Standard Operating Procedure

Version:	1.3
Policy owner:	Clinical Effectiveness Domain Lead
Date approved:	25th October 2016
Approved by:	Integrated Governance Committee
Review date:	1st November 2017
Target audience	All staff

Version Control

Version Number	Issue Date	Revision from previous Issue
1.1	TBC	▪ Adding version control ▪ Updated education referral process
1.2	2nd March 2017	▪ Initial management section added
1.3	6th April 2017	▪ care home CQUIN updated

Table of contents:

1. Purpose of Document

- To describe the operation of the service to ensure the attached care pathways for patients with diabetes are followed and the service delivers the required outcomes for patients.
- Please note that all pathways where it states non-face to face will include email and web based viewing of blood glucose monitoring and Skype or similar consultations when available.

2. Philosophy

The primary care Diabetes Team at NEEDS will seek to provide local, prompt access to a consistent, high quality service based on sound evidence for all people with diabetes in North East Essex.

3. Scope

- NEEDS operates a 9am – 5pm service Monday to Friday (excluding public holidays). Outside these times Voicemail messages may be left on the number above and will be responded to within one working day, unless a message informs a period of planned absence.
- These SOPs relate to the patients attending the
    - Multidisciplinary clinic,
    - Nurse led clinics,
    - Diabetes Podiatry clinics,
    - MDT Foot clinic,
    - Young person's MDT,
    - Structured Education,
    - Dietetic services
    - Insulin Pump service
    - Pre-pregnancy diabetes and pregnancy with diabetes services

4. Location of the Service

Base: Colchester Primary Care Centre, Turner Road, Colchester C04 5JR

5. The team

The team is formed of highly skilled and experienced Diabetes Specialist Practitioners with extended training and qualifications in the Management of Diabetes.

- Consultant
- Diabetes Specialist Nurses
- Diabetes Specialist Dietitians
- Diabetes Specialist Midwife
- Dedicated clerical assistants

6. Service Identity

North East Essex Diabetes Service is the identity of the service which is managed by Suffolk GP Federation CIC.

7. Services Delivered through an Integrated Pathway Hub

The development of a high quality service requires a sustained and co-ordinated effort by policy makers, managers and clinicians in the NHS and its partner agencies. The Diabetes Team will seek to develop the following:

- A highly trained and skilled workforce
- Structured care pathways that will work across boundaries, responsive and sensitive to differing needs
- Knowledge-based decision making that takes account of international, national and local research
- A well informed public

By striving to achieve these principles, the service is likely to achieve improvements in the health and wellbeing of people with diabetes and to reduce complications resulting from the condition.

8. Responsibilities

- As outlined in individual care pathways

9. Related Documents

- Referral and Booking process as outlined on care pathways
- Specialist practitioner competency framework.
- System One Management
- Care pathways and Referral processes
- Related clinical policies such as infection control, NICE guidance, Prescribing Policy, Clinical Governance (CCG or Suffolk Fed)
- Mandatory training requirements

10. Definitions

- MDT - Multidisciplinary
- YP – young persons
- RBS – Referral Booking Service
- IPH -

11. Referral Process –

Please see separate schedule for referrals.

- Timeframes for referral are as individual care pathways.
- Outcome measures – the service is to deliver improved patient outcomes based on the:
- 8 care processes
- 9 KPIs

8 care processes are:

- BMI

- Blood pressure
- Smoking Status
- HbA1c
- Urinary Albumin
- Serum Creatinine
- Cholesterol
- Foot examination

12. Prescribing

The Diabetes Practitioners will inform, in writing, the patient's GP of any decision made in relation to ongoing treatment, advice and support given; however, the primary responsibility of care remains with the patient's GP. The CCG prescribing policy is currently being updated and will be available from the NEEDS website.

13. Audits

Will be undertaken on a regular and ongoing basis as agreed by the group. This will also help to inform the revalidation for nurse's process which will be required from the end of 2015. Topics will be agreed by the group on an annual basis.

Schedule 1:

14. Referral / Clinical Pathways

Outside Pathway

Procedure for referral outside IPH

- RBS not to register on SystmOne
- Record on internal spreadsheet
- Forward to relevant service as defined below

Referral for children under 16 years

- Refer to on call paediatric registrar : 01206 747474 Bleep 840

Referral to ophthalmology

- Telephone 01206 286633 or Fax 01206 286631

Referral to retinal screening

- Scan and email to Health Intelligence or re-direct to 01245 806100 advising voicemail

Referral to renal

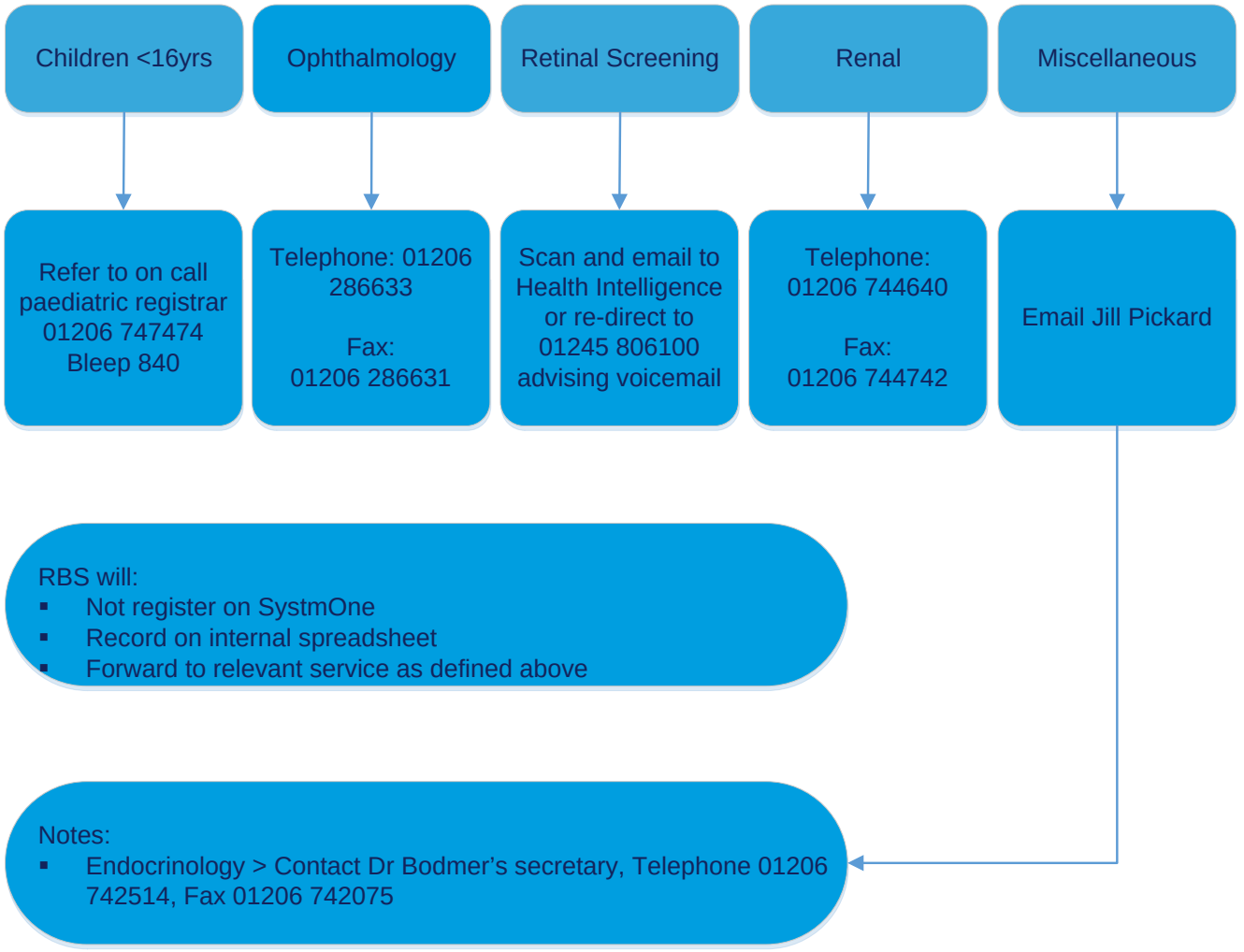
- Telephone 01206 744640 or Fax 01206 744742

Referral to other miscellaneous

- Email Jill Pickard (Senior Administrator)

OUTSIDE IPH – PATHWAY

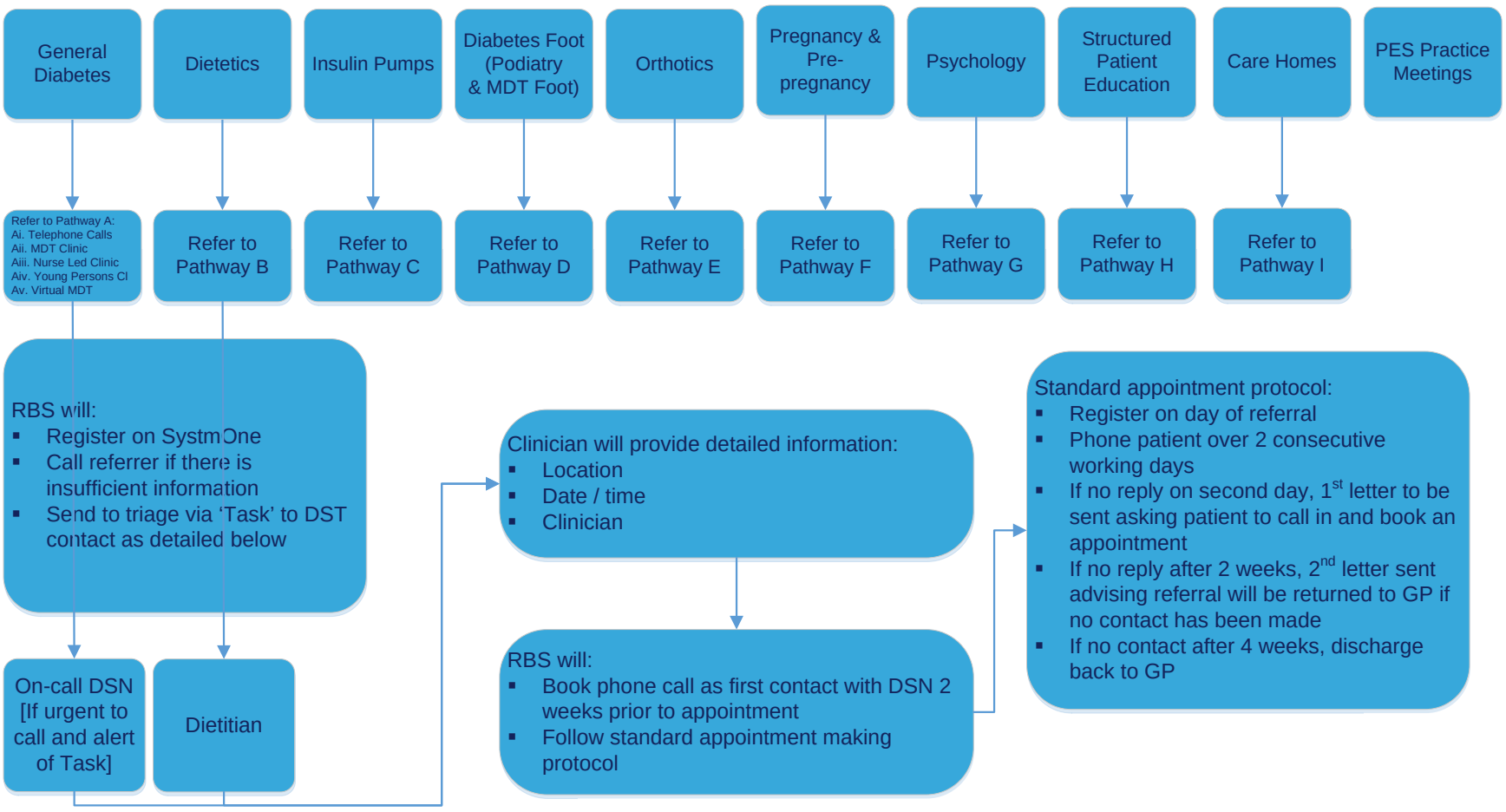
OUTSIDE IPH – PATHWAY



Procedure for referral inside IPH

Inside Pathway

INSIDE IPH PATHWAY (Referrals)



General Diabetes

Telephone calls

Telephone calls received from Patient

- If urgent
  - Register on SystmOne and set Task for on-call DSN to contact patient (call on-call DSN to alert of Task)
- If routine
  - Register on SystmOne and add to routine telephone clinic and advise patient the date

Telephone calls received from Health Care professional

- If urgent
  - Take details to register patient on SystmOne and provide on-call DSN number
- If routine
  - Register on SystmOne and add to routine telephone clinic and advise HCP the date

Note: Urgent response within two working hours.
Routine response within one working day

Standard Appointment protocol

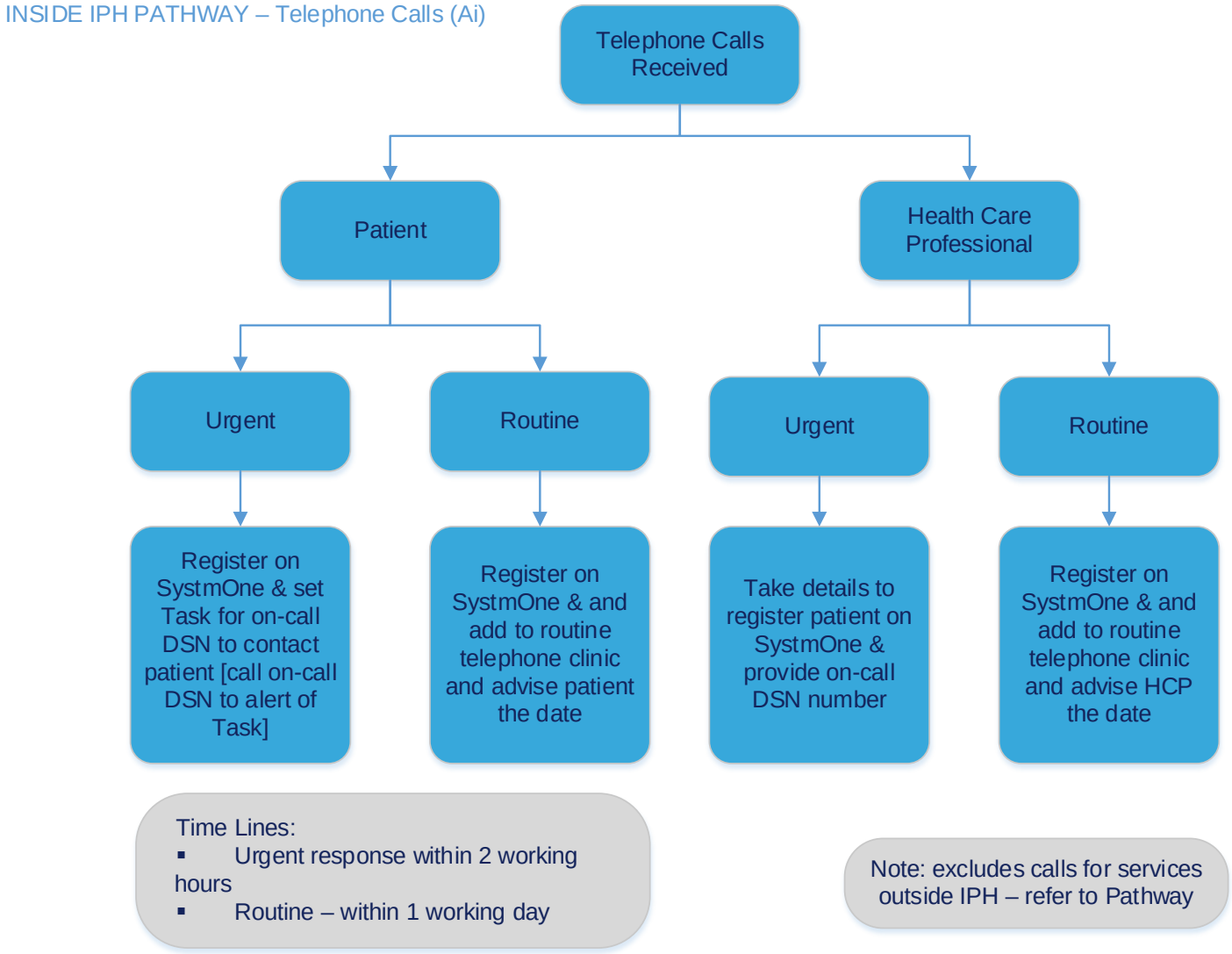
- Register on day of referral
- Phone patient over two consecutive working days
- If no reply on second day, 1st letter to be sent asking patient to call in and book an appointment
- If no reply after two weeks, 2nd letter sent advising referral will be returned to GP if no contact has been made
- If no contact after four weeks, discharge back to GP.

