A Collaborative Working Project Between St Helens Cares and Sanofi to review the diabetes pathway and population health
End of Project Evaluation Report

1.0 Project Aim

St Helens Cares have identified the commissioning of an effective and efficient diabetes service as a priority. They have been allocated transformation funding to drive service improvement. Currently, only 26.67% of patients aged 18 and over are achieving all 3 NICE treatment targets in St Helens (ref: Cheshire and Merseyside ICB Integrated Diabetes Dashboard, August 2023) and variation in attainment of diabetes care standards (9 Care Processes) across member primary care practices has been highlighted, therefore analysis of population health of diabetes patients and mapping of diabetes pathways and services was needed to understand where current gaps and areas for improvement sit.

Aim

This collaborative working project aimed to identify areas for improvement in services, pathways, and care standards that could inform optimal utilisation of available transformation funding.

2.0 Project Objectives

The initial objectives of the Collaborative Working Project were:

Objectives

- Conduct a diabetes population health analysis.
- Conduct analysis of diabetic outpatient DNA (Did Not Attend) data.
- Conduct a mapping of diabetes pathways and services.
- Produce an options appraisal and a population health analysis infographic.

3.0 Project Outcomes and Benefits

The expected outcomes and benefits of the project were:

Patients

During the project period, existing patient services and pathways remained un-altered. Whilst the project itself did not directly improve patient outcomes, the analysis conducted will inform future interventions and funding decisions aimed at:

- Improving equity of care and access to services for patients
- Improving patient pathways
- Reducing waiting times

NHS

- Ensuring the system works for patients, helping professionals to provide seamless value for money services. Review which diabetic pathways work and those that need more support.
- Reduction in unwarranted variations in care through targeting areas of high deprivation and health inequality.
- Learning from the implementation of a population health management approach for patients with diabetes. This will allow the NHS to inform and implement this approach in other elective care specialities.
- Improvement in the quality of referrals to specialist services.

- More effective and efficient commissioning of services.

Sanofi

- To add further insight into how Sanofi can improve population health management in other populations.
- An opportunity to learn about the range of educational/training resources that are required by a place of care such as St Helens to reduce variation in patient management across member practices.
- Improved corporate reputation with St Helens Cares and partner organisations.
- As a result of improved performance against the 8 care processes, some appropriate patients may be prescribed Sanofi products in line with NICE guidance.

4.0 Project Implementation

A Project Steering Group was established to agree on a project plan to oversee delivery of the project, consisting of:

-Commissioning Lead, St Helens Place
-Senior Commissioner, St Helens Place
-Diabetes Lead GP for Primary Care, St Helens Place
-Clinical Director of Diabetes, St Helens Hospital
-Business Intelligence Lead, St Helens Place
-Business Intelligence Analysts, St Helens Place
-NHS Engagement Manager, Sanofi
-National Engagement Lead, Sanofi
-Medical Science Liaison, Sanofi
-Project Support Manager, Sanofi

Weekly meetings of the Project Steering Group were organised to review project delivery. A Microsoft Teams site was established to hold all project documentation and serve as a communication platform. A proposed project plan was presented at the first meeting and agreed by the group. The project analysis would involve the collection of quantitative (by analysing NHS data sets) and qualitative data (by interviewing both clinical and non-clinical individuals working within the diabetes pathway).

The group agreed on the datasets to be analysed and how they would be presented and standardised. The data sets agreed were:

-Quality Outcomes Framework (QOF) (2022-23)
-Type 2 Diabetes Mellitus National Diabetes Audit (NDA) (2022-23)
-Hospital Episode Statistics (HES) (2022-23)

Sanofi conducted the data analysis, working with NHS Business Intelligence to validate and standardise the data. The Steering Group members agreed on the key findings from the data analysis during a Steering Group meeting.

The data analysis helped the group formulate a healthcare professional questionnaire to better understand barriers within the pathway and what might be effective options for improvement. Mid-way through the project, a question was added to also ask what was working well. The questionnaire formed part of an interview process with local clinical and non-clinical individuals working within the diabetes pathway within Primary, Secondary Care and Community Services, including those commissioned by Public Health. 16 interviews took place covering 19 interviewees. All but one planned interview took place. The interview process was used to create a map of the pathway and to inform the identification of pathway barriers and development of an options appraisal.

