Type 2 Diabetes Mellitus in Adults
A guide for Southwark General Practice

Key Messages

1. Lifestyle: if overweight, agree a weight loss goal of 5–10% of body weight\(^1\)
2. Blood pressure: target BP ≤140/80 (130/80 in established cerebrovascular, eye and kidney disease)\(^1\)
3. Cholesterol: Statin if QRISK2 ≥ 10%\(^2\)
4. HbA1c: target ≤ 58mmol/mol (≤7.5%)\(^1, 3\)

Always work within your knowledge and competency

November 2018 (review May 2020, or earlier if indicated) ©
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Why focus on Type 2 Diabetes (T2DM) in Southwark?

- Even modest improvements in glucose control reduce incidence of complications including foot ulcers, amputations and neuropathy.⁴
- Tight blood pressure control substantially reduces diabetes complications and improves survival.⁵
- Cholesterol lowering drugs reduce the risk of major vascular events.⁶
- Weight management may normalise blood sugar levels without the use of drugs.⁷
- Smoking is a risk factor for T2DM and supporting patients to stop smoking reduces their risk of premature death, heart disease and other complications.⁸
- Primary care management of, and screening for, diabetes are key areas where improved quality of care could contribute to NHS cost savings.⁹
- Diabetes was chosen as a priority area by Southwark practices (Protected Learning Time event – October 2017).

Increasing T2DM prevalence and control will deliver better outcomes for patients and improve practice income

Risk factors for T2DM¹⁰

- Age over 40 and white
- Age over 25 and black or south Asian
- Family history
- High blood pressure
- BMI > 25 especially apple shape
- History of coronary heart disease or stroke
- Serious mental illness
- Polycystic ovarian syndrome and gestational diabetes

Calculate T2DM risk using a QDiabetes calculator

Management of Pre-Diabetes

- Use CES Pre-Diabetes template to ensure accurate coding
- Refer to structured education:
  - 42-43 mmol/mol refer to Walking Away from Diabetes
  - 44-47 mmol/mol refer to Diabetes Prevention Programme (DPP)
- Annual review for patients with pre-diabetes and history of gestational diabetes
  - HbA1c
  - BP
  - BMI
  - Brief advice

Diagnosis of T2DM using HbA1c¹¹

<table>
<thead>
<tr>
<th>HbA1c</th>
<th>MMol/mol</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>Normal</td>
</tr>
<tr>
<td>5.9%</td>
<td>Pre-diabetes (IGR)</td>
</tr>
<tr>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>6.4%</td>
<td></td>
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<tr>
<td>6.5%</td>
<td>Diabetes symptoms + 1 result or 2 results on separate days</td>
</tr>
</tbody>
</table>

Normal haemoglobin is a requirement to interpret HbA1c results. The diagnosis and monitoring of T2DM using HbA1c is dependent on normal erythropoiesis, no genetic or chemically altered haemoglobins, normal glycation and normal erythrocyte destruction rates. HbA1c is not suitable for diagnosis in rapid onset diabetes including Type 1 and pregnancy.¹¹

New Diagnosis: ENSURE THE DIAGNOSIS IS BELIEVED AND UNDERSTOOD

- Use CES T2DM template to ensure accurate coding
- Refer to Structured Education Programme – Diabetes Book and Learn Southwark
- Agree a clear review date

Use Diabetes UK Information Prescriptions to support personal care

Considering pregnancy

- Refer Community Diabetes Single Point Referral, Diabetes Pre-pregnancy Clinic KCH or GSTT

New T2DM, >60 years, weight loss

- 2WW referral for suspected cancer of pancreas¹²
## T2DM Eight Care Processes

<table>
<thead>
<tr>
<th>Care Process</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body Mass Index kg/m²</strong></td>
<td><img src="Image1.png" alt="Image" /></td>
</tr>
<tr>
<td><strong>Blood Pressure</strong></td>
<td><img src="Image2.png" alt="Image" /></td>
</tr>
<tr>
<td><strong>Cholesterol</strong></td>
<td><img src="Image3.png" alt="Image" /></td>
</tr>
<tr>
<td><strong>HbA1c</strong></td>
<td><img src="Image4.png" alt="Image" /></td>
</tr>
<tr>
<td><strong>Renal function and albumin creatinine ratio (ACR)</strong></td>
<td><img src="Image5.png" alt="Image" /></td>
</tr>
<tr>
<td><strong>Smoking</strong></td>
<td><img src="Image6.png" alt="Image" /></td>
</tr>
<tr>
<td><strong>Foot Check</strong></td>
<td><img src="Image7.png" alt="Image" /></td>
</tr>
</tbody>
</table>