For Dietetics or General Diabetes: (for referrals to foot, pregnancy, orthotics or patient education see separate pathways)

- RBS to register on SystmOne
- Call referrer if there is insufficient information
- Send to triage via "Task" to DST contact
  - Dietitian – DST will provide detailed information on Location, Date/Time and Clinician
  - On call DSN (if urgent to call and alert of Task – DST will provide detailed information on Location, Date/Time and Clinician
- RBS to book phone call as first contact with DSN two weeks prior to appointment
- Follow standard appointment making protocol

Telephone Calls

INSIDE IPH PATHWAY – Telephone Calls (Ai)



Initial Management of new onset Type 1 DM

Phone call from GP/PN

1. Clear presentation of Type1 DM, clinically **unwell**, abdominal pain, ketones +++, weight loss polyurea elevated BG readings: GP to refer to EAU/A&E, inform Inpatient DSN of referral.

2. Clear presentation of Type1 DM, clinically **well** no abdominal pain, ketones ++, weight loss polyurea elevated BG readings: Patient must be reviewed the **same day** in clinic, if contact is made after 4.30pm arrange for the patient to be seen in EAU the same day.

3. Possible Type1 or mixed presentation, clinically well but lethargic no abdo pain, ketones neg - +, weight loss polyurea elevated BG readings: review in clinic within 24hrs. Where possible speak directly to the patient to make your own clinical judgement giving advice on sick day rules and to attend A&E if they become unwell. Check that patient is not drinking Lucozade or other high glucose drinks for energy. Provide your mobile number for reassurance.
   If it is a Friday pm referral, arrange for the patient to be seen in EAU by Inpatient DSN Saturday morning. Inform the DSN on duty over the weekend.
   Phone the EAU staff on 01206 742400 to inform of the patients attendance.

If any doubts, contact one of the Consultants for advice. Document all correspondence and advice

Obtaining the prescription

It is our responsibility to prescribe the first prescription and not the practice, a prescriber must be available to review the patient and prescribe as per NMC code of practice.

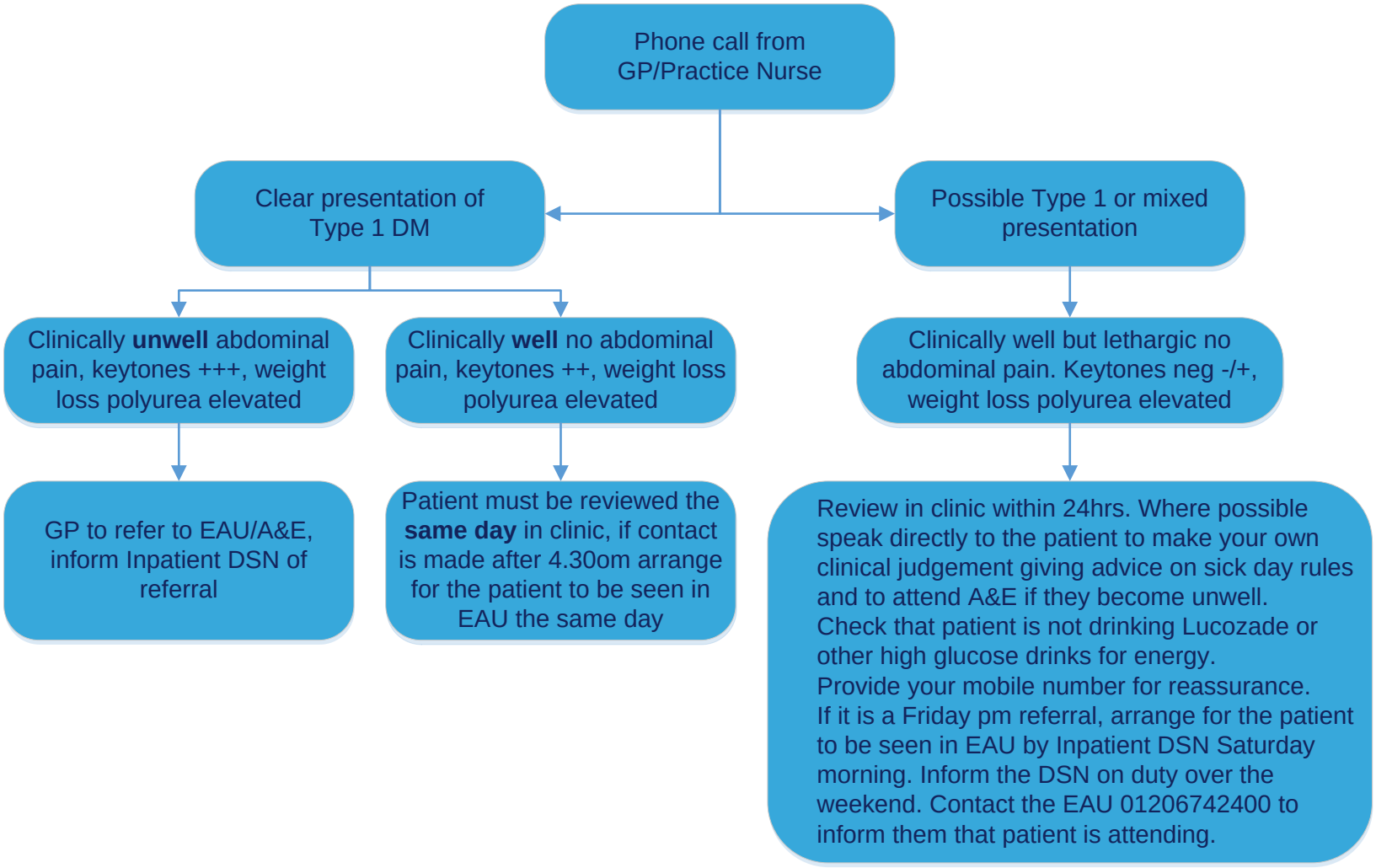
The 1st line choice for Type 1 DM is Levemir BD & Apidra with meals (dose dependent on BG and Ketone levels), however to ensure the insulin is available at the patients local chemist, phone the chemist ahead of writing the prescription. The choice of insulin will be dependent on the available insulin.

Ketone testing: this is essential, urine ketone reagent strips or B ketone test strips must be supplied or prescribed and available to collect from the chemist, check which is in stock before prescribing.

Always add your mobile phone number on the prescription, this will enable the pharmacist to make contact with your if there are any queries.

Type 1 Newly Diagnosed patients are to be managed within the service and should not be managed by the practice until stable.

Initial management of new onset Type 1 DM



Multidisciplinary (MDT) clinic

Referrals: Referrals are received from:

- GP/Practice Nurse or
- Via risk stratification in the practice
- Nurse led clinic

Process: Once referral received triage is undertaken and if the patient meets criteria they are accepted and admin are tasked to provide the patient with information on timeframe and date for appointment, clinical location and specialist they will see (booking process). If the patient does not meet the criteria, the DSN will phone the referrer to offer engagement and support at practice level.

Once seen in clinic the first appointment will include assessment and completion of the care plan. They will then either:

- Arrange follow up in MDT clinic if required
- Discharge back to GP with recommendations, advice
- Book into nurse led clinics AND/OR dietitian AND/OR structured education.

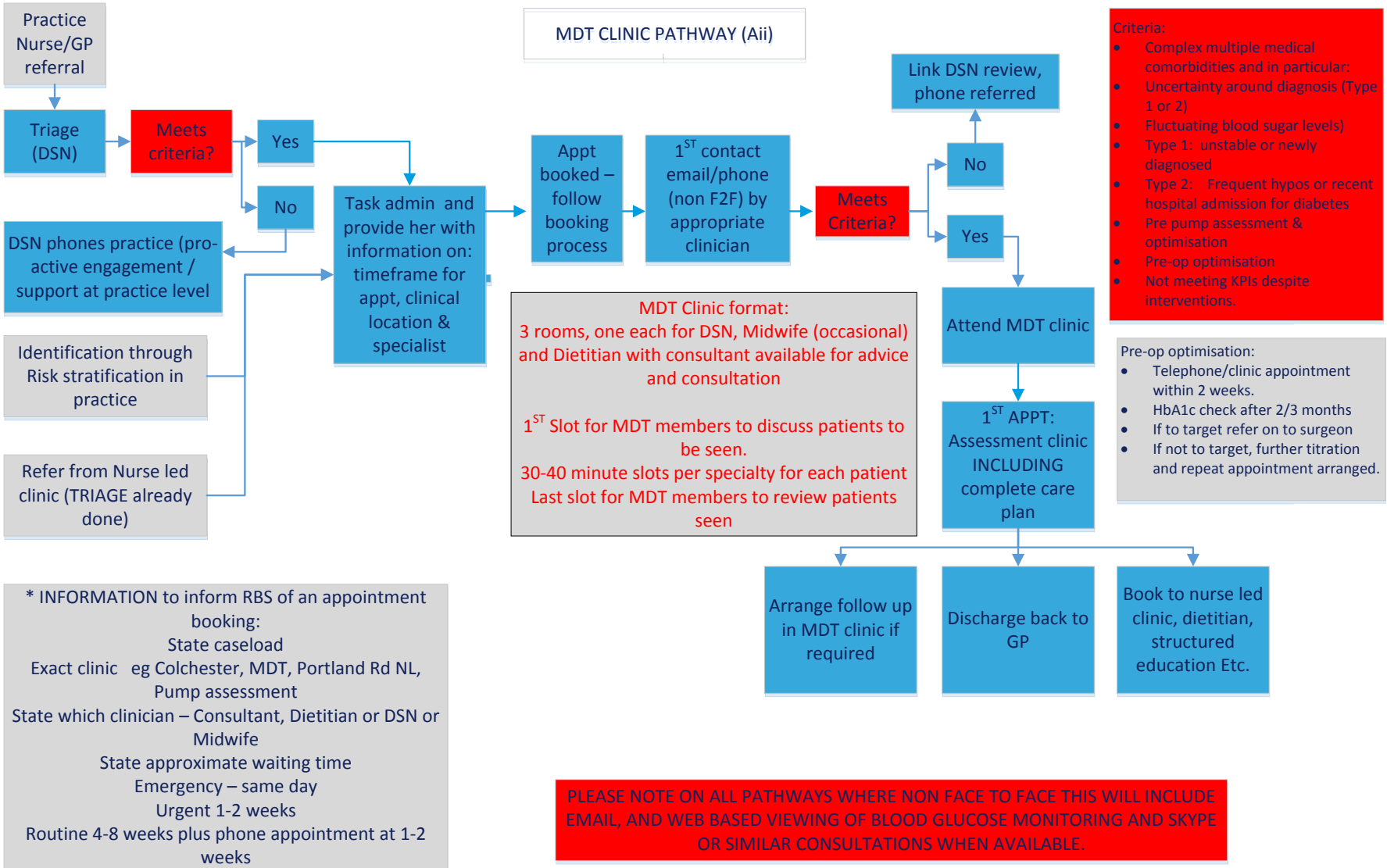
Clinic format: There are 3 rooms, one each for DSN, Midwife (occasional) and Dietitian with consultant available for advice and consultation. There will be 40 minute slots per specialty for each patient.

Criteria:

- Complex multiple medical comorbidities and in particular:
  - Uncertainty around diagnosis (Type 1 or 2)
  - Fluctuating blood sugar levels
  - Type 1: unstable or newly diagnosed
  - Type 2: frequent hypos or recent hospital admission for diabetes
  - Pre-pump assessment & optimisation
  - Pre-op optimisation
  - Not meeting KPI's despite interventions
- Pre-op optimisation
  - Telephone/clinic appointment within two weeks
  - HbA1c check after 2/3 months
  - If to target refer on to surgeon
  - If not to target, further titration and repeat appointment arranged.

Data entry: Patient consultation to be entered into SystmOne and letter generated to GP within 48 hours

If medication changed letter to be emailed.


MDT CLINIC PATHWAY (Aii)
Practice Nurse/GP referral
Triage (DSN)
Meets criteria?
Yes
No
DSN phones practice (pro-active engagement / support at practice level
Identification through Risk stratification in practice
Refer from Nurse led clinic (TRIAGE already done)
Task admin and provide her with information on: timeframe for appt, clinical location & specialist
Appt booked – follow booking process
1ST contact email/phone (non F2F) by appropriate clinician
Meets Criteria?
Link DSN review, phone referred
No
Yes
Criteria:
Complex multiple medical comorbidities and in particular:
Uncertainty around diagnosis (Type 1 or 2)
Fluctuating blood sugar levels)
Type 1: unstable or newly diagnosed
Type 2: Frequent hypos or recent hospital admission for diabetes
Pre pump assessment & optimisation
Pre-op optimisation
Not meeting KPIs despite interventions.
MDT Clinic format:
3 rooms, one each for DSN, Midwife (occasional) and Dietitian with consultant available for advice and consultation
1ST Slot for MDT members to discuss patients to be seen.
30-40 minute slots per specialty for each patient
Last slot for MDT members to review patients seen
Attend MDT clinic
Pre-op optimisation:
Telephone/clinic appointment within 2 weeks.
HbA1c check after 2/3 months
If to target refer on to surgeon
If not to target, further titration and repeat appointment arranged.
1ST APPT: Assessment clinic INCLUDING complete care plan
Arrange follow up in MDT clinic if required
Discharge back to GP
Book to nurse led clinic, dietitian, structured education Etc.
* INFORMATION to inform RBS of an appointment booking:
State caseload
Exact clinic eg Colchester, MDT, Portland Rd NL, Pump assessment
State which clinician – Consultant, Dietitian or DSN or Midwife
State approximate waiting time
Emergency – same day
Urgent 1-2 weeks
Routine 4-8 weeks plus phone appointment at 1-2 weeks
PLEASE NOTE ON ALL PATHWAYS WHERE NON FACE TO FACE THIS WILL INCLUDE EMAIL, AND WEB BASED VIEWING OF BLOOD GLUCOSE MONITORING AND SKYPE OR SIMILAR CONSULTATIONS WHEN AVAILABLE.

Nurse led clinics

Referrals: Referrals are received from:

- GP/Practice Nurse or
- Via risk stratification in the practice
- MDT teams
- Other specialists within the team

Process: Once referral received triage* is undertaken and if the patient meets criteria they are accepted and admin are tasked to provide the patient with information on timeframe and date for appointment, clinical location and specialist they will see (booking process). If the patient does not meet the criteria, the referrer is contacted with advice and the patient is either

- Referred on to appropriate clinic/specialist
- Sent back to GP/PN for primary care to manage

If the patient cannot be contacted by phone then a letter is sent asking patient to ring the office for an appointment. A first letter and then a second letter and if no response the patient is discharged back to the GP.

Once the first appointment has taken place an appropriate follow up appointment is made either F2F or telephone or the patient is discharged back to the practice with a management plan.

At first assessment the 8 care processes are checked, these will be completed, if not already complete, time permitting and any outstanding will be reviewed at 2nd review. Treatment and care plan created and agreed with the patient.

The patient can then be:

- Referred back to PN/GP and discharged
- Referred to structured education and discharged
- Initiate or titration medication (see treatment pathway)
- Referred to other specialty and discharged
- Follow up in nurse led clinics for a maximum from referral to discharge of 6 months (unless YP). Following 6 months with no or little improvement, the patient will be reviewed at MDT meeting. See new MDT pathway Schedule 12.

