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ORIGINAL RESEARCH

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Process evaluation of a primary care-based type 2 diabetes remission project in the North East of England

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Abstract

A type 2 diabetes remission project, *Remission in Diabetes* (*REMI.D*), funded by Sport England, was developed by stakeholders based in the North East of England and begun in early 2020. This local delivery pilot sought to tackle health inequalities by working with multiple organisations to demonstrate a way of scaling up an effective type 2 diabetes remission strategy which included both physical activity and dietary components. The intended delivery of the original project was impacted by the COVID-19 pandemic and changes were made to the project delivery in 2022. The aim of this process evaluation was to learn from the reactive decisions taken by stakeholders which altered the *REMI.D* project in response to the COVID-19 pandemic. Twelve stakeholders (from local authorities, secondary care, universities, NHS England commissioning, Diabetes UK, Sport England, Everyone Active and Active Partnerships) involved in the design and delivery of the intervention took part in a semi-structured interview lasting up to 60 min. Interviews were recorded and transcribed verbatim. Thematic analysis used the pre-determined 'core content' themes from the Medical Research Council and National Institute for Health Research framework for developing and evaluating complex interventions. Three topics for discussion emerged as follows: (a) lack of effective collaboration, (b) perception of change and (c) scalability of the intervention. Hierarchy within the stakeholder group initially hampered collaboration. Change was reactive as a result of the COVID-19 pandemic. Project changes reduced project sustainability and scalability but offered valuable learning about the need for explicit project theory for partnership working, co-production with service users and project flexibility for long-term health behaviour change.

KEYWORDS
diabetes, nutrition, obesity, primary care, review, system change

INTRODUCTION

Across the North of England, the estimate for people with type 2 diabetes (T2D) exceeds 1 million (DUK, 2023a). The recent *Health Survey for England* reported a prevalence rate for total diagnosed diabetes of 7% (4% in least deprived areas; 10% in most deprived areas) (NHS, 2023a). The *Remission in Diabetes* (*REMI.D*) project is situated in the most deprived one per cent of areas nationally based on the Index of Multiple Deprivation (Noble et al., 2019). Nationally, one-quarter of adults with T2D live in the most deprived areas of England (NHS, 2022). As health inequalities in England continue to worsen, T2D remission strategies that have been shown to be effective need to be scaled up (DUK, 2023b; Marmot, 2020). Public health teams located within local authorities are well-placed to make this happen (Stansfield et al., 2020). A whole systems approach (WSA) is defined as a dynamic way of working, bringing stakeholders and communities together to develop 'a shared understanding of the challenge'

and to action sustainable, long-term system changes (Buck et al., 2018; p. 17). A place-based approach uses the principles of a WSA locally with 'place' often being defined as local authority boundaries (NHS, 2021). This T2D remission project is located within the Middlesbrough and Redcar and Cleveland local authority areas. Place-based partnerships are considered a key building block of integrated care boards (ICBs; statutory bodies responsible for planning and delivery of regional health and care services) and play an important role in coordinating local services and driving improvements in population health (Charles, 2020). Meanwhile, the 'Health in All Policies' approach (which WSAs align with) seeks to avoid harmful health impacts to improve population health and health equity (WHO, 2014). Similarly, in England, the focus of the NHS Long Term Plan for diabetes is on equity in effective management (NHS, 2019). These approaches were integral to the design of this T2D remission project.

Type 2 diabetes remission project: *Remission in Diabetes* (*REMI.D*)

This North East T2D remission project *REMI.D* was a local delivery pilot funded by Sport England and designed with the potential to offer impact at scale (SportEngland, 2021). The guiding principles for the *REMI.D* project included (a) developing collaborations and partnerships with T2D experts both locally and nationally, (b) using and building on local assets, (c) offering a range of T2D remission dietary and physical activity interventions to address barriers to engagement and enable people living with T2D to take part and (d) increasing control for people with T2D over their health and lives.

A diabetes development group was convened in 2020 following the successful bid. This group brought together key local stakeholders from the local authorities (health improvement managers and public health practitioners), primary and secondary care (practice managers, practice nurses, consultant diabetologists/endocrinologists and diabetes dietitians), universities, NHS England commissioning, Diabetes UK, Sport England, Everyone Active and Active Partnerships.

