Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

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Health and Social Care: Disability and Wellbeing

Health and Social Care: Person Centred and Integrated

2023

Trawsnewid Addysg; Trawsnewid Bywydau
Transforming Education; Transforming Lives

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PERSON-CENTERED CARE

ALSO CALLED ‘PATIENT-FOCUSED’ OR ‘PATIENT-CENTERED’

WHAT DO YOU THINK OF WHEN YOU HEAR 'PERSON-CENTERED' CARE?

What is Person-Centred Care?

Person centred care refers to a process that is:

- people focused
- promotes independence and autonomy
- provides choice and control
- based on a collaborative team philosophy

It considers people's:

- needs and views
- builds relationships with family members

It recognises that care should be holistic and so includes a spiritual, pastoral and religious dimension.

http://www.wales.nhs.uk/governance-emanual/supporting-guidance-patient-centred-care

Defining 'person-centre'

(The Health Foundation, 2016, p. 7)

"The term 'person-centred care' is used to refer to many different principles and activities, and there is no single agreed definition of the concept.

This is partly because person-centred care is still an emerging and evolving area. It is also because, if care is to be person centred, then what it looks like will depend on the needs, circumstances and preferences of the individual receiving care.

What is important to one person in their health care may be unnecessary, or even undesirable, to another.

It may also change over time, as the individual's needs change"

Four Principles

1. Affording people dignity, compassion and respect.
2. Offering coordinated care, support or treatment.
3. Offering personalised care, support or treatment.
4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

(The Health Foundation, 2016, p. 7)

Overview

The call for personalised care stems from disabled people, their families and allies

Recognises people are their own best experts

Some organisations recognise this

But some struggle to escape their institutional roots

It can be more cost effective

But can be pushed aside during budget cuts

(Sanderson and Lewis, 2012, pp 15-18)

Person-centred

(The Health Foundation, 2016, p. 7)

- Stems from the social model of disability
- It focuses on transforming people's options rather than 'fixing' them
- Also has roots in calls for inclusive education and inclusive communities
- Institutionalisation meant people had become 'trapped by their labels'
- To support people back into their communities 'Essential Lifestyle Planning' (ELP's) were used
- By 1995, 'person-centred planning' was used
- From the 2000s it became part of policy
- (Sanderson and Lewis, 2012, pp 15-18)

Institute for Health Research, Lancaster University (2005)

- Commissioned by the Department of Health, Lancaster University undertook research into person-centred planning for people with intellectual disabilities (Robertson et al, 2005)

- After the introduction of PCP for those who received a plan, positive changes were found in the six areas:
  - Social networks
  - Contact with family
  - Contact with friends
  - Community-based activities
  - Scheduled day activities
  - Choice

Efficacy of person-centered planning (Robertson *et al*, 2007)

Finding	Description
Characteristics of participants	People with: • mental health, emotional or behavioural problems • autism; • complex health needs and reduced mobility were less likely to receive a plan
Contextual factors	Person-centred ways of working prior to the introduction of PCP (e.g., having an individual plan and/or keyworker) was associated with increased chances of getting PCP Having a care manager was associated with better outcomes Living nearer to family was associated with increased chances of getting PCP The probability of getting a plan was associated with possible indicators of leadership and stability of the staff team
The process of person-centred planning	Commitment of facilitators to PCP was the most powerful predictor of whether people would receive a plan Personal involvement of the focus person with learning disabilities (e.g., in directing their own meetings) were associated with increased benefits Identity and role of facilitators: facilitators for whom facilitation was part of their formal job role or were managers in the service meant it was more likely to deliver plans

Joseph Rowntree Foundation (2006)

JRF JOSEPH ROWNTREE FOUNDATION

- Found several barriers to making person-centred planning work, including:
  - Attitudes to PCP; Resources; Funding; Training; Management style

- JRF argued that to make person-centred planning work, it needed:
  - Adherence to the underlying principles of person-centred planning;
  - Sufficient resources and appropriate funding
  - A trained, confident and well-equipped staff team
  - Who are managed in an inclusive and empowering style that institutes clear planning and direction for the future.

Three core values of person-centered practice (Sanderson and Lewis, 2012, pp 25-30)

Independence and rights

Co-production, choice and control

Inclusive and competent communities

1. Independence and rights

- People with disabilities have the same level of choice, control and freedom as everyone else
  - Over assistance
  - Equal access to housing, transport, mobility, health, employment, educations and training
- Traditionally this was decided by professionals focusing on what people can't do
- Acknowledges that everyone needs support and some need more than others
- Persons-centred thinking asks:
  - 'How would you like to live your life?'
  - 'What would make sense for you?'
  - 'How could we work with you to make this possible?'

