

This essay will critically reflect upon the concept of person-centred practice within health and social care by firstly describing what person-centred practice is and its link to Advocacy and social work. Secondly, this essay will focus on person-centred practice from a medical perspective, critically analysing the historic concept of the mind and body split, with emphasis on an individual's disability being a catalyst for legislation change and how person-centred practice should be available to all despite their abilities. Thirdly, this essay will consider the structures in which person-centred practice is delivered through, its importance within the medical model and the new understandings in which society has adapted to humanise the structures that society has become accustomed to. Fourthly, this essay will consider the role of person-centred practice within those structures, extended from the individual systems in which it is delivered, exploring the professional's role in the delivery of person-centred practice. Finally, this essay will critically analyse new legislation, designed to incorporate the medical, social divide by providing a new framework in which puts the individual at the centre of all structures, detailing the implications for service users, concluding with the argument that both advocacy and person-centred practice are, and have been within all areas of health and social care, however, in an attempt to humanise science and politics, the concept that a person is an individual and should be treated as such has become a minefield that needs to be vigorously negotiated.

Thompson, Kilbane and Sanderson (2007) suggest that there are ways of working that circulate around the person, with the focus on ensuring that the person has what is important to them by providing support and for them to achieve their dreams and aspirations within a healthy manner, ensuring that they are safe and well. Thompson, Kilbane and Sanderson (2007) continues by describing Person-centred practice as an integration, synthesis and application of key elements that are coherent within person-centredness in collaboration with person centred values, approaches, planning and thinking and that person-centred practice as a whole is the integration of recognising the uniqueness of every individual person and the respect that must be shown in a mutual capacity.

Following person-centred practice, an individual person, no matter what their views, beliefs or personal values are, have the right to have their voice heard. Through an advocacy lens, the Advocacy Charter (2014) confirm that each individual has the right to be in full control of their own lives, expanding that the advocate will ensure that person-centred practiced will be the practice that it follows, to ensure that the wishes and interests of the individual person is

respected and followed within a non-judgemental and respectful context. Through a social work lens, the Social services and wellbeing (Wales) Act (2016) despite being enacted after the Advocacy Charter, does not directly mention person-centred practice, however, one of its main principles is 'Voice and Control' which they describe as putting the individual and their needs at the centre of their own care, the same description as person-centred care. The British Association of Social Workers (2020) however, describe person-centred practice as a support system for the individual person to gain the skills to be able to make their own decisions about their own health and social care creating a view of two different contexts, depending on what field of social work you work in.

Thompson, Kilbane and Sanderson (2007) accept that there are challenges in delivering services that put individuals more in control of their lives, in particular the practices in which professionals use when working with people in a social capacity. The development of practices, such as person-centred practice has been both complicated and problematic, as at the centre is the individual, and every individual is different. This means that these practices can-not form a solid structure, it must be a flexible with one clear goal, and a collective focus on the person. In order to do this, person-centred practice must be understood by both the professional and the person.

Thompson, Kilbane and Sanderson (2007) believes that in order for our society to move forward within person-centred practice, professionals need to integrate approaches to support planning and greater community inclusion into their day to day work, arguing that we should not simply place people in the centre of the interventions, instead, professionals need to understand where they fit within the context of the persons individual life, and by extension, the control in which the person has on their own life. Wilks (2012, p.50) suggests that the person-centred approach contrasts with human rights. Within an Advocacy context, a person-centred approach is similar to citizen advocacy, by placing the relationship between advocate and client at the centre of the process as opposed to just the client. Koubel and Bungay (2008) explain that this is in order to compliment the approach and the orientation in which health and social care has towards the client compared to the advocates orientation. Wilks (2012, p.50) Continues that it is in fact those who support the person-centred approach who argue that it is the most effective way of not only building up a picture of the client, their like and dislikes for example, but also an effective way of maintaining a person's wellbeing, upholding their personhood and ensuring that they are respected as an individual person, with individual needs.

This in turn promotes confidence and self-esteem, allowing the client to be empowered contributing to their own personal well-being.