A skills and knowledge questionnaire was constructed by the Steering Group and digitally circulated among health care professionals in Primary Care involved in delivering diabetes care standards by the senior commissioner and GP Diabetes Lead. 41 questionnaires were completed. A patient interview to understand why patients might “Did Not Attend” (DNA) appointments was compliantly delivered to 2 patients by the St Helens Cares commissioning team in the absence of Sanofi personnel.

Whilst the initial data analysis was underway, the project was presented to the local PCN (Primary Care Networks) Clinical Directors, and Primary Care Medical Director, and was well-received and supported. The group’s support drove engagement with the pathway interviews and the skills and knowledge questionnaire. The group will also be crucial in future interventions resulting from the outcomes of the project.

When all analysis was complete, the Steering Group met face-to-face to agree a consensus on key findings and what their actions moving forwards would be. This was summarised in a consensus report. Key data and content for a static infographic were agreed, and a simplified patient pathway, with contact details, was created for circulation across the area.

A final report was drafted and agreed by all stakeholders, and all outputs, analysis and documentation were handed over to the Steering Group members before bringing the project to close.

The key milestones delivered in implementation of the Project are as follows:

Dec 2023

- Developed a Project Plan to set out and monitor delivery of the aims and objectives of the Project.
- The Steering Group were granted access to a Teams site where the project plan and other relevant documents are stored.
- The Steering Group agreed on data sets to be analysed and which codes would be included using best practice from a similar project in Dudley as a starting point.
- An action plan was developed to ensure that the pathway barrier and options analysis was conducted within project timelines. This involved identifying interviewees and contacting them to arrange interviews from week 2.
- Public Health were identified as a department who would add value to the pathway analysis.
- The St Helens Informatics Lead nominated a colleague to support with analysis.

Jan 2024

- Data standardisation method was agreed between Sanofi and the NHS Business Intelligence stakeholders.
- Sanofi presented the QOF, NDA and HES data analysis back to the Steering Group.
- The NHS Steering Group members agreed on key findings in the data analysis.
- The NHS Steering Group members formulated a diabetes pathway questionnaire to support interviews with local healthcare professionals and strategic roles working within the pathway to uncover barriers to delivering care and options for improvement. The questionnaire also gathered insights into why patients might DNA appointments.
- A healthcare professional Diabetes Skills and Knowledge questionnaire was developed by the NHS stakeholders to assess skills and knowledge-level around diabetes.

Feb 2024

- Diabetes prevalence rates reported in the Sanofi QOF analysis were confirmed by the St Helens Informatics team.
- The diabetes pathway questionnaire was delivered to identified stakeholders via interview by the Sanofi Project Manager.
- Using the interview process, the diabetes pathway was mapped in Microsoft Visio, with associated barriers and options for different steps of the pathway recorded. These barriers and options were later summarised in a report in Excel.
- Microsoft Visio was also used to map outcomes from the DNA section of the questionnaire. These were also summarised in Excel.
- The HCP Skills and Knowledge questionnaire was finalised by NHS stakeholders and circulated via Microsoft Forms.
- 2 patients were interviewed by the Senior Commissioner to understand barriers to attending appointments, as part of the DNA analysis.

Mar 2024

- The Diabetes Specialist Outreach Team Lead Nurse joined the Steering Group, contributing crucial system insight and a stronger outcomes consensus.
- The HCP Skills and Knowledge questionnaires were completed by 41 HCPs (healthcare professionals).
- The Steering Group met face-to-face and agreed a consensus on the key findings from the barriers and options summaries taken from the data analysis and pathway interviews. Actions for each key finding were agreed by the group.
- During the consensus meeting, key findings and actions were also agreed for the Skills and Knowledge questionnaire and DNA analysis.
- During the consensus meeting, the findings from the NDA, QOF and HES analysis were used to inform targeted actions.
- A simplified pathway with service contact numbers was created for circulation across the locality.
- Content for a project static infographic was agreed by the Steering Group.

Apr 2024

- An end of project report was drafted, and agreed with the Steering Group.
- 50 copies of the simplified pathway were produced for circulation among stakeholders. A digital copy was also provided.
- A final consensus summary was agreed by the Steering Group.
- All data analysis and documentation were handed over to the NHS steering group members.
- The project was closed on 24th April 2024.

