Type 2 Diabetes Mellitus (T2DM) in adults

A guide for South East London Primary Care

Key messages

1. Lifestyle: If overweight, agree a weight loss goal of 5-10% of body weight
2. Blood pressure: Target BP ≤140/90mmHg
3. Cholesterol: Initiate statin if QRISK2/3 ≥ 10% or history of CVD
4. Optimise HbA1c: Target ≤ 53mmol/mol (≤7%)

Personalise all targets considering e.g. age, co-morbidities and frailty

References

Always work within your knowledge and competency

Published date May 2025 Review date May 2026 – sooner if new evidence/guidance

Contents

Why focus on T2DM in SEL?

Common
There are approximately 100,000 people with T2DM in SEL.

Hidden Prevalence
Approximately 30,000 to 40,000 patients in SEL are living with T2DM but have not yet been diagnosed and are not receiving care.

Health Inequalities
T2DM disproportionately affects those from deprived households, Black African, Black Caribbean and Asian communities.

Preventable and treatable
Achieving a healthy blood pressure, cholesterol and HbA1c levels (the triple target) reduces T2DM complications and improves life expectancy.

Early onset T2DM
In SEL, there is a high rate of early-onset T2DM (diagnosed before 40 years), which is more prevalent among ethnic minorities, particularly South Asian communities, and in the most deprived areas. Early-onset T2DM tends to be more aggressive, leading to worse outcomes, and is often linked to unmet psychological and social needs.

New treatments
With a growing number of diabetes medication options, it can be difficult to the determine the best treatment options for your patients. This guide helps your medication choices.

Risk factors and diagnosis

References

Risk factors for developing T2DM

Ethnicity
People of Asian, Black African and Black Caribbean ethnicities have 2-4 times greater risk of T2DM than people of white ethnicities and may develop T2DM at an earlier age.

Long-term conditions
Chronic Kidney Disease (CKD), existing cardiovascular disease (CVD), serious mental health illnesses and polycystic ovarian syndrome

Medications
Statins, corticosteroids, combined thiazide diuretic, anti-psychotics and beta-blockers.

Family history(FH)
15% increased risk if one parent has T2DM.
75% increased risk if both parents haveT2DM.

Age
> 25 years and Asian, Black African, Black Caribbean
> 40 years White European.

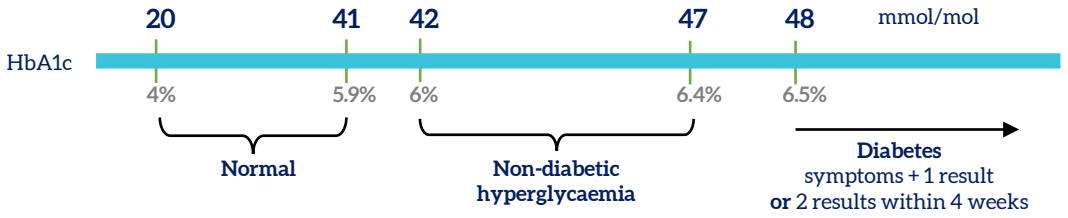
Obesity
accounts for 80-85% of the risk for developing T2DM.

Gestational diabetes (GDM) and polycystic ovarian syndrome (PCOS)
Substantially increased risk, offer HbA1c check annually for history of GDM, every 1-3 years for PCOS.

Metabolic syndrome
a combination of raised blood pressures, dyslipidaemia, fatty liver disease, central obesity and a tendency to develop venous thromboembolism.

Diet
Low fibre, high glycaemic index diet

Diagnosis using HbA1c



Cautions with HbA1c

Liaise with lab if patient has haemoglobinopathy, severe anaemia or altered red cell life-span e.g. post-splenectomy, recent blood transfusion.

Do NOT use HbA1c to diagnose

Type 1 diabetes, T2DM in <18 years, rapid onset of diabetes symptoms, in pregnancy, up to 2 months post-partum, end-stage renal disease, acute pancreatic damage, HIV infection or if taking medication linked with hyperglycaemia e.g. long-term corticosteroids. Instead test with random or fasting glucose.

	New diagnosis of non-diabetic hyperglycaemia (NDH or pre-diabetes)	New diagnosis of T2DM
Support understanding	Help patients and caregivers understand the diagnosis, its implications, and how to manage their own care. Offer written materials and online resources.	
Code	Use Ardens pre-diabetes clinical template	Use Ardens diabetes clinical template
Refer/ signpost to education	Self-referral to Healthier You - National Diabetes Prevention Programme (NDPP) • 9-month programme, face-to-face or digital, provided in SEL by Thrive Tribe. • Share the NDPP link, patient's NHS no, HbA1c result with date of test (set up an Accurx message). Signpost to Diabetes UK Advice on Pre-diabetes	Encourage self-referral to Diabetes Book & Learn to choose from a range of face-to-face or online education programmes e.g. DESMOND and HEAL-D. See Page 16 for more detail. Share information from Diabetes UK
	Consider local lifestyle support programmes such as weight management or exercise-on-prescription, tailor to individual preferences and circumstances.	
Follow up	Offer annual review. HbA1c + Vital 5: BP, BMI, smoking status, mental health and alcohol intake	Explain annual review process: eight care processes (8CP) plus retinal screening. Assess risk of developing a diabetic foot problem. Arrange 1st appointment for full review.

Atypical presentation?

Seek advice of specialist diabetes accredited clinician/team if considering alternative diabetes diagnosis.
See World Health Organisation Guide.

RED FLAG: **Weight loss and new T2DM >60 years-** 2WW referral for suspected cancer of pancreas or urgent CT pancreas if available.

Early onset Type 2 diabetes: <40years, associated with poorer outcomes, deprivation, social and psychological problems, black and Asian ethnicities. Aim for tight HbA1c control and offer flexible access to care. Training available here.

Slowly evolving immune mediated diabetes of adults (SEIMS): Relatively low BMI. Subset of Type 1, often misclassified as Type 2, usually needs insulin within 1-5 years. Previously called latent autoimmune diabetes in adults (LADA)

Maturity onset diabetes of the Young (MODY): Not obese, usually < 25 years. Often misclassified as Type 1 or 2. Dominantly inherited: FH of diabetes in multiple generations at a young age:. Guidelines for Genetic Testing in MODY // Diabetes

Ketosis-prone diabetes: Presents with ketosis/prone to DKA, requiring insulin but may not need to continue once controlled. Increased prevalence in West African, Afro-Caribbean and Hispanic people and with those a family history of diabetes.

Pancreatic pathology: Trauma, tumour or inflammation that impacts on pancreatic function leading to insulin dependence.

T2DM and Health Inequalities

References

Health Inequalities

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people.

Learning Disabilities (LD)

People with learning disabilities (LD) tend to develop T2DM at a younger age and are less likely to receive regular checks.

Include an HbA1c in the annual health check review for patients at risk of T2DM.

Consider making reasonable adjustments, such as:

- Ensure you and your colleagues are trained and confident in supporting individuals with LD, (e.g. Oliver McGowan training).
- Offer extended appointment times.
- Involve both the patient and their carers in treatment decisions.
- Provide easy-read materials, available from Diabetes UK Resources for LD.

Severe Mental Illness (SMI)

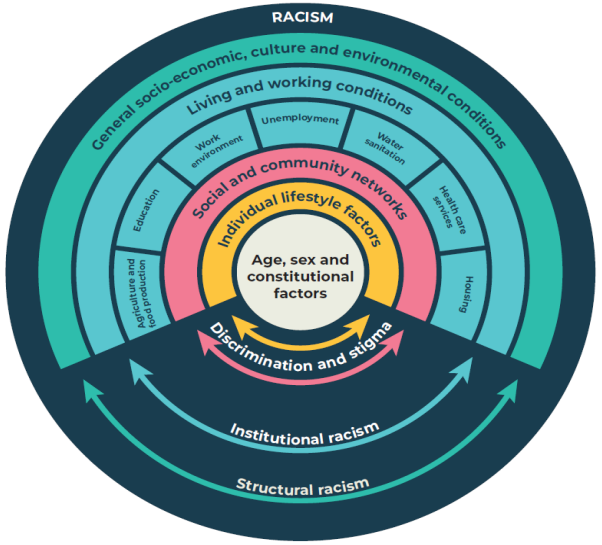
- SMI increases the risk of developing T2DM.
- SMI is linked to poverty, homelessness, incarceration, social isolation and unemployment, contributing to poor medication adherence and missed appointments.
- Include HbA1c in your annual SMI health checks and offer flexible access
- Diabetes increases the likelihood of depression - see CESEL Depression & Anxiety Guide.
- Screen for mental health issues in annual diabetes review.

Deprivation

- Diabetes is 40% more common in people from the most deprived communities, with higher rates of complications and risk of death.
- This increased risk is associated with obesity, lack of physical activity, unhealthy diet and poor blood pressure control.
- Aim for a flexible access offer – to meet the needs of your most deprived patients.

Ethnicity

- **Asian, Black African and Black Caribbean communities** are disproportionately affected by T2DM, with increased prevalence at a younger age and with poorer outcomes.
- Contributing factors include overcrowded houses, poverty, unemployment, limited access to education, and experiences of racism.



*'Though social determinants are universal, **racism** is one of a range of driving forces that exists in our societies and that acts on these determinants.'*
Jones, D. (2021). Beyond the conversation about race. Better Health for All

Barriers to effective detection and management of T2DM include:

- Lack of **trust** in health services and professionals.
- Challenges in **accessing services** and **using technology**.
- Healthcare providers often lack an **understanding** of patients' **cultural foods and beliefs.**
- Patients may not understand their T2DM, impacting on compliance and can also feel inundated with excessive information.

How can we tackle health inequalities?

- **Co-design care:** work with your communities and patient groups.
- **Know your data:** use SEL Diabetes dashboards (contact bi@selondonics.nhs.uk for access).
- **Target patient groups e.g.** Ardens case-finder searches
- **Ask for help:** contact your CESEL facilitator for support

Team and system actions

- Patients often prefer **face-to-face care**, especially for a new diagnosis of diabetes or pre-diabetes.
- Encourage **self-management.**
- **Undertake cultural humility training**

Individual actions

- Establish trust with patient-centred consultations and shared decision making.
- Offer. flexible access, targeted services, community engagement, contact in patients' 1st language.
- Signpost to culturally appropriate support.
- Acknowledge that patients may have experienced racism in healthcare services.

Through this guide

- We signpost to culturally helpful diabetes resources.

Personalised care

Structured personalised care – health professionals helping patients become more involved in decisions about their care and goal setting reduces patients' risk of developing complications.

Personalised Care Institute, offers learning modules.

Social Prescribing Link Workers (SPLW) and Care Coordinators can support people to take control of their T2DM.

Goal Setting

Support your patients to make individualised SMART goals, e.g.

SPECIFIC: 'I want to lose weight.'

MEASURABLE: 'I'll aim to lose 2kg.'

ACHIEVABLE: 'I attend a Book and Learn course to help me.'

REALISTIC: 'I'll ask my family to help too.'

TIMED: 'I will do this over the next 6 months.'

See this short patient video on achieving goals.