Person-centred practice is not a new concept, it does however vary when exploring from alternative angles. Person-centred practice from a disability perspective is coherent within the medical model. Carmel and Felix-Bortolotti (2014) explains that focussing on the individual as a person is a 'major challenge' with the current research paradigms focussing on the individualisation of care and enhancing the personal experience within the health care setting. Carmel and Felix-Bortolotti (2014) Further argues that person-centred practice within health care has a strong moral prerogative which requires a deep respect for the person as an individual and the obligation in which the health care professionals and the decision makers have to care for them, on the individual's terms. Thus concluding that 'Patients are known as persons in the context of their personal worlds' they must be heard, engaged, valued and involved in all aspects of their care, ensuring that their preferences are at the core of all care delivery and enacted upon in an ethical and thoughtful way throughout their health care journey (Carmel and Felix-Bortolotti, 2014).

Hughs (2013) strongly suggests however, that further research needs to be done to explore and recognise the centrality that it is not just the person who is central, it is also other members of the persons family, and the influence that they may have during the decision process consistent with the ethics of person-centred practice within the advocacy provision. Carmel and Felix-Bortolotti (2014), confirms that person-centred practice within the health care setting has now become the focus of all research because of the dominant emphasis of scientific research which has still yet to deliver the expected positive health gains for the individuals, suggesting that person-centred practice has not evolved sufficiently, as it does not focus fully on the individuals needs or their individual journey, following science, not social. Mehta (2011) explains that the distance between health and social care has always been apparent, from the early 1500's, during the scientific revolution, the body was explored biologically to look for biological symptoms, however, the mind was left to the church, creating a mind and body division, the body being medical, and the mind being social which Mehta explains is Cartesian dualism.

Wade and Halligan, (2017) explain that it is the classic medical model that is characterised by a reductionist approach that attributes illness to a single cause which is located within the body. Unravelling that within the medical world, the main issue is the medical problem, whether it

be a broken arm or a lifelong chronic illness, that is what is at the forefront of the doctor's mind. George Engel (1977) began to emphasise the importance of the link between the body and the mind in 1977,

“The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological and behavioural dimensions of illness. The biomedical model not only requires that disease be dealt with an entity independent of social behaviour. It also demands that behavioural aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) process”.

Disability has become a catastrophic dilemma, catapulting into legal rows and the questioning of human rights, with legislation being introduced to protect those who may not of had a voice previously, it is now rightly considered that those with disabilities are not different from those ‘able bodied’ and therefore should not be treated as such. Carnwell and Buchanan (2009) address the need for those in society who are disabled or disadvantaged which experience discrimination to have legislation in order to tackle that very discrimination in which they are subjected to. Equality legislation has been extended multiple times with public sector bodies, which include those within the health and social care sector are currently required by law to promote equality of opportunity and good relations between people, providing a more personal, tailored service to the client. The Disability Discrimination Act (2005) required public sector bodies to promote an equal opportunity for those who are disabled within all aspects of their life, including during their medical journey and the service in which they receive throughout this journey within a social capacity. The Equality Act (2006) offers a similar duty for public bodies relating to equality and human rights, combining the functions of the three existing equality commissions, however, Bradshaw and Bennett (2004) acknowledge that even though the duties within the public bodies are important for promoting equality across the public sector, it is not always accomplishable resulting in no guarantee that equality will be achieved.

Those who are disabled have no less rights than those who are able bodied, with the Education, Health and Care Plan Task Group (2014) explaining that we all think about and plan our lives individually and in different ways, with some having very clear ideas about what they want and how they want to achieve it and others not having a clear idea, instead simply take opportunities as they arise. Person-centred practice should be at the heart of everything that we do as professional practitioners, arguing that every person is different, with different views,

aspirations and dreams regardless of their ability, even though they may differ to encapsulate that individual's ability, the mind still has the ability to dream. Education, Health and Care Plan Task Group (2014) emphasise that person-centred practice can help those who are disabled to become more independent, by empowering them to create their own path within their medical and social journey, to promote their independence and help them to achieve their own personal goals. Recent research has shown that person-centred practice has significantly changed areas of social development, learning, relationships, contact and community-based activities and levels of choice. Equally Person-centred Practice has provided the professional with a way of viewing an individual's life, by putting the person at the centre and incorporating the family and the friends of the person within the planning process, the professional has the ability to create a well-structured plan, that provides a true reflection of what is important, including their capacity, reflecting what is possible for them, not just what is available, resulting in an ongoing listening and learning circle, by both professional and person, collaborating every aspect of that individuals life, both medically and socially, achieving exactly what they want and need.

