

Perspectives: Is health and social care person centred? Hello, my name is not enough

Sally Hardy

Professor of Mental Health Nursing and Practice Innovation, School of Health and Social Care, London South Bank University, UK; Adjunct Professor, Faculty of Medicine, Nursing and Health, Monash University, Australia

The World Health Organisation (www.who.int) confirms a growing global population that requires access to effective health care, yet the economic burden of delivery raises questions about whether individualised care is realistic or achievable. Person-centred care places people as equal partners in addressing their individual health care needs. Such a ‘personalised’ approach aims to ensure treatment options are the most appropriate for each person’s specific health requirements, thereby increasing the likelihood of a positive and satisfactory outcome. It involves putting patients and their families/carers at the heart of all decisions.

In England, the White Paper ‘Equity and Excellence: Liberating the NHS’ (2012) set out the Government’s vision to put patients and the public first; where ‘no decision about me, without me’ is the set standard for care commissioning and delivery. Whilst considered an ambition, the notion of person-centred care delivery is rarely contested, yet major reports into poor care (c.f. Francis, 2013; Kirkup, 2015) suggest that the policy directive has yet to be universally implemented in practice. Health and social care services across the globe are facing a huge rise in demand, as people live longer and as treatment options become more sophisticated. Take, for example, the experiences outlined in health and social care institutions such as Alder Hey Hospital, Mid Staffordshire Hospitals, Morecombe Bay Hospital and Winterbourne View care homes, to name but a few of the public inquiries into neglect that have revealed evidence of depravity and cruelty, which has led to widespread proportioning of blame on those who deliver care. Subsequent pressure on the Care Quality Commission (which monitors quality provision in England) is to publicly expose large National Health Service (NHS) organisations, such as those mentioned, but often these reports neglect to explain the broader context that organisations are battling against increased demand alongside fiscal austerity from a £2.4bn deficit in government

Corresponding author:

Sally Hardy, Head of Department for Mental Health and Learning Disabilities, School of Health and Social Care, London South Bank University, 103 Borough Road, London SE1 0AA, UK.

Email: sally.hardy@lsbu.ac.uk

funding. The situation at hand for health and social care has led to what many of the UK newspapers are calling 'a crisis in the NHS'.

Despite the media frenzy around these reports and public inquiries, the heart beat of the health and social care services remains its employees: those who daily face the reality of working in a complex bureaucracy that requires a rapid response to external pressures to continually improve from limited resources. (See, for example, the recent response to current Health Secretary Jeremy Hunt's call for a 24/7 NHS from practitioners, using the twitter hashtag, #ImInWorkJeremy).

At the second of a new series of debates, held on 2 July 2015 at London South Bank University's (LSBU) School of Health and Social Care, the topic: 'Is health and social care person centred?' (@LSBU_HSCPCC) was verbally sparred between four eminent panel members. As with the previous debate on the 6C's (Baillie, 2015) the audience were once again asked to vote on statements before and after the debate. Speakers were from care commissioning, care providers, academia and journalism, who came together to debate whether the 2012 vision had been achieved and, if not, why not? Whilst the debate was situated within the experiences of the NHS in England, contextual constraints are likely to apply across all private and public organisations, health and social care provision, and have resonance across UK and international borders, when looking to explore how to cost-effectively continue to improve individualised health care delivery.

Starting in the 'for' corner was Kath Evans, Head of Patient Experience, Children and Young People, NHS England (@KathEvans2), who asked the audience to introduce themselves to the person next to them by name. This emulates a recent trend in nursing (and social media noms de plume) of starting any interaction by politely stating your name. However, as the evening's debate continued it became evident that this simple act of kindness and social courtesy just isn't enough to respond to a complex health and social care culture where 'Everyone Counts' (NHS England, 2013) isn't widely or universally experienced. In such a complex and pressurised reality is, 'hello, my name is', good enough to initiate the level of widespread cultural and social change required? Or is this simplicity a starting point towards changing a culture where people can reclaim their workplace as a caring and person-centred one? It is when resources are limited that people become creative and devise innovations to tackle and showcase where best care and practices are embedded in a workplace culture of humane (priceless) acts of kindness. Lord Rose (Department of Health, 2015) has reported on the need for better leadership in the NHS and concludes that an emphasis on quality has led to the 'extraordinary people who staff the NHS' being significantly overlooked as the potential cure for the ills within an NHS focused on high-quality performance. He recommends the need to simplify complex matters wherever possible.

Factors affecting our nation's health and social care are far more complex today than ever. Not long after the @LSBU_HSCPCC debate I noticed and read an article from a mother of two who had attended Accident and Emergency (A&E) at Lewisham Hospital in South London following a fall, with a suspected broken elbow (South London Press, 2015). She wrote a letter to the hospital, 'complaining' that she had come to A&E expecting a long wait (armed with a book and some self-prescribed medicinal chocolate with the intention of a having a few hours peaceful reading time), but within minutes she had received prompt triage, been sent for an X-ray, then back again to be seen and advised about self-care of her broken elbow. She was back home within two hours. Albeit a light-hearted and charming letter, this captured for me the essence of a complaining, litigating culture that is permeating

the NHS. What makes us ‘whinging pommies’, who take for granted the free at point of delivery NHS that many of us have been born into and has provided us with lifelong careers?