Pregnancy planning/contraception

Discuss pregnancy planning and effective contraception in women of childbearing age. See page 10.

Co-morbidities

Consider an aligned contact/appointment for hypertension, CKD, atrial fibrillation and established CVD to improve patient convenience and practice workload.

Diet

Signpost to healthy eating advice:

10 tips for healthy eating with diabetes | Diabetes UK

The Eatwell Guide: What does it mean for diabetes? | Diabetes UK

Signpost to culturally appropriate advice e.g. Diabetes and African and Caribbean foods - Diabetes Africa, Healthy Eating for South Asians - Healthy Diet Tips.

Complete CDEP Nutrition learning module to increase your knowledge of diet and T2DM. (South London Teams click here for access to CDEP).

WHOLE PERSON CARE FOR T2DM

Encourage patients to sign up to

NHS HEALTHY LIVING PROGRAMME and

Refer to SEL **DIABETES EDUCATION.**

Weight management

Weight loss can reverse T2DM, reduce CVD risk, improve glucose control and quality of life. People from Black African, Black Caribbean and Asian family backgrounds are at increased risk of health conditions at a lower BMI than people from a white background. Refer to Heal-D for culturally tailored support and see page 16 for local pathways.

- Be mindful of the language you use to discuss weight.
- Tailor interventions to people's circumstances, choices and culture.

Signpost to Calculate your body mass index (BMI) for adults - NHS

and to local support **See weight management pathways on page 16**

Physical Activity

Increased physical activity, even without weight loss, brings health benefits. Adults should try to do at least 30 minutes of moderate physical activity on 5 or more days a week.

Use brief advice and agree individualised SMART goals.

- **ASK:** "What physical activities do you enjoy?"
- **ASSIST:** "Can you think of opportunities to introduce activity into your day?"
- **ACT:** Support SMART goals

Physical activity infographic for patients, MECC Link with resources.

Diabetes for exercise | Type 1 and type 2 | Diabetes UK.

Psychological wellbeing

Diabetes distress

Feelings of frustration, defeat and being overwhelmed by T2DM can progress to depression and poor diabetes control. Signpost to e.g. Diabetes Support Forum | Diabetes UK.

Mood

People with T2DM have higher rates of depression. Explore mood and impact on wellbeing. See CESEL Depression and Anxiety Guide.

Diabetes complications

Ask about and support management of complications:

- Eyesight: offer retinal screening.
- Oral health: check seeing dentist regularly.
- Gastroparesis: associated with erratic glucose control.
- Sexual dysfunction: offer phosphodiesterase type 5 inhibitor to men.
- Neuropathy: offer pain management if needed.
- Feet: see page 6.
- For hypo and hyperglycaemia see page 12.

T2DM Eight Care Processes (8CP) Share this animation with your patients on the importance of the 8CPs

References

Individualise all targets, review dates and monitoring **Ensure all care processes undertaken at diagnosis and at least annually** **Include safe drinking and healthy mind for a complete Vital 5 check**

1 Body Mass Index kg/m²

Overweight

BMI ≥ 25 kg/m² white groups, BMI ≥ 23 kg/m² South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background.

If overweight, agree an initial weight loss target of 5–10% of body weight.

2 Blood Pressure

	Targets	
QOF	≤140/90mmHg	excludes moderately or severely frailty
NICE	≤140/90mmHg	≥ 80 years ≤ 150/90mmHg
CKD	If ACR ≥ 70 mg/mmol	BP ≤130/80 mmHg

QOF and NICE targets 5mmHg lower for home (HBPM) and ambulatory monitoring (ABPM)

See CESEL Hypertension Guide.

3 Cholesterol

Primary prevention: offer statin if QRISK2 or 3 ≥ 10% after trial of lifestyle modification

QOF target excludes those with moderate or severe frailty.

Consider Lifetime Qrisk for younger patients.

Secondary prevention: offer statin to all patients with established cardiovascular disease (CVD)

See page 7 for more details.

4 HbA1c

Individualise target especially for reduced life expectancy, risk of falls and/or significant co-morbidities. In younger patients (under 40) aim for especially tight control and check HbA1c more frequently e.g. 3-6 monthly.

Recheck 3 months from medication dose change and 3 monthly until stable, then 6 monthly.

Use NICE patient decision aid to support discussions.

HbA1c targets for women with T2DM planning a pregnancy/pregnant see page 10

NICE Targets	≤48mmol/mol (6.5%)	unless taking a drug which can cause low sugars/hypos e.g. gliclazide, insulin
	≤53mmol/mol (7%)	if on a drug that could cause low sugars/hypos and patients with moderate/severe frailty.
QOF Targets	≤58mmol/mol (7.5%)	without moderate or severe frailty
	≤75mmol/mol (7.5%)	with moderate or severe frailty

5 Smoking

Signpost patients to local Stop Smoking website and Help with giving up smoking | Diabetes UK.

Complete or refresh your learning with Very Brief Advice Training E learning Module.

6 + 7 Renal function and albumin creatinine ratio (ACR)

ACR ≥ 3mg/mmol is clinically significant – early morning sample ideal but not essential.

Check eGFR - <60ml/min consider chronic kidney disease (CKD).

See: CESEL CKD guide for full details of investigation and managing patients with CKD and T2DM.

8 Foot Check: at diagnosis and annual review

LOW RISK Normal examination ➢ annual review with practice team. Emphasis importance of foot care. Low-Risk-Foot.pdf patient leaflet	**MODERATE RISK** Deformity, neuropathy or absent pulse ➢Refer to Foot Health Community Clinic. Moderate-Risk-Foot.pdf patient leaflet
HIGH RISK History of ulcer or amputation, neuropathy + absent pulse/callus/deformity, absent pulse + callus/deformity➢ Urgently Refer to Foot Health Community Clinic. High-Risk-Foot.pdf patient leaflet	**ACTIVE DIABETIC FOOT PROBLEM** Ulcer/gangrene/limb threatening ischaemia/infection/suspected Charcot arthropathy or unexplained swelling with colour change ➢ Urgent diabetic foot clinic or A&E out of hours

Handbook: Diabetes footcare in dark skin tones - Diabetes Africa

Eye Check – 'the 9th Care Process'

- Retinopathy screening within 3 months of diagnosis, every 2 years for low-risk patients otherwise annually. More information on SEL service here.
- Coded patients will receive an automatic invite. Check this is happening at annual review.
- Patients may be excluded from screening if they are unable to sit upright, use a chin rest or able to follow instructions.
- Patients can choose to opt out.
- Code if patients do not attend and encourage to attend at their next review.
- Pregnant women with diabetes should be offered eye screening more frequently.
- Use Ardens Diabetes Review template to code all 8CP and retinopathy screening.
- Patient information of SEL service can be found here.

BP and Lipid Management

References

Identify and address modifiable risk factors → Individualise targets & goals, including for frailty, comorbidities, end of life care → Check understanding, adherence and set a review date

Summary of Blood pressure management

For detailed hypertension guidance see CESEL hypertension guide (includes for pregnant women)

Which BP target in T2DM?

NICE	Age <80yrs ≤140/90mmHg	ABPM/HBPM≤135/85
	Age ≥80yrs ≤150/90mmHg	ABPM/HBPM≤145/85
	With CKD/ACR ≥70mg/mmol ≤130/80mmHg	Systolic range = 120-129mmHg
QOF	≤140/90mmHg excludes those with moderate or severe frailty	ABPM/HBPM≤135/85

Step 1

ACEI or ARB*

Ramipril/Lisinopril or Losartan

Step 2

ACEI or ARB* + CCB or thiazide-like diuretic

Ramipril/Lisinopril or Losartan

Amlodipine or Indapamide

Step 3

ACEI or ARB* + CCB + thiazide-like diuretic

If uncontrolled at this stage refer to CESEL Hypertension guidance

***For people of Black African or African-Caribbean family origin** use ARB instead of ACEI as increased risk of angioedema with ACEI.

For pregnant women or women planning a pregnancy see CESEL Hypertension guidance

Optimise medication to most effective tolerated dose, and **check adherence** at each step before stepping up

Summary of Lipid Management in T2DM

Primary Prevention

Assess CVD risk

- Bloods: non-fasting lipid profile, ALT or AST, HbA1c, TSH, renal function
- Recent BP, BMI, smoking status
- Calculate QRISK 2/3,
- For younger patients calculate Lifetime Qrisk
- Patients with familial hypercholesterolaemia and/or CKD should be offered statin regardless of QRISK

Decision to treat

- First offer lifestyle advice see Cholesterol & Cholesterol levels | HEART UK - The Cholesterol Charity
- Then offer statin if QRISK 2/3 ≥ 10%
- Support patient decision with NICE Patient decision aid: Should I take a statin?

Starting statins

Offer daily **atorvastatin 20mg OD** (or rosuvastatin 10mg OD)
Calculate baseline non-HDL level (total cholesterol minus HDL cholesterol)

Review at 3 months

Repeat lipids and ALT or AST **aiming for 40% reduction in non-HDL cholesterol**

≥ 40% reduction	AST or ALT at 3 months and 12 months only unless clinically indicated. Review annually: assessing adherence to drugs, diet and lifestyle.
< 40% reduction	Consider up-titration to max dose **atorvastatin 80mg** (or rosuvastatin 20mg). If intolerant to higher dose, consider adding ezetimibe 10mg daily. If intolerant to statins start ezetimbe and consider bempedoic acid. (See SEL Lipid management SEL Pathways Refer to local lipid clinic if not acheving target or intolerance to treatment options.

Secondary Prevention

History of CVD: offer lifestyle advice and **atorvastatin 80mg** OD (or equivalent) or max tolerated dose regardless of cholesterol levels.

Repeat lipid profile at 2-3 months and treat to lipid profile target:

LDL ≤ 2.0 mmol/l or non-HDL ≤ 2.6 mmol/l

Achieved target

Review annually: assessing treatment to target, adherence to drugs and offering support for diet and lifestyle measures

Not achieved target

See SEL Lipid management SEL Pathways

T2DM Glycaemic Control Pathway (Part 1)

References

Identify and address modifiable risk factors → Individualise targets & goals, including for frailty, comorbidities, end of life care → Check understanding, adherence and set a review date

Step 1

On initial diagnosis: person centered lifestyle advice

If BMI <22kg/m² or symptomatically hyperglycaemic think insulin (seek early/urgent advice from diabetes team).
Agree personalised target, see NICE patient decision aid.
If HbA1c remains ≥ 48 mmol/mol or individually agreed target move to step 2.

Step 2

Target : personalised target

Assess HbA1c, kidney function and calculate QRISK 2/3

Not at high CVD risk
QRISK2 or 3 < 10%

High Risk of CVD
QRISK 2 or 3 ≥ 10%

Chronic heart failure (HF) and/or atherosclerotic CVD
(Atherosclerotic CVD includes coronary heart disease, acute coronary syndrome, history of MI, stable angina, coronary or other revascularisation, ischaemic stroke, trasnsient ischaemic attack, peripheral artery disease).

Offer Metformin
Start 500mg (standard release) daily with/after food and increase by 500mg every 2 weeks until on 1g bd (offer slow release if GI side effects)

If metformin is CI or not tolerated, consider DPP-4i or SU or Pioglitazone.

