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Introduction

In this assignment, I will explore the need and benefits of Person-Centred Care. From understanding the concept of it to the underpinning person-centred care. The ethics of having access to health and social care, along with legislation and regulators to support the importance of good health and social care practice. Looking into the limitations of person-centred care with recommendations in a certain area of care. Analysing how important it is, not just to focus on people's medical needs but a whole scale of other needs and wants as individuals.

According to (England, 2021) "Personalised care means people having choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs, and preferences. This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity, and potential of people, families, and communities in delivering better health and wellbeing outcomes and experiences."

Concept of Person-centred Care

In the lesson, I understood that the main purpose of person-centred care is so that the service user prefers, wishes and needs could be met. The service provider should support the person's ability, independence along with their participation. Supporting family or next of kin to make choices about what service they may need or require. Person-centred care is tailor-made to suit individuals. As the service provider, it becomes your duty to know the patient as an individual, get to understand them and their essential requirements, enable them to actively participate as long as possible, and continue care throughout their journey.

According to (Person-centred care, 2021) "Person-centred is about focusing care on the needs of an individual, ensuring users preferences, needs and values guide clinical decisions, with providing care that is respectful and responsive to the service user. Health and wellbeing outcomes need to be co-produced by individuals and members of the workforce working in partnership, with evidence suggesting that this provides better patient outcomes."

The foundation of person-centred care is the following according to (Person-centred care, 2021)

"Person-centred care approach is a core skills education and training framework that articulates what it means to be person-centred and how to develop and support the workforce to work in this way. Developed in partnership with Skills for Health and Skills for Care, the Framework aims for best practice and to set out the core, transferable behaviours, knowledge, and skills. These skills should be applicable across services and sectors (e.g. health, social care, local authorities, and housing) and different types of organizations (e.g. public, private, and not-for-profit). Person-centred Approaches underpins existing Dementia, learning disability, mental health, and end of life care core skills frameworks."

Underpinning Person-Centred Care

We have the Care Quality Commission (CQC) which is the regulator and enforcing authority for patients and service user's health and safety is monitored, inspected, and regulates services to make sure the fundamental standards of quality and safety are met. They Have the responsibility to publish what they find including the service provider's performance ratings to help the public chose.

According to (Care Quality Commission, 2021) "The Care Quality Commission (CQC) regulates all health and social care services in England, the commission ensures quality and safety of care in hospitals, dentists, ambulances, and care homes, and the care given in people's own homes are meet by the standard of law, CQC is an executive non-departmental public body, sponsored by the Department of Health and Social Care."

In the United Kingdom, we have Codes of Conducts along with the Regulators we also have The Professional Regulatory Bodies who ensure standards are maintained by the Health and Social Care Professions, ensuring actions to be taken when code of conducts are not followed. These bodies act as a duty to achieve similar processes in different professions across the UK. Their main duties include

- Maintain an up to date register of professions
- Set and maintain standards in education, training, and conduct
- Investigations to be taken when these standards are not met or when a professional is in doubt.

The Healthcare Professional Bodies are:

- General medical council (GMC)
- Nurse and midwifery council (NMC)
- General Dental Council (GDC) –
- General Optical Council (GOC) –
- General Chiropractic Council (GCC) –
- General Osteopathic Council (GOC) –
- General Pharmaceutical Council (GPC) -
- Health and Care Professions Council (HCPC) – Regulates 15 health care professions

Although these are all there and doing their part, it is not Person-centred care. The UK has Key Legislations in Health and Social Care which I learned in class, here are a few:

- | | |
|------------------------------------|---|
| >Care Act 2014 | >Mental Capacity Act 2005 |
| >Children and Social work Act 2017 | >Putting People first 2007 |
| >Children and Families Act 2014 | >Safeguarding Vulnerable groups Act 2006 |
| >Health and Social Care Act 2008 | >The Children Act 2010/2004/1989 |
| >Equality Act 2010 | >United Nations Convention on the Rights of the Child |

Ethics of Person-centred care

The principle for person-centred care is so that an individual can feel respected and recognized as an individual their diversity, culture, preferences, or values should be supported. It is everyone's entitlement in the UK to have access to Healthcare. Everyone should be joined to their local GP and in an emergency, you can go into the nearest hospital. However, even in the UK some people not receiving equal health treatments due to certain situations which is inevitable.

According to (What are health inequalities? 2021) " Health inequalities are about the differences in the status of an individual's health. But the term is also commonly used to refer to differences in the care that people receive, the opportunities that they must lead healthy lives, both of which can contribute to their health status. Health inequalities can involve differences in:

- health status, e.g. life expectancy and prevalence of health conditions
- access to care, e.g. availability of treatments
- quality and experience of care, levels of patient satisfaction
- behavioural risks to health, smoking rates
- wider determinants of health, e.g. quality of housing."

According to (England, 2021) "Health inequalities are unfair and avoidable, health inequalities arise due to conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel, and act, which shapes our mental health, physical health, and wellbeing.

Health inequalities have been documented between population groups across at least four dimensions, as illustrated in the figure below. It is important to note that these are overlapping dimensions with people often falling into various combinations of these categories.

- Socio-economic status and deprivation: e.g. unemployed, low income, people living in deprived areas e.g. poor housing, poor education, and/or unemployment.
- Protected characteristics: e.g. age, sex, race, sexual orientation, disability
- Vulnerable groups of society, or 'inclusion health' groups: e.g. vulnerable. migrants; Gypsy, Roma, and Traveller communities; rough sleepers and homeless people; and sex workers
- Geography: e.g. urban, rural.