Current trial data suggest that the most successful approaches to T2D remission are bariatric surgery or total diet replacement (TDR) using formula food products (Taylor et al., 2021). The majority of patients with T2D access non-surgical treatment for overweight and obesity (NHS, 2023c). The *Diabetes Remission Clinical Trial* (*DiRECT*), a TDR intervention, showed that after 5 years, almost one-quarter of participants remained in diabetes remission with an average weight loss of almost 9 kg (DUK, 2023b; Lean et al., 2018, 2019). However, the Diabetes UK position statement on T2D remission continues to recommend an individualised approach, recognising that people with T2D have achieved remission using various dietary interventions, including the Mediterranean ('healthy') diet, calorie-controlled (low-fat) diets, low-carbohydrate diets and TDR (DUK, 2021). Type 2 diabetes remission may be defined as an HbA1c <48 mmol/mol maintained without diabetes medications for at least 3 months (DUK, 2021; Nagi et al., 2019).

The *REMI.D* T2D remission project differed from the *DiRECT* trial in that in the *REMI.D* project, TDR formula food products were self-funded by participants and a structured physical activity component was also included. A choice of dietary and physical activity strategies was offered in an attempt to reduce barriers to engagement for patients living in an area of significant deprivation. Eligible patients were presented with a choice of three dietary options (a) formula food products TDR, (b) food-based TDR and (c) healthy lifestyle plan. The healthy lifestyle approach supported participants to set tailored goals based on other commonly used dietary strategies for the management of T2D: Mediterranean diet, portion-controlled (lower carbohydrate, higher protein and lower calorie) and/or lower glycaemic index foods. Similarly, there was a choice of three physical activity pathways (a) everyday life (walking, climbing stairs and getting off the bus early), (b) general practitioner (GP) referral (gym, swimming and chair-based exercises) and (c) social hub (activity indirectly through social activities and day trips).

The *REMI.D* project eligibility criteria (Data S1) followed the NHS England real-world implementation model for the delivery of a TDR-based intervention for people with T2D (NHS, 2023b). The *REMI.D* project planned that GPs and practice nurses, located within the two local authorities, would identify suitable patients with T2D for inclusion in the T2D remission project. The dietary interventions were to be delivered at the general practices with initial support from the project dietitian (a dietitian on secondment from NHS employment). Figure 1 summarises the T2D remission strategies offered at the beginning of 2020 (pre-COVID-19 pandemic).

The COVID-19 pandemic and the associated lockdowns meant that it was not possible to deliver these strategies. The *REMI.D* stakeholders made revisions to the intended T2D remission project in March 2022 (Figure 2), due to the loss of primary care stakeholder engagement (GP and practice nurses) during and following the COVID-19 pandemic (Finch, 2022). These changes resulted in the project dietitian taking sole responsibility for both the recruitment and the delivery of the dietary interventions, and the latter being relocated out of general practice.

Sixty-five patients were recruited to the *REMI.D* project by the project dietitian out of the proposed 200

