

PCT Reconfiguration

The Impact on Diabetes Networks

The planned reduction in the number of PCTs is rapidly becoming a reality. From October 2006 there will be only 152 PCTs compared to more than 300 previously. This reconfiguration will see the majority of PCTs having the same boundaries as their local authorities promoting easier sharing across health and social care agendas. It will also allow prevention strategies based on diet and fitness to be more effectively developed. Full details of the new PCTs can be seen at http://www.dh.gov.uk/NewsHome/NewsArticle/fs/en?CONTENT_ID=4135088&chk=oJufTo

Thus the restructuring of PCTs does provide opportunities to further develop and improve diabetes services. Local networks will continue to be the vital element in ensuring that all the necessary elements of diabetes care and prevention are brought together.

Although the restructuring of NHS organisations will impact on how many services are planned and delivered there is no necessity that the fundamental structure of networks will change – even if the numbers of representatives does.

Networks are not based solely on PCT boundaries but are focused on patient flows through primary care focused on a specialist service. If that central focus remains the same then the core structure of networks should remain valid. This may mean a single PCT engaging with more than one network.

There will be an understandable determination by the managers of the new PCTs to re-examine all the networks and organisations they are engaged with.

However there should not be an automatic determination that existing networks need to be abandoned or radically restructured if they are based on natural patient flows.

Both the Diabetes NSF and its Delivery Strategy see diabetes networks as the essential contributor to improving diabetes care. Detailed explanation of the benefits they bring can be found at <http://www.dh.gov.uk/assetRoot/04/03/28/23/04032823.pdf>

The reconfiguration of PCTs has not changed that key role and that should be recognised in any decisions taken on their future.

Network Guide

The NDST has produced *Beyond Boundaries: A Guide to Diabetes Networks* which spells out the benefits of networks and provides practical advice on how to develop and promote them. It defines a network as:

“Connections across disciplines which provide integrated care across institutional and professional boundaries, raising clinical quality and improving the patient experience”

(DH 2004)

This highlights that clinical networks need to be at the centre of planning, commissioning and delivery of clinical care, whilst putting the patient at the focus of it all. Involving the service user in the process will shape and improve services around patient experience.

Clinically-led, managed diabetes networks, involving people with diabetes, provide one means of embedding these principles in practice. A network of this type provides structure for service planning and delivery, promotes seamless care and supports staff by targeting resources where they are most needed. This results in:

- integrated care
- improved clinical outcomes
- cost-effective services
- improved patient experience
- equity of service provision

Networks have the potential to improve services by promoting a whole system approach across all organisations and professions involved. They aim to bring all partners together with a common sense of purpose in improving services for people with diabetes.

Diabetes Clinical Networks will be crucial to the successful implementation of the recommendations in *Our Health, Our Care, Our Say* (DH, 2006). They will ensure that all aspects of care delivery, from specialist care to primary care together with local authorities and social care are engaged in partnership working and have an active part to play in commissioning.

Primary Care Commissioning and Networks

Networks will also have a key role in supporting commissioning of diabetes services.

“Firstly, we need to see commissioning as a positive experience:

not just specifying services and buying them; but how we use this process to develop and deliver better services.

Not just, as occasionally with GP fundholding, a “gun fight”; but as far as possible a collaborative process. Think COPD services, diabetes – crossing boundaries, led by clinicians – a process of working together – not of one group being “done to” by another.”

Sir Nigel Crisp, speech to NHS Confederation 1 November 2005:

Networks and The Future of Health Services

Diabetes networks have a real opportunity to take forward new policies in reforming health care and shaping their local services. They are the mechanism to creating joined up care that involves everyone, including people with diabetes, parents and carers. The advantage of working in an integrated, collaborative manner will ensure that diabetes services meet the specific local population need and reduce inequalities. In addition, the model of care that is developed needs to incorporate people who have a specific remit which includes managing complex care situations, training, education, research and implementation of evidence.

Beyond Boundaries: A Guide to Diabetes Networks can be seen at www.diabetes.nhs.uk