North Merseyside Diabetes Collaborative Working Project between Liverpool, Sefton, and Knowsley Places, and Sanofi

End of Project Evaluation Report

1.0 Project Aim

Liverpool, Sefton, and Knowsley are three place-based partnerships within Cheshire and Merseyside ICS. They share a common goal of improving the population health management and care of people living with diabetes. All three places refer people living with diabetes to NHS University Hospitals of Liverpool Trust (Liverpool, South Sefton PCN (1 of 2 PCNs in Sefton Place), and Knowsley) or Mersey and West Lancashire Teaching Hospitals (Knowsley and Southport and Formby PCN (Southport and Formby PCN is 1 of 2 PCNs in Sefton Place)) for specialist appointments and care. However, the community diabetes models in these three places differ in structure and investment. It is an objective of the NHS Transformation leads to provide an optimum community diabetes service across the three places.

NHS England, Priorities and Operational Planning Guidance for 2023-24 (*contemporary at the time of project conception*) calls on systems to continue to develop their core population health management capabilities and the 25/26 guidance suggests maximising value and delivering against the priorities set out in the 10-year plan. Regular testing and completion of the 8 Care Processes to monitor and manage type 2 diabetes can help to reduce the risk of complications and identify any complications earlier. This is a key population health management measure. If blood glucose, blood pressure, and cholesterol treatment targets were met there would be improvements in health and reductions in healthcare costs. These 3 Treatment Targets are a key measure of care. The ICB wish to improve the rates of these measures and remove variation across settings.

2.0 Project Objectives

The initial objectives of the Collaborative Working Project were:

- Review and compare the community diabetes services in Liverpool (LDP), Sefton, and Knowsley.
- With agreed parameters from the National Diabetes Audit (NDA), Quality Outcomes Framework (QOF), and Hospital Episode Statistics (HES) datasets, conduct a population health analysis of diabetes patients in Liverpool, Sefton, and Knowsley, identifying prevalence, deprivation scores, variation in care and management standards, and interaction with secondary care services.
- Obtain and analyse qualitative data from interviews with clinical stakeholders and service users to review and map the diabetes pathways and services in Liverpool, Sefton, and Knowsley so that barriers and options for improvement can be identified.

- Reach a stakeholder consensus of key findings and proposed actions based on the project analysis findings.
- The consensus may inform decision-making about the future of service composition across this system and the utilisation of funding to make changes to address identified gaps or to target areas in need of re-design/enhancement. Any changes implemented as a result will be out of scope of this specific project.

3.0 Project Outcomes and Benefits

The expected outcomes and benefits of the project were:

Patients

- Improve the pathway for patients to ensure they receive the right care at the right place at the right time.
- More equitable care across places, ensuring patients living with diabetes receive consistent. treatment.
- Reduction in waiting time for patients accessing appropriate treatment.
- Reduce reliance on secondary care for management of diabetes and receive good quality care in the community closer to home.
- Better treatment options for patients with improved outcomes.

NHS

- Evaluation of the performance of community diabetes services in each location against their respective service specifications.
- Evaluate which aspects of diabetic pathways are effective and identify areas requiring additional support.
- Reduce unwarranted variations in care across associated ICB locations.
- Learn from the implementation of a population health management analysis approach for patients with diabetes, enabling the NHS to apply this methodology to other elective care specialties.
- Improve the quality of referrals to specialist services.
- Commission services more effectively and efficiently.

Sanofi

- To add further insight into how Sanofi can support improvement in population health management in other populations.
- An opportunity to learn about the range of educational/training resources that are required by places such as Liverpool, Sefton, and Knowsley to reduce variation in patient management across member practices.
- Improved corporate reputation with the associated places and partner organisations.

- As a result of improved performance against the 8 care processes and 3 treatment targets, some appropriate patients may be prescribed Sanofi products in line with NICE and local guidance.

4.0 Project Implementation

Project Steering Groups were established in each area to agree on a project plan to oversee delivery of the project, consisting of:

Liverpool Place Steering Group:

- Long Term Conditions (LTC) Delivery Manager, Liverpool Place
- Clinical Director, Liverpool University Hospital Foundation Trust (LUHFT)
- Clinical Directors, LUHFT (Aintree & Royal teams)
- Operations Lead/Consultant, LDP
- Business Manager, LDP
- Diabetes Lead, Public Health
- Podiatry Lead, Merseycare
- Diabetes Specialist Practice Nurse, Liverpool Place
- Medicines Management Lead, Liverpool Place
- General Service Manager, Endocrine and Diabetes, Aintree
- Business Intelligence Representative, Cheshire & Merseyside (C&M) ICB
- GP Clinical Lead for LTCs

Sefton Place Steering Group:

- Senior Manager Cancer & Long-Term Conditions, Sefton Place
- Transformation Manager, Long- Term Conditions
- Clinical Lead Academic Consultant Diabetes & Endocrinology, Mersey & West Lancs Teaching Hospital NHS Trust
- GP Lead, Sefton Place LTC & Planned Care
- Primary Care Nurse Lead, Sefton Place
- Clinical Services Manager – Specialist Nursing Services, Mersey Care NHSFT
- Operational Service Manager, Mersey Care NHSFT
- Diabetes Team Leader, Mersey Care NHSFT

Knowsley Place Steering Group:

- Transformation and Partnerships Program Manager, Knowsley Place
- Long-Term Conditions and Inequalities Lead Primary Care, Knowsley Place
- Clinical Director Diabetes Service, Mersey & West Lancs Teaching Hospital NHS Trust
- Business Manager, LDP
- Clinical Lead, Knowsley Community Diabetes Service
- Primary Care Diabetes Specialist Nurse, Knowsley Place

Sanofi Steering Group:

- Lead Project Manager
- Supporting Project Manager
- National Project Support Lead

Weekly meetings of the Project Steering Group were organised for each place to facilitate project delivery. An MS Teams site was established to hold all project documentation and serve as a communication platform. Proposed project plans were presented at the first meetings and agreed on by the members of each 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). As the Liverpool steering group formed and commenced work before the Sefton and Knowsley groups, it was agreed by all Steering groups, that in the interest of progress within project timelines, Liverpool would lead on decision-making on some parts of the process. Project timeline permitting, joint decision-making across the three areas would be applied.

For the Population Health Analysis, the groups agreed on the data sets to be analysed and how they would be presented and standardised. The data sets agreed were:

- Quality Outcomes Framework (2023-24)
- Type 1 and Type 2 Diabetes Mellitus National Diabetes Audit (NDA) (Quarterly Data Publication Jan 2023-Mar 2024)
- Hospital Episode Statistics (2023-24)

Sanofi conducted the data analysis, after agreeing the process to validate and standardise the data with the steering group and the NHS Business Intelligence steering group member. The NHS steering group members agreed on the key findings from the data analysis during their respective steering group meetings.

After the analysis was complete, the three steering groups co-created a Healthcare Professional Pathway Questionnaire, Healthcare Professional Skills and Knowledge Questionnaire, and a Patient Questionnaire.

The Healthcare Professional Pathway Questionnaire was conducted with individuals or in groups across the three places and covered those working with people with diabetes across Primary, Secondary, and Community Care. Barriers within the pathway and options for improvement were captured via interview (held by Sanofi Project Managers) or Microsoft Teams Forms. “What’s working well”, Call and Recall Process, and Exemption Reporting were also captured. The information was plotted against codes in the local Diabetes Pathway diagrams, that had been drafted with the steering groups and recorded into a Barriers and Options Summary. In Liverpool, 39 questionnaires were completed, 26 in Sefton, and 25 in Knowsley.

The Patient Questionnaire was distributed digitally across the three places by various approaches. 1,121 patient questionnaires were received: 247 in Liverpool, 261 in Sefton, and 598 in Knowsley. Insights from the questionnaire were captured in a report that was formed by Microsoft Forms.

The Healthcare Professional Skills and Knowledge Questionnaire was not shared during the project due to the Steering Group focusing their efforts on successfully obtaining satisfactory numbers of

HCP and Patient Questionnaires. The NHS Steering Group members plan to disseminate this after project close as part of their continued work.

All analysis and Barrier and Options Summaries were reviewed by the Steering Groups in respective face-to-face consensus meetings. Consensus was recorded before Static Infographics showing fundamental analysis charts linked to the Barriers and Proposed Actions tables were produced for each Place.

Static infographics, consisting of key analysis and outputs, were co-created by the Steering Groups in each Place.

Key milestones delivered in Implementation of the Project

October 2024

- Project plans were agreed upon to outline and monitor the delivery of the project's aims and objectives.
- The Steering Groups were granted access to Teams sites where the project plan and other relevant documents are stored.
- The Steering Group agreed on the data sets to be analysed and the codes to be included, using best practices from a similar project in St Helens as a starting point.
- An action plan was developed to ensure that pathway barrier and options analysis was conducted within project timelines. This involved identifying interviewees and contacting them to arrange interviews at the earliest opportunity.

November 2024

- A method for standardising population health data was agreed upon between Sanofi and the NHS Business Intelligence stakeholders.
- Population health analysis parameters were agreed upon by the Liverpool Steering Group, to be followed by Sefton and Knowsley.
- Sanofi presented the initial stages of NDA, QOF, and HES data analysis to the Steering Groups.
- The NHS Steering Group members agreed on key findings from the data analysis.
- It was agreed that a Healthcare Professional Diabetes Skills and Knowledge questionnaire would be produced to identify gaps in diabetes skills and knowledge in primary care.
- Community diabetes service specifications were provided to Sanofi by the NHS Steering Group.
- A risk was logged in the plan due to the lack of forthcoming data on Community Diabetes Service KPIs/Outcomes, preventing the commencement of the review in line with the plan.

December 2024

- The final analysis of NDA, QOF, and HES data was presented to the NHS Steering Groups, who reached a consensus on the findings.
- Drafts of a Healthcare Professional Pathway Mapping (HCP) Questionnaire, Healthcare Professional (HCP) Skills & Knowledge Questionnaire, and Patient Questionnaire were co-created by the three Steering Groups. Example questionnaires from St Helens were shared and adopted.
- The NHS Steering Group members began booking Pathway Mapping interviews to start in the new year, focusing on healthcare professionals working across different diabetes services.
- The Service Review Project Stage was postponed due to a lack of data received.
- A two-week pause was taken for the Christmas break and was accounted for in the project timeline.