### Body Mass Index kg/m²
- **Overweight**
  - BMI ≥ 25 White groups
  - BMI ≥ 23 Black African, African Caribbean and Asian groups
- **Agree an initial weight loss target of 5–10% of body weight**

### Blood Pressure
- **Target ≤140/80mmHg**
  - ≤130/80mmHg for established cerebrovascular, eye and kidney disease
  - ≤150/90mmHg if ≥80 years

### Cholesterol
- **Primary prevention**
  - Statin if QRISK2 ≥ 10% after 3 months lifestyle advice

### HbA1c
- **Check 3-6 monthly until stable, then 6 monthly**
  - Target: ≤48mmol/mol (6.5%) unless on a drug that could cause adverse events
  - ≤58mmol/mol (7.5%) if on a drug that could cause adverse events e.g. gliclazide and insulin

### Renal function and Albumin Creatinine Ratio (ACR)
- **ACR**
  - Ideally early morning urine.
  - If random sample then confirm with early morning sample
  - **Women ACR ≥ 2.5 mg/mmol = nephropathy**
  - **Men ACR ≥ 3.5 mg/mmol = nephropathy**
- Nephropathy – start an ACEI/ARB even if normotensive
- Consider CKD in patients with raised ACR and low eGFR

### Smoking
- **Ensure you are trained to deliver Very Brief Advice (VBA)**
- **ASK ADVISE ACT Very Brief Advice Training Module**
- If ready to quit refer to appropriate local service.

### Foot Check
- **Medium risk** – neuropathy or absent pulse ➢ Refer Podiatry Community Clinic
- **High risk** – neuropathy or absent pulse + plus deformity or skin changes in previous ulcer ➢ Urgently Refer Podiatry Community Clinic
- **Active ulcer/infection/ischaemia** ➢ KCH/GSTT diabetic foot clinic or A&E out of hours
- Referral details on [Diabetic Foot Pathway for Southwark and Lambeth](#)

### And remember
- Flu annually and pneumococcal immunisation once
- Retinopathy screening within 3 months of diagnosis and at least annually
- Patients called automatically once coded for T2DM
**Blood pressure management in T2DM**¹,¹⁵,²²

**Treat Stage 1 Hypertension in T2DM**

BP ≥ 140/90mmHg + ABPM/Home monitoring average ≥ 135/85mmHg

**Patients of Afro-Caribbean origin should start at Step 2**

Pregnant or chance of becoming pregnant? – avoid ACEI and use CCB first line¹⁵

**Monitor every 1-2 months until target is reached and then every 4-6 months**

**Step 1**

A: ACEI 1st Line (ARB if intolerant)

ramipril/lisinopril/enalapril

**Step 2**

A+C or D: ACEI (ARB if intolerant) + CCB or thiazide-type diuretic

amlodopine

indapamide

**Step 3**

A+C+D: ACEI (ARB if intolerant) + CCB + thiazide-type diuretic

**Step 4**

Add an alpha-blocker, beta-blocker or a potassium sparing diuretic (the last with caution if on an ACEI or ARB)

Alpha-blocker (doxazosin) or beta-blocker (atenolol/bisoprolol)

Consider seeking specialist advice

**KEY:**

A = ACEI/ARB  
B = β-Blocker  
C = CCB  
D = diuretic (thiazide type)

**HBPM: Home BP monitoring**

- Ensure patient is using an accurate BP machine and advise to record two BP readings every morning and evening every day for 7 days
- In the practice, disregard the first days readings and take an average of all other readings
HbA1c management in T2DM