SGLT2 inhibitor monotherapy can be considered if sulphonylurea (SU) and pioglitazone are not appropriate, and a DPP-4 would otherwise be prescribed.
NICE TA390 and NICE TA572

and consider / and offer

SGLT2 inhibitor
canagliflozin, dapagliflozin, empagliflozin are of proven CVD benefit

Start metformin alone to assess tolerability before adding SGLT2i.
If metformin contraindicated/not tolerated start SGLT2i.
Review DKA risk factors before starting an SGLT2i – see pages 12 and 14 and
SEL Guide for Prescribing SGLT2 Inhibitors in HbA1c Managements in Adults with T2DM

Recheck HbA1c and QRISK 2/3 at 3 months

If CVD risk or status changes at any point, return to step 2 to as SGLT2 inhibitor may now be indicated

Personalised target achieved

Reinforce lifestyle advice

Plan review date

Personalised target NOT achieved

Move to Step 3

See the next page

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T2DM Glycaemic Control Pathway (Part 2)

References

Identify and address modifiable risk factors → Individualise targets & goals, including for frailty, comorbidities, end of life care → Check understanding, adherence and set a review date

Step 3

1st intensification
Target : personalised target

ADD THERAPY

	Metformin	SGLT2 inhibitor (-flozins)	*Sulfonylureas (SU) Gliclazide is preferred SU in SEL	DDP-4 inhibitor (gliptins) 1st line Sitagliptin linagliptin in severe renal impairment	Pioglitazone
HYPOGLYCAEMIA RISK *Hypoglycaemia risk may increase if antidiabetic drugs are used with insulin and/or sulfonylurea therapy. Consider reducing dose of sulfonylurea or insulin if clinically indicated.	low	low	moderate: higher risk in older and frail patients	low	low
WEIGHT EFFECT	none	loss	gain	none	gain
SIDE EFFECTS/NOTES For doses, more cautions and side effects see page 13-15 sick day rules page 12, (BNF and EMC)	GI disturbance Reduced vitamin B12 Caution in renal impairment	Genitourinary infections, hypotension, dehydration, DKA Caution in renal impairment. See SEL Guide for Prescribing SGLT2 Inhibitors in HbA1c Managements in Adults with T2DM	**Hypoglycaemia:** caution in elderly, frail and certain occupations e.g. driving, operating heavy machinery. *See SEL Self-Monitoring and DVLA guidance*	Pancreatitis Caution in renal impairment	Oedema, heart failure, fractures, bladder cancer risk
WHICH SGLT2 INHIBITOR? Different SGLT2i are indicated when combining with other diabetes drugs either in dual or triple therapy *See* SEL Guide for Prescribing SGLT2 Inhibitors in HbA1c Managements in Adults with T2DM	**Dual therapy** SGLT2 inhibitor + Metformin If SU is contraindicated or not tolerated or person is at significant risk of hypoglycaemia or its consequences canagliflozin, dapagliflozin, empagliflozin are of proven CVD benefit		**Triple therapy** SGLT2 inhibitor + Metformin+ SU Canagliflozin, empagliflozin or dapagliflozin	**Triple therapy** Metformin+ DDP-4 inhibitor + Ertugliflozin only if not controlled on dual therapy (metformin + DDP-4i) and SU AND Pio not appropriate	**Triple therapy** SGLT2 inhibitor+ Metformin + Pioglitazone Canagliflozin, empagliflozin

Step 4

2nd Intensification
Target : personalised target

RECHECK HBA1C AND CVD RISKS AT 3 MONTHS

If CVD risk or status changes at any point (if the patient develops a QRISK 2 or 3 >10% or chronic Heart failure or CVD), return to step 2 to consider/offer SGLT2 inhibitor

Personalised target achieved
Reiterate lifestyle advice

→ **Plan review date**

Personalised target NOT achieved

→ Refer to specialist diabetes accredited clinician/team for consideration of GLP-1 analogues or insulin
See SEL GLP-1 analogue pathway for adults aged 18 and over with T2DM
See Insulin Safety - Prescribing & Dispensing Insulin Safely SEL IMOC Feb 22

T2DM and Pregnancy

References

Pregnancy planning is key

- There is increasing prevalence of T2DM amongst younger patients in SEL.
- Include opportunistic contraceptive advice and pregnancy planning in diabetes reviews for all women of childbearing age.
- Refer to pre-pregnancy clinic when planning pregnancy.
- Support **immediate** referral to diabetes pregnancy clinic when pregnancy confirmed. Advise seek urgent GP appointment when positive pregnancy test.

Structured education
Signpost if not already done this.

Lifestyle advice
Provide advice and support for weight management, exercise, and healthy eating. Target pre-conception BMI: ≤27 kg/m^2 .

Folic acid
5mg daily pre-pregnancy and for the first 12 weeks to reduce neural tube defect risk..

Comorbidities
Optimise control of other conditions e.g. hypertension.

Contraception
Offer effective contraception if not planning a pregnancy or until BMI and HbA1c are optimised.

Mental health
Early onset T2DM (under 40 years) is associated with increased psychological and social needs. Enquire about and address any mental health concerns.

HbA1c
Women should aim for an HbA1c ≤ 48 mmol/mol before pregnancy and . avoid pregnancy if ≥ 86 mmol/mol due to higher risks. Pre-pregnancy clinic will agree a targeted range for glucose monitoring to minimize hypo risks.

Kidney check
Check renal profile and urine ACR in pre-pregnancy period. Note that eGFR is unreliable during pregnancy.

Retinopathy
Retinopathy screening is particularly important pre-pregnancy and during pregnancy.

Diabetes medicines pre-pregnancy, pregnancy and breast feeding

Seek specialist advice on diabetes medicines pre-pregnancy and during pregnancy.
Stop teratogenic medicines before pregnancy e.g. ACE, ARB, statins.
See CESEL Hypertension Guide for safe prescribing for hypertension in pre-pregnancy/pregnancy

Useful information sources for in prescribing in pre-pregnancy, pregnancy and breastfeeding

BUMPS: Best use of medicines in pregnancy

UKTIS: UK teratology information service

Women may be asked to frequently monitor their glucose both pre pregnancy and in pregnancy.
Please prescribe a good supply of lancets and test strips.

Gestational diabetes (GDM)

Risk factors for GDM

- Previous GDM
- BMI≥ 30 kg/m^2
- Previous baby ≥ 4.5kg
- 1st degree relative with diabetes
- Ethnicity with high prevalence of diabetes
- Glycosuria: +2 once, +1 twice
- Polycystic Ovarian Syndrome

→ Patients with risk factors are tested in antenatal clinic with HbA1c or OGTT (oral glucose tolerance test).

Post natal period

Follow Up

Pre-pregnancy T2DM

Ensure appropriate diabetes follow-up.
Pregnancy is an opportunity to offer optimal post natal and ongoing diabetes care.

GDM diagnosed in pregnancy

- Ensure GDM coded
- Remind of hyperglycaemia symptoms
- Highlight risks of recurrence in future pregnancies.
- Advise diabetes testing when planning future pregnancies
- Offer annual HbA1c screening
- Signpost to Diabetes Prevention Programme

13 weeks postnatal offer HbA1c (or fasting glucose (not OGTT))

HbA1c	or fasting glucose	Advice
<39mmol/l	<6.0mmol/l	Low probability of having diabetes Give lifestyle advice Annual check for diabetes (HbA1c)
39-47mmol/l	6.0-6.9mmol/l	High risk of developing diabetes Give lifestyle advice Annual check for diabetes (HbA1c)
≥48mmol/l	≥7.0mmol/l	Likely to have diabetes, offer confirmatory test (HbA1c)

Annual T2DM Review: a personalised care approach

References

Consider who is best in the team for each step, make maximum use of all roles

	Tasks/Activity	Where?	Tools/Support
Review planning	**Call/recall planning:** Use Ardens searches to prioritise for review	Remote	*Ardens and UCLP searches available on your EMIS system* *Contact your CESEL facilitator if you need help.*
Pre-patient review	**Contact patient for:** 1. **Pathology tests:** renal function, FBC, lipids, HbA1c & urine ACR 2. **BP measurement:** in practice, pharmacy or home monitoring 3. **Weight and height:** patient may be able to provide recent home measurements for remote reviews	Remote or Face to face (F2F)	*Accurx have diabetes review Florey for pre-review information gathering - text/contact patient to encourage to complete ahead of review.* *Share 8CP animation.*
Patient review	• **Ask the patient their concerns, expectations, and questions** • **Review trend for BMI and BP** • **Review investigations:** urine ACR, renal function, HbA1c, lipid profile. • **Discuss risk-reduction + life-style**: in context of QRISK2 or 3 and Vital 5 : smoking, weight, alcohol, mental health and blood pressure. • **Medication review**: any concerns with a focus on side-effects and adherence. Signpost to community pharmacy for New Medicines Service. Ensure renal function, HbA1c, cholesterol and BP satisfactory and adjust medications if needed. • **Re-calculate QRISK2/3** for primary prevention. **If ≥10% discuss option of adding a statin and/or substituting an SGLT2i.** If you are adding an SGLT2i consider reducing the dose of any drug that may contribute to hypos e.g. SU, especially if HbA1c is already at the agreed individual target. On initiation educate on symptoms of hypoglycaemia and follow up with a 3 monthly HbA1c. Share patient advice leaflet.- SGLT2i use for patients with diabetes. • **Foot check examination and advice on foot care** - share link via Accurx Diabetes UK advice on Footcare and leaflets re foot risk, • **Eye check:** Check patient is receiving annual eye check ups. • **Driving:** Use Driver and Vehicle Licensing Agency (DVLA)'s Assessing fitness to drive: a guide for medical professionals. • **Education:** Signpost to Diabetes Book and Learn for structured education. • **Pregnancy planning and contraception:** for women of childbearing age • **Complications and comorbidities:** explore and manage including erectile dysfunction.	Remote or F2F – except foot check which needs F2F	*Use clinical templates: Ardens Diabetes ensures correct coding, annual review, medication review & Vital5*
	• Goal setting • **Self management** • **Referral/signposting to community resources** (see local resources page 16)		*Self-management resources - send links via AccuRx.* *Diabetes UK Information Prescriptions to support personal care*
Post-review	• **Follow-up plans:** agreed with patient e.g. review BP monthly until it is at target, HbA1c every 3 months until at target and then 6 monthly.	Remote or F2F	***Update Recall Dates:*** *Replace existing diary entries with the updated recall date/ update review date for diabetes medication review* ***Prioritise Patients****: Use UCLP Priority searches in Ardens to identify high-risk patients. UCLP tools support proactive care by stratifying patients based on risk.* ***Focus on Patients not achieving targets:*** *Recall patients not meeting their diabetes care targets first.* *Work with community pharmacy colleagues for BP checks, lifestyle advice etc* *Contact your CESEL facilitator if you need help.*

QRISK 2 or 3

QRISK 2 and 3 are tools for estimating CVD risk. The QRISK2 calculator is integrated into EMIS, the QRISK3 Ardens template requires manual data entry.
A link to QRISK3 can be found [here].
Consider using lifetime QRISK assessment for individuals with early-onset type 2 diabetes (under 40 years).
Use QRISK estimates alongside with clinical judgment and patient preferences.