January 2025

- Three versions of the HCP Pathway Questionnaire were created (Primary Care, Secondary Care, Community Services).
- The HCP Pathway Mapping Questionnaire was tested by clinicians in the Steering Group.
- The three Steering Groups reached a consensus on the final drafts of the HCP Pathway and Patient Questionnaires.
- The Patient Questionnaires were converted to Teams Forms ready for dissemination.
- Draft Diabetes Pathways were created for each Place. Steps in the pathways were coded (e.g. PC-S1 = Primary Care Step 1).
- Pathway interviews commenced with HCPs. Barriers and options for improvements were logged against coded steps in the pathways to signify where barriers occurred. Other information, such as what's working well and call and recall systems, was also recorded.
- The Steering Group continued to pursue Community Diabetes Service KPI and Outcomes data.

February 2025

- Each group acknowledged the challenge of engaging with primary care HCPs for virtual face-to-face interviews and took action to increase the number of booked interviews.
- The HCP Pathway Mapping Questionnaire was converted to a Microsoft Form to support engagement in primary care.
- Sanofi Steering Group members began entering data into the Barriers and Options summary for each Place, coding against steps in the approved Diabetes Pathways.
- The NHS Steering Group members acknowledged that the lack of Community Diabetes Service KPI's and Outcomes data represented a risk to the completion of Stage 2 of the Project and continued to pursue the data.

- Patient Questionnaires were circulated across the three Places via various means.
- Liverpool Place quickly accrued more than 200 patient questionnaire responses, which was deemed a very successful result by the Steering Group. The response from the other two Places wasn't immediate.
- An issue was raised in Project Plans due to a lack of responses to Patient Questionnaires in Sefton and Knowsley. Actions were agreed upon by the Steering Groups.
- The final version of the Skills and Knowledge Questionnaire was agreed upon by the three Steering Groups and converted to a Teams form.
- The groups agreed that the Skills and Knowledge Questionnaire would be a final product of the project but not shared until project close due to current demands on the system and the focus of the Steering Groups on obtaining patient questionnaires and additional HCP pathway questionnaires.
- Consensus meetings were booked in the three Places for March and April.
- It was agreed that there would be two Consensus Meetings for the Liverpool group due to the size and complexity of the area.
- Sefton and Knowsley booked one Consensus meeting for early April.

March 2025

- After extending deadlines and concerted efforts by their respective Steering Groups, Sefton and Knowsley received a satisfactory number of responses from the Patient Questionnaires and HCP Pathway Questionnaires.
- After a concerted effort from each of the NHS Steering Groups:
    - A full set of KPI and Outcomes data for the designated years was obtained from Liverpool Place, and a report was put together by Sanofi Project Managers.
    - A limited set of KPI and Outcomes data for the designated years was obtained from Sefton Place (South Sefton PCN), and a report was put together by Sanofi Project Managers.
    - No data was obtained in time to perform the Knowsley Community Diabetes Service Review ahead of the consensus meetings.
- Due to incomplete data across the three Places, it was agreed that the Community Diabetes Service reviews could be viewed in silo and compared, with limitations, in Liverpool and Sefton. Due to time constraints, Concierge, an AI tool, was used to generate comments. The NHS Steering Group members amended the comments for accuracy.
- To complement the Service Review Data, a comparative Type 2 NDA analysis comparing data between the three Places over four time points was shared with the groups and circulated for comments. Due to time constraints, Concierge, an AI tool, was used to generate comments. The NHS Steering Group members amended the comments for accuracy.

- All project analysis documents were shared with NHS Steering Group members for review ahead of the consensus meetings.
- Liverpool's face-to-face consensus meetings took place on March 21st and March 28th. Patient Questionnaire data and Service Review data were reviewed before the group identified key challenges for the area and key barriers and proposed actions, which were recorded by the Sanofi Project Manager who chaired the meeting.

April 2025

- Final HCP Pathway Questionnaire data was added to the Barrier and Options Summaries in Sefton and Knowsley.
- Successful face-to-face Consensus Meetings were conducted in Sefton and Knowsley.
- Barriers and proposed actions were agreed with the Sefton and Knowsley Steering Groups.
- Static infographic content was agreed by the Steering Groups in all 3 Places.
- The Liverpool Steering Group discussed intentions of sharing findings with the ICB and agreed on a May date.
- A draft Final Report was produced and handed over to NHS Steering Group Members for finalisation.

May 2025

- After several circulations, the final draft of the Final Report was agreed among the 3 Steering Groups.
- Final products would be handed over after approval and certification from Cheshire and Merseyside ICB and Sanofi.
- Final Steering Group Meetings took place and the project was closed.

5.0 Outcomes and Benefits Achieved

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

Objective	Outcomes	Benefits
Review the community diabetes services in Liverpool (LDP), Sefton and Knowsley.	• Obtaining Activity Key Performance Indicators and Outcome Measures was challenging for each Steering Group, requiring concerted efforts in each case. • The lack of forthcoming data made the comparative analysis outlined in the project plan impossible. It was agreed to produce individual reports for Liverpool and Sefton and compare them where possible. A more comprehensive data set was provided for Liverpool. No data was received for the Knowsley Service. • The AI tool, Concierge, provided initial commentary on the analysis, which the Steering Group reviewed and amended for accuracy. • The NHS Steering Group amended the AI commentary for accuracy and to reflect opinion on findings. • A comparative T2D NDA analysis was also produced for the years 2017-18, 2021-22, 2022-23, and 2023-24 (2017/18 was chosen as one-year post-LDP service development, pre-pandemic, during the pandemic, pandemic recovery, and later). • The comparative NDA analysis showed pandemic recovery for each Place and benchmarked against ICB and national averages.	• In Liverpool and Sefton, the KPI/ Outcome reports gave insight into Service Delivery over the given time-points. • The comparative NDA analysis complemented the Population Health Analysis Project Stage and identified areas of variation in the 8 Care Processes and 3 Treatment Targets for each Place. • This analysis informed decision-making in the final consensus meeting. • An Executive Summary for each analysis was created which captured the key points and contributed to the decision making for the Barriers and Proposed Actions summary. • The project has created a platform for the Steering Group members to obtain regular service KPI data moving forwards. • Efforts to obtain Activity Key Performance Indicators and Outcome Measures, despite challenges, can lead to better tracking of diabetes management and outcomes. This can help identify areas needing improvement and ensure resources are allocated effectively.