5.0 Outcomes and Benefits Achieved

The table below outlines the key project outcomes against the objectives of the project.

Objective	**Outcomes and benefits achieved**
-Conduct a diabetes population health analysis.	-Diabetes Mellitus Prevalence rates, list sizes and deprivation scores were reported at PCN level. -A National Diabetes Audit analysis focused on the delivery of the 3 treatment targets and 9 care processes at PCN level. 2 PCNs were identified by the Steering Group due to their variance in performance against the Place average. These PCNs were then analysed at practice level, identifying some practices whose performance deviated away from the place average. -A QOF analysis of diabetes indicators was performed at local PCN level, comparing the percentage of available points achieved to the St Helens Cares average. One PCN stood out as having variation against 4 of the QOF indicators. Further analysis at practice level within this PCN showed lower performance in QOF points achievement in a group of practices in this PCN. -HES analysis, standardised per 1,000 diabetic pts, identified some variation in specific markers at PCN level. -The above data provides St Helens Cares with an understanding of where care could be improved within local PCNs. -The Steering Group used the analysis to target one PCN with a pilot PCN Hub-model DSN Clinic and Podiatry Clinic as an action from the project. -It also provides a benchmark to measure the effect of agreed actions.
-Conduct analysis of diabetic outpatient Did Not Attend (DNA) data.	-DNA rates were analysed within the HES analysis. -A DNA rate report spanning several years was acquired from St Helens Hospital. -Qualitative data was obtained from a cohort of clinical/ non-clinical individuals working within the pathway by means of a questionnaire. -Qualitative data was obtained from 2 people living with diabetes in St Helens. -The data acquired was captured in a diagram displaying barriers to attending appointments and options for improving attendance. -The steering group agreed on key findings and interventions as a result of the analysis.
-Conduct a mapping of diabetes pathways and services.	-19 healthcare professionals across Primary Care, Secondary Care and Public Health community services were interviewed to identify barriers within the pathway and make suggestions for improvement. -Following the completion of the data analysis and stakeholder interviews, a pathway map was drafted into Microsoft Visio. This displays the patient journey from diagnosis, and referral pathways into numerous services across primary, secondary and community care (including Public Health). -Barriers within the pathway and accompanying options for improvement were mapped. -A simplified pathway map was created as a product to improve those working within the pathway's understanding of the whole service and how it is navigated. Service contact numbers were added to the pathway.
-Conduct a Diabetes Skills and Knowledge Assessment across Primary Care	- A Skills and Knowledge Questionnaire was drafted by the Diabetes Primary Care Lead and agreed by the steering group. The questionnaire was circulated via Microsoft Forms to staff working with people living with diabetes across primary care. 41 responses were achieved. -Key findings from the questionnaire were agreed by the steering group.

-Produce an options appraisal and a population health analysis infographic.	-A barriers and options appraisal was produced as a result of the pathway interview process. Steering group members reached consensus on which barriers should be the key focuses of the project and created a targeted action plan to make interventions. -The action plan also considered the variation in standards of care reported in the NDA, QOF and HES analysis. -The group followed the same process for each section of the analysis. The consensus was captured in a report.

Pathway Barriers and Options Analysis Actions Consensus:

PATHWAY ANALYSIS BARRIERS AND PROPOSED ACTIONS	
Barrier	**Proposed Actions**
Transport/ accessibility to clinics.	Focusing on Central PCN as per QOF/ NDA/ HES analysis, pilot a PCN-based structured clinic led by DSN Outreach Service and a PCN-based podiatry clinic.
Wait for appointments in secondary care.	Pilot PCN-based Diabetes Outreach Service-led clinics (as above).
Availability of accessible phlebotomy services.	Aim to address with phlebotomy service commissioner.
Capacity/ demand of services.	Explore the role of group consultations to improve service uptake (including Health and Wellbeing, podiatry, structured education etc.). An RAS pilot has started with the view to reduce waiting times. Since starting, 30% of patients are referred with Advice and Guidance.
Lack of Podiatry capacity is a big issue/ skill level of some practice nurses in delivering foot checks.	Two elements to consider: Training of Practice Nurses and clinics. Run a parallel PCN-based podiatry clinic to the proposed DSN clinic in Central PCN. Lead Commissioner has received a proposed job description for an Advanced Clinical Practitioner, which would extend the capability of the service. The Commissioner will share this with the group for review before deciding next steps.
Primary and Secondary Care patient communication/results duplication.	Group to explore utilising Gateway system with local lead.
Clarity among those working within the pathway on what services are available and how to access them.	Create a physical and digital map of the services and how they are accessed/ contact numbers and then distribute for consultation. Final distribution would include all patient touch points in the pathway and social prescribers and locations such as gyms. Action: Consider a card with contacts for various services (QR code): Podiatry, acute, DUK etc.
Communication between services: Difficultly accessing foot/eye screening results PC &SC. And other clinical notes between PC/ SC.	Work with internal team to develop primary care referral management/ referral system. The group are currently developing a best-practice referral form. The relevant information would need to be included before the form could be sent.