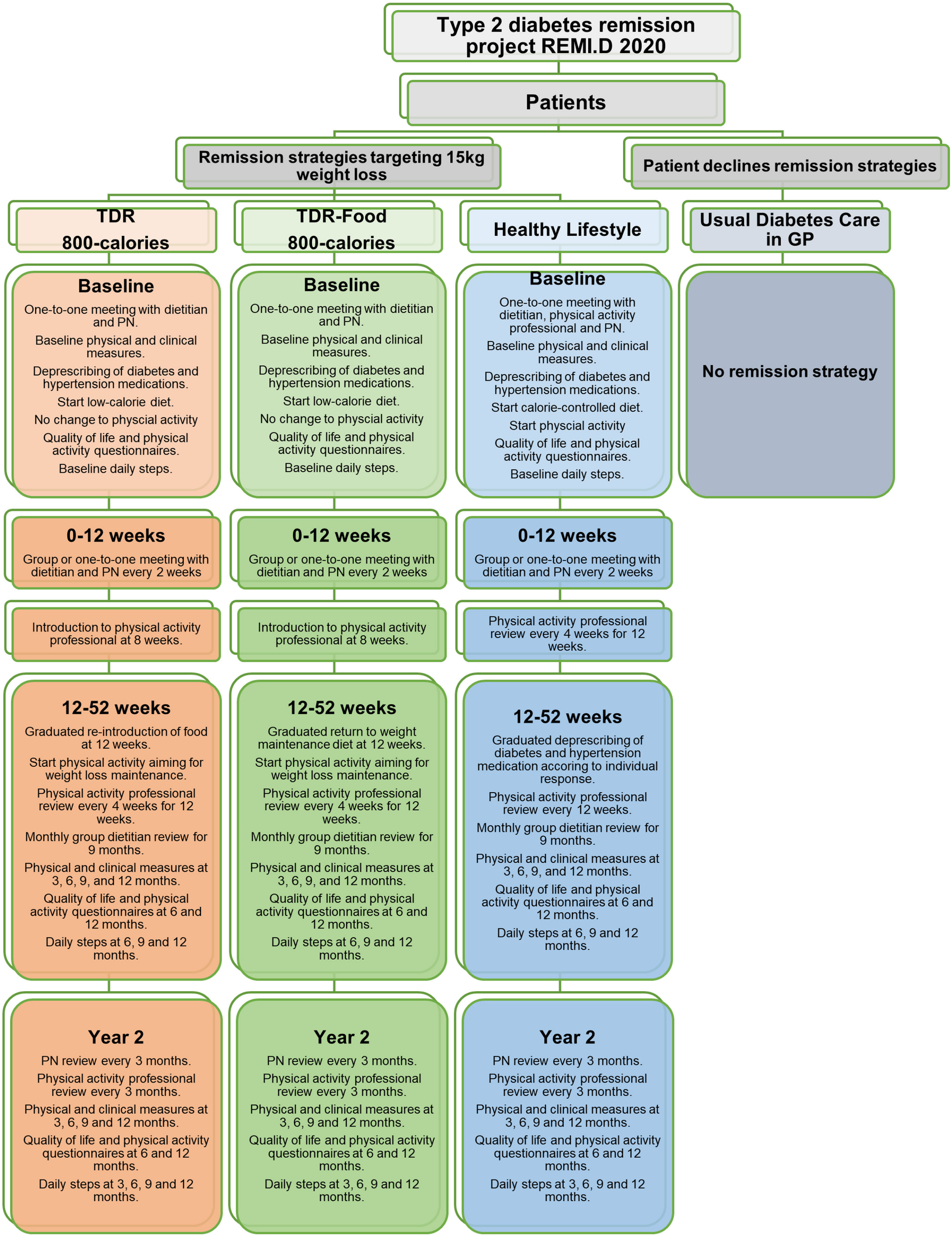

FIGURE 1 Type 2 diabetes remission strategies in 2020. TDR, total diet replacement; PN, practice nurse.

