Meeting Individual Care and Support Needs

5

Getting to know your unit

To be able to provide the care and support that meets the needs of an individual in a health and social care environment, it is important that you understand the principles and practicalities that are the foundation of all the care disciplines. This unit introduces you to the values and skills that you will need for a career in social care or health care. Ethical issues will arise and challenges will need to be overcome when personalising care. You will reflect on the different methods used by professionals working together in a multi-agency team to provide a package of care and support that meets individual needs.

How you will be assessed

This unit will be assessed internally by a series of tasks set by your tutor. Throughout this unit, you will find assessment practices that will help you prepare for your final assessment. Although these activities do not contribute towards your final grade, it is important to complete them because they provide you with an opportunity to practise or they suggest useful research to undertake, both of which will be good preparation for your assessment.

You should check that you have met all the Pass grade criteria as you work your way through the assignment. If you fail to meet one of the Pass grade criteria, you will be unable to gain a Merit or Distinction even if the rest of your work reaches the required standard. To pass you need to be able to explain and describe the information asked for in your assignment. To gain a Merit or Distinction, you need to make sure that you present the information in the style that is required by the relevant assessment criteria shown in the table below. For example, to gain a Merit you need to be able to successfully analyse and assess and, to gain a Distinction, you need to be able to use the higher-order skills of evaluating and justifying.

The final assessment set by your tutor will consist of a number of tasks designed to meet the criteria in the assessment criteria table. This is likely to consist of a written or oral activity such as:

▸ analysing and evaluating situations in case studies to reflect on the promotion of equality and diversity, and the values and skills needed to care and support others
▸ writing a report on how an ethical approach to providing support benefits service users
▸ preparing a presentation on the communication techniques used when providing care for service users with different needs
▸ using case studies to reflect on how professionals work together to meet the needs of individuals.

Assessment criteria

This table shows you what you must do in order to achieve a **Pass, Merit** or **Distinction** grade, and where you can find activities to help you.

Pass	Merit	Distinction
Learning aim A Examine principles, values and skills which underpin meeting the care and support needs of individuals.		
A.P1 Explain the importance of promoting equality and diversity for individuals with different needs. **Assessment practice 5.1**	**A.M1** Analyse the impact of preventing discrimination for individuals with different needs. **Assessment practice 5.1**	**A.D1** Evaluate the success of promoting anti-discriminatory practice for specific individuals with different needs. **Assessment practice 5.1**
A.P2 Explain the skills and personal attributes necessary for professionals who care for individuals with different needs. **Assessment practice 5.1**	**A.M2** Assess different methods professionals might use when building relationships and establishing trust with individuals with needs. **Assessment practice 5.1**	
Learning aim B Examine the ethical issues involved when providing care and support to meet individual needs.		
B.P3 Explain how to incorporate ethical principles into the provision of support for individuals with different needs. **Assessment practice 5.2**	**B.M3** Analyse how an ethical approach to providing support would benefit specific individuals with different needs. **Assessment practice 5.2**	**BC.D2** Justify the strategies and techniques used to overcome ethical issues and challenges experienced by individuals with different needs when planning and providing care. **Assessment practices 5.2 and 5.3**
Learning aim C Investigate the principles behind enabling individuals with care and support needs to overcome challenges.		
C.P4 Explain the strategies and communication techniques used with individuals, different needs to overcome different challenges. **Assessment practice 5.3**	**C.M4** Assess the strategies and communication techniques used to overcome different challenges faced by individuals with different care and support needs. **Assessment practice 5.3**	
C.P5 Explain the benefits of promoting personalisation when overcoming challenges faced by individuals with different needs. **Assessment practice 5.3**		
Learning aim D Investigate the roles of professionals and how they work together to provide the care and support necessary to meet individual needs.		
D.P6 Explain why meeting the needs of the individuals requires the involvement of different agencies. **Assessment practice 5.4**	**D.M5** Assess the benefits of multi-disciplinary and multi-agency working for specific individuals with care and support needs. **Assessment practice 5.4**	**D.D3** Justify how organisations and professionals work together to meet individual needs while managing information and maintaining confidentiality. **Assessment practice 5.4**
D.P7 Explain the roles and responsibilities of different members of the multi-disciplinary team in meeting the needs of specific individuals. **Assessment practice 5.4**	**D.M6** Analyse the impact of legislation and codes of practice relating to information management on multi-disciplinary working. **Assessment practice 5.4**	**D.D4** Evaluate how multi-agency and multi-disciplinary working can meet the care and support needs of specific individuals. **Assessment practice 5.4**
D.P8 Explain the arrangements for managing information between professionals. **Assessment practice 5.4**		

Think about an occasion when you've been asked by a friend to do something, that you believe to be wrong. Did you do it so that you didn't upset your friend? Did you say 'no' and explain why? Write down what makes you feel that something is right or wrong. Imagine that this happened if you were working in a health or social care environment. How might this affect how you respond to service users and providers?

A Examine principles, values and skills which underpin meeting the care and support needs of individuals

Promoting equality, diversity and preventing discrimination

Definition of equality, diversity and discrimination

Equality

Equality in the health and social care sector means everyone having equal access to the services they need, that is, receiving a service of equal quality that meets their personal needs, no matter where they live or how they live their lives. This is not the same as everyone receiving the same service. For example, everyone has the right to register with a doctor but a seriously or chronically ill person will need more of the doctor's time. Treating people as individuals by taking into account their different **beliefs** and abilities is crucial when caring for others, and service providers should acknowledge an individual's personal beliefs, even if they do not share them. If a person's religious beliefs mean they can only eat certain foods or have to pray at a certain time, they would feel unvalued if a hospital did not accommodate these beliefs, and it might slow down their recovery.

> **Reflect**
>
> In a group of three or four, discuss your differences and similarities. Think about your appearance, how you each live your life, your preferences in music, clothes and so on, and your dislikes. Reflect on how many differences you find.

Diversity

Diversity means a variety or range of differences. To value diversity is to respect and value the **cultures** and beliefs of other people. If you are unwilling to do this, and so dismiss or ignore the cultures and beliefs of others, you will be unable to learn about them or from them. You will be unable to understand them or meet their needs if you are caring for them. Similarly, you must respect and value differences such as age, gender and disability. It is a legal requirement for health and social care organisations to respect and value all individuals, irrespective of their religious or cultural beliefs, attitudes or other differences.

Britain is a **multicultural** society and this has an impact on health and social care delivery. Not only do health and social care professionals come from a diverse range of backgrounds, but so do the people receiving health and social care services. Living and working in a culturally and socially diverse society can provide access to a wide range of skills and expertise from different traditions and cultures. For those working in health and social care, this can create exciting opportunities such as new forms of treatment, different ways to deliver social care and, most importantly, learning

> **Link**
>
> Principles, values, skills and qualities underpin work in all health and social care disciplines. Links can be found between this unit and almost every other unit in this qualification. Look out for them.

opportunities for professional practitioners. A good service provider will be open to other people's life experiences and differences, will value their diversity and form good relationships with their colleagues and the people who use the services. A team of service providers who have different interests and skills is more likely to be able to handle a range of tasks when helping an individual, and the team will enjoy working together.

Discrimination

Discrimination is when someone has a **prejudice** against a person or a group of people. This might be for reasons such as age, gender, race, ethnicity, social class, religious beliefs, secular beliefs, family structure, sexuality, ability, health, disability, address (where they live), dress or appearance. They might then discriminate against that person or group and treat them differently.

There are four types of discrimination.
- **Unfair discrimination** is when a person is treated unfairly compared with someone else. For example, when someone is not considered for a job because they are older than another candidate, despite having the same qualifications and experience.
- **Direct discrimination** is when someone is rude, hostile or offensive to someone because they see them as being different. For example, when someone who is overweight is called names. This form of discrimination is easy to prove because it is heard or witnessed by other people.
- **Indirect discrimination** is harder to prove. For example, a manager may appear to be supportive and friendly towards a member of staff, but may show disrespect for their ideas by dismissing them in a jokey way.
- **Positive discrimination** is when a decision is made in a person's favour because there is something different about them. For example, when an advertising agency seeks to hire a person who has red hair and fair skin because they are to play the part of the sister of someone who has these characteristics; or when a service has few people from an ethnic minority at a certain level, so they appoint someone from that ethnic minority.

Importance of preventing discrimination

It is crucial to prevent discrimination, so that everyone receives a service of equal quality, which meets their personal needs. Some of the possible effects of discriminatory practice are shown in Figure 5.1.

Link

Learning aim A in *Unit 7: Work Experience in Health and Social Care* also looks at diversity and equality.

Key terms

Beliefs – strongly held opinions stored in the subconscious mind.

Diversity – a variety or range of things.

Culture – the beliefs, language, styles of dress, ways of cooking, religion, ways of behaving, etc. shared by a particular group of people.

Multicultural – many cultures or ethnic groups living in one area.

Discrimination – treating a person or group of people differently from others.

Prejudice – an unreasonable feeling against a person or group of people.

- **Figure 5.1:** Can you think of any other effects of discrimination on service users or service providers?

In some cases, this can lead to malpractice and abuse, putting individuals at risk of significant harm. Care workers need to understand the importance of avoiding discriminatory language and behaviour in order to employ anti-discriminatory practices in their own work. Don't forget that discrimination, whether from other service providers or from service users, affects service providers too.

Initiatives aimed at preventing discrimination in care

There are many ways in which care services can be adapted to meet individuals' specific needs and prevent discrimination.

▶ **Access:** the environment can be adapted, for example by having wide corridors, ramps, disabled toilets, lifts, wide automatically opening doors, counters and signs at wheelchair level, no obstacles or clutter, hearing loops.

▶ **Diet:** there is choice for those with medical conditions, religious requirements or cultural preferences.

▶ **Support:** appropriate resources and information are provided in a wide range of formats and languages to reflect local cultures, with advocates, translators, interpreters and carers available to help.

▶ **The use of advocacy services:** someone, referred to as an advocate, can speak on behalf of someone else (who maybe can't speak for themself due to illness, disability or lack of confidence).

Discussion

In groups, consider this statement from The Children's Society's website: 'Many children who are looked after in care or who are in the child protection system are not consulted about matters affecting their lives. Choices are made for them, often without their consent.'

What sort of choices and decisions do you think are being referred to? How do you think having choices made for them will make the children feel? How do you think advocacy services will help?

▶ Can you think of any health care situations where advocacy services could help older adults?

II PAUSE POINT	Can you explain what has been covered in the learning aim so far? What elements did you find easiest?
Hint	Close your book and write down what is meant by the words equality, diversity and discrimination.
Extend	Why is it important to prevent discrimination? Give at least five reasons.

Skills and personal attributes required for developing relationships with individuals

In order to care for and meet the needs of others, you need to develop relationships with them, and to do that you need certain **skills** and **personal attributes**. A skill is an ability to undertake a task, such as being able to communicate or give an injection correctly. Personal attributes are qualities you have that make you the person you are. These are based on your values: the things you believe to be important in life, such as being kind and treating others with respect. The way professionals work in each health and social sector is underpinned by a set of basic values that influence working practices and enable relationships to be developed between service providers and users. One example is the 6Cs.

The 6Cs

Compassion in Practice is the national strategy for nurses, midwives and care staff. It was launched in December 2012, following nationwide concern about the standard of nursing care after the failings at the Mid Staffordshire Hospital and Winterbourne View, a hospital for people with learning disabilities and autism. A key part of this strategy is a programme of work based on the 6Cs: six values or behaviours felt to be essential to providing quality care. The 6Cs (see Table 5.1) have rapidly been adopted by many organisations across the whole spectrum of health and social care.

> **Key terms**
>
> **Skill** – the ability to do something well or to be expert in something.
>
> **Personal attributes** – the qualities or characteristics that make an individual who they are: ie their personality.

▸ **Table 5.1:** The 6Cs

Value	Definition
Care	Looking after and providing for the needs of a person.
Compassion	The awareness of the needs of others and the desire to help them.
Competence	The ability to understand a person's needs, combined with the expertise and knowledge to deliver effective care to meet those needs.
Communication	The exchange of information between two or more people that helps to provide care and support.
Courage	The personal strength and vision to do the right thing for the people being cared for.
Commitment	The determination to improve care and meet the needs of people.

> **Research**
>
> Research the charity Compassion in Action. Look at the ways in which it and different health and social care organisations are implementing holistic approaches similar to the 6Cs. Produce a slideshow presentation that would be suitable for explaining to patients in a health centre what the Compassion in Action strategy is, and how it could help them.

> **Discussion**
>
> Research the review of the failings at the Mid Staffordshire Hospital and Winterbourne View Hospital. In small groups, discuss and compare what you have found out.
>
> How do you think the use of the Compassion in Action approach to the 6Cs would help to prevent such situations happening again?

People skills

People skills are the skills that help us to get on with other people, and so develop relationships with them. Some of these skills are:

▶ **empathy** – the ability to share and understand the emotions of others, such as sadness, anxiety or happiness

▶ **patience** – the capacity to accept or tolerate problems without becoming annoyed or anxious

▶ **engendering trust** – the ability to get people to trust you

▶ **flexibility** – being able to fit in with others and change your own plans if necessary

▶ **a sense of humour** – being able to see the funny side of situations

▶ **negotiating** – the process by which two parties with different interests or perspectives attempt to reach agreement, for example a doctor and a patient

▶ **honesty** – being truthful and sincere

▶ **problem solving** – the ability to ask the right questions and find an answer to a problem.

Case study

Different perspectives

Toni, a 45-year-old woman with chest pain, is brought to the Accident and Emergency Department (A&E) in the middle of the night. The junior doctor tells her that she has had a minor heart attack and needs a surgical procedure on her heart to make sure that this doesn't happen again. However, the pain has receded and Toni feels much better. She is worried and agitated because her husband, who is severely disabled, is home alone and she is his only carer. She says she'd rather come back the next day. The junior doctor is near the end of a double shift, is very tired and, although he clearly tells Toni the risks, he is rather abrupt and aloof with her and doesn't ask her why she wants to go home, before he is called

away to another emergency. Toni discharges herself, but is brought back in an ambulance a few hours later in cardiac arrest, which leads to more serious damage to her heart.