Patient uptake of Structured Education.	Project underway to improve suitability and uptake of education by Research Fellow. Action: Group to look at new education specifications and explore if a patient training resource could be housed on a Trust or ICB website.
Accessibility to site of care - transport and time of clinics, parking.	Explore Enhanced Access Clinics in Primary Care (See PCN model pilot). Explore idea of "out of hours" appointments in SC/ Weekend clinics.
Long waiting times.	Continue to monitor the effect of RAS.
Patients not understanding the importance of/reason for referral.	Group to develop basic patient one-pager communicating importance and removing anxiety. Information to be provided in a format and language suitable for the local population.
DNA for young people is 3 in 10.	Manage capacity better by more active management in secondary care.

8.0 Observations and Recommendations

A number of key observations were made, and lessons were learned that would be valuable for other project groups to know if they were to explore a similar project:

- With a relatively short project timescale, and learning from a similar project in Dudley, the group foresaw that it was important to contact stakeholders who would be interviewed as part of the analysis during the mid-stages of the project. The Project Manager from the St Helens Cares commissioning team, and the GP Primary Care Lead set about doing this from week 1. The result was that we were able to complete a satisfactory number of interviews beginning immediately after the data analysis.

- Key local stakeholders were engaged during a PCN Clinical Director's meeting, where the project was presented, and a progress report was delivered. The buy-in gained drove engagement with interviews and will support next steps and actions.

- The methodology used in the data and pathway analysis, and the presentation of barriers and options was well-received by the steering-group. This is transferrable to other similar projects.

- In a similar project, it would be recommended to interview more Practice Nurses who deliver 8 of 9 care processes in Primary Care. This would improve the comprehensiveness of understanding of barriers in delivering this key stage of care.

- It is recommended to include a section in the pathway healthcare professional questionnaire to also understand what is perceived to be working well. This was added mid-way through the interviews.

- It is acknowledged that the PCN-level data analysis process used in the NDA and QOF analysis is useful to identify PCNs which are performing below the Place or ICB averages. The next step in this project was to drill down on the identified PCNs to practice level, which showed that some practices were performing at average or above, and that some were performing lower than average. If a similar project was carried out and the steering group wished to identify all under-performing practices in that locality, then a practice level analysis should not be dictated by PCN overall performance but carried out across the whole locality as standard as some underperforming practices may not be picked up in the analysis used as they could be masked by the high performance of other practices in their respective PCN.

- The final products of the project were produced using a waterfall approach. It is recommended that an agile approach be taken on further projects, producing these products with working drafts throughout the project timeline. This would allow the project to be completed sooner.

- Involving stakeholders from Commissioning, Primary Care and Secondary Care allowed the project to reach more meaningful outcomes. The consensus gained on the key findings and actions is agreed across all settings which will facilitate progress when implementing change.

- The addition of the Diabetes Specialist Nursing team added extra insight to the project and it is recommended that this role be included at the start of future projects.

9.0 Next Steps

- NHS Steering Group stakeholders will share results with key stakeholders (PCN Clinical Directors and St Helens Medical Director) in the locality as part of the action implementation plan.
- A Task and Finish Group will be created and led by the senior commissioner to implement the agreed actions.
- A diabetes patient pathway map with service contact details will be distributed to those working in the locality.
- A static infographic documenting the results of the project will be shared with the locality and will provide a baseline to measure the impact of agreed interventions.