Towards a coherent person-centred measurement system

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We *tell* our workforce to be more person centred
However:
We don’t tell them what it is we want them to do differently

I support patients to self manage all the time
I always share decisions with patients

85% of clinicians think they share decisions. 50% of patients agree.
Blakeman T et al BJGP 2006. eScholarID: 1d13962.
GPPS surveys 2006-15

And:
We don’t routinely and reliably measure person-centred processes and outcomes

Because:
We tend to value system-centric processes and outcomes; perhaps because we *can* measure them

Enhanced Service Specification

Avoiding unplanned admissions: proactive case finding and patient review
Enhanced Service Specification

Supporting people with long term conditions to keep well at home

We have a *perspective problem*
Person-centredness: a means to an end and an end in itself

A person-centred system

A safe and effective system

We need a coherent, *person-centred* measurement system, where we:

- **Define**
  - The context of our system (e.g., scheduled/unscheduled care; in-patient/out-patient; acute/long-term condition)
  - The purpose of our system (the person-centred outcomes we are trying to achieve)

- **Define and measure** person-centred processes which deliver the outcomes under question

- **Clarify** the relationships between those processes and outcomes

- **Link** those processes and outcomes to other ‘downstream’ system metrics
High quality systems demonstrate process reliability

High quality measurement systems demonstrate *measurement coherence*
High quality person centred measurement systems are likewise coherent

Measuring what really matters

Dorothy
Dorothy is 79 and was recently widowed- she now lives alone and life is a struggle. Her knees are playing up- she is seeing a surgeon next month to discuss an operation. She is worried about that- her diabetes hasn't been good for a year or two and her doctor has recently told her that her smokers cough is more serious and is something called 'COPD'. All in all, she is feeling quite low; maybe she should talk to someone? Maybe she should even think about moving home- even the stairs are a struggle now.

**Context:** scheduled care planning encounters
Dorothy centred care and support system **purpose**

Passive recipient to active participant

Increasing levels of knowledge, skills and confidence to manage own health and healthcare

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Dorothy centred care and support system **principles**.

**Transactional work**

**Relational work**

Could Dorothy park?

Was Dorothy supported to develop her own sense of resourcefulness?
The principles of person-centred care and support

Dorothy should be treated with respect, dignity, compassion, kindness and understanding.

Was Dorothy’s experience seamless? Does she have a care co-ordinator?

Does the system support Dorothy to recognise her own personal and social resources and draw on them/develop them?

What matters; what is important to Dorothy. Her goals, her preferences.
Metrics that support the principles
Data in health and social care in England

• 1706 commonly used single indicators
• Held in 8 different databases:
  – Health and social care information centre
  – 4 national surveys
  – 2 national outcomes frameworks
  – QOF
• Plus a variety of datasets that can be used to assess care co-ordination, integration and effectiveness of personal budgets

Back to Dorothy....
Developing our coherent measurement system

1. **Define** the context
2. **Clarify** the purpose
3. **Co-design** the system
4. **Specify** the person-centric logic model
5. **Populate** the model with indicators
6. **Run the system** and learn

A system logic model

- System supports Dorothy to prepare for appointment
- Dorothy discusses what is important to her and her goals
- Dorothy told of the care or support options available
- Dorothy chooses care, support or treatment that is right for her
- Optimal outcome for Dorothy
A system logic model

System supports Dorothy to prepare for appointment

Dorothy discusses what is important to her and her goals

Dorothy told of the support options available

Dorothy chooses care, support or treatment that is right for her

CQCOPS 38

CQCIPS 36

GPPS 21, 23, 32

CQCIPS 36

Deep dive system logic model

System supports Dorothy to prepare for appointment

1. Dorothy meets empathetic and enabling professional

2. Dorothy is supported to tell her story and to set the agenda

2. The professional shares information-tailoring it to Dorothy’s current level of knowledge and health literacy

1. CARE measure: www.caremeasure.org
2. Health Literacy Questionnaire (HLQ):
What is this system trying to achieve?

- Improvements in PROMs (PDOMs/PCOMs)/goal attainment
- Improvements in Activation (PAM: www.insigniahealth.com)
- Maintenance or improvement in QOL (EQ5D: www.euroqol.org)

Goal attainment and patient activation as a primary mediators of downstream indicators.
A flipped system- a flipped measurement system

Measure what *really* matters

In order to deliver treatment, care or support that informed patients want

Not treatment, care or support professionals think they should have

www.personcentredcare.health.org.uk

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