

PeoplePower in healthcare delivery: Remodelling for the future

As medical science and technology have advanced, the healthcare delivery system has struggled to provide consistent high-quality care. The National Service Frameworks and NICE guidelines are important contributions to establishing quality care. Although these approaches are to be applauded, they suffer from a lack of specific direction as to how the diabetes service should be provided and what a future service provision should look like.

Healthcare in a land called PeoplePower (Delbanco et al, 2001) takes us on a journey that evaluates what the clinician–patient relationship should look like, and what the components of that relationship are that would represent a quality service. It goes to the core of what medicine is about and recruits a broad church to tackle what it sees as the problems. The paper takes the patient and places him or her at the centre of care. It uses expertise from many areas outside medicine, such as quality control/assurance, to construct a quality system for care delivery.

Several publications have highlighted the discrepancy between what should be achieved in health care and what is actually delivered (Institute of Medicine [IoM], 2001). There remains a shortfall between knowledge acquisition and safe and appropriate translation into practice. Resource issues are cited as part of the problem but this ignores the fact that better use of resources will become increasingly important as investment will only be undertaken on the proviso of increased value for money.

Diabetes is a classic chronic condition that requires continuous monitoring and input, involves different specialties, and demands a high level of patient or parent involvement. Although this complexity is acknowledged, in practice there is little evidence that healthcare systems really understand this. Service provision in the UK is prone to widespread inconsistencies in care delivery and outcomes, and remains firmly medico-centric despite clear evidence that this approach is less than helpful (Butler and Lawlor, 2004). The health care offered to people with diabetes has safety and quality problems because the system that is used is largely outmoded.

PeoplePower adopts as its measures of quality the six components identified by the IoM (2001):

- Safe for patients and staff.
- Effective in providing services based on scientific knowledge to all who can benefit and refraining from providing services to those that will not benefit.
- Patient-centred, which respects and responds to patient preferences, needs and values.
- Timely, reducing waits and delays to patients and staff.
- Efficient in avoiding waste of equipment, supplies, ideas and energy.
- Equitable.

Table 1 considers two aspects of diabetes care and how the components might be applied. One important tenet of PeoplePower is the pre-eminence of the patient as the centre of care building on extensive research in chronic care provision (Wagner et al, 1996).

One of the reasons why diabetes sets itself up as a model for chronic care is that the underlying physiology and treatment modalities force the clinician and the person with diabetes or their carers to embark on a more equal interrelationship, rather than adopting the classic medical model. The physiology of insulin secretion relies on the pancreatic islet cells constantly sensing the ambient glucose environment and making appropriate adjustments to the



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Table 1. Examples of how the six components of quality identified by the Institute of Medicine (2001) might be applied to aspects of diabetes care.

Component of quality	General	Information technology
Safety	Diabetic ketoacidosis care	Online information on risks and ease of access to records
Effective	Evidence-based monitoring for complications	Real-time home monitoring
Patient-centred	Self-monitoring	Continuous single patient records
Timely	Access to results, information and clinics	Secured messaging systems
Efficient	Care across multiple sites	Shared healthcare records
Equitable	All populations	Available in multiple languages

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amount of insulin secreted. As the basic tenet of endocrine replacement therapy is to mimic this physiology as closely as is possible, this automatically generates for the person with diabetes or their carer a less dependent role on the clinician's services, as the situation dictates devolution of decision-making to the patient or carer. As intensive treatment is clearly beneficial in terms of a reduction in diabetes complications (Diabetes Control and Complications Trial Research Group, 1993), patient-centred care assumes a pivotal position in the care model.

ENCOURAGING SELF-DECISION-MAKING AND ACTION

Our understanding of the process of self-decision-making and the concept of patient autonomy has advanced considerably over the past 10–15 years. Medical ethicists have extended this principle to a number of areas of patient care, carefully refining the argument that involvement of the individual in all decision-making regarding their health and welfare is an essential component in modern healthcare practice (Schneider, 1998). This concept works extremely well with the evolving realisation in diabetes care that the scale of the problem can only be addressed by empowerment of the person with diabetes.

This switch necessitates a rethink in education and training programmes provided by healthcare professionals for people with diabetes and their families, and indeed for the healthcare professionals themselves. Education and training becomes an absolute necessity rather than a desirable part of healthcare provision – a point reiterated in PeoplePower. The challenge is to provide the person with diabetes with easy access to the information they require for executing their daily tasks, plus a background feedback system of how well they are performing with respect to the overall targets they have set themselves. Simple management tools, such as “Plan, Do, Study, Act” cycles can be easily put into practice at various levels of care. Interventions are more likely to be effective if they demonstrate the inter-relatedness of various aspects of diabetes management and are owned by the individual. For example, integrating medical and non-medical aspects of diabetes in multi-component interventions is more successful in improving metabolic control, particularly in adolescents, than those that focus on only one aspect (Grey et al, 2000; Laffel et al, 2003).

CONCLUSION

What PeoplePower tells us is that we are unlikely to improve diabetes care and control by continuing with the classic medical model. *Table 2* repositions the medical model in the framework outlined in PeoplePower. Given UK performance in diabetes care delivery, we can no longer ignore these issues. The health, social and economic issues argue against no change as an option.

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Table 2. Reconstructing the current model of care in the light of PeoplePower.

Current rule	New rule
Care is based primarily on visits.	Care is based on continuous healing relationships.
Professional autonomy drives variability.	Care is customised to patients' needs and values.
Professionals control care.	The patient is the source of control.
Information is a record.	Knowledge is shared freely.
Decision-making is based on training/experience.	Decision-making is based on evidence
“Do no harm” is an individual responsibility.	Safety is a system property.
Secrecy is necessary.	Transparency is necessary.
The system reacts to needs.	Needs are anticipated.
Cost reduction is sought.	Waste is continuously decreased.
Preference is given to professional roles over the system.	Cooperation among clinicians is a priority.