**Step 1**
3 months
- If HbA1c ≥ 48mmol/mol (6.5%) go to Step 2

**Step 2**
3 months
- Metformin standard release
  - Start 500mg daily with/after food and increase by 500mg every 2 weeks until on 1g bd
  - Aim for HbA1c of ≤ 48mmol/mol (6.5%)
  - If HbA1c ≥ 58mmol/mol (7.5%) go to step 3

**Step 3**
3 months
- Gliclazide
  - 40mg-80mg once to twice daily with meals
  - Titrate on pre-meal blood glucose target 4-6mmol/l or HbA1c
  - Consider alternative if BMI>35, frail elderly or concern re hypoglycaemia e.g. Group 2 driver
  - If HbA1c ≥ 58mmol/mol (7.5%) go to step 4

**Step 4**
3 months
- Please refer to South East London Blood Glucose Control Management Pathway for Adults with Type 2 Diabetes Mellitus

**Primary Prevention**
Atorvastatin 20mg

**Secondary Prevention**
Atorvastatin 80mg

Or maximum tolerated dose if not able to tolerate advised dosage

- Baseline lipid profile, TFT, LFT (ALT or AST). Do not start if hypothyroid or AST/ALT > 3 x upper limit of normal
- LFT (ALT or AST) at 3 and 12 months – not again unless indicated
- History of unexplained muscle pain with or without statins: check CK, do not use statin if CK persistently > 5x upper limit of normal
- Check lipid profile annually to check efficacy and adherence

Also refer to South London Guidance on Lipid Management and Prescribing Statins

**Need Help?**
Community Hypertension and Lipid Clinic: DXS referral or email for advice
gst-tr.KHPCommunityCVD@nhs.net

**Cholesterol Management in T2DM**

Primary Prevention
If QRISK2 ≥ 10% after 3/12 lifestyle advice
Atorvastatin 20mg

Secondary Prevention
Atorvastatin 80mg

Or maximum tolerated dose if not able to tolerate advised dosage

- QOF and PMS target = cholesterol ≤ 5 mmol/mol
- Lower than 100% target is recognition that not all those with T2DM meet criteria for statin treatment

**Need Help?**
Community Diabetes Clinic Single Point Referral or arrange a Virtual Clinic
GST-TR.southwark-diabetes@nhs.net