The person-centred practice that the patient receives depends on the top level beliefs within different professional structures, which have been developed to meet the evolving need within society, however, following the industrial revolution, the concept of people being a 'machine' was diminished, and with the rise of democracy, the idea of humans being 'individual' catapulted the 'new' humanism and postmodernism concepts, resulting in a backlash against the medical model (Wade & Halligan, 2017). "Humanism emphasised the value of and the agency of people, whilst postmodernism in part challenged notions of power, including the power of knowledge" (Wade & Halligan, 2017). During this time however, Wade and Halligan (2017) remind us that the medical model had in fact been curing diseases, but an unsettling paradox had come to light. It became apparent that sometimes, people felt ill but had no physiologically identifiable diseases, while others, who had obvious identifiable diseases, did not feel ill at all, conducting the notion that the mind and body are connected, resulting in a new discipline of psychiatry (Elkins, 2010).

It was George Engel (1977) who identified the need to replace the medical model, which evolved from the medical to the biomedical, with a new, more incorporating system, named the biopsychosocial model, arguing that the existing medical model was not modern or sufficient enough to provide a basis or understanding of disease because it did not take into

account the patient as a person or indeed the social context in which that person lives. Engel suggested that in order to deal with the disruptive effects of illness, a physician and health care professionals should work together in collaboration within a new biopsychosocial model incorporating domains of humans that have been neglected. Wade and Halligan (2017) argue that Engels forty-year-old social incorporation of the medical model has shaped the guidelines, producing structure, not only by its use clinically, but its innovative incorporation of the 'person-patient-client' as an individual, birthing the now known 'person-centred care' (George Engel (1977)).

Person-centred practice is challenged within this relationship, however, the individuals circumstance must be considered as with any positive advance, there will always be criticism, (Farre and Rapley, 2017) suggest that the "biopsychosocial approach requires the clinicians to gather an unreasonable amount of data on each patient" prolonging diagnosis and treatment. (Searight, 2016) and (Western, 2005) suggest that it is from this context, the medical model reverts back to the original, suggesting that medical professionals "do not spend enough time with their patients"(Western, 2005). In retaliation to this statement, (Searight, 2016) suggests that medical professionals have found an ethical loophole, by offering the solution of 'Person-centred clinical care' in an attempt to honour the biopsychosocial principles, allowing them to 'bypass' the social context of the new medical model, putting into question the person-centred planning, their person-centred care and ultimately their person-centred practice, creating a therapeutic relationship as opposed to a holistic one.

With multiple models of disability being available to practice within, it can be difficult to navigate between the medical, social and affirmation structures of society, however, it is within the confusion of these structures, the need to consolidate them into a singular, modern approach is apparent, by using the understanding that without an individual person, none of these models would exist, confirming the need for the individual person to be central within all of their health and social care needs. McCormack and Collins (2010) explain that disabled and non-disabled people live within the same cultural norms, however, many disabled people adopt a negative view of themselves and become controlled by their disability, shadowing them from the support and services that are available to them. (Mansell and Beedle-Brown, 2004) Explain that this is representative of the social system that has focussed on their disability as a priority rather than the person, however, with the emerging person-centred practice, individuals are gaining a power that they may not have had before, changing the negative orientation of disability into a positive notion. McCormack and Collins (2010) demonstrates that those who learn to reject the

dominant culture which oppresses those with a disability and a negative view will become substantially more visible, portraying a positive self-image, represented by the emergence of the affirmation model of disability.

Sumsion and Law (2006) explain that empowerment, partnership, choice and hope are key components in person-centred practice that are well recognised and entwined within all practice methods within health and social care. Ballantyne and Muir (2008 p.147) argue that these professional occupations have been dominated by the medical model, influencing the perception of the service users, resulting in many professional practices focussing on the individuals 'impairment', as opposed to the individual as a person, resulting in the individual being seen as a problem that needs remediating and the deficit being diminished. McCormak and Collins (2010) argue that disability studies prove that all fields of health and social care have the potential to support person-centred practice, suggesting that each individual field may be conformed to their particular way of working, and may find it difficult to accept a new concept, but it is possible.

The Health Foundation (2016) establish that a person-centred approach has multiple principles and activities, partly due to the concept being new and evolving. They also argue that it is because of its evolving nature that the concept of 'person-centred' and its delivery will very much depend on the nature of the professional who is delivering it. The Health Foundation (2016) continues to explain, that within health and social care, person-centred practice is co-ordinated and tailored to the individual, arguing that health care often does 'to' or 'for' people rather than 'with' them, suggesting that it is because the structures within the system find it difficult to include people in decisions, even though the systems have been adapted to support person-centred practice. Further research shows that the ideology of person-centred practice has been written into all areas within health and social care, however, it is the way in which it is practiced and by whom that determines the success it has within this field.