2. Co-production, choice and control

- Important as disabled people and older are powerless: others control their lives
- Seeks to shift control back from professionals to the individuals
- Services are delivered in an equal and reciprocal relationship
- Respects people's capacities, gifts and skills
- Opposite of ‘deficiency-led assessments’
- Focuses on the positives
  - What people can do
  - Their passions and interests
  - What others like and admire about them

Six components of Co-production, choice and control

Building on people's existing capabilities

- Altering the deficit model; providing opportunities to grow people's capabilities; supports them to use these at individual and community level

Reciprocity and mutuality

- Offering incentives to engage; working in reciprocal relationships; mutual responsibilities and expectations

Building support networks

- Peer and personal networks alongside professionals; best way to share knowledge and support

Six components of Co-production, choice and control

Blurring	Blurring distinctions • Removing distinctions between profession/recipient, producers/consumers
Facilitating	Facilitating rather than delivering • Public service agencies to become catalysts in change; facilitators rather than providers
Recognising	Recognising people's assets • Transforming the perceptions of people being passive recipients and burdens to being equal and essential partners

3. Inclusive and competent communities

- Communities can allow opportunities for people to support one another
- Person-centred practice helps create and maintain friendships outside of paid helpers
- Asks: “how can we find someone who know about this?”
- Respectful ways of strengthening peoples connections family, friends and community

HOW COULD YOU ENSURE SERVICES ARE DELIVERED WITH DIGNITY, COMPASSION AND RESPECT?

HOW COULD YOU SUPPORT PEOPLE TO MANAGE THEIR OWN HEALTH?

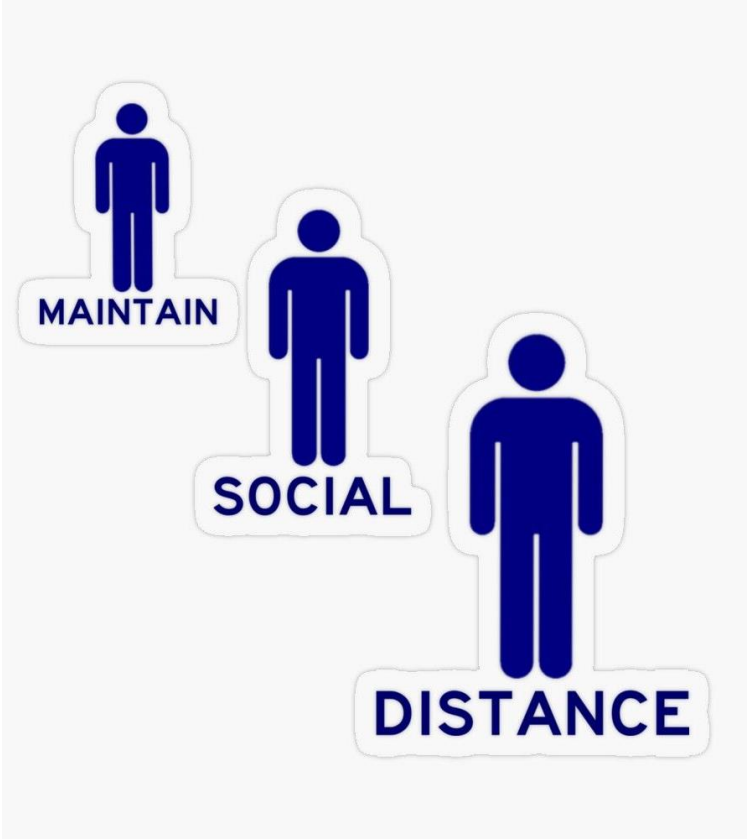
Person-Centred Care and the LGBT+ community (Roe and Galvin, 2021)

LGBT+ older adults face barriers in access to care, impacting their ability to receive person-centred care in old age, which is central to the prevention and management of frailty, disability and disease

Heteronormativity and discrimination must be addressed across the whole health system to achieve the health policy goal of supporting all older adults to enjoy health and well-being