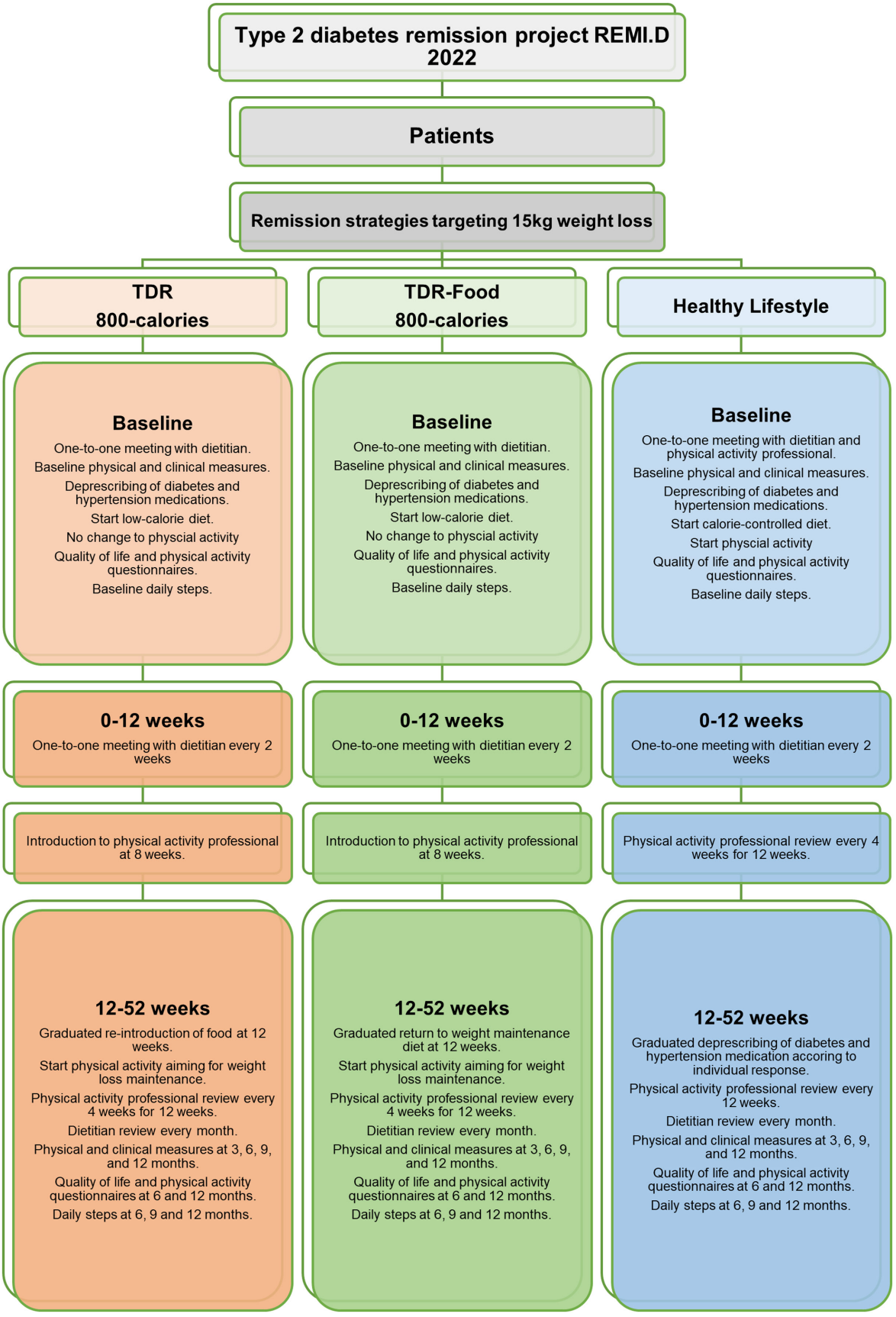

FIGURE 2 Type 2 diabetes remission strategies in 2022. TDR, total diet replacement.

patients. The decision to stop recruitment took into consideration the capacity of the project dietitian, the duration of the intervention (52 weeks) and the finite funding. Twenty of these patients participated in qualitative research exploring barriers and enablers to engagement with this T2D remission strategy. The descriptive statistics and qualitative research findings are under review for publication elsewhere.

The aim of this process evaluation was to learn from the reactive decisions taken by stakeholders which altered the *REMI.D* project in response to the COVID-19 pandemic.

Process evaluation

A process or implementation fidelity evaluation determines whether an intervention has been implemented as intended and may be conducted periodically throughout the life of a project (Carroll et al., 2007). Despite increasing awareness of the importance of fidelity in complex healthcare interventions over the past 20 years, the assessment and impact of fidelity is often under-reported (McGee et al., 2018). The latest UK Medical Research Council (MRC) and National Institute for Health Research (NIHR) framework (Figure 3) recognises the need for such evaluations to maximise the efficiency, use and impact of research (Skivington et al., 2021a, 2021b).

METHODOLOGY

Stakeholders who sat on the *REMI.D* diabetes development group in 2022 were eligible for inclusion in this process evaluation. Sampling was purposive (Braun & Clarke, 2013). The *REMI.D* project manager invited the stakeholders, by third-party email, to participate in this research. A participant information sheet (PIS) and consent form were attached to the email, and stakeholders were asked to contact the researcher (RB) to take part. Health Research Authority ethical approval was granted (IRAS project ID: 278107; REC reference: 20/LO/0615). A semi-structured interview schedule was created which drew on the core elements within the MRC and NIHR framework (Skivington et al., 2021a, 2021b) and the Template for Intervention Description and Replication (TIDieR) checklist and guide (Hoffmann et al., 2014). The university-based research team (RB, HM, AL and AH) reviewed and agreed on the last version of the stakeholder interview schedule (Data S1). Interviews of up to 60 min were undertaken by the researcher (RB) virtually, video- or audio-taped using two devices, and transcribed verbatim. Data collection and analysis were undertaken concurrently, with the results of the ongoing analysis informing future interview questions and data collection (Miles et al., 2020). Researcher reflexivity (bias) was acknowledged through journaling to build the trustworthiness of findings (Braun & Clarke, 2013). Thematic analysis by the researcher (RB) supported both inductive and deductive coding and enabled the researcher to use the pre-determined 'core content' themes within the MRC and NIHR framework and to identify new themes (Gibbs, 2018; Skivington et al., 2021b). The researcher (AH) independently looked for inconsistencies in the coding decisions. Inconsistencies in coding not readily resolved by joint review (RB, AH and HM) were referred to a team member (AL). This process evaluation