When blood glucose monitoring is important

References

Self-monitoring (finger prick checking)

Offer self-monitoring of blood glucose (SMBG) for patients

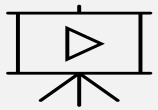
- On insulin
- With history of hypoglycaemia
- On medication that risks hypos while driving – see DVLA guidance e.g. gliclazide, insulin
- Pregnant or planning a pregnancy
- Treated with steroids
- To confirm suspected hypoglycaemia
- On specialist advice

See Self-monitoring of Blood Glucose (finger prick checking) in Adults SELIMOC

HbA1c mmol/mol	Average blood glucose level mmol/l
42	7.0
53	8.5
64	10.1
75	11.7
86	13.3
97	14.9
108	16.5

Average Blood Sugar Level Converter - HbA1c

Short Diabetes UK video on how to use a blood glucose meter



Continuous glucose monitoring

SEL guidance on continuous glucose monitoring patients with T2DM can be found here.

Sick Day Rules

SADMAN: Consider stopping the following drugs temporarily during a dehydrating illness, change back when better – usually after 2 days of normal eating and drinking.

- **S**GLT2 inhibitors
- **A**CE inhibitors
- **D**iuretics
- **M**etformin
- **A**RBs
- **N**SAIDS

Patient information links

SEL Sick day guidance for patients
TREND: What to do when you are ill, patient information

Insulin when unwell

Patients on insulin who are unwell should check their glucose at least four times a day and may need to adjust their insulin dose in response.

Diabetes during Ramadan

Ask patients at their annual review if they plan to fast, offer a planning appointment 2-3 months before their fast.

Develop a management plan that considers needs for SMBG, impact on driving, medication and risks.
See Greater Glasgow and Clyde Guidelines for the Management of Diabetes Mellitus during Ramadan

Hypoglycaemia

Hypoglycaemia is usually when blood glucose is below 4mmol/mol. It is a common side effect of insulin and sulphlyonureas (e.g. gliclazide) Consider hypoglycaemia in patients who are acutely unwell, drowsy, unconscious, unable to co-operate, aggressive, with seizures.

Consider reducing diabetes medication in older, frail patients to reduce the risk of hypos, and agree realistic personalised HbA1c targets that do not risk hypos. Be cautious of the low/normal HbA1c in frail patients, it may alert to hypo risk and can be missed when reviewing blood tests results.

Treating hypoglycaemia

If patient is unconscious or very aggressive: arrange for emergency admission

If oral intake safe: advise quick-acting carbohydrate (e.g. 200mls of sugary drink/ 5-6 dextrose tablets/3-4 heaped teaspoons of sugar dissolved in water).

If blood glucose is still <4mmol/l after 15min then repeat the above step up to 3 times.
If still no improvement, see practice guidance on treating hypoglycaemia or British National Formulary Quick reference hypoglycaemia guide

If the person feels better then advise them to eat a small starchy snack (banana, slice of bread or 2 plain biscuits) and take usual medication - monitor blood glucose regularly for the next 24-48 hours.

Review possible causes of hypo and adjust medication accordingly.

Hyperglycaemia

Random **blood glucose ≥ 20 mmol/l and/or HbA1c ≥ 97mmol/mol**

Hyperglycaemia management for adults with T2DM (excluding pregnant patients) – urgent treatment decision tree for primary care clinical settings SELIMOC

Hyperglycaemia may result in diabetic ketoacidosis (DKA) or hyperosmolar, hyperglycaemic state (HHS), though you may see a mixed picture of these two conditions. **If in doubt seek urgent specialist help.**

Symptoms of DKA: polyuria, polydipsia, weight loss, abdominal pain, diarrhoea and vomiting, breathless, lethargy, confusion, fruity breath, tachypnoea, tachycardia , shock.
Urinary or blood ketones. May have normal blood glucose levels

Symptoms of HHS: Confusion and/or drowsiness, polyuria, polydipsia, nausea, clinical dehydration,
No urinary or bloods ketones. Glucose usually ≥ 30mmol/l

Precipitating factors: infection, inadequate insulin, new onset diabetes, physiological stress. hypothyroidism, pancreatitis, drugs e.g. corticosteroids, atypical antipsychotics, sympathomimetic drugs e.g. salbutamol

T2DM: Preferred Medication

For detailed information on individual drugs, please check: SEL Joint Medicines Formulary, Electronic Medicines Compendium, British National Formulary and SELIMOC Diabetes Guidance

	Drug	Starting dose	Daily Range	**Notes** (these are not extensive, please refer to the latest BNF and/or SPC for further information especially titration increments/cautions/contra-indications)
Biguanide	Metformin Do **NOT** adjust the estimation of glomerular filtration rate (eGFR) in people of Black African or African-Caribbean family background. NICE CKD guidance	500mg OD	Metformin standard release Start 500mg daily with/after food and increase by 500mg every 2 weeks until on 1g BD or maximum tolerated dose	• Maximum dose standard release: 2-2.5g daily (3g in 3 divided doses in exceptional circumstances). • Maximum dose for M/R: 2g once daily with evening meal. • Routine renal function at least annually, 6 monthly for those at risk of renal impairment. • Review dose if eGFR is <45ml/min (also review at 60ml/min if on >2g daily). Stop/avoid if eGFR <30ml/min. • Consider slow-release preparation if standard preparation causes gastrointestinal side effects. • Take with meals to reduce gastrointestinal side effects. • Remember sick day rules ☛ p12. • Manufacturer advises patients and carers should be informed to seek urgent medical advice if symptoms of lactic acidosis e.g. dyspnoea, cramps, abdominal pain. • Long term use can reduce B12 absorption – if suspicion of B12 deficiency, monitor B12 serum levels.
Sulfonylureas	Gliclazide is SEL preferred sulfonylurea	40mg – 80mg daily	160mg-320 mg daily, doses over 160mg divided. Titrate every 2 weeks according to pre-meal blood glucose – 4-6mmol/L or individualised target or against 3 monthly HbA1c.	• Inform patients of risk of adverse events/hypoglycaemia, particularly if renal impairment. • Advise patients on how to manage hypoglycaemia. • Self monitor according to SEL IMOC Self-monitoring of Blood Glucose (finger prick checking) in Adults and consider alternative if Group 2 driver (large lorries and buses). • Consider alternative if BMI >35kg/m^2. • Caution in use in elderly, housebound, frail and in certain occupations e.g. operating heavy machinery. • Kidneys: gliclazide – use in caution with eGFR 30-60mL/min due to increased risk of hypoglycaemia. Avoid if eGFR<30mL/min. • Liver: AVOID in severe hepatic impairment due to increased risk of hypoglycaemia.
DDP-4 inhibitors (gliptins)	Sitagliptin 1st line	100mg once daily	Sitagliptin eGFR 30-44 ml/min reduce dose to 50mg OD eGFR <30 ml/min : 25mg OD See medicines.org.uk for advice on other DPP-4i and renal impairment	• Increased risk of pancreatitis: Dipeptidylpeptidase-4 inhibitors: risk of acute pancreatitis. • Patient on dual or triple therapy of DDP4 inhibitors with a SU or dual therapy with insulin may be at risk of dose related hypoglycaemia, therefore dose reduction of SU or insulin may be needed.
	Linagliptin in severe renal impairment	5mg once daily		
Pioglitazone		15-30mg once daily	Adjust according to response up to 45mg daily	• Safety & efficacy should be reviewed every 3-6 months in continued therapy. • Contraindicated in people with heart failure history, uninvestigated macroscopic haematuria, DKA, hepatic impairment or current/history of bladder cancer. • Caution: risk factors for heart failure or for those at increased risk of bone fractures, risk factors for bladder cancer, concomitant use with insulin, elderly. • Patient on dual or triple therapy of pioglitazone with an SU or dual therapy with insulin may be at risk of dose related hypoglycaemia, therefore dose reduction of SU or insulin may be needed.

References

T2DM: Preferred Medication

For detailed information on individual drugs, please check: SEL Joint Medicines Formulary, Electronic Medicines Compendium, British National Formulary and SELIMOC Diabetes Guidance

	Drug	Starting dose	Daily Range		
SGLT2 inhibitors (flozins) See SEL guide for prescribing SGLT2 inhibitors and Electronic Medicines Compendium for hepatic impairment dosing,. Note glycaemic benefit will be limited for all SGLT2 inhibitors if eGFR< 45ml/min as the glucose lowering efficacy of SGLT2 inhibitor therapy is dependent on renal function. Further glycaemic control may be required. Diabetes UK information for patients Patient advice leaflet. - SGLT2i use for patients with diabetes	Canagliflozin	100mg once daily	Increase to 300mg daily if tolerated and required for glycaemic control. eGFR 45-59 ml/min : max 100mg once daily eGFR <45 ml/min : not recommend for glycaemic control in T2DM	**Use with CAUTION in the following circumstances** - Body mass index <25kg/m2 (<23kg/m2 in South Asian people) - Person adhering to a ketogenic/low calorie/low carbohydrate diet/intermittent fasting - Recent weight loss - Potential for pregnancy - People at risk of hypotension/hypovolaemia (e.g. elderly) - People diagnosed with or at risk of frailty - Cognitive impairment or use of medicine compliance aids (may imply inadequate understanding required to follow sick day rules and take action to prevent and identify DKA) - On high dose diuretics for heart failure (may need dose adjustment, contact heart failure team for advice) - On long term or recurrent courses of steroids (either IV or oral) - Raised haematocrit - Severe hepatic impairment - Recurrent urinary tract or genital tract infections - Long duration of diabetes (generally over 10 years since diagnosis) - Person with very high HbA1c (>86mmol/mol) - Person considered at high risk of acute effects of hyperglycaemia e.g. dehydration due to non-adherence to medication - Past history of active foot disease/foot ulceration - Existing diabetes foot ulcers - Previous lower limb amputation - History of peripheral arterial disease (PAD) - Taking sulfonylureas and/or insulin – increased risk of hypoglycaemia if started on SGLT2 inhibitors if eGFR>45 ml/min - Recurrent problematic hypoglycaemia - Those with risk factors for DKA e.g. low reserve of insulin secreting cells, conditions that restrict food intake or can lead to severe dehydration, a sudden reduction in insulin or increased requirement for insulin due to illness, surgery.	**AVOID in the following circumstances** - Age <18 years - Pregnant, breastfeeding, planning pregnancy, female in their child-bearing years and sexually active without contraception - Person with excess alcohol consumption or intravenous drug user - Hypersensitivity to active substance or excipients - Acutely unwell person (acute medical illness including COVID19, surgery or planned medical procedure) - Active foot disease or acute ischaemic limb event - Inpatient with vascular event who is not stable - Eating disorder - eGFR lower than allowed in the up-to date licensing of the medication being considered (see EMC) - Multiple pre-disposing risks for Fournier's gangrene - Clinical features of significant insulin deficiency e.g. weight loss, symptoms of hyperglycaemia - Organ transplant (unlicensed - discuss with diabetes team) - T1DM or suspected or possible T1DM - Current/past history of DKA including ketone prone T2DM - Any diagnosis or suspicion of latent autoimmune diabetes (LADA), other genetic causes of diabetes, known pancreatic disease or injury - Rapid progression to insulin (within 1 year of diagnosis) - Recent major surgery **Discuss risks and benefits, side effects and sick day rules** Side effects include: Increased risk of urinary tract and genital tract infections, polyuria and polydipsia, thirst, postural dizziness, hypotension, dehydration, hypoglycaemia with insulin or SU. Uncommon but serious: DKA, Fournier's gangrene, lower limb amputation, fracture risk **Ensure adequate understanding of:** - Routine, preventative foot care. - Importance of keeping hydrated and drinking plenty of sugar free fluids. If restricting fluid due to other conditions e.g. heart failure, please contact heart failure team for advice and guidance (unless advised to restrict fluids by healthcare professional due to kidney or heart problems or some other reason) - Minimising risk of DKA by not starting a very low carbohydrate diet or ketogenic diet without discussing with healthcare professional first - Management and prevention of hypoglycaemia
	Dapagliflozin	10mg once daily	eGFR <45 ml/min : not recommend for glycaemic control in T2DM		
	Empaglifozin	10mg once daily	eGFR ≥ 60 ml/min : increase to 25mg if tolerated and required eGFR 45-59 ml/min : Initiate with 10mg for those with T2DM and established CVD. For those already taking empagliflozin, continue with 10mg only eGFR 30-44 ml/min : For insufficiently controlled T2DM: initiate or continue with 10mg for those with T2DM and established CVD only. Further glycaemic control may be required eGFR <30 ml/min : not recommend for glycaemic control in T2DM **For decompensated HFrEF** (heart failure reduced ejection fraction) - **See SEL guide for prescribing SGLT2 inhibitors**		
	Ertugliflozin (At the time of publication, the SGLT2 inhibitors with proven cardiovascular benefit are canagliflozin, dapagliflozin and empagliflozin.)	5mg once in the morning	eGFR>60ml/min: increase to 15mg daily if tolerated and required for glycaemic control. eGFR 45-59ml/min: do not initiate. For those already taking ertugliflozin, therapy can be continued at 5mg or titrated to 15mg daily as needed. eGFR<45ml/min: not recommended for glycaemic control in T2DM.		