		• Producing individual reports for Liverpool and Sefton allows for tailored insights and comparisons. With a more comprehensive data set for Liverpool, targeted interventions can be designed to address specific needs of the diabetic population in the area. • The use of AI tools like Concierge for initial commentary and analysis can streamline data interpretation and provide accurate insights. This can enhance decision-making and strategy development for diabetes care. • The comparative T2D NDA analysis across different years provides a clear picture of pandemic recovery and benchmarks against ICB and national averages. This helps in understanding the impact of various interventions and adjusting strategies accordingly • The analysis of pandemic recovery for each Place, benchmarked against ICB and national averages, offers valuable insights into how diabetes care has evolved post-pandemic. This can guide future planning and resource allocation to ensure continued improvement in diabetes management.

Objective	**Outcomes**	**Benefits**

With agreed parameters from the National Diabetes Audit (NDA), Quality Outcomes Framework (QOF) and Hospital Episode Statistics (HES) datasets, conduct a population health analysis of diabetic patients in Liverpool, Sefton and Knowsley, identifying prevalence, deprivation scores, variation in care and management standards, and interaction with secondary care services.	• In all cases, to clearly identify variation, Place analysis was benchmarked against ICB and National Averages. PCN and Practice analysis was benchmarked against Place, ICB and National averages. • Method of analysis, including standardisation, was agreed by the Steering Group, including a member of the ICB Business Intelligence Team. • A National Diabetes Audit (NDA) analysis focused on the delivery of the Three Treatment Targets and Eight Care Processes for Type 1 and Type 2 Diabetes at PCN level for each Place. • Diabetes prevalence rates, list sizes, and deprivation scores were reported at PCN level for each Place. A practice level analysis was produced in a select few PCNs as requested by Liverpool. • A QOF analysis of diabetes indicators was performed at PCN level. • (QOF) Variation in Personalised Care Adjustment (PCA) rates in certain PCNs and Practices were of interest across the three Steering Groups. Consequently, a question was added to the HCP Pathway Questionnaire and Skills and Knowledge Questionnaires to gather insight into reasons for this variation. • HES analysis identified variations in inpatient and outpatient referrals at PCN level.	• In all cases, Place analysis was benchmarked against ICB and National Averages, while PCN and Practice analysis was benchmarked against Place, ICB, and National averages. This helps clearly identify variations and areas needing improvement. • The method of analysis, including standardisation, was agreed by the Steering Group, including a member of the ICB Business Intelligence Team. This ensures consistency and reliability in the data. • A National Diabetes Audit (NDA) analysis focused on the delivery of the 3 Treatment Targets and 8 Care Processes for Type 1 and Type 2 Diabetes at PCN level for each Place. This provides detailed insights into diabetes care delivery. • Diabetes prevalence rates, list sizes, and deprivation scores were reported at PCN level for each Place. A practice level analysis was produced in select PCNs as requested by Liverpool. This helps understand the demographic and socio-economic factors affecting diabetes care. • A QOF analysis of diabetes indicators was performed at PCN level. This helps track performance against national standards and identify areas for improvement. • Variation in Personalised Care Adjustment (PCA) rates in certain PCNs and Practices were of interest across the three Steering Groups. Consequently, a question was added to the HCP Pathway Questionnaire and Skills and Knowledge Questionnaires to gather insight into reasons for this variation. This helps understand the reasons behind different care adjustments.

		• HES analysis identified variations in inpatient and outpatient referrals at PCN level. This helps track healthcare utilisation and identify areas needing attention. • Insight into performance variation across PCNs and practices will help to target interventions for improvement. • The observations from the data analysis help the Steering Groups focus on specific areas needing improvement. These observations have been used for short-term interventions and will inform long-term strategic planning. • In Liverpool, observations from the NDA data analysis helped the LDP Community Service focus on specific areas needing improvement. Certain practices were identified where the team could support improvements in the delivery of the Eight Care Processes and attainment of the Three Treatment Targets. These observations will be used for short-term interventions and could inform long-term strategic planning. • In Liverpool, the QOF analysis triggered immediate interventions concerning PCA rates with several practices. • In Knowsley, it was flagged that a plan should be made to improve the rates of Urine Albumin testing, Cholesterol measuring, and Foot Checks. • Sefton highlighted care processes which require additional action from the patient -such as providing a urine or blood sample- were more challenged in performance. The Steering Group suggest a Hub model may improve outcomes around this.