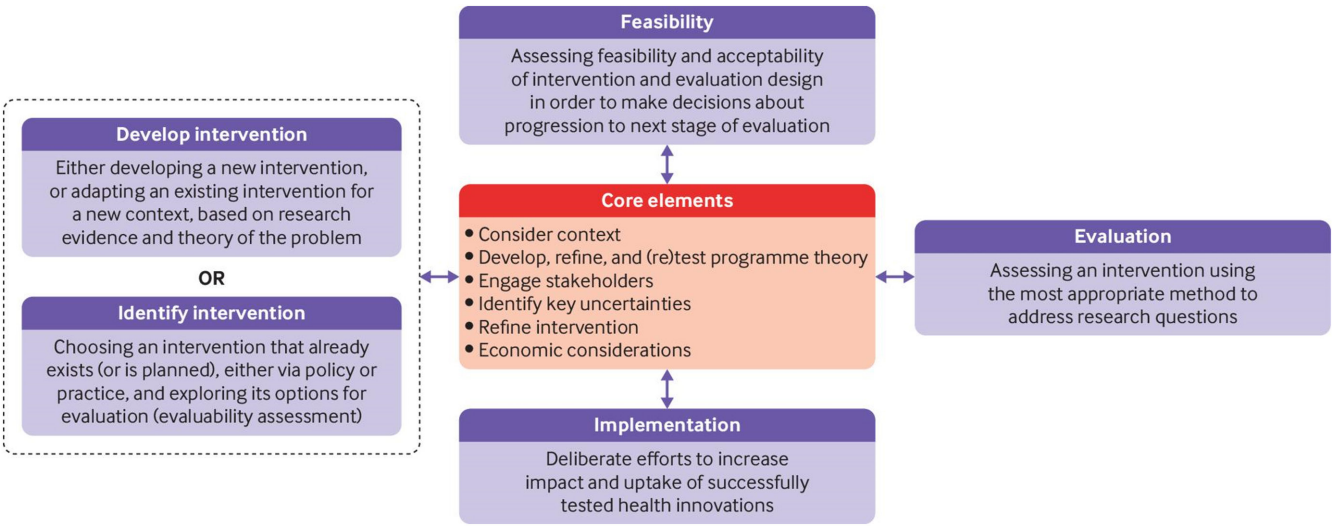

FIGURE 3 The Medical Research Council and National Institute for Health Research framework for developing and evaluating complex interventions.

was carried out in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Data S1) (Tong et al., 2007) and guidance on standards for reporting qualitative research findings (O'Brien et al., 2014).

RESULTS

Results are presented under the emerging themes of (a) lack of effective collaboration, (b) perception of change and (c) scalability of the intervention. All current members of the diabetes development group (12 stakeholders) participated in the process evaluation (Table 1). The stakeholder voice is reported in italics and each different voice noted, by S (for stakeholder) and the participant number, in square brackets, for example [S1].

Lack of effective collaboration

As the funder was Sport England, there had to be a significant element of physical activity in the intervention. However, Sport England was particularly interested in working with healthcare professionals and academics to better understand the current emphasis placed on physical activity within healthcare settings. Stakeholders reflected:

> It was the more medicalised workstreams and working with health care professionals that was most attractive to them (Sport England).
>
> [S4]

> Real learning can often be learning how to be wrong…gaining insight from that and creating the conditions, the culture and the trust in order for that to be unearthed and shared.
>
> [S7]

The local authority stakeholders agreed that collaborations with primary and secondary healthcare professionals through the inclusion of a dietary intervention alongside the activity pathways would attract 'high level buy-in from secondary care (physicians)' [S8]. The assumption was that secondary care physicians were more invested in T2D dietary strategies, rather than physical activity management strategies. This was corroborated in the interviews with the secondary care stakeholders.

> We (secondary care) wanted the dietitian to do joint clinics with the practice nurse in primary care, with the vision that every practice will have a practice nurse doing this under a community dietitian who will work across five or six practices.
>
> [S11]

The *REMI.D* project, like many projects designed in real-world settings, lacked an explicit project theory (a road map of how the intervention will be conducted and what impact each part will have on other components of the project) (Skivington et al., 2021b). Despite the local authority stakeholders clearly describing the interventions at the outset, the consequences of a lack of defined roles and responsibilities in the bid were described by one stakeholder at interview

> We (the local authorities) cannot look over what everyone is doing…everyone has their own agendas and it's just trying to make sure that we're all working in the same direction.
>
> [S4]

Further examples of uncertainty around stakeholder priorities were voiced by other stakeholders