**Identify and address all modifiable risk factors**

**Individualise targets and goals e.g. frail, elderly, end of life care**

**Check understanding and adherence and set a review date**

**Check understanding and adherence and set a review date**
# T2DM: Preferred Medication

<table>
<thead>
<tr>
<th>Drug</th>
<th>Starting dose</th>
<th>Daily Range</th>
<th>Notes (these are not extensive, please refer to the latest BNF for further information especially titration increments/cautions/contraindications)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Biguanide</strong></td>
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<td></td>
</tr>
<tr>
<td>Metformin</td>
<td>500mg OD</td>
<td>Metformin standard release</td>
<td>• Ensure corrected eGFR &gt;45ml/min, or review dose. Contraindicated if corrected eGFR &lt;30ml/min, check renal function at least annually.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Start 500mg daily with/after</td>
<td>• Consider slow release preparation up to TDS if standard preparation not tolerated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>food and increase by 500mg</td>
<td>• Take with meals to reduce gastrointestinal side effects.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>every 2 weeks until on 1g BD</td>
<td>• Has a ‘legacy’ effect of reduced complications from T2DM.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or maximum tolerated dose</td>
<td>• Remember sick day rules ☛ p.10.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Ensure corrected eGFR &gt;45ml/min, or review dose. Contraindicated if corrected eGFR &lt;30ml/min, check renal function at least annually.</td>
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<td></td>
<td></td>
<td>• Remember sick day rules ☛ p.10.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Manufacturer advises patients and carers should be informed to seek urgent medical advice if symptoms of lactic acidosis e.g. dyspnoea, cramps, abdominal pain.</td>
</tr>
<tr>
<td><strong>Sulfonylureas</strong></td>
<td></td>
<td>160mg-320mg daily divided</td>
<td>• Inform patients of risk of adverse events/hypoglycaemia, particularly if renal impairment.</td>
</tr>
<tr>
<td>Gliclazide</td>
<td>40mg – 80mg daily</td>
<td></td>
<td>• Use with care in those with mild to moderate renal impairment (eGFR 30-60ml/min), only prescribe under specialist advice in severe impairment (eGFR &lt;30ml/min).</td>
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<td></td>
<td></td>
<td>pre-meal blood glucose –</td>
<td>• Self monitor according to DVLA guidance and consider alternative if Group 2 driver (large lorries and buses).</td>
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<tr>
<td></td>
<td></td>
<td>target 4-6mmol/l or against</td>
<td>• Consider alternative if BMI &gt;35.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 monthly HbA1c.</td>
<td>• Care with frail elderly, housebound and certain occupations e.g. working heavy machinery.</td>
</tr>
<tr>
<td><strong>Lipase inhibitor</strong></td>
<td></td>
<td>120mg up to three times a day</td>
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<tr>
<td>Orlistat</td>
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<td></td>
<td>• Take before, during or up to one hour after each meal.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Aim for a target weight loss of at least 5% of body weight after 12 weeks. Note; weight loss may be slower in T2DM and so less strict targets may be considered on a case by case basis.</td>
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<tr>
<td></td>
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<td></td>
<td>• Omit the dose if a meal is missed or does not contain fat.</td>
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<td></td>
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<td></td>
<td>• May impair absorption of fat soluble vitamins e.g. Vitamin D, and drugs if taken concurrently.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• SPC: discontinue after 12 weeks if patients have been unable to lose at least 5% of the body weight as measured at the start of therapy.</td>
</tr>
<tr>
<td><strong>ACEI</strong></td>
<td></td>
<td>1.25-10mg OD</td>
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<tr>
<td>1st line</td>
<td></td>
<td></td>
<td>• Check base line renal profile (Na/K/Cr/eGFR). Hyperkalaemia may occur, therefore close monitoring of potassium is required.</td>
</tr>
<tr>
<td>Ramipril</td>
<td>2.5mg OD</td>
<td></td>
<td>• Recheck renal profile within 2/52 of initiation or dose increase and then at least annually.</td>
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<tr>
<td></td>
<td>(1.25mg OD in frail/elderly patients)</td>
<td></td>
<td>• Titrate ACEI/ARB up at 4 weekly intervals to achieve optimal BP.</td>
</tr>
<tr>
<td>2nd line</td>
<td>10mg OD</td>
<td>10-80mg OD (maintenance dose 20mg for hypertension)</td>
<td>• Initiation/dose titration: If Cr increases by &gt;20% (or eGFR falls by &gt;15%) stop ACEI and seek specialist advice. ACEI dose should only be increased if serum creatinine increases by &lt;20% (or eGFR falls by &lt;15%) after each dose titration and potassium &lt;5.5mmol</td>
