‘Moderately frail’ patients requiring paramedic for hypo management or admitted to hospital with hyper or hypoglycaemia.	HbA1c 53 - 69mmol/mol Avoid low levels of HbA1c <59 if on insulin or SU ‘Target’ HbA1c may not be necessary except as a means of assessing the risk of hypoglycaemia or severe metabolic decompensation Less aggressive glycaemic targets but avoid hypoglycaemia and be aware that hyperglycaemia can increase risk of infections and cause urinary incontinence, thirst and dehydration No need to measure urine albumin-creatinine ratio	De-escalate treatment – Reduce drugs - Consider whether possible to stop insulin (seek advice) and/or SU Do not use GLP-1, Pioglitazone or SGLT-2i. SGLT2i can cause increased risk of DKA/dehydration.

4. Other considerations

	Rockwood CFS 1-5	Rockwood CFS 6	Rockwood CFS 7-8
Blood Pressure (BP) Measure BP when sitting and one minute after standing – use lower value for therapeutic decisions (8)	Age < 80 years Clinic BP < 140/90mmHg Age 80 years plus Clinic BP < 150/90mmHg	Average systolic BP in range of 140-160mmHg.	No set BP target may be appropriate. Harms likely to exceed benefits. Deprescribing advised.
Cholesterol (8)	Lipid lowering treatment unless contraindicated	Primary prevention: deprescribing advised. Secondary prevention: NNT likely to exceed 100/year to prevent one cardiovascular event – discuss stopping	Harms likely to exceed benefits. Deprescribing advised
Chronic Kidney Disease	Ensure antidiabetic prescribing is appropriate given the patient's renal function. Note: eGFR is known to over-estimate renal function in frail elderly patients consider Cockcroft-Gault equation to estimate CrCl). Stop metformin (and caution with other drugs) if eGFR is deteriorating, or below 30 or adversely impacting on appetite. Renal metabolism of insulin decreases with reduced eGFR leading to an increase in risk of hypoglycaemia (7) The glucose lowering efficacy of SGLT-2i also reduces with reduced eGFR so additional glucose lowering treatment should be considered. For dapagliflozin, it is reduced when eGFR is < 45 mL/min/1.73m², and is likely absent in patients with severe renal impairment (8). They may however still be clinically appropriate as a nephroprotective agent.		

5. Targets for capillary blood glucose (CBG) levels in frail patients (including inpatients)

Rockwood CFS	Intermediate risk of hypoglycaemia Patients on insulin and/or sulphonylurea therapy	High risk of hypoglycaemia or recurrent hypos in spite of optimisation of insulin and/or oral hypoglycaemic therapy (seek advice)
CFS 1-5: 'mild frailty'	CBG (pre-meal) 6-11mmol/l	CBG (pre-meal) 8-15 mmol/l
CFS 6: 'moderate frailty'	CBG (pre-meal) 8-15 mmol/l	CBG (pre-meal) 10-20 mmol/l
CFS 7-8: 'severe frailty'	CBG (pre-meal) 8-15 mmol/l	CBG (pre-meal) 10-25 mmol/l In the very frail it may be appropriate to accept higher CBGs than this but care is needed to avoid decompensation and DKA/HHS

6. Appendix 1

[NICE 2 page visual summary](#) on factors to take into account when choosing, reviewing and changing medicines.

Type 2 diabetes in adults: choosing, reviewing and changing medicines

Diet and healthy living advice

At each point, reinforce advice about diet and other aspects of healthy living (also see the [NICE guideline on overweight and obesity](#) and the [NHS better health website](#)).

Involving people in medicine discussions

Discuss the benefits and risks of each medicine treatment option with adults with type 2 diabetes, and support them to make an informed decision about their treatment. Take into account the:

- effect of each medicine on HbA1c and weight
- effectiveness of each medicine at preventing and managing cardiovascular and renal conditions
- factors that might prevent the person from following a specific treatment option (for example, pioglitazone is contraindicated for people with heart failure)
- cost: when more than 1 medicine from the same drug class are equally suitable for the person, use the least expensive.