Person-centred care and Covid-19

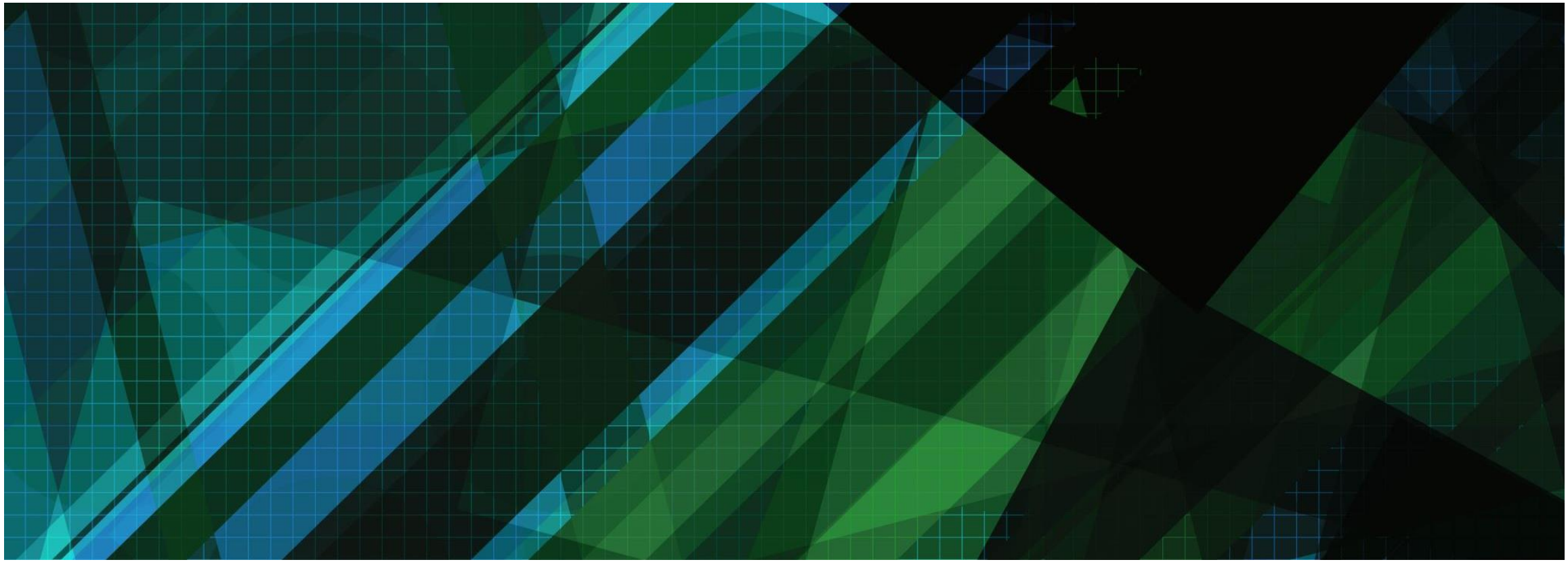
- The BMJ (2020) argue that care needs to remain person-centred
- But the exclusion of families in care means this isn't happening
- They argue that healthcare providers needs to develop 'emotional literacy'
- They also argue that moving away from person-centred care will increase health inequalities



Discussion

How could health and social care providers remain person-centred in the time of Covid-19?

Integrated Care



Integrated Care

(Baxter *et al*, 2018, p. 1)

New models of integrated care are charged with:

- Achieving more care beyond the hospital walls
- Change in the size and shape of acute hospitals
- Increase attention to prevention and population health

Integrated care can see seen as a way to connect health and social care systems

Integrated Care Systems (ICS)

ICSs are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners, to collectively plan and integrate care to meet the needs of their population.

ICSs are the latest in a long line of initiatives aiming to integrate care across local areas

ICSs are part of a fundamental shift in the way the health and care system is organised

In 2019, NHS England set out their aim for all areas of England to be covered by an ICS by April 2021

(Charles, 2020)

WHY DO YOU THINK INTEGRATED CARE MAY BE NEEDED?

USE YOU OWN EXPERIENCES OF HEALTH AND SOCIAL CARE SERVICES

Why are Integrated Care Systems needed?

- The NHS was set up to provide episodic treatment for acute illness
- But it now needs to deliver joined-up support for growing numbers of older people and people living with long-term conditions
- So, the NHS needs to work differently by providing more care in people's homes and the community
- This will break down barriers between services
- The central aim is to integrate care across different organisations and settings
- This will connect hospital and community-based services, physical and mental health, and health and social care.
- (Charles, 2020)

(Social Care Institute for Excellence, 2014)

Integrated Care in Wales

- Pre-devolution, health and social care policy in Wales closely followed that in England
- Since the devolution of powers in 1999, the gap between health and social care policy in Wales and England has steadily widened.
- E.g., Wales insists on the benefits of collaboration between public services
- Especially between the NHS and local government
- This joint effort seeks to improve well-being and to deliver seamless services which place the citizen at their heart.

