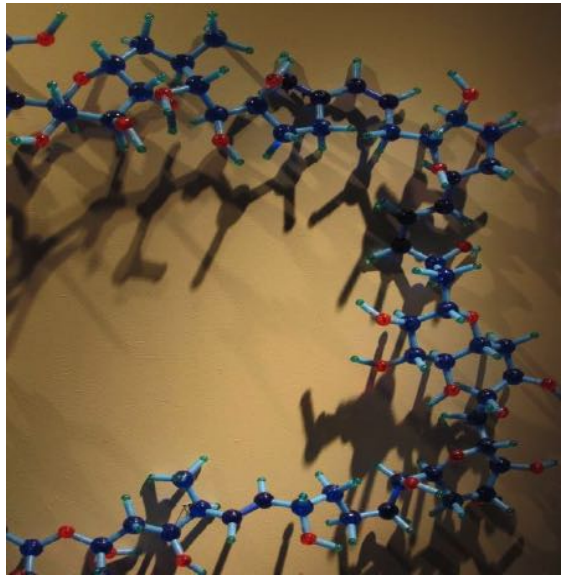
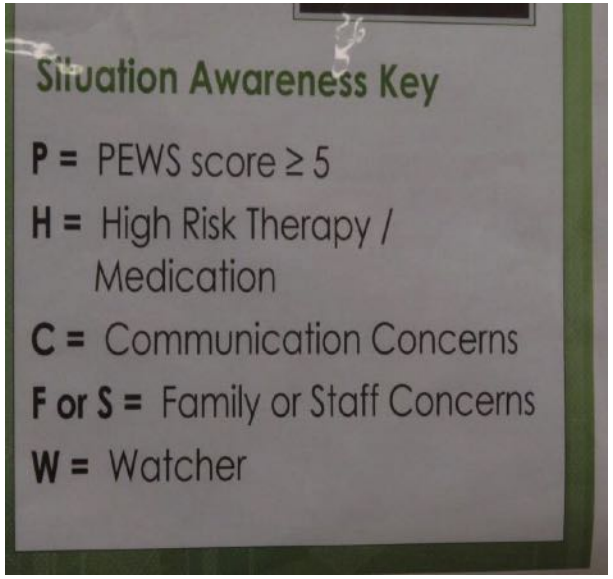
DNA





Mindfulness

Person-centred Care

Dr. Tricia Woodhead BM MBA FRCR

Health Foundation Quality Improvement Fellow, Associate Director for Patient Safety West of England, Visiting Senior Research Fellow University of Bath

ISQuA Expert Faculty

Purpose

- My presentation will provide a background to the current evidence of the benefits of Person Centred Care.
- We will consider the structures and processes one might expect to be in place where this is truly delivered or aspired to in an NHS provider organisation.
- The aim is to provide surveyors with insight and practical ways to promote and provoke their organisations to review and rethink their approach to person centred caring and why it is of benefit to provider and person to do so.

How would we know what mattered to me and my family was hat mattered to the organisation?

Feelings

Words

Actions

Structures

Communication

Processes

- **The problem**
- The 15 million people in England with long term conditions have the greatest healthcare needs of the population (50% of all GP appointments and 70% of all bed days) and their treatment and care absorbs 70% of acute and primary care budgets in England.
- It is clear that current models of dealing with long term conditions are not sustainable. Rather than people having a single condition, multimorbidity is becoming the norm. The number of people with three or more long term conditions is set to increase from 1.9 million to 2.9 million by 2018, and this will be associated with an extra £5 billion a year spend.
- The barriers to great care for people with long term conditions have been identified by a wide range of reports and reviews, and can best be summed up as failure to provide integrated care around the person:
- **Single condition services:** services dealing with single conditions only and adopting single condition guidelines (with attendant dangers of polypharmacy, and excluding a holistic approach to service users).
- **Lack of care coordination:** people being unaware of whom to approach when they have a problem, and nobody having a generalist's 'bird's eye' view of the total care and support needs of an individual.
- **Emotional and psychological support:** in particular, a lack of attention to the mental health and wellbeing of people with 'physical' health problems (as well as failure to deal with the physical health of people with mental disorder as their primary long term condition).
- **Fragmented care:** the healthcare system remaining within its own economy, and not being considered in a whole system approach with social care or other services important to people with long term conditions (e.g. transport, employment, benefits, housing). Failure to support people with 'more than medicine' offers as provided by, for example, third and voluntary sectors.
- **Lack of informational continuity:** care records which can't be accessed between settings, or to which patients themselves don't have access.
- **Reactive services, not predictive services:** failure to identify vulnerable people who might then be given extra help to avoid hospital admission or deterioration/complications of their condition(s).
- **Lack of care planning consultation:** services which treat people as passive recipients of care rather than encouraging self-care and recognising the person as the expert on how his/her condition affects their life.