		• This analysis will compliment local JSNA which is being developed around diabetes management in Knowsley. • Some proposed actions in the Barriers and Proposed Actions Summary may utilise this analysis for targeted interventions
Objective	**Outcomes**	**Benefits**
Obtain and analyse qualitative data from interviews with clinical stakeholders to review and map the diabetes pathways and services in Liverpool, Sefton and Knowsley so that barriers and options for	• Three HCP questionnaires were co-created by the NHS Steering Group members (one for Primary Care, one for Secondary Care, and one for Community Services). • Data was obtained from HCPs working within the pathway in Community Services (including Podiatry and Public Health), Primary Care, Community Diabetes Services, and Secondary Care.	• The Steering Groups met face-to-face to reach a consensus on key barriers and proposed actions. This was a crucial step in formulating the project's end products: a Barriers and Proposed Action Report and a Static Infographic. • The HCP Questionnaires remain as an asset on Microsoft Forms and may be edited and utilised across the ICB to gather further information.

improvement can be identified. **A: HCP Pathway Questionnaire**	• A total of 90 completed questionnaires were obtained (Liverpool: 39, Sefton: 26, Knowsley: 25). • Some information was gathered during group interviews. • Initially, qualitative data was gathered via remote interviews conducted by Sanofi Steering Group members. • Engaging with Primary Care proved challenging across all three places, so the questionnaire was converted to a digital Microsoft Form and distributed electronically across Primary Care. • Data captured included barriers, options for improvement, what's working well, call and recall, DNA, management of staff challenges (absence, vacancies, etc.), and QOF exemption reporting approach. • Diabetes Pathway Maps were co-created for each Place by the respective Steering Groups using Microsoft Visio. Defined steps in the pathways were given codes. • For each Place, the qualitative data from the questionnaires was assigned the appropriate code in the Diabetes Pathway maps to signify where that information applied and entered into an Excel spreadsheet, forming a Barriers and Options Report.	• The collaborative working project approach to obtaining questionnaire responses has seen a large uptake of user feedback to support the overall aims and objectives of the program.
Objective	**Outcomes**	**Benefits**

B: Patient Questionnaire	• A patient questionnaire was co-created by the three Steering Groups. • The patient questionnaire was converted to a Microsoft Form. • The questionnaire was distributed via various means, including SMS via EMIS, waiting room posters with QR codes, websites, and via Health Watch. • A total of 1,120 responses were received (Liverpool: 247, Sefton: 260, Knowsley: 598).	• The Patient Questionnaire informed the final Barriers and Proposed Actions Report. • Engagement with patient education and the need for more emotional support were identified as areas requiring further investigation and development. • The approach to the Patient Questionnaire may form the opportunity for a publication with the objective of sharing best practice. • The Patient Questionnaire remains as an asset on Microsoft Forms and may be edited and utilized across the ICB to gather further patient information.
Objective	**Outcomes**	**Benefits**
C: Skills and Knowledge Questionnaire	• A Diabetes Skills and Knowledge Questionnaire was co-created by the three Steering Groups. • Due to the challenges with engagement with Primary Care in obtaining interviews and responses to Pathway Mapping Questionnaires and Patient Questionnaires, it was decided that further engagement during the project's remaining timeframe was not advisable. • Consequently, the Steering Groups agreed to distribute the Skills and Knowledge Questionnaire after the project had closed as part of their ongoing strategic plan.	• The Steering Committee implementing the Project recommendations plan to use the Skills and Knowledge Questionnaire post-project to identify training and education needs for patient-facing HCPs in Primary Care. This could drive further improvements in diabetes care in Primary Care and remove pressure from Specialist Services. Upskilling of HCPs working in Primary Care also supports the attainment of QOF outcomes.
Objective	**Outcomes**	**Benefits**

Produce a Barriers and Proposed Actions Report and a Project Static Infographic	• The project aims and all the analyses listed above were reviewed and considered before the groups agreed on Key Challenges. • Barriers and options associated with these Key Challenges were extracted from the Pathway Barriers and Options Summary Analysis and formed the Barriers and Proposed Actions Report, which was co-created by the Steering Groups.	• Key analyses, alongside the Barriers and Proposed Actions, were used to create a static infographic. • The report and infographic will be utilised by diabetes leaders to support local diabetes benchmarking and strategic planning and implementation.

6.0 Pathway Barriers and Options Analysis Actions Consensus:

The tables below outline challenges and barriers identified within each place and the proposed actions to address these.

LIVERPOOL

Challenge	Barrier	Proposed Actions
Improve Attainment of Treatment Targets	Innappropriate referrals to MDT clinics + Criteria	Produce and implement consitent referral criteria to LDP
		Both hospitals and LDP to be able to redirect between services (inter team referal / education of service)
	Clinician not receiving weight/ height/ blood pressure in clinic	Consistent HCA support in each clinic (One Stop Shop Approach) *Jan FR to add vacanies to Trac approved by Hassan*
	Practices not engaging with LDP	consistant engagement approch needed
	Service barriers	Review LDP service specification with reference to reference to contract duration (2016)
	Patient engagement with services	Targeted approach to pts out of target within certain threshold in Primary Care (No access to pt data to target out of range pts) *use of CIPHA?*
		Review quality aspects of contract and look to identify pts use of CIPHA?
		Target HBA1C management
		Improve HBA1C management with SGLT2 for CVD protection.
	On-site rx/ing capability of LDP/Pt attending 1hr insulin start clinics without bringing insulin	JFR has fixed this and is now possible- pt can collect rx and start treatment on the day
		Every rx/er in LDP should recieve repeated reminders until refresher training on on-site rx/ing in next 6 weeks
	Rejection of referrals to LDP	Review of referral and care plan to be provided to Primary Care prior to discharge.