**Triage includes*

- *Patient phoned and appointment booked. This may be:*
    - *Telephone assistance and start treatment*
    - *Face to face offered in clinic*
    - *Telephone follow up booked.*

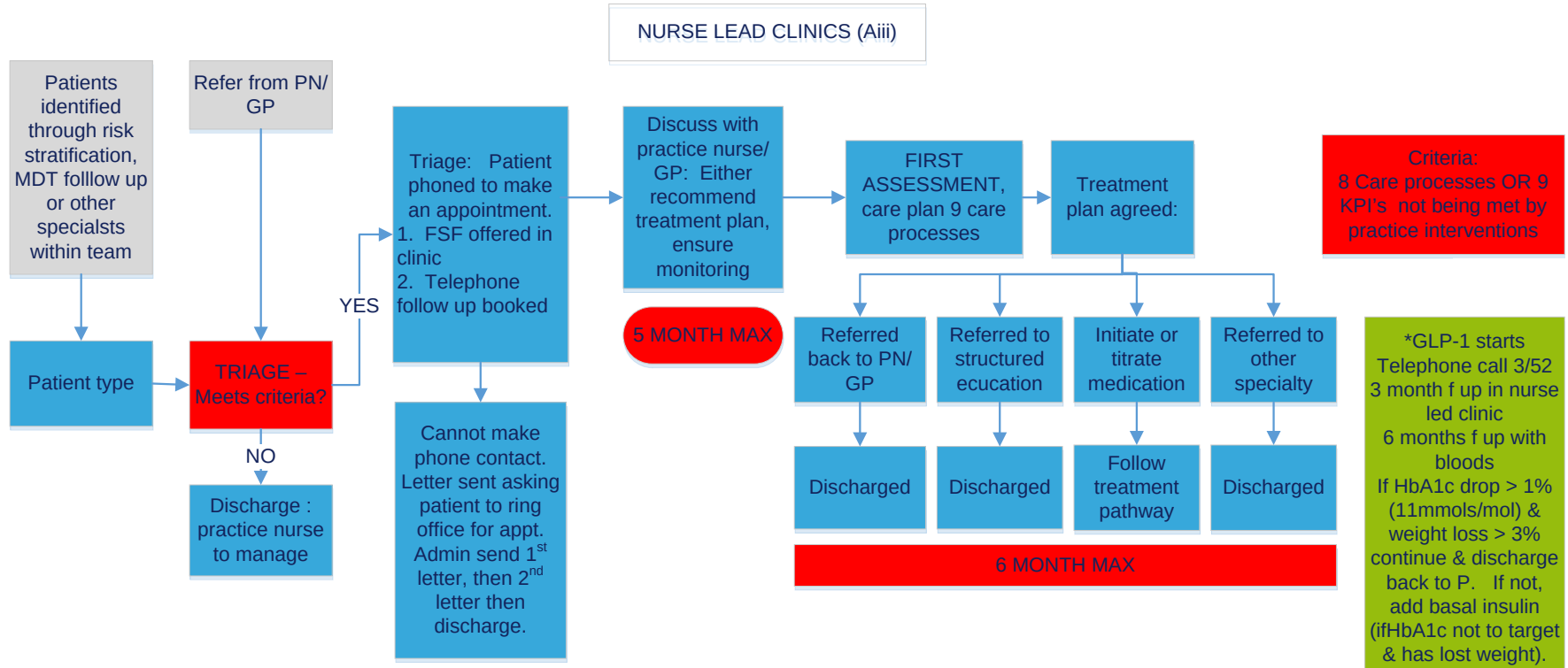
Treatment Pathway:

GLP-1 starts:

- Telephone call at 3 weeks
- 3 month follow up in nurse led clinic or discharge to appropriate GP practices for follow up
- 4 months follow up with bloods
- If HbA1c drop > 1% (11mmols/mol) & weight loss > 3% continue & discharge back to GP
- If HbA1c not to target, add basal insulin (if HbA1c not to target and has lost weight)
- If no weight loss & no reduction in HbA1c, stop GLP-1 & consider Insulin (NICE guidance)

Criteria:

- Patients not meeting KPIs and/or 8 care processes despite previous intervention.


NURSE LEAD CLINICS (Aiii)
Patients identified through risk stratification, MDT folllow up or other specialsts within team
Refer from PN/ GP
Patient type
TRIAGE – Meets criteria?
YES
NO
Discharge : practice nurse to manage
Triage: Patient phoned to make an appointment.
1. FSF offered in clinic
2. Telephone follow up booked
Cannot make phone contact. Letter sent asking patient to ring office for appt. Admin send 1st letter, then 2nd letter then discharge.
Discuss with practice nurse/ GP: Either recommend treatment plan, ensure monitoring
5 MONTH MAX
FIRST ASSESSMENT, care plan 9 care processes
Treatment plan agreed:
Referred back to PN/ GP
Referred to structured ecucation
Initiate or titrate medication
Referred to other specialty
Discharged
Discharged
Follow treatment pathway
Discharged
6 MONTH MAX
Criteria:
8 Care processes OR 9 KPI's not being met by practice interventions
*GLP-1 starts
Telephone call 3/52
3 month f up in nurse led clinic
6 months f up with bloods
If HbA1c drop > 1% (11mmols/mol) & weight loss > 3% continue & discharge back to P. If not, add basal insulin (ifHbA1c not to target & has lost weight).
If no weight loss & no reduction in HbA1c, stop GLP-1 & consider Insulin (NICE guidance)
* INFORMATION to inform RBS of an appointment booking:
State caseload
Exact clinic eg Colchester, MDT, Portland Rd NL, Pump assessment
State which clinician – Consultant, Dietician or DSN or Midwife
State approximate waiting time
Emergency – same day
Urgent 1-2 weekss
Routine 4-8 weeks plus phone appointment at 1-2 weeks
PLEASE NOTE ON ALL PATHWAYS WHERE NON FACE TO FACE THIS WILL INCLUDE EMAIL, AND WEB BASED VIEWING OF BLOOD GLUCOSE MONITORING AND SKYPE OR SIMILAR CONSULTATIONS WHEN AVAILABLE.

Young Persons MDT

Criteria: Aged 16 to 30 years of age. Type 1 and Type 2 Diabetes

- The aim is to review every 3 months if required to stay in the clinic (see below) and follow up by face to face or none face to face, as required. Alternate between dietitian, DSN and Consultant
- If the HbA1c is not achieved then practice supported to continue and maintain progress
- If under psychology DO NOT offer MDT until discharged
- All patients offered DAFNE at 1st appointment, if criteria met

Referrals: Referrals are received either from:

- Paediatric transition
- GP/Practice Nurse (newly diagnosed)
- Via risk stratification in the practice (existing patients or hard to reach)
- Out of area transfers

Process: Once referral received if they do not meet the criteria then they are referred back to the GP/PN with guidance OR referred to other appropriate clinics.

If they meet the criteria admin are tasked to book an appointment depending on their referral route as below.

Paediatric transition

- Book new appointment
- Offer DAFNE in 1st Face to face appointment

Out of area transfers

- Book new appointment
- See in YP MDT and treatment plan agreed

Newly diagnosed/urgent same day/post discharge

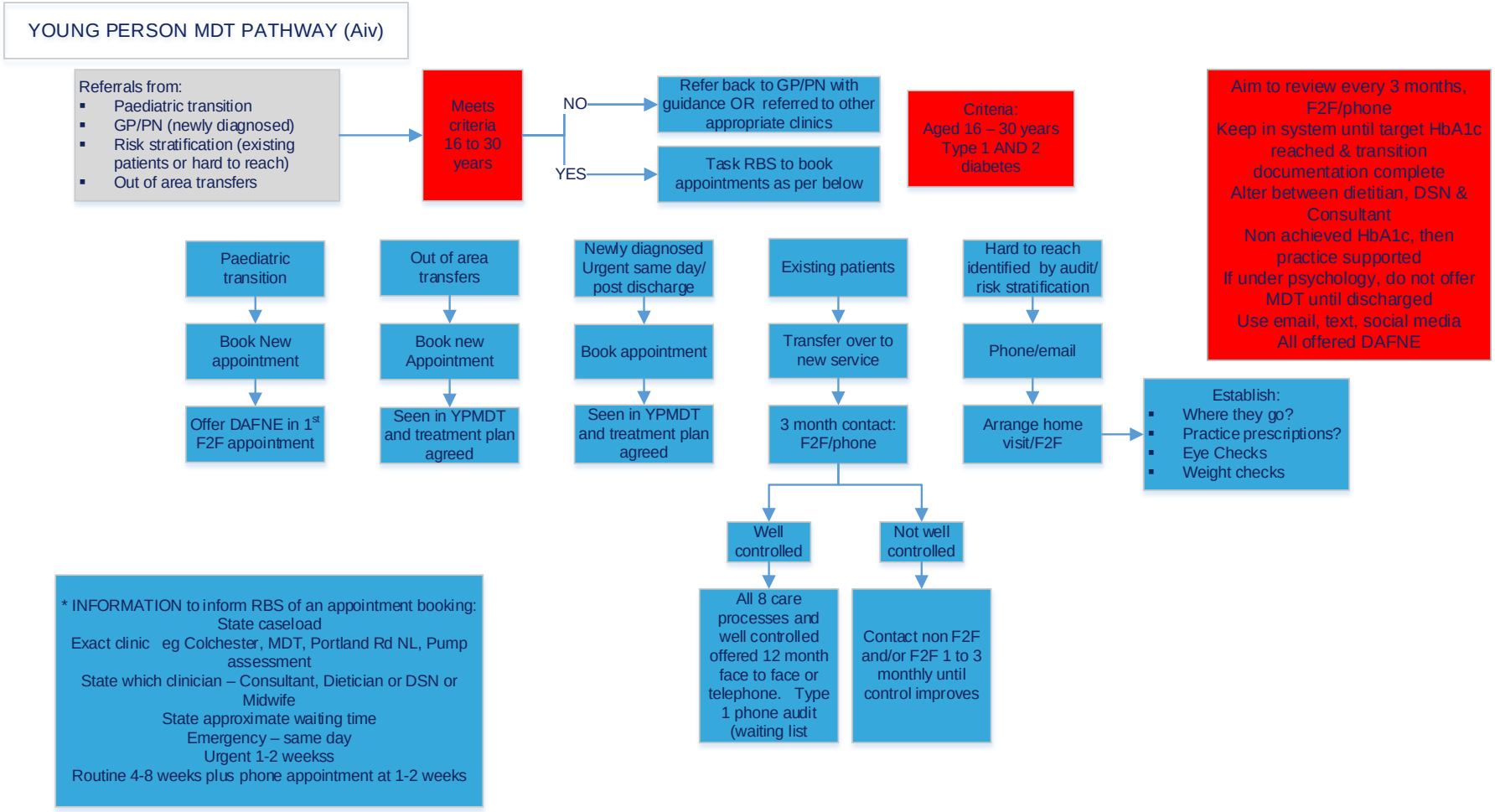
- Book appointment
- Seen in YP MDT and treatment plan agreed

Hard to reach identified by audit/risk stratification

- Phone, text or email contact initially
- Arrange home visit or face to face appointment
- Establish where they go for practice prescriptions, eye checks, and weight checks.

Data entry: Patient consultation to be entered into system 1 and letter generated to GP within 2 working days.

If medication changed letter to be emailed.



MDT Virtual Clinic

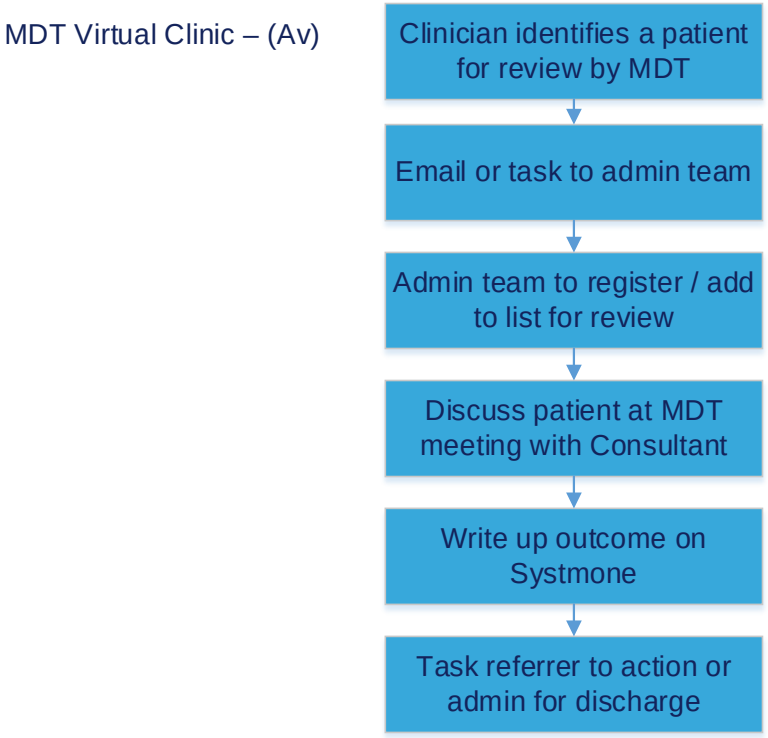
Referrals: received from

- Community DSN/Dietitian clinics
- Inpatient DSN
- Triage
- Consultants

Criteria: Any patient that the practitioner feels would benefit from the MDT approach.

Process: MDT virtual clinics will be held during the Monday MDT meeting.
When a patient is identified, practitioner to notify the admin team.
Admin team will then register patient and add to list for review.

Outcome: The member of staff accessing the clinic list will write up the care decisions and task the referring member of staff to action.
If the patient is to be discharged the admin team will be notified.