- https://www.england.nhs.uk/ourwork/ltc-op-eolc/ltc-eolc/house-of-care/

What does good look like ? Moving from good to great

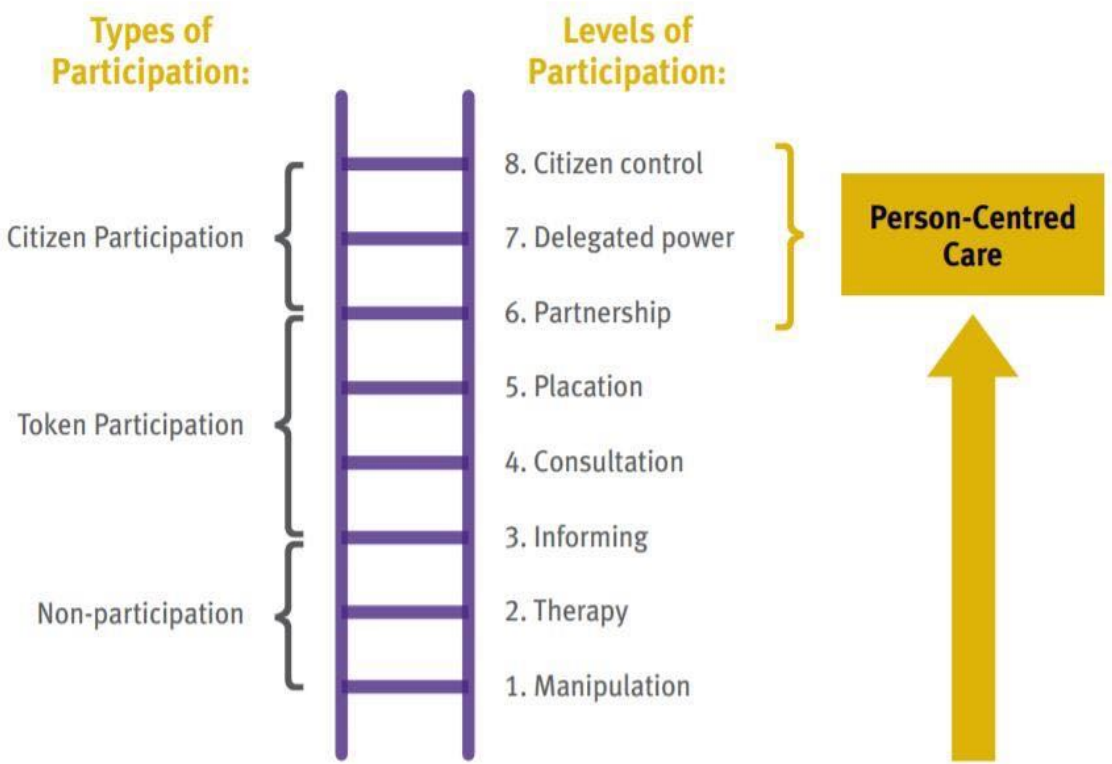


Figure 2 Ladder of Participation, adapted from Arnstein's Ladder[17]

https://lithgow-schmidt.dk/sherry-arnstein/ladder-of-citizen-participation.html

- **Citizen control** – citizens organise, plan, deliver and have budget access
- **Delegated Power-** partnership approach but citizens have the overall decision to make
- **Partnership**- clear ground rules, shared decision making, transparent
- **Placation**-involve and listen but system decides what actually changes
- **Consulting**-but not including ideas/concerns in any delivered action
- **Informing**-as a one way messaging system
- **Therapy** -to involve but using involvement to treat or meet some necessary standard
- **Manipulation**- token patient on a committee, no vote, no voice,no respect

Regulatory Environment

- The key lines of enquiry (KLOEs), prompts and sources of evidence in this section help our inspectors to answer the five key questions: is the service safe, effective, caring, responsive and well-led

Is it safe?

- Safeguarding and protection from abuse
- Managing risks
- Safe care and treatment & Medicines management
- Track record & Learning when things go wrong

Is it effective?

- Assessing needs and delivering evidence-based treatment &Monitoring outcomes and comparing with similar services
- Staff skills and knowledge & How staff, teams and services work together
- Supporting people to live healthier lives & Consent to care and treatment
- Caring icon

Is it caring?

- Kindness, respect and compassion
- Involving people in decisions about their care
- Privacy and dignity

Is it responsive?

- Person-centred care
- Taking account of the needs of different people & Timely access to care and treatment
- Concerns and complaints

Is it well-led?

- Leadership capacity and capability & Vision and strategy
- Culture of the organisation & Governance and management
- Management of risk and performance
- Management of information
- Engagement and involvement
- Learning, improvement and innovation

Person-centredness should be woven into every strand of work undertaken in a hospital

CQC Person-centred care (healthcare services)

- R1. How do people receive personalised care that is responsive to their needs?
- R1.1 Do the services provided reflect the needs of the population served and do they ensure flexibility, choice and continuity of care?
- R1.2 Where people's needs and choices are not being met, is this identified and used to inform how services are improved and developed?
- R1.3 Are the facilities and premises appropriate for the services that are delivered?
- R1.4 How does the service identify and meet the information and communication needs of people with a disability or sensory loss? How does it record, highlight and share this information with others when required, and gain people's consent to do so?

Avedis Donabedian(1966) ‘Healthcare is a system in which Structures + Processes = Outcomes’

Structure

- **Structure** includes all of the factors that affect the context in which care is delivered. This includes the physical facility, equipment, and human resources, as well as organizational characteristics such as staff training and payment methods. These factors control how providers and patients in a healthcare system act and are measures of the average quality of care within a facility or system. Structure is often easy to observe and measure and it may be the upstream cause of problems identified in process.[5]

Process

- **Process** is the sum of all actions that make up healthcare. These commonly include diagnosis, treatment, preventive care, and patient education but may be expanded to include actions taken by the patients or their families. Processes can be further classified as technical processes, how care is delivered, or interpersonal processes, which all encompass the manner in which care is delivered.[6] According to Donabedian, the measurement of process is nearly equivalent to the measurement of quality of care because process contains all acts of healthcare delivery.[5]Information about process can be obtained from medical records, interviews with patients and practitioners, or direct observations of healthcare visits.

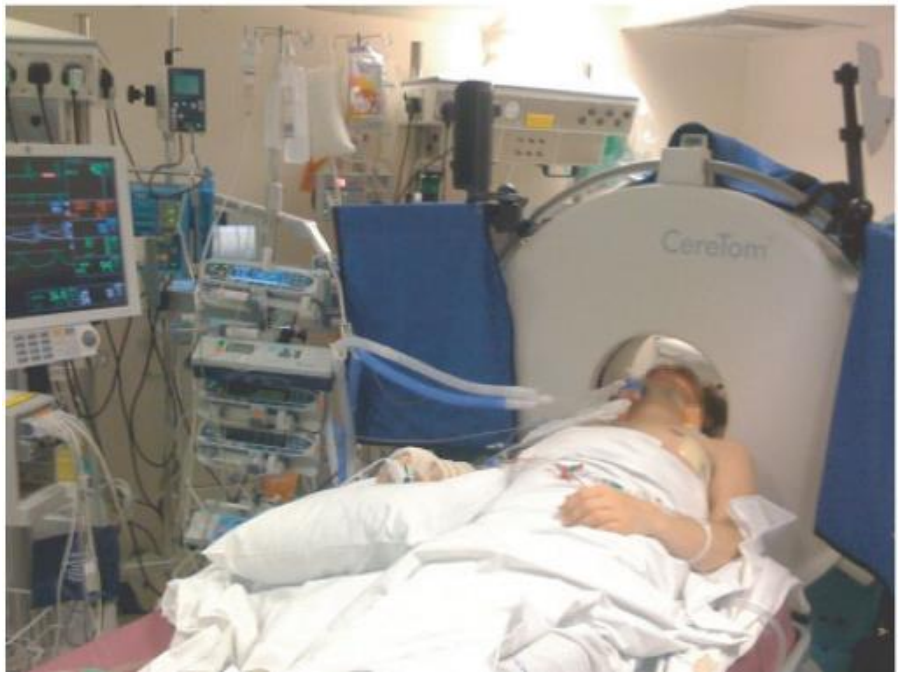
Outcome

- **Outcome** contains all the effects of healthcare on patients or populations, including changes to health status, behaviour, or knowledge as well as patient satisfaction and health-related quality of life. Outcomes are sometimes seen as the most important indicators of quality because improving patient health status is the primary goal of healthcare. However, accurately measuring outcomes that can be attributed exclusively to healthcare is very difficult.[6] Drawing connections between process and outcomes often requires large sample populations, adjustments by case mix, and long-term follow ups as outcomes may take considerable time to become observable.[

- https://en.wikipedia.org/wiki/Donabedian_model#cite_note-Donabedian_a-5

Triangulating the evidence

‘How a system is organised, what it pays attention to, the processes that make it work and the experience that is the outcome of those processes and cultures- each viewed with the perspective of a person’



What is driving the Person Centred Care approach?