If a person has more than one comorbidity (for example, [atherosclerotic cardiovascular disease](#) and obesity; see [recommendation 1.9.3](#)), make a shared decision with them about which comorbidity to prioritise when choosing medicines. Take into account: medicines required for cardiovascular and renal protection (for example, subcutaneous semaglutide (Ozempic) for people with atherosclerotic cardiovascular disease), medicines that are contraindicated (for example, metformin for people with chronic kidney disease and an eGFR of less than 30 mL/min/1.73 m²), and any other medicines they are taking and at what dose, particularly if the person has frailty (see [recommendations for people with frailty in the initial medicines section](#)).

Give clear sick day rules in each person's individualised treatment plan (also see [the guideline section on sick day rules](#)).

Reviewing medicines

When reviewing treatments, make a shared decision about changes with the person with type 2 diabetes. See the [recommendations on involving people in medicine discussions](#). Optimise their current treatment regimen before changing treatments, taking into account factors such as:

- adverse effects
- prescribed doses and formulations
- adherence to, and management of, existing medicines
- the need to revisit advice about diet and healthy living.

If response to medicines suggests that type 2 diabetes might not be the correct diagnosis, see the [recommendations on initial diagnosis and revisiting initial diagnosis in NICE's guideline on managing type 1 diabetes](#).

If the person has reached their individualised glycaemic and weight targets (as defined in [NICE's guideline on overweight and obesity](#)), consider continuing any medicines that have contributed to this.

Consider continuing SGLT-2 inhibitors for their cardiovascular or renal benefits, even if they do not help the person reach their individualised glycaemic targets.

Stop GLP-1 receptor agonists or tirzepatide if:

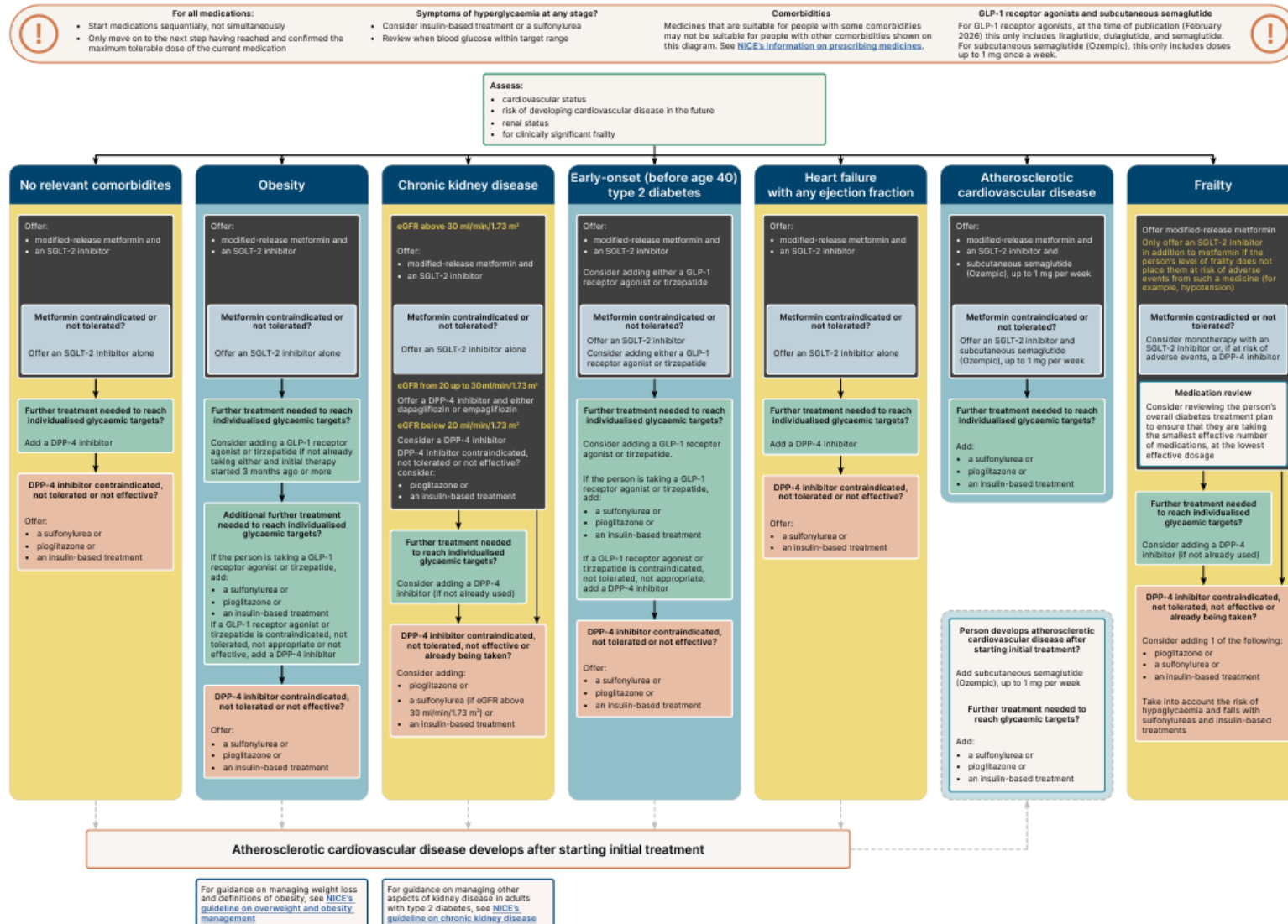
- the person becomes underweight (BMI under 18.5 kg/m²), or
- they do not help the person reach their individualised glycaemic targets and they are not being taken for their cardiovascular benefits.