Check your knowledge

1 Which of the people skills did the doctor use in dealing with Toni? How do you know this from the case study?

2 Which people skills could the doctor have used better? Explain your answer.

Communication skills

Good communication skills are vital for people working in health and social care as they help them to:

▶ develop positive relationships with people using services and their families and friends, so that they can understand and meet their needs

▶ develop positive relationships with work colleagues and other professionals

▶ share information with people using the services, by providing and receiving information

▶ report on the work they do with people.

Link

Refer to learning aim C of this unit and learning aim A of *Unit 7: Work Experience in Health and Social Care* for more information about communication skills and techniques.

Active listening and responding

Listening to people involves more than just hearing what they say. To listen well, you need to be able to hear the words being spoken, think about what they mean and then think what to say in reply. You can also show that you are listening and what you think about what is being said through your body language, facial expressions and eye contact.

By yawning, looking at your notes or watch, or looking around when someone is speaking, you will give the impression that you are bored by what is being said. This is not only very rude but can also cause the person distress and negatively affect their self-esteem.

The process of active listening and responding involves:

▶ allowing the person who is talking time to explain

▶ not interrupting

▶ giving encouragement by smiling, nodding and making encouraging remarks such as 'Really?' and 'Oh yes.'

▶ asking question for **clarification**, such as 'Can you explain that again please?'

▶ showing empathy by making comments such as 'That must be so difficult for you.'

▶ looking interested by maintaining eye contact and not looking at anything else

▶ not being distracted by anything else – switch off your mobile

▶ summarising to check that you have understood what has been said. For example, 'So what you mean is ...'

> **Key term**
>
> **Clarification** – making something clear and understandable.

▶ How can you tell that the service providers in this picture are interested and listening carefully to each other?

Tone of voice

It is not just what you say but also the way in which you say it that is important. If you talk to someone in a loud voice with a fixed tone, the person will think that you are either angry with them or treating them as though they are less intelligent than you. It is important to speak calmly and quietly, with a varying tone, so that the other person will think you are being friendly and kind, and are interested in what they are saying. If the person has difficulty hearing, you might speak more loudly, but still calmly and with a varying tone.

Use of appropriate language

You probably wouldn't like it if your tutor started to use slang and text language in an attempt to appear cool while they were teaching you. You would feel embarrassed for the tutor. It is important to adjust your language to match the situation you are in and the person you are talking to. People usually do this without even realising it, unconsciously changing their dialect or accent depending on who they are speaking to. For example, when they are speaking to a friend on the phone they will be less formal than if they are ringing up the optician for an appointment.

> **Reflect**
>
> Work with a partner and decide who will be the speaker and who will be the listener. The speaker should tell the listener about a recent visit to a health care service, such as the dentist or doctor. They should talk for three minutes. The person listening must listen carefully and they are not allowed to take any notes or to interrupt. The listener has to repeat what they have heard. The listener must then reflect on how well they feel they have listened. The speaker will then feed back whether they agree or not, and say why. The speaker then reflects on whether they spoke clearly and used appropriate language so that the listener could understand what was being said. Swap and repeat the activity, this time taking the other role. Do you think that you could have been a better listener and/or speaker?

Observation skills

Observing changes in an individual's condition

A carer has to be constantly alert to changes in patients' conditions, and the implications of this in terms of care. For example, if a person lapses from being asleep to being unconscious, they will need immediate medical help. If you do not have good observation skills, you may not notice that a person's condition has changed. There are two types of observations: ones that are measurable, such as volume of blood in the urine, pulse rate, blood pressure and temperature, and ones that you can see, such as whether the patient is pale or flushed, alert or sleepy, sad or happy, or eating properly. Both of these types of observation are important when maintaining a watch on a patient's overall condition.

Monitoring children's development

Another area where good observation skills are essential is in child development work. It is important to watch a child carefully and take note of all aspects of their development, including their physical condition, non-verbal communication, behaviour, relationship to others and how they play, so that problems can be identified quickly and addressed before they get worse.

Other observations

Good observation skills also help a service provider to note signs of abuse or negligence and identify any areas of care that could be improved. For example, the manager of a care home noticing that a service user is unclean and bruised, and investigating in order to remedy the situation.

Dealing with difficult situations

Having a range of skills and personal attributes that allow you to develop relationships with individuals means that, as a service provider, you will find it easier to deal with difficult situations.

Case study

Breaking bad news

Aurel is a patient of Dr Kumah's, and has a good relationship with him. Aurel is 62 years old and has been having difficulty passing water for the last few months. He is worried that he has something wrong so, although he is embarrassed, he goes to see the doctor. He has blood tests and, when the results come back, the doctor explains that one of the things in his blood showed higher levels than usual. He tells Aurel that this may mean that there is something wrong and he'd like Aurel to see a specialist.

Dr Kumah refers Aurel to a consultant in the urology department at the local hospital. In a ten-minute appointment, Aurel is told in a very forthright manner that he has prostate cancer. He is upset but does not let it show in front of the consultant. The consultant tells Aurel to go to his own doctor to have his Prostate Specific Antigen (PSA) levels monitored. This is to watch for any signs of the cancer spreading to other parts of his body. Aurel has only heard the words 'cancer' and 'spreading'. Because he is upset, and thinks that he is not going to receive any treatment, he is convinced he is not going to survive.

Aurel goes back to his doctor and is tearful and resentful. Dr Kumah spends a long time with him, explaining that many men with prostate cancer do not die of it because it is one of the most easily controlled cancers. Dr Kumah goes over the treatment with Aurel, explaining how often he has to come for a blood test and to have his condition monitored. He even teases Aurel about it not stopping him going to watch his favourite football team. Aurel feels much better and by the time he leaves he is feeling more optimistic about the future.

Check your knowledge

1 How did having a good relationship with Dr Kumah help Aurel when he first became aware that he had a problem?

2 How do you think Aurel felt when he was told by the consultant that he had prostate cancer? Why do you think he felt like this?

3 What, if anything, could the consultant have done differently? Was it his fault that Aurel was upset?

4 How did having a good relationship with Dr Kumah help Aurel to come to terms with his condition?

5 What did Dr Kumah do that helped? What skills and personal attributes did Dr Kumah use to deal with a difficult situation?

❚❚ PAUSE POINT Can you explain what this section of the learning aim was about? What elements did you find hardest?

> **Hint** Close your book and draw out a concept map about skills and personal attributes.
>
> **Extend** Why are good observation skills so important in health and social care?

Empathy and establishing trust with individuals

Empathy is the ability to understand another person's condition from their point of view, by placing yourself 'in their shoes' and imagining what they are feeling or thinking. You need to have an overview of the different methods of establishing positive relationships using an empathetic approach with individuals in your care.

## Attachment and emotional resilience theory

John Bowlby (1907–1990) first proposed the theory (theory of attachment) that highlights the importance of a child having a significant adult (a person who is important to the child) with whom to form a close bond. This is usually the mother but it can be any other adult, such as the father, a grandparent or a main carer. Bowlby
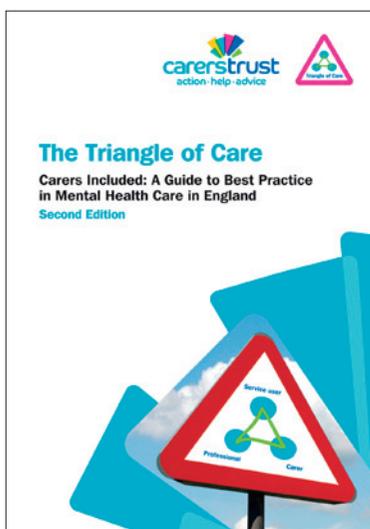
▶ The Triangle of Care. Do you know anyone who is a carer struggling to get information and support because they are not the actual service user?
https://professionals.carers.org

said that children who are not able to bond in this way do not develop as successfully as infants that they may and who can have difficulties forming relationships with others later in life. The bonding process comes about through touch, eye contact and making contact through sounds. Children who have had support and a safe, secure and stable upbringing will form a secure **attachment** with their carer and are most likely to be **resilient** as they grow and develop. This means that they will be able to deal better with disappointments and overcome problems. They will trust others and expect people to be good to them, and so will want to spend time with others and develop relationships with them. They will feel and act confidently, secure in the knowledge that their needs are being met, that they are loved and that they can depend on their carer for emotional and practical support when they need it. This will enable them to become increasingly **autonomous** as they will have the confidence to make decisions independently.

The triangle of care

The 'triangle of care' is used in mental health care and is a three-way partnership between the service user, the service provider and the carer, with each being able to contribute their views and influence care and treatment decisions. It was launched in July 2010, after a number of years of research into the information and support that mental health carers need from service providers. This approach leads to the best possible care by promoting safety, supporting recovery and sustaining wellbeing. It acknowledges the essential role that a carer plays every day with the service user: for example, in looking after a person with dementia.

Carers are often the only constant in the service user's mental health care journey. They are there on both good and bad days, and they understand the service user's needs and condition really well. This makes the carer a key partner in the service user's care. Carers wish to be trusted, involved and thought of as part of the care team as they are delivering routine, daily care. This will only happen if the service provider and the carer are willing to engage with each other and share information. It is the responsibility of the service provider to actively encourage this partnership. This not only helps the service provider and the service user, but also improves the wellbeing of the carer, as they feel valued and included.

Reflect

Think about the words empathy and sympathy. What do you think is the difference in meaning between these two words? Would you rather someone had sympathy for, or empathy with, you? Why?

Empathy theories

Empathy theory attempts to offer a **psychological** explanation of empathy as being not only a person's capacity to share emotions with others, but also their ability to engage emotively with the world around them and with the intentions underlying art, music and literature. A few empathy theories are mentioned very briefly below.

Johannes Volkelt

Johannes Volkelt (1848–1930) was a German **philosopher**. He said that you could only really appreciate an object, such as a work of art or piece of music, if your personal identity and the object become one, so you not only see an object or hear music but also feel it with your body.

Robert Vischer

Robert Vischer (1847–1933) was also a German philosopher. He invented the term *Einfühlung*, which was later translated in English as empathy. He said this word referred to when you imagine yourself as being one with a piece of art or literature and feel the emotions that the artist tried to reproduce, so **imbuing** the piece with relevant emotions.

Max Scheler

Another German philosopher, Max Scheler (1874–1928) said that we should look at objects differently, so we didn't just give the facts about an object, such as it being big and a particular colour, but also give our opinion of it, such as it being beautiful, ugly, bland or majestic.

Martin Hoffman

Martin Hoffman is a contemporary American **psychologist**. His work is based on social and emotional development, especially empathy, and its bearing on how we develop morally. Our moral development includes our principles, how we behave and our sense of right and wrong.

> **Key terms**
>
> **Philosopher** – someone who studies or writes about the meaning of life.
>
> **Imbuing** – filling up with, or becoming soaked in, an emotion.
>
> **Psychologist** – someone who studies people; how they think, how they act, react and interact.

Assessment practice 5.1   `5A.P1` `5A.P2` `5A.M1` `5A.M2` `5A.D1`

Dooriya is from the traveller community. Her three-year-old daughter, Rosie, is ill and she takes her to see the local GP, accompanied by several members of their extended family. The GP allows only Dooriya and Rosie into her room. However, after speaking to Dooriya, she learns that within the traveller community, family members expect to be included in discussions about health. She arranges for the extended family to wait outside while she examines Rosie and then invites them to come in.

Task 1

Write a thank you letter to the GP from Dooriya which:

- explains how she felt at different points in the appointment
- gives her opinion of how the GP has conducted herself today, and the skills and personal attributes she demonstrated.

Task 2

Create a presentation that the GP will deliver to the practice staff which:

- analyses how the service could further promote anti-discriminatory practice in the future
- assesses and evaluates different ways that the service staff could build relationships and establish trust across different groups.

Plan
- Have I read the task carefully? What exactly am I being asked to do?
- Is there anything I am unclear about? Is there anything I need to speak to my tutor about so I do not struggle to complete this task successfully?

Do
- Could I start by writing an outline plan that sets out what I need to include in each paragraph of the letter, and check this against the task?
- Have I covered all of the assessment criteria in my letter?

Review
- Which bits of this task did I find challenging? Why do I think this is?
- Would I approach a task of this nature differently next time? If so, why and how?

B Examine the ethical issues involved when providing care and support to meet individual needs

Ethical issues and approaches

Ethical working includes respecting the basic values and principles that underpin practice, but ethics also involves facing **moral** questions such as whether to prolong life against the wishes of a terminally ill patient.

Discussion

Discuss the following issues in small groups and try to come to an overall decision before sharing this with the rest of the class.

- There should be women-only carriages on trains to stop men harassing them, especially late at night.
- The death penalty should be brought back for murderers.
- The UK should have tougher rules on immigration to stop so many immigrants entering the country.

Once all groups have shared their views, reflect on your own about how the discussion went. Was there much difference of opinion within your group and between the groups? Did you find it hard to accept the views of others when they differed from your own? Were you able to justify your own opinions to others? Were you able to change the opinions of others?

Ethical theories

For centuries, philosophers have come up with theoretical ways of telling right from wrong and for giving guidelines about how to live and act ethically. When you are faced with a difficult situation in life, you can use ethical theories to guide your decisions. Each theory emphasises different points, in order for you to reach an ethically correct decision. You will have your own individual choice of theory based on your life experience. Some of the key theories are described briefly here.

Consequentialism

Early writers on consequentialism were Jeremy Bentham (1748–1832) and one of his students, John Stuart Mill (1806–1873). A modern writer on consequentialism is Peter Singer (born 1946). This theory says that the correct moral response is related to the outcome, or consequences, of the act, not its intentions or motives. If you were making a decision about a person's health or social care using this theory, you would look at the likely results of your decision for that person's wellbeing and the wellbeing of others. For example, a critically-ill child needs a very expensive surgical treatment and has low survival expectancy. Should the NHS do the operation or should the money be allocated to carry out hundreds of tonsillectomy operations? What are the consequences of spending the money either way? Which is the most important?

Deontology

Writers on deontology include Immanuel Kant (1724–1804) and W.D. Ross (1877–1971). Deontology theory says that you should stick to your obligations and duties to a person or society when making a decision because this is ethically correct. It focuses on your intentions rather than the outcomes of your actions. This means, for example, that rules about who receives what treatment are applied universally and consistently.

All patients are owed the duty of care and the duty of not being harmed. This theory does not take various factors into account, such as a lack of resources making it impossible to give everyone the same care everywhere.