</tr>
<tr>
<td>Lisinopril</td>
<td></td>
<td></td>
<td>• ACEI/ARB dose should be optimised before adding in a second agent.</td>
</tr>
<tr>
<td><strong>ARBs</strong></td>
<td></td>
<td>50-100mg OD</td>
<td>• Side effects: symptomatic hypotension can occur on first dosing – suggest take at night.</td>
</tr>
<tr>
<td>Losartan</td>
<td>50mg OD</td>
<td></td>
<td>• Dry cough with ACEI, consider switch to ARB.</td>
</tr>
<tr>
<td></td>
<td>(25mg OD if &gt;75 yrs old)</td>
<td></td>
<td>• Caution: Do not combine ACEI and ARB to treat hypertension.</td>
</tr>
<tr>
<td>Candesartan</td>
<td>8mg OD</td>
<td>8mg-32mg OD</td>
<td></td>
</tr>
<tr>
<td><strong>Drug</strong></td>
<td><strong>Starting dose</strong></td>
<td><strong>Daily Range</strong></td>
<td><strong>Notes</strong> (these are not extensive, please refer to the latest BNF for further information especially titration increments/cautions/contra-indications)</td>
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<tr>
<td><strong>CCBs</strong></td>
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</tr>
</tbody>
</table>
| Amlodpine| 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 amlodpine causes ankle oedema consider alternative CCB e.g. Lacidipine (not nifedipine)  
• CI: Unstable angina, aortic stenosis |
| **Thiazide diuretics** |                             |                |                                                                                                                                |
| Indapamide (IR) | 2.5mg OD        | 2.5mg OD       | • Check baseline renal profile, then after 2/52, then at least annually. If K < 3.5mmol/L or eGFR <25 ml/min stop indapamide and seek specialist advice.  
• Note: BNF states 25mg OD starting dose, whilst NICE suggests 12.5mg starting dose.  
• An alternative to indapamide, but tablets need to be halved/quartered for appropriate dosing. Morning dosing.  
• Step 4 – offer only if spironolactone not suitable. Step 4 dose is 50mg OD but only if potassium >4.5mmol/L. |
| Chlortalidone | 12.5mg OD       | 12.5-50mg OD   | • Check baseline renal profile, then after 2/52, then at least annually. If K < 3.5mmol/L or eGFR <25 ml/min stop chlortalidone and seek specialist advice.  
• Note: BNF states 25mg OD starting dose, whilst NICE suggests 12.5mg starting dose.  
• An alternative to indapamide, but tablets need to be halved/quartered for appropriate dosing. Morning dosing.  
• Step 4 – offer only if spironolactone not suitable. Step 4 dose is 50mg OD, but only if potassium >4.5mmol/L. |
| **Aldosterone receptor antagonist** |                             |                |                                                                                                                                |
| **(K-sparing diuretic)** |                             |                |                                                                                                                                |
| Spironolactone | 25mg OD         | 25-50mg OD     | • Spironolactone is the preferred diuretic at Step 4. Consider only if potassium ≤ 4.5mmol/L (caution in reduced eGFR<60ml/min as increased risk of hyperkalaemia)  
• High dose at step 4 = 50mg OD but only potassium is ≤ 4.5mmol/L. Monitor Na/K/Renal function within one month and repeat as required thereafter. |
| **α-B** |                 |                |                                                                                                                                |
| Doxazosin (IR) | 1mg OD          | 2-16mg OD      | • Consider at Step 4. Initial dose of 1mg usually increased after 1-2 weeks to 2mg OD  
• At doses above 8mg/day, consider split dosing from OD to BD to reduce BP variation  
• Caution with initial dose as may cause postural hypotension |
| **β-B** |                 |                |                                                                                                                                |
| Atenolol | 25mg OD         | 25-50mg OD     | • Particular caution in T2DM – symptoms of hypoglycaemia may be masked. Consider at Step 4  
• CI in pregnancy, breast feeding, avoid or address contraceptive needs women of childbearing age, co-existent anxiety/tachycardia/heart failure.  
• CI include asthma, 2nd/3rd degree AV block, severe PAD  
• Caution – beta blockers can cause bradycardia if combined with certain CCBs e.g. Verapamil/Diltiazem  
• Caution: increased risk of diabetes when beta-blocker is prescribed with a thiazide diuretic. |
| Bisoprolol | 5-10mg OD       | 5-20mg OD      |                                                                                                                                |
| **Statin** |                 |                |                                                                                                                                |
| Atorvastatin | 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, limit or avoid grapefruit juice  
• Advise patient to visit GP if they experience unexplained muscle pains  
• Refer to SELAPC Guidelines on Lipid Management**2** |
Educational Resources