Medical

- Long term health care not acute time limited events
- Challenges of providing treatments that have positive and negative benefits and personalise care

Societal

- The culture of customer service
- The complexity of systems providing care
- Peoples expectations of care not just treatment
- Transparency of provision – you can complain if it does not deliver
- The global communications environment (for example social media)

This is a global directive thanks to the World Heath Organisation see SIXTY-NINTH WORLD HEALTH ASSEMBLY WHA69.24 Agenda item 16.1 28 May 2016

URGES Member States:

(1) to implement, as appropriate, the framework on integrated, people-centred health services at regional and country levels, in accordance with national contexts and priorities;

(2) to implement proposed policy options and interventions for Member States in the framework on integrated, people-centred health services in accordance with nationally set priorities towards achieving and sustaining universal health coverage, including with regard to primary health care as part of health system strengthening;

(3) to make health care systems more responsive to people's needs, while recognizing their rights and responsibilities with regard to their own health, and engage stakeholders in policy development and implementation;

(4) to promote coordination of health services within the health sector and intersectoral collaboration in order to address the broader social determinants of health, and to ensure a holistic approach to services, including health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services;

(5) to integrate, where appropriate, traditional and complementary medicine into health services, based on national context and knowledge-based policies, while assuring the safety, quality and effectiveness of health services and taking into account a holistic approach to health;

- Integrate components
- Sustain universal health coverage
- Responsive to needs and people centred
- Respect rights & encourage responsibilities
- Address social determinants of health
- Integrate traditional approaches
- Assure safe, effective and holistic provision

What would your Mum think?

Improving healthcare through the patients eyes

http://pickerinstitute.org/about/picker-principles/

http://www.healthpolicypartnership.com/wp-content/uploads/International-Environment-Scan-on-Person-Centred-Care-18th-Dec-FINAL.pdf

- Respect for patients' values, preferences and expressed needs
- Coordination and integration of care
- Information, communication and education
- Physical comfort
- Emotional support and alleviation of fear and anxiety
- Involvement of family and friends
- Transition and continuity

Four key principles of person-centred care
Principle 1. Being person-centred means affording people dignity, respect and compassion
Principle 2. Being person-centred means offering coordinated care, support or treatment
Principle 3. Being person-centred means offering personalised care, support or treatment
Principle 4. Being person-centred means being enabling
Measuring what really matters. The Health Foundation, London, 2014

Chronic caring adds new dimensions alongside effectiveness and efficiency

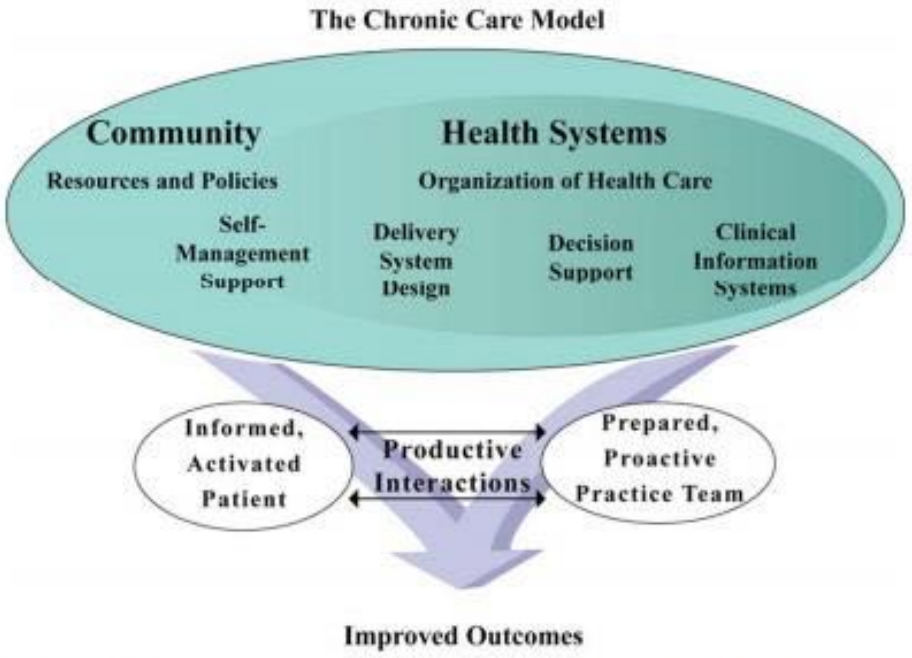


Figure 2 Chronic Care Model, developed by The MacColl Institute, © ACP-ASIM Journals and Books, reprinted with permission from ACP-ASIM Journals and Books. First published in: Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? *Eff Clin Pract* 1998;1:2–4.

https://www.england.nhs.uk/ourwork/ltc-op-eolc/ltc-eolc/house-of-care/

To change outcomes you must shift Structures **and** Processes and thus Cultures – Avedis Donabedian

Our guiding principles to improve quality are STEEEP

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Person centred –

PCC requires another level of thinking, design and performance

(The Institute of Medicine)

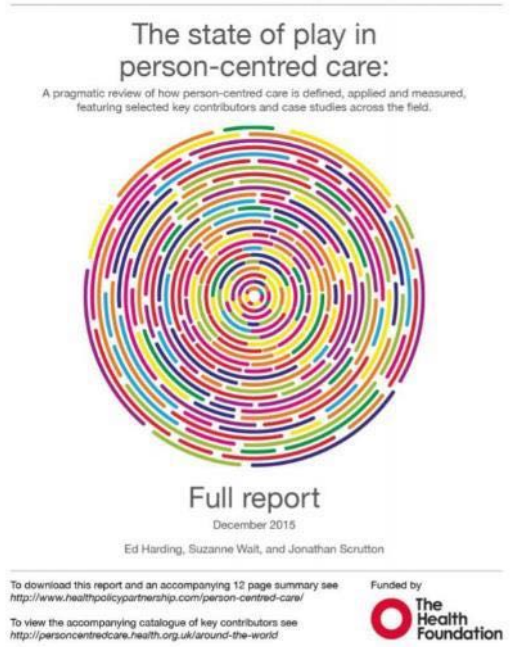
- Patients are **partners** in their own health and health care, and the person should be the focus of health care, not their illnesses or conditions.
- A person-centred healthcare system is one that **supports people** to make **informed decisions** about and successfully **manage their own health and care**, including choosing when to let others act on their behalf, and one that delivers care **responsive to people's individual abilities, preferences, lifestyles and goals.**