> Initially the physical activity aspect felt more like a bolt-on rather than an integral part of the model (*REMI.D* project)…unclear whether physical activity is discussed (by the project dietitian) and people's perceptions or motivation about activity recorded at initial meeting. If people are not interested in that (physical activity), they shouldn't be doing *REMI.D*.
>
> [S1]

> Felt like initial priority was being given to the three dietary solutions (rather than the three physical activity pathways).
>
> [S9]

Stakeholder tension around the delivery of the dietary component over the physical activity component seemed to lessen in the second half of 2022. This coincided with conversations around ongoing funding and clarity around the focus for this intervention (to embed physical activity within treatment pathways). One stakeholder acknowledged that

> Relationships (between the stakeholders in the diabetes development group) developed to a more equal footing.
>
> [S1]

Perception of change

Health Research Authority ethical approval was granted in May 2020. Due to the COVID-19 pandemic, the first patient participant was not interviewed as part of the qualitative research until August 2022. The stakeholders recalled the decisions made in March 2020

TABLE 1 Self-reported roles and responsibilities of the stakeholders.

Stakeholder	Role	Responsibilities
1	Health improvement manager, local authority	Wrote bid, obesity lead, programme board member and nutrition expertise
2	Research dietitian, secondary care	Employed to deliver intervention
3	Diabetes UK representative, charity	Project linked to Diabetes UK research priorities, engineer local links and relationships, share best practice/resources and support engagement
4	Programme officer, local authority	Funded by Sport England, programme board member and sport/activity expertise
5	Commissioner, NHS England	Diabetes portfolio, share information, avoid duplication and support role for this Sport England-funded programme
6	Programme director, local authority	Programme board member, whole systems approach expertise
7	Strategic lead, Sport England	Funder, active participant and learner in this space
8	Local lead, Active Partnership	Tasked with rolling out local delivery of Sport England initiatives, business expertise and lived experience
9	Consultant diabetologist, secondary care	Diabetes expertise
10	Local team lead, Everyone Active	Exercise and physical activity agenda, employed to deliver intervention and involved in previous Sport England initiatives
11	Consultant endocrinologist, secondary care	Tier 3 weight management and T2D remission expertise
12	Advanced public health practitioner, local authority	Wrote bid, obesity lead, sports science and tier 2 weight management expertise

Abbreviation: T2D, type 2 diabetes.

> When the pandemic struck, the meetings (diabetes development group) stopped.
>
> [S9]

> Training events for the practice nurses were postponed.
>
> [S2]

> We (health care professionals) were deployed to manage COVID-19…when the meetings started again, we had major problems re-engaging with primary care.
>
> [S9]

Virtual dialogue broke down as the diabetes development group stakeholders failed to agree on a way forward during the COVID-19 pandemic. Pressure demands on primary care were evident. Healthcare professionals were tasked with rolling out the COVID-19 vaccination programme and treating those who contracted the coronavirus. While digital offers for long-term conditions became the norm during the COVID-19 pandemic, perceived resistance from secondary care-based stakeholders led to the ongoing postponement of the *REMI.D* project. One stakeholder reflected

> We (secondary care) probably made a mistake in delaying…we thought it (the effects of the COVID-19 pandemic on health care) was all going to go away in a few months… we were probably quite attached to the methodology as we developed it.
>
> [S9]

The same stakeholder offered justification for the delay

> There is a significant amount of motivational interviewing required that we weren't convinced you would get with an online model.
>
> [S9]

Another stakeholder shared the group's thinking behind holding out for an in-person intervention.

> There was the whole question around digital exclusion…hard for some people (patients) to get to grips with technology, let alone being able to afford the technology.
>
> [S5]

This stakeholder further rationalised the delay

> We (the diabetes development group) would have been relying on primary care to do the referrals and they were absolutely swamped with everything that was going on (pandemic).
>
> [S5]

When the diabetes development group meetings were reconvened early in 2022, the landscape had changed. General practice faced additional demands related directly (vaccination programmes) or indirectly (additional physical and mental health patient needs) to the COVID-19 pandemic. This resulted in a fundamental change to project delivery described by the stakeholders below:

> Before COVID-19, we (the diabetes development group) had five or six practices working with us on shaping this project but then the pandemic hit and we couldn't get any practice engagement.
>
> [S4]

> Due to being 'unable to access practice nurses (after the COVID-19 pandemic)… the project dietitian (based in secondary care) agreed to replace them to some extent. One of challenges will be to move away from this model (i.e. return to original *REMI.D* project vision; Figure 1)'.
>
> [S6]

Scalability of the intervention

While flexibility and agility are essential in any real-world setting research, it is for the stakeholders to judge the significance of the *REMI.D* project changes (Gordon, 2021). Here, the *REMI.D* stakeholders identified three challenges that called into question the viability of this T2D remission project (a) the novelty of intervention, (b) the referral pathway and (c) lack of primary care engagement.