Principlism

Writers on principlism include Tom L. Beauchamp and James F. Childress. This approach uses the following four key ethical practices.

▶ **Autonomy**: respecting the decision-making capabilities of autonomous people by enabling them to make independent, reasoned and informed choices about their own care.

▶ **Beneficence**: balancing benefits of treatment against the risks and costs, so acting in a way that benefits the patient and promotes the wellbeing of others. For example, using the cancer drug trastuzumab (Herceptin®) costs £22,000 to treat one person for one year (correct in August 2015). Would this money be better spent on saving many people who suffer a heart attack each year?

▶ **Non-maleficence**: doing no harm, so avoiding causing harm. For example, by making sure that any side effects of a treatment do not outweigh the benefits of that treatment.

▶ **Justice**: being morally right and fair, distributing a fair share of benefits, doing what the law says and looking at the rights of the people involved.

The aim of principlism is to bring together the best elements of the various other ethical theories that match with most social, individual or religious belief systems.

Virtue ethics

This theory, which has its roots in the work of Plato and Aristotle, focuses on the moral character, or virtues, of the individuals. If using this theory as a health or social care professional, you would make decisions based on your morals and what you feel is the right way to behave towards patients and colleagues. For example, you might take time to explain treatment options to a patient and find out what they want to happen.

Theory into practice

Jenna is 23 years old. She has a baby who is 6 months old and a partner, and they have just moved into their first flat together. She smokes 40 cigarettes a day to cope with the cravings she now has because, when she was 16, she became addicted to drugs. She has been clean for two years now.

David is 60 years old and has always made healthy lifestyle choices, so he is fit and active. He lives with his wife in a cottage in the countryside and has four grown-up children who are all married, or with a long-term partner, and have their own homes.

Both Jenna and David have a life-threatening illness and need very expensive treatment to save their lives. There is only enough money in the budget to give one of these two patients the treatment. Who should it be? Apply each of the ethical theories to the situation. Explain your thinking using each theory. Then identify the decision that you personally think is the most ethical.

II **PAUSE POINT** Can you understand the different empathy and ethical theories? Which do you find hardest to understand?

Hint Read them all again. If there are any you still don't understand, ask your tutor to explain them to you again.

Extend What is the difference between consequentialism and deontology?

Managing conflicts

It is important that you know how to handle conflict if you work in the health and social care sector because, as a group, health and social care professionals probably face more conflict and greater complexity than any other profession. Conflict happens with service users, carers and/or families for reasons such as disagreement over care decisions, concern about the quality or cost of care, or the behaviour of staff. People may be more critical or overwrought and their emotions may be less controlled than usual because they feel ill or are concerned about a friend or family member. Conflict can also occur between colleagues, maybe over decisions made based on different ethical theories.

▶ **Table 5.2:** NHS checklist for running a meeting to manage conflict

Do	Don't
Make sure that the issues are fully outlined.	Conduct your conversation in a public place.
Acknowledge emotions and different styles.	Leave the discussion open – instead create an action plan.
Have a comfortable environment for any meetings.	Finish people's sentences for them.
Set a time frame for the discussion.	Use jargon.
Establish good rapport.	Constantly interrupt.
Use names and, if appropriate, titles, throughout.	Do something else whilst trying to listen.
Work to cool down the debate in a hot conflict.	Distort the truth.
Convince parties in a cool conflict that something can be done.	Use inappropriate humour.

Conflicts of interest

Key term

Conflict of interest – a situation where the concerns or aims of two or more different parties are incompatible.

When working with groups of vulnerable people in health and social care settings, there are times when care workers are faced with a **conflict of interest** for which they will need to find an ethical solution. Often, ethical dilemmas will not have a 'correct' answer and the solution will depend on a number of considerations.

Nevertheless, the care worker is faced with a dilemma and is expected to make a decision. Before making a decision, the care worker must consider the following questions.

▶ What are the risks to the individual and any other people?

▶ What are the professional and legal responsibilities?

▶ What are the policies of the organisation?

▶ Have I got all the facts of the case?

Examples of potential dilemmas include:

▶ being asked to prescribe the contraceptive pill to a girl under the age of 16 without parental consent
▶ having to involve social services when parents have drug addictions
▶ having to decide on the allocation of scarce resources
▶ deciding whether to pass information on to other agencies.

One of the most controversial dilemmas involves the treatment of terminally ill patients, who are very close to death and may be in a great deal of pain. In such cases, a doctor may not wish to prolong the situation and may, therefore, withhold treatment; this is known as an act of omission.

> **Discussion**
>
> Aman is a 23-year-old man who has been rushed into A&E in an ambulance. He is unconscious, seriously ill and urgently needs intensive care support. The intensive care unit (ICU) is full with some patients who are critically ill and others who have improved slightly and are in a stable condition. Evidence shows that moving a patient out of ICU too soon can increase their chances of complications. There is an intensive care bed available in another hospital 50 miles away, but Aman may not survive the journey. The consultant has to decide what to do.
>
> In a group, discuss the situation and decide what the consultant should do.

▶ Does the hospital have a moral responsibility to provide intensive care even if a person's chance of survival is small and it involves potential risk to other patients?

Balancing services and resources

There has been a lot of discussion about the way in which health and social care services should be provided, especially when there is limited funding and almost unlimited demand. The funding pressures will continue to rise due to issues such as an ageing population, rising expectations and innovative but very expensive medical technologies. Practical decisions on how resources should be allocated are often difficult to make. Should children and young people get priority, as they have their whole lives ahead of them? Or should consideration be given to the ageing population, as they have paid their national insurance contributions and taxes for longer? Should the focus be on people living in poverty or people who have disabilities? These sorts of situations require ethical decisions to be made by groups of people such as hospital boards. For example, any decisions on health care research are made by research ethics committees that review research proposals using policies which lay down the principles, requirements and standards they are expected to adhere to.

> **Reflect**
>
> In small groups, discuss the various questions asked and points made in this section. Then reflect on your own thoughts and reach your own conclusions. If you had to make such decisions would you be able to make strong enough arguments to support your decision?

Minimising risk when promoting individual choice

When working with vulnerable people receiving social care services, there can quite often be a conflict of interest between the individual and the organisation.

For example, an older person who uses a wheelchair and is living in a residential care home might be a smoker who is unable to give up their habit; yet the legal requirements and policies and procedures of the organisation state that the environment does not permit smoking. Should the older person have to go outside the building or should the care home manger provide a space for the person to smoke inside? What about the rights of those who are caring for that person not to be exposed to smoke in the workplace when they go into that space inside? A possible solution is to have a covered veranda-type smoking shelter, open at the sides, that is not near the front door, so that other residents, carers and visitors are not exposed to the smoke, but which the person can access via a wheelchair-friendly path, wearing a call button round their neck in case they need urgent assistance. An alternative solution is to help the older person to give up smoking by providing the resources necessary.

For people with learning disabilities, the conflict of interest could be related to whether they live on their own or not. It has to be decided whether the benefits of the person having their own independence are worth any possible risk to that person or to others. In situations like these, policies and procedures have to be followed closely and a risk assessment could be undertaken to assess the level of potential harm to the individual concerned and to other people. It is important that the individual is able to express what they would like; vulnerable people can be more involved in decisions about their lives when supported by an independent advocate.

Sharing information and managing confidentiality

Workers in health and social care have a duty of confidentiality that protects the rights of individuals. This means keeping information private by not sharing information about individuals without their knowledge and agreement, even with the service user's friends, family or other individuals. Health and social care workers should never:

▶ discuss one individual with another

▶ discuss matters relating to service users outside the care setting, or in a public place where they might be overheard

▶ share written information without permission

▶ leave any form of records insecurely stored

▶ leave records that are in use unattended, where they may be read by unauthorised people.

Maintaining confidentiality also safeguards service users. If, for example, a member of staff puts a photo on social media of people living in a shelter for victims of domestic abuse to escape their abusive partners, then this could lead to abusive partners discovering their whereabouts.

However, there are occasions when confidential information has to be shared. For example, if an individual is at risk of being harmed or of harming another person. All health and social care settings have procedures in place that must be followed with regard to the breeching of confidentiality.

Link

For more information about confidentiality turn to learning aim D of this unit, and learning aim A of *Unit 7: Work Experience in Health and Social Care*.

Reflect

There is a clear difference between breeching confidentiality by sharing information with a care setting manager and telling a friend. Do you know the difference? Have you ever told someone a secret told to you by someone else and caused a problem by doing so? Has anyone shared your secrets with someone else? If so how did it make you feel?

Case study

Managing confidentiality

Fred is 91 years old and has lived on his own for many years, since his wife Sheila died. His niece, Elizabeth, is his next of kin and regularly visits to help him when he needs it. One day, shortly after moving into a care home, he is taken into hospital as a non-emergency with pain in his back. Elizabeth is on holiday. She rings the hospital several days running to try to find out what is wrong with Fred and what his treatment is. However, Elizabeth is repeatedly told that they are not allowed to give out information over the telephone unless she goes into the hospital and sets up a password on the system. She is unable to do this as she is many miles away.

After three days, one nurse, who is more understanding than the others she has spoken to, sets up a password for Elizabeth over the telephone, so that she is then able to get the information she requires. After six days, Fred is sent back to the care home and the day after, on returning from her holiday, Elizabeth goes straight to the care home to see him. She is met by the manager of the home who is very relieved to see Elizabeth. The hospital has sent Fred home with a back brace but no information about how to put it on, how long for or what it is for. The care home manager has rung the hospital but, although the home cares for him on a day-to-day basis, the hospital has refused to give any information because the manager is not a family member. Elizabeth is able to provide this information and Fred can then wear his back brace.

Check your knowledge

1 How do you think the hospital's reluctance to release information made Elizabeth feel while Fred was in hospital?
2 How do you think the hospital could have dealt with this situation better?
3 What effect has the hospital's refusal to share information with the care home manager had on:
   a Fred
   b the care home manager and other care home staff looking after Fred?
4 Think back to learning aim A. How would a triangle of care approach have helped:
   a Elizabeth as his closest family member, who looks after him as best she can despite living an hour's drive away
   b the care home staff, as the people who provide his day-to-day care?

Ⅱ **PAUSE POINT**	Can you explain the ethical issues and approaches described in this section? What elements did you find easiest?
Hint	Close your book and draw a mind map of what you know about managing conflict.
Extend	Why should all information about a service user be password protected? What could happen if someone gained access to a person's records and found that they were currently in a care home for respite care, or in hospital having an operation?

Legislation and guidance on conflicts of interest, balancing resources and minimising risk

There are organisations, legislation and guidance that influence or advise on ethical issues within the health and social care sector. These play a vital role in solving conflicts of interest, balancing resources and minimising risk to service users, their carers and/or families and service providers.

Organisations

Within the UK, there are a number of organisations – publicly and privately funded – that are involved in health and social care provision. Table 5.3 looks at some of them.

▶ **Table 5.3:** Some publicly funded organisations involved in delivering health and social care in the United Kingdom

Name	About the organisation
National Health Service (NHS)	• Launched in 1948 from the ideal that good health care should be available for all, regardless of wealth • Provides a wide range of health services, the vast majority of which are free at the point of delivery for people legally resident in the UK • Made up of four, mainly independent, publically funded health care systems: NHS (England), Health and Social Care in Northern Ireland, NHS Wales and NHS Scotland • All services are often referred to as the NHS, although only the English NHS is officially called the National Health Service
Department of Health (DH)	• A ministerial department of the government • Helps people to live better for longer • Leads, shapes and funds health and care in England by creating national policies and legislation
National Institute for Health and Care Excellence (NICE)	• Set up in 1999 to help prevent ill health and promote healthier lifestyles • Provides national guidance and advice to improve health and social care, officially only in England, but does provide certain NICE products and services to Wales, Scotland and Northern Ireland • Accountable to its sponsor department, the DH, but operates independently from the government • Role is to improve outcomes for people using the NHS and other public health and social care services
Health and Safety Executive (HSE)	• Set up as the national independent watchdog for work-related health, safety and illness • Executive public body, sponsored by the Department for Work and Pensions • Acts in the public interest to reduce work-related death and serious injury across the UK's workplaces • Shapes and reviews policies, reviews regulations, produces research and statistics and enforces the law

Research

Research the organisations listed in Table 5.3 that you know least about. Prepare a presentation, in whatever form you want, to show a range of ways in which the chosen organisation benefits the service user.

Key terms

Statutory – required by law and governed by legislation.

Legal guidance – policies or procedures that support the implementation and practice of laws or regulations.

Legislation

An Act of Parliament creates a new law or changes an existing law. Legislation refers to those laws that parliament makes. These laws reflect the **statutory** rights of organisations, groups and individuals; some examples are given in Table 5.4. In a health and social care setting, you need to understand the importance of adhering to **legal guidance**, as this protects against poor practice. Legislation also ensures that everyone is clear about their rights and responsibilities within the care environment.

▶ **Table 5.4:** Some of the legislation affecting health and social care in the UK

Legislation	Brief summary
Human Rights Act 1998	• Means that public organisations including the government, police, hospitals and local councils must treat everyone equally, with fairness, dignity and respect • Gives everyone the right to defend their rights in the UK courts • Sets out fundamental rights and freedoms that individuals in the UK have access to: for example, the right to life, liberty, security and a fair trial, freedom of thought and expression, and protection from discrimination
Mental Capacity Act 2005	• Designed to protect and empower people aged 16 and over who may lack the mental capacity to make their own decisions about their care and treatment • States that individuals must be given the help they need to make a decision themselves • States that treatment and care should be the least restrictive of their basic rights and freedoms possible, while providing the required care and treatment

▶ **Table 5.4:** – *continued*

National Health Service Act 2006 Section 140	• Act brought in to promote an improved health service with regard to physical and mental health and the prevention, diagnosis and treatment of illness • Section 140 is about primary care trusts giving financial assistance to people to do preparatory work for pilot schemes providing local pharmaceutical services without involving a primary care trust. This could lead, for example, to setting up pharmacies in supermarkets.
Mental Health Act 2007	• Changes the definition of mental disorder • Makes it no longer possible for patients to be compulsorily detained, unless appropriate treatment and all other information is available to that patient • Broadens the role of practitioners • Gives relatives and civil partners more rights • Provides more help, such as age-appropriate services, independent mental health advocacy, quicker tribunals, more safeguards around electro-convulsive therapy (ECT), and supervised community treatment
Equality Act 2010	• Protects people from discrimination in the workplace and in wider society • Ensures consistency in making workplaces a fair environment for both employees and employers • Replaces previous legislation (eg Sex Discrimination Act 1975, Race Relations Act 1976, Disability Discrimination Act 1995) with a single Act, making the law easier to understand • Sets out the ways in which it is unlawful to treat someone
Care Act 2014	• Replaces numerous previous laws to provide a coherent approach to adult social care in England • Aims to give clearer, fairer care and support for the physical, mental and emotional wellbeing of both the person needing care and their carer • Aims to speed up the provision of care and support where needed • Gives people control of their care

Case study

Bournewood Hospital

This is a true story. In 1994, HL, a 49-year-old man with autism, left Bournewood Hospital, where he had lived for 32 years, and moved in with carers. People with autism have problems with social interaction and communication, and have restrictive and repetitive patterns of thought, and so they become upset when set routines are disrupted. HL couldn't talk and needed help with basic tasks, such as washing and getting dressed, but he grew in confidence and made significant progress.

