What Are The Critical Components For, And Obstacles To, Implementing Person-centred, Coordinated Care?

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Abstract

Title
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Summary
This article considers the difference between people-centred, patient-centred and person-centred care. It provides a review of the components that are important in delivering person-centred, coordinated care and the obstacles that need to be overcome to deliver such care in an effective manner.

Keywords: people-centred, patient-centred, continuity, shared decision making, holistic, coordinated.

Introduction

Ensuring that the care a person receives is focussed solely on their personal needs might appear to be an inherently straightforward objective. The increasingly complex operation of the NHS does, however, create a number of barriers to ensuring that such care is effectively coordinated and implemented.

People, patient or person-centred care?

People-centred
The World Health Organisation (WHO) provides a relatively all-encompassing definition of people-centred health services as ‘an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways.’

Patient-centred
Starfield expanded on this, suggesting that patient-centred care, from a clinician point of view, refers to episode-based interactions in visits focussed on the management of disease states. In contrast, they discussed that person-centred care was delivered effectively when based on relationships developed over time and ensured that care was focussed on managing a person’s life experience as well as their disease state – focussing on problems experienced by patients as opposed to their diagnoses.

Person-centred
When care is person-centred, the individual involved is active in their own healthcare.
Continuity of care

Continuity of care is an important component of person-centred care. Paddison indicated that continuity of relationships between patients and clinicians was essential to allow clinicians to really understand an individual patient’s healthcare needs and goals, which is essential in the delivery of person-centred care. However, in reality, continuity of relationships with clinicians can be a challenge for the NHS at present.

Levene et al reported that, irrespective of patient demographics, continuity of relationships between General Practitioners and patients fell by 27.5% between 2012 and 2017. A potential critique of this work is the methodology used to report the decline – the measurement was based on establishing whether patients actually wanted to see a regular GP and how often they got to see their GP. Less than 50% of patients reported they wanted to see a regular GP – to generalise this as a decline in continuity for all patients is not therefore possible. However, in the experience of the author, both as a patient and a general practice healthcare professional, it is becoming more difficult for patients to see a practitioner of their own choice for a multitude of reasons. This therefore presents a potential barrier to the delivery of person-centred care.

A lack of relationship continuity between a patient and clinicians does mean that continuity of care cannot be provided over a number of episodes of care or where different settings or services, which may be relatively short-term (e.g. Accident and Emergency attendances), are involved. Haggerty et al undertook a multidisciplinary review of continuity of care and highlighted that care continuity is not just based on relationships between clinicians and patients. Continuity can be provided through informational means (i.e. using information about a person’s history and individual situation to ensure continuity of care), as well as through managerial means (i.e. ensuring that a person is managed consistently in response to their needs).

In the experience of the author, it is possible to deliver person-centred care irrespective of the setting. The effective communication of information across providers of care, and between recipients of care and clinicians, is of utmost importance to allow all services to deliver person-centred care.

Shared Decision Making

A key component of person-centred care as indicated in the WHO definition is people being actively involved in their own health care as ‘partners’. One way to do this is by ensuring that clinicians engage people in ‘shared decision making’ i.e. ensuring that no decision about a patient is made without their involvement. Barry and Levitan discuss how sharing decisions enables clinicians to offer choices to patients and explain risks and benefits as well as allowing the patient to express their preferred choice and their own personal values and beliefs.
about their health care. This is intended to ensure that both parties can have obtain a better mutual understanding of one another, as well as sharing accountability for the course of action chosen.

Although sharing decisions may seem like a simple concept, it presents a number of barriers in practice. Joseph-Williams et al published findings from the ‘MAGIC’ (making good decisions in collaboration) programme and described five key barriers to true implementation of shared decision making described by clinicians:

- Clinicians felt that they were already practicing shared decision making.
- Clinicians reported they did not have the correct resources to enable shared decision making.
- Some clinicians felt that patients did not want to share decisions.
- Some clinicians felt that shared decision was immeasurable.
- Some clinicians felt too busy to share decisions fully with patients.

Despite key themes emerging from the programme, the authors were able to respond to a number of the common barriers faced. One potential criticism of this work is the potential bias the authors had in ensuring the programme of work was presented positively. A balanced approach would state that some of the barriers faced by clinicians were true and not always insurmountable. In the experience of the author, if being truly person-centred it is important to consider whether a person, or their relatives, want to be involved in decision making. Depending on the context, from experience some truly will not want to be given choices. It is most important to never make assumptions about a patient’s wishes.

