Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS

BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE (APC)

CHRONIC KIDNEY DISEASE (CKD) MANAGEMENT

Ratified by BLMK APC: July 2025
Review date: July 2028

The following organisations contribute to and participate in the BLMK APC – Bedfordshire Luton and Milton Keynes Integrated Care Board; Bedfordshire Hospitals NHS Foundation Trust; Cambridgeshire Community Services NHS Trust; Central and North-West London NHS Foundation Trust; East London NHS Foundation Trust; Milton Keynes University Hospital NHS

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

NHS

Chronic Kidney Disease Management

Optimisation of cardiovascular risk factors

Lifestyle advice
Weight loss, exercise, smoking cessation, diet etc

Optimise BP as per NICE guidelines
Ideally ARB/ACEI titrated to maximum tolerated dose
< 140/90mmHg if uACR<70mg/mmol
< 130/80mmHg if uACR >70mg/mmol

Optimise Lipid Control
Offer atorvastatin 20mg to all CKD patients unless contraindicated. Increase the dose if > 40% reduction in non-HDL cholesterol is not achieved.

Optimise Diabetes Control
Discuss and agree individualised HbA1c target with patients as per NICE NG28 guidance.

CKD without Type 2 Diabetes

Check urine ACR

- uACR persistently < 22.6mg/mmol → Lifestyle advice
- uACR persistently ≥ 22.6mg/mmol

Offer ARB/ACEI
Offer ARB*/ACEI, irrespective of whether hypertension present or not (unless contraindicated). Titrate to maximum tolerated licensed dose, reducing other antihypertensives if needed.
*ARB (Losartan 50mg) in preference to ACEI (Ramipril 2.5mg) as per local guidance.

Offer SGLT2 inhibitor
Once ARB/ACEI at maximum tolerated dose then offer SGLT2i** according to following criteria
- If eGFR 45 – 90 ml/min, and uACR ≥ 22.6mg/mol offer dapagliflozin or empagliflozin
- If eGFR 20 – 45 ml/min, regardless of uACR offer dapagliflozin or empagliflozin

** **SGLT2i- Offer Dapagliflozin as 1st choice *(where suitable)***

Table 1 : Conditions requiring dose adjustment:

		Current finerenone dose (once daily)	
		10mg	20mg
Current serum potassium (mmol/L)	≤ 4.8	Increase to 20mg daily**	Continue same dose
	> 4.8 to 5.5	Continue same dose	Continue same dose
	> 5.5	Withhold. Consider re-starting at 10mg daily when serum potassium < 5.0mmol/L. Consider use of Lokelma	

**Maintain 10mg daily if eGFR has decreased > 30% compared to the previous measurement

CKD with Type 2 Diabetes

Check urine ACR

- uACR persistently < 3 mg/mmol → Standard diabetes management
- uACR persistently ≥ 3 mg/mmol

Offer ARB/ACEI
Offer ARB*/ACEI, irrespective of whether hypertension present or not (unless contraindicated). Titrate to maximum tolerated licensed dose, reducing other antihypertensives if needed.
*ARB (Losartan 50mg) in preference to ACEI (Ramipril 2.5mg) as per local guidance.

Offer SGLT2 inhibitor
Once ARB/ACEI at maximum tolerated dose then offer SGLT2i** according to following criteria
- If eGFR 20 – 90 ml/min, offer dapagliflozin or empagliflozin

** **SGLT2i – Offer Dapagliflozin as 1st choice *(where suitable)***

Offer Finerenone
If eGFR 25 -60ml/min start at 10mgOD, and if eGFR > 60ml/min start at 20mg OD. Do not initiate if serum potassium > 5mmol/L. Recheck potassium 4 weeks after initiation and after any dose change - dose adjustments to be guided by table 1, thereafter monitor 3 -4 monthly.

This pathway does not apply to patients with T1DM in whom SGLT2is are relatively contraindicated. Patients with ADPKD or on immunological therapy for renal disease should be discussed with renal team before initiation of SGLT2i.

This pathway is a guide only and should not override clinical judgement. Responsibility for checking suitability of treatments rests with the prescriber.
Adapted from Cambridgeshire & Peterborough CKD Pathway. Approved: July 2025 Review: July 2028 Version 1.1

Glossary

ACEi	**Angiotensin-converting enzyme inhibitor**
ADPKD	**Autosomal dominant polycystic kidney disease**
ARB	**Angiotensin receptor blocker**
BP	**Blood Pressure**
CKD	**Chronic Kidney Disease**
DM	**Diabetes Mellitus**
eGFR	**Estimated glomerular filtration rate**
RAS/RAAS	**Renin–angiotensin system/Renin–angiotensin–aldosterone system blockade**
SG LT2i	**Sodium/glucose co-transporter-2 inhibitors**
uACR	**Urine albumin-creatinine ratio**