In 1997, on his set weekly trip to a day centre, a new driver took him on a different route, which caused HL to become agitated. He was taken back to Bournewood Hospital, without his consent or the knowledge of his carers and, because he couldn't speak, he was unable to object. He was kept there for three months. During this time, his carers were not allowed to see him and, when he was finally allowed to return to them, they found him to be half-starved, with blackened toenails and scabs on his face. They took the case to the High Court, then the House of Lords and, finally, to the European Court of Civil Rights, who, in 2004, found that HL had been deprived of his liberty and hadn't been allowed his right to have the lawfulness of his detention reviewed by a court. This case led to the introduction of the new *Deprivation of Liberty Safeguards* in 2009, and is also reflected in the *Mental Capacity Act 2005* as amendments to the *Mental Health Act of 1983*.

Check your knowledge

1 Why do you think HL became agitated when the new driver took him on a different route?

2 Which parts of the Mental Health Act 2007, listed in Table 5.4, do you think came about as a result of the Bournewood Case?

3 Do some research into the details of this case. Write an article for a magazine that covers the facts and ethics of this case, including how other Acts now help protect people like HL.

Guidance

Some of the key pieces of guidance that help health and social care services tackle issues such as conflicts of interest, balancing resources and minimising risk are described in this section.

The DH Decision Support Tool

If it is considered that if an individual needs extra support from a healthcare setting, such as an older person who is no longer able to live in their own home, the first step will be an assessment by a professional using a screening tool called the NHS Continuing Healthcare Checklist. If the results suggest that the individual is **eligible** for NHS continuing healthcare, a full up-to-date assessment of their needs will be arranged using a tool called the Decision Support Tool. Multi-disciplinary teams set out the individual's needs in relation to twelve care domains, and then make a recommendation as to whether the person is entitled to NHS continuing health care.

Five Step Framework

This approach is a model that can be used to help with making an ethical decision or to support improvement projects, from the initial idea through to completion. It can be applied to all walks of life and is used extensively by health and social care services. A step-by-step approach can be used to make an ethical decision, as shown below.

Step by step: Using a Five-Step Framework to make an ethical decision

`5 Steps`

1 Recognise the decision or issue; identify the need to make a decision.
- Are you being asked to do something that may be wrong or illegal?
- Are you aware of others involved who are behaving unethically or illegally?
- Are you unsure about the ethical course of action to take?

▼

2 Think before you act; make a prediction about which decision is most likely to give a good outcome.
- Summarise the issue so that it is clear to you, and explain why it is bothering you.
- Consider the various options and consequences.
- Consider who may be affected and consult others for their views.

▼

3 Decide on a course of action; identify your feelings.
- Identify your responsibility in this process.
- Review all the relevant information.
- Assess any risks and how they can be reduced.
- Decide on the best course of action..

▼

4 Test your decision; can you live with your decision?
- Review it against ethics and values.
- Consult polices, laws and professional standards.
- Consult others about your plan of action.

▼

5 Proceed and evaluate; can you explain your reasoning clearly and engage with others in a discussion about the morals of your decision?
- Communicate the decision and reasoning to all involved, so that the action taken becomes the norm.
- Celebrate achievement by sharing successful outcomes with other stakeholders.
- Record and reflect on anything you have learned and any principles decided.

NICE and NHS guidance on care pathways and care plans

The steps taken to care for and treat a service user are called care pathways; care plans are drawn up for the service user based on the care pathway. These pathways are designed to implement national standards of care, such as those produced by NICE and the NHS. The pathways are developed by multi-disciplinary teams to reflect local services and staffing arrangements. They identify who carries out key parts of the care or treatment and where care or treatment should be delivered. The pathways usually include decision support systems to help make ethical decisions about appropriate care in specific circumstances, and to help reduce unnecessary variations in treatment and outcomes between service users. One example is the controversial *Liverpool Care Pathway*, withdrawn in 2015, which aimed to improve end-of-life care, making the final hours of life as pain free and dignified as possible. Details of a wide range of NICE and NHS guidance can be found on their websites.

Managing Conflicts of Interest: Guidance for Clinical Commissioning Group (2013) (NHS)

Clinical Commissioning Groups (CCGs) manage conflicts of interest as part of their routine activities. This guidance was put in place to help CCGs manage this efficiently, to avoid the risk of loss of confidence in their decisions and the risk of undermining the integrity of clinicians. The *National Health Service Act 2006*, later amended by the *Health and Social Care Act 2012*, sets out clear guidance for CCGs to make arrangements for managing conflicts of interest. This means that they can demonstrate that they are acting fairly and transparently, and in the best interest of their patients and local populations.

HSE guidance on risk assessments

The Health and Safety Executive (HSE) provides guidance to businesses about carrying out risk assessments in order to:
- control risks in the workplace
- keep everyone working in the business (employers and employees) as safe as possible
- ensure that businesses do not break health and safety laws.

How guidance may be counterbalanced by other factors

There are other factors that need to be taken into account when using any of this guidance, including religion, personal choice and government policies. For example, if a piece of guidance leads a person down a care pathway which suggests the use of certain drugs for a particular condition, but something along that path is against their particular religious beliefs, adjustments have to be made to allow for this. For example, an alternative to porcine-based drugs should be found for those who are of Jewish or Muslim faith as they are forbidden to eat pork. Similarly, alternatives to bovine-based drugs or cattle-derived cartilage transplants are needed for those of the Hindu faith and also for some vegans and vegetarians.

Key term

Clinical Commissioning Groups (CCGs) – groups of general practices (in England) working together to ensure best delivery of local health services: for example, buying health and care services such as hospital care.

Assessment practice 5.2　　　　　5B.P3　5B.M3　5BC.D2

Jamie has Down's syndrome. He lived at home with his family until the age of 21. Recently Jamie moved into a residential home for younger adults with moderate learning difficulties so that he can make the first steps towards living independently without his parents. The home has 15 single bedrooms, and a number of communal areas. Jamie will receive independent living training while he lives there.

He quickly settles in and becomes very friendly with Susan, who is 23 and has learning difficulties. They spend more and more time together and one day one of the carers walks into Jamie's room and finds Jamie and Susan kissing. The carer reports the incident to her manager, Dawn, who decides that Jamie and Susan are not to be left alone together in future. Jamie and Susan are very upset by this and do not understand what they have done wrong. The decision is not discussed with them and they feel confused, hurt and betrayed.

Task

Imagine you are the area manager for the chain of care homes of which this one is a part. Write a report (no longer than two pages of A4 paper) that can be used across the whole chain, which:

- explains the ethical dilemma that managers and carers face in such a situation
- suggests and analyses an ethical solution to this problem, with guidance for future similar situations, and that allows residents such as Jamie and Susan their independence and enables them to have a safe relationship
- evaluates whether the home is promoting anti-discriminatory practice and justifies the strategies used to overcome the ethical issue arising from Jamie and Susan's relationship.

Plan
- How should I set about starting this task?
- What do I need to understand in order to complete this task successfully?

Do
- I can use the Five Step Framework to help me decide what I think is the right course of action to solve this dilemma.
- I will draw up a rough draft, so I know what to include in each part of my report.

Review
- I can justify what I have suggested if my tutor disagrees with me.
- I know how I would tackle this task better.

C　Investigate the principles behind enabling individuals with care and support needs to overcome challenges

Enabling individuals to overcome challenges

Different types of challenges

Individuals with care and support needs face different types of challenges. The following are examples based on older people, but other groups will also face many of these challenges.

▶ **Awareness and knowledge**: an older person may not be aware of the funding help available if they need to move into a care home, and so may be worried about how they can afford this type of care. Similarly, if service providers are not aware of the latest guidance or do not consistently refer to it, they will not change their way of working, so those they care for will not benefit from the guidance.

▶ **Practical challenges**: an older person may find it increasingly difficult to cook meals or wash themselves as they become less mobile. A service provider may find it cannot offer the best care possible because it does not have the resources to do so.

▶ **Skills challenges**: an older person who can no longer get out of the house may want to find out what help is available but doesn't have the ICT equipment or skills to find the relevant phone numbers or to research online. Likewise, service providers may need time to learn and practice new ICT skills.

▶ **Acceptance and belief challenges:** an older person who has lost most of their mobility may find it hard to accept that they can no longer manage on their own, and may feel that they have lost their independence. An older person with certain beliefs may find the challenge of the approach of the end of life easier to deal with due to their religious beliefs. Similarly, a service provider's response to new guidance is affected by whether they think the change is right, or whether they believe they are capable of adapting to it.

▶ **Motivational challenges**: an older person who is morbidly obese may find it very hard to find the motivation to start what they see as the very long task of trying to lose weight. Similarly, a service provider may lack the drive to improve, wanting to stick to the 'old way' of doing things, so that change for the better doesn't happen.

▶ **Communication challenges**: an older person may start to lose their sight or hearing, or become very hesitant in their speech and find it increasingly hard to communicate with others. A person who provides a service may also have communication difficulties, either because they have a disability or develop a problem.

Case study

Children's Centre Advisory Boards

Children's centres were set up as part of the Sure Start programme to improve the outcomes for young children and their families, with a particular focus on the most disadvantaged families. In some local authority areas, children's centres are **governed** by an **advisory board**. These can have up to about 20 people on them and are made up of people such as children's centre managers, primary school head teachers, health professionals, and representatives from the local authority and various other organisations offering services for children and families. There are also two representatives of governors from local primary schools.

There are meant to be at least two parent representatives on the board but some struggle to find anyone willing to join them. One particular board meets between 4 and 6 pm four times a year. The meeting is mainly taken up by each organisation delivering a report on their own areas of expertise, including details such as how far they have come towards meeting their targets for the year and what difficulties they are facing. The reports are full of **acronyms** and **abbreviations**.

Check your knowledge

1 What are the challenges facing children's centre boards in terms of recruiting parents to attend?

2 What will happen if these challenges are not overcome?

3 Suggest ways in which these challenges could be overcome.

Key terms

Children's centre – a place providing services for young children and their families.

Govern – exercise a controlling influence.

Advisory Board – a group of people who meet and give advice.

Acronym – a word made from using the initial letters of other words or phrases, such as AIDS (acquired immunodeficiency syndrome) or FAST (face, arms, speech, time)

Abbreviation – a shortened form of a word or phrase, such as Mon for Monday.

Methods of identifying challenges

There are various methods for identifying challenges, such as the following.

▶ **Observation**. One of the most important skills you will learn if you become a care worker is observation. This skill will help you identify problems quickly, so they can be addressed before they get any worse. Observing and identifying patterns of behaviour, and any changes, may point to a developing problem that needs attention: for example, a change in the way a person walks, signs of abuse or negligence, or noticing any areas of care that could be improved, such as hand washing.

▶ **Focus groups**. A focus group is a small group of, typically, around eight people. They are invited to discuss a particular issue, such as introducing new early intervention services, in a session run by a facilitator and, maybe, an assistant. The group shares ideas and explores issues rather than reaching decisions. The information gathered is used to clarify situations and identify challenges. Health and social care services can then provide the services needed to meet these challenges.

▶ Have you taken part in discussions in a group of this size? Did you manage to speak up and contribute?

▶ **Talking to individuals informally**. Chatting casually to individuals, using plain language instead of jargon or technical words, can help to identify any challenges that an individual is facing without them feeling that they are being questioned or watched. This could be used to gather opinions on a new procedure being introduced at a dental surgery or on a hospital ward.

▶ **Using questionnaires**. Questionnaires are sets of questions used to collect people's opinions on certain topics, to get a snapshot of the views of a large number of people. They could be used, for example, when a primary care trust is looking for feedback from a group of practice-based GPs within their area. A well-designed questionnaire is useful because it can collect a lot of information from a large group of people much more quickly than other methods. Questionnaires are also relatively inexpensive to administer. However, they do not allow for follow-up questions and the response rate may be poor.

Strategies used to overcome challenges

Educational information materials

Educational information materials can take a range of forms, such as leaflets, posters, games, slide presentations, wall displays, CD-ROMs, DVDs, flyers, web-based materials and newspaper or magazine adverts or articles, TV and radio coverage. These materials inform people about current thinking on how to live healthily and also give

advice on how to overcome challenges, such as giving up smoking, or how to apply for funding. They help raise awareness and knowledge, and can provide information for people who have communication difficulties, as they are presented in so many different forms, including Braille. Such materials also alert service providers to changes in practice and provide a resource that they can continually refer to.

> **Reflect**
>
> Think about health promotion materials that you have seen. How could they be changed to make you pick them up, read them, and act on them?

Training courses

Courses are available to help people with care and support needs to overcome challenges. For example, if you are a carer for a family member who has an illness or disability, you can go on a course to learn how to help them move around so that you don't hurt them or yourself. If a person has had a stroke and has been left with a disability, they can access training to learn how to overcome the problems associated with their disability: for example, how to do routine tasks with reduced use of part of their body. Organisations such as local councils and hospitals run these courses, and there are also courses available online, covering a wide range of challenges. Training courses are also used to educate service providers about the latest developments in their area of care.

Opinion leaders

An opinion leader is a well-known individual or organisation that has the ability to influence public opinion. An opinion leader can be anyone who has an active voice in a community, who speaks out and is often asked for advice. In health and social care, this tends to be people who are chief executives of bodies such as the NHS, Skills in Care or Care England, but, equally, it could be a local GP. They could be asked to use their influence to discuss, for example, how to cope with the challenge of caring for the ageing population as the demand for services rises but the resources shrink as funding is cut. They can use their influence to motivate health and social care service providers to achieve the best possible care for service users.