- Achieving a person-centred system requires a change in behaviour and mindset from patients and clinicians, supported by a system that puts patients at its heart.

http://www.healthpolicypartnership.com/wp-content/uploads/International-Environment-Scan-on-Person-Centred-Care-18th-Dec-FINAL.pdf

Examples of structural components

- Buildings and geography
- Organisational arrangements and reporting lines
- Professional and clinical training and alignments
- Community relationships and involvement
- Government or regulatory oversight
- International or national partnerships
- Cultural norms or traditions

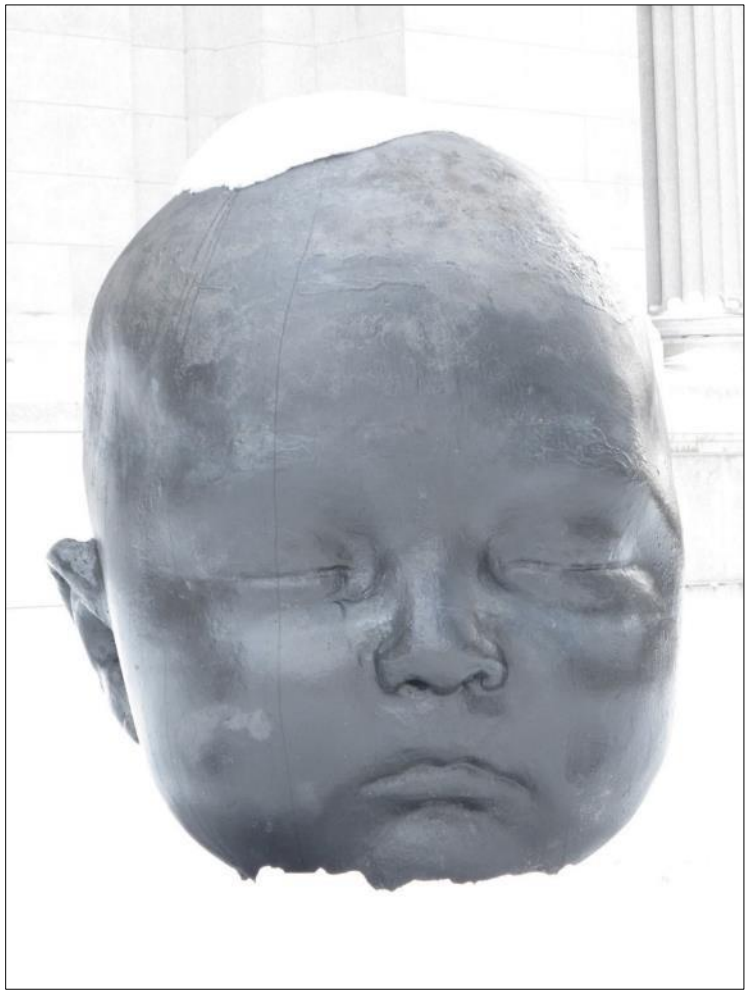


Let us consider processes- as the person experiences them!

- Existing systems of referral and care provision
- Professional language, routines, approaches to person and family
- Use of support such as IT, family, third sector for example
- Feedback sought from the person not the system
- Measurement of what matters to the person not the system
- Cultural sensitivities and expectations

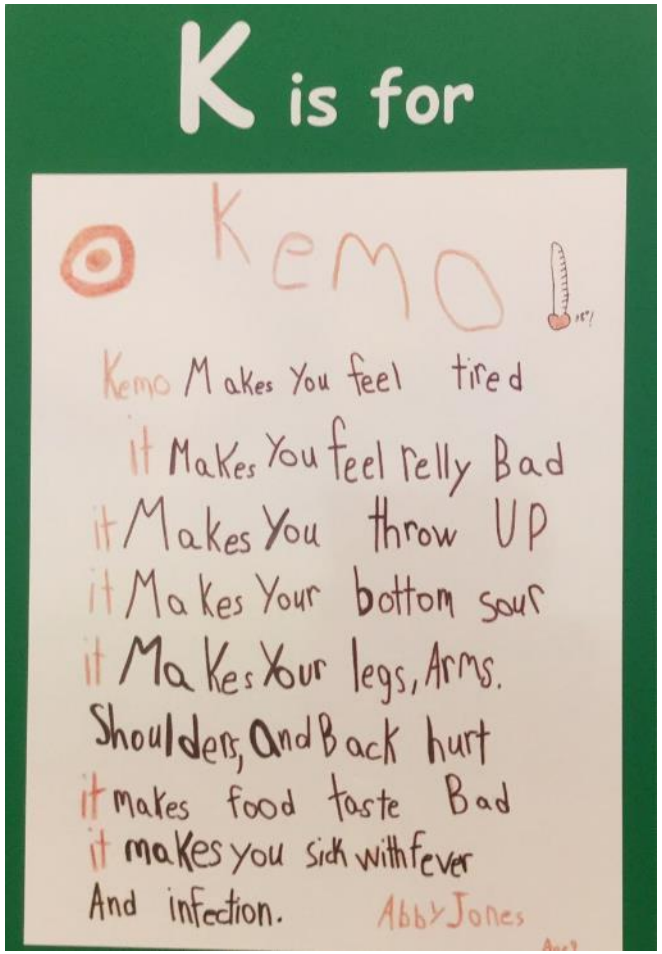
Listen & Reflect
Explore and discover work as it is done not as it is imagined

Building Will- opening eyes and minds to new perspectives



- Question the essence of the purpose of the care
- Multidimensional experience requires multidimensional evidence
- Have all those contributing to care had the opportunity to contribute to ideas
- Have all the contexts and diversities been included
- Are there obvious areas to look at and improve culturally or medically (for example; long term conditions, dementia care, children and young people, HIV)

