Delivering personalised care in practice

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Personalised care planning aims to put people with diabetes firmly in the driving seat of their care and support them to self-manage more effectively. It transforms the traditional annual diabetes review into a constructive and meaningful dialogue between the healthcare professional and the person with diabetes. Included by NICE (2012) as a Quality Standard in diabetes, and adopted by the Royal College of General Practitioners within professional standards to be incorporated into training (Clinical Innovation and Research Centre, 2011), it should now be considered as much of a "must do" as optimising diabetes control or screening for neuropathy.

The Year of Care (YOC) programme has demonstrated how to embed personalised care planning as the normal way to deliver care for everyone with diabetes. Developed and rigorously tested in three diverse, pilot health communities (Tower Hamlets, Calderdale and Kirklees, and North of Tyne), YOC has produced a practical model for implementation, with components that can be understood, articulated, measured and transferred. This prototype has been spread in depth and breadth – to 12 other sites, to other single long-term conditions (LTCs) such as cardiovascular disease and chronic obstructive pulmonary disease, and, more recently, to people with multiple comorbidities. So, what have we learnt?

A key component of the YOC approach involves sending people with diabetes personal information on their test results prior to the care planning consultation. Putting information exchange at the heart of the routine clinical encounter was hugely welcomed by patients, and also positively rebalanced the power relationships with clinicians. Working across diverse health settings and populations has shown that this is valued by all, and is a potential way to improve health literacy and reduce inequalities. This process of information exchange also encouraged a systematic approach to the collection of routine clinical data.

The importance of the mind-set of clinicians as the driver of these changes cannot be emphasised too much. Clinicians often endorse a positive attitude towards a partnership approach and supporting self-management, but patient surveys have shown that only about half feel that they are routinely asked what was important for them and asked for their ideas about how to manage their diabetes (Healthcare Commission, 2007).

To address this, the YOC programme has developed a carefully tailored training and support programme that links changes in attitudes, skills and local infrastructure. Delivered to over 1000 practitioners via 40 quality-assured trainers, it has provided commissioners with the reassurance of a reproducible intervention designed for local adaptation and with a track record of changing clinicians' attitudes and behaviours.

As a result, YOC has demonstrated improved outcomes, including experience of care and real changes in self-care behaviours for people with diabetes and also improved knowledge, skills and job satisfaction for clinicians. Incorporating service redesign has increased quality including improved team-work, better systems for disease surveillance and Quality and Outcomes Framework checks, and a more systematic approach to delivering care; these are improvements that were shown to be cost neutral at practice level. Clinical indicators also improved, although the culture change involved takes time to embed for people with LTCs and staff alike and it may take two or three care-planning cycles for these to be realised.

The final, but arguably, most important message is that effective care planning consultations rely on four elements working together in the local healthcare system: an engaged, informed patient working with healthcare professionals committed to a partnership approach, supported by appropriate and robust organisational systems and underpinned by responsive whole-system commissioning.

Ultimately, YOC has shown that while implementing care planning is a significant challenge, it can be systematically delivered in routine care, and can provide benefits that are good for everyone: better self-management by individuals, a better way of working for clinicians and better use of resources. For further information about the YOC programme, visit www.diabetes.nhs.uk/year_of_care. ■

Clinical Innovation and Research Centre (2011) *Care Planning. Improving the Lives of People with Long Term Conditions.* Royal College of General Practitioners, London. Available at: http://bit.ly/Mgh4wf (accessed 15.05.12)

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