> **Discussion**
>
> In a small group, discuss people who live or work in your community and decide between you who you consider to be a local opinion leader. Write down their name and why you have picked them. Be prepared to share your choice with the rest of your class.

Clinical audits

A clinical audit is a systematic review of care based on standards of best practice and explicit criteria. Based on the results, changes are then implemented, wherever necessary. For example, a clinical audit of the level of care that GPs provide individually for continuing care for a certain long-term condition may show that patients have been on the same medication for a number of years, and highlight the fact that new drugs have been developed that might be of more help to those patients. Such audits highlight challenges for both service users and providers.

Computer-aided advice systems

These are online decision support systems that supply service providers with specific information when they need it, such as to pharmacists and doctors when they are prescribing medication. These systems provide prompts designed to reflect best practice and remind service providers to take or avoid a certain action. They are effective in the delivery of preventative services.

Patient-mediated strategies

Patient-mediated strategies provide information via mass-media campaigns to service users and the wider public about the latest evidence-based practice. Evidence shows that this enables service users to be more able to influence decisions made during a consultation about their own care, and more accepting of any changes because they are already well informed about them. These strategies also educate and motivate service providers about changes in practice.

<table>
<tr><td>⏸</td><td>**PAUSE POINT**</td><td>Can you identify the different types of challenge faced by individuals with care and support needs, and the methods for identifying them?</td></tr>
<tr><td></td><td>**Hint**</td><td>Write out the types of challenge in alphabetical order. Then devise a way to remember them.</td></tr>
<tr><td></td><td>**Extend**</td><td>Draw a concept map that shows the different strategies used to overcome challenges.</td></tr>
</table>

Policy frameworks

A policy framework is a structure used to organise sets of principles and long-term goals into a logically documented set of rules, providing guidance and an overall direction for planning and development. Many policy frameworks are used in the health and social care sector to reduce inequality of care and improve integration of services. Some include ways in which to assess needs, and some include ways in which to decide whether a service user is eligible for help with their needs.

NHS Patient Experience Framework

This framework sets out a working definition of a positive patient experience, built around the eight elements of the definition of good patient care. It uses these elements as a framework for measurement and improvement of the patient experience. 'When using this framework, the NHS is required, under the *Equality Act 2010*, to take account of its Public Sector Equality Duty, including eliminating discrimination, harassment and victimisation, promoting equality and fostering good relations between people.' (DH)

▶ **Table 5.5:** The NHS Patient Experience Framework (2011)

	Elements critical to the patients' experience of NHS Services
1	Respect for patient-centred values, preferences and expressed needs, including: cultural issues; the dignity, privacy and independence of patients and service users; an awareness of quality-of-life issues; and shared decision making.
2	Coordination and integration of care across the health and social care system.
3	Information, communication, and education on clinical status, progress, prognosis and processes of care, in order to facilitate autonomy, self-care and health promotion.
4	Physical comfort, including pain management, help with activities of daily living and the provision of clean and comfortable surroundings.
5	Emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis and the impact of illness on patients, their families and their finances.
6	Welcoming the involvement of family and friends, on whom patients and service users rely, in decision-making, and demonstrating awareness and accommodation of their needs as care givers.
7	Transition and continuity regarding information that will help patients care for themselves away from a clinical setting; and co-ordination, planning, support and empowerment to ease transitions.
8	Access to care, giving attention, for example, to time spent waiting for admission or time between admission and placement in an in-patient setting, as well as waiting time for an appointment or visit in the out-patient, primary care or social care setting.

Health Action Plans

Health Actions Plans are plans that set out the NHS's commitment to patients and how services will improve. These plans aim to minimise challenge by looking at future pressures on the health service and planning ahead. These pressures are:

▶ an ageing society

▶ a rise in long-term conditions, such as dementia, and those due to unhealthy lifestyle choices

▶ increasing expectations of the health service by the general public and service users.

These pressures have to be dealt with at the same time as considering:

▶ the increased costs of providing care

▶ the limited productivity gains, which means that there is not much improvement in services after a lot of time and money have been spent

▶ **constrained** public resources.

There are plans in place for tackling issues such as obesity, late HIV diagnosis and many other areas of health. Individuals may have their own health action plan to minimise the risks from their own challenges, such as lack of exercise, giving up smoking or coping with mental health issues.

Research

Research some of the areas of health for which Health Action Plans have been created in the last ten years. Draw a table on a single sheet of A4 paper to summarise the key points of each, such as its topic, the year it was created, its aim and other points that you think are important.

Adult Social Care Outcomes Framework

Launched in 2011, the framework measures performance against the aim of ensuring that the most vulnerable people in our society receive high-quality care, regardless of where they live. The framework covers four areas:

▶ **enhancing** quality of life for people with care and support needs

▶ delaying and reducing the need for care and support

▶ ensuring that people have a positive experience of care and support

▶ safeguarding adults whose circumstances make them vulnerable, and protecting them from avoidable harm.

The framework also provides yearly results about how each local authority performs against the framework, which allows people to see how well their own local authority is performing and how it compares with other local authorities.

Common Assessment Framework (CAF)

If a service provider, such as a teacher, has any concerns about a child, they complete a CAF pre-assessment checklist.

Key terms

Constrained – restricted, limited or forced to follow a particular course of action.

Enhance – to improve.

Worked Example: Completing the pre-assessment checklist for Carly, who lives with her father as her mother has died, referred by her teacher to the Special Educational Needs COordinator (SENCO).

Step 1: Complete identifying details (name, date of birth, contact name and telephone number, address)
Carly, age 8

Step 2: Does the unborn baby, child or young person appear to be healthy?
No. Carly is looking thinner and paler. She is also tired all the time and increasingly scruffy

Step 3: Does the child appear to be safe from harm?
Yes

Step 4: Does the child appear to be learning and developing?
No, Carly has started to miss days from school every couple of weeks and is quiet and withdrawn when she does attend

Step 5: Does the child appear to be having a positive impact on the others?
No, she is falling out with her friends more often or being left out because she has been missing from school. She is becoming isolated.

Step 6: Does the child appear to be free from the negative impact of poverty?
Not sure. Her weight loss suggests she may be undernourished and her scruffiness may suggest there is less money for uniform.

Step 7: If you answered no to any of the previous questions, what additional services are needed for the unborn baby, infant, child or young person or their parent(s), carer(s) or families?
I feel that Carly is not having all her needs met at the moment. I would like someone to have a chat with Carly's father to look at every aspect of her care to try to identify why Carly has changed in recent months.

Step 8: Can you provide the additional services needed?
No

Step 9: If you answered 'No' or 'not sure' to any of the previous questions, or it is not clear what support is needed, would an assessment under the Common Assessment Framework help?
*Yes*

Step 10: If you answered 'yes' to the previous question, who will do this assessment?
Another practitioner

Step 11: Sign and date the form

If the pre-assessment checklist suggests there is a need, the service provider will use a CAF to assess the child's needs. This is a simple, early intervention process for gathering and recording information in a standard format, on a CAF form, identifying the needs of the child at an early stage and how those needs can be met. The framework is common to all children's services and all local authority areas in the UK; it plays a central role in delivering integrated services focused on the needs of children and young people. A CAF aims to provide early intervention, to improve communication and joint working between all service providers and also to help stop children and their families having to repeat their details to each separate service or agency. It is voluntary, so the child or young person and their parent or carer has to give their permission at the start of the process and then again for the information to be stored and shared with other service providers.

The CAF is for children and young people who have additional needs in one or more of the three areas shown on the sides of the triangle in Figure 5.2.
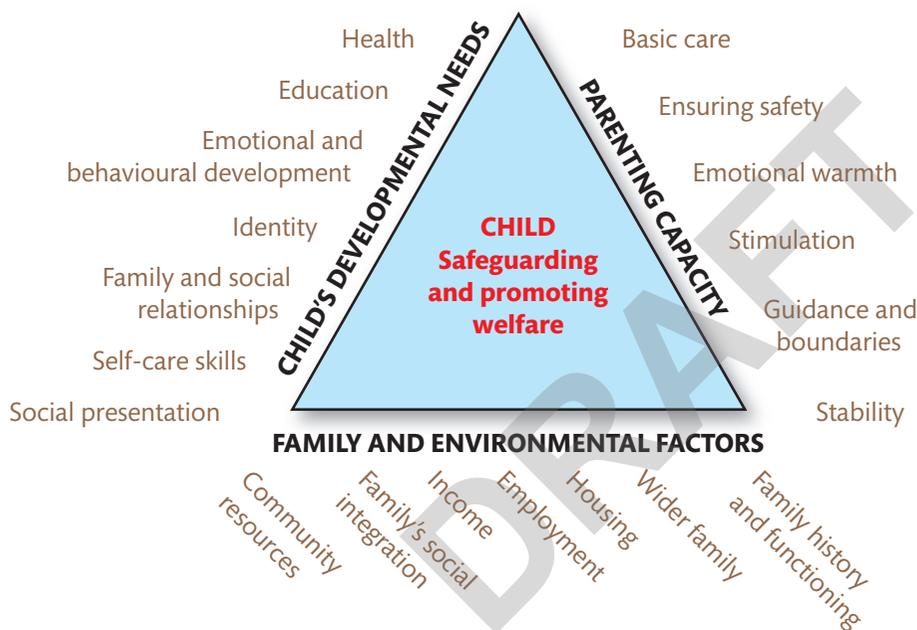
▶ **Figure 5.2:** Make sure you know what all these different terms mean

Completion of a CAF does not always ensure that the child or young person will have access to all the services they need locally, as the local area will prioritise the services it provides based on local need.

> **Safety tip**
>
> All service providers using CAF must have an enhanced **DBS check**.

> **Key term**
>
> **DBS check** – Disclosure and Barring Service check, carried out on anyone working with or adopting children and anyone working in other areas such as health care, to make sure the individual does not have a criminal record.

> **Reflect**
>
> Have you ever been in hospital or visited someone in hospital and noticed how every member of staff checks their name and date of birth? Why do you think they do this? Would you feel less irritated by repeating the same information if you knew the reasons why? How does a CAF stop a service user having to keep repeating their story?

Impact of not enabling individuals to overcome challenges

It is difficult to ensure that all service providers know about the latest guidance in their particular field of care, what needs to change as a result of it and be motivated or accepting enough to make changes. Sometimes there are several sets of guidance

coming from different bodies, which can make it hard to get service providers and users to engage with the guidance. If service providers don't make the changes, then service users aren't able to make the changes necessary to improve their health and wellbeing. A challenge, such as the ageing population not being effectively tackled, could become a crisis in the future. The NHS could reach breaking point because it has reached its capacity, and environments such as care homes may have to turn people away. Services and outcomes for service users won't improve, and early identification and intervention won't happen, which leads to a greater need for specialist services.

⏸ **PAUSE POINT**	Do you know the policy frameworks available to minimise challenges?
Hint	Close your book and draw a table with two columns. Write the names of the four frameworks in the first column and what they are for in the second column.
Extend	Why are these frameworks so important to minimising challenges? What do they all have in common that makes them so useful?

Promoting personalisation

Personalisation

Personalisation is the term used for ensuring that every person receiving care and support is able to set their own personal goals, and have choice and control over the shape of their care and support. Service users can be given control over the services they receive by being allowed to control how some of the budget for their support is spent. They can decide the service they want, the provider they wish to purchase it from and how they want it delivered. For example, older people in need of care and support can claim Attendance Allowance. This is a weekly amount that they can choose how to spend. For example, they could put this towards the cost of paying for **supported living services** in their own home, ranging from 15-minute visits to 24-hour assistance, or it could be used to pay towards living in residential care, either in a care home or in sheltered housing. Similarly, a parent may decide to spend their childcare vouchers on a childminder or on a nursery place for their child.

If an adult of any age has care and support needs (such as those shown in Figure 5.3), the local authority will start by carrying out a care and support needs assessment to decide whether the person's needs meet the **national eligibility criteria**: that is whether their needs:

▶ arise from, or are related to, a physical or mental impairment or illness

▶ make them unable to achieve two or more specified outcomes

▶ mean that there is likely to be a significant impact on their wellbeing if these two or more outcomes are not met.

If the person does not meet the national eligibility criteria, the local authority will give the person information about other services and ways in which they can find funding. If, however, their needs do meet the national eligibility criteria, the local authority will have to meet these needs. The local authority starts by drawing up a care and support plan, and discussing with the person how they wish to live their life. This may be in their own home or in residential care. The local authority will look at preventative services, such as aids to make it possible for the person to stay in their own home, and/or information about other support available, such as help in the home or care in a care home. The person will be involved throughout the whole process, if necessary with the help of a family member or advocate. If the local authority is paying for the person's care it is allowed to choose what it feels is the most cost-effective method.

Key terms

Supported living services – services that can help a person live in their own home on a long-term basis.

National eligibility criteria – a minimum threshold of needs for adult care and support.
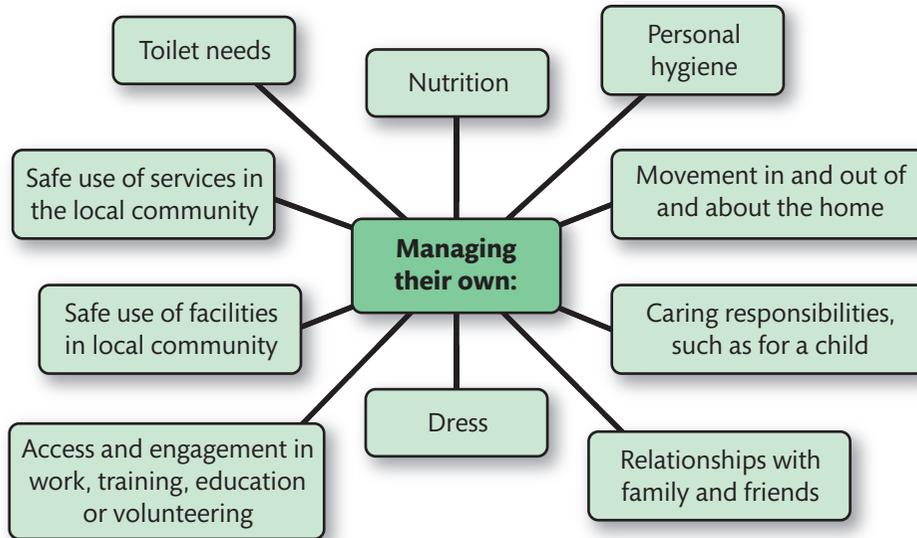
Figure 5.3: Specified outcomes for assessment for eligibility threshold

However, if the person is **self-funding** their care, then they can make the choice. From April 2020, there will be a cap on the costs of meeting eligible care needs (not including normal daily living costs and residential care), above which the local authority will take over payment.