Consideration was given to re-purposing the funding elsewhere but Sport England remained willing to invest in their 'test and learn' approach, despite the project changes. The addition of physical activity is a potentially useful adjunct to any remission strategy, and the *REMI.D* project offered an opportunity to address barriers to people becoming more active. Strongly coming through the stakeholder conversations was a desire for equity within the locality

> We (diabetes development group) didn't want to have 'just another intervention that happened while it was funded'.
>
> [S6]

> In terms of sustainability, the norm has been investment over so many years which is great but eventually funding will stop. The *REMI.D* project turned the telescope around, looking bottom up to see whether we could use the convening power of place, identity and systems that exist locally…to shift that in a way that would be sustainable and would create transferable learning.
>
> [S7]

Other stakeholders considered the current political landscape

> Place-based footprints mean that this *REMI.D* project is the kind of thing that they (ICBs) are looking for where local initiatives can be established and rolled out.
>
> [S5]

> Buy-in from ICBs would enable this remission service model to be scaled out without us (diabetes development group and Sport England funding).
>
> [S4]

In 2022, T2D remission projects were no longer novel. The *REMI.D* T2D remission project bid was submitted in 2019. National roll-out of the NHS T2D Path to Remission programme launched in 2020 is expected in Autumn 2023 (NHS, 2023b). The NHS England-funded programme offers greater access routes where commissioned, compared with the *REMI.D* project. At the time of the stakeholder interviews, local weight management pathways within the ICB were being streamlined. One stakeholder reflected:

> A choice of in-person and digital versions may confuse health care professionals (in general practice with responsibility for referring to these programmes) and heighten health inequalities where the affluent (well-educated patients) manage to navigate the complex systems (better than patients from lower socio-economic groups).
>
> [S12]

The original *REMI.D* project pathway relied on general practice to generate the referrals into the project and practice nurses to deliver the T2D remission intervention long-term. A sample size of 200 patients was proposed from the outset to enable a quantitative 'value for money' assessment. The reality of the project changes, with a final sample size of 65 patients, is captured in the stakeholder voices below:

> In 2022, we (the diabetes development group) could not get patient lists from primary care…we 'took patients from DESMOND (a T2D structured education programme) patient waiting lists to see if we could redeploy them'.
>
> [S9] (DESMOND, 2020)

> The project dietitian is doing the intervention on her own…not going to be able to see half the intended numbers. If they (patients) keep trickling in…how long do we keep piloting for? We've only got finite funding. Ideally you would want to get to a point

where you have enough numbers to prove that it is working.

[S1]

Trained practice nurses were a key part of the project…only way of scaling this (*REMI.D* intervention) out but something else always takes priority in the short term.

[S6]

I'm not sure if we'll ever get it done as practice nurses are in short supply…many now deal with multiple lifelong conditions not just diabetes.

[S5]

We (the diabetes development group) no longer know how practice nurses feel about being involved (in *REMI.D* project) or how much confidence and trust they (patients) would have in their practice nurse to give the same information.

[S2]

DISCUSSION

In this process evaluation, stakeholders' perceptions and experiences of participating in the design and delivery of the T2D remission project before, during and after the COVID-19 pandemic were elicited. The themes of lack of effective collaboration, perception of change and scalability of the intervention are discussed below.

Lack of effective collaboration

This T2D remission project required interprofessional collaboration, the perspectives of multiple stakeholders and effective teamwork across hierarchical organisational levels (Norris et al., 2017). Although the physical activity component of this project provided the funding for this project, the dietary intervention and the secondary care stakeholders were initially given more power and status. The *DiRECT* trial format, a primary care-based dietary intervention, was seen as the way to embed physical activity into a primary care-based T2D remission strategy (DUK, 2023b; Lean et al., 2019). A discussion around re-purposing the funding elsewhere in late 2022 resulted in a more open and honest dialogue between the local authorities and secondary care stakeholders and a renewed focus on the physical activity offer.