Challenge	Barrier	Proposed Actions
Diabetes Service Suitability	Location of clinics (inc education)	Review specification and contract suitability, due to age, across LDP and acute. Review criteria for referral to A+E and Community Diabetes Services.
	CGM- (thoughts on including digital tech in service spec)	
	Phone clinics appointments don't have appointment slots/time	
	On-Call taking up case load visit time	
	Structure of clinics	One-Stop MDT Diabetes Clinics in LDP
	IT Systems and Equipment (DSNs and PCs in clinics)	JFR following up laptops for DSNs
		Escalate issue of PCs in clinics- GR to assist
	Difficulty accessing service data to monitor against service Some KPI reporting is not picking up all activity specification	Agree across the 3 Places on what data will be gathered and how
		Ensure KPI reporting uptakes all activity data inc. all iterations of EMIS (e.g.currently missing Practice Based Clinics)
		Add the above to the BI reporting reporting schedule

Challenge	Barrier	Proposed Actions
Improve Education Uptake (Low uptake of Structured Education (referrals to attendace ratio/ pt voice of awareness)	Low uptake of Structured Education (referrals to attendace ratio/ pt voice of awareness)	Implement Quick Wins
		Assess current education service relevance
		Form a steering group for primary care and structured education
	Branding of education deemed unsuitable by steering group	Re-brand/ Re-name
	Timing of education offer at diagnosis and also ppost diagnosis	Offer education "when pt is ready" and more often every year at review
		Create pt self-referral process
		Digital - offer more online and digital optons as well as f2f
		Provide one-off sessions with follow-ups.
	Low patient awareness of diabetes education offer (Post-diagnosis)	Improve and raise awareness
		Include "My Diabetes My Way" resources in clinic letters.
		Encourage primary care referrals to education.
		Utilise LDP Facebook for engagement.

Challenge	Barrier	Proposed Actions
Improve emotional support resource in Primary Care in line with "need" reflected in pt Q	Lack of emotional support resource in Primary Care in contrast to "need" reflected in pt Q	Consider wider stakeholder meeting including pt group to understand what is needed/ possible. (E.g. providing diabetes-specific support). (Could be delivered by PN). (involve Mark Griffith).
		Address gaps in diabetes-specific and general support.
		Consider creation of Steering Group to follow-up
		Patient Support Group *like Xpert Patient*

Challenge	Barrier	Proposed Actions
OTHERS	Podiatry team cannot prescribe antibiotics - home visits in particular is a problem	This is possible. Re-train podiatry staff. Check PGD and Fridges wth Merseycare (Gemma Cartledge)
	Urine Samples challenge	DUK- handover analysis to DUK for action
	Variation in care processes between PCNs and Practices	Levelling up of care processes between practices and PCNs
		Link and train ARRS staff in primary care.
	Language and Cultural Barriers	Produce materials in top 8 spoken languages
		Increase staff awareness about resources available
	Low foot care attainment in care processes (ulcers increased)	Steering group of clinical leads to agree way forwards on barriers raised in review
		Training of staff

SEFTON

Challenge	Barrier	Proposed Actions
Improve 8 Care Process attainment overall and improve North South Variation	Local Primary Care incentive for 8 CP completion is due to expire	Implement new ICB performance assurance metric around achievement of care processes
	Housebound patients access to care	Create focus group to review post project
	Inequity of access for patients	Review NDA practice level data for variation and adopt a targetted approach
		Deploy Skills & Knowledge questionnaire post project
	Duration of diabetic review	Use Neighbourhood/ Practice HUB MDT model insights strategically
	Capacity in primary care	
	Collecting Urine samples from patients	Standardise a Best Practice approach
	Low completion of foot surveillance	Deploy Skills & Knowledge questionnaire post project
		Standardise a Best Practice approach
	Phlebotomy Services access	Understand current phelobotmy access performance
		Communication of importance of bloods to patients

Challenge	Barrier	Proposed Actions
Improve attainment of Treatment Targets	Variation in Primary Care of injectable starts	Deploy Skills & Knowledge questionnaire post project Education and upskill of generalist workforce
	Pan Mersey Formulary list injectables as Amber start and stabilization	
	Skill level of Practices Nurses (gaps with regards to injectables knowledge)	
	Variation in metobolic Management	Type 2 management guide to be launched in Primary Care

Challenge	Barrier	Proposed Actions
Address challenges within the Community Diabetes Team	Service Specification may be outdated to no recent review	Review service specification and assure it is fit for purpose
	Referral quality into community diabetes team	Implementation of new T2D C&M PW and patient management before referring including risk stratification and triage
		Merseycare have ongoing review of current patients on caseload, with view to discharge
		Consider different models of working
	Location of clinics / cost of travel to appointments /parking	Local hub model
		Consider if F2F appointment is needed / Can advice and guidance suffice?
	Decline in discharge rate	Investigate why
	Patients having more time with specialist nursing team	
	Capacity of specilaist community team	Review referral & discharge criteria (standardise across N&S Sefton)
		Upskilling of specialist team - increase skill set mix
		Group start clinics
		Diabetes portal
		Explore a standardised approach to advice & guidance given

Challenge	Barrier	Proposed Actions
Improve patient engagement & support	Lack of emotional support for patients	Embed Talking Therapies offer in pathways
		Improve peer support offering
	Uptake of education around self management	Improve digital offering
		Group education
		Link in with SCN around review of Structured Education offer across Cheshire and Merseyside
	Patient DNA across services	Collaborative approach across all LTC's
		Consider is F2F needed - can advice & guidance suffice?
		Refine Communication Strategy
		MDT across pathways (Public Health, Podiatry Specialist Care)