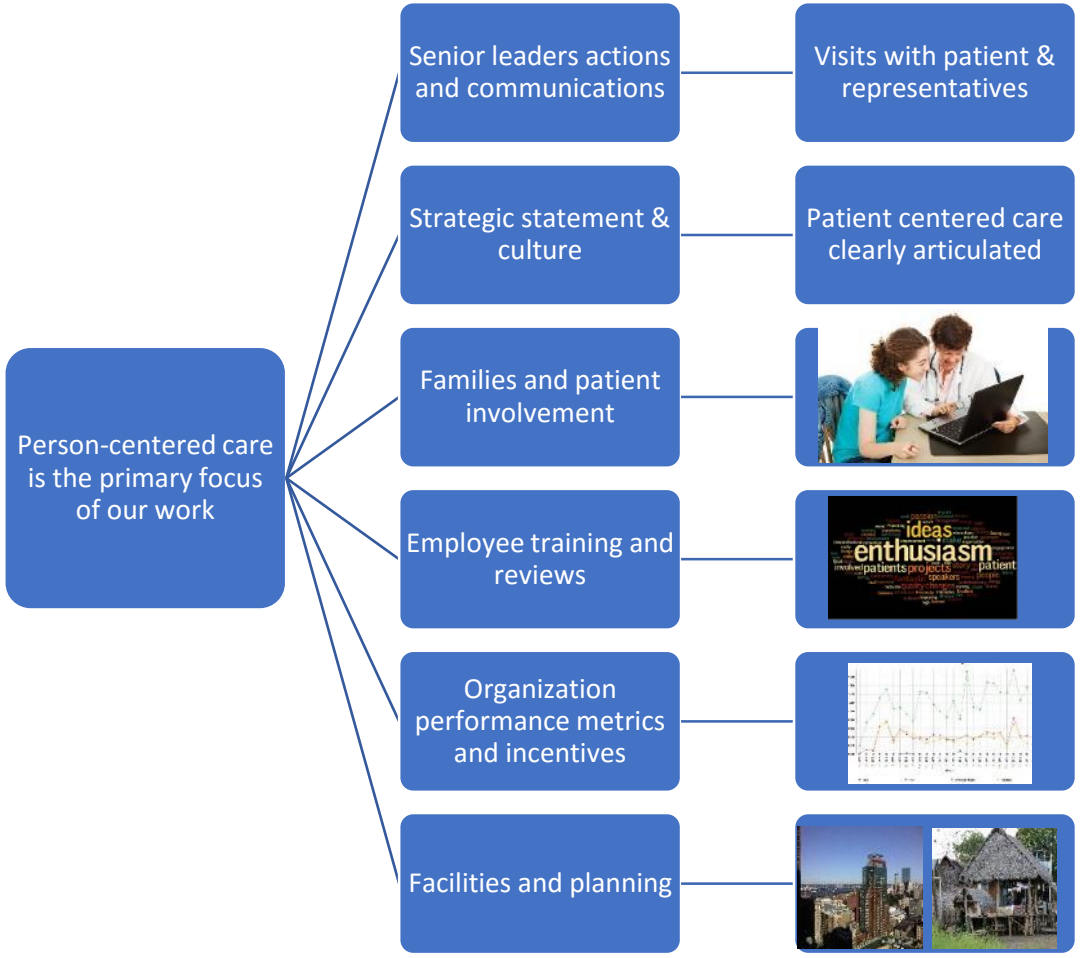
Having Ideas –where are the teams sourcing their ideas from- how do they turn them into change



What are the leadership saying, doing, recognising and rewarding ?

- 1. Strong, committed senior leadership
- 2. Communication of strategic vision
- 3. Engagement of patients and families
- 4. Sustained focus on employee satisfaction
- 5. Regular measurement and feedback reporting
- 6. Adequate resourcing for care delivery redesign
- 7. Building staff capacity to support delivering patient-centred care
- 8. Accountability and incentives
- 9. Culture strongly supportive of change and learning

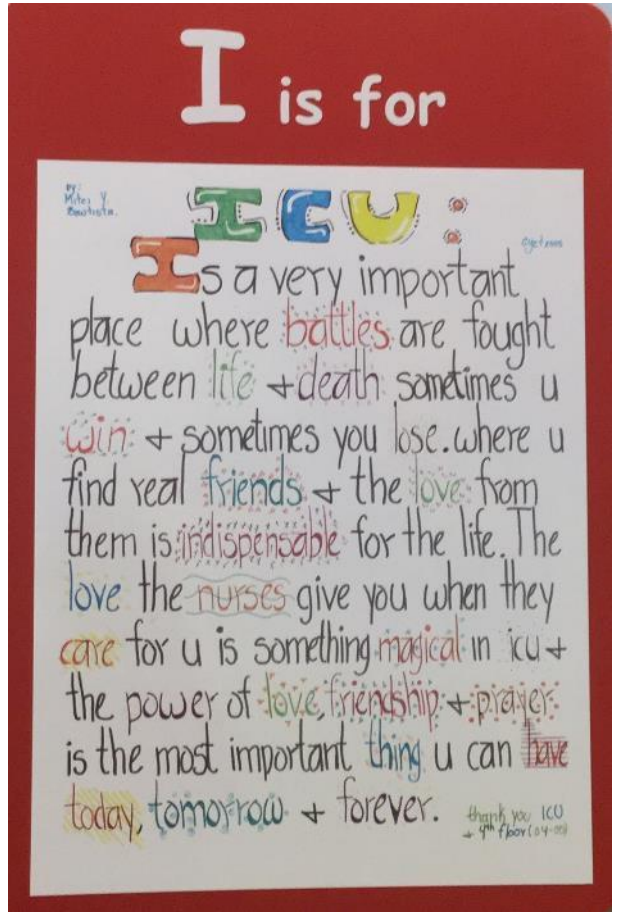
- Luxford K, Safran DG, Delbanco T. Promoting patient-centered care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience. International Journal for Quality in Health Care, 2011



What could teams do at the front line?