References

T2DM: Preferred Medication

For detailed information on individual drugs, please check: SEL Joint Medicines Formulary, Electronic Medicines Compendium, British National Formulary and SELIMOC Diabetes Guidance

	Drug	Starting dose	Daily Range	Notes (these are not extensive, please refer to the latest BNF for further information especially titration increments/cautions/contra-indications)
ACEI	1st line Ramipril	2.5mg OD (1.25mg OD in frail/elderly patients)	2.5mg-10mg OD	• For people of Black African or African-Caribbean family origin, use ARB instead of ACEI (as increased risk of angioedema with ACEI). • Check baseline renal profile (Na/K/Cr/eGFR). Hyperkalaemia may occur, therefore close monitoring of serum potassium is required. • Re-check renal profile within 2 weeks of initiation or dose increase and then at least annually. • **Titrate ACEI/ARB up at 2-4 weekly intervals to achieve optimal BP control.** • Initiation/dose titration: if Cr increases by >20% (or eGFR falls by >15%) stop ACEI and seek specialist advice. ACEI dose should only be increased if serum creatinine increases by <20% (or eGFR falls by <15%) after each dose titration and potassium <5 mmol. • **ACEI/ARB dose should be optimised before the addition of a second agent.** • Side effects: symptomatic hypotension can occur on first dosing – suggest take at night. Dry cough with ACEI, consider switch to ARB. • **Caution:** Do not combine ACEI and ARB to treat hypertension. • For diabetic nephropathy ARB of choice: losartan and irbesartan.
	2nd line Lisinopril	10mg OD	10-80mg OD (maintenance dose 20mg for hypertension)	
ARBs	Losartan	50mg OD (25mg OD if >75yrs old)	50-100mg OD	
	Candesartan	8mg OD	8mg-32mg OD	
CCBs	Amlodipine	5mg OD	5-10mg OD	• Increase after 2-4 weeks to maximum dose of 10mg OD. • Caution: Interacts with simvastatin – consider switching to atorvastatin. • If amlodipine causes ankle oedema consider using a thiazide-like diuretic instead. • Contraindication: unstable angina, aortic stenosis, severe hypotension. • Side effects include flushing and headaches at initiation; swollen ankles especially at higher doses.
Thiazide-like diuretics	Indapamide (IR)	2.5mg OD	2.5mg OD	• Check baseline renal profile, then after 2 weeks, then at least annually. If K < 3.5mmol/L or eGFR <25ml/min, stop indapamide and seek specialist advice.
Statin **(See page 7)**	Atorvastatin (alternative is rosuvastatin)	20mg OD	20-80mg OD	• Seek specialist advice if eGFR <30ml/min, liver disease, untreated hypothyroidism, heavy drinker. • **CI** in pregnancy, breast feeding, avoid or address contraceptive needs women of childbearing age. Advise to stop 3 months before conception. • Multiple drug interactions, check BNF for advice, avoid grapefruit juice • Advise patient to visit GP if they experience unexplained muscle pains. • Refer to SEL IMOC Guidelines on Lipid Management

References

Local resources and referral pathways

Bexley

Bromley

Greenwich

Lambeth

Lewisham

Southwark

Health warning:
Services are constantly changing.
If you know of a new service, or a service listed is not correct, please let us know and we will update this information:
clinicaleffectiveness@selondonics.nhs.uk

Bexley T2DM resources and referral pathways

Services Offered	Department	How to refer
Bexley Care Community Diabetes Specialist Nurses	Endocrinology	DXS Bexley Care 'Single Point of Contact Referral form' under 'Diabetic Pathway', email address oxl-tr.diabetes@nhs.net
General Diabetic Medicine	Endocrinology	Specialist diabetes referral via ERS to • Queen Mary's Hospital • Queen Elizabeth Hospital • Darent Valley Hospital (DVH) • Lewisham Hospital • King's College Hospital (KCH) • Guys & St Thomas (GSTT)
Renal Diabetes	Endocrinology	Renal impairment & diabetes (GSTT) KCH Renal Kidney Disease Referral Form (DXS) kch-tr.renal@nhs.net
Community Hypertension and Lipid Clinic	Cardiology	DXS form or email for advice gst-tr.KHPCommunityCVD@nhs.net
Erectile dysfunction	Urology	Intermediate service at Bexley Group Practice (24 Station Road, Belvedere). Referral DXS 'Erectile Dysfunction Clinic Referral form' email to bex.erectiledysfunction@nhs.net
Podiatry and foot	Podiatry	(Routine and urgent*) – Oxleas (*different forms) or use DART form, both on DXS
Bexley Health Neighbourhood Care (BHN) Phlebotomy Plus	Phlebotomy	Annual review for housebound patients including phlebotomy service. Referral form on DXS 'Phlebotomy Plus Referral form', send via ERS.
Pre-conception & Pregnancy	Obstetrics	GSTT/KCH - on ERS specialty Obstetrics, Maternal medicine. For QEH* (lg.sidcupdiabetes@nhs.net), DVH* (dgn-tr.dvhdiabetescentre@nhs.net), refer by email with patient details or use the DART form (on DXS).
		Women with diabetes who become pregnant should be under a Consultant Obstetrician/Obstetric Physician at site of booking (e.g. LGT, DVH, GSTT) (also if pregnant with complex and/or multiple co-morbidities including renal disease)
General advice – non-urgent		Consultant Connect via telephone or App, Advice and Guidance using 'Diabetes Non-Emergency' on ERS

Weight Management Pathways

See more resources on MECC and Bexley council, DXS 'Diabetes Info Pack' and 'Bexley Healthy Weight Pathway

Services	Referral criteria	How to refer	Tier
NHS Digital Weight Management Programme	BMI ≥ 30kg/m² or BMI > 27.5kg/m² if Black African, African – Caribbean and Asian background	Form on DXS	Tier 2
Type 2 Diabetes Pathway to Remission - Oviva Supports total diet replacement for significant weight loss to achieve diabetes remission.	BMI ≥ 27kg/m² or BMI > 25kg/m² if Black African, African – Caribbean and Asian background & has a diagnosis of T2DM within the last 6 years	Form on DXS (ovivauk.t2dr@nhs.net)	
Gro Health	BMI > 25kg/m²	Form on DXS or share self referral link	
Healthy Weight programme	BMI ≥ 40kg/m² or BMI ≥35kg/m² with T2DM	Form on DXS: SEL Healthy Weight Management Programme Referral form . Refer via ERS Dietetics, Weight Management, SEL Tier 3 Healthy Weight Programme (Include BP, BMI, blood tests in last 6 months: HbA1c, lipids, renal):.	Tier 3
Bariatric service	BMI ≥ 35kg/m² + would consider bariatric surgery + Tier 3 completed	For Guy's and St Thomas' Service see details here For Queen Mary's Hospital Service see details here (Include details of completed Tier 3 programme for eligibility.	Tier 4

Bexley T2DM resources and referral pathways

Structured education T2DM

NHS South London Diabetes Book & Learn
DXS – email form to diabetes.booking@nhs.net

Services	What they are	How to refer
Heal D	HEAL-D is a digital platform providing culturally tailored diabetes education and support for African and Caribbean communities.	Via Diabetes Book & Learn (DXS - diabetes.booking@nhs.net) Face-to-face and online options available
DESMOND	DESMOND is a structured education program for people with T2DM, offering support to manage their condition effectively.	
X-PERT	X-PERT Health provides education programs to help individuals manage diabetes, improve health, and make informed lifestyle choices.	
Second Nature	Second Nature offers a digital weight loss and lifestyle program focusing on healthy habits, nutrition, and long-term behavior change.	
Low Carb Program	The Low Carb Program is a digital health platform helping people manage T2DM and weight through low-carb nutrition.	