National Disability Practitioners (2016) (NDP) consider that every conscientious and committed professional person who works within health and social care believes that the best approach when working with people is the person-centred approach. NDP explain that the professional's personality is a critical element of whether or not person-centred practice is applied correctly, suggesting that morals and ethical beliefs play a key role. NDP further explain that most professionals within the health and social work field initially commit

themselves to help and support individuals, however, it is the system in which they work for that operates as a business, following the medical model, institutionalising their employees and creating a capitalist's system. The professional person becomes a worker, dependent on the financial gain from their job role and therefore conforms to the service/system centred approach because they have no other choice (National Disability Practitioners, 2016).

Dowling, Manthorpe and Cowley (2006) Believe that staff are the key resource within the delivery of person-centred practice, claiming that some health and social care workers are naturals, drawing on personal life experiences or using their instincts in order to deliver services with a person-centred approach, however, they argue that not every professional has this ability, therefore training is essential in order for them to learn these skills. Dowling Manthorpe and Cowley further suggest that person-centred practice is not possible without good management, suggesting that the support for the frontline staff is critical, explaining that it is the managements skills that must be person-centred, have firm support structures and be inclusive of the frontline staff that will influence the teams delivery of person-centred practice. This suggests that if a service must use a top-down approach, it must be person-centred, confirming that your positionality is vital within the delivery of such care giving the impression that person-centred is the perfect approach as long as it sits within the budget. Carmel and Felix-Bortolotti (2014) argues that there is an urgent need for person-centred research to take place in order to evolve the health care setting as the marriage between the medical need and the person's need is complex, arguing that a transdisciplinary and complex systems approach would provide a sense-making framework.

The Welsh Government attempted to construct this framework, by enacting the Health and Social Care (Quality and Engagement) (Wales) Act (2020), in order to make provision to provide an improvement within the health and social care structure, obeying the need for a transdisciplinary approach to both health care and social care as a collaborative. Underpinning the Act are four main principles, 1) To ensure that all NHS bodies consider the quality of their service when making decisions. 2) To ensure that all NHS bodies including the primary care services are 'open and honest' referring to if or when something goes wrong with the persons care. 3) To create a new 'Citizens Voice Body' as an independent body to represent the views of people across both the health and the social care services. 4) To further support the appointment of vice chairs for all NHS trusts.

An overview of this Act largely tightens up guidelines surrounding the professional-patient relationship providing a greater, much needed, external support system. By enacting changes about the duty of quality, the new Act will ensure that professionals will consider how changes will affect people who use health and social care services, with an implementation on how these changes can improve health services, giving the impression that whilst considering the person as an individual, the NHS must use the information they gain through a census to improve the service, listening to the individual, letting them have a voice, and in turn, improve their practice, putting the patient at the centre of all practices, using both Advocacy and person-centred practice (Health and Social Care (Quality and Engagement) (Wales) Act (2020).

Upon review, the Wales council for voluntary action (WcVa) and the Co-production Network for Wales (CNW) (2019) both believe that the intention of the Act is to strengthen the citizen voice, which is essential to improving the services received within Wales. However, both the WcVa and the CNW (2019) criticise the Act for being predominately health focussed, arguing that more weight needs to be considered for the social care organisations to ensure quality and improvement of social care provision, further arguing the integrity of the Act, questioning if this Act has been produced due to a lack of confidence in existing Legislation that is predominantly aimed at either health care or social care.

Bennett (2019), the Public Services Ombudsman for Wales welcomes the new Act, specifically the aspirations in which it provides to improve the quality of care in which the NHS delivers to its patients. Bennet (2019) states that nearly half of his complaints; 46% in 2018/19, are in regard of health services and is pleased that there is an 'evident desire' to improve the accountability of the NHS. Bennett (2019) identifies that the Citizen Voice Body is simply a new name given to an already established 'Advocacy Body' however, 'very much' supports the combination of both health care and social care issues being addressed by one public body. The Department of Health (2001) explain that advocacy is one of the ways in which people could get more choice and control within their lives, concluding that independent advocacy, being independent from statutory roles and responsibilities, can focus solely on the persons needs and wishes, putting them at an advantage point from those who are working within a health and social framework, although they are concerned that there are not enough independent advocates to supply demand. Bennett (2019) explains that the advocacy that is apparent within the Citizens Voice Body is imperative as there is currently no consistent provision of advocacy services for the joint health/social care however, discredits the new Act,