PATIENT-CENTERED CARE IMPROVEMENT GUIDE — **III. SELF-ASSESSMENT TOOL**

Total Score out of a Possible of 14		Percent of Total:		%
	Fully Implemented Throughout Organization	*Partially Implemented (in progress or in place in some areas, but not all)*	*No activity*	*Not applicable*
ACCESS TO INFORMATION, pg. 137				
A process is in place by which patients and family may request additional information on their diagnosis, treatment options, etc.				
Patients have access to their medical record while they are being treated, and are assisted in understanding the information contained within.				
Patients are made aware of the opportunity to review their medical record with the support of a health care professional.				
Patients are able to contribute their own progress notes in their medical record.				
Patient education materials appropriate for readers of varying literacy levels and for speakers of different native languages are readily available.				
Patients and families have access to a consumer health library.				
A process is in place to disclose unanticipated outcomes to patients (and family as appropriate).				
Total Score out of a Possible of 14		**Percent of Total:**		**%**



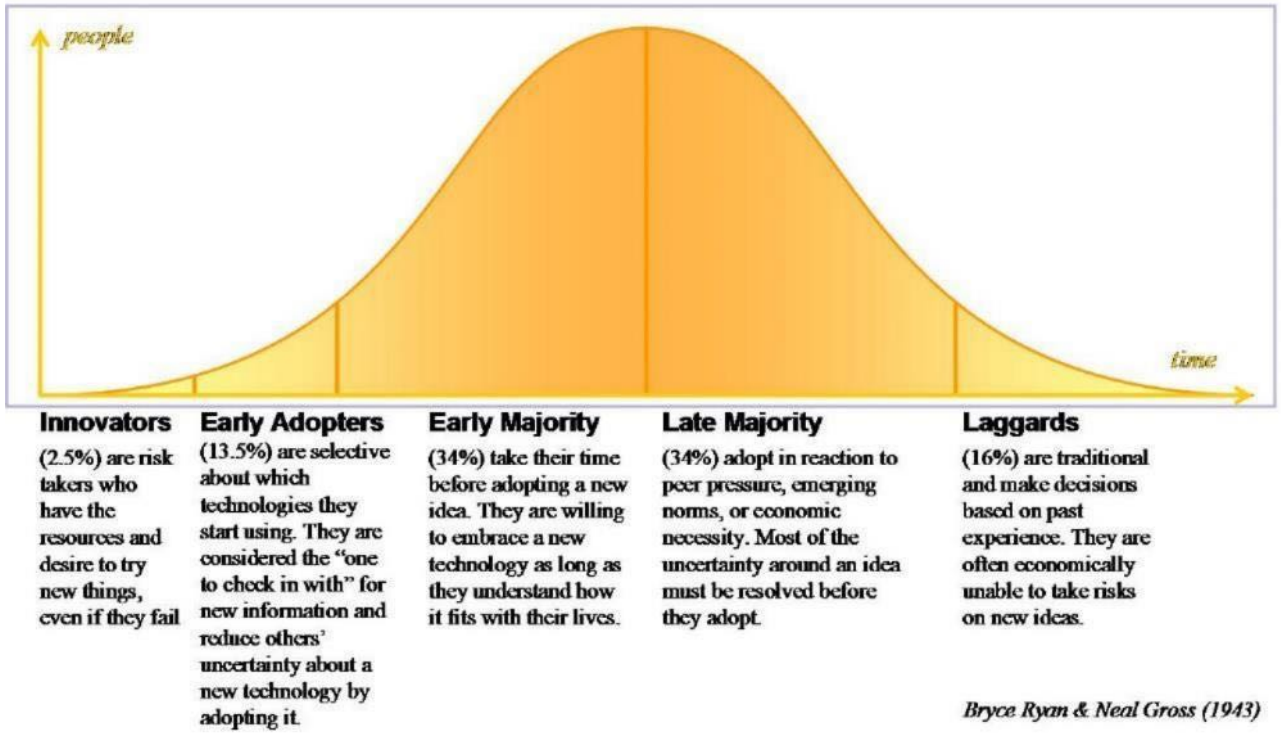
http://www.hqontario.ca/PORTALS/0/MODALS/QI/EN/PROCESSMAP_PDFS/TOOLS/PATIENT-CENTERED%20CARE%20IMPROVEMENT%20GUIDE.PDF

Are professionals, patients and families working together respectfully?

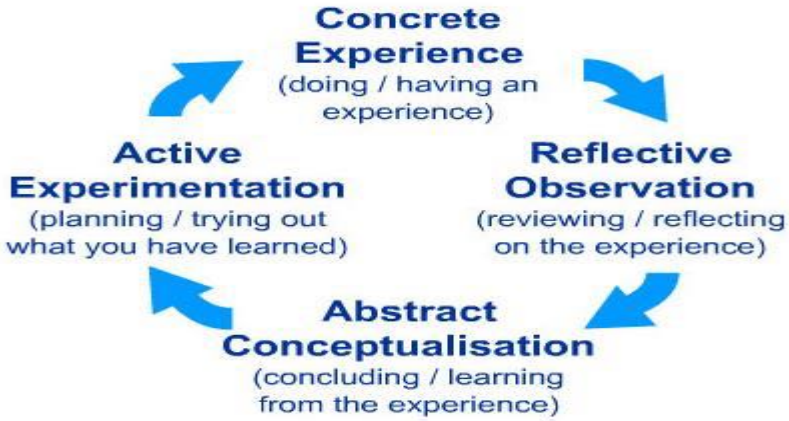
- BEING PATIENT-CENTERED IS TOO TIME-CONSUMING. Staff are working too hard as it is
- Lets map the journey and include the patient and family in our discussions about what can be changed to improve things for everyone

- IF WE INVOLVE THE FAMILY OR THE PATIENT WE RISK INFECTIONS-
- Lets explore what is best and ensure everyone knows the safest approach and design a way that works for us all together

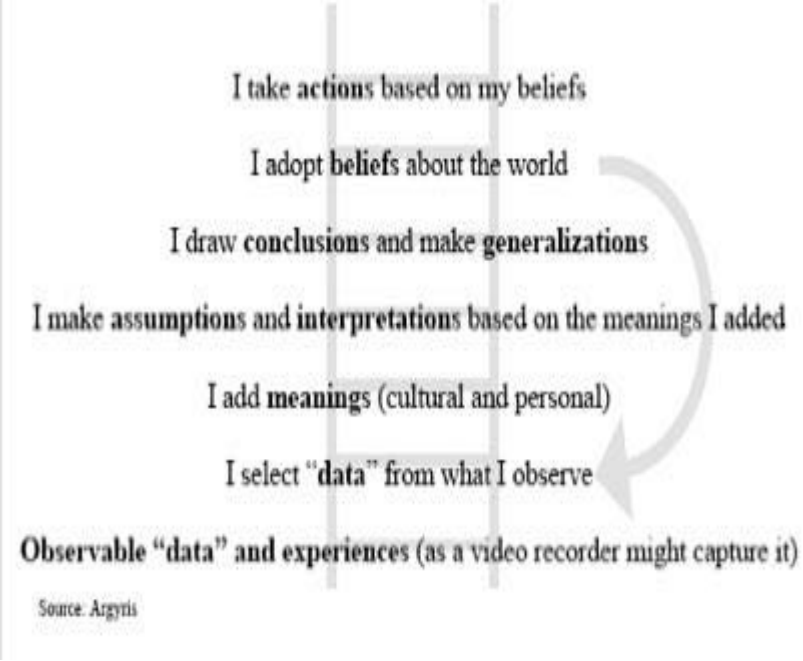
What are the barriers to change do not overlook their importance



