

## Improving the care of people with diabetes

The National Primary Care Collaborative (NPCC) Phase III focused on helping GP practices to achieve improvements for patients with diabetes and chronic obstructive pulmonary disease (COPD). The programme ran in three waves - Wave 1 was run from the Manchester office and Waves 2 and 3 covered the whole country via our area teams. Diabetes is a chronic condition with potentially devastating consequences for health and there are an estimated 2.35 million sufferers in England. Complications of diabetes include a higher risk of heart disease, stroke, kidney failure, eye disease (diabetic retinopathy) that can lead to blindness, and foot ulceration, which can lead to amputation. There is however a strong and robust evidence base that good diabetes care reduces the risk of these complications. The Government's [National Service Framework for Diabetes: Standards](#), published in 2001, set out the first ever national standards for the treatment of diabetes. The 12 standards cover all aspects of diabetes care and prevention, and together with the delivery strategy, provide a 10-year programme of change and improvement which will raise the quality of services and reduce unacceptable variations. If you are interested in working with the Improvement Foundation please go to [How we can help](#) or [click here to contact us](#). Who is involved All PCTs took part, including 1,931 general practices, which included 5,793 primary care team members and 300 lay/patient representatives, covering a population of nearly 13 million people. Each PCT established an improvement team of up to 15 people. These included, GPs, practice nurses, practice managers, project manager, PCT senior managers and secondary care colleagues. PCTs were strongly encouraged to ensure that they had patient or carer representation on the team. What we are doing Phase III of the NPCC had a clear aim and focus:

To support patients, frontline clinicians and PCT managers in using quality improvement skills and techniques to deliver significant improvements in the management of chronic diseases Specifically, improving diabetes care and the management of patients with COPD

Central to good chronic disease management is having an effective partnership between the patient and the practice. The programme involved patients as key members of the participating teams, and worked closely with the national Expert Patient Programme to assist in promoting the importance of self-care. Specifically practices were asked to focus efforts around change principles and associated change ideas that the experience of others had shown to deliver maximum effect. These were:

Adopt a multi-skilled, multi-agency approach to ensure effective coordination of the care of people with diabetes and COPD  
Establish a system for creating, validating and updating a register of people with diabetes  
Be systematic and proactive in managing the care of people with diabetes and COPD  
Involve patients in delivering and developing their care (create expert patients)

Key results CHANGE PRINCIPLES MEASURES RESULTS POPULATION COVERAGE

PARTICIPANTS Establish a system for creating, validating and updating a register of people with diabetes Be systematic and pro-active in managing the care of people with diabetes Involve patients in delivering and developing their care Adopt a multi-skilled, multi-agency approach to ensure effective co-ordination of the care of people with diabetes % of people with diabetes with a last recorded HbA1c of % of people with diabetes with a last recorded cholesterol reading of % of people with diabetes with a last recorded BP reading of % of people with diabetes with a retinopathy screening recorded within the previous 12 months 17% improvement in diabetic patients with excellent control (HbA1c 33% improvement in diabetic patients with cholesterol 31% improvement in diabetic patients with BP 80% improvement in digital retinopathy screening 2,000 fewer Myocardial Infarctions and strokes a year 12,932,575 All PCTs 1,931 general practices Minimum of 1,931 GPs 5,793 primary care team members 300 lay/patient representatives as part of improvement teams