Dietetic Referral Pathway

Referrals: Referrals are received either from:

- GP/Practice Nurse or
- External referral (dietitian) not for MDT
- NEEDS team referral (MDT or nurse led)

Process:

If the patient is referred by the NEEDS team ether via MDT or nurse led clinic they book a suitable dietitian appointment and location and give the patient the appointment card during their MDT/NL clinic attendance**.**

If the patient is referred by the GP/PN or external referral

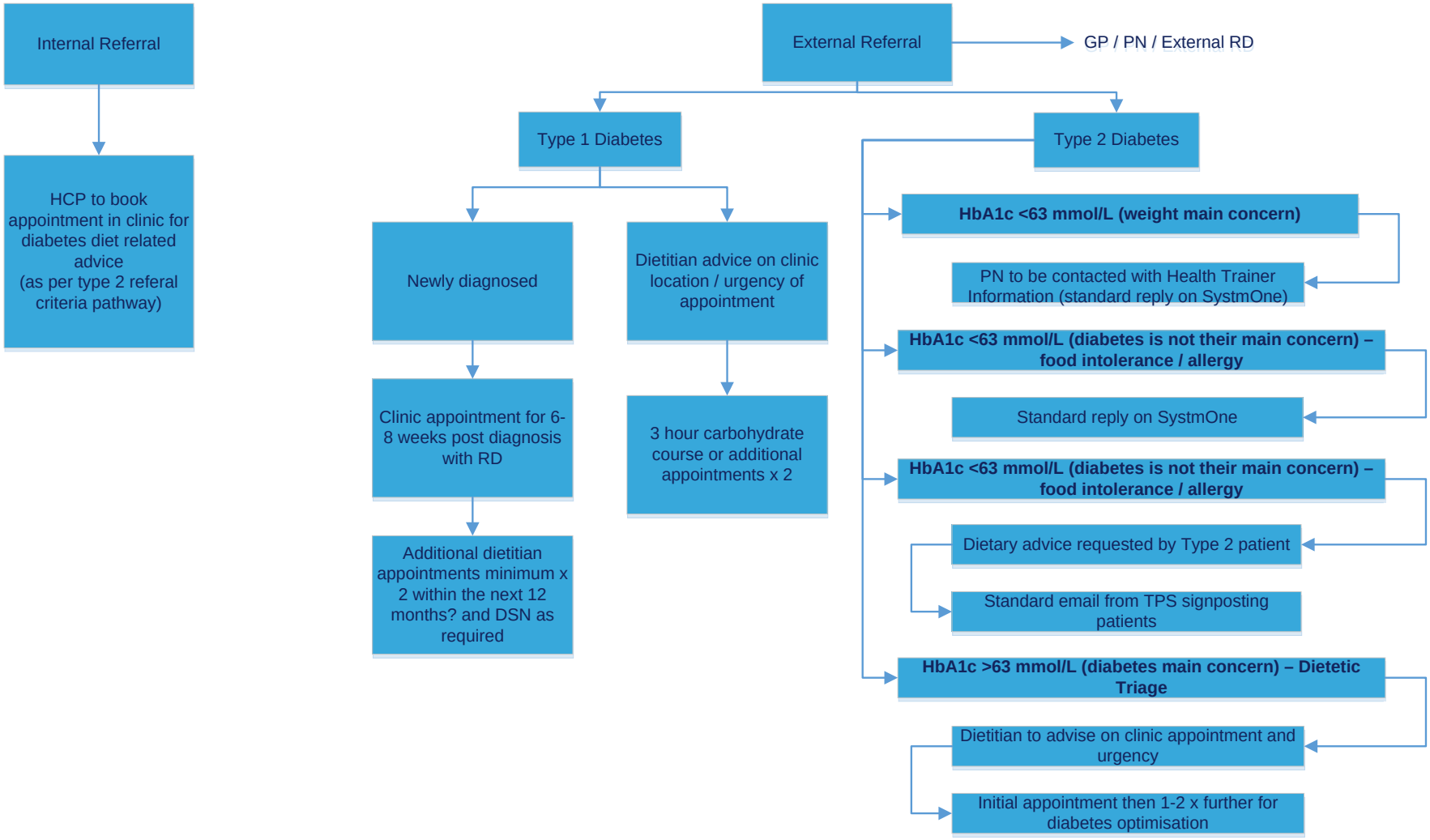
- Patient is registered on system 1 through RBS
- If they are ***type 1***
    - Task sent to dietitian to triage
    - Dietitian inform RBC of priority and which clinic to book
    - Patient booked on
    - Patient attends and ongoing follow up as per clinical pathway.
- If they are type 2
    - Have they previously attended structured education? If the answer is no
        - Check if ***they meet*** criteria
            - If yes then the dietitian inform RBC of priority and which education to book
            - Patient booked on
            - Patient attends and ongoing follow up as per clinical pathway
        - If they ***do not*** meet criteria then
            - If they want diabetic advice and are not willing or able to complete structured education or do not meet criteria for this they are offered advice over the phone initially +/-
            - Written information in the post
            - Triage by dietitian and type 2 given advice, type 1 clinic appointment for dietary advice given
            - Ongoing follow up by practice nurse
    - Have they previously attended structured education? If the answer is yes
        - Check if the patient priority is weight loss (not specifically linked to diabetes). If the answer is yes:

- Referred to health trainers, shape up, my weight matters, 1 to 1 health trainer – THEY ARE NOT FOR NEEDS APPT AT THIS TIME. Standard reply on SystmOne to Practice Nurse.
- If the answer to the patient priority weight loss is NO then
- First line dietary advice will be structured education. Patient if willing referred onto DESMOND, DIABLO, Patient Conference, Conversation maps. NOT FOR NEEDS APPT AT THIS TIME.
- If following structured education they require follow up then the DSN or Dietitian is tasked to triage to appointment or weight loss service.
- If patient requires advice on food intolerance / allergy, diabetes is within target, standard response on SystmOne, Practice Nurse to refer to CHUFT dietitians.

Criteria:

- Type 1 – Newly diagnosed, carb counting, diabetic dietary advice, lifestyle intervention, optimisation
- Type 2 – complex (on insulin, injectable therapies, specific diabetes advice), not meeting KPI despite primary care intervention, specific weight issues related to diabetes.

Dietetic Referral Pathway B



Insulin Pumps

Insulin Pump referral pathway

Referrals: Referrals are received either from:

- GP/Practice Nurse or
- NEEDS team
- Pregnant lady requiring urgent pump
- Patient already on pump and known to NEEDS pump team requiring urgent appointment or review

Criteria:

PATIENTS MUST FULFIL NICE CRITERIA FOR CSII (Nice Technology Appraisal 151)

Type 1

- On MDI (including user of long acting analogues
- Those receiving the treatment have the commitment & competence to use the therapy effectively (test min 4x day, CHO counting)
- Unable to achieve good control <8.5% (69) without disabling hypos

PATIENTS NOT SUITABLE for CS11

- Poor concordance with diabetes care.
- Poorly motivated
- Significant psychological problems
- Does not like to disclose their diabetes
- Inappropriate self-care*
- Frequent non-attender
- Unrealistic expectations of CS11 therapy

*Inappropriate self-care

- Omitting insulin injections
- Inappropriate treatment of hypo/hyperglycaemia
- Adjusts insulin's according to single BG result
- Poor injection technique

Process for referral from GP/practice Nurse

- Task a member of the pump team to triage into MDT clinic where NEEDS team check optimisation of current regime and appropriate for PUMP.
- If the patient is NOT suitable for Pump then follow up with MDT/NL/Dietitian is booked to work on carb counting and optimising current regime.

- Follow up as required and recheck if meet criteria in 4 to 6 months.
    - If no
        - Then further follow up with MDT/NL/Dietitian as required
        - Discharge back to practice
    - If yes
        - Book into consultant pump clinic for discussion with patient and final decision on pump
        - Decision for pump made.
            - If yes then follow pump clinical pathway
            - If no then further follow up MDT/NL/Dietitian or discharge back to practice
- If the patient IS appropriate for pump and Consultant in MDT clinic then decision made here. If not then a member of the Pump team phones and discusses with the patient ensures meet criteria
- Book into consultant pump clinic for discussion with patient and final decision on pump
- Decision for pump made
    - If yes then follow pump clinical pathway
    - If no then further follow up MDT/NL/dietitian or discharge back to practice

Process for referral from NEEDS team

- Member of the pump team phones and discusses with the patient ensures meet criteria
    - If no then book follow up with MDT/NL/Dietitian as above
- Book into consultant pump clinic for discussion with patient and final decision on pump
- Decision for pump made
    - If yes then follow pump clinical pathway
    - If no then further follow up MDT/NL/dietitian or discharge back to practice

Process for pregnancy lady requiring urgent referral

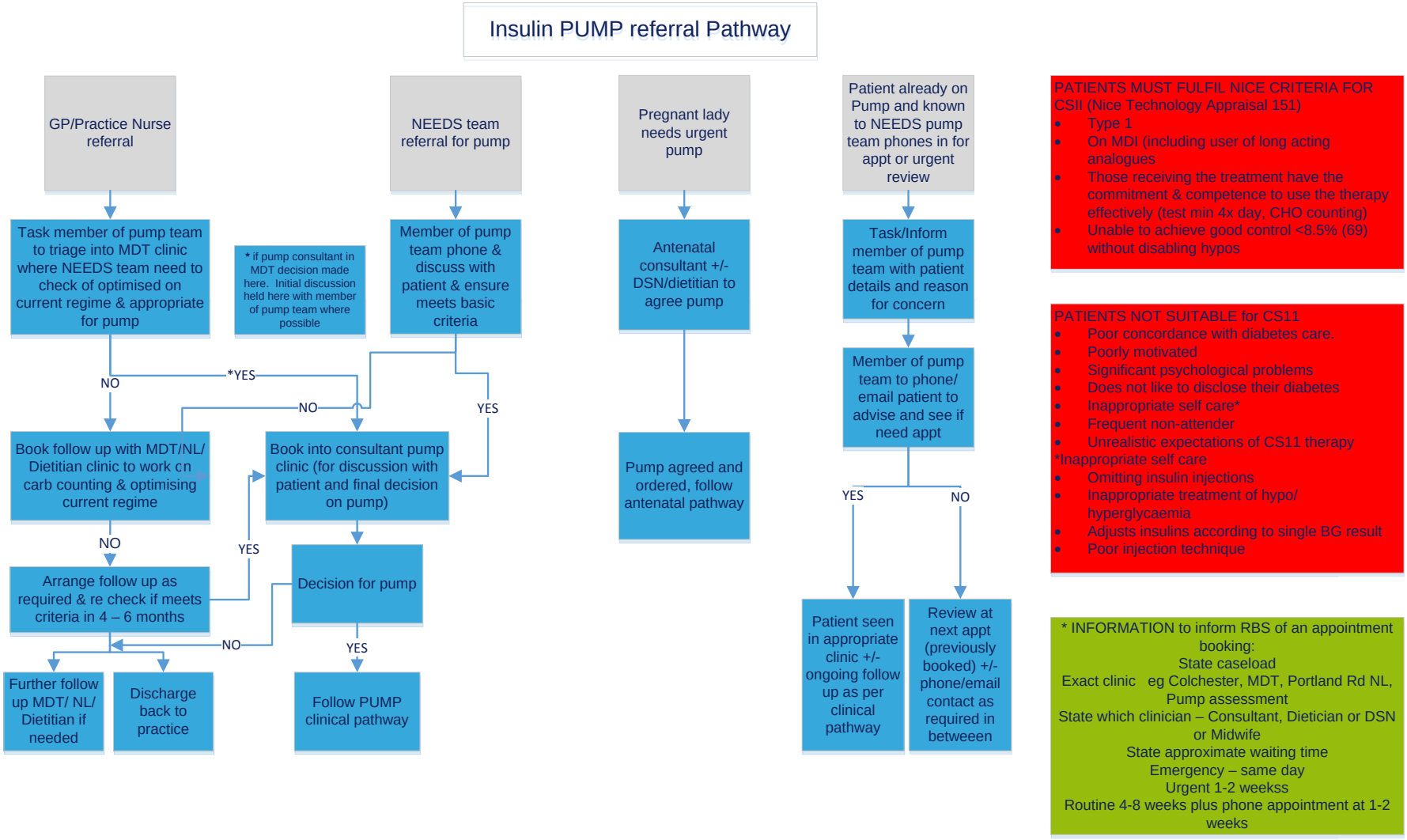
- Antenatal Consultant +/- DSM/Dietitian to agree pump decision
- Pump agreed and ordered
- Follow antenatal pathway.

Process for existing patient:

- Task/inform member of pump team with patient details and reason for concern
- Member of pump team to phone/email patient to advise and see if they need appointment
- If they need appointment then the patient is seen in appropriate clinic with ongoing follow up as per clinical pathway
- If they do not need an appointment revert to face to face and non face to face contact as required.

Data entry: Patient consultation to be entered into system 1 and letter generated to GP within 48 hours

If medication changed letter to be faxed.

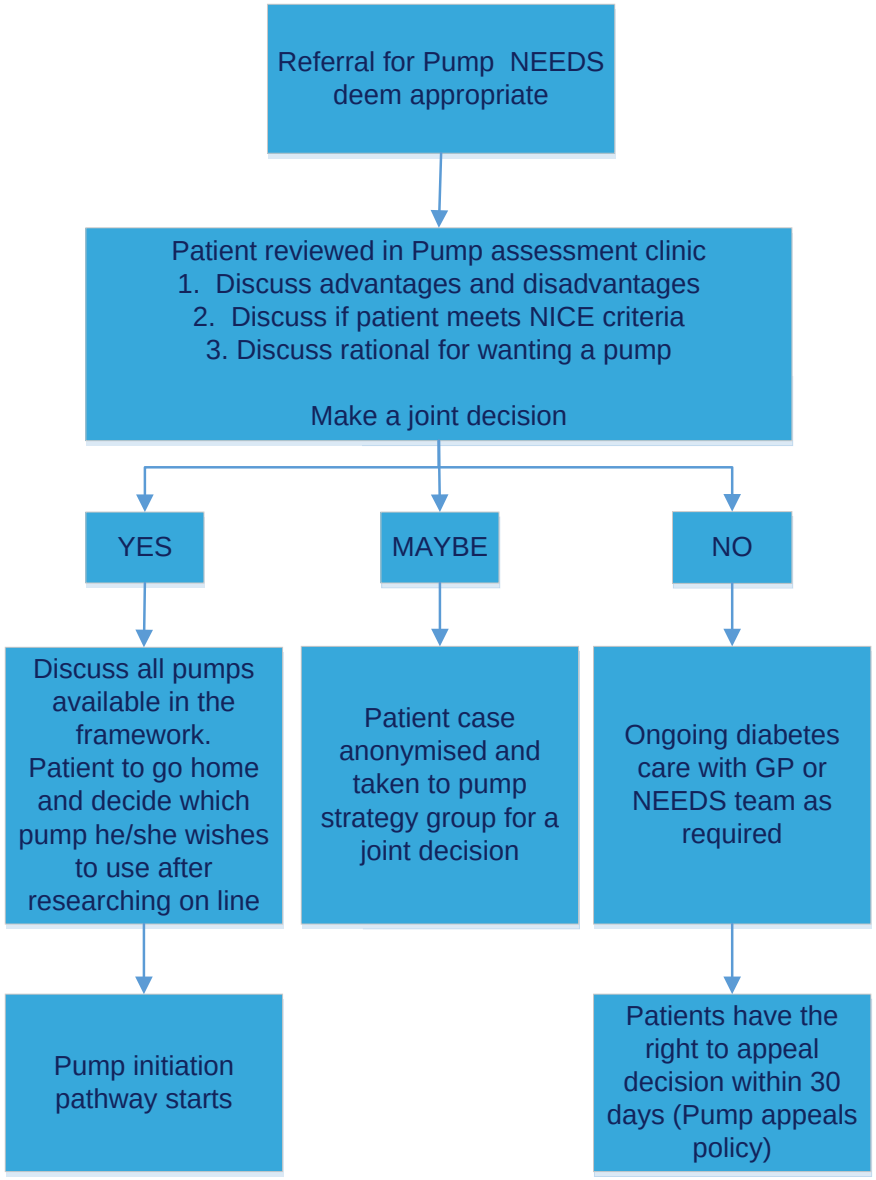


Pump Decision

Process:

- Patient reviewed in Pump assessment clinic
  - Discuss advantages and disadvantages
  - Discuss if patients meet NICE criteria
  - Discuss rationale for wanting a pump
- Joint decision made.
- <u>If the decision is No</u>
  - Ongoing diabetes care with GP or NEEDS team as required
  - Patients have the right to appeal decision within 30 days
- <u>If the decision is Maybe</u>
  - Patient case anonymised and taken to pump strategy group for a joint decision
- <u>If the decision is Yes</u>
  - Discuss all pumps available in the framework. Offer first line insulin pump(s), if accepts to start pump initiation pathway. If wants non first line pump team to complete exceptional circumstances form to be assessed by pump planning group and decision on type of pump made > start pump pathway. If patient declines pump choice may opt not to start pump
  - Patient to go home and decide which up he/she wishes to use after researching on line
  - Pump initiation pathway starts

PUMP DECISION PATHWAY



Pathway for Insulin Pump
(CSII referral)

Criteria: Once pump therapy agreed.

Process:

- Patient decided on pump
- Patient/Pump team to contact pump administrator
- Pump administrator sets up account with the chosen pump company and orders pump and 1 month supply of consumables
- Once pump arrives administrator contacts patient to book into the first Wednesday pump start clinic available.
- Add to database

Pump start 1 (2-3 hours) (can be up to 3 patients if all choose same pump. +/- rep)

Pump loaded with saline or air. Education & demonstration re:

- How to load battery
- How to set date & time
- How to prime pump
- What is a basal rate & how to set
- What is a bolus & how to give
- Review carbohydrate counting ratios
- How to insert a cannula
- Patient takes pump home & practices with pump
- Given PAID/Hypo
- Patient contract set and agreed
- Given list of what to do for review appointment

Pump start 2 (1-2 hours) - 1 or 2 weeks after 1st appointment depending on patient confidence.