Differing stakeholder agendas and levels of engagement raised questions about implementation fidelity, for example, equal promotion of both dietary and activity elements from the outset of the intervention, and perceived resistance to exploration of an alternative digital delivery method. Norris et al. (2017) described three interrelated components of engagement (a) active participation and commitment from stakeholders; (b) shared stakeholder focus and decision-making around relevant change; and (c) two-way communication, early in the change process, where stakeholders felt heard and understood. Arguably more explicit project theory (detailing stakeholder roles and responsibilities) may have increased confidence within the diabetes development group around delivery priorities (dietary vs. physical activity) of the intervention (Skivington et al., 2021b).

Perception of change

The funder (Sport England) promoted a 'test and learn' approach to this pilot project. While clinical outcomes were important to the diabetes development group, Sport England was focused on creating blueprints for effective collaboration with healthcare professionals which would enable them to identify and tackle patient barriers to increasing physical activity. This flexibility and willingness to continue funding the T2D remission project despite major refinements to both recruitment and delivery methods enabled a primary care-based project to become a secondary care-based project post the COVID-19 pandemic. The question of whether the findings of this process evaluation would have influenced funding review decisions differently is unknown.

Other unanswered questions are how primary care practitioners felt about no longer being involved in the project post the COVID-19 pandemic, and whether practice nurses have time to take part in this type of T2D mission project. This evaluation project was unable to use and build on local assets within primary care, despite the attempts of the diabetes development group to re-engage with previously committed and new general practices. Stakeholders perceived a change in the preferences of primary care practitioners to one of signposting to, rather than delivery of, the *REMI.D* project. Practice nurses in Australia have previously shared the challenges faced when implementing a dietary intervention as part of their regular work practices, due to interruptions and concurrent commitments (Govindasamy et al., 2022).

Interestingly, co-production was absent from the project delivery. The term 'co-production' describes working in partnership by sharing power between people who draw on care and support (C4PC, 2020). The patient voice is part of the qualitative research arm of this project but was not represented in the diabetes development group. Stakeholder opinions about patient choices of dietary and physical activity interventions and changes post the COVID-19 pandemic were speculative.

Scalability of the intervention

The vision of scalable, successful dietary and physical activity interventions leading to T2D remission or delayed progression with deprescribing of diabetes medications is unlikely to be realised without a renewed commitment from primary care stakeholders. Uncertainty expressed by some stakeholders about the capability of nurses giving dietary advice and, in turn, the confidence of patients receiving it, may be resolved through knowledge and skills training. The planned behaviour change training for primary care was cancelled due to the onset of the COVID-19 pandemic. Rehackova et al. (2022) noted training provided for a specific dietary intervention was positively received by healthcare professionals (nurses and dietitians).

At the heart of this project was physical activity and the desire to influence physical inactivity associated with health inequalities in this 'place' (local authorities) by identifying and overcoming barriers to participation. While the physical activity professional was still able to work with the patients recruited and offer physical activity solutions, the demographic of patients taking part may have differed due to the project changes made; patients from more deprived areas may not have understood the significance of the *REMI.D* project following invitation by letter as opposed to referral by their GP or practice nurse, compared to those from affluent areas (Stokes et al., 2019). This change in the referral process may have negated an opportunity to reduce health inequalities locally.

A return to traditional dietetic-led one-to-one dietary interventions resulted in individually tailored diabetes patient care and potentially less scripted and scalable dietary strategies intended for use by practice nurses. Interestingly, Rehackova et al. (2022) recently concluded that a level of tailoring of interventions to patients in the *DiRECT* trial helped to sustain health behaviour modification. Achieving positive outputs by delivery in primary care in a reimagined way may still create an opportunity to secure ongoing local funding for this T2D remission model.

CONCLUSION

Engagement is a core element in the development and evaluation of complex interventions such as this T2D remission project (Skivington et al., 2021a). As place-based partnerships evolve, this process evaluation offers valuable insights into the challenges of collaborative working for stakeholders across multiple organisations, co-production with service users, the importance of project theory (clear road maps) and the timely consideration of the consequences of project changes. Such insights may inform more flexible decision-making during projects to bring about successful outcomes for funders, stakeholders and service users.

AUTHOR CONTRIBUTIONS

RCB designed the process evaluation, collected and analysed the data and prepared the manuscript. AH, HJM and AAL supported the design process, interpretation of the data and preparation of the manuscript. All authors approved the last version of the paper submitted for publication.

FUNDING INFORMATION

The authors have no funding to declare.

CONFLICT OF INTEREST STATEMENT

All authors have no conflict of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this process evaluation are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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