Final Project Report

A Collaborative working project between NHS Devon ICB & Sanofi to review the diabetes pathway using a population health management approach in Plymouth

1.0 Project Aims

The collaborative working project aims to identify areas for improvement in services, pathways, and care standards that could inform optimal use of resource.

To deliver the project objective the Project Manager (Rhian Edwards & with support from Adam Brown) and Project Support Manager (Martin Cassidy) from Sanofi worked alongside the Project Steering Group to deliver on the objectives of the project.

The Project Steering Group consisted of the following organisations Primary Care, University Hospitals Plymouth (UHP) NHS trust, Public Health Plymouth & NHS Devon ICB:

Ginny Snaith, Director Population Health, NHS Devon ICB
Nicola Jones, Head of Locality Commissioning, Plymouth Locality, NHS Devon ICB
Dr Patrick English, Consultant Diabetologist, University Hospitals Plymouth
Peter Kelly, Diabetes Nurse Consultant, University Hospitals Plymouth
Dr Amanda Harry, GP West Hoe Surgery, Clinical Director Waterside Health Network
Zoe Hope, Practice Nurse, Southway Surgery
Ruth Harrell, Director of Public Health, Plymouth (until end November 2024)
Siobhan Cambridge, Head of Outcomes & Prevention, NHS Devon ICB
Teresa Cullip, Public Health Consultant Plymouth (From December2024)

2.0 Project Objectives

The project objectives were:

- Analysis of the quantitative data for the outcome measures benchmarking for locality, Primary care Network (PCN) & practice to identify variation
- Gathering insight to barriers that may be causing variation from the standards through qualitative interviews with stakeholders across the diabetes pathway.
- Develop an updated visual map of the diabetes pathway.
- Develop an options appraisal that will help inform decision making, direct appropriate resource to address identified gaps or to target areas in need of re-design/enhancement.

The outputs of this project will be used to:

- Evidence to the ICB the health inequalities across the diabetes pathway through an updated pathway map of services.
- Identify areas of variation in outcomes across the PCNs
- Develop options appraisal to support the development of integrated care across acute, community and primary care-based services.
- Develop an action plan to implement agreed recommendations

3.0 Project outcomes and benefits

The expected outcomes and benefits of the projects were as follows. The collaborative working project will deliver the following benefits for Patients, the NHS and Sanofi:

Patients

During the project period, existing patient services and pathways will remain un-altered. Whilst the project itself will not directly improve patient outcomes, the analysis conducted will identify possible ways to improve the pathway for patients to ensure they receive the right care at the right place at the right time. Which;

- May result in better treatment options for patients which may improve outcomes
- May result in reduction in waiting times for patients accessing appropriate treatment
- May improve equity of care & access to services for patients

NHS

This project aims to identify potential for change, ensuring the system works for patients, helping professionals to provide seamless value for money services.

- Identifying potential for change through review of diabetic pathways to target support
- Identifying 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 Plymouth & Western locality to reduce variation in patient management across member practices
- Enhanced corporate reputation with Devon ICB, University Hospital Plymouth NHS Trust 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 Progress against Project Objectives

A summary of the key outcomes in relation to the objectives of the project are shown in the table below:

Analysis of the quantitative data for the outcome measures benchmarking for locality, PCN & practice to identify variation	
Analysis of Quality & Outcomes Framework	A detailed analysis was undertaken at PCN and GP practice level. This identified the following findings and agreed actions: 1.The diabetes prevalence in Plymouth varies across Primary Care Networks (PCNs), ranging from 7.15% to 9.56% suggesting potential differences in population demographics, risk factors, or diagnostic practices 2.Personalised Care Adjustment (PCA) rates vary across PCNs, ranging from 13.60% to 20.56% indicating differences in patient engagement, care accessibility, or recording practices - Investigate reasons for high PCA rates in some PCNs. Develop strategies to reduce barriers to care and improve patient engagement. 3.Focus on improving HbA1c control (DM020 and DM021 indicators), especially in PCNs with lower achievement rates.
Analysis of National Diabetes Audit	A detailed analysis was undertaken at PCN and GP practice level. This identified the following findings and agreed actions: 1.Blood tests (HbA1c, BP, Cholesterol, Serum Creatinine) consistently have the highest completion rates across practices. This might be due to these tests being routine and easily performed during regular check-ups. 2.Urine Albumin testing stands out as the care process with the lowest completion rates and highest variability. This suggests a systemic issue that needs addressing across most practices. 3.Foot Surveillance shows the second-lowest average completion rate, indicating another area for potential improvement across the board. 4.A practice was identified that consistently performs at or near the top for all care processes, suggesting they may have best practices that could be shared with other practices. 5.Some practices, appear multiple times as achieving lower percentages of attainment, indicating they may need additional support across multiple care processes. 6.The Western Average is above 90% for 5 out of 8 care processes, showing generally good performance overall. However, there's significant room for improvement in Urine Albumin testing and Foot Surveillance.
Analysis of Hospital Episode Statistics	The analysis of hospital episode statistics found that: 1.Inpatient admissions in 2 PCNs are higher than average admission rates for diabetes primary diagnosis & this correlated with the cost of admission being higher in the same 2 PCNs, however this is consistent with the national & ICB benchmarks 2.One PCN is identified as having notably high rate of hypoglycaemia admissions (21.38 per 1000 diabetic patients vs. 12.67 Western Collaborative average)