- Download pump & review usage during practice week (can delay start if issues)
- Pump checklist completed
- Pump loaded with insulin
- Pt asked to check at least 4 times during day plus 3 am BG
- Hypoglycaemia treatment discussed with CSII therapy

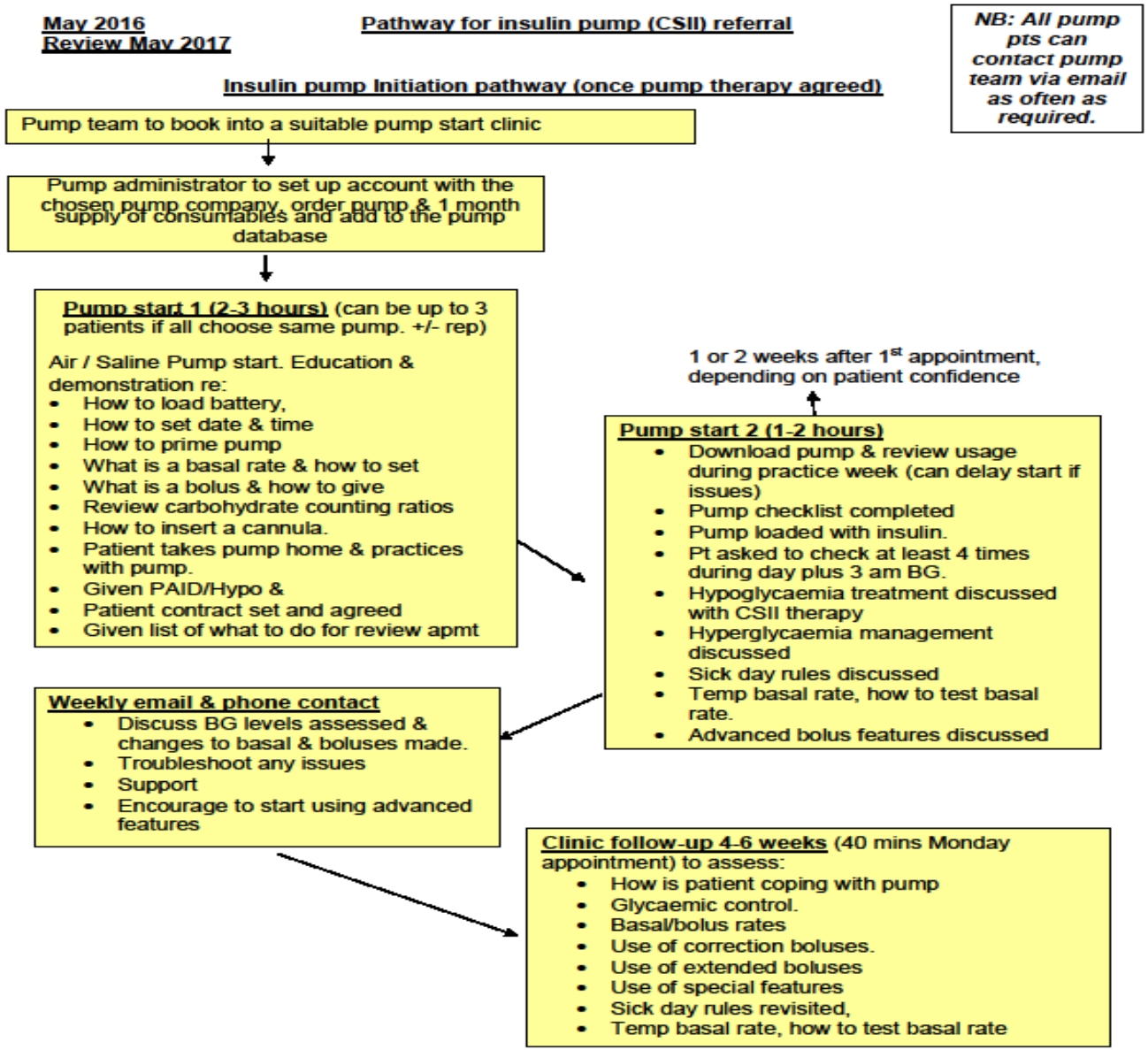
- Hyperglycaemia management discussed
- Sick day rules discussed
- Temp basal rate, how to test basal rate
- Advanced bolus features discussed

Weekly email & phone contact

- Discuss BG levels assessed & changes to basal & boluses made
- Troubleshoot any issues
- Support
- Encourage to start using advanced features

Clinic follow-up 4-6 weeks (40 mins Monday appointment) to assess:

- How is patient coping with pump
- Glycaemic control
- Basal/bolus rates
- Use of correction boluses
- Use of extended boluses
- Use of special features
- Sick day rules revisited
- Temp basal rate, how to test basal rate


May 2016
Review May 2017
Pathway for insulin pump (CSII) referral
NB: All pump pts can contact pump team via email as often as required.
Insulin pump Initiation pathway (once pump therapy agreed)
Pump team to book into a suitable pump start clinic
Pump administrator to set up account with the chosen pump company, order pump & 1 month supply of consumables and add to the pump database
Pump start 1 (2-3 hours) (can be up to 3 patients if all choose same pump. +/- rep)
Air / Saline Pump start. Education & demonstration re:
How to load battery,
How to set date & time
How to prime pump
What is a basal rate & how to set
What is a bolus & how to give
Review carbohydrate counting ratios
How to insert a cannula.
Patient takes pump home & practices with pump.
Given PAID/Hypo &
Patient contract set and agreed
Given list of what to do for review apmt
1 or 2 weeks after 1st appointment, depending on patient confidence
Pump start 2 (1-2 hours)
Download pump & review usage during practice week (can delay start if issues)
Pump checklist completed
Pump loaded with insulin.
Pt asked to check at least 4 times during day plus 3 am BG.
Hypoglycaemia treatment discussed with CSII therapy
Hyperglycaemia management discussed
Sick day rules discussed
Temp basal rate, how to test basal rate.
Advanced bolus features discussed
Weekly email & phone contact
Discuss BG levels assessed & changes to basal & boluses made.
Troubleshoot any issues
Support
Encourage to start using advanced features
Clinic follow-up 4-6 weeks (40 mins Monday appointment) to assess:
How is patient coping with pump
Glycaemic control.
Basal/bolus rates
Use of correction boluses.
Use of extended boluses
Use of special features
Sick day rules revisited,
Temp basal rate, how to test basal rate

Community Diabetes Podiatry

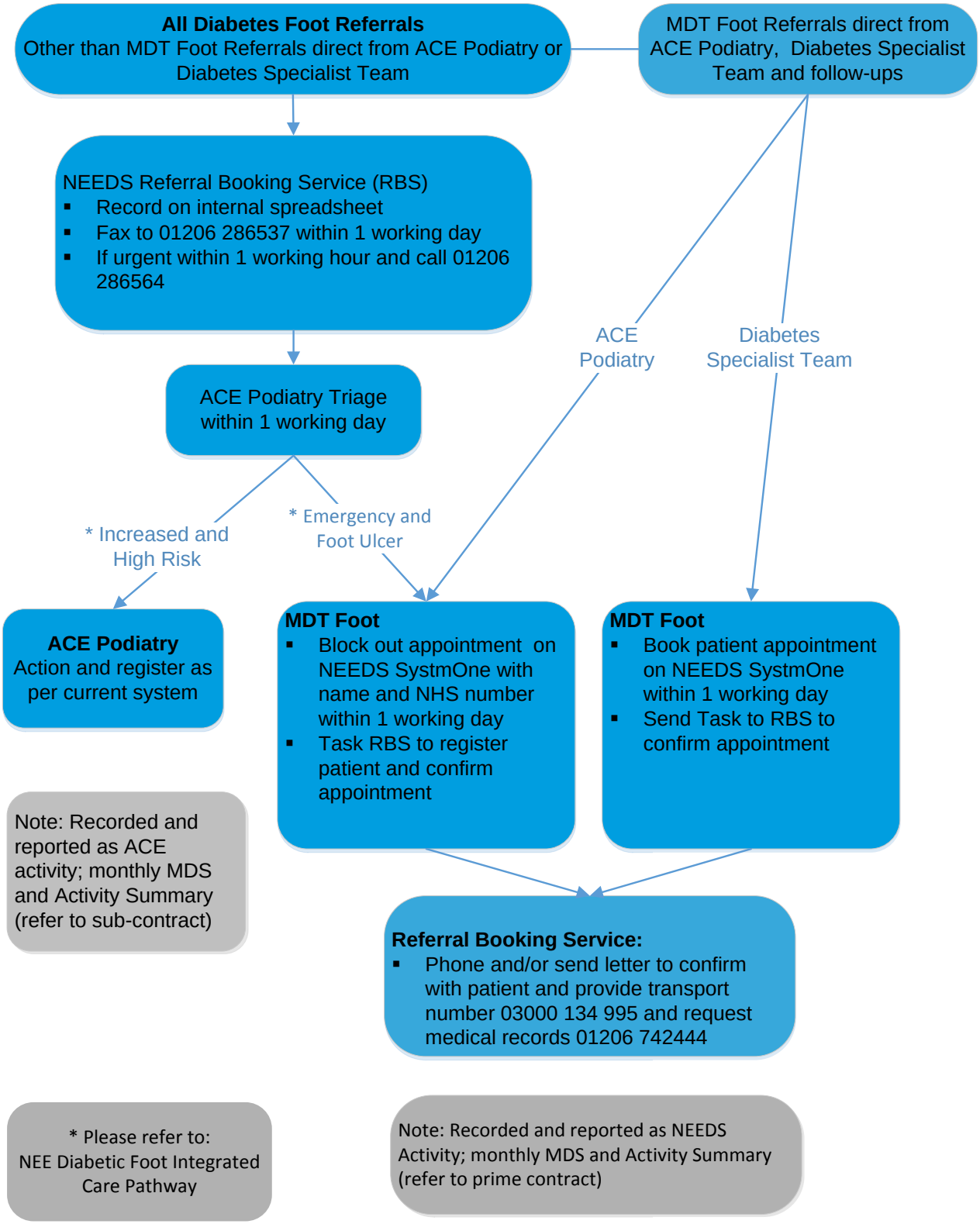
Diabetes Foot (Podiatry & MDT Foot)

For all diabetes foot referrals other than MDT foot referrals direct from ACE Podiatry or DSN team

- NEEDS RBS to record on internal spreadsheet
- RBS to email acecic.communitygateway@nhs.net within one working day or if urgent within one working hour and call the Gateway 0300 0032 144
- ACE Podiatry Triage within one working day.
    - If moderate and high risk ACE podiatry action and register as per current system (note: recorded and reported as ACE activity)
    - If emergency/foot ulcer to book MDT foot appointment
        - Block out appointment on NEEDS SystmOne with name and NHS number within one working day
        - Task RBS to register patient and confirm appointment
        - RBS phone and/or send letter to confirm with patient, to provide transport number 03000 134 995 and request medical records 01206 742444

For MDT foot referrals direct from ACE Podiatry, DSN team and follow ups (recorded and reported as NEEDS activity)

- For ACE podiatry referrals – MDT foot
    - Block out appointment on NEEDS SystmOne with name and NHS number within one working day
    - Task RBS to register patient and confirm appointment
    - RBS phone and/or send letter to confirm with patient, to provide transport number 03000 134 995 and request medical records 01206 742444
- For DSN team – MDT foot
    - Book patient appointment on NEEDS SystmOne within one working day
    - Send Task to RBS to confirm appointment
    - RBS phone and/or send letter to confirm with patient, to provide transport number 03000 134 995 and request medical records 01206 742444


All Diabetes Foot Referrals
Other than MDT Foot Referrals direct from ACE Podiatry or Diabetes Specialist Team
MDT Foot Referrals direct from ACE Podiatry, Diabetes Specialist Team and follow-ups
NEEDS Referral Booking Service (RBS)
Record on internal spreadsheet
Fax to 01206 286537 within 1 working day
If urgent within 1 working hour and call 01206 286564
ACE Podiatry Triage within 1 working day
ACE Podiatry
Diabetes Specialist Team
* Increased and High Risk
* Emergency and Foot Ulcer
ACE Podiatry
Action and register as per current system
MDT Foot
Block out appointment on NEEDS SystmOne with name and NHS number within 1 working day
Task RBS to register patient and confirm appointment
MDT Foot
Book patient appointment on NEEDS SystmOne within 1 working day
Send Task to RBS to confirm appointment
Note: Recorded and reported as ACE activity; monthly MDS and Activity Summary (refer to sub-contract)
Referral Booking Service:
Phone and/or send letter to confirm with patient and provide transport number 03000 134 995 and request medical records 01206 742444
* Please refer to:
NEE Diabetic Foot Integrated Care Pathway
Note: Recorded and reported as NEEDS Activity; monthly MDS and Activity Summary (refer to prime contract)

Diabetes Podiatry Pathway

Referrals: Referrals are received either from:

- GP/Practice Nurse or
- Via risk stratification in the practice

Process: Once referral received is triaged and meets the current criteria of Moderate or High Risk the patient is offered an initial appointment and a foot risk assessment to classify the foot risk is undertaken. This may then lead to:

Low risk

- No risk factors present except callus alone

Management – by primary care team

- Agree management plan to maintain foot health & give advice on self-care
- No requirement for ongoing podiatry.
- Refer back to primary care for annual review.

Moderate risk

- Deformity **or** neuropathy **or** non-critical limb ischaemia.

Management by primary care team and podiatry

- Agree management with the patient to maintain foot health
- Enhanced foot care/footwear education
- Further examination & referral as indicated (e.g. vascular)
- Biomechanical review and treatment as required (e.g. orthoses)
- Conservative management of nail and skin lesions
- Ongoing review as indicated –.

High Risk

Previous ulceration or amputation, on renal replacement therapy, neuropathy and non-critical limb ischaemia together **or** neuropathy in combination with callus and/or deformity **or** non-critical limb ischaemia in combination with callus and/or deformity

Management by primary care team and podiatry

- Agree management with the patient to maintain foot health
- Enhanced foot care education and ensuring patient aware of high risk status
- Enhanced footwear education
- Further examination and referral as indicated (e.g. vascular)
- Biomechanical review and treatment as required (e.g. orthoses/padding/offloading/specialist footwear)
- Intensive management of nail and skin lesions as indicated to prevent tissue breakdown
- Nail surgery as indicated
- Onward referral for further management options as indicated
- Ongoing review as indicated

Active diabetic foot problem: ulceration, spreading infection, critical ischaemia, gangrene, suspicion of an acute Charcot arthropathy, or an unexplained hot, red, swollen foot with or without pain.