Structured education Non-Diabetic Hyperglycaemia (Pre Diabetes)

Healthier you	The South East London NHS Diabetes Prevention Programme helps individuals reduce their risk of Type 2 diabetes through lifestyle changes. (Patients need Hba1c with date taken & NHS number) (Accumail template include patient needs)	Referral form - DXS - healthier.you@nhs.net Patients with pre-diabetes can self-register

Patient resources

- Diabetes UK website
- Health and Care patient information videos on range of diabetes topics
- London Diabetes
- Diabetes Peer support
- Ramadan & Diabetes
- Diabetes UK Patient information leaflets in different languages
- NHS Better Health free tools and support to kickstart your health (weight, smoking, activity, alcohol)
- Short patient film- Diabetes care processes Access here
- Diabetes and Looking After Your Feet Diabetes UK patient leaflet
- NHS Video library guide how to check your blood glucose level
- Annual **foot review** Diabetes UK
- Carbs & Cals resources for patients

Professional resources

- 'Summary of Diabetes Pathways in Bexley' and 'Bexley Healthy Weight Pathway' - on DXS
- Diabetes foot care pathway for SEL, Dartford & Gravesham – on DXS
- Annual foot review pathway, Diabetes UK
- Diabetic foot infection: antimicrobial prescribing. NICE
- Handbook: Diabetes footcare in dark skin tones - Diabetes Africa
- Cambridge Diabetes Education Programme: comprehensive, competence-based learning. https://www.cdep.org.uk/ (Registration code : SOUTH LONDONDIABETES)
- Diabetes in Healthcare Diabetes UK free online learning for health professionals
- RCGP Diabetes Hub
- Personalised Care Institute
- Primary Care Diabetes Society
- PITstop for Diabetes training – email admin@pitstopdiabetes.co.uk to enquire about free courses for Bexley
- TrendDiabetes
- Eden training for early onset type 2 diabetes

Bromley T2DM resources and referral pathways

Services Offered	Department	How to refer
Community Diabetes Centre	Community	REFER - ROP - Diabetic Medicine / Referrals/ Community Diabetes Referral Form Telephone Advice:. Office Hours: Community Diabetes Centre 01689 865911 Out of Hours: Consultant Connect
Preconception planning	Obstetric Medicine	REFER to Bromley Healthcare Diabetes Clinic (Preconception) ROP - Diabetic Medicine / Referrals/ BHC Diabetes Service Referral Form Community Diabetes Referral Form - Specify 'Preconception and Diabetes Type (1 or 2)
Referral to retinal screening		Patients correctly coded with diabetes will identified automatically; the GP does *not* need to make a referral.
Lipid clinics	Lipid	Via ROP
Renal Diabetes	Nephrology	ROP – Nephrology > Referrals > Renal Services Referral form
Podiatry and foot	Podiatry	ROP - Diabetic Medicine / Referrals/ Podiatry ROP- Podiatry/Referrals/ Refer to diabetic foot or team or podiatry Nail cutting services are not available on the NHS. Patients who require help with nail cutting can be signposted to the patient-funded Age UK "Clip It" service:

Weight Management Pathways

See more resources on MECC and Bromley Council, 'Dietetics and Weight management' via Referrals Optimisation Protocol (ROP). Referral. Weight management referral options. Options are automatically displayed according to patient eligibility via ROP. Consider referral at lower BMI for patients from BAME backgrounds

Services	Referral criteria	How to refer	Tier
NHS Digital Weight Management Programme	BMI ≥ 30kg/m^2 or BMI > 27.5kg/m^2 if Black African, African – Caribbean and Asian background	ROP> Dietetics >Referrals > weight management - ERS	Tier 2
Type 2 Diabetes Pathway to Remission - Oviva Supports total diet replacement for significant weight loss to achieve diabetes remission.	BMI ≥ 27kg/m^2 or BMI > 25kg/m^2 if Black African, African – Caribbean and Asian background & has a diagnosis of type 2 diabetes within the last 6 years		
Slimming World	BMI ≥ 30kg/m^2 or BMI > 27.5kg/m^2 if Black African, African – Caribbean and Asian background	ROP> Dietetics >Referrals > weight management	
Weight Watchers			
Healthy Weight programme	BMI ≥ 35kg/m^2	ROP> Dietetics >Referrals > weight management (Include BP, BMI, blood tests in last **6** months: HbA1c, lipids, renal):	Tier 3
Bariatric service	Patients newly diagnosed with diabetes and BMI 30-34.9kg/m^2	ROP> Dietetics >Referrals > weight management	Tier 4
	BMI ≥ 40kg/m^2 or (BMI ≥ 35kg/m^2 with complex comorbidities)	ROP> Dietetics >Referrals > weight management	

Bromley T2DM resources and referral pathways

Structured education T2DM

NHS South London Diabetes Book & Learn
DXS - diabetes.booking@nhs.net

Services	What they are	How to refer
Heal D	HEAL-D is a digital platform providing culturally tailored diabetes education and support for African and Caribbean communities.	Via Diabetes Book & Learn (DXS - diabetes.booking@nhs.net) Face-to-face and online options available
DESMOND	DESMOND is a structured education program for people with Type 2 diabetes, offering support to manage their condition effectively.	
X-PERT	X-PERT Health provides education programs to help individuals manage diabetes, improve health, and make informed lifestyle choices.	
Second Nature	Second Nature offers a digital weight loss and lifestyle program focusing on healthy habits, nutrition, and long-term behavior change.	
Low Carb Program	The Low Carb Program is a digital health platform helping people manage Type 2 diabetes and weight through low-carb nutrition.	

Structured education Non-Diabetic Hyperglycaemia (Pre Diabetes)

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Patient resources

- Diabetes UK website
- Health and Care patient information videos on range of diabetes topics
- London Diabetes
- Diabetes Peer support
- Ramadan & Diabetes
- Diabetes UK Patient information leaflets in different languages
- NHS Better Health free tools and support to kickstart your health (weight, smoking, activity, alcohol)
- Short patient film- Diabetes care processes Access here
- The Diabetes UK Bromley Group Support and information for everyone with diabetes and their carers.
- Diabetes and Looking After Your Feet Diabetes UK patient leaflet
- NHS Video library guide how to check your blood glucose level
- Annual **foot review** Diabetes UK
- Carbs & Cals resources for patients

Professional resources

- Diabetes foot care pathway for SEL, Dartford & Gravesham – on DXS
- Annual foot review pathway, Diabetes UK
- Diabetic foot infection: antimicrobial prescribing. NICE
- Handbook: Diabetes footcare in dark skin tones - Diabetes Africa
- Cambridge Diabetes Education Programme: comprehensive, competence-based learning. https://www.cdep.org.uk/ (Registration code : SOUTH LONDONDIABETES)
- Diabetes in Healthcare Diabetes UK free online learning for health professionals
- RCGP Diabetes Hub
- Personalised Care Institute
- Primary Care Diabetes Society
- TrendDiabetes
- Eden training for early onset type 2 diabetes

Greenwich T2DM resources and referral pathways

Services Offered	Department	How to refer
3 Triple Target (3TT) Service	Endocrinology	Support in managing the poorest controlled diabetes in Greenwich (HbA1c > 75). (form available on DXS) Email DSN: greenwichhealth.diabetes@nhs.net
Greenwich Intermediate Diabetes Service	Endocrinology	(Oxleas service): Support for GHL/practices to help patients meet 3TT with HbA1c > 75, including home visits and insulin/GLP-1 initiation. Via Single Point of Access form available on DXS. Referral address: oxl-tr.greenwich-singlepointofaccess@nhs.net General Enquiry: oxl-tr.diabetes@nhs.net
Considering pregnancy	Endocrinology	Refer to Community Diabetes Single Point Referral via DXS, Diabetes Pre-conception clinic KCH or GSTT (ERS)
Maternity and Pregnancy	Obstetrics	For pregnant women with diabetes, refer to Queen Elizabeth Hospital (QEH) via email: lg.qe-anreferrals@nhs.net Direct contact to Diabetes midwives - lg.qe-gdmreferrals@nhs.net Generic antenatal clinic - lg.qe-antenatalclinic@nhs.net
Podiatry and foot	Podiatry	Podiatry single point of access details: oxl-tr.greenwich-singlepointofaccess@nhs.net form on DXS Diabetes Single Point of Access Form (Greenwich) on DXS. For urgent queries use consultant connect (diabetes and endocrinology or vascular) and A+E.
Urgent telephone advice	General	Consultant connect
Non-urgent 'Advice & Guidance	General	Via ERS
Community Hypertension and Lipid Clinic	Hypertension/ Lipid Clinic	Referral form on DXS or email for advice: gsttr.KHPCommunityCVD@nhs.net

Weight Management Pathways

See more resources on MECC and Healthy Weight Greenwich

DXS '**Diabetes Info Pack**' and Consider referral at lower BMI for patients from BAME backgrounds

Services	Referral criteria	How to refer	Tier
NHS Digital Weight Management Programme	BMI ≥ 30kg/m² or BMI > 27.5kg/m² if Black African, African – Caribbean and Asian background	Form on DXS	Tier 2
Type 2 Diabetes Pathway to Remission - Oviva Supports total diet replacement for significant weight loss to achieve diabetes remission.	BMI ≥ 27kg/m² or BMI > 25kg/m² if Black African, African – Caribbean and Asian background & has a diagnosis of type 2 diabetes within the last 6 years	Form on DXS - ovivauk.t2dr@nhs.net	
Weight Loss with Better	BMI ≥ 30kg/m²	Multiple options, please refer to **'Greenwich Weight Pathway'** on DXS	
TBC Healthcare	BMI ≥ 30kg/m² with T2DM or BMI ≥ 27.5kg/m² Minor Ethnic Background or BMI ≥ 35kg/m²	Form and criteria on DXS. Refer via e-RS or e-mail gst-tr.tier3@nhs.net (Include BP, BMI, blood tests in last **6** months: HbA1c, lipids, renal	Tier 3
Bariatric service	BMI ≥ 35kg/m² + Would consider bariatric surgery + Tier 3 completed	For Lewisham and Greenwich Hospital Trust Service see details here	Tier 4

Greenwich' T2DM resources and referral pathways

Structured education T2DM

NHS South London Diabetes Book & Learn (education through programmes)
DXS - diabetes.booking@nhs.net

Services	What they are	How to refer
Heal D	HEAL-D is a digital platform providing culturally tailored diabetes education and support for African and Caribbean communities.	Via Diabetes Book & Learn (DXS - diabetes.booking@nhs.net) Face-to-face and online options available
DESMOND	DESMOND is a structured education program for people with Type 2 diabetes, offering support to manage their condition effectively.	
Live Well	Live Well offers health and wellbeing support, resources, and advice for residents to live healthier, happier lives.	
X-PERT	X-PERT Health provides education programs to help individuals manage diabetes, improve health, and make informed lifestyle choices.	
Second Nature	Second Nature offers a digital weight loss and lifestyle program focusing on healthy habits, nutrition, and long-term behavior change.	
Low Carb Program	The Low Carb Program is a digital health platform helping people manage Type 2 diabetes and weight through low-carb nutrition.	