	3.Outpatient waiting times have fallen significantly since the introduction of the community diabetes service where DSNs & consultants support clinics in primary care 4.DNA rates are lower than national & ICB averages; however, in this locality the highest outpatient DNA cost correlates with the 4 PCNs with IMD most deprived.
Development of Infographic	The development of the infographic was based on aligning the qualitative & quantitative data across several steering group meetings. A face-to-face workshop held in Plymouth on 24th February focused on the story board for the key information to be included in the infographic. The discussion centred around what outcomes were desired to be achieved by identifying the gap, the benefits of addressing the gap & the call to action. The key priorities identified were patients with high HBA1c & patients with no hba1c recorded in the last 12 months, with a waterfall graph representing the practices in the locality & an approximate total number of patients this is likely to represent. The benefits of addressing this are referenced in both clinical outcome measures & benefit to the system. The infographic is designed to speak to both clinicians & commissioners to act. The key information was then sent to an agency to design the infographic as indicted in the PID. The final infographic was agreed by the steering group & certified by Sanofi for distribution by the NHS.
Gathering insight to barriers that may be causing variation from the standards through qualitative interviews with stakeholders across the diabetes pathway.	
Qualitative Interviews	The steering group formulated a set of questions to create a structured interview process based on the data analysis. The questions we designed to provide greater insight on the data reviewed, including how the 8 care processes were delivered, how practices managed recall & review and how the 3 treatment targets were met. Each of the steering group contributed to making introductions to the stakeholders of the diabetes pathway for Sanofi personnel to independently conduct the interview process. Qualitative interviews commenced on 9th December 2024 & ran until 12th February 2025. A total of 20 interviews across the stakeholders of diabetes pathway including practice nurses, GPs, DSNs, Podiatrists, pharmacists, consultants & business managers. Analysis of the pathway was broken down into areas pre-diagnosis, diagnosis, initial care, ongoing care, primary/secondary care interface & specialist care. An artificial intelligence program was used to categorise the responses by stakeholder group & by area of the pathway. This analysis was reviewed by the steering group alongside the pathway map to produce a template for potential improvement opportunities along the pathway. In addition to the pathway map the steering group requested some information to look at what was driving achievement of the 8 care processes. A capacity & capability survey was developed to be shared with 6 identified practices. the response rate was 5/6 giving further depth to the understanding of delivery of primary care diabetes services.
Development of Visio Pathway map	
	The qualitative information was used to plot the current pathway in Microsoft Visio, with information from the interviews being used to identify areas where there could be potential improvement

	opportunities. A heat map was developed as an overlay to the pathway to plot potential barriers to patient care. The pathway map produced was reviewed by the steering group, who refined & simplified the information to an easy read format which could be used & distributed as the standard pathway across the locality. The pathway map was certified by Sanofi as an output of the project for distribution by the NHS.
Options Appraisal	
	At each stage of the project consensus was agreed by the steering group for the key insights from the quantitative & qualitative data analysis & these were collated into a template for further discussion about the prioritised actions to take forward. The steering group were asked to prioritise the actions, identify any quick wins & consider an action plan to ensure the implementation of improvement activities along the pathway. The options appraisal is detailed in section 6 of this report.

5.0 Project implementation

The collaborative working project commenced in November 2024 & met as a steering group every 2 weeks, except for the Christmas period. The key milestones delivered in implementation of the project were as follows:

November 2024

- Developed project plan to set out and monitor delivery of the aims and objectives of the project
- Established project steering group to oversee the delivery of the project and agree project plan
- Initial interviews held with stakeholders to understand the service

December 2024

- Sharing of the initial data sets from the population health analysis
- Steering group directed where to provide additional focus
- Commencement of the pathway mapping interviews

January 2025

- Continuation of the pathway mapping interviews
- Presentation of more detailed analysis as requested by steering group
- Capacity & capability questionnaire development & deployment to 6 practices as agreed by the steering group.

February 2025

- First draft of the pathway map, overlayed with the perceived barriers
- Refinement of pathway as requested by steering group
- Workshop event to achieve consensus of information to be included in the infographic & simplification of pathway

March 2025

- Infographic development
- Simplified pathway map consensus

- Options appraisal development – identification of opportunities, options & actions.