questioning the independence, as the members within would be appointed by the Welsh Government, with Welsh ministers having ‘effective veto’ on the chief executive, coupled with the funding complications. Bennett (2019) calls into question the independence of the Citizens Voice Body, suggesting that it may be more effective to employ a ‘wholly independent body’ to make, or at least oversee appointments or decisions, with the latter only causing more complication and further excluding the personal element in which the Citizens Voice Body claims to be.

It can be argued that person-centred is a concept in which has highlighted the Advocacy role. Advocacy is within all areas of health and social care, perhaps with different names or job descriptions but nevertheless, Advocacy is there. It can be seen throughout this essay, that person-centred practice is a concept in which has multiple benefits for the person, remembering that each individual person is just that, an individual person. However, because of the structures that each professional follow’s, whether it be medical or social, depends upon the service that the person receives. Person-centred practice is designed to be holistic, it is in fact, as shown throughout this essay, a scientific, clinical, political approach and therefore the implications for the service user depends on which area of care that they need, should it be medical, they are likely to receive care dictated by the medical model, should it be social, they are likely to receive care dictated by the social model. Person-centred practice on paper is exactly what people need, it is evident however, that the actual practice is far from its paper accompaniment.

References:

- Advocacy Charter, The (2014) *Code of Practice* Available at:
<https://qualityadvocacy.org.uk/wp-content/uploads/2018/05/Code-of-Practice-1.pdf> (Accessed: 8th October 2020)
- Ballantyne, E and Muir, A (2008) *In practice from the viewpoint of an Occupational Therapist: Disability on equal Terms* London: Sage
- Bennett, N (2019) *Response by the Public Services Ombudsman for Wales in Response to the consultation on the Health and Social Care (Quality and Engagement)(Wales) Bill* Available at: <https://www.legislation.gov.uk/asc/2020/1/contents/enacted> (Accessed: 29th November 2020)
- Bradshaw, J and Bennett, F. (2004) *United Kingdom National Action Plan on Social Inclusion 2003-2005* Available at:
https://ec.europa.eu/employment_social/social_inclusion/docs/3uk_en.pdf (Accessed: 12th November 2020)

- Carmel, M and Felix-Bortolotti, M. (2014) 'Person-Centred Health Care: A Critical Assessment of Current and Emerging Research' *Journal of Evaluation in Clinical Practice* 20(6), pp. 1056-1064
- Carnwell, R and Buchanan, J. (2004) *Effective Practice in Health and Social Care*. United Kingdom: McGraw-Hill Education.
- Department of Health (2001) 'Valuing People: a new strategy for learning disability for the 21st century', London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/250877/5086.pdf (Accessed 20th November 2020)
- Disability Discrimination Act (2005) Available at: <https://www.legislation.gov.uk/ukpga/2005/13/contents> (Accessed: 1st November 2020)
- Dowling, S, Manthorpe, J and Cowley, S (2006) *Person-centred Planning in Social Care* Available at: <https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/9781859354803.pdf> (Accessed: 29th November 2020)
- Education, Health and Care Plan Task Group (2014) *Person-Centred Approaches: All About Me* Available at: <https://www2.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/childreneducationandfamilies/educationandlearning/specialeducationalneeds/PersonCentredPlanningTools.pdf> (Accessed: 15th November 2020)
- Elkins, D. (2010) 'David Elkins responds' *Journal of Humanistic Psychology* 50(2) pp.256-263 Available at: <https://journals.sagepub.com/doi/pdf/10.1177/0022167809355195> (Accessed: 11th November 2020)
- Engel, George L. (1977) 'The need for a new medical model: A challenge for biomedicine' *Science* 196(4286) pp.129-36 Available at: <http://www.drannejensen.com/PDF/publications/The%20need%20for%20a%20new%20medical%20model%20-%20A%20challenge%20for%20biomedicine.pdf> (Accessed: 15th November 2020)
- Equality Act (2006) Available at: <https://www.legislation.gov.uk/ukpga/2006/3/contents> (Accessed: 3rd November 2020)
- Farre, A and Rapley, T (2017) 'The New and Old (and old new) Medical Model: Four decades Navigating the Biomedical and Psychosocial understandings of Health and Illness' *Healthcare* 5(4) p.88 Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5746722/> (Accessed: 22nd November 2020)
- Health and Social Care (Quality and Engagement) (Wales) Act 2020 Available at: <https://www.legislation.gov.uk/asc/2020/1/contents/enacted> (Accessed: 29th November 2020)
- Hughs, L. (2013) 'Patient Centred Care: It Starts with a Letter' *British Journal of Family Medicine* Available at: <https://www.bjfm.co.uk/patient-centred-care-it-starts-with-a-letter> (Accessed: 12th October 2020)
- Koubel, G and Bungay, G. (2008) *the Challenge of person-centred care: An interprofessional Perspective* Basingstoke: Palgrave Macmillan
- Mansel, J and Beedle-Brown, J. (2004) 'Person-Centred Planning or Person-Centred Action? Policy and practice in intellectual disability services' *Journal of Applied Research in intellectual disabilities* 7(1) pp.1-9 Available at: <https://onlinelibrary.wiley.com/doi/full/10.1111/j.1468-3148.2004.00175.x> (Accessed: 12th November 2020)