Adopted for use within BLMK ICB with kind permission from the East of England Renal Network	
Authored by:	**Nephrology Department, Cambridge University Hospitals NHS Foundation Trust and ratified by Cambridgeshire and Peterborough Joint Prescribing Group**
Date approved by BLMK APC	**July 2025**
Review date:	**July 2028**
Version number:	**1.1**

APPENDIX

3 Key actions that can be completed within 3 months to save lives (3 in 3)- *adapted from the LKN CKD Optimisation Pathway*

In adults with Type 2 diabetes and CKD (eGFR 20–90ml/min/1.73m²)	
Action 1	**Month 1 (Visit 1) - RAS/RAAS blockade** ➢ Ensure patient is on high intensity statin (Atorvastatin20mg) unless contraindicated. • Start RAS/RAAS blockade - ARB (Losartan 50mg) or ACEI (Ramipril 2.5mg) once daily unless contraindicated and titrate to maximum tolerated licensed dose to achieve appropriate BP – refer to pathway. Other BP agents may need to be reduced to optimise ARB/ACEI dosing. *(In people with significant frailty, consider individualised BP targets as appropriate)* - refer to Hypertension Pathway • Recheck creatinine and potassium within 2 weeks of initiation; eGFR reduction is expected with ARB or ACEI therapy but this can continue unless ≥30% decrease or potassium >5mmol/l. (*Stop any nephrotoxic medications: Advise against use of NSAIDs and discuss alternatives)* • Optimise glycaemic control as per NICE guidelines (NG28)
Action 2	**Month 2 (Visit 2)** • Initiate SGLT2-inhibitor according to NICE recommendations - see CKD pathway for choice. • Consider/counsel on risks of diabetic ketoacidosis (which may be euglycaemic), sick day rules, risk of UTI/fungal infections and Fournier's Gangrene. Consider adjusting sulfonylureas/insulin where eGFR > 45ml/min and HbA1c < 58mmol/mol to mitigate risk of hypoglycaemia.
Action 3	**Month 3 (Visit 3)** • If BP remains above target initiate 2nd line agent (as per BLMK Hypertension Guidelines) • For Type 2 Diabetes and CKD, consider Finerenone as an add on therapy in patients with eGFR 25-60ml/min, uACR >3mg/mmol and potassium <5mmol/L- refer to CKD pathway

3 Key actions that can be completed within 3 months to save lives (3 in 3)- *adapted from the LKN CKD Optimisation Pathway*
Adults without Type 2 diabetes, with CKD (excluding polycystic kidney disease or on immunological therapy for renal disease, and renal transplant patients)

In adults without Type 2 diabetes, with CKD (eGFR 20– 45ml/min/1.73m² irrespective of presence of albuminuria or eGFR 45 -90ml/ min/1.73m² and uACR >22.6mg/mmol)	
Action 1	**Month 1 (Visit 1) - RAS/RAAS blockade** ➢ Ensure patient is on high intensity statin (Atorvastatin20mg) unless contraindicated. • Start RAS/RAAS blockade - ARB (Losartan 50mg) or ACEI (Ramipril 2.5mg) once daily if indicated (uACR >70mg/mmol or >30mg/mmol if hypertensive) and not contraindicated, titrate to maximum tolerated licensed dose to achieve appropriate BP – refer to pathway. • Other BP agents may need to be reduced to optimise ARB/ACEI dosing *(In people with significant frailty, consider individualised BP targets as appropriate)* – refer to Hypertension Pathway • Recheck creatinine and potassium within 2 weeks of initiation; eGFR reduction is expected with ARB or ACEI therapy but this can continue unless ≥30% decrease or potassium >5mmol/l (*Stop any nephrotoxic medications: Advise against use of NSAIDs and discuss alternatives).*
Action 2	**Month 2 (Visit 2)** • Initiate SGLT2-inhibitor according to NICE recommendations - see CKD pathway for choice. • Counsel patients on sick day rules, risk of UTI/fungal infection and Fournier's Gangrene.
Action 3	**Month 3 (Visit 3)** • If BP remains above target (<140/90mmHg unless uACR >70mg/mol, then <130/80mmHg) initiate 2nd line agent (as per BLMK Hypertension Guidelines).

At Each Review

- **Inform patient of their eGFR, uACR and BP. Assess adherence with medications and discuss any reasons for non-adherence.**
- **Reiterate the meaning of each marker. Give detailed advice on lifestyle/diet.**
- **Discuss progress with each target.**

Acknowledgments

- **Key actions contained in the appendix have been adapted with kind permission from The London Kidney Network Optimisation Pathway.**

Ratified by BLMK APC: July 2025
Review date: July 2028
(Version 1.1)