(Longley, 2013, pp. 58-59)

Integrated Healthcare in Wales: some advantages and disadvantages

- ✓ Local Health Boards (LHBs): They have no financial or performance disincentives to ensuring that services best meet patients' current and future needs. They have access to specialist expertise and data in abundance
- ✓ NHS and social services focus on patient's/client's experience and empowering service users to ensure that services meet their needs
- ✗ LHBs: have little experience in or appetite for pooled budgeting, and labour under multiple information systems, each serving elements of the integrated care package
- ✗ Progress to date in integration has often depended on the abilities of individual leaders and the coincidence of their shared workplace, criteria which are unpredictable and fragile

(Longley, 2013, p75).

At the heart of this situation lies an old paradox. While most leaders in health and social care in Wales readily accept that greater integration would deliver better care for their patients and clients, and would be a key element in solving many of the other problems which currently confront them, it often seems just too difficult to make the initial step change that is required.

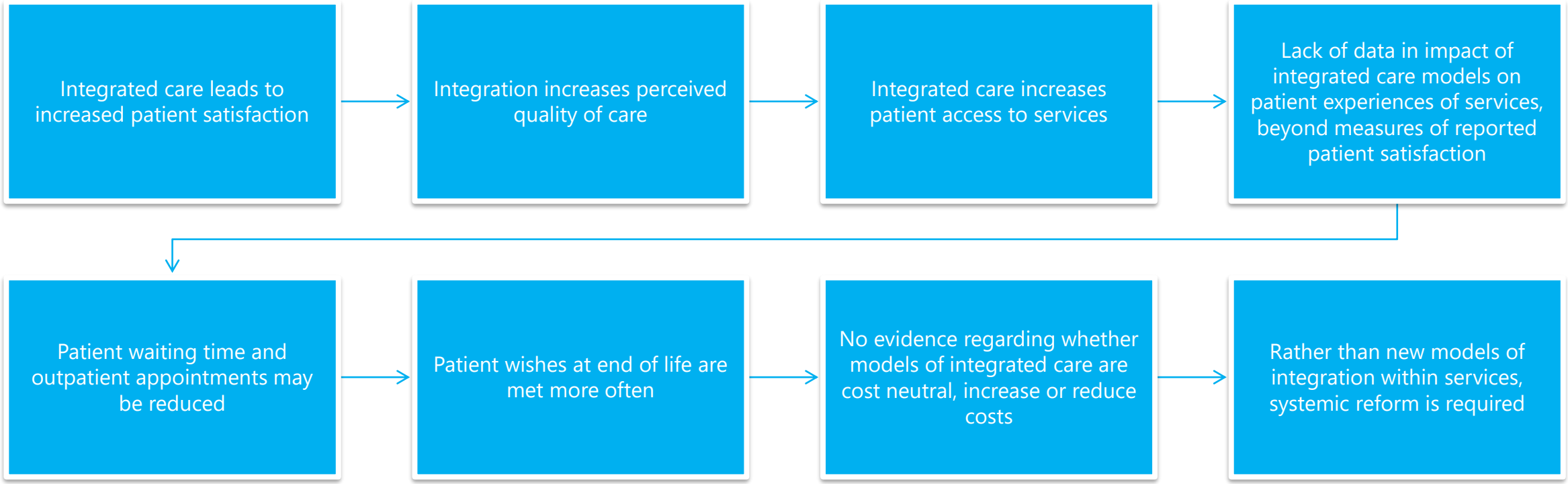
(Longley, 2013, p. 76)

To make integrated care work there needs to be:

- Coherent policies designed to promote and support integrated care
- Governance arrangements that enable different organisations (especially local authorities and NHS bodies) to work together to develop joint strategies
- Political, managerial and clinical leadership at all levels that ensures a clear and consistent focus on integrated care
- Organisational stability to avoid the distractions and delays that occur when structures are altered frequently
- Willingness to challenge and overcome professional, cultural and behavioural barriers to integrated care both within the NHS and between the NHS and social care
- Commitment to integrated care as a policy priority for government as a whole
- Willingness to provide financial support and flexibilities to enable the introduction of new models of care
- Action to share information both within the NHS and between health and social care
- An ability to manage the differences and tensions that arise when different public services are organised differently

Ham *et al*, (2013, pp. 80-81)

Systemic Review of Integrated Care (Baxter *et al*, 2018, pp 8-13) (See Moodle)



WHAT DO YOU THINK OF INTEGRATED CARE?

WHAT ARE THE ADVANTAGES AND OBSTACLES?

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