Whether the NHS is or can deliver person-centred care (PCC) when considered to be in a state of crisis, and what is person centredness anyway, does perhaps help us to understand why this debate set the @LSBU_HSCPCC ‘twitter-sphere’ that evening into the top three activities, even when up against the opening week of Wimbledon’s tennis championship.

Person-centred health care practice enables consideration of an effective working relationship to be achieved and maintained between the care provider and the person in need of care. The use of the phrase ‘person centredness’ in health care contexts focuses on understanding and recognizing the person behind their health care problem; aiming to value and respect each individual’s social context rather than foreground their illness state (McCormack and McCance, 2010). McCance et al. (2008) explored caring dimensions and explain person-centred practice as being underpinned by values of respect for the person’s individual rights to self-determination, mutual respect and understanding. It is enabled through workplace cultures of empowerment that foster continuous approaches to striving for safe and effective care delivery. McCormack and McCance (2010) identify person-centred processes as focusing on how care is delivered, including consideration of the attributes of the caregiver and attributes of the care environment.

Person centredness as a term has been traced back to the writings of Martin Buber (1936), whose ‘I and Thou’ philosophical-religious writings helped articulate the relationship between self and others. His work still resonates in the modern world, as interest in the notion of ‘mindfulness’ and positive psychology gains empirical evidence for linking a person’s nature to their physical health and mental wellbeing. It is now being widely adopted by health and social care to become a recognised approach to personalised and holistic care provision. However, the term has only more recently been adopted as a political imperative, following the Chief Nursing Office for England’s call for the promotion of compassion as a means to providing high-quality care delivery (Department of Health and NHS Commissioning Board, 2012).

Person centredness has become an adopted phrase seen in many political documents as a value-based principle of the NHS. Being person centred requires that the needs and requirements of the individual be foregrounded from what the professional thinks is best for that person. Not only is it about understanding the person, but also about considering their social situation, alongside their medical and psychological needs. As one of the core principles of nursing practice (Royal College of Nursing, 2010), adopted across England, Scotland, Wales and Northern Ireland, policy documents refer to being person centred as making sure the patient is recognised as a person in their own right, placing that person at the centre of decision making about their health. The focus of research into PCC has centred on older people and learning disabilities, which Ross et al. (2014) argues makes expanding PCC to all contexts of care across health and social settings difficult. Indeed, this was identified at the end of the debate as the evening’s discussions focused largely on offering examples taken from large health-orientated settings.

McCance, McCormack and Dewing (2011) outline the application and historical lineage of person centredness by providing a tabulated continuum that spreads into different terminology, such as: patient-centred care (Drach-Zahavy, 2009), family-centred care (Shields et al., 2006) and relationship-centred care (Nolan et al., 2004). Each term offers additional emphasis on the need to consider individuals within their wider social context in order to achieve effective care delivery. This broad perspective to PCC was captured in the

debate amongst the four panel members, followed by a lively and impassioned audience question and answer time that made it difficult for the panel Chair, Professor Warren Turner, Dean of the School of Health and Social Care at LSBU, to bring the evening to a close.

Kath Evans reminded us of the scale of the issue being debated. According to the NHS Confederation (2015) there are 1.4 million NHS staff caring for 1 million health care users every 36 hours. With just 150,000 NHS doctors, and just under 380,000 nursing staff dealing with 22 million A&E attendees, 15 million hospital admissions, 52 million outpatient appointments and 1.7 million mental health service users. Despite these big numbers the statistics reveal that the patient experience feedback survey remains high at 84% satisfaction, with 89% of patients stating that they were treated with respect and dignity.

The first speaker against the motion, Andrée le May, Emeritus Professor of Nursing, Southampton University, brought the person-centred care debate back to the organisational culture within which NHS staff are expected to deliver person-centred care. She claimed that it is the workplace environment that is devoid of personalisation and dignity, and claiming that the political context of care is ironically the starting point where care giving becomes devoid of person centredness, which in turn enlarges the barrier between care givers and the people to whom they deliver care. She explored from an academic perspective insurances of neglect and a universal undermining of 'softer skills of emotional labour and coproduction' as not being recognised and rewarded, particularly from a largely female nursing workforce (cf. Payne, 2006; Smith, 1992). Therefore if the organisational culture is not person centred, how can staff be expected to portray these values within their daily routines and practices at the level of workplace culture?

John Walsh, Practice Manager, York Street Practice in Leeds (@johnwalsh88) then took over the debate as a supporter of the motion that the NHS is person centred. John reminded us of the changes arising from the civil rights movements, and the power shift that can take place when there is a socially driven cultural shift in both attitudes and opinions. He advocated for a raise in the public's consciousness toward an awakening of what needs to change in society, but also how that change can be witnessed and delivered in our health and social care organisations. He asked, 'How can we care for – if we do not care about – our fellow man?' John stipulated being person centred is about wanting to make a difference. This can be achieved, he claimed, through the process of coproduction, where the care users and care givers work jointly to tackle the areas in need of improvement as a process of transformational change, working from our collective values and beliefs in societal cohesion.