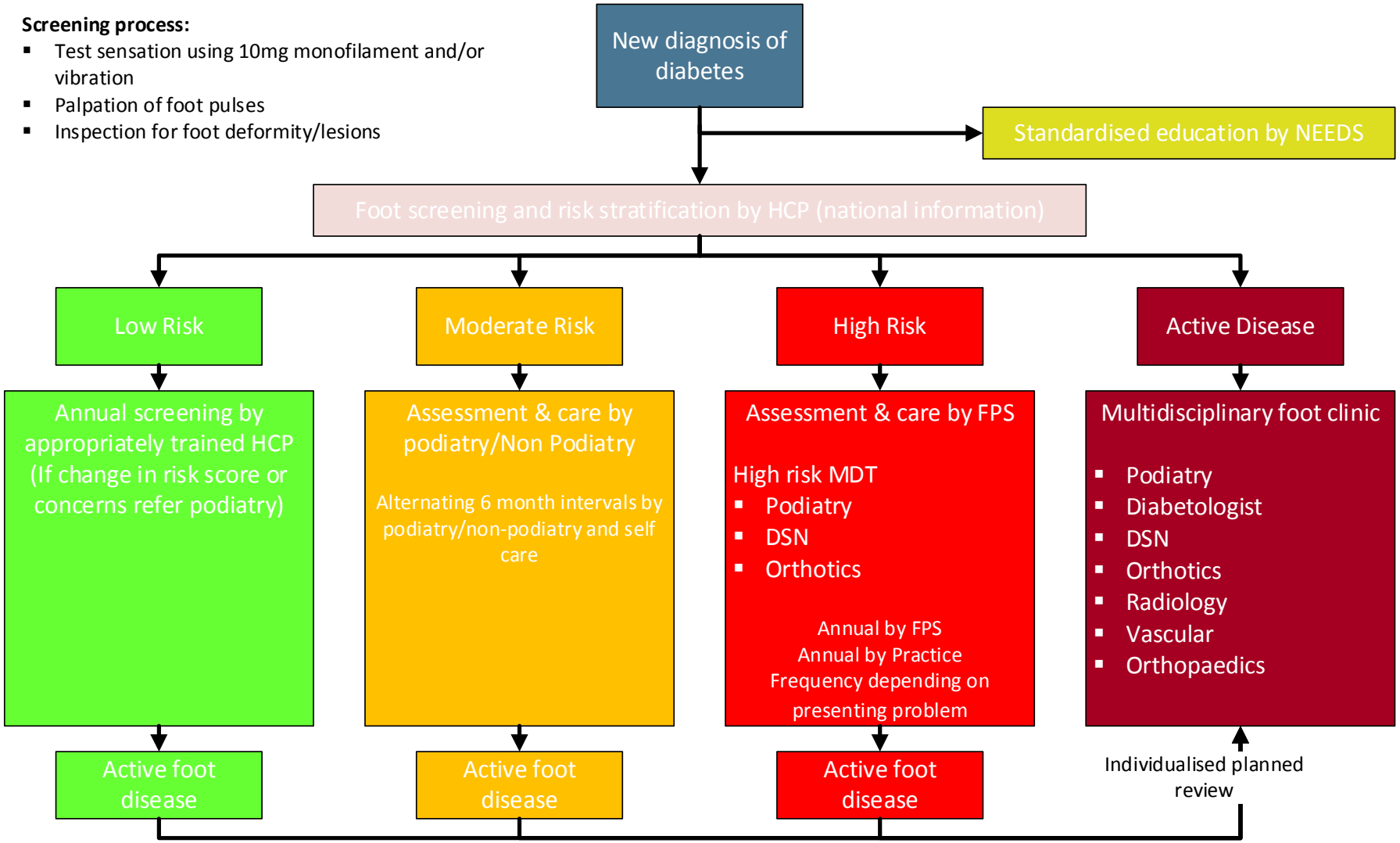
Management

To be seen within one working day of triage, treatment commence and follow up at the next MDT foot clinic. If life or limb threating presentation, to be admitted to EAU for assessment and treatment.

The Annual Foot Assessment

Screening process:

- Test sensation using 10mg monofilament and/or vibration
- Palpation of foot pulses
- Inspection for foot deformity/lesions



MDT Foot Pathway

Referrals: Referrals are received either from:

- GP/Practice Nurse or
- Via risk stratification in the practice
- Nurse led clinic
- Podiatry

Process: Once referral received the patient is offered an appointment.

If the patient does not attend or cancels then this is followed up through admin procedure of 1st letter, 2nd letter and discharge.

If the patient attends then there is a Podiatry initial assessment followed by a Consultant and DSN review of their diabetes control. A letter is then generated to the referrer if required.

Treatment Plan: Once the patient has been seen by Podiatry/Consultant/DSN then a treatment plan is agreed. This could be:

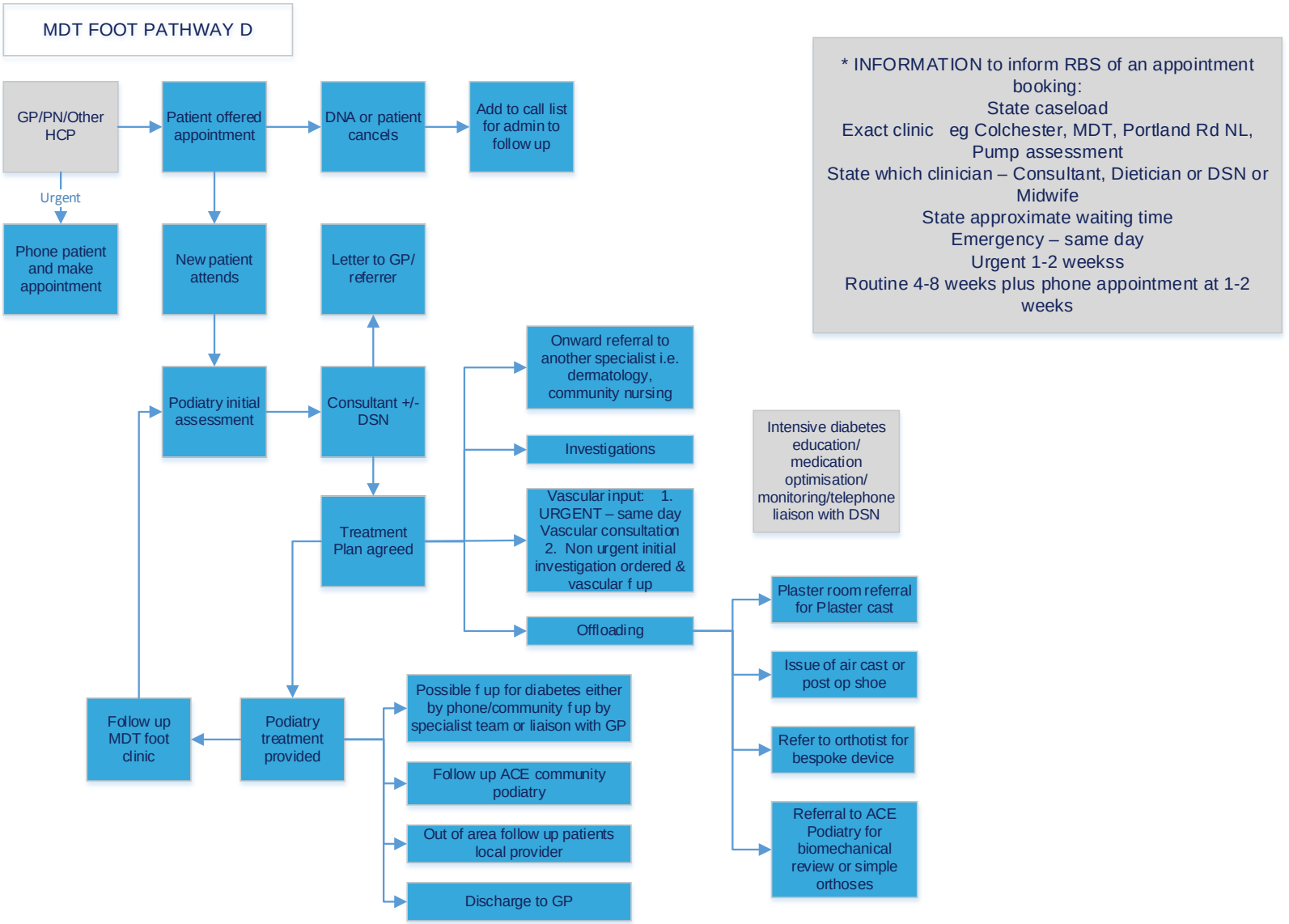
- Further investigation
- Onward referral to another specialist i.e. dermatology, community nursing
- Vascular input – URGENT this is same day NON URGENT initial investigation ordered and offered vascular follow up
- Offloading to
    - Plaster room referral for plaster cast
    - Issue of air cast or post op shoe
    - Refer to orthotist for bespoke device
    - Referral to ACE Podiatry for biomechanical review or simple orthoses
- There is always intensive diabetes education, medication optimisation and monitoring or telephone liaison with DSN
- Podiatry treatment provided which may include:
    - Possible follow up for diabetes either by phone/community by specialist team or liaison with GP
    - Follow up by ACE community podiatry
    - Out of area follow up by patient's local provider
    - Discharge back to GP
    - Follow up by MDT foot clinic.

Criteria:

- Ulceration
- Infection
- Gangrene
- Osteomyelitis
- Acute Charcot

Data entry: Patient consultation to be entered into system 1 and letter generated to GP within 48 hours

If medication changed letter to be sent to GP and other services if involved in care.

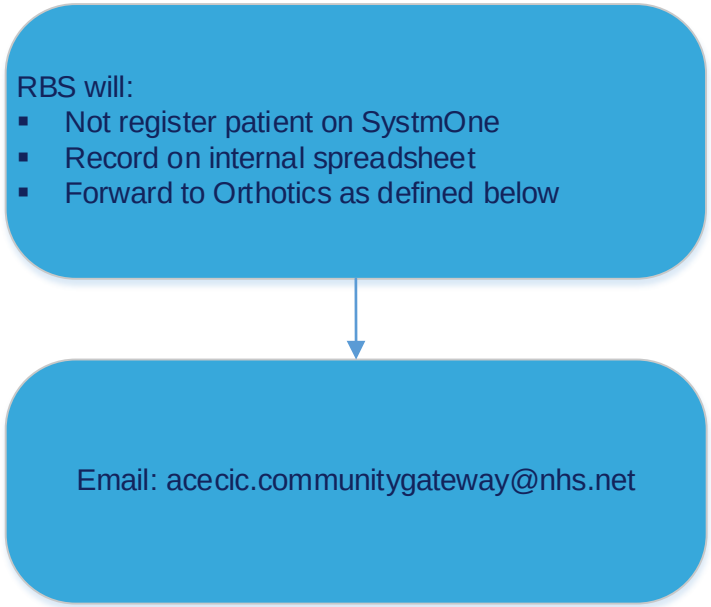

MDT FOOT PATHWAY D
GP/PN/Other HCP
Patient offered appointment
DNA or patient cancels
Add to call list for admin to follow up
Urgent
Phone patient and make appointment
New patient attends
Letter to GP/ referrer
* INFORMATION to inform RBS of an appointment booking:
State caseload
Exact clinic eg Colchester, MDT, Portland Rd NL, Pump assessment
State which clinician – Consultant, Dietician or DSN or Midwife
State approximate waiting time
Emergency – same day
Urgent 1-2 weekss
Routine 4-8 weeks plus phone appointment at 1-2 weeks
Podiatry initial assessment
Consultant +/- DSN
Onward referral to another specialist i.e. dermatology, community nursing
Investigations
Intensive diabetes education/ medication optimisation/ monitoring/telephone liaison with DSN
Treatment Plan agreed
Vascular input: 1. URGENT – same day Vascular consultation 2. Non urgent initial investigation ordered & vascular f up
Plaster room referral for Plaster cast
Offloading
Issue of air cast or post op shoe
Refer to orthotist for bespoke device
Referral to ACE Podiatry for biomechanical review or simple orthoses
Possible f up for diabetes either by phone/community f up by specialist team or liaison with GP
Follow up MDT foot clinic
Podiatry treatment provided
Follow up ACE community podiatry
Out of area follow up patients local provider
Discharge to GP

Orthotics

- RBS will
  - Not register patient on SystmOne
  - Record on internal spread sheet ?
  - Forward to Orthotics email acecic.communitygateway@nhs.net

Recorded and reported as ACE activity

ORTHOTICS – PATHWAY E



Note: Recorded and reported as CHUFT activity; monthly MDS and Activity Summary (refer to sub-contract)

Pregnancy

All calls will be classed as urgent

- RBS will
  - Phone Midwife with patient details
  - Register patient on SystmOne
  - Send to triage via task as below
- Specialist Midwife will
  - Respond within 2 working hours
  - Triage referral
  - Send details of caseload to RBS
  - Book patients into hospital PAS

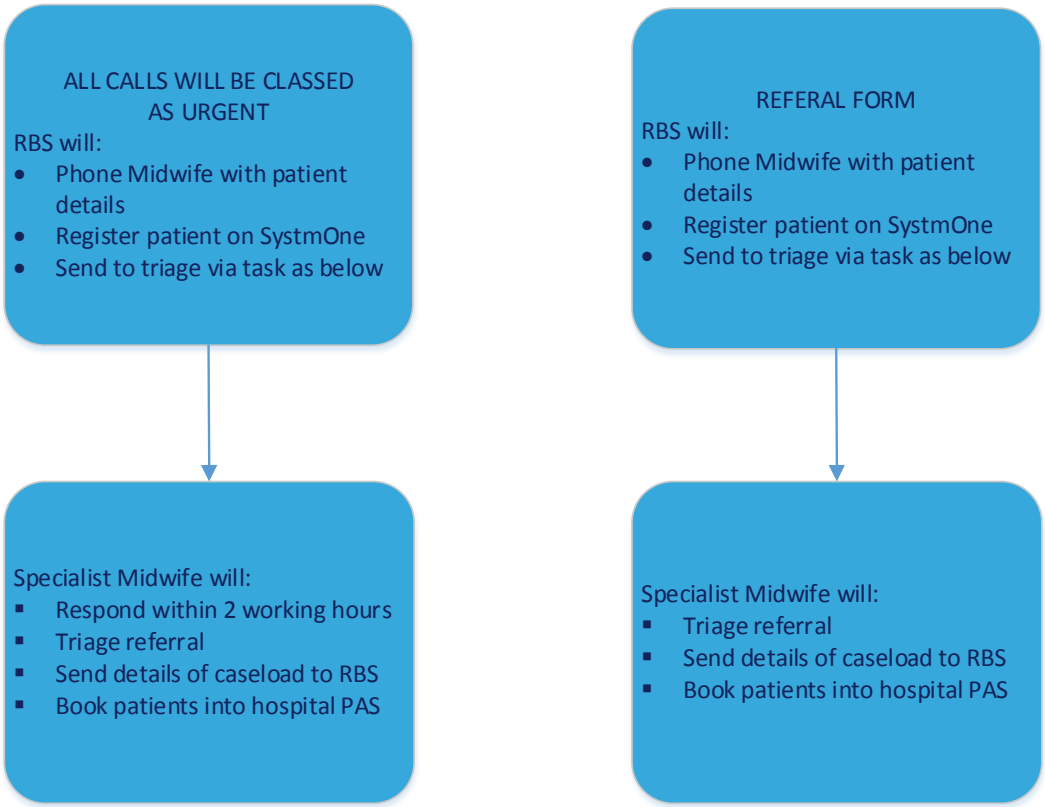
Referral form received

- will
  - RBS Phone Midwife with patient details
  - Register patient on SystmOne
  - Send to triage via task as below
- Specialist Midwife will
  - Triage referral
  - Send details of caseload to RBS
  - Book patients into hospital PAS

Please note when midwife is on leave, call will be diverted to on-call DSN
Recorded and reported as CHUFT activity but also recorded on NEEDS SystmOne.

