

NICE GUIDELINE NG28 · UPDATED 18 FEBRUARY 2026

Type 2 Diabetes and Frailty

The frailty arm of NG28 — a multimorbidity-focused case discussion

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Frailty rarely travels alone

In older people with type 2 diabetes, frailty almost always sits alongside several other long-term conditions. The treatment that is “correct” for any single condition can be the wrong treatment for the whole person.



Frailty is common in diabetes

Frailty is more prevalent and develops earlier in people with type 2 diabetes than in those without it.



Multimorbidity is the norm

Most frail older adults live with multiple conditions — heart failure, CKD, ASCVD, cognitive impairment — not diabetes in isolation.



Treatment burden adds up

Polypharmacy, hypoglycaemia and adverse drug events drive falls, hospital admissions and reduced quality of life.



Goals shift with frailty

Function, independence and avoiding harm often matter more than tight glycaemic control or single-organ targets.

The NG28 frailty arm is, at heart, a multimorbidity decision.

NG28 now prescribes by comorbidity, not by HbA1c alone

The February 2026 update moves decisively away from a glucose-centred ladder. First-line therapy is chosen according to the comorbidities a person has, prioritising cardiovascular and renal protection. NICE structures the recommendations into seven groups — frailty is one of them.

No relevant comorbidity

Metformin MR + SGLT2i

Heart failure

Metformin MR + SGLT2i

Atherosclerotic CVD

+ subcutaneous semaglutide

Early-onset T2D

+ consider GLP-1 / tirzepatide

Living with obesity

Metformin MR + SGLT2i

Chronic kidney disease

eGFR-led choices

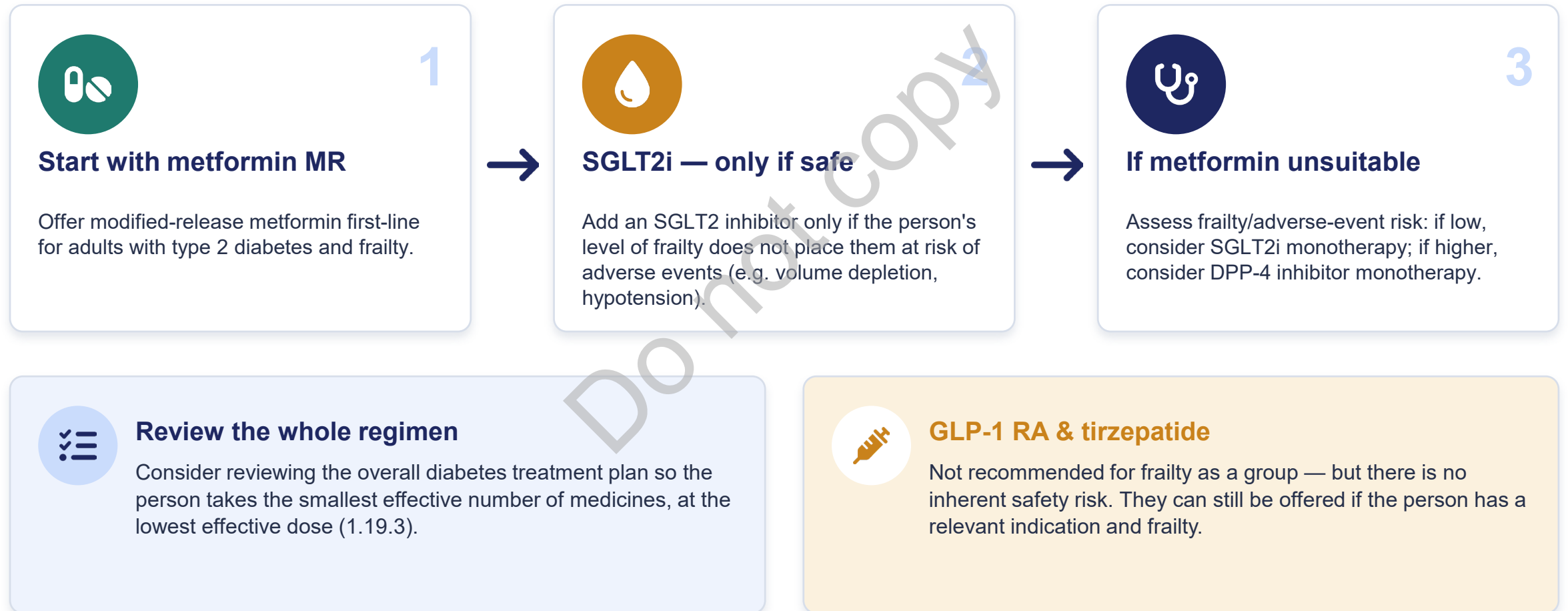
Frailty

Individualised — caution with SGLT2i



Today's focus: the frailty arm and what it means across multiple conditions.

The frailty arm: what NICE recommends



From single-disease rules to whole-person decisions

NG28 explicitly signposts its frailty recommendations to NICE's guidance on multimorbidity, medicines optimisation and shared decision making. When several conditions compete, these principles decide the case — not the diabetes algorithm alone.



Prioritise with the person

Where more than one comorbidity is present, agree which to prioritise for treatment — a shared decision, not a default (NG56, NG197).



Weigh treatment burden & harm

