

Chapter 4

Personal and Public Involvement in Healthcare Provision

ABSTRACT

Personal and public involvement in healthcare provision has become an essential part of the governance framework of the National Health Service (NHS) today. Patient safety, quality, and responsiveness of care are the main priorities of national healthcare providers. Yet in practice, there are significant limitations to the introduction of a true patient- or person-centred approach, which will be described in this chapter. Two case studies have been included to illustrate the challenges to implementing a true person-centred approach in the NHS. The first relates to the Mid-Staffordshire Hospital Trust where hundreds of patients died as a result of sub-standard levels of care. The second focuses on a family's struggle to access a joined-up package of care for a Parkinson's disease sufferer in a primary care setting.

INTRODUCTION

In recent years, the involvement of the patient in the process of treating and providing greater choice to the individual has become an important part of healthcare practice in the UK. The governance of the National Health Service (NHS) is increasingly about co-production and granting the patient and public (family or advocate) an active role in healthcare provision. The

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clinical governance framework introduced by New Labour in the late 1990s ensured that the patient-centred or person-centred approach was at the very heart of public healthcare provision. Although there is no widely accepted definition, person-centred care can be defined as a holistic approach to meet the needs and priorities of the person receiving healthcare ahead of all other stakeholders of the system (health professionals, etc.). Starfield (2011) underlines the subtle difference between patient and person-centred care. While patient-centred care tends to focus on care of diseases (generally chronic), person-focused or centred care is provided to patients over time, independent of care for particular diseases. However, in practice NHS documents tend to mix the two. Mead and Bower (2000), after an extensive literature review, underline five key components that make up patient-centred care: patient-as-person (focusing on the patient as a person); sharing power and responsibility (creating an egalitarian relationship between patient and providers, informing the patient and family and allowing the patient to choose...); therapeutic alliance (emphasis on empathy and respect; and doctor-as-person (clinical encounter). Personal and Public Involvement (PPI) is also at the heart of the health governance framework. PPI can be described as the active and effective involvement of service users, carers and the public in Health and Social Care (HSC) services. Yet in practice, there are significant limitations to the introduction of a true PPI, patient- or person-centred approach, which will be described in this chapter. Two case studies also included here illustrate the challenges of implementing a true person-centred approach in the NHS.

THE ORIGINS OF PATIENT- OR PERSON-CENTRED HEALTHCARE

The Health Foundation has traced the origins of person-centred healthcare and attributed this expression to psychologist Carl Rogers (1951) who used the term in relation to psychotherapy. In the late 1970s, the American psychiatrist George Engel promoted a bio-psychosocial model of health; that is a person-centred model of healthcare. It is not necessarily the definition adopted by the NHS today but it did put focus on the need for empathy and for the professional to be prepared to suspend judgment and appreciate the services user's or patient's perspective (The Health Foundation, 2013).

The World Health Organisation (WHO) explains that while there have been significant health improvements over the last century, despite increasing

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