The fourth and final panel member was Shaun Lintern, a journalist for the *Health Service Journal* (@ShaunLintern). Shaun outlined, all too clearly, the impact and consequences of non-person-centred care. These are stories that need to be retold, in all their devastating and shocking detail, to understand where and how the NHS has failed people, at all levels of society. He described what he called 'the lethal mix', where person-centred care is not evident at organisational and workplace levels and how this has devastating results. Shaun articulated how person-centred care is not a universal experience despite being a universal expectation. He eloquently expressed the need for passionate and committed NHS staff to be left alone in their fight to collectively remove the 'ugly side of health care', and to replace this with more of the stories of how and where we can and do get it right. 'There is no model better for health care than the NHS, which at its heart is person centred' he said. The risk, he stated, is the political agenda, which is moving away from the foundational NHS values of care, and moving steadily towards a more fiscally driven decision making 'care for yourself' option. If this continues, the individualist approach to person centredness moves away from

a collective consciousness that focuses on our relationships and a shared notion of caring. What is required, he claimed, is to allow those who are able to make a difference to be left alone. Innovation in the workplace can only be unleashed when those who can start to make a difference.

During audience question time, the notion that PCC is not a 'one size fits all approach' to quality care provision was emphasised. This reminded me of the findings from the RCN Institute's Expertise in Practice Project (Manley et al., 2005). A most interesting finding from these five years of research was that many 'expert' nurses had to circumnavigate the health care system in order to provide personalised care packages that met the needs of their clients. Another surprising and significant finding at that time was that the people being cared for were very well able to identify and articulate what it was that made their nurse stand out from others as an 'expert'. It was, fundamentally, that those nurses knew them as a person, knew their social situation, their particular and individual needs and requirements – resulting in the need to work collaboratively to ensure that the best care required was accessed, which most often was not an off-the-shelf intervention or treatment option, but required a more maverick approach to obtaining the right care delivery package.

The audience response to the pre- and post-debate questions raised further questions about the complexity of the situation being debated. The first question statement was: 'Today's health and social care services are planned to ensure care is coordinated around individuals' needs and preferences'. Pre-debate, 24% somewhat agreed, and 21% disagreed. By the close this opinion had changed to reveal an increased level of disagreement. Only 10% agreed post debate, with the majority (39%) of the audience vote going toward a clear disagreement with the statement. At the close of the debate, looking at whether 'this house believes that health and social care is person centred', a significant number (79%) of the audience voted the statement as being false.

So what can be done to improve and alter a swathe of negative opinion?

There is more work to be done in understanding what influences positive change within highly complex organisation and workplace cultures such as contemporary health and social care. Working from a person-centred perspective to care delivery has significant implications on how clinical teams and individual practitioners are educated, and are able to work collectively to influence and embed person centredness (Hardy et al., 2013). McCormack and McCance's (2010) framework offers the constituent parts for achieving effective PCC delivery. Yet, they too recognise the complexity such a model brings to staff who are already burdened with long (unsociable) shift patterns and who are described as 'inquiry fatigued', and working on goodwill (Department of Health, 2015).

I conclude this perspective piece with how important it is to provide what Shaun Lintern called, 'the people who can' (such as clinical leaders and practice innovators) with the materials, tools and quality data that can be used to evaluate and further inform person-centred, practice-driven innovations. This is further borne out in the vast literature on innovation uptake and leading transformational change (the subject of our next LBSU HSC debate). Through participating in a series of strategically driven internal changes that promote effective communication and strengthening practice-driven leadership, clinical staff do become more empowered to transform their work place culture, and improve the health care experience for all involved.

Person-centred care is and will remain a highly emotive and potentially stressful role when the organisational culture demands more than just being good enough, and still does not

recognise or place value on the simple humane impact of being polite, caring and treating all we encounter with the dignity and respect they deserve.

Providing practitioners with the adequate support that they need (whether that is emotional, practical, educational, resource intensive or an insistence for a compassionate Trust board) to continue to deliver high-quality health care is imperative to future health care quality and delivery. It is the people who make the health and social care system person centred. Let's advocate for people to remain at the centre of all our decision making.

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Sally Hardy is Head of Department for Mental Health and Learning Disabilities, at London South Bank University. Sally trained as a general nurse and mental health nurse, and has worked as an academic in England and Australia. Sally continues to research and implement practice driven innovation. Particular interest is how to influence innovation uptake that helps others, through for example understanding what makes effective clinical teams, and how the workplace environment can hinder or enhance achieving maximized health and wellbeing. Sally works inclusively with people with direct experience of health and social care to further understand how to enable all to flourish and reach their full potential through collaboration and mutual respect.