Methods of recognising preferences

Plans

There are several methods available to help a service user recognise their preferences for how their care and support needs will be met. These include various types of plan, all of which are written documents drawn up as an agreement between a person and their care and support professional, describing, in an accessible way, the services and support being provided. However, as every plan is developed for the individual concerned, they are not standardised.

▶ Table 5.6: Three types of plan

Type of plan	What does it plan?	Who do they help?
Care	The care services and support to be provided.	Individuals needing extra help with daily living.
Learning	A programme of learning that takes into consideration the person's strengths and weaknesses.	Individuals with learning difficulties.
Behavioural	How a person's behaviour may be changed.	Individuals with conditions such as autism.

Specialist support from health and social care professionals

The local authority adult social services department will carry out a care and support needs assessment. This is usually done in a person's own home. However, it may be carried out in a hospital if, for example, an older person has had a fall or illness and the hospital staff and family do not think the person will be well enough, or safe, to be discharged to their own home to look after themselves. This will always involve the adult concerned, unless they are too unwell or have severe learning difficulties. Once the assessment has been carried out, other health and social care professionals will be involved, depending on the needs identified.

Key term

Self-funding – a person paying all the costs of their care and support services.

The importance of promoting choice and control and the financial impact of this on care

A basic aim of all service providers is to promote a way of life for service users that allows them to enjoy, as far as possible, their rights as individuals. One of the most important rights we have is to be independent, to make our own decisions and our own choices, and to feel in control of our own lives. How would you feel if you were never allowed to choose which clothes to wear, or how to style your hair? Often, a carer will select clothes to be worn because they are easy to put on, or easy to wash when food is spilled down them. However, the person being cared for might prefer a different outfit because it suits them better and makes them feel better about themselves. Having choice and control helps people maintain their independence and positive self-esteem.

Case study

The right to choose

Mavis is 85 years old. She recently moved to a residential care home. As the carers go along the corridors putting people to bed, they start at Mavis' end every night, so she is almost always in bed by 9 p.m. The carers leave the remote control by the television so she cannot reach it, because they don't want any noise at night. This means that Mavis misses most of her favourite television programmes. She has asked the carers whether the routine can be varied but they just say that someone has to be first and it is most efficient for them if she is first. Mavis is often bad tempered with the carers and sometimes awkward when they are trying to undress and wash her.

Check your knowledge

1   Should Mavis be allowed to turn the television on once she is settled in bed? Explain your answer.
2   How is Mavis having her rights **infringed**?
3   Why is Mavis being bad tempered and awkward with the carers?
4   What could the carers do to make life better for Mavis?

By providing personalised care, people are helped to live with **long-term conditions**, such as arthritis, asthma or depression. The emphasis has moved to being proactive, that is, acting before the condition worsens, and allowing people choice and control, rather than services reacting when something goes wrong. By acting early and by making it possible for people to live in their own homes, supported by family and friends, limited health care resources can be used more appropriately, which should lead to reduced use of urgent and emergency care.

The aim is to find cost-effective solutions to managing long-term conditions in the community so as to reduce the cost of funding this care. Promoting choice and control should reduce the cost of this area of care provision.

Key terms

Infringe – to limit, violate or intrude on something.

Long-term condition – conditions that cannot currently be cured but which can be managed.

Research

The NHS made a commitment that, by April 2015, everyone with a long-term condition would be offered a personalised care plan. Research whether the NHS met this target. Design some form of promotional material to advertise the merits of care plans, and how to go about getting one.

⏸ PAUSE POINT   Do you feel that you understand personalisation?

Hint   Close your book and try to draw a spidergram to summarise everything you have learned about personalisation.

Extend   How might personalisation of care help the economy of the UK in the long term?

Communication techniques

Good communication skills are vital for people working in health and social care as they help them to:

▶ develop positive relationships with services users and their families and friends, in order to understand and meet their needs

▶ develop positive relationships with work colleagues and other professionals

▶ share information and feelings with people using the services, by providing and receiving information

▶ report on the work they do with people.

Communication between service users and providers is almost always **interpersonal**. However, service providers may never actually meet, and so communication may be by telephone, text or email.

Key term

Interpersonal – between people present in the same place, face-to-face.

Reflect

Write down all the different ways you communicated with somebody yesterday. Reflect on how effective your communication was. Did other people always seem to be listening to, and understanding you? Did you listen to, and understand, all the various forms of communication that came your way?

Different approaches for effective communication

Health and social care providers use a range of techniques to communicate with, and gather information about, service users. Some of the psychological approaches are summarised in Table 5.7. A service provider, such as a therapist, has to ask themselves questions such as whether a particular approach fits the problem, whether they have the right skills to use a certain approach, etc. before deciding which approach to use. The strengths and weaknesses of each approach need to be considered as well as the impact it will have on the service user.

▶ **Table 5.7:** Psychological approaches to effective communication

The approach	Strengths	Weaknesses
Humanist Person-centred	• Non-intrusive, meet as equals • Unconditional, depends on basic trust in the service user • Uses a positive manner, thoughts and actions, empathy, shows respect • Gives person choices and believes they can change their lives • Positive approach • Used in lots of situations	• Ignores behaviour • Short term • Relies on good communication skills • Uses complicated terms • Hard to be non-judgemental

The approach	Strengths	Weaknesses
Behavioural Looks only at observed behaviour	• Objective, so people can agree about what is happening • Easy to understand • An approach that comes naturally • Doesn't rely on communication skills, so works with all ages and abilities, eg a baby imitating adults to acquire language skills	• Doesn't look at what's going on inside someone's head, so limited • Deals with symptoms not causes, so can be short term • Can only be used to change behaviour
Cognitive Structured approach of understanding and changing behaviour	• Easy to understand, logical and makes sense to service users • Takes notice of what service users think and feel • No interpretation or hidden meaning	• Relies on good communication skills, need to express thoughts and to understand what service providers want the individual to do • Rational approach, so not suitable for those who don't have a rational mind • Only one problem worked on at a time
Psychoanalytical Interprets what the person says and does	• Effective • Gives service users insight into why they think or feel as they do, so gets deeper into problems • Can change many parts of lives, not just behaviour • Can be used for a wide range of problems	• Very complicated to use • Needs specialist training • Based on service providers' analysis • Lengthy
Social Studies individuals in a social context	• Uses real-life situations when studying behaviour • Uses the results from experiments, such as the BBC prison study, to explain and offer solutions to an individual's problems • Helps understanding of social behaviour in general	• Presence of observer may have a negative effect on participants • Findings are generalised • Members of the group being studied may not be representative of population as a whole, ie they may be more motivated

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Theory into practice

Work with a partner on one of the theories listed in Table 5.7. Your tutor will tell you which one to look at.

• Research to find more details about your theory, so you understand it better.

• Think of one example of a situation in a health and social care setting where a professional could use the theory to work with a service user.

Write a clear, easy-to-read guide for workers in that setting to explain how to use the theory in a session with a service user. You should give details explaining why it is the best approach to use.

Types of communication

Verbal

Verbal communication uses words to present ideas, thoughts and feelings. Good verbal communication is the ability both to explain and present your ideas clearly through the spoken word, and to listen carefully to other people. This involves using a variety of approaches and styles appropriate to the audience or person you are addressing.

> **Discussion**
>
> In pairs, discuss a TV soap opera or drama that you both watch. Choose two characters and a recent storyline. How did the storyline convey the feelings and moods of the characters? List as many ways as you can remember, and discuss how well the soap did this.

Body language

Body language is very important. It often gives service providers a better idea of how someone is feeling than what the service user says. It is also important, as a carer, that you understand what messages your own body is giving to the person you are trying to help. Body language includes the following.

▸ **Posture**: the way you sit or stand can send messages. Even the way you move can give out messages. For example, shaking your head while someone else is talking might indicate that you disagree with them, or waving your arms around might mean you are excited. Sitting facing the person you are talking to, with your arms unfolded and a smile on your face shows a positive and warm response.

▸ **Facial expression**: the human face is very expressive. It is able to express countless emotions without any words being used. The facial expressions for happiness, sadness, anger, surprise, fear and disgust are the same across cultures. It is important to match your facial expressions to the conversation: for example, not smiling when someone is talking about something sad.

▸ **Eye contact**: most people find that what they see affects them most so eye contact is especially important. You can often tell what someone is feeling by their eyes. Our eyes become wider when we have positive feelings, for example, when we are excited or happy, attracted to, or interested in someone. Eye contact is also important in keeping a conversation going and for judging the other person's response.

▸ **Appropriate use of touch**: touching another person can send messages, for example care and affection or power and control. It is important to think about the setting you are in and what you are trying to convey before touching a person in a health and social care environment.

▸ **Gestures**: there are certain common signs or gestures that most people automatically recognise, but it is important to understand cultural norms so that you do not unintentionally cause offence. For example, in Western cultures, thumbs-up can mean that all is well and is perfectly acceptable whereas in the Middle East, it is not only unacceptable but also one of the biggest insults possible. It also causes offence in countries such as Greece and Russia.

▸ **Non-threatening body language**: it is important not to give out negative messages through your body language. Turning away slightly with your arms folded portrays negative feelings of boredom, coldness and lack of interest. Getting too close to someone, and so invading their personal space, can cause discomfort, intimidation or distress.

▸ **Personal space**: getting too close to, or too far away from, someone can create unease. The size of a person's personal space depends on cultural norms. For example, Americans tend to require more personal space than many other cultures. Also, getting too close to someone with a mental illness can be very distressing for them. If a person backs away a little when you are speaking to them, don't try to close the gap as this will make them feel uncomfortable. How close you can move into a person's personal space depends very much on individual preference and context.
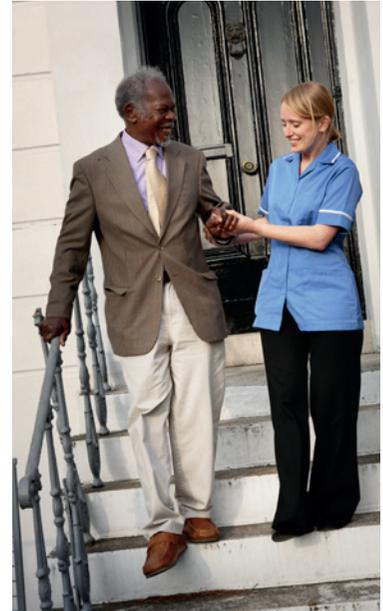
▸ Can you tell the emotions of these two people by looking at their facial expressions?

To tell or not to tell

Charles is 70 years old and lives on his own since his wife died last year. About 6 months ago he had a heart attack, from which he has made a good recovery. However, the doctors have told his daughter, Laura, that he is to take regular exercise, watch his diet and have as little stress as possible. Laura (aged 40) and his granddaughter Chloe (aged 6) try to visit him every week and he very much looks forward to their visits. Laura's husband, Alex, occasionally joins them.

Chloe and Laura are walking home from school one day when a cyclist mounts the pavement and knocks Chloe down. She bangs her head on the pavement and is taken to hospital, where she has to stay due to her injuries. Laura and her husband decide not to tell Charles about the accident as they don't want to cause him any stress. Alex and Laura visit Charles. They tell him that Chloe is absent as she is at a sleepover and then carry on a different conversation to distract him. Charles feels uneasy but doesn't know why. Laura and Alex make cups of tea and change the subject whenever they think Charles is going to mention Chloe, and make an excuse to leave earlier than normal.

Check your knowledge

1 How will Laura and Alex be feeling?
2 What signals is Charles likely to pick up from Laura and Alex?
3 In a group of three, role play Laura and Alex's visit to Charles.
4 What could have been the better course of action to take, rather than leaving Charles feeling uneasy and worried?
5 Role play an alternative way of handling the situation.

Written

Written communication is central to keeping records and writing reports when anyone is providing a service in a health and social care environment. Different types of communication need different styles of writing and different ways of presenting information, but all require **literacy skills**. Meaning has to be clear and writing needs to be well structured and legible, with grammar, spelling and punctuation used correctly. A more formal style of writing and language are needed when recording information about a patient.

Formal

Formal communication tends to start with a greeting such as 'Good afternoon. How are you feeling today?' It can be used to show respect for others. Formal conversation is often used when a professional person, such as a health or social care worker, speaks to a service user. It is clear, correct and avoids misunderstanding.

Informal

Informal communication is more likely to start with 'Hi, how are you?' and allows for more variety, according to the area someone lives in. Informal communication is warm and friendly. People usually communicate more informally with friends, including those they work closely with on a day-to-day basis.

> **Key term**
>
> **Literacy skills** – the ability to read and write.

II PAUSE POINT Can you remember what you have been taught so far about communication techniques?

Hint With a partner, take it in turns saying something new that you have learned about communication techniques.

Extend How is communication important in the health and social care sector?

Alternative communications

It is sometimes necessary to find an alternative form of communication to meet people's differing needs, such as when someone has visual or hearing impairment or learning difficulties.

Makaton

Makaton is a method of communication that uses signs and symbols. Unlike British Sign Language, it uses speech as well as actions and symbols. Makaton uses picture cards, and ties facial expressions to a word to make the word more easily recognised by those with learning difficulties.

British Sign Language (BSL)

BSL is a language in its own right. It was first recognised in the UK in 2003. BSL uses visual signs instead of sounds. These are made up of the shapes, positions and movements of the hands, arms or body and facial expressions. Sign language is commonly used by communities that include the families and friends of deaf people, as well as by those who are deaf or hard of hearing.

Braille

The Braille system is a method widely used by blind people to read and write. It was devised in 1821 by Louis Braille, a Frenchman. Braille is a system of raised marks that can be felt with the fingers. Each Braille character is made up of six dot positions, arranged in a rectangle. A dot may be raised in any of the six positions to form sixty-four possible combinations and these raised dots are read by touch.