- McCormack, C and Collins, B. (2012) 'The Affirmation Model of Disability: A Means to include a disability Orientation in Occupational Therapy?' *The British Journal of Occupational Therapy* 75 (3) pp.156-158 Available at: https://www.researchgate.net/publication/272204507_The_Affirmative_Model_of_Disability_A_Means_to_Include_Disability_Orientation_in_Occupational_Thera (Accessed: 22nd November)
- Mehta, N. (2011) 'Mind-body dualism: A Critique from a Health Perspective' *Mens Sana Monographs* 9(1), pp. 202-209 Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3115289/> (Accessed: 12th October 2020)
- National Disability Practitioners, The (2016) *What is a person-centred approach?* Available at: <https://www.ndp.org.au/images/factsheets/346/2016-10-person-centred-approach.pdf> (Accessed: 12th November 2020)
- Searight, H (2016) 'The Biopsychosocial Model: Reports of My Death Have Been Greatly Exaggerated' *Culture, Medicine and Psychiatry* 40(2) pp.289-298 Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5746722/> (Accessed 12th November 2020)
- Social Services and Wellbeing (Wales) Act 2014 Available at: <https://www.legislation.gov.uk/anaw/2014/4/contents> (Accessed: 8th October 2020)
- Sumsion, T and Law, M. (2006) 'A Review of the evidence on the conceptual elements informing client centred practice' *Canadian Journal of Occupational Therapy* 73(3) pp.153-162 Available at: <https://journals.sagepub.com/doi/10.1177/000841740607300303> (Accessed: 15th November 2020)
- The British Association of Social Work (2020) *Person-centred Care Made Simple: What everybody should know about Person-centred Care* Available at: <https://www.basw.co.uk/resources/person-centred-care-made-simple> (Accessed: 10th October 2020)
- The Health Foundation (2016) *The Person-centred care made simple: what everybody should know about person-centred care* Available at: <https://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf> (Accessed: 17th November 2020)
- Thompson, J, Kilbane, J and Sanderson, H. (2007) *Person Centred Practice for Professionals* Berkshire: Open University Press
- Wade, D and Halligan, P. (2017). The biopsychosocial model of illness: A model whose time has come. *Clinical Rehabilitation*, 31(8), 995-1004. Available at: <https://journals.sagepub.com/doi/full/10.1177/0269215517709890> (Accessed: 14th October 2020)
- Wales Council for Voluntary action and the Co-Production Network for Wales (2019) *Health and Social Care (Quality and Engagement) (Wales) Bill: A joint Response from WCVA and the Co-Production Network for Wales* Available at: <https://wcva.cymru/wp-content/uploads/2020/01/Health-and-Social-Care-Bill-.pdf> (Accessed: 25th November 2020)
- Western, W. (2005) 'Patient Centred medicine: A guide to the Biopsychosocial Model' *Families, Systems and Health* 23(4) p.387 Available at: https://www.researchgate.net/publication/232590378_Patient-centered_medicine_A_guide_to_the_biopsychosocial_model (Accessed: 14th November 2020)
- Wilks, T. (2012) *Advocacy and Social Work Practice* Berkshire: Open University Press