Challenge	Barrier	Proposed Actions
Others	Overly complex insulin requirements for patients requiring assistance from District Nurses and Carers with injecting	More proactive HbA1c and follow up to support stabilisation of diabetes
		More realistice insulin regimes with regards to resources available to support
		Improve reviews upon discharge
		MDT ahead of insulin regimine start
		Self administration of insulin in hospital setting
		Implement new guidance, which supports this
	Podiatry reports not always accessible between secondary care and community team	Improve communication between community & secondary care podiatry (IT)
	Lack of admin support in podiatry team	Increase admin support for podiatry
	Patients in mental health beds access to care	Diabetes management plan
		Link to specialist team for support (virtual/phone)
		Education of mental health team re diabetes
		Could there be a Pan Mersey helpline for this?

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Challenge	Barrier	Proposed Actions
Improve 8 Care Processes	Clinical Inertia	Pt to have access to a clinical decision maker in timely manner
		Utilise Skills and Knowledge Questionnaire to identify gaps
		Utilise interface teams in most effective manner
	Lack of incentive in Primary Care to perform 8 CPs	Add incentive into GP contract
	Local quality incentice scheme (LQIS)	This is now in place and supports any interventions in PC
	8 CP may not be being picked up if done by staff other than practice staff	These can be pulled from ICE report- communicate this with staff
		Focus on identifying practices doing well/ not so well. Share best practice.
	Lack of HCA support in Primary Care (Liverpool CPs have benefited from this)	LDP HCAs to support Knowsley Place
		Improve data collection from other sources
		LDPS/KDS review HCA support and applied short term to Knowsley
		Practice nurse prescriber-review this given volume of patients within PCN
		Creation of task and finish group to implement actions
	Structure and process of call and recall	Review effective processes across practices and standardise
	Duration of appointment	Utilisation of Kiosks
		Utilisation of HCAs for pts who are within targets
		SOP
	Urine, Foot, Cholesterol	Foot check training for all practices to be offered by LDP
		Train HCAs in Practice to do foot checks
		Input of LDP HCAs

Challenge	Barrier	Proposed Actions
Address Community Diabetes Service Challenges	Innappropriate referrals	SOP around diagnosis and referral onwards
	Difficulty accessing service data to monitor against service specification	Agree across the 3 Places on what data will be gathered and how
		Add the above to the BI reporting schedule
	Pts not being discharged from Diabetes Care Partnership at same rate as Liverpool	Improve education for clinicians in Primary Care
		Have a commissioned service that is assess and treat with defined programs of care
	Capacity: Staff Numbers vs Caseload	Advice and guidance for some patients
		Create referral and discharge criteria for the service
		Education of Practice Nurses and GPs to reduce number of referrals.
	Less engagement in Primary Care from community DSN team since Diabetes Care Partnership takeover (practice-based clinics)	To ensure all PCN's and partners form part of the newly establish Diabetes Steering Group
	Inconcistency in access to pt blood tests (ICE system) when Diabetes Care Partnership conultants doing community clinics	To scope out the realtionship between local Phlabotomy services and how this can be supported as part of the current phlabotomy pathway

Challenge	Barrier	Proposed Actions
Engagement and uptake of education	Low uptake of Structured Education (referrals to attendace ratio/ pt voice of awareness)	To prioritise this area of work as part of the Steering group, with support from PCN's, and local partners
	Awareness of education referral pathways	SOP around diagnosis and referral onwards

Challenge	Barrier	Proposed Actions
Improve peer support options	Low report of engagement with peer support groups in patient questionnaire	Link in with education sessions

Challenge	Barrier	Proposed Actions
Other	Gap in knowledge of DN team around new tech	Training being organised
	Insulin rx choice affecting DN capacity	Offer of training to DN team from LDP
	Gap in knowledge of DN team around new tech	
	Travel challenges for secondary care appointments	To review this on an individual patient level
	Waiting times for secondary care appointments	This will need to be reviewed to understand what Patients are presenting with and how this differs and/or could have been supported within a community setting

7.0 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 pathway transformation:

Baseline Data for Service Measurement, Comparison and Standardisation
This review provides a baseline set of data which could be used to compare the changes to key performance indicators over time and also aid the comparison between different services. In the longer term this would help to standardise the community diabetes services across all areas of the region.

Collaborative working approach
The collaborative working project which has been undertaken clearly highlights and demonstrates the effectiveness of systems working together, and, especially for the ICB, how this approach can further be developed wider across the footprint. This will lend itself to strengthening existing partnership working when a number of systems have individually commissioned the same or similar service.

Opportunities to share good practice
Several areas of good practice have been highlighted across the three community diabetes services. The local steering groups for each service can compare the data available, to implement service changes, learning from the positive experience of other services. Improving the provision of diabetes education to patients, upskilling of practice-based staff by specialist community teams & support provided to care homes with regards to diabetes management are some examples of this.

Comprehensive stakeholder feedback
This review has been successful in gathering valuable feedback about the services from a variety of sources including patients, primary care teams, community services & secondary care teams. Also, a wide mix of clinical multidisciplinary team members have provided feedback & suggestions. This gives the opportunity to comprehensively review all aspects of the service and change the services accordingly to improve patient care & experience and provide the best support to MDT teams to perform their duties.