Structured education Non-Diabetic Hyperglycaemia (Pre Diabetes)

Healthier you	The South East London NHS Diabetes Prevention Programme helps individuals reduce their risk of Type 2 diabetes through lifestyle changes. (Patients need Hba1c with date taken & NHS number) (Accumail template include patient needs)	Referral form - DXS - healthier.you@nhs.net Patients with pre-diabetes can self-register

Patient resources

- Diabetes UK website
- Health and Care patient information videos on range of diabetes topics
- London Diabetes
- Diabetes Peer support
- Ramadan & Diabetes
- Diabetes UK Patient information leaflets in different languages
- NHS Better Health free tools and support to kickstart your health (weight, smoking, activity, alcohol)
- Short patient film- Diabetes care processes Access here
- Diabetes and Looking After Your Feet Diabetes UK patient leaflet
- Live Well Greenwich – Diabetes Community
- Diabetes UK - Local Groups - Greenwich Nepalese local group (diabetesukgroup.org) support and information for Greenwich Nepalese group with diabetes and their carers.
- NHS Video library guide how to check your blood glucose level
- Annual **foot review** Diabetes UK
- Carbs & Cals resources for patients
- Champions 4 change Wellbeing

Professional resources

- Diabetes foot care pathway for SEL, Dartford & Gravesham – on DXS
- Annual foot review pathway, Diabetes UK
- Diabetic foot infection: antimicrobial prescribing. NICE
- Handbook: Diabetes footcare in dark skin tones - Diabetes Africa
- Cambridge Diabetes Education Programme: comprehensive, competence-based learning. https://www.cdep.org.uk/ (Registration code : SOUTH LONDONDIABETES)
- Diabetes in Healthcare Diabetes UK free online learning for health professionals
- RCGP Diabetes Hub
- Personalised Care Institute
- Primary Care Diabetes Society
- https://pitstopdiabetes.co.uk/ comprehensive, competence based learning.
- TrendDiabetes
- Eden training for early onset type 2 diabetes

Lambeth T2DM resources and referral pathways

Services Offered	Department	How to refer
Urgent telephone advice	Endocrinology	Consultant connect
Virtual diabetes clinics	Endocrinology	Available for practices via Lambeth Diabetes Intermediate Care Team (DICT) email at lamccg.diabetes@nhs.net
Lambeth Diabetes Intermediate Care Team (DICT)	Endocrinology	Referral criteria on form on DXS, also via email at lamccg.diabetes@nhs.net
Specialist clinics	Endocrinology	Request advice and guidance or referral via ERS to: • Diabetes medicine (GSTT/KCH) • Pre-conception counselling clinic (GSTT/KCH) • Diabetes Pregnancy clinic (GSTT/KCH)
Renal Diabetes	Nephrology	Request advice and guidance or referral to specialist clinics via ERS (GSTT/KCH)
Maternity and Pregnancy	Obstetrics	Diabetes Pregnancy Clinic. Contact: Kings College Hospital (KCH): kch-trdiabetesnurses@nhs.net Guys & St Thomas' Hospital (GSTT): gst-tr.diabetesandendocrine@nhs.net
Lipid clinics	Lipid	Via ERS, Endocrine & metabolic medicine > lipid disorders >select local hospitals

Weight Management Pathways

See more resources on MECC and Lambeth Council, DXS 'Diabetes Info Pack' and 'Consider referral at lower BMI for patients from BAME backgrounds

Services	Referral criteria	How to refer	Tier
NHS Digital Weight Management Programme	BMI ≥ 30kg/m² or BMI > 27.5kg/m² if Black African, African – Caribbean and Asian background	Forms on DXS	Tier 2
Lambeth healthy weight hub	BMI ≥ 30kg/m² with co-morbidity or BMI ≥ 27kg/m² for BAME adults		
Type 2 Diabetes Pathway to Remission - Oviva Supports total diet replacement for significant weight loss to achieve diabetes remission.	BMI ≥ 27kg/m² or BMI > 25kg/m² if Black African, African – Caribbean and Asian background & has a diagnosis of type 2 diabetes within the last 6 years	Form on DXS - ovivauk.t2dr@nhs.net	
Healthy Weight programme	BMI ≥ 30kg/m² with T2DM or BMI ≥ 35kg/m²	Form on DXS: SEL Healthy Weight Management Programme Referral form . Refer via e-RS (Include BP, BMI, blood tests in last **6** months: HbA1c, lipids, renal): Dietetics, Weight Management, SEL Tier 3 Healthy Weight Programme.	Tier 3
Bariatric service	BMI ≥ 35kg/m² + Would consider bariatric surgery + Tier 3 completed	For Guy's and St Thomas' Service see details here Include details of completed Tier 3 programme for eligibility	Tier 4

Lambeth T2DM resources and referral pathways

Structured education T2DM

NHS South London Diabetes Book & Learn
Form on DXS - diabetes.booking@nhs.net

Services	What they are	How to refer
Heal D	HEAL-D is a digital platform providing culturally tailored diabetes education and support for African and Caribbean communities.	Via Diabetes Book & Learn (DXS - diabetes.booking@nhs.net)
DESMOND	DESMOND is a structured education program for people with Type 2 diabetes, offering support to manage their condition effectively.	
X-PERT	X-PERT Health provides education programs to help individuals manage diabetes, improve health, and make informed lifestyle choices.	
Second Nature	Second Nature offers a digital weight loss and lifestyle program focusing on healthy habits, nutrition, and long-term behavior change.	
Low Carb Program	The Low Carb Program is a digital health platform helping people manage Type 2 diabetes and weight through low-carb nutrition.	
Structured education Non-Diabetic Hyperglycaemia (Pre Diabetes)		
Healthier you	The South East London NHS Diabetes Prevention Programme helps individuals reduce their risk of Type 2 diabetes through lifestyle changes. (Patients need Hba1c with date taken & NHS number) (Accumail template include patient needs)	Referral form - DXS - healthier.you@nhs.net Patients with pre-diabetes can self-register

Patient resources

- Diabetes UK website
- Health and Care patient information videos on range of diabetes topics
- London Diabetes
- Diabetes Peer support
- Ramadan & Diabetes
- Diabetes UK Patient information leaflets in different languages
- NHS Better Health free tools and support to kickstart your health (weight, smoking, activity, alcohol)
- Short patient film- Diabetes care processes Access here
- Diabetes and Looking After Your Feet Diabetes UK patient leaflet
- Lambeth health and wellbeing information and support
- Physical activity for older people with Silverfit
- Lowering your blood pressure with DASH diet
- NHS Video library guide how to check your blood glucose level
- Annual **foot review** Diabetes UK
- Carbs & Cals resources for patients

Professional resources

- Diabetes foot care pathway for SEL– on DXS
- Annual foot review pathway, Diabetes UK
- Diabetic foot infection: antimicrobial prescribing. NICE
- Handbook: Diabetes footcare in dark skin tones - Diabetes Africa
- Cambridge Diabetes Education Programme: comprehensive, competence-based learning. https://www.cdep.org.uk/ (Registration code : SOUTH LONDONDIABETES)
- Diabetes in Healthcare Diabetes UK free online learning for health professionals
- RCGP Diabetes Hub
- Personalised Care Institute
- Primary Care Diabetes Society
- https://pitstopdiabetes.co.uk/ comprehensive, competence based learning.
- TrendDiabetes
- Eden training for early onset type 2 diabetes

Lewisham T2DM resources and referral pathways Part 1

Services Offered	Department	How to refer
Diabetes Clinic - Lewisham	Endocrinology	Integrated diabetes team referral form (DXS). Use for referrals to Consultants, community nurses, diabetic renal clinic, insulin conversion, diabetes-related dietetic issues, poor glycaemic control, pre-conception advice
Diabetic Clinics – Guys & St Thomas' Hospital (GSTT)	Endocrinology	Referral via ERS Diabetic medicine : • Diabetic medicine clinic • Lipids & cardiovascular risk adult (for diabetic patients with obesity or lipid disorders) • Diabetes with complications • Renal impairment and diabetes • Diabetic Medicine Rapid access clinic
Diabetic Clinics – Kings College Hospital (KCH):	Endocrinology	Referral via Diabetic medicine ERS: • Diabetes general • Diabetes with complications, including renal
Non-Urgent 'Advice & Guidance	Endocrinology	ERS 'Advice and Guidance' – Diabetes and Endocrinology
Urgent Telephone Advice	Endocrinology	• Consultant connect – Diabetes and Endocrinology • Lewisham community diabetes nurses –0203 192 6450 • Ambulatory Care UHL (07880026233)
Lipid clinics	Lipid	Via ERS, Endocrine & metabolic medicine > lipid disorders >select local hospitals
Specialist Dietitian	Dietetics	Via ERS, T2DM new to insulin, change in insulin regime, GLP start, suboptimal glucose control, VLCD programme for T2DM/NDH patients.
Lewisham Foot Health general diabetes problems	Podiatry & Foot Protection	form on DXS Foot health | Lewisham and Greenwich – accepts self referral
Lewisham Hospital Acute Foot Service	Podiatry & Foot Protection	Email or phone lh.acutefootservices@nhs.net / 020 3192 6602

Lewisham T2DM resources and referral pathways Part 2

Weight Management Pathways
See more resources on MECC and Lewisham Council, DXS '**Diabetes Info Pack**' and 'Consider referral at lower BMI for patients from BAME backgrounds

Services	Referral criteria	How to refer	Tier
NHS Digital Weight Management Programme	BMI ≥ 30kg/m² or BMI > 27.5kg/m² if Black African, African – Caribbean and Asian background	Form on DXS	Tier 2
Type 2 Diabetes Pathway to Remission - Oviva Supports total diet replacement for significant weight loss to achieve diabetes remission.	BMI ≥ 27kg/m² or BMI > 25kg/m² if Black African, African – Caribbean and Asian background & has a diagnosis of type 2 diabetes within the last 6 years	Form on DXS - ovivauk.t2dr@nhs.net	Tier 2
UP! UP! Tier 2 Weight Management Programme (GSTT Provider)	BMI ≥ 30kg/m² or BMI > 27.5kg/m² if Black African, African – Caribbean and Asian background Or BMI ≥ 35kg/m² or BMI > 32.5kg/m² if BAME – patient has T2DM or more obesity comorbidities	GSTT Email gst-tr.up.up@nhs.net, Tel 020 7188 2010 Self referral- https://www.guysandstthomas.nhs.uk/our-services/healthy-weight-programmes/12-week-programme-lewisham	Tier 2
Slimming World	BMI ≥ 30kg/m² or BMI > 27.5kg/m² if Black African, African – Caribbean and Asian background	Form on DXS	Tier 2
Healthy Weight programme	BMI ≥ 35kg/m² or BMI > 32.5kg/m² if Black African, African – Caribbean and Asian background	Form on DXS: SEL Healthy Weight Management Programme Referral form . Refer via e-RS (Include BP, BMI, blood tests in last **6** months: HbA1c, lipids, renal): Dietetics, Weight Management, SEL Tier 3 Healthy Weight Programme.	Tier 3
Bariatric service	BMI ≥ 35kg/m² + Would consider bariatric surgery + Tier 3 completed	For Guy's and St Thomas' Service see details here For Lewisham and Greenwich Hospital Trust Service see details here Include details of completed Tier 3 programme for eligibility	Tier 4

Lewisham T2DM resources and referral pathways Part 3

Structured education T2DM

NHS South London Diabetes Book & Learn
DXS - diabetes.booking@nhs.net

Services	What they are	How to refer
Heal D	HEAL-D is a digital platform providing culturally tailored diabetes education and support for African and Caribbean communities.	Via Diabetes Book & Learn (DXS - diabetes.booking@nhs.net)
DESMOND	DESMOND is a structured education program for people with Type 2 diabetes, offering support to manage their condition effectively.	
X-PERT	X-PERT Health provides education programs to help individuals manage diabetes, improve health, and make informed lifestyle choices.	
Second Nature	Second Nature offers a digital weight loss and lifestyle program focusing on healthy habits, nutrition, and long-term behavior change.	
Low Carb Program	The Low Carb Program is a digital health platform helping people manage Type 2 diabetes and weight through low-carb nutrition.	