Hypoglycaemia, volume depletion, falls and polypharmacy can outweigh marginal glycaemic or single-organ gains.



Aim at what matters

Function, independence, symptom control and quality of life often outrank tight HbA1c or aggressive risk-factor targets.



Right-size the regimen

Fewest effective medicines, lowest effective doses; relax glycaemic targets where intensive control offers little benefit.

The trials behind NG28's cardiorenal shift

The metformin-plus-SGLT2i backbone rests on a decade of cardiovascular, heart-failure and renal outcome trials. The catch: most enrolled people who were younger and fitter than many we treat in frailty.



Cardiovascular

- EMPA-REG, CANVAS, DECLARE — SGLT2i cut major CV events
- LEADER, SUSTAIN-6 — GLP-1 RAs cut CV events
- SELECT — semaglutide cut CV events in obesity



Heart failure

- DAPA-HF, EMPEROR-Reduced — fewer HF events (low EF)
- DELIVER, EMPEROR-Preserved — benefit at preserved EF
- Fewer HF hospitalisations and CV deaths



Renal

- DAPA-CKD, EMPA-KIDNEY — slowed CKD progression
- CREDENCE — fewer kidney and CV events
- Protection retained at lower eGFR



Mind the gap. Older, frail and multimorbid people — especially with severe frailty, dementia or care-home residence — were under-represented (mean trial ages were typically in the 60s). NG28's frailty caution fills a real evidence gap with clinical judgement.

References (all N Engl J Med unless stated): EMPA-REG OUTCOME (Zinman 2015); CANVAS (Neal 2017); DECLARE-TIMI 58 (Wiviott 2019); LEADER (Marso 2016); SUSTAIN-6 (Marso 2016); SELECT (Lincoff 2023); DAPA-HF (McMurray 2019); EMPEROR-Reduced (Packer 2020); DELIVER (Solomon 2022); EMPEROR-Preserved (Anker 2021); DAPA-CKD (Heerspink 2020); EMPA-KIDNEY (Herrington 2023); CREDENCE (Perkovic 2019).

Reading the same trials through a frailty lens

A few analyses speak directly to frailty and older age — and they cut both ways: benefit can persist, but so does harm, and tight glucose control is its own risk.



Benefit can persist

- DELIVER's pre-specified frailty analysis: dapagliflozin reduced HF events / CV death across all frailty strata.
- The most frail gained the largest absolute benefit and quality-of-life improvement.
- An argument against writing frail patients off.



...but harm scales too

- Frail participants had more adverse events and treatment discontinuations.
- Severe frailty, dementia and care-home residents remain under-studied.
- Exactly why NG28 makes SGLT2i conditional on adverse-event risk.