Collaborative learning
The project built on learning from a similar collaborative working project in St Helens Place, in the same ICB. The project method, sample questionnaires, and observations around engaging with more Healthcare Professionals, in particular Practice Nurses, were useful to planning and outcomes, and could be adopted and further developed across the rest of the Places within Cheshire and Merseyside ICB.

Adaptation of questionnaire approach
Due to time pressures in Primary Care, the initial approach to the Healthcare Professional Pathway Mapping Questionnaire was adapted to include a digital version. Some HCPs who did not have time for a virtual interview were happy to fill in a digital form. This increased the number of overall responders. More context and richness of information can be gathered from face-to-face interviews; however, the group recommends using both approaches (face-to-face and digital) in future projects to obtain the maximum number of responders.

Patient questionnaire distribution
Through concerted efforts, the three Steering Groups had obtained 1,121 patient questionnaires at the time of writing this report. Deadlines were extended in Sefton and Knowsley as the Steering Group members tried different approaches before responses began to register. It has been suggested that this section of the project be published to share the methods utilised by the Steering Group and answers provided by people living with diabetes. This should be discussed by the Project Implementation Steering Group.

Stakeholder involvement
Involving stakeholders from Commissioning, Primary Care, Secondary Care, and Community Diabetes Services 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.

Methodology and presentation
The methodology used in the project, and the presentation of analysis, was well-received by the steering group. This is transferrable to other similar projects and may also form a publication.

Inclusion of amputation and ketoacidosis Rates
Future projects should include metrics around avoidable diabetes complications such as diabetes related amputation data. Patients who are more controlled are less likely to undergo these types of procedures. In another project, the HES analysis could be designed to include this data as well as Diabetic Ketoacidosis (DKA) admission rates. Other relevant metrics should be discussed at the onset of a similar project.

Financial envelope observation
One significant limitation encountered during the project was the inability to obtain the financial envelope for the three places regarding their expenditure on diabetes care. This lack of financial data prevented the project from accurately estimating potential cost savings that could result from the proposed interventions and improvements. It also prevented a comparison of funding per diabetic population across each community diabetes services. One barrier to obtaining this information could have been the willingness to share with the Steering Groups due to the involvement of an industry 3rd party. Future projects should prioritise obtaining comprehensive financial data to enable a more robust analysis of cost-effectiveness and potential savings. It should be set out in the Project Plan, upon initiation, how the industry—involvement barrier mentioned can be mitigated. Differing contracting mechanisms can also present barriers to transparency on service costs.

Additional limitations

1. **Community Diabetes Service Data Completeness**: The project faced challenges in obtaining complete data sets for all three places, particularly for Knowsley and North Sefton. This limited the ability to perform a comprehensive comparative analysis across all locations.
2. **Engagement challenges**: Engaging with primary care providers proved difficult, impacting the quantity and quality of data collected from this sector. Great efforts were made across several months to obtain this data, and, ultimately, the Steering Groups were satisfied with the amount of

data received. An observation is that the engagement with Primary Care may have been impeded by the timing, which coincided with the end of the QOF year.

In Sefton, engagement with HCPs working within the diabetes pathway was more challenging in some instances. Sefton Place may benefit by establishing more connected networks as are in Place in Liverpool and Knowsley.

3. **Time constraints**: The project timeline of 6 months limited the depth of analysis and the ability to implement certain methodologies. However, the relatively short time-period did drive the Steering Groups to work through the project plan with productive intensity. Working within tight time constraints, the project successfully met most objectives through focused collaboration and effective prioritisation.

NHS RightCare Best Practice

The NHS RightCare Pathway for Diabetes outlines several key areas of focus and recommendations that align with the observations and recommendations from this project:

1. **Structured Education Programmes:** Addressing barriers to attendance at structured education programmes for diabetes care, which remains a significant challenge.

2. **Multidisciplinary Teams:** Promoting integrated multidisciplinary teams to support patient activation, individual behaviour change, self-management, and shared decision-making.

3. **Amputation Prevention:** Implementing protocols for major amputations and ensuring access to multidisciplinary clinics to reduce the incidence of diabetes-related amputations.

4. **Financial Analysis:** Prioritising the collection of comprehensive financial data to enable robust analysis of cost-effectiveness and potential savings from diabetes care interventions.

These perspectives from the NHS RightCare Pathway reinforce the importance of early intervention, structured education, multidisciplinary approaches, and comprehensive financial analysis in improving diabetes care outcomes[1].

Patient involvement

The NHS mandates patient involvement in service design through three key documents:
1. **NHS Long Term Plan** - 'shared responsibility for health' [2]
2. **NHS Constitution** - Guarantees patient right to involvement[3]
3. **NHS England's Patient and Public Participation Policy** - Makes patient involvement mandatory[4]

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[1] **[1]** NHS RightCare Pathway: Diabetes - NHS England **[2]** NHS RightCare Pathway: Diabetes: The Magnificent Seven **[3]** NHS England releases diabetes pathway - The Diabetes Times

[2] **NHS Long Term Plan (2019)** - Chapter 1, 1.38, pg25.
[3] NHS Constitution - Section 3a "Working in Partnership with Patients"
[4] NHS England Patient and Public Participation Policy (2017)

NHS England's framework provides detailed guidance.

8.0 Next steps

Steering groups will be formed to implement the project's proposed actions. The project will be presented to Transformation and Partnerships Directors, Place Directors, and Cheshire and Merseyside ICB as part of the implementation plan. A static infographic documenting the results of the project will be shared with the locality and stand as a benchmark to measure the effectiveness of agreed interventions.