Action on health inequalities requires improving the lives of those with the worst health outcomes, fastest. People who are homeless/rough sleepers, vulnerable migrants (refugees and asylum seekers), sex workers, and those from the Gypsy, Roma, and Traveller communities. Evidence shows that people living in deprived areas face worse health inequalities in health access, experiences, and outcomes. Working to address inequalities in urban and rural deprived areas of England needs to be taken. What defines an area which is deprived, is based on multiple things e.g. Income Deprivation, Employment Deprivation; Education, Skills and Training Deprivation; Health Deprivation and Disability, Crime, Barriers to Housing and Services and Living Environment Deprivation."

Limitation and Benefits of person-centred care

According to (Newton, 2015) "The main limitation for person-centred care is unsupportive staff, lack of attitudes, Physical resources, and environmental constraints along with high staff workloads, time pressures, staffing constraints and reduced levels of staff experience. This included both clinical and administrative workloads. Some managers outlined that these workloads were increasing because of increasing patient presentations. Managers often spoke about being below their full-time-equivalent target due to recruitment delays and staff leave."

There are more benefits in person-centred care According to (Burton and Burton, 2021) "Person-centred care benefits patients to receive more appropriate care and allows them to feel more wholly cared for as a human being, it also brings so many other benefits to patients and healthcare centres overall. The service user feels more comfortable and confident in the service, as their dignity and independence build mutual respect. The patient will trust you to do what's best for them, which makes the situation easier for both. You can meet their emotional, social, and practical needs, which ensures they maintain a high quality of life. Supporting those who may not be able to communicate their wants and needs. Conditions or disabilities can affect a person's ability to communicate effectively, such as dementia, learning disabilities, or those who simply don't have the confidence to do so. Person-centred care helps you find suitable ways to help them communicate and maximize their quality of care. It can improve their independence, which is beneficial on a personal level for the patient, but it also encourages them to take part in decisions. It can raise their engagement, which helps you reach better and more suitable decisions relating to their care. Furthermore, it gives them the confidence and ability to look after themselves with less input from you. Other benefits include Patients sticking to treatment plans and taking their medicine. Hospitals in the UK are extremely strained because too many patients admit themselves when they don't need to. Person-centred care improves patients' understanding of their condition and when a need for emergency services. The service can motivate patients to adopt positive health behaviours that improve and help them manage their own health. This is important for people with long-term conditions. It is time and cost-efficient tailored to enabling care for patients to receive the medication they will take, as well as attend and engage in the right services. Valuable time and money will be spent on what people really want and need."

Application of person-centred care for Dementia

People living with Dementia and coming to the last days of life should absolutely use person-centred care. The families should have opportunities with the care provider to make the last days of life as peaceful and comfortable for the patient. Considering the family's choices of meals, pain management, ways for the family to be any form of an assistant if possible, e.g. saying prayers. Having their last moments of respect and dignity fulfilled in the setting, as dying is the nature of life patients should by now be known as the individuals. Advance care planning will help the staff be prepared to do what is important to the patient and know which family to speak to for the final decisions on behalf of the patient. This sort of planning allows you to record down information discuss it with the doctors and share it with others who need to know this information.

According to (National Centre for Biotechnology Information, 2021) "The process of advance care planning in dementia is far from straightforward, as dementia progresses, the ability to consider future thoughts and actions become compromised, which affects decision-making abilities. Family carers find themselves needing to inform, or directly make, decisions on behalf of the person with dementia."

Recommendation for Postnatal care

This area of care needs a lot more attention and improvement for everyone's sake, as it affects the future of the mother, partner, and children involved.

According to (RCM, 2021) "Surveys of women's views of maternity care repeatedly inform that their unhappiness with the current provision of postnatal care which does not provide them with the support they need. Despite policy rhetoric that supports women's choice and their involvement in decision making, the findings are evidence that the NICE recommendation for individualized care planning could improve continuity of care and ensure women and their babies receive the number of postnatal contacts appropriate to their needs, is not being implemented.

The role of the maternity team in supporting women and recognizing the complications is vital, however, there has been a decrease in the period of postnatal stay in hospital and the number of home visits is given little recognition or importance. This has led to the current content and timing of postnatal care is not meeting women's health needs or support families need. Individualized care is key to providing important information at the correct time, recognizing the additional support is needed, and offering targeted interventions through the appropriate multiple agency care pathway should be done. The NICE quality standard recommends that; A documented, individualized postnatal care plan should be developed with the woman ideally in the antenatal period or as soon as possible after birth. Postnatal care should always be based on women's needs and not on how underfunded and overstretched local maternity services are. Providers of NHS maternity care need to ensure that midwives and MSWs are given time to prioritize a postnatal care plan with women and partners, this would be models of care that provide continuity, the RCM recognizes that continuity of care is a very significant factor in determining the satisfaction women feel when reviewing their postnatal care."

Conclusion

I believe we have a long way to go before person-centred care is available in many health sections e.g. pregnancies, surgeries, hospital visits, etc. Although there are many benefits the cost is too much for the country and cannot afford it as of so yet. However, looking at the evidence shows The Year of Care Programme found in 2011 that those in areas of socioeconomic deprivation gained the most from personalized care planning interventions. This means that unlike many health interventions, care and support planning will narrow the health gap (England, 2021). I believe person-centred care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing, and monitoring care to make sure it meets their needs. According to (Evidence: Helping people help themselves | The Health Foundation, 2021) "Evidence suggests that supporting people to look after themselves can improve their motivation, the extent to which they eat well and exercise, their symptoms and clinical outcomes can change how they use the health services. A wide range of initiatives are described as 'self-management support' and some may be more effective than others."

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