Why we relax targets

- ACCORD: intensive control (HbA1c <6%) raised mortality; ADVANCE & VADT showed no mortality gain.
- Sulfonylureas and insulin drive hypoglycaemia, falls and harm.
- Favour low-hypo agents (DPP-4i — CV-safe in CARMELINA / CAROLINA) and relaxed targets.



Bottom line: the evidence backs the cardiorenal backbone and supports relaxing targets in frailty — but it doesn't license aggressive prescribing in the most frail. Incretin-driven weight loss also includes lean mass, a concern in sarcopenic frailty.

References: DELIVER frailty analysis — Butt JH et al., *Circulation* 2022;146:1210. ACCORD (NEJM 2008); ADVANCE (NEJM 2008); VADT (Duckworth, NEJM 2009); CARMELINA (Rosenstock, JAMA 2019); CAROLINA (Rosenstock, JAMA 2019).

When every comorbidity pulls a different way



Tariq Mahmood, 62

Housebound, carer-supported · severely frail
(Clinical Frailty Scale 7) at just 62

Diabetes Early-onset type 2 — diagnosed aged 30
(32 years)

Cardiac Heart failure, reduced EF (~30%)

Renal CKD — eGFR 32 ml/min/1.73m²

Other Recurrent UTIs, 2 falls in 6 months, postural
blood-pressure drop

Current diabetes treatment

- Metformin standard-release 500 mg twice daily
- Gliclazide 80 mg twice daily
- Latest HbA1c 71 mmol/mol (8.6%)



The clinical question

Three decades of complicated diabetes have left Tariq severely frail at 62. His heart failure and CKD would normally mandate an SGLT2 inhibitor — but he has falls, postural hypotension and recurrent infections. Do the cardiorenal benefits still apply, and what about his sulfonylurea?

Protection vs. harm: let frailty temper the cardiorenal default

Conditions in play: Early-onset T2D (32 yrs) · heart failure · CKD (eGFR 32) · recurrent UTIs · falls · postural hypotension



Prioritise & frame

- Frailty tracks disease burden, not age — at 62, Tariq is as frail as many people over 80.
- Several comorbidities compete — agree priorities with Tariq and family (NG56).
- Top priorities: avoid falls, hypoglycaemia and dehydration; relax the glycaemic target.



Apply the frailty arm

- Metformin first-line, consider to switch to MR and cap dose — eGFR <45 means reduce to ≤1 g/day.
- SGLT2i is conditional (1.19.1): his volume depletion, hypotension, falls and recurrent UTIs are exactly the adverse-event risks NICE flags.
- If SGLT2i prognosis felt important, only with cardiology/renal input, BP/volume monitoring, sick-day rules — and a low threshold to stop.



Pause / avoid

- Deprescribe gliclazide — sulfonylurea + frailty drives hypoglycaemia and falls.
- Don't reflexively start an SGLT2i just because HF/CKD boxes are ticked.
- GLP-1 / tirzepatide: no relevant driver here and weight loss is unwanted.



Shared decision: Simplify to a tolerable metformin dose, stop the sulfonylurea, hold SGLT2i pending specialist review of his volume/BP status, and target function and safety over glycaemic numbers.

When the 'textbook' regimen is the wrong regimen



Grace Okonkwo, 80

Lives alone with a daily carer · moderate-to-severe frailty (CFS 6)

Diabetes Type 2, HbA1c 49 mmol/mol (6.6%)

Cardiac Myocardial infarction 3 years ago (ASCVD)

Cognition Early Alzheimer's dementia

Other Dysphagia (crushes tablets), sarcopenia, weight 56 kg and falling

Current diabetes treatment

- Metformin modified-release 1 g twice daily
- Gliclazide 40 mg once daily
- Carer reports a morning episode: clammy, confused, resolved with juice



The clinical question

Her ASCVD would normally call for metformin + SGLT2i + subcutaneous semaglutide. Yet her HbA1c is already 49, she is having hypos, she can't swallow tablets and she is losing weight. What should actually change?