Pregnancy Pathway – F

Pregnancy Pathway - F



When Midwife is on leave, call will be diverted to on-call DSN

Note: Recorded and reported as CHUFT activity: monthly MDS & activity summary (refer to sub-contract) but also recorded on NEEDS SystmOne

Pre pregnancy

Referrals: received from

- GP practice (if insufficient information then RBS to phone referrer)
- Nurse, MDT, Dietitian and informed wanting to get pregnant

Process:

- RBS registers patient on system 1

Pre Pregnancy clinical care pathway:

- Notify DSM on system 1
- DSM completes triage
- DSM returns task with specific details of appointment
- RBC phones patient to arrange an appropriate appointment
- Frist appointment (face to face)
- Further advice and refer to consultant or dietitian as appropriate
- Telephone 4 – 6 weeks
- Re book appointment to see midwife after further 6 weeks if needed and/or nurse led/GP practice

Treatment Pathway

- Complete template/medical history
- Review medication – Stop Statins. Stop ACE and ARB's and use appropriate Blood pressure medication as required.
- Consider change to insulin. Start folic acid 5mg or when actually trying to conceive
- Start blood glucose testing for pregnancy targets (pre breakfast 3.5 – 5.5mmol or 1 hour post meals less than 7.8mmol)
- Discuss pregnancy care
    a) Hypo awareness (Type 1)
    b) Insulin resistance (Type 1 and 2)
- Provide booklet (Abbott), contact number – midwife to notify area early pregnancy referral team
- 6 weekly HbA1c – pre pregnancy

Clinical pathway for women with diabetes in pregnancy

Women with Type 1/Type 2, pregnancy referral received by CHUFT – Maternity, to register on Portal, arrange BODAL appointment at earliest opportunity (6-8 week gestation). Send copy of referral by fax to DSM/NEEDS for early contact

DSM/NEEDS to make telephone contact to discuss current medication care for pregnancy and timing of first appointment

Woman to be seen in BODAL, ideal 6-8 weeks gestation, by MDT

Arrange further BODAL clinics as necessary (4 weekly minimum), follow A/N care pathway as per CHUFT Diabetes in Pregnancy guideline 2.6. Liaise with other services/ specialist as appropiate

DSM/NEEDS to maintain 2 weekly telephone contact with these women to asses diabetes control

DSM to see women on Lexden ward to discuss care for labour and following post-natal care, or ensure plan of care has been recorded

DSM/NEEDS to be notified by phone/fax of any admission/ visit to Triage/Delivery suite/Lexden ward (over weekend) to follow up by telephone contact

Contact DSM/Obstetrician/Diabetologist if require advice re management of diabetes, during visit/admission of woman in antenatal period. Type 1 and Type 2 ladies to be seen if possible on admission/discharge

Woman with Type 1/Type 2 to have post-natal appointment in BODAL, 6 weeks following delivery

Gestational Diabetes, screening for pregnancy women as per NICE (2008, 2015)/ CHUFT Diabetes in Pregnancy guideline, GTT at 26-28 weeks gestation based on criteria, late GTT may be result of glycosuria

Abnormal GTT result to be communicated to DSM (if unable to contact, to fax details to NEEDS (01473 225391) or email referral.bookingservice@nhs.net

DSM/NEEDS to contact women, advice regards diagnosis and arrange to see within 5 working days to discuss diet and provide blood glucose meter.
To arrange follow up in BODAL clinic with ultrasound scan (28, 32 and 36 week gestation)

Follow up for woman with GDM to have blood test, HbA1c at 3 months post-partum. DSM to check result and inform both woman and GP, of result with appropriate follow up care

Following initial appointment with DSM/ BODAL to continue care as per pathway (see left)

Previous pregnancy with GDM

DSM/NEEDS to be notified of woman following community midwife booking (8-10 weeks)

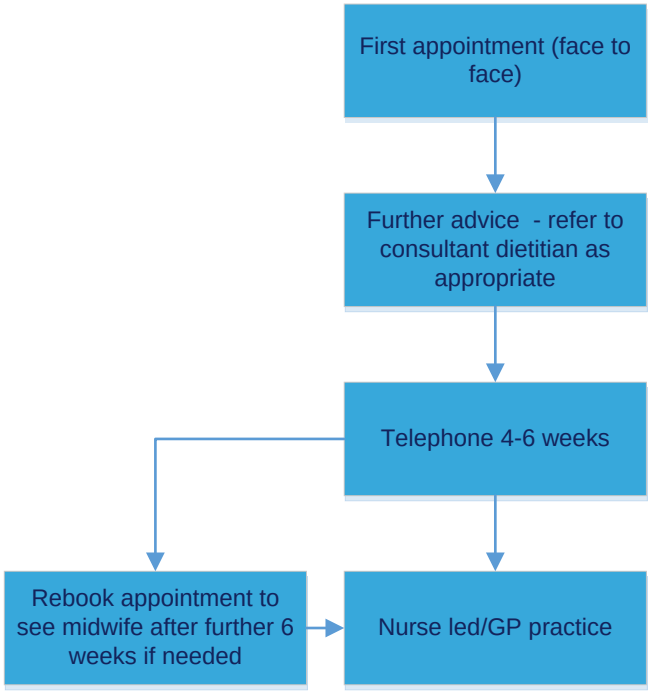
DSM to contact woman by telephone/arrange appointment as necessary. To discuss diet and advice regards monitoring of blood glucose levels daily/or GTT early in pregnancy and repeat at 26-28 weeks gestation if first test normal

DSM to maintain 2-4 weekly contact with woman to assess/review blood glucose levels if monitoring

DSM/NEEDS to evaluate on BG levels as to whether woman has GDM, if confirmed to refer to BODAL clinic and continue pathway (see far left)

GDM not identified to continue with midwife led care or refer to consultant if indicated

Pre-pregnancy clinical care pathway



TREATMENT PATHWAY

- Complete template/medical history
- Review medication – Stop Statins. Stop ACE and ARB's and use appropriate Blood pressure medication as required.
- Consider change to insulin.
- Start blood glucose testing for pregnancy targets (pre breakfast 3.5 – 5.9mmol or 1 hour post meals less than 7.8mmol)
- Discuss pregnancy care
    a) hypo awareness (Type 1)
    b) Insulin resis tance (Type 1 and 2)
- Provide booklet (Abbott), contact number – midwife to notify area early pregnancy referral team
- 6 weekly HbA1c – pre pregnancy

* INFORMATION to inform RBS of an appointment booking:
State caseload
Exact clinic eg Colchester, MDT, Portland Rd NL, Pump assessment
State which clinician – Consultant, Dietician or DSN or Midwife
State approximate waiting time
Emergency – same day
Urgent 1-2 weekss
Routine 4-8 weeks plus phone appointment at 1-2 weeks

Pregnancy Clinical Care

Referrals from:

- Hospital
- GP/PN
- Nurse led/MDT
- Self-referral

Criteria:

- Last menstrual period – regular periods
- Hypo awareness (type 1)
- Pain/Bleeding
- Check of folic acid
- Other medications
- Seen GP

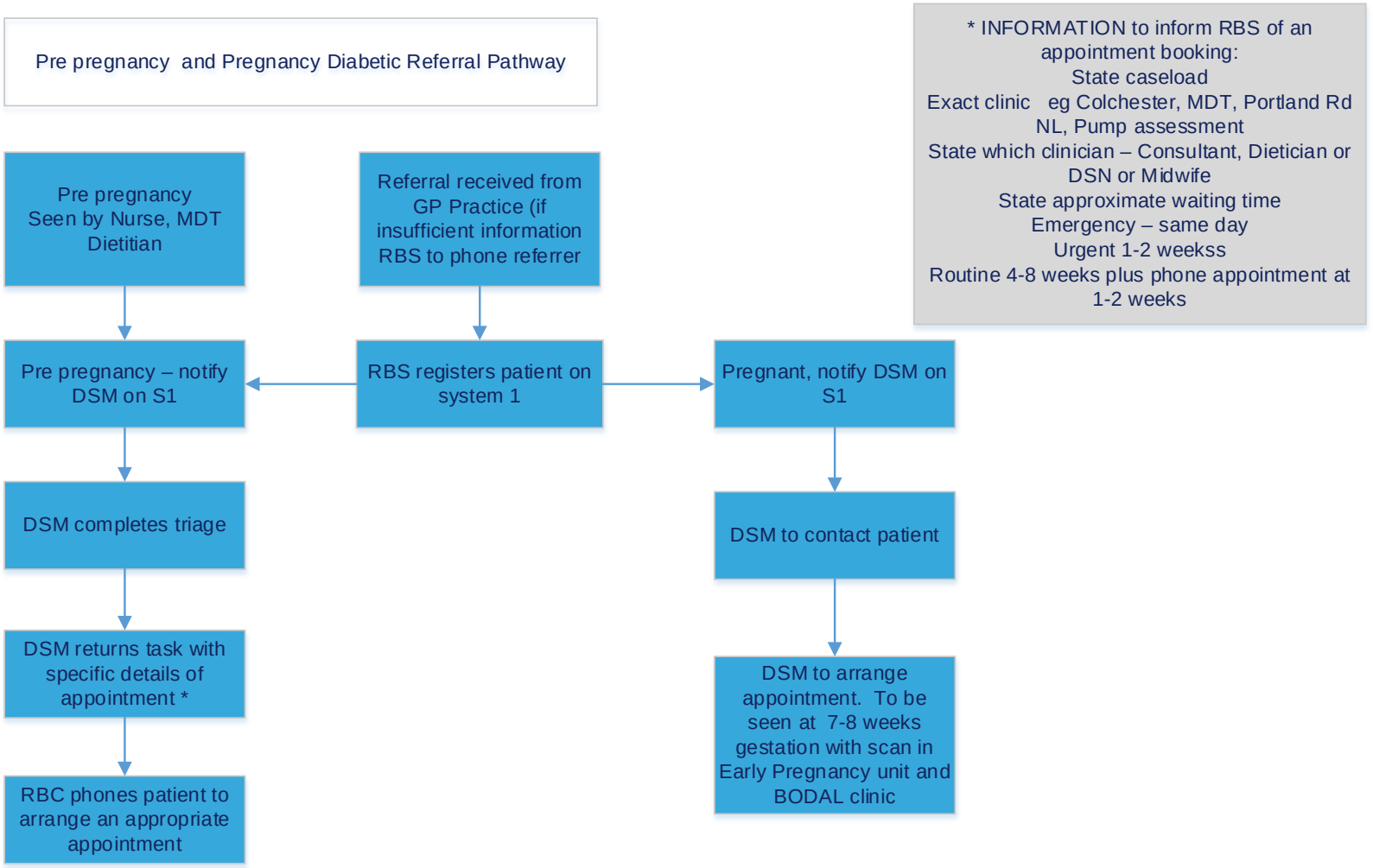
Pregnancy Targets

- Pregnancy targets
- Adjust medication
- Clinical History
- Refer retinal screening
- Prescription folic acid 5 mg o.d.
- Aspirin 75 mg o.d.
- Pregnancy care
- Baseline bloods:
    - HbA1c
    - Cholesterol
    - Renal
    - Liver
    - Thyroid
    - Urine – microalb
    - Meter
    - Dietary discussion

Process:

- Woman contacted
- BODAL at 6-7 weeks gestation or ASAP then either
    - Review in BODAL or midwife led clinic in 2 – 4 weeks depending on Blood glucose control
    - Booking and history on Maternity Medway by CHUFT community midwife

- o E/PU for viability scan 8 weeks gestation. If ongoing pregnancy see next step. If miscarriage DSM contact by phone 2 weeks and then return to normal diabetes care.
- o If ongoing pregnancy booked in for additional ultrasound scans booked from 20-40 to take place at 28,32,36 weeks gestation
- o Follow maternity pathway
- o Plan delivery at 38 weeks



Gestational Diabetes

Criteria: Abnormal GTT at 16 and/or 28 weeks gestation or previous GDM wishing to self monitor

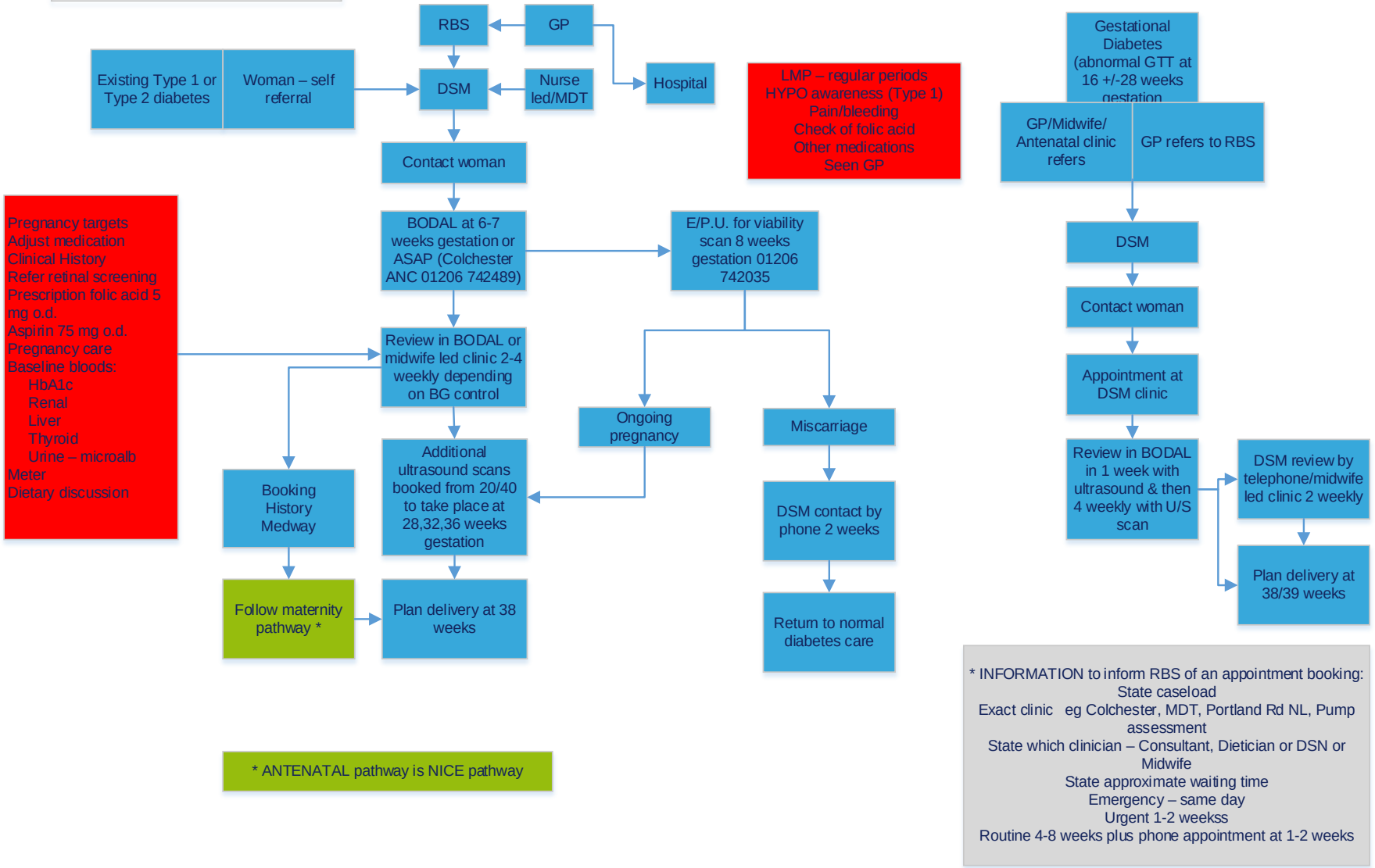
Referrals: from

- GP
- Midwife
- Antenatal clinic

Process:

- DSM is contacted
- DSM contacts woman
- Appointment at DSM clinic (previous GDM for monthly reviews of blood glucose levels, if appears GDM developing for review in BODAL and follow process below)
- Review in BODAL in 1 week with ultrasound and then 4 weekly with ultrasound scan then either
    - Plan delivery at 38 – 39 weeks
    - DSM review by telephone/midwife led clinic 2 weekly then plan delivery at 38-39 weeks

Pregnancy Clinical Care Pathway



SCHEDULE 7:

Education sub pathways
Referrals

TYPE 2 Diabetes:

Referrals: Referrals are received either from:

- GP/Practice Nurse
- Self-referrals

Process: Once referral received the patient is registered and patient is telephoned, if unable to reach by telephone, they will be telephoned on the following working day. If they are unable to be reached by 2 telephone calls they will be sent a letter identifying the different courses available. If newly diagnosed, added to type 2 education database

If there is no response

- A second letter sent and if no response
- If newly diagnosed, telephone once to ascertain why they do not wish to attend and recorded
- Patient discharged

If the patient at any stage is contacted successfully, a selection of dates and venues are offered and then

- They are booked onto the course
- Confirmation letter sent
- Reminder letter sent 1 to 2 weeks prior to course
- The patient attends course
- Discharged back to GP care.
- If newly diagnosed type 2 DNA's course, telephoned x 1 to ascertain why they did not attend and recorded

TYPE 1 Diabetes:

Referrals are received either from:

- GP or PN
- DSN
- Diabetes Practitioner referrals already triaged

Process:

If a patient is referred from a GP/PN or DSN then the patient is registered and triaged by the DSN.