Cambridge Diabetes Education Programme, comprehensive, competence based learning. Free for all Southwark clinicians www.cdep.org.uk
REGISTRATION KEY CODE: SOUCCGCDEP

RCGP Essential Knowledge Update: Type 2 Diabetes in Adults: Management Free to all clinicians, brief update of NICE guidance

Quality Improvement Resource

RCGP Quality Improvement Toolkit for Diabetes Care

Sick Day Rules

DAMN Drugs\textsuperscript{25} Consider stopping Diuretics, ACEI/ARB, Metformin, NSAID during acute inter-current illness to reduce risk of kidney injury.

Acknowledgements

CES would like to thank all our colleagues who participated and fed-back during the consultation process, and we would also like to thank King's Health Partners and the Health Innovation Network, who helped produce this guide.
### References

1. Type 2 Diabetes in adults: Management. NICE Guideline (NG28) Dec 2015, updated May 2017
2. Lipid Management for the Primary and Secondary Prevention of Cardiovascular Disease (CVD) in Adults. SEL Area Prescribing Committee October 2016
3. South East London Blood Glucose Control Management Pathway for Adults with Type 2 Diabetes Mellitus (updated and approved April 2018, review date August 2019)
10. Diabetes UK website
11. Viapath
13. National Diabetes Audit
20. Weight management programme, Guy’s and St Thomas’ NHS Foundation Trust:
24. DVLA Assessing fitness to drive: a guide for medical professionals.
25. NB Medical Education Hot Topics Course GP Update Course Handbook 2014

### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>2WW</td>
<td>Two week wait referral</td>
</tr>
<tr>
<td>α-B</td>
<td>Alpha blocker</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ABPM</td>
<td>Ambulatory blood pressure monitoring</td>
</tr>
<tr>
<td>ACEI</td>
<td>Angiotensin converting enzyme inhibitor</td>
</tr>
<tr>
<td>ACR</td>
<td>Albumin-creatinine ratio</td>
</tr>
<tr>
<td>ALT</td>
<td>Alanine aminotransferase</td>
</tr>
<tr>
<td>ARB</td>
<td>Angiotensin receptor blocker</td>
</tr>
<tr>
<td>AST</td>
<td>Aspartate aminotransferase</td>
</tr>
<tr>
<td>β-B</td>
<td>Beta blocker</td>
</tr>
<tr>
<td>BD</td>
<td>Twice daily (dosing)</td>
</tr>
<tr>
<td>BMI</td>
<td>Body mass index</td>
</tr>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>CES</td>
<td>Clinical Effectiveness Southwark</td>
</tr>
<tr>
<td>CCB</td>
<td>Calcium channel blocker</td>
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<tr>
<td>CK</td>
<td>Creatinine Kinase</td>
</tr>
<tr>
<td>CKD</td>
<td>Chronic Kidney Disease</td>
</tr>
<tr>
<td>Cr</td>
<td>Creatinine</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>DASH</td>
<td>Dietary approaches to stop hypertension</td>
</tr>
<tr>
<td>DESMOND</td>
<td>Diabetes Education and Self-Management for Ongoing and Diagnosed</td>
</tr>
<tr>
<td>DPP</td>
<td>Diabetes Prevention Programme</td>
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<tr>
<td>DVLA</td>
<td>Driver and Vehicle Licensing Agency</td>
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<tr>
<td>DXS</td>
<td>Point-of-care tool for EMIS Web</td>
</tr>
<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
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<tr>
<td>eGFR</td>
<td>Estimated glomerular filtration rate</td>
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<tr>
<td>ERS</td>
<td>Electronic Referral System</td>
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<tr>
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<td>Full blood count</td>
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<tr>
<td>FAST</td>
<td>Frailty Assessment Screening Tool</td>
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<td>Fundamentals of Care Medicine program</td>
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<tr>
<td>HHIS</td>
<td>Health and Health Insurance System</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality and outcomes framework</td>
</tr>
<tr>
<td>SELAPC</td>
<td>South East London Area Prescribing Committee</td>
</tr>
<tr>
<td>SPC</td>
<td>Summary of product characteristics</td>
</tr>
</tbody>
</table>

2. **10.** Diabetes UK website
3. **11.** Viapath
5. **13.** National Diabetes Audit
10. **18.** Diabetic patient foot pathway for Southwark and Lambeth August 2016
12. **20.** Weight management programme, Guy’s and St Thomas’ NHS Foundation Trust:
13. **21.** British National Formulary, last updated Feb 2018
15. **23.** Guidance on Prescribing Statins, SEL Area Prescribing Committee: October 2016
17. **25.** NB Medical Education Hot Topics Course GP Update Course Handbook 2014
Making the right thing to do the easy thing to do.