**Holistic care**

The WHO definition of person-centred care states that care should be humane and holistic. Holistic care is a term widely used to describe nursing and medical approaches to care. Holistic care has similarities and overlaps with person-centred approaches as it ensures that patients’ full needs are considered and not just their clinical ones. For example, holism would ensure that a patient’s spiritual needs were assessed and met in addition to any clinical needs. An evaluation of experience of some service users in a mental health setting found that not addressing the spiritual needs of patients, or doing so inappropriately, can lead to patients not engaging in their care. While this work only looked at spiritual care in a mental health setting, it could be argued that the lessons are important for all sectors. One limitation of this study was that it was conducted with patients who, in the main, identified as Christian and in an area where the demographic was predominantly Christian – spiritual care is not confined to one religion. This, in turn, shows another potential barrier to delivering person-centred care. Dependent on the location and demographics of the area, patients may not have equitable access to spiritual care to sufficiently meet their needs.

**Coordinated care**

The NHS has an incredibly complex structure, and patients are often passed between providers of care for various investigations, treatments or procedures. At an organisational level, the National Audit Office highlighted that recent attempts at integration in England had been unsuccessful and that poor information sharing across organisations was a barrier to successful integration.

The report highlighted that little progress had been made with some issues (e.g. interoperability of IT systems) over the last 20 years.

Approaches to coordinating care at a patient level have proven more successful. National Voices (a coalition of charities that represent people being in control of their health care) have defined person-centred coordinated care from a service user perspective. This provides a unique insight into what matters to patients receiving coordinated care: “I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

This patient insight highlights a few more key components of coordinated care – that care is planned in partnership, that care providers work in collaboration, that the patient is provided with sufficient control over what happens to them, and that the patient achieves goals which matter to them most.

Wallace et al reviewed literature and posed potential solutions for management of patients with multimorbidity in primary care.

Multimorbidity can be defined as when a patient suffers from two or more chronic conditions e.g. asthma and hypertension. Evidence shows this can lead to uncoordinated care due to the involvement of multiple clinicians across primary and secondary care. As a consequence, patients are more at risk of adverse drug reactions and this could lead to a reduced quality of life. It could therefore be argued that patients with multimorbidity are most likely to suffer if

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their care is not coordinated. Wallace et al highlighted the benefits of ‘shared decision making’ in multimorbidity. One potential critique of the work is that they pose continuity through named GPs as a potential solution to uncoordinated care – as previously highlighted this is not always practical.

One model attempting to address uncoordinated care is the ‘Year of Care’ approach. This approach is a model of care and support planning that aims to improve outcomes for patients with multimorbidity. The model moves away from patients receiving single-condition reviews in General Practice, towards a two-stop model. The patient attends for diagnostics and results are shared by post, with a prompt allowing them to highlight what is important to them and what their health goals are. The patient then attends for a review with a clinician with their results and prompt, and the intention is to have a person-centred discussion at the review. An outcome of this review is the development of a personalised care plan. This model incorporates the essential components of coordinated person-centred care as defined by National Voices – patients are involved in the planning of their care to meet outcomes that are important to them.

While the ‘Year of Care’ approach is supported by an evidence base, a potential limitation of the particular approach is that there is a lack of independent, robust evaluation data to show its benefit. However, evaluation of a very similar model of care has produced mixed results. A randomised controlled trial was commenced to establish the benefits of care and support planning. While the model was shown to improve measures of patient-centred care, the model of care delivery was not shown to improve patient quality of life or perceived symptoms of disease. The model significantly improves the number of patients reporting that they were able to discuss what was important to them, that they were satisfied with their care and that they had a written care plan. It is difficult to critique these results – ultimately there was no improvement in quality of life for patients. However, this can be difficult to achieve in patients with long-term conditions and multimorbidity due to the sheer impact diseases have. The model does ensure care is coordinated and has been shown to improve patient experience, which should be considered a success.

How well do we deliver person-centred, coordinated care?

