

# Sustainability and Transformation Plans Will they improve diabetes care?

It's a year since the NHS in England was told it needed to write Sustainability and Transformation Plans (STPs). **Robin Hewings**, Head of Policy, and **Tara Finn**, Policy Officer, at Diabetes UK have been speaking to people in the diabetes community about whether the plans are helping them to improve care

## A potted history of STPs

Just over a year ago, the NHS and local authorities in England were told that they needed to identify the natural health economy 'footprint' for their area and develop a plan for health and care services as a whole. The areas are big – on average, 1.2 million people live in each one.

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of 'transformation' kick in that will provide better care at a reduced cost. A big ask.

All 44 areas have now published their plans, but these will continue to be refined. And, it seems that an STP is not a plan that is written once and then left on a shelf. The STPs are becoming the only process for accessing NHS transformation funding. All of the applications for diabetes transformation funding had to have the approval of their local STP.

## The theory

Basically, STPs are a regional planning function that tries to maximise value across the system. This approach is very different to the Andrew Lansley reforms that were about more than 200 groups of GPs covering smallish areas commissioning between competing providers. Competition rules were beefed up. So much so, that some people working in diabetes told us commissioners would not even speak

to them in case of a legal action.

Now, commissioners and providers are supposed to come together to plan collaboratively. This change in the healthcare system is all being done without legislation.

The change is welcome. In our snappily titled report, *Improving the Delivery of Adult Diabetes Care through Integration*, we found that it was very hard to get elements of a local diabetes



PHOTOS: THINKSTOCK

system to work together. Diabetes care crosses organisational boundaries, so specialists and generalists need to support each other and people with diabetes should be seen in the right place for their needs. The system was pushing against all of these elements.

The need to maximise income and cut spending meant patients often got stuck in the wrong part of the system – people who needed to see specialists did not, for instance. Meanwhile, people who could be supported in primary care carried on using specialist services. It was also not straightforward for generalists to get specialist support.

The areas we found where they had been able to take a comprehensive look at their diabetes services, and use their money collectively, could provide better services with the same amount of money. Just halting the rise in spending on diabetes and its complications is a Herculean achievement.

And it's not just in diabetes where this collaborative integrated approach is needed. The King's Fund points out that there is a recognition that the financial problems faced by the NHS cannot be addressed by organisations working in isolation. All of the commissioners and providers in an area may be given a control total for what they can spend. The King's Fund want a 'place-based' approach that focuses not just on health services, but works with partners beyond health and care to improve the health and wellbeing of the whole population. As we know that the successful prevention of Type 2 diabetes will need action across society, we can see the potential in this approach.

There's a lot to like about the theory, but turning it into practice is hard. For a start, no one thinks that the plans were developed with enough engagement from patients or staff. With 'patient-centred care' on the tip of everyone's tongue, this is ironic. Areas were given just six months to form themselves into footprints and then write a high-quality plan.

At Diabetes UK, our general sense was that a few people had been seconded on to drawing up their area's document, but that no one had time to have any in-depth conversations outside of a small group. This process brings together people who may have previously been in conflict with each other's priorities. Getting all those who are involved in the planning and implementation process around the same table and talking to each other is clearly easier said than done. Talking to people outside this group clearly proved even harder.

National NHS leaders say that STPs will need to do more engagement as they are refined this year. But this needs to be more than asking people about a *fait accompli*.

### One size fits all?

The STP footprints aim to work at the level of the natural health economy: the area in which a local population naturally lives and works, incorporating clusters of cities and commuter areas. For diabetes care, the clinical commissioning group (CCG) level of planning functions and health economy often works fairly well; primary and community care supported by specialist and acute care.

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But STPs are nearly five times larger than CCGs. On average, they each cover 1.2 million people. Some CCGs have made some excellent progress in improving care and diabetes outcomes. If an STP decides to focus on diabetes, what happens to the good work of the CCGs inside it?

They might all refer into the same teaching hospital for advanced cancer treatment, but diabetes care does not have to be the same in a big city, a small seaside town and a rural area.

The worry is that CCGs will have a model of care that is working for them, that is then bulldozed by the new STP plan. We’ve certainly heard of areas where progress is on hold in this situation while an attempt is made to have a ‘consistent’ approach across a widely varying patch. An ideal STP would look at areas of good practice, learn, adapt and apply appropriately to the wider STP. With many of the plans still in development, there is this opportunity.

### Practical help

NHS England has worked with Diabetes UK to produce a quick guide to help local leaders work on the big issues in diabetes care. The diabetes ‘aide-memoire’ focuses on the components of a good local system, as well as structured education, footcare, and reducing the growth of Type 2, for example through the NHS Diabetes Prevention Programme. You can easily find it by searching for diabetes STP aide memoire.

And there are great examples of where the STP process has helped spread good practice. The Buckinghamshire, Oxfordshire and Berkshire West STP has chosen to address diabetes. Buckinghamshire CCG and the public health team have already worked together to provide

a Single Point of Access (SPA) Lifestyle Gateway for services such as the NHS Diabetes Prevention Programme. Patients may be referred by a clinician or self-refer. They are then triaged by receptionists who explain the full range of interventions on offer irrespective of the initial reason for making contact. A patient may be referred for structured education, but the discussion may also identify a wish to increase exercise, which could be addressed by an exercise programme. It is still early days, but, through the STP, there is a very real possibility that the SPA Lifestyle Gateway approach will be adopted more widely across the STP.

In structured education, the Aylesbury Vale and Chiltern CCG is exploring education for patients with Type 1 across the region and the possibilities for referral across geographical boundaries. Kathy Hoffman, Diabetes Clinical Lead for Bucks, at Aylesbury Vale and Chiltern CCGs, says: “To use an analogy functional STPs should provide the relationships that allow one organisation to benefit from the invention of the wheel by another, such that the former can start to build a car in which to travel towards a given destination rather than waste time and resource reinventing the wheel and going nowhere.”

Cambridgeshire and Peterborough STP has a very challenging health economy. There are 40,000 people living with diabetes in the patch, so the condition has been prioritised. With NHS Right Care, they are working towards improving their offer and uptake of structured education, inpatient and community care and education for healthcare professionals.

From the initial launch meeting they have involved all stakeholders including the third sector,

and encouraged patient representation. It has been a great opportunity for Diabetes UK to support and work collaboratively with them, ensuring they focus on improving key areas of the diabetes service, which will in turn reduce long-term complications and improve the lives of people with diabetes in the area.

Brioni Maker, Regional Influencing Manager for Diabetes UK, says: “I think that Diabetes UK engagement with STP plans has varied a lot from one area to another, and regionally as well, depending on where diabetes lies among their priorities. In Cambridge and Peterborough’s case, diabetes is one of their key areas to deliver improvements and, although the CCG is geographically large, with a diverse demographic, it is the only CCG within the STP plan which means it has been possible to meet as a working group on a regular basis and include the local patient voice.”

It’s clear that the idea of bringing people together to work out how best to use resources in the system as a whole could be a really powerful force for good in diabetes. But a rushed timetable, that squeezes out time for engagement or that ignores local differences, puts this at risk.

The task for STPs, and all of us trying to improve diabetes care, is to make sure the lessons of what works are learnt, so that we can improve services even when money is very, very tight.