- The patient is phoned to discuss if they meet criteria and are willing to attend. If, from the referral, it is felt clinic appointment is required prior to attendance of education, appointment is booked.
- If not appropriate for education then an appointment is booked for the DSN or dietetics if required and meet appropriate criteria for this service
- If yes then they follow the same pathway as a successfully contacted Type 2 above.

If the patient is referred by DSN and already triaged

- If they do not meet criteria then they are booked for specialist clinic OR discharged back to GP
- If they meet the criteria they are booked onto DAFNE. A 3 hour carbohydrate course available for those unable to attend DAFNE
- They then have a DAFNE pre assessment clinic appointment booked one face to face or telephone for DAFNE 5 x 1.
- Attend DAFNE pre assessment clinic prior to the course.
- Start course.
- Post DAFNE follow up within 6 months of the course.

Patient Education

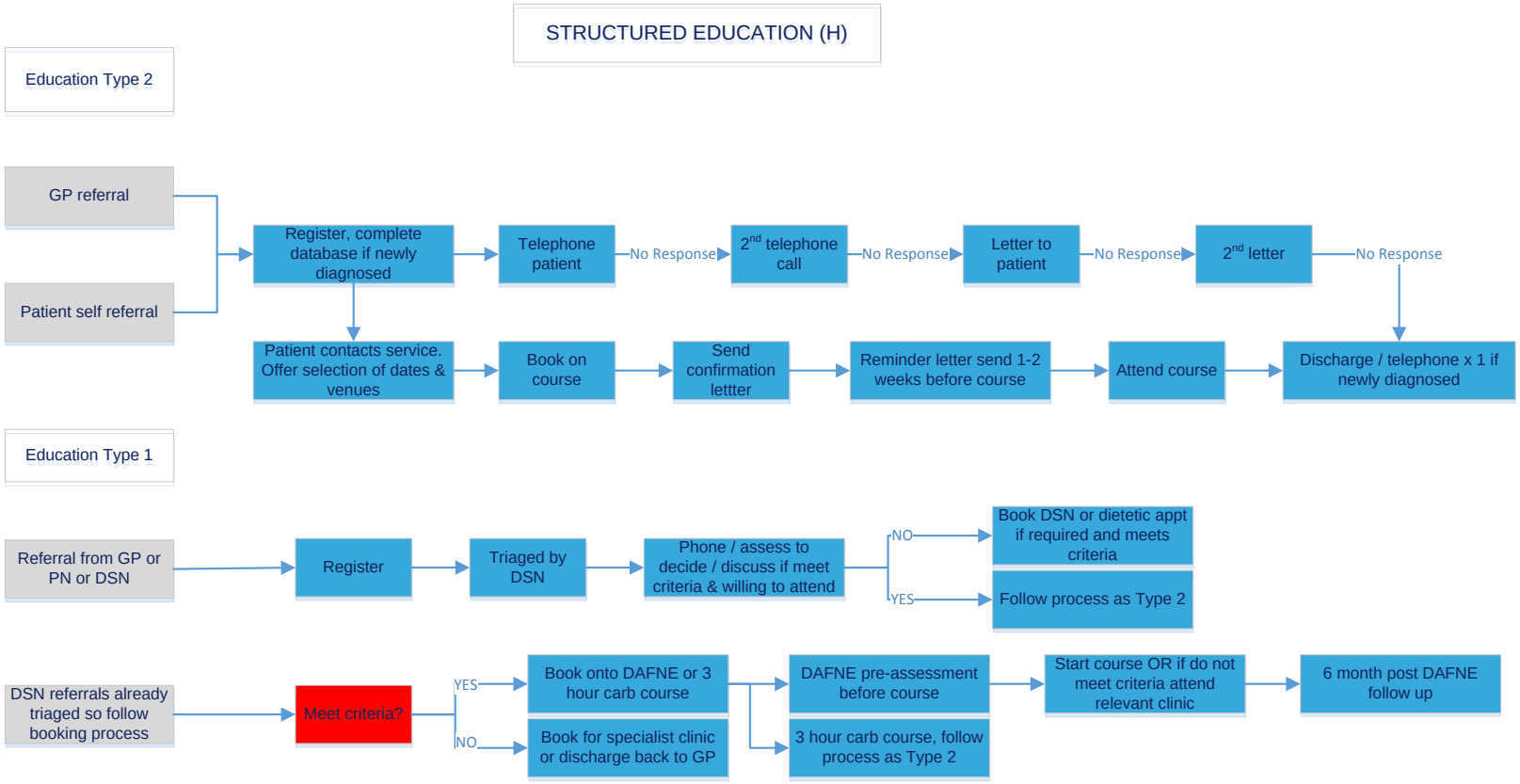
Referral via RBS

- RBS to register patient on SystmOne

Referral via DST

- Tick the box on template for the referral to education

Admin team will then register and follow standard booking procedure, which includes giving choice of dates and types of education.



Psychology

Referrals: received from

- GP practice (if insufficient information then RBS to phone referrer)
- Consultants
- DSNs

Process:

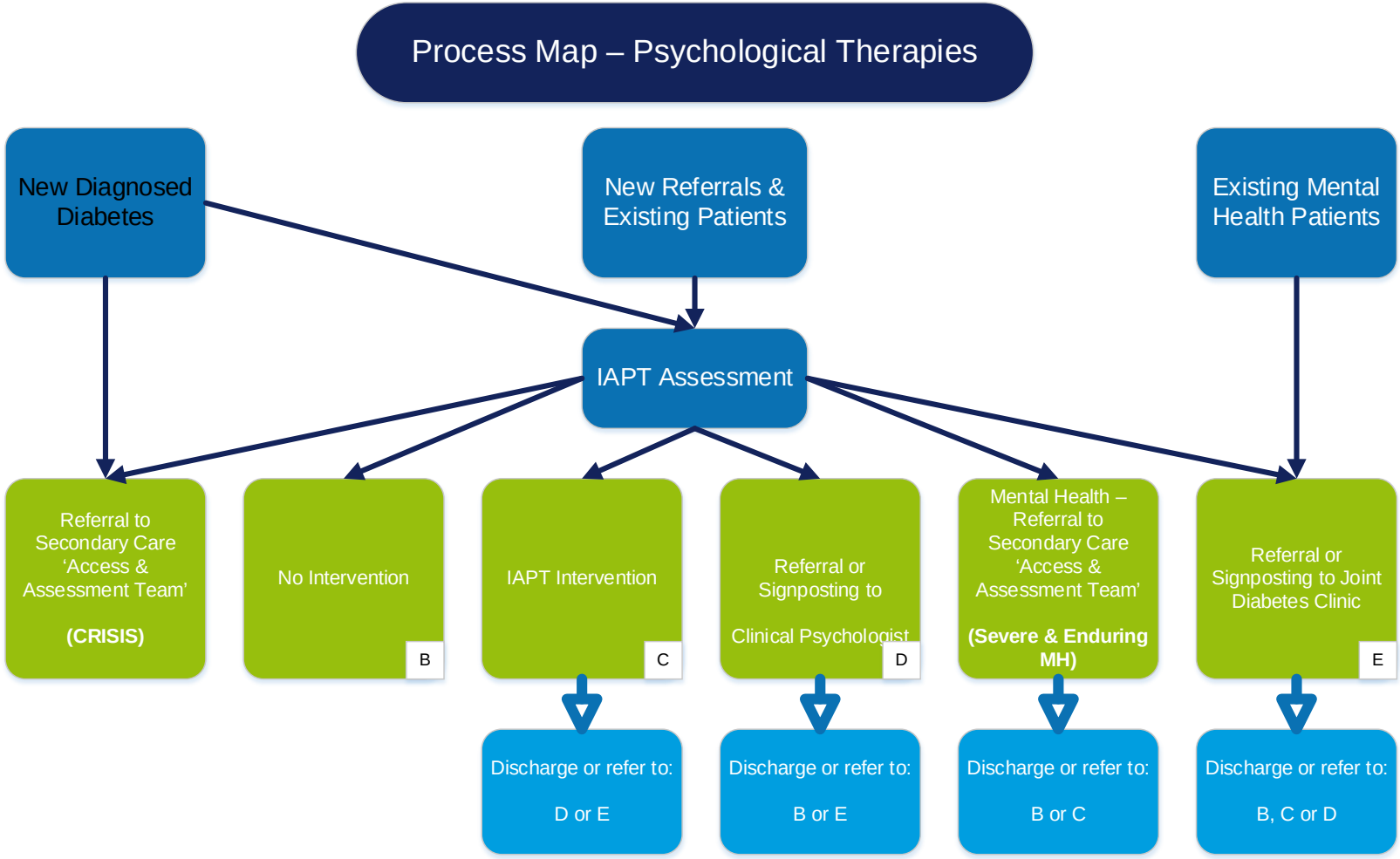
- One slot is available for urgent referrals. Urgent patients will be the next clinic
- Triage by Senior DSN, reviewing referral and placing patient clinic based on need (need is if the psychologist sees a clinical requirement to see again sooner (urgent new referral))
- Triage to also determine if IAPT is appropriate*
- Send details of which clinic date and time to RBS to follow RB procedure
- Telephone call to patient in two weeks (non-urgent)
- Seen in clinic
- Discharge when goals achieved

***IAPT pathway to be agreed at later date**

Treatment Pathway

- Care Planning agreed
- Review depending on initial consultation
- Monitor progress at each visit or arrange non Face to Face consultation and support
- Discharge when goals achieved

Psychology pathway



V1: January 2016 / due for review January 2018

Care Homes

Roles of care Home DSN

- To visit the homes where residents have diabetes
- Collect names of residents with diabetes (if not already known) – pass to RV who will register on S1 & Care Home data base
- Review residents, identify if they have had CP's completed in the last 12 months, does the PN visit home for CP? Yes/No
- If the PN does not visit, then DSN to visit to complete all 8 CP's (urine excluded if incontinent)
- Complete entry on S1 as an assessment. Completing 8 CP's
- Set review date 1. Annual Review - 2. Follow up of clinical outcomes. Write to GP with CP's
- Provide home with Fair Processing leaflet

SystmOne

To collect and audit

- Home
- Date of Annual Review
- Training
- Name on a list – caseload or other identifiable care home project
- Tick box to say information or project given and consent obtained

Run both S1 and database until satisfied S1 can provide reports

Identify residents by

- Inpatients & A&E
- Virtual wards
- Homes who request training
- RV / DSN making contact with any others

Information to homes / person with diabetes
Provide each resident and manager the SF information leaflet

Process

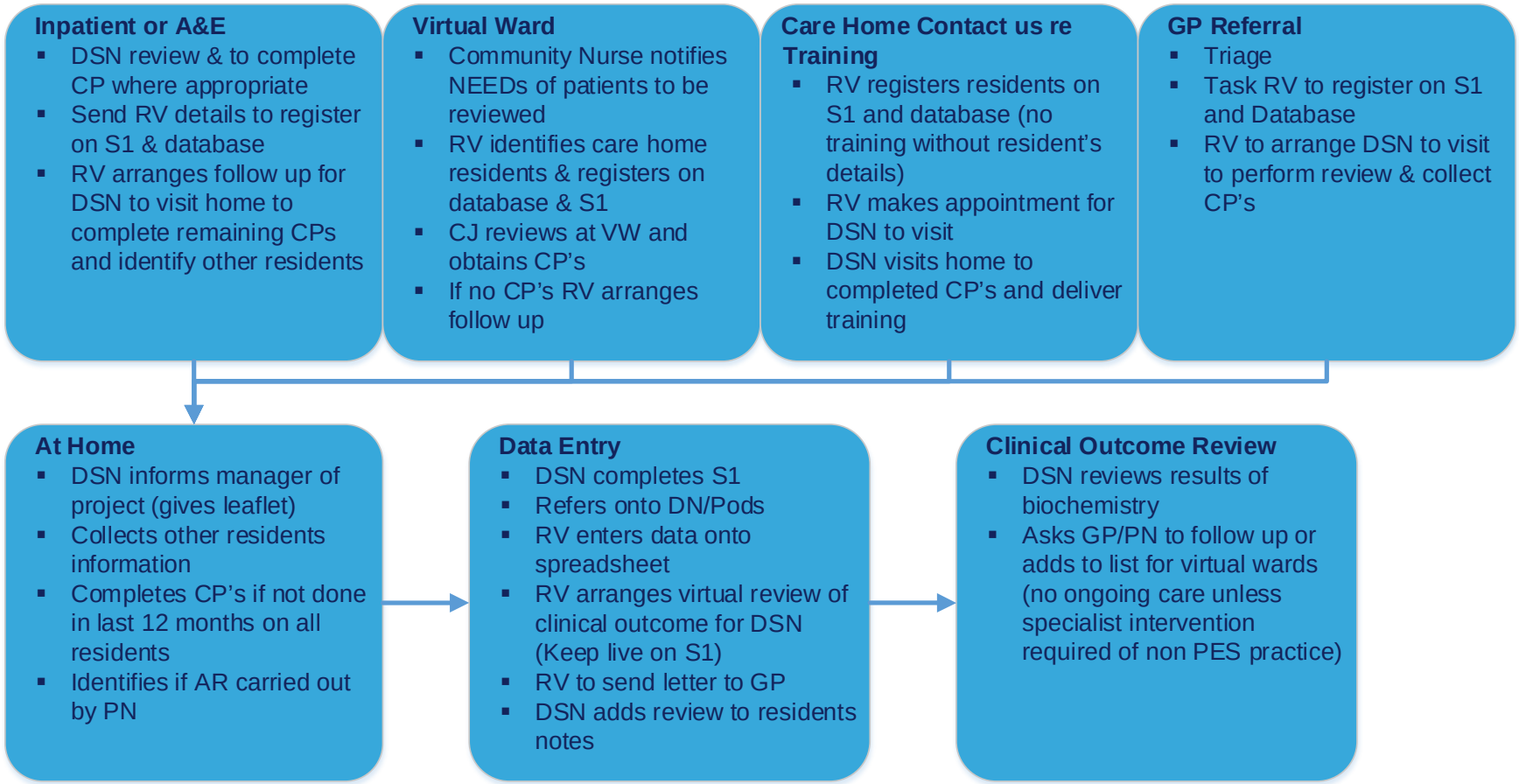
- Identify resident with diabetes
- Check which CP's require completing
- Carry out CP's including full foot assessment plus ITT

Document all information on S1

- Send letter to GP cc DN if under their care
- Follow up results – Hba1c, review medication, 1st follow up only, foot screen – onward referral/DN or pressure reliving aids – care to be taken on by GP not to be ongoing care at NEEDS unless deemed specialist intervention required
- Add to yearly review for CP's

Message to Home

- We are the North East Essex Diabetes Team and have been notified that you have residents with diabetes. We are carrying out Annual Reviews on all people with diabetes and would like to make an appointment for the Diabetes Specialist Nurse (DSN) to visit and assess all your residents.
- Please have the resident's details available for the DSN.
- If the resident have been reviewed by their Practice Nurse then no additional reviews will be undertaken. However details are required for the register.



15. PES Practice Meetings

Practice meetings structure and format

- Look up the PES/ Dashboard and PES training log before the visit and identify any shortfalls.
- Introduce yourself and explain the new NEEDS service.
- Discuss the PES, exemptions, where their practice is and quarterly meetings.
- Find out what formal training the HCP's have had and what education needs they have.
- Offer leaflet on diabetes education options available.
- Establish whether the practice has attended the YOC training and are there others who still need to attend and inform Teresa.
- Ask if HCA's involved in the YOC – do they require any further training e.g. foot training.
- Look at the dashboard with them; explain if coding wrong to liaise with health intelligence.
- Look at the 8 care processes in particular, also explain to call in patients with an HbA1c 8 – 9% to start with to improve their control.
- Look at impaired glucose tolerance patients. Do they have a register and annual recall?
- Offer case note reviews/ facilitation clinic/ insulin starts in surgery if they are not qualified and emergency phone number for HCP's (9- 5 only)

Use the following form:

Practice Meeting
Practice Name
Date
Present
KPI's
Dashboard
Registered for YoC
Registered for Foot Training
Identified problem areas
Actions agreed
DSN