Rogers Innovation Diffusion Curve



Kolb Learning cycle



Argyris Ladder of Enquiry

Organising complexity

Structures

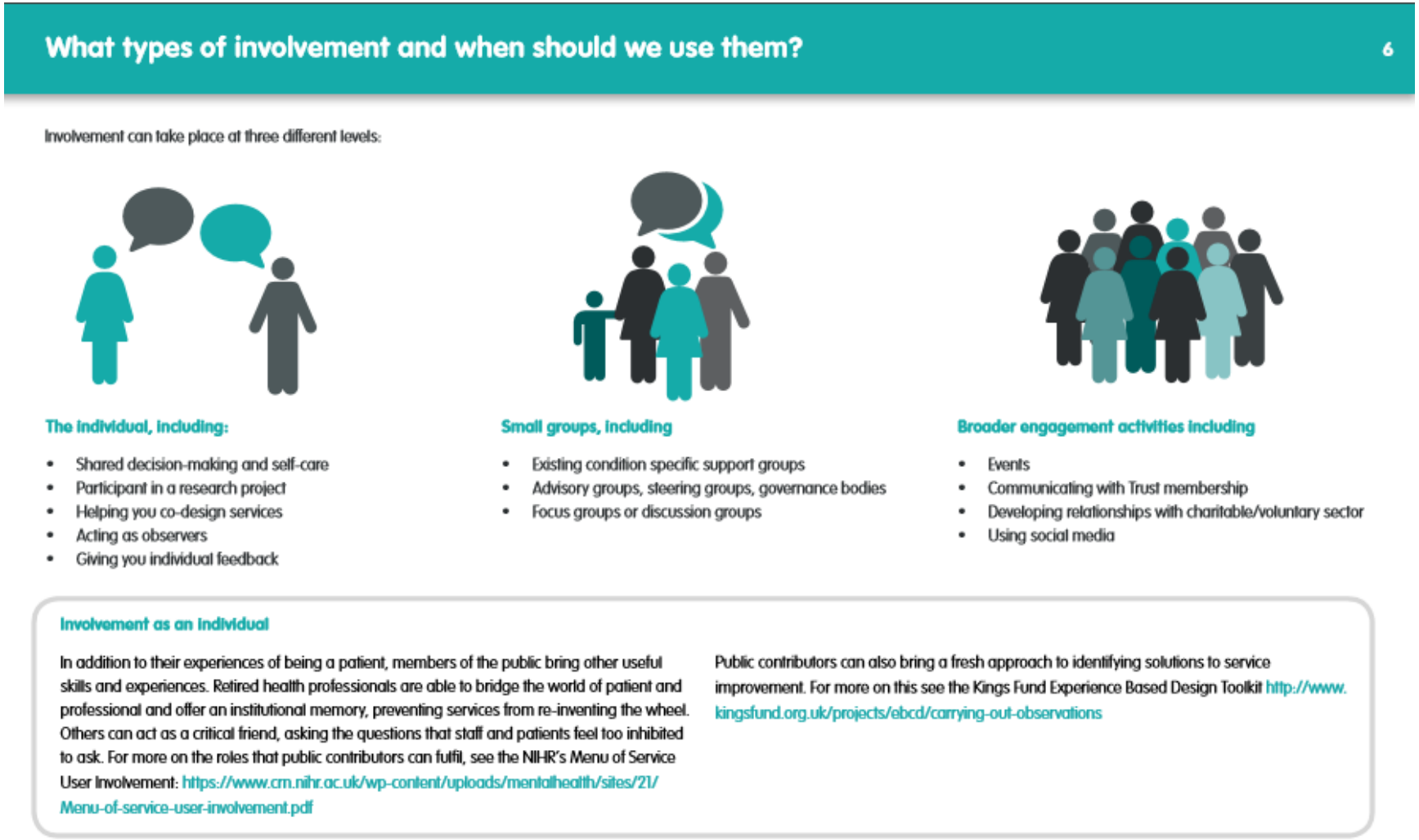
Processes

Person-centered care is the primary focus of our work

And we can show the progress we have made in the last year

- Senior leaders
  - Visits with patient representatives
  - Board meeting agenda includes report on PCCC progress
- Strategic statement
  - Patient-centered care clearly articulated
  - Each team agrees one process this year to make more Patient centered
- Families and patient involvement
  - A new patient and family forum organized to hear feedback
  - Ideas from this group are priority actions for the organization
- Employee training and reviews
  - All staff have to demonstrate their action in a PCC project
  - Staff are given tools and training to be better at working with patents
- Organization performance metrics
  - Change the performance measures to PCC focused in all reports
- Facilities and planning
  - Review current building plans for patient involvement in design and include them

How to get started when asking patients and families to be involved.



What types of involvement and when should we use them?

6

Involvement can take place at three different levels:

The individual, including:

- Shared decision-making and self-care
- Participant in a research project
- Helping you co-design services
- Acting as observers
- Giving you individual feedback

Small groups, including

- Existing condition specific support groups
- Advisory groups, steering groups, governance bodies
- Focus groups or discussion groups

Broader engagement activities including

- Events
- Communicating with Trust membership
- Developing relationships with charitable/voluntary sector
- Using social media

Involvement as an Individual

In addition to their experiences of being a patient, members of the public bring other useful skills and experiences. Retired health professionals are able to bridge the world of patient and professional and offer an institutional memory, preventing services from re-inventing the wheel. Others can act as a critical friend, asking the questions that staff and patients feel too inhibited to ask. For more on the roles that public contributors can fulfil, see the NIHR's Menu of Service User Involvement: https://www.crn.nihr.ac.uk/wp-content/uploads/mentalhealth/sites/21/Menu-of-service-user-involvement.pdf

Public contributors can also bring a fresh approach to identifying solutions to service improvement. For more on this see the Kings Fund Experience Based Design Toolkit http://www.kingsfund.org.uk/projects/ebcd/carrying-out-observations

http://www.weahsn.net/wp-content/uploads/PPI_Toolkit.pdf

Use Improvement Methodologies

Model for Improvement

1. What are we trying to achieve?
2. How will we know its and improvement?
3. What are we going to do?

Clinical Microsystems

Five Ps and small team coaching

Purpose, Patient, Professionals, Processes & Patterns

Governance – shared responsibility with patients as partners

- Governance –

Corporate, clinical, financial, research, information (education, staff)