April 2025

- Agreement of Infographic & options appraisal in final form
- Certification of Infographic & Pathway map as outputs of the project
- Final report compilation

May 2025

- Final project meeting
- Project outputs shared
- Project close

6.0 Options Appraisal

Identified Opportunity	Option	Potential Action for consideration	Next Steps:
Prevention & early intervention	Preventing or delaying the onset of type 2 diabetes – potentially reducing costs & improving patient outcomes Preventative foot care	A holistic view on potential support recognising the causes of diabetes diagnosis are broad & complex Collaboration across the system to support all determinants of health Multi-skilled practitioner – upskilling foot check across the care organisations	Diabetes delivery group*
Treatment targets & care processes variance	Facilitate knowledge sharing across from areas of high achievement – focus on structure & processes Specific variance of care process Urine Albumin - consider as part of the LTC strategy of why there is variance	Share & discuss evidence & variance found in the project with the western collaborative board for engagement with neighbourhood teams to standardise processes Audit: Sample request v received sample to provide further insight to variance in UA across LTC Results shared with the Collaborative board for further understanding of the identified issue. Consider inclusion of future audits where identified issues arise	Western Collaborative board
Tailored approaches to diabetes management that consider the socio-economic factors in	Person centred offer – scope beyond NHS supporting the needs of patients working across organisational boundaries & across roles	Multi-skilled practitioner – make every contact count Programme development to increase education and improve the knowledge and confidence of care home staff and community care teams to	Diabetes delivery group

collaboration with community organisations	Use of well-being hubs as person centred support for diabetes management Building on the continued evaluation of the work of the community health & well-being workers e.g. Deep End practices – including support in attending medical appointments	effectively manage people with Diabetes LCP development as part of long-term conditions approach Evaluation of the reduction in DNA rates for appointments to be shared more widely within the Collaborative board for wider adoption	
Patient engagement – support patients more holistically	Consider a different approach to traditional health care models for hard-to-reach patients Incorporate more patient reported outcomes into care planning to improve the patient centredness of on-going care	Share findings with the Deep End group with other PCNs to support reinforcement of the need for differential approaches & investment and address them- Seek to further understand patient barriers to access Evidence patient changes & impact on lives	Deep End group
Training & development of workforce	Targeted & sustainable delivery across roles & organisations – workforce applied across long term conditions	Multi-skilled practitioner development – across care organisations	Diabetes delivery group
Digitalisation of structured medical education presents a risk for some patient groups	Understand the impact from change in provision of structured medical education from face to face to digital	Education support for patients, carers & public, through efforts to improve & support health literacy	Diabetes Delivery Group
Potential to use technology more effectively for risk stratification, patient communication & care coordination post diagnosis	Development of standardised searches for risk stratification Tailored messaging to patients for recall	Deploy search across locality that identifies those uncontrolled patients who haven't been seen for last 12months - ICB build for replication across the system Increase practice uptake of one Devon dataset Work with practices that currently tailor messages for recall & review Risk stratification tools e.g. PARM to identify high risk patient cohorts Discuss potential of LES to support this	Western collaborative board / ICB Diabetes delivery group
Treating complex care patients that require	Developing **intermediary care services** – increase resource for complex patients closer to home – aligned hubs with	Propose Diabetes as a priority area for LCP	UHP NHS Trust Care board, Collaborative

specialist support in the patient's own community	PCNs to increase quality of care, improve patient engagement & releasing capacity back to community care	Present impact data to Western collaborative board to shared understanding of the increased resource consumption of complex patients in community Consider prioritisation of potential population health funding.	board, Healthy Lives partnership, Population health management group
Designing care pathways that allow patients to seamlessly flow between community & specialist care based on patient need	Develop robust data sharing agreements to facilitate better information flow between care settings	Agree which mechanism would support (nearly) live data dashboard to proactively manage flow of patient information using existing platforms	Diabetes delivery group*

***Diabetes Delivery Group to review the plan & oversee the actions**

7.0 Stakeholder Feedback

Written feedback on the outcomes of the collaborative working project and working with Sanofi was received from the following stakeholders involved in the project:

The team are well organised and structured, they communicate well and had demonstrable skill in meeting and project management. They had access to relevant data to support the process and the skills and ability to present and explain in an easily digestible and relevant format so that we could engage with it and identify clear goals. The infographic and care pathway outcomes were particularly impactful for me and the options appraisal generated is really helpful for the next stage in our service development. (**Patrick English, Consultant in Diabetes, Endocrinology, Acute and General Internal Medicine. University Hospitals Plymouth NHS Trust**)

I really enjoyed being a part of this project - the Sanofi team managed the project well and presented very clearly, the relevant data for the project to us, in an easily understood format. The organisation of the project was excellent and provided enablement to the working group in identifying aims in a collaborative way.
The resultant pathway map brought together all the different pathways in a simple easy to follow one page document, and the infographic that has been produced was particularly useful to me in recognising the achievements of diabetes care across the locality to date, but also where good practice might be shared to benefit the local population. **(Zoe Hope, Lead Practice nurse, Southway Surgery Plymouth)**

8.0 Lessons Learned & Next Steps

1. Take the discussion on digital education to the diabetes delivery group and ICB commissioners to explore alternatives for those excluded

2. Take options appraisal to the collaborative board, the healthy lives partnership team and the population health management group to discuss the sections relevant to each of them and to take this into the next phase of action-focus here on: tailored approaches to management section; engagement; training and development; technology for risk stratification, communication and care co-ordination; ,management of more complex patients in the community requiring specialist support with seamless care across organisations and the development of an "**intermediate care service**" to support this

3 Intermediate care service options also to be taken to our care group in the Trust