Structured education Non-Diabetic Hyperglycaemia (Pre Diabetes)

Healthier you	The South East London NHS Diabetes Prevention Programme helps individuals reduce their risk of Type 2 diabetes through lifestyle changes. (Patients need Hba1c with date taken & NHS number) (Accumail template include patient needs)	Referral form - DXS - healthier.you@nhs.net Patients with pre-diabetes can self-register

Patient resources

- Diabetes UK website
- Health and Care patient information videos on range of diabetes topics
- London Diabetes
- Diabetes Peer support
- Ramadan & Diabetes
- Diabetes UK Patient information leaflets in different languages
- NHS Better Health free tools and support to kickstart your health (weight, smoking, activity, alcohol)
- Short patient film- Diabetes care processes Access here
- Diabetes and Looking After Your Feet Diabetes UK patient leaflet
- Lowering your blood pressure with DASH diet
- NHS Video library guide how to check your blood glucose level
- Annual **foot review** Diabetes UK
- Carbs & Cals resources for patients

Professional resources

- Diabetes foot care pathway for SEL– on DXS
- Annual foot review pathway, Diabetes UK
- Diabetic foot infection: antimicrobial prescribing. NICE
- Handbook: Diabetes footcare in dark skin tones - Diabetes Africa
- Cambridge Diabetes Education Programme: comprehensive, competence-based learning. https://www.cdep.org.uk/ (Registration code : SOUTH LONDONDIABETES)
- Diabetes in Healthcare Diabetes UK free online learning for health professionals
- RCGP Diabetes Hub
- Personalised Care Institute
- Primary Care Diabetes Society
- https://pitstopdiabetes.co.uk/ comprehensive, competence based learning.
- TrendDiabetes
- Eden training for early onset type 2 diabetes

Southwark T2DM resources and referral pathways

Services Offered	Department	How to refer
Community diabetes clinic	Endocrinology	Referral criteria and form on DXS, can also provide T2DM drug-related advice via email at gst-TR.southwark-diabetes@nhs.net Phone: 02030498863. Refer ERS Diabetes Medicines, General Diabetes Management, Bermondsey or Dulwich Site (GSTT)
Urgent telephone advice	General	Consultant connect
Non-urgent 'Advice & Guidance	General	Via ERS Diabetes Medicines, General Diabetes Management, Bermondsey or Dulwich Site (GSTT) or KCH
Considering pregnancy	Endocrinology	Refer to Community Diabetes Single Point Referral, Diabetes Pre-conception clinic KCH or GSTT (ERS)
Community Hypertension and Lipid Clinic	Hypertension & Lipid Clinic	Referral form on DXS or email for advice: gsttr.KHPCommunityCVD@nhs.net, via DXS.
Lipid clinics	Lipid	Via ERS, Endocrine & metabolic medicine > lipid disorders >select local hospitals

Weight Management Pathways
See more resources on MECC and Southwark Council, DXS '**Diabetes Info Pack**' and 'Consider referral at lower BMI for patients from BAME backgrounds

Services	Referral criteria	How to refer	Tier
NHS Digital Weight Management Programme	BMI ≥ 30kg/m^2 or BMI 27.5 kg/m^2 if Black African, African – Caribbean and Asian background	DXS 'Southwark Tier 2 referral form'	Tier 2
Type 2 Diabetes Pathway to Remission - Oviva Supports total diet replacement for significant weight loss to achieve diabetes remission.	BMI ≥ 27kg/m^2 or BMI > 25kg/m^2 if Black African, African – Caribbean and Asian background & has a diagnosis of type 2 diabetes within the last 6 years	Form on DXS - ovivauk.t2dr@nhs.net	
Healthy Weight programme	BMI ≥ 30kg/m^2 with T2DM or BMI ≥ 35kg/m^2	Form on DXS: SEL Healthy Weight Management Programme Referral form . Refer via e-RS (Include BP, BMI, blood tests in last **6** months: HbA1c, lipids, renal): Dietetics, Weight Management, SEL Tier 3 Healthy Weight Programme.	Tier 3
Bariatric service	BMI ≥ 35kg/m^2 + Would consider bariatric surgery + Tier 3 completed	For Guy's and St Thomas' Service see details here For Lewisham and Greenwich Hospital Trust Service see details here Include details of completed Tier 3 programme for eligibility	Tier 4

Southwark's type 2 diabetes resources and referral pathways

Structured education T2DM

NHS South London Diabetes Book & Learn
DXS - diabetes.booking@nhs.net

Services	What they are	How to refer
Heal D	HEAL-D is a digital platform providing culturally tailored diabetes education and support for African and Caribbean communities.	Via Diabetes Book & Learn (DXS - diabetes.booking@nhs.net)
DESMOND	DESMOND is a structured education program for people with Type 2 diabetes, offering support to manage their condition effectively.	
X-PERT	X-PERT Health provides education programs to help individuals manage diabetes, improve health, and make informed lifestyle choices.	
Second Nature	Second Nature offers a digital weight loss and lifestyle program focusing on healthy habits, nutrition, and long-term behavior change.	
Low Carb Program	The Low Carb Program is a digital health platform helping people manage Type 2 diabetes and weight through low-carb nutrition.	
Structured education Non-Diabetic Hyperglycaemia (Pre Diabetes)		
Healthier you	The South East London NHS Diabetes Prevention Programme helps individuals reduce their risk of Type 2 diabetes through lifestyle changes. (Patients need Hba1c with date taken & NHS number) (Accumail template include patient needs)	Referral form - DXS - healthier.you@nhs.net Patients with pre-diabetes can self-register

Patient resources

- Health Lifestyle Hub – access via NHS Health Checks
- Diabetes UK website
- Health and Care patient information videos on range of diabetes topics
- London Diabetes
- Diabetes Peer support
- Ramadan & Diabetes
- Diabetes UK Patient information leaflets in different languages
- NHS Better Health free tools and support to kickstart your health (weight, smoking, activity, alcohol)
- Short patient film- Diabetes care processes Access here
- Diabetes and Looking After Your Feet Diabetes UK patient leaflet
- Lowering your blood pressure with DASH diet
- NHS Video library guide how to check your blood glucose level
- Southwark Sport and Leisure
- Southwark Wellbeing Hub Directory for community resources
- Annual **foot review** Diabetes UK
- Carbs & Cals resources for patients

Professional resources

- Diabetes foot care pathway for SEL– on DXS
- Annual foot review pathway, Diabetes UK
- Diabetic foot infection: antimicrobial prescribing. NICE
- Handbook: Diabetes footcare in dark skin tones - Diabetes Africa
- Cambridge Diabetes Education Programme: comprehensive, competence-based learning. https://www.cdep.org.uk/ (Registration code : SOUTH LONDONDIABETES)
- Diabetes in Healthcare Diabetes UK free online learning for health professionals
- RCGP Diabetes Hub
- Personalised Care Institute
- Primary Care Diabetes Society
- https://pitstopdiabetes.co.uk/ comprehensive, competence-based learning.
- TrendDiabetes
- Diabetic foot infection: antimicrobial prescribing. NICE
- Southwark Healthy Weight training for professionals
- Eden training for early onset type 2 diabetes

References and Abbreviations

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2WW – Two-week-wait referral
8CP – 8 Care Processes
α-B – Alpha blocker
A&E – Accident and Emergency
ABPM – Ambulatory blood pressure monitoring
ACEI-– Angiotensin converting enzyme inhibitor
ACR – Albumin-creatinine ratio
ALT – Alanine aminotransferase
APL – Active patient link tools
ARB – Angiotensin receptor blocker
AST – Aspartate aminotransferase
BAME – Black, Asian and Minority Ethnic
β-B – Beta blocker
BD – Twice daily (dosing)
BM- Blood monitoring
BMI – Body mass index
BNF - British National Formulary
BP – Blood Pressure
CDEP – Cambridge diabetes Education Programme
CESEL – Clinical Effectiveness South East London
CCB – Calcium channel blocker
CI – Contra-indication
CK – Creatinine Kinase
CKD – Chronic Kidney Disease
Cr – Creatinine
CVD – Cardiovascular disease
CT – Computed tomography
DASH – Dietary approaches to stop hypertension
DESMOND – Diabetes Education and Self-Management for Ongoing and Diagnosed
DICT – Diabetes Intermediate Care Team (Lambeth)
DKA – Diabetic ketoacidosis
DPP – Diabetes Prevention Programme
DPP-4i – Dipeptidylpeptidase-4 inhibitor
DVH -Darent Valley Hospital
DVLA – Driver and Vehicle Licensing Agency
DXS – Digital Document Management System, integrated with EMIS - Egton Medical Information System
ECG – Electrocardiogram
eGFR – Estimated glomerular filtration rate
ERS – Electronic Referral System
F2F – Face-to-face
FBC – Full blood count
FH – Family history
GDM – Gestational diabetes
GSTT – Guy's and St.Thomas' Hospital Trust
GLP-1 – Glucagon-like peptide -1
GI – Gastro-intestinal
GLP1 – glucagon like peptide analogue
IGR – Impaired Glucose Regulation
IR – Immediate release
K – Potassium
KCH – King's College Hospital
HbA1c – Glycated Haemoglobin expressed as percentage
HBPM– Home blood pressure monitoring
HDL – High-density lipoprotein
HEAL-D – Healthy eating and active lifestyle in diabetes
HHS – Hyperosmolar, hyperglycaemic state
IGR – Impaired glucose regulation
IHD – Ischaemic Heart Disease
IMOC – Integrated Medicines Optimisation Committee (South East London)
KCH – Kings' College Hospital
LFT – Liver function tests
LADA – Latent autoimmune diabetes in adults
LD – Learning difficulties
LDL – Low-density lipoprotein
LGT – Lewisham and Greenwich Hospital Trust
MECC – Make every contact count
MODY – Maturity onset diabetes on the young
MI – Myocardial infarction
mmHg – millimetres of mercury
NDA – National Diabetes Audit
NDDP – National Diabetes Prevention Programme
NDH – non-diabetic hyperglycaemia
NICE – The National Institute for Health and Care Excellence
NSAID – Non-steroidal anti-inflammatory drug
OD – Once daily (dosing)
OGTT – Oral glucose tolerance testing
PAD – Peripheral arterial disease
PCOS – Polycystic ovarian syndrome
PHM – Population health management (contract)
PLT – Protected learning time
PMS – Primary medical services (contract)
QEH – Queen Elizabeth Hospital
QOF – Quality and outcomes framework
QRISK2 – a prediction algorithm for CVD. EMIS currently using QRISK2 (although QRISK3 released in 2017)
RCGP – Royal College of General Practitioners
Renal profile – includes serum sodium, potassium, creatinine, eGFR
ROP – Referral Optimisation Protocol
SEIMS – Slowly evolving immune mediated diabetes in adults
SELAPC – South East London Area Prescribing Committee
SEL – South East London
SBP – Systolic blood pressure
SMI – Serious mental illness
SPC – Summary of product characteristics
SGLT2i - Sodium Glucose Co-transporter 2 (SGLT2) inhibitors
SPLW – Social Prescribing Link Worker
SU - Sulphonylurea
T2DM – Type 2 Diabetes Mellitus
TIA – Transient ischaemic attack
TSH – Thyroid stimulating hormone
TT – Triple target
UCLP – University College London Partners

Clinical Effectiveness
South East London

South East London
Integrated Care System

NHS

Making the right thing to do the easy thing to do.

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