‘Arrangements to ensure an organisation fulfils its purpose and achieves its outcom)es in a transparent way that can stand up to scrutiny, be evidenced and assure public, patients, regulators and all those working to care for patients’

(Healthcareimprovement Scotland.org)

- Strong and organisation wide leadership
- Risk informed decision making
- Effective communications across and within the whole organisation
- Transparency and evidence based action and change
- Professionalism to achieve best for patients and in the most effective, efficient and equitable way.
- Continuous improvement culture
- Just culture

(http://www.health.org.uk/sites/health/files/ConsultationResponseGovernanceReviews.pdf)

Person-centred care as an integral component of good governance

1. How does a Board assure itself of Person Centred Care

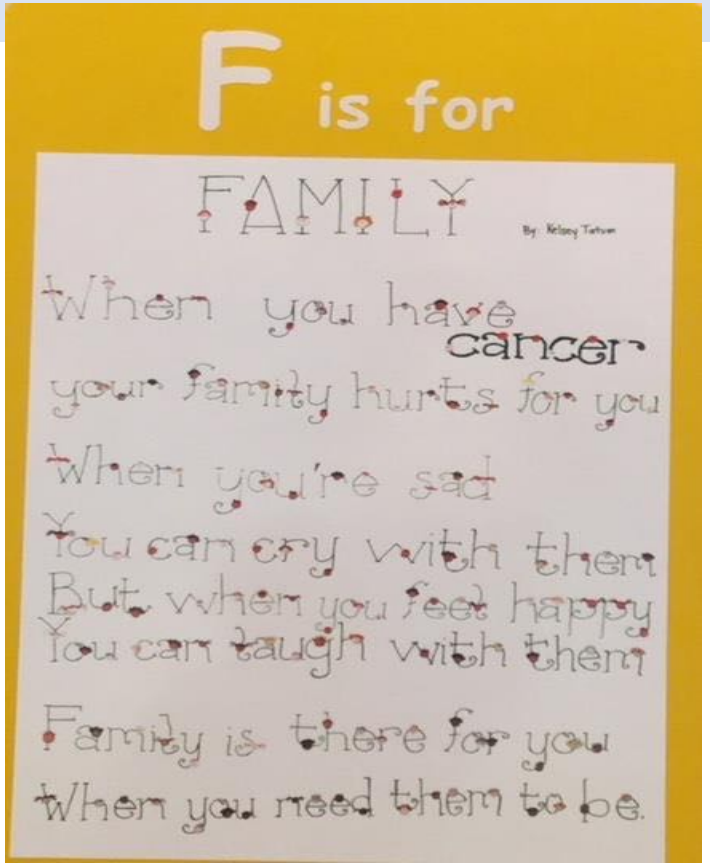
- All patients treated with respect and dignity (measure and share)
- At decision cross roads patients are supported to share in the decision making process (tools, methods, training, feedback)
- Care is co-ordinated by a named individual (define and design with patients)
- All aspects of decision making in corporate, financial, information and staff governance have clear strategies and activities to involve and include patients and families in their work (inclusion and all the items in box 2)

2. How are patients and public enabled to contribute to good governance

- Invited and respected so equal participation
- Trained and informed
- Data literacy developed
- Clear roles and descriptions and support to enable participation
- Recognition and possibly financial support to attend
- Reflection and dialogue on how it's working (continuous improvement)
- Maintain diversity and use wisely the people who offer/volunteer but seek as wide a range as possible.
- Aim to have public members working together on groups not as an individual
- Be clear about how long the role lasts

Structures + Processes= Outcomes

‘Person centred care requires us to do all we can to enable people who have been or are unwell to return to their lives with as little hindrance from the system or the professionals as possible so they can achieve their goals and wishes’



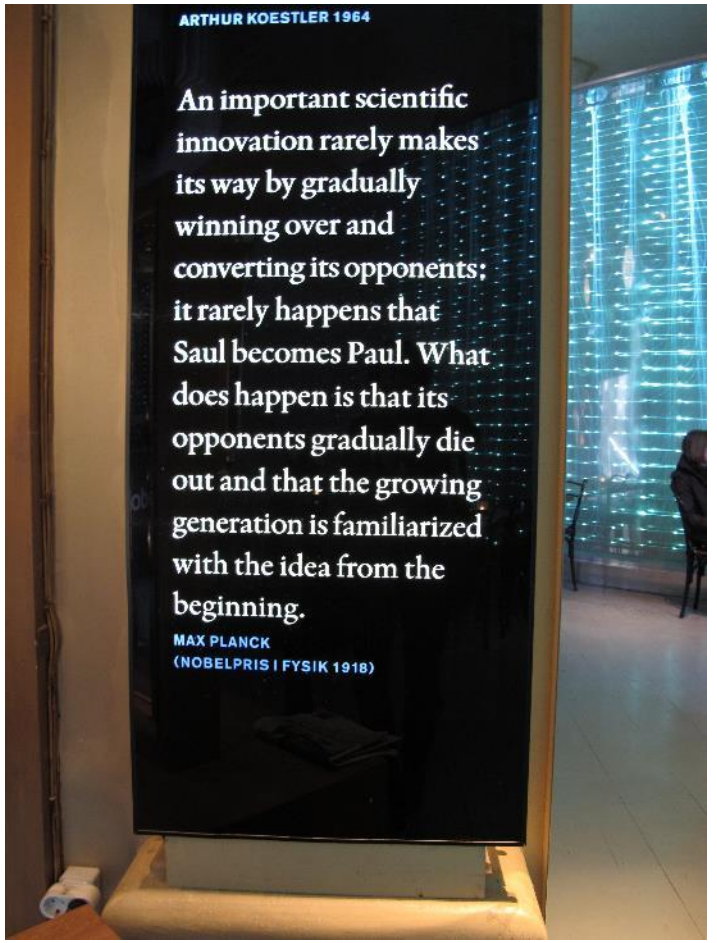
Person centred caring – is and should be at the heart of what we do and how we do it

Prepare

1. Establish a sense of urgency
2. Form a powerful guiding coalition
3. Create a Vision
4. Communicate the Vision
5. Empower others to act on the Vision
6. Plan for and create short-term wins
7. Consolidate improvements and produce more change
8. Embed and institutionalise new approaches

John Kotter

My Iceberg is Melting



How do we put the person in the driving seat and clearly navigate with them to their destination ?

Thank you

Questions and comments

for discussion