Do not offer a GLP-1 receptor agonist or tirzepatide and a DPP-4 inhibitor together to treat type 2 diabetes.

People already on standard-release metformin

Continue standard-release metformin if it is effective. Switch to modified-release metformin if standard-release metformin is not tolerated, or this is the person's preference.

Type 2 diabetes in adults: choosing medicines for first line and further treatment



This diagram covers only part of the guideline content. For full details, see [NICE's Type 2 diabetes in adults: management](#). © NICE 2026. All rights reserved. Subject to [notice of rights](#). Last updated February 2026. ISBN 978-1-4731-9285-0.

7. References

1. Clegg A, Bates C, Young J, et al. Development and validation of an electronic frailty index using routine primary care electronic health record data. *Age Ageing* 2016; 45: 353–360.
2. [Rockwood Frailty Scale](#): Figure 1. Clinical frailty scale. Adapted with permission from Moorhouse P, Rockwood K. Frailty and its quantitative clinical evaluation *R Coll Physicians Edinb*. 2012;42:333-340
3. National Institute for Health and Care Excellence (2019) Hypertension in adults: diagnosis and management NG136, <https://www.nice.org.uk/guidance/ng136> (accessed 12 November 2025).
4. National Institute for Health and Care Excellence (2015) Type 2 diabetes in adults: management NG28, <https://www.nice.org.uk/guidance/ng28> (accessed 12 November 2025).
5. Diabetes and frailty: guidance on the management of older adults with type 2 diabetes Strain, Down, Brown, Puttanna, and Sinclair *Diabetes Ther*. 2021 May; 12(5): 1227–1247.
6. <https://primarycare.northeastlondon.icb.nhs.uk/wp-content/uploads/2024/07/Kidney-disease-in-the-frail-and-elderly.pdf>
7. Astra Zeneca (2025) *Dapagliflozin 10 mg film coated tablets SmPC*. Available at: <https://www.medicines.org.uk/emc/product/101534/smpc> (Accessed: 25 Feb 2026)

8. Additional Resources

1. [PrescQIPP Bulletin 371](#): Polypharmacy and de-prescribing.
2. [British Geriatrics Society](#): Pragmatic prescribing to reduce harm for older people with moderate to severe frailty
3. Sinclair A, Gallagher A. Managing frailty and associated comorbidities in older adults with diabetes: [Position Statement on behalf of the Association of British Clinical Diabetologists \(ABCD\)](#). December 2019. Archived on website: This resource has not been reviewed within the last three years to reflect up to date clinical guidelines and should be referenced with care. Tables 1, 2 and 3 give useful considerations of the medicines when using in older frail populations.