▶ Have you ever tried to read Braille? It's harder than it looks.

Communication boards

Pictures can be used to communicate with people who have no ability to speak or use a language: for example, many people with autism use picture cards as they tend to learn visually and communicate with images and pictures. Communication boards are also used with people who have suffered a stroke or other brain injury. They are a universal means of communication, understandable by people of all ages and abilities.
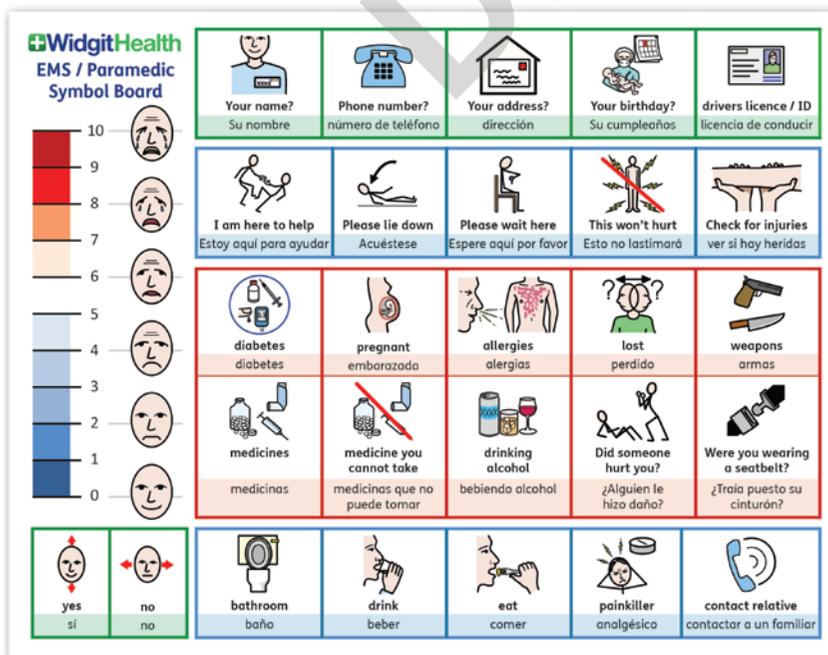
▶ Can you see how you could use this board to communicate your needs to a family member if you couldn't speak?

Symbol systems

Every day, we see and immediately understand symbols such as traffic signs or no smoking signs. Makaton and communication boards are examples of systems that use symbols. Symbol systems are used with children and adults who are either not able to use speech effectively or cannot use speech at all. These systems enable them to share information with others and to receive messages back, by pointing to the symbol that conveys what they want to communicate. Some symbols are pictures or photos and others may be tactile – actual objects or parts of objects to touch. Symbols can be arranged in order, for example in a series of trays or compartments called a calendar box, to let the person know what will be happening on a particular day. These systems are often designed for a particular person, to meet their specific needs as well as possible.

Commercial symbol systems are also available. For example, Bliss symbols, sometimes written Blissymbols or Blissymbolics, are used to provide people with severe speech disabilities with a written language that is based on concepts rather than words. Blissymbolics was originally developed by Charles Bliss, as a universal written language in which people speaking any language could learn and communicate.

Case study

A smile is worth a thousand words

Harry is 15 years old and has Rett syndrome. This is a rare **genetic condition** affecting the development of the brain. It causes severe physical and mental disabilities in early childhood. Harry developed normally at first; however, Rett syndrome was diagnosed when he was three after he lost the ability to walk or even crawl, and was still showing no signs of talking.

His parents loved him very much but struggled to cope with meeting his increasing needs as he was unable to communicate effectively with them. At the age of 12, he moved into a local residential school for children with severe special needs, where he could be given the expert help he needed. His parents were able to visit him every day. Harry has always responded well to any form of music and, in music therapy, he was taught to hit a drum if he liked a piece of music. Once Harry got the hang of hitting the drum, he was given a tambourine to hit whenever he wanted more of anything, such as a particular food or activity. The school staff and his parents are now rewarded with a huge smile every time he uses his tambourine to ask for, and receive, more.

Check your knowledge

1 How do you think Harry's parents managed to communicate with him at home before he moved to the residential school?

2 How do you think this limited communication might have affected family life?

3 How has music therapy helped Harry to communicate?

Theories of communication

Charles Berner

In 1965, Charles Berner developed the idea of looking at communication as a cycle in twelve parts.

Step by Step: Communication cycle   `12 Steps`

1   **You choose:** to communicate (independently).

2   **They choose**: to communicate (independently).

3   **Be specific**: you find a specific idea to communicate.

4   **Put it out**: present the idea in such a way that the other person can understand it.

5   **Take it in**: the other person receives the idea as presented.

6   **Directed connection:** the other person is connected with you.

7   **Do the work:** the other person interprets what the words mean.

8   **Acknowledge sender:** the other person decides to acknowledge the idea they have just received back to you.

9   **Put out acknowledgment:** the other person sends a body-language signal or uses some other process to let you know that he or she understood what was said.

10   **Take in acknowledgment:** you receive the acknowledgment from the other person.

11   **Acknowledgment is valid:** you are reacting appropriately to the message sent.

12   **New reality:** you have a reality shift due to the completion of a communication cycle.


Michael Argyle

Michael Argyle (1925–2002), a social psychologist, specialised in the study of interpersonal behaviour, social skills and body language, or non-verbal communication. In the 1960s, he found that non-verbal signals can be more important than verbal communication in conveying people's attitudes. His research showed that, when you talk to a stranger, your gaze tends to be averted but, with a close friend, you make direct eye contact more often. Argyle said that feelings of friendship and a positive attitude can be encouraged simply by looking at people in the right way. He also said that it was important not to let verbal and non-verbal signals conflict. For example, if you speak sternly to a child with a smile on your face this will undermine the main point of the communication, namely, to tell them off, because they will remember the smile more than the words.

In 1972, he built on Berner's work by developing the simpler communication cycle (shown in Figure 5.4) that we refer to today. He said that interpersonal communication was a skill that could be developed, and involved building an understanding of listening, observing and reflecting on what another person is trying to communicate.

Work in a group of four. Two of the group should sit opposite each other and talk about an agreed topic, such as what they did last weekend. The other two observe and see if they can spot the six different stages of the communication cycle. Repeat this with two different people talking to each other, but, this time, one has to keep interrupting the other. What happens to the communication? Is it as effective? Which part of the cycle is missed out when this happens?

Reflect on your own communication with a parent or carer. Do you always allow the communication cycle to work effectively? If not, how can you improve this in future?

1. Ideas occur

2. Message coded

3. Message sent

4. Message perceived

5. Message decoded

6. Feedback – what was understood
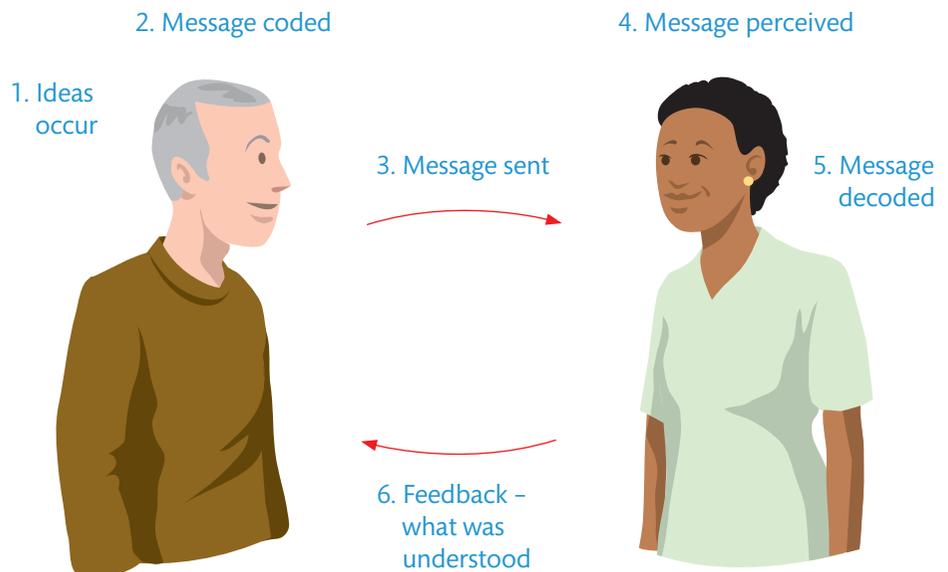
▶ **Figure 5.4:** The communication cycle happens very quickly and subconsciously. Do you know that we think three times faster than we speak?

Bruce Tuckman

In a formal group brought together for a specific purpose, such as a committee or working party, communication is regulated as it is led and controlled by a chairperson. Bruce Tuckman (born 1938) carried out research on how groups develop and operate. In 1965, he suggested that, when groups work together, they go through a series of stages as they become more effective at communicating as a group.

Step by step: Stages to achieve effective communication between members of a group

5 Steps

1 Forming
- A group of strangers come together; there is high dependence on the group leader.
- They talk about themselves and share information.

2 Storming
- The members of the group starts to fall out with each other as they compete for position, so there are tensions within the group.
- There is disagreement about how the group acts.

3 Norming
- Things calm down in the group.
- The group comes to an agreement on **group values,** either consciously or unconsciously.

4 Performing
- The group is sorted, with any disagreements resolved positively.
- The group works effectively and members look after each other.

5 Adjourning (added around 1977)
- The group breaks up when the task is completed successfully.
- All feel good about achievements, but there is some sadness about loss of the group.

New technologies and communication techniques

Technology is developing rapidly and there are now many electronic aids to help communication. The following are some examples of these developments.

▶ **Voice activated software** can turn the spoken voice into movement and the written word, such as instructing the user's wheelchair to move.

▶ **Voice output communication aids (VOCA)** can turn small movements into written word and then into speech, such as that used by the scientist Professor Stephen Hawking. These devices are now being used more widely: for example, NHS Wales announced plans, in 2015, to provide electronic devices such as VOCA and Augmentative and Alternative Communication (AAC) devices.

▶ **Mobile phones and minicoms** can be used to send text messages and emails. Those who are hearing impaired can feel a vibration when a message arrives.

▶ **Hearing aids** are devices with small microphones that pick up and increase the volume of sound. They are battery operated, very small and light and many are hardly noticeable as they are tucked behind the ear. However, in a noisy environment, hearing aids will amplify background noise which may cause problems for the user.

▶ **Text relay service** is operated by the charity Action on Hearing Loss. This service makes it possible for a person who can't speak and/or hear to text their message to an operator, who then reads it to a hearing person. The operator types the reply so that the original sender can read it.

▶ **A loop system** is cable that surrounds a given area, such as a lecture theatre. The cable amplifies sound from various sources, such as a music system or from a speaker wearing a microphone. This loop produces sound that can be heard by a person wearing hearing aids set to a special setting.

▶ **Braille software** is used by those who are visually impaired. It creates Braille that is printed out using a special printer. The software comes in a wide range of packages, including those that create mathematical, musical and text Braille, and those that translate different languages.

▶ **Speech recognition software** can be used by the visually impaired, or those with dyslexia, to generate messages without using a computer keyboard.

> **Key term**
>
> **Group values** – a common system of beliefs and values shared by all members of a group.

Assessment practice 5.3   5C.P4   5C.P5   5C.M4   5BC.D2

Imagine you are the owner of a newly opened residential care home for older people who need extra help and support. Some of the new residents have conditions such as dementia. The home has 33 rooms and your prospective new residents range in age from 72 to 101.

Task

Prepare a presentation to deliver at an open day for the older people planning to move in and for their families.

In your presentation, you should explain and assess the strategies and communication techniques that you and your staff plan to use with individuals with different needs, to overcome different challenges.

You should explain the personalised care that you will be delivering and what its benefits are. You should also justify the strategies and techniques that you will use to overcome any ethical issues and challenges that may arise.

Plan
- What am I being asked to do?
- Do I need clarification about anything?
- What strategies will I use to tackle this task?

Do
- I can evaluate whether my planning strategies are working.
- I can set myself small milestones and evaluate my progress and success each time I reach one.

Review
- I can explain which elements I found the hardest.
- I can explain how I would approach the hard elements differently next time.

D Investigate the roles of professionals and how they work together to provide the care and support necessary to meet individual needs

How agencies work together to meet individual care and support needs

Research shows that, in areas of high unemployment, where there are issues with housing and a lack of public transport, people struggle to be healthy. Historically, one of the major problems with health and social care has been the lack of co-ordination between services. A family living in an impoverished area of the UK could be dealing with tens of different agencies at a time, repeating their stories each time to a different agency. They may find that they are dealing with the same agencies a year later, still repeating their stories. They may have services forced on them, rather than agencies working with them to meet their needs, with little or no progress towards better health or wellbeing. In recent years, there has been a drive to integrate services, to make the system more efficient and cost effective. You can see, in Figure 5.,5 all the different organisations that may be involved in providing care.

Role of organisations responsible for commissioning healthcare services

There are a number of key organisations responsible for the **commissioning** of healthcare services. These are explained in Table 5.8.