Considering the models discussed above, it may seem obvious that implementation of such approaches should be standard practice. In reality this is not the case. Specifically, in England, management of multimorbidity in General Practice remains heavily influenced by achieving Quality Outcome Framework (QOF) targets to ensure practices receive adequate funding. QOF targets were designed to ensure that patients with long-term conditions received effective interventions; however, the quality of care is not measured as such. In the author’s experience, GP practices are placed in a ‘Catch-22’ situation – if they don’t achieve QOF targets they will likely not receive sufficient funding to deliver core services and patients will suffer. Consequently, models of managing multimorbidity may not be as person-centred or coordinated as one would hope. In England, we have an NHS where in both primary and secondary care payment is driven by activity; one could argue there are few incentives to move towards more person-centred models of care.

Sinnott et al conducted a qualitative study investigating what affects clinicians’ treatment decisions in patients with multimorbidity. The main conclusion of the study was that clinicians tend to find a level of compromise between being person-centred and delivering evidence based treatment. The study showed that patient wishes were just one of seven domains considered by clinicians when reaching a decision. One
limitation of this study is that it was conducted on a small scale (interviewing 20 GPs). However, it does demonstrate that barriers towards delivering truly person-centred care are complex and multi-factorial. Healthcare professionals are bound by codes of conduct to ensure they do no harm, yet patients have the right to make decisions that may be unwise in the view of others.

In the author’s experience this can prove very difficult – in a litigious society it is not always possible to be as person-centred as one would like. An example of this can be illustrated by considering an average patient with a new diagnosis of Atrial Fibrillation (AF). Guidance states that patients with AF and additional risk factors for stroke should be placed on anticoagulation to reduce their risk of ischaemic stroke. Anticoagulation is well-recognised as a critical medication. Some patients do not wish to take anticoagulation; while it is possible to ensure they are aware of the potential risks of not doing so, it is very difficult for a healthcare professional to not advocate the patient takes potentially lifesaving medicine. However, if being truly person-centred, the healthcare professional should present all options, benefits and risks in an unbiased manner – yet doing so could conflict with their professional and moral codes and own personal values. In addition, the healthcare professional may feel biased towards advocating treatment to reduce risk and the chance of their own practice being questioned at a later date.

It is important to consider how performance in delivering person-centred, coordinated care can be measured across the NHS. The Health Foundation suggest a number of methods which organisations can use: These include surveys and interviews of patients and professionals, as well as structured observations of care being delivered. These recommendations have varying uptake. NHS England guidance advocates measuring person-centred care but it does not dictate how this should be done. Guidance also suggests that the ‘Friends and Family Test’ may be a suitable measurement to use. This is a simple survey that asks the question: “How likely are you to recommend our service to friends and family if they need treatment?” A criticism of using this method is that, while it may be effective at capturing patient satisfaction, it is not sufficiently detailed enough to capture the nuances of how well person-centred care is being delivered.

In Scotland, significant work has been undertaken to enable clinicians and health services to effectively deliver person-centred care. There has been open acknowledgement that health services must move away from a ‘doctor knows best’ culture. The Chief Medical Officer has set out a strategy entitled ‘Realising Realistic Medicine’ to ensure that, by 2025, anyone providing healthcare in Scotland takes a realistic medicine approach. The term realistic medicine infers person-centred health and social care, and applies to all professionals who use their skills and knowledge to help people maintain health and to prevent and treat illness. One such example of this initiative in practice is the development of ‘Polypharmacy Guidance, Realistic Prescribing’, to enable healthcare professionals to undertake reviews in a person-centred context with the aim of reducing unnecessary polypharmacy and associated harm for patients.

Conclusion
There are a number of critical components to the implementation of person-centred, coordinated care:

- being clear about what it constitutes
- recognising of what it means to patients
- continuity of care (provided through effective communication at all levels between services, clinicians and patients)
- ensuring that decisions are shared with patients when possible
- ensuring that care is holistic
- ensuring patients are involved in the planning of their care to deliver outcomes which are important to them

There are a number of obstacles to the implementation of person-centred care:

- relationship continuity in some settings
- extent of availability of resources
- the willingness and ability of clinicians
- insufficient capacity for organisations to reform
- a lack of effective organisational integration and information sharing. This presents a huge barrier to truly coordinated patient care, and progress in this area has been slow despite many NHS reforms.
- a lack of standard measurement across the NHS. This would allow true benchmarking and improvement in areas of concern.

“In Scotland, significant work has been undertaken to enable clinicians and health services to effectively deliver person-centred care.”
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