Frailty overrides the ASCVD aspiration: deprescribe and simplify

Conditions in play: Type 2 diabetes · ASCVD (prior MI) · dementia · dysphagia · sarcopenia · weight loss · hypoglycaemia



Prioritise & frame

- Frailty arm takes precedence over the ASCVD triple-therapy aspiration.
- She is over-treated: HbA1c 49 on a sulfonylurea, with a documented hypo.
- Hypos worsen falls and cognition — safety and simplicity are the goals (NG56, NG5).



Apply the frailty arm

- Stop gliclazide now — the hypo risk is unacceptable at this HbA1c.
- For dysphagia, standard-release metformin is preferred (crushable / liquid) over MR.
- Review whether any glucose-lowering beyond metformin is needed; relax the target upward.



Pause / avoid

- Don't add subcutaneous semaglutide — appetite loss and weight loss are harmful in a sarcopenic, underweight-trending woman (stop incretins if BMI <18.5).
- SGLT2i: frailty, low weight and dehydration/DKA risk make adverse events likely — DPP-4 inhibitor is the safer option if a second agent is ever needed.



Shared decision: Deprescribe the sulfonylurea, move to crushable metformin, abandon the ASCVD triple-therapy target, and align the plan with her dementia care, carer capacity and advance-care planning.

CASE 3

“Should she be on the weight-loss jab?”



Mei Chen, 58

Post-stroke at 56, carer-supported · frail in her late 50s (CFS 5–6)

Diabetes Type 2, HbA1c 64 mmol/mol (8.0%)

Vascular Ischaemic stroke at 56, residual weakness

Weight Living with obesity, BMI 33

Other Hypertension, knee osteoarthritis, low mood, limited mobility

Current diabetes treatment

- Metformin modified-release 1 g twice daily
- Antihypertensives; analgesia for osteoarthritis
- Family ask why she isn't on “Mounjaro or Ozempic like everyone else”



The clinical question

Mei lives with obesity and has vascular disease, so a GLP-1 receptor agonist or tirzepatide seems obvious to her family. But a stroke at 56 has left her frail in her late 50s. Does the NG28 frailty arm allow it — and is it the right call?

Incretins in frailty: permitted, but individualised — protect muscle and function

Conditions in play: Type 2 diabetes · prior stroke (vascular disease) · obesity · hypertension · osteoarthritis · low mood · frailty



Prioritise & frame

- Stroke can precipitate frailty young — Mei is frail at 58, not 88.
- Agree goals that matter to Mei — mobility, independence, mood — with her and family (NG197).
- Obesity in frailty is nuanced: unintended weight loss can worsen sarcopenia and frailty.



Apply the frailty arm

- NG28 doesn't recommend GLP-1/tirzepatide for frailty as a group — but there's no inherent safety risk, so they can be offered if there's a relevant indication and frailty.
- So it's a 'maybe', decided case-by-case — not an automatic yes or no.
- Continue metformin MR; review the wider regimen for burden (1.19.3).



Pause / avoid

- Weigh incretin-driven weight/muscle loss, nausea, dehydration and injection burden on a carer against the gains.
- Assess frailty risk before any SGLT2i (volume depletion, post-stroke hypotension, continence).
- If weight loss is the primary aim, that's NICE NG246 territory — still filtered through frailty.



Shared decision: Explain the evidence gap honestly; if a GLP-1 is pursued for vascular/glycaemic benefit, set function-and-muscle-preserving goals, monitor weight and nutrition closely, and keep the regimen as light as possible.

FIVE TAKE-HOME MESSAGES

Treating the person, not the algorithm

1

Frailty is a multimorbidity decision

NG28 sends you to NG56, NG5 and NG197 — prioritise conditions with the person.

2

Metformin MR first, SGLT2i conditionally

Add an SGLT2i only if frailty doesn't expose the person to volume depletion or hypotension.

3

Clinical judgement, no fixed cut-off

NICE sets no frailty score threshold — you weigh the risks for this individual.