▶ **Table 5.8:** Organisations responsible for commissioning healthcare services

Organisation name	Formation (when and why)	Roles	Members
Clinical Commissioning Groups (CCGs) in England	• Formed in April 2013 by NHS England • To take on greater delegated commissioning responsibilities for GP services • To give patients, communities and clinicians more scope in deciding how local services are developed and more influence over the wider NHS budget	• Assess the health needs of the area • Commission most of the hospital and community NHS services in their local area, including most planned hospital care, **rehabilitative care**, urgent and emergency care (including out-of-hours), most community health services, mental health services and learning disability services • Overseen by NHS England	GP practices Other health professionals, such as practice nurses
Local Health Boards in Wales	• Formed in October 2009 • Consists of seven Health Boards working alongside three NHS Trusts • To redesign the delivery of the NHS in Wales, to improve health outcomes and deliver care effectively with its partners	• Plan, source and deliver primary care, hospital and community health services, and provide information in their local area • Provide more care close to people's homes • Strong emphasis on public health and long-term planning	Representatives at executive level: GPs and other health professionals, such as nurses, dentists, pharmacists and **optometrists**; people from areas such as public relations and finance
Health and Social Care Board in Northern Ireland	• Formed in April 2009 • Consists of five Local Commissioning Groups and five Health and Social Care Trusts (covering the same local areas) • To reform and modernise the management of health and social care services • To integrate provision of services in an efficient, effective and economic manner	• Effective commissioning of health and social care services, resource management, performance management and service improvement	Representatives at executive level of various health and social care services; also people from areas such as public relations and finance

DEPARTMENT OF HEALTH

OTHER GOVERNMENT DEPARTMENTS

PARLIMENT

SECRETARY OF STATE

REGULATION & SAFEGUARDING

NATIONAL ORGANISATIONS

LOCAL ORGANISATIONS

HEALTH & WELLBEING BOARDS

LOCAL HEALTH & CARE SERVICES

PEOPLE & COMMUNITIES

Care Quality Commission

Healthwatch England

Local Healthwatch

Human Tissue Authority

NHS Litigation Authority

Human Fertilisation & Embryology Authority

NHS Blood & Transplant

Health Research Authority

National Institute for Health Research

NIHR Clinical Research Networks

NHS Commissioning Board

Clinical Commissioning Groups

Monitor

NHS Trust Development Authority

NHS Business Services Authority

Public Health England

Local Government

Medicines & Healthcare Products Regulatory Agency

Health & Social Care Information Centre

Local Education & Training Boards

Health Education England

Professional Regulators

National Institute for Health Care Excellence

Community groups

Online/phone services

GP Surgeries

Ambulances

Care homes

Hospitals

Personal helpers

Home

Health centres

Opticians

Dentists

Pharmacies

KEY

● Providing care

● Commissioning care

● Improving public health

● Empowering people and local communities

● Supporting the health and care system

● Education and training

● Safeguarding patients' interests

▸ **Figure 5.5:** This diagram was produced by the Department of Health to show how health and social care would look in England from 2013. Can you spot all the different organisations involved?

Role of organisations responsible for commissioning social care services

Local authorities commission social services to achieve personalised, community-based support that promotes health and wellbeing by using evidence, local knowledge, skills and resources as best they can. Local authorities work in close partnership with other organisations, such as housing and NHS partners, using guidance such as the *Adult Social Care Outcomes Framework*, *Making it Real* statements and the *Public Health Outcomes Framework*.

Role of bodies responsible for integrating health and social care

Health and Wellbeing Boards (HWB)

The *Health and Social Care Act 2012* introduced Health and Wellbeing Boards to be a forum for local health and social care leaders. The aim of the boards is to integrate public services for health and social care. They are tasked with:

▶ assessing the needs of their local population

▶ reducing inequalities in provision

▶ setting out strategies and shared approaches for local authorities, CCGs and NHS England to use to improve their commission decisions

▶ encouraging greater integration and more partnership working, such as joint commissioning, integrated provision and shared budgets and leadership.

These boards are at the centre of the *Care and Health Improvement Programme*, introduced in April 2015, which aims to help HWBs develop their leadership and better support the integration of services.

The boards are made up of key leaders from the health and social care system. HWBs have no formal powers; instead, they depend on building relationships and strong lines of communication to achieve success, and are invaluable in getting all key local leaders together to share ideas and to forge links between local services. The website www.local.gov.uk provides an interactive map for health and wellbeing priorities (you will need to search for this). You can select an area of England and a theme, such as alcohol and drug abuse, to find a summary of local priorities and links to various reports and examples of good practice in the area. This allows sharing of information and practice.

Role of assessment and eligibility frameworks

In learning aim C, you learned what policy frameworks are. Frameworks that include ways in which to assess needs, and eligibility to have those needs met, are also called assessment and eligibility frameworks. These frameworks are key to integrating health and social care. Their use should lead to:

▶ reduced inequalities in service provision

▶ greater clarity, transparency and consistency

▶ greater emphasis on the individual person rather than the services

▶ better integration of services

▶ reduced repetition of a person's story

▶ greater focus on prevention, by earlier consideration of people's care and support needs.

Ⅱ **PAUSE POINT** The roles of the *Common Assessment Framework* (CAF), the *National Eligibility Criteria* (Care Act 2014) and the *National Framework for NHS Continuing Healthcare* were covered in learning aim C. The role of the Department of Health was covered in learning aim B. Draw a mind map to summarise the roles.

Extend How do you think such frameworks contribute towards the way in which agencies work together to meet individual care and support needs?

The Education, Health and Care Plan (EHC)

An EHC plan is for children and young people aged up to 25 who need more support than is available through special educational needs (SEN) support. An EHC plan can be requested by a parent, someone from the child's school, a doctor, a health visitor or a nursery worker. If it is thought that a child needs an EHC plan, the local authority carries out an assessment.

Roles and responsibilities of key professionals on multi-disciplinary teams

Multi-disciplinary teams, members and formation

A multi-disciplinary team is made up of professionals from the same service who have different roles. These professionals work together to support an individual or a family facing complex situations. Effective multi-disciplinary working means that the individual gets a better service and better outcomes from the service provider. This is possible because the team takes a holistic approach to providing care, looking at all the person's needs and how they can be met. Multi-disciplinary working also helps avoid duplication of roles and responsibilities. The team must work together to be aware of conflicts that may arise between professionals, or between the service provider and user, to make sure the service user's wishes are acknowledged. You need to know the specific roles and responsibilities of a variety of health and social care professionals within a multi-disciplinary team which relate to meeting an individual's health and social care needs.

Healthcare professionals

Multi-disciplinary teams are formed based on the individual's specific needs. For example, for someone diagnosed with cancer, the team might be made up of an oncologist, a radiologist, a haematologist, a dietician, a clinical nurse specialist and other specialist nurses. Each team member has a different role and responsibilities (see Table 5.9).

Theory into practice

Research to find out what SEN support for a child of school age includes, how your local authority assesses a child for an EHC plan, and what legally must be included as a minimum in any EHC plan. Draw up an EHC plan for a child aged 5 with hearing difficulties.

Professional	Role	Responsibilities
GP	• First point of contact with NHS • Assess problem, make a diagnosis and decide on appropriate course of action, treatment or referral to another service, such as a hospital consultant • Provide a complete spectrum of care within the community	• Maintain the health of patients through preventative care and health promotion • Ease difficulties of individuals with **chronic conditions** • Help patients access specialist secondary care services when needed
Nurse	• Provide hands-on care to patients • Provide emotional support to patients and their families	• Help patients, eg by administering medicines, monitoring conditions, maintaining records, providing health promotion and other information, communicating with doctors
Paediatrician	• Manage medical conditions affecting babies, children and young people • Provide health maintenance for healthy children • Provide medical care for child who is acutely or chronically ill	• Reduce infant and child mortality • Control infectious disease • Foster healthy lifestyles • Ease difficulties of children and young people with chronic conditions
Clinical psychologist	• Reduce psychological distress • Enhance and promote psychological wellbeing	• Use psychological methods and research to make positive changes to their clients' lives • Offer treatment for a variety of different mental or physical health problems

Key term

Chronic condition – a long-term or recurrent condition, such as arthritis, asthma or diabetes.

Reflect

Think about times you have needed a doctor. Have you ever needed any of the other health professionals mentioned above? How did they work together? Do you think they could have worked together better? Can you think of other health care professionals who might be involved in a team to help a child who has had a serious accident and faces a long stay in hospital.

Research

Draw up a table similar to Table 5.9 for *each* of the following:
• social care professionals, to include at least social worker, occupational therapist
• education professionals, to include at least SENCO (Special Educational Needs Coordinator), educational psychologist
• allied health professionals, to include at least a speech and language therapist.

Think of a situation for the social care team, such as an adult who has had a stroke, where a person may need the support of the multi-disciplinary team you have just drawn up, and write a case study to illustrate how the team would help that person. Be prepared to share your case studies with others in your class.

▶ A Macmillan nurse. You can read her story, and that of others on the Macmillan website

Voluntary sector workers

A multi-disciplinary team of voluntary sector workers may include:
▶ **Macmillan nurses**: Macmillan nurses are funded by the charity Macmillan Cancer Support. They are specialist nurses who provide guidance and support to individuals with cancer, and to their families.
▶ **Family support worker**: a family support worker's job is to provide emotional and practical help and advice to families with short- or long-term difficulties, such as drug or alcohol addiction, marital or financial difficulties, disability, problems accessing services due to a language barrier or having a parent in hospital or prison.

The family support worker helps the family to deal with the situation, maybe by teaching them new skills or encouraging them to seek help from various other health and social care professionals. A family may be referred to a family support worker by a social worker.

Case study

Maria's story

When Maria was 27 years old she was involved in a serious road traffic accident, and has to use a wheelchair. She is now 33 years old and stays at home to look after her 5-year-old son and 3-month-old daughter. Her husband Sven, works on a production line in a local factory and has just been diagnosed with bowel cancer. He needs radiotherapy and chemotherapy. Sven has been told that he may need

an operation later on and regular tests to make sure the cancer has not spread to other parts of his body.

Check your knowledge

1   How do you think Maria will be feeling?

2   What practical problems will the family now face?

3   How could a multi-disciplinary team of voluntary sector workers help them?

How multi-agency and multi-disciplinary teams work together to provide co-ordinated support

A multi-agency team is made up of professionals from different health and social care services (see Figure 5.6). For example, a local authority social services department may work with a mental health organisation such as Mind (a mental health charity) to help a service user with mental health problems live in the community.

The benefit of working in partnership is that all the professionals are working together, communicating and planning as a team, so support is coordinated. Professionals can use their skills more effectively by concentrating on meeting just some of an individual's needs, rather than all of them, and focus on what they do best. There will also, hopefully, be no gaps in care and, because the care is planned and resources are not wasted, costs are reduced. However, some difficulties may also arise, such as professional animosity between agencies, poor communication, manipulation by service users, logistical problems, limited budgets and breakdown in services. It is important to have a strong leader of the team to minimise these difficulties.

▶ **Figure 5.6:** What do you know about autism?

Maintaining confidentiality

Definition of confidentiality

You were reminded, in learning aim B, that confidentiality means keeping information private, and not sharing information about individuals without their knowledge and agreement, even with a service user's friends, family or other individuals. Confidentiality refers to all information relating to those using health and social care services, as well as the records associated with them, no matter what format those records are in.

Working practices to maintain confidentiality

Confidentiality is one of the most important values when caring for others. By breaking confidentiality you can destroy the trust and relationship between you and the person you are caring for, as this may cause that person embarrassment, loss of dignity or harm. Safety might be put at risk if sensitive information is disclosed to those who should not have access to it. For example, if an abused child has been removed from their family and adopted by a family living in a different part of the country, for the child's safety, it may be important that their whereabouts are not disclosed.

Keeping yourself informed of the relevant laws

The law and the underpinning values of care practice demand that all health and social care professionals maintain people's confidentiality at all times. The law sets out duties, which combine the decisions made by the courts, known as the common law of confidentiality, and legislation such as the *Data Protection Act 1998* and the *Human Rights Act 1998*. The Data Protection Act aims to protect the right of the individual to privacy with respect to the processing of personal data. The Human Rights Act reflects this when it says that everyone has a right to respect for private and family life.

It is, therefore, very important that as a health or social care service provider you keep yourself informed of, and up to date with, the relevant laws. Every organisation or workplace in the health and social care sector must have a confidentiality policy, as well as procedures in place that must be followed with regard to breaching of confidentiality. *A guide to confidentiality in health and social care* (2013) gives clear user-friendly guidance for processing confidential information about an individual's

care. It states that service providers should not hide behind the Data Protection Act to avoid taking decisions that benefit the service user. For example, if they do not share that an older person is struggling with their own care, that person may struggle for longer as they may not know how to get the extra help they need.

Keeping information locked away or password protected

It is very important that information stored on paper should be kept locked away when not in use. Decisions have to be made about paper records such as where they should be stored, how to keep them safe, who can have access to them, how long they should be kept, what information should be stored and how often it needs to be reviewed and updated.

Although most health and social care settings still use paper records, many records are now stored electronically. Some form of electronic patient record (EPR) system is in place in most GP practices and hospitals, and is used to record information about a patient's medical history, diagnosis and treatment. As people can now make appointments and order prescriptions via their computer, smart phone or other devices, it is necessary to have secure passwords and networks to avoid unauthorised people accessing an individual's personal information. When using EPRs, decisions have to be made about who has access to passwords and who will train staff, given the confidential nature of the records. When working in health and social care, it is very important that you do not store or transmit data and photographs of service users using your insecure smart phone, or share information about service users on social networking sites.
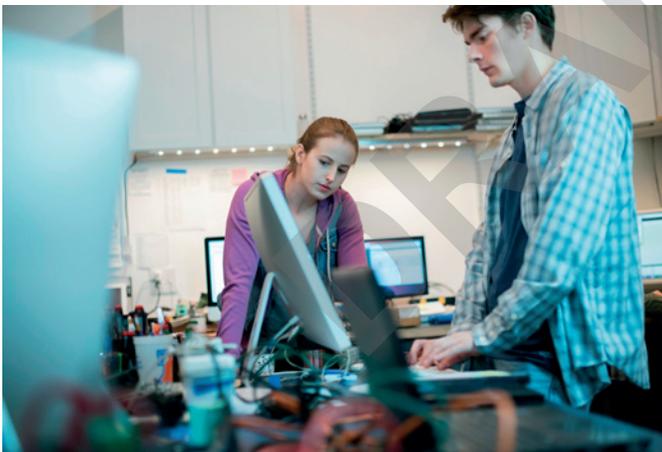
▶ What happens when the system fails? Who will carry out the repairs and will they see any of the information?

Sharing information only with people who are entitled to have access to the information

The need to respect a service user's wishes in relation to how their information is used has to be weighed against the duty of staff to share information to ensure safe and effective care for that service user. Times when confidentiality needs to be broken include:
▶ if an individual is at risk of being harmed or killed
▶ if an individual is at risk of causing harm or death to others
▶ if an individual is about to break, or has already broken, the law.

Information should only be shared with people who are entitled to it, for example other people in a multi-disciplinary team, service users and their carers or families, depending on the situation.

In a small group, discuss the following situation and decide what action you should take. Be prepared to share, and justify, your decisions with the rest of the class.

As a carer in a residential home for young adults with severe learning difficulties, you are told by a service user that she is going to have a baby. You tell her that you will have to inform her key worker. She becomes very upset, saying that you are letting her down and telling her secrets.

Being professional about how information is shared

If information is to be shared, it is important that this is done professionally. You should first ask the individual concerned for their agreement to pass it on, even if it is something like an