4

Deprescribe and right-size

Smallest effective number of medicines, lowest effective doses; relax glycaemic targets.

5

Incretins: permitted, not routine

GLP-1/tirzepatide aren't recommended for frailty but carry no inherent risk — individualise, protect muscle.

“The right medicine for the disease can be the wrong medicine for the person.”

Primary Care Diabetes & Obesity (PCDO) Society

On World Obesity Day 2025 the Primary Care Diabetes Society became the PCDO Society, reflecting the shift to whole-person diabetes-and-weight care. Useful primary-care resources include:



PCDO Society

Professional body and education hub for the whole primary care team — membership, national conference and e-learning (pcdsociety.org).



Diabetes & Primary Care journal

Peer-reviewed 'How to' guides, 'At a glance' factsheets and audit tools — including QI work on frailty targets, coding and deprescribing.



'How to' guides & position statements

Practical, algorithm-style aids for prescribing, annual reviews and medicines (SGLT2i, GLP-1 RAs).



Prescribing guidance ('Question Time')

Establish frailty status, then match the HbA1c target (fit $\approx$ 58 mmol/mol; relax as frailty increases); cautions on GLP-1-driven weight loss where sarcopenia is a risk.

Access via pcdsociety.org / diabetesonthenet.com (HCP login). A related UK frailty-target consensus (JBDS; Strain et al.) suggests $\approx$ 58–64 mmol/mol in frailty. Check the Society site for current versions.

References and resources



NICE NG28 — Type 2 diabetes in adults: management

Last updated 18 February 2026. See Section 1.19 'People with frailty' and the Initial medicines chapter.



NICE NG56 — Multimorbidity: clinical assessment and management

Framework for prioritising care and reducing treatment burden across multiple conditions.



NICE NG5 — Medicines optimisation

Supports structured medication review and safe deprescribing.



NICE NG197 — Shared decision making

Underpins agreeing priorities and goals with the person and their family.



Key trial evidence

DELIVER pre-specified frailty analysis (Butt et al., Circulation 2022); ACCORD / ADVANCE / VADT on intensive control; SGLT2i CV, HF and renal outcome trials.

Notes: Case studies are illustrative and fictional, created for teaching. Glycaemic targets follow NG28's individualised-care principles and PCDO / JBDS frailty consensus; NG28 does not mandate a specific frailty tool — the Clinical Frailty Scale and electronic Frailty Index are widely used. Always check current product characteristics and local formulary.

Obesity Management in Frail Patient Population

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Committee Member (co-opted) – Primary Care Diabetes and Obesity Society



Obesity Management in Frail Patient Population

- Frailty is a **distinctive** health state related to the ageing process in which multiple body systems **gradually lose** their in-built reserves.
- Around 10 per cent of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 ⁽¹⁾.
- Older adults with obesity face health care **challenges** due to multimorbidity, functional dependency and disability.
- NHS 10 year Long Term Plan outlines several important changes⁽²⁾

Improving care for older people living with frailty or multiple long-term conditions is one of its priorities and the aim is to **support** people to age well and to **stay independent** at home for longer.

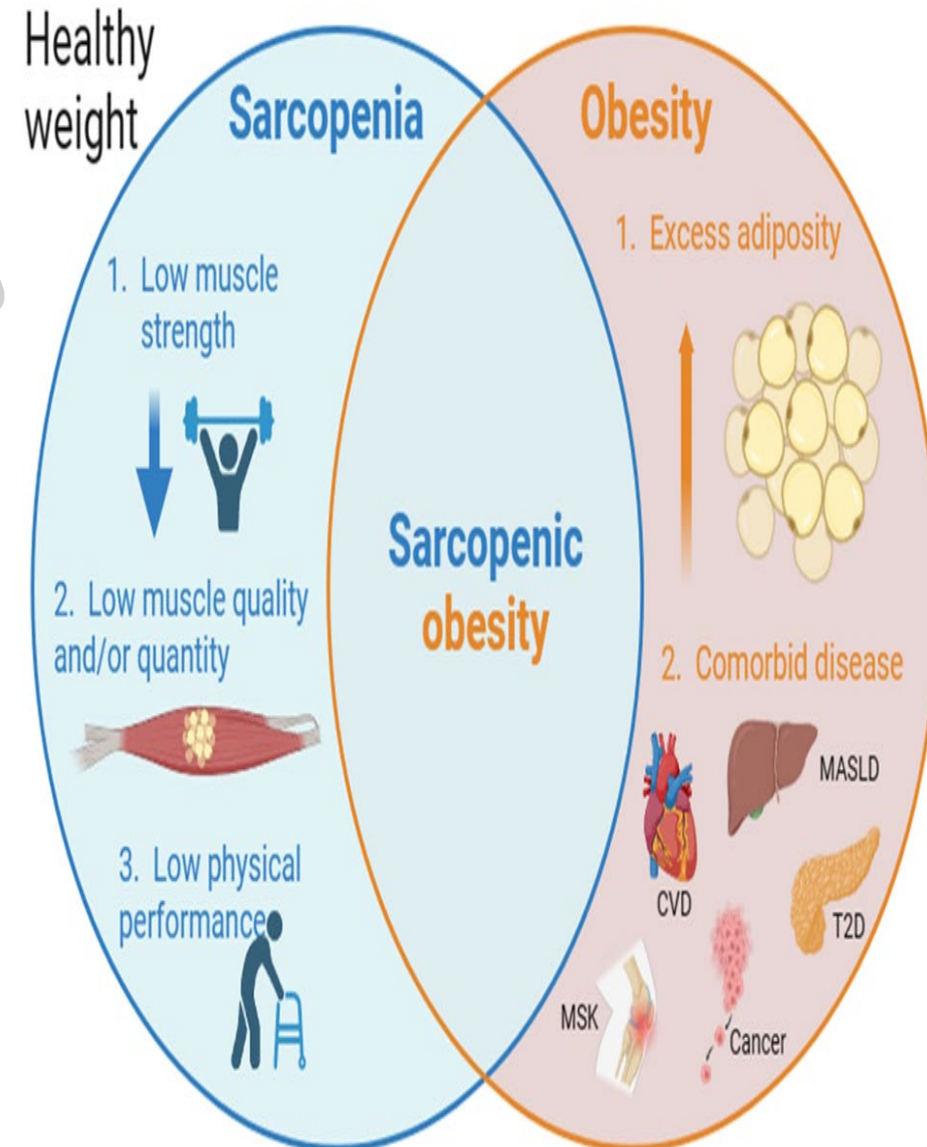
Obesity Management in Frail Patient Population

Sarcopenic obesity ⁽¹⁾

This is **characterized** by a concurrent decline in muscle mass and function, along with increased adipose tissue

It poses a **major health risk** to older adults and **presents** diagnostic and management challenges in clinical settings

The multifaceted pathophysiology of sarcopenic obesity **requires** a comprehensive understanding of hormonal shifts, inflammation, muscle and adipose tissue changes, and lifestyle factors for effective patient care.



Ref: (1) Prado, C.M., Batsis, J.A., Donini, L.M. et al. Sarcopenic obesity in older adults: a clinical overview. Nat Rev Endocrinol 20, 261–277 (2024). <https://doi.org/10.1038/s41574-023-00943-z>

Obesity Management in Frail Patient Population

- **Geriatric Assessment of older adults with obesity** ⁽¹⁾

Cognitive function - Mini mental score / 3 item recall

Functional status – handgrip strength / activities of daily living

Mobility / balance – limited space, any falls, challenges in walking / rising

Psychosocial assessment – PHQ-9 questionnaire / GAD 7

Social determinants of health – housing, food insecurity, transportation

This comprehensive geriatric assessment serves as an **instrument** to provide a cognitive, functional and psychosocial baseline of older adults **to identify** the sub-group of at-risk older adults with obesity and **recommend** tailored nutrition and physical activity and **screening** for appropriateness for anti-obesity medications

- Ref: (1) Dewar S. A geriatrician's approach to managing the complex older adult with obesity. Obesity (Silver Spring). 2025;33(Suppl. 1):41-56. doi:10.1002/oby.24267

Obesity Management in Frail Patient Population

- **Obesity Paradox⁽¹⁾**

term used whereby overweight and obesity seem to be **protective** against disease and mortality in older adult population

- **Key approaches used in obesity management**

Prioritize independence and quality of life **instead** of solely targeting weight reduction in frail older adults

Use measures **beyond** BMI like waist circumference, grip strength, and gait speed to detect sarcopenic obesity

Optimize protein intake and calorie consumption to **prevent** falls in frail, obese older adults

- Ref: (1) Porter J, Gaskin C Clinical practice guidelines for older adults living with overweight and obesity: A scoping review Clinical Nutrition Open Science, 2024; 56, 26-36

Obesity Management in Frail Patient Population

Role of communication in adult obesity management ⁽¹⁾

Communication – fundamental aspect of obesity management

Avoid stigmatization – we must acknowledge that this is surprisingly common

Stigma: a strong feeling of disapproval that most people in a society have about something, especially when this is unfair

Potential consequences of stigmatization in patients living with overweight / obesity

Increased risk of depression

Low self-esteem

Poor body image

Increased risk of eating / binge eating disorders

Exercise avoidance

Further weight gain

Suicide

Avoidance of medical consultation

Obesity Management in Frail Patient Population

Older adults with obesity and the resultant multiple chronic conditions are **predisposed** to be on a high number of prescription medications leading to polypharmacy

There is an **unmet need** among both primary care and specialist team members to be mindful of the weight-promoting cumulative effect of the medications which leads to substantial weight gain.

Medications **promoting** weight gain includes⁽¹⁾

Antidiabetic medications

Anti-depressants

Corticosteroids (oral)

Neuropathic pain meds

Beta Blockers

Atypical antipsychotics

Anticonvulsants

First generation anti-histamines

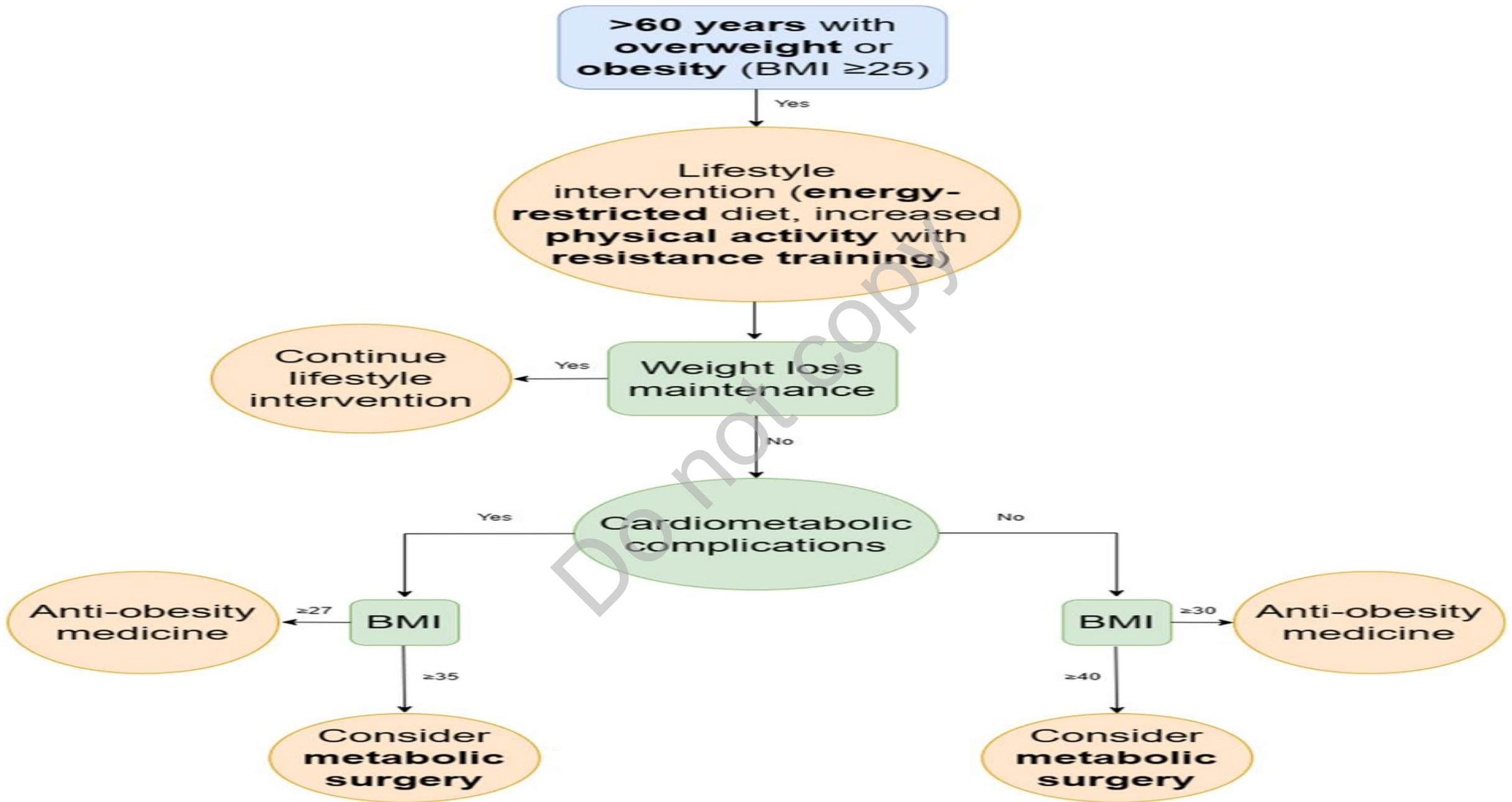
Obesity Management in Frail Patient Population

- Obesity in frail patients needs **tailored** weight-management approach given that this population has complex needs, which is predicted to impact health care economics due to the related comorbidities and disabilities
- Weight-loss intervention needs a **personalized approach** especially in this group, taking into consideration weight-loss attempts, relapse, and life events, including functional limitations, psychosocial status, and current residential environment
- Racial, ethnic and systemic **disparities** based on gender, sexual orientation, rurality, area code, and income merit attention, as they are **barriers** to obesity management.

- Ref: Dewar S. A geriatrician's approach to managing the complex older adult with obesity. Obesity (Silver Spring). 2025;33(Suppl. 1):41-56. doi:10.1002/oby.24267

Obesity Management in Frail Patient Population

- One of the key aspects of obesity management includes **deprescription** of weight-promoting medications
- Intensive lifestyle intervention with dietary changes and physical activity remains the **cornerstone** of obesity management, with pharmacotherapy and bariatric surgery as adjuncts.
- Clinical and biological heterogeneity in older adults that is further exacerbated by obesity - this subset of older adults would benefit from a **patient-centred** and **weight-loss** approach with attention to **mobility** and **functional impairment** and **polypharmacy**.



Obesity Management in Frail Patient Population

- Careful consideration of the **risks and benefits** of treatment, alongside patient priorities, should guide selection of all weight management strategies in older adults.
- Weight reduction is **recommended** for older adults with obesity; however, overweight adults (without comorbidities) are recommended to **maintain** a stable body weight
- Use physical exercise and nutritional intervention to **avoid** sarcopenia
- In appropriate cases consider **adjunct** therapy with anti-obesity medications like orlistat, liraglutide, semaglutide, tirzepatide, or naltrexone/bupropion for weight reduction after considering the risks and benefits to the individual patient
- **Reserve** bariatric surgery for obese older adults who are refractory to behavioural interventions and pharmacological weight-loss therapy after careful consideration of the risks and benefits

Thank you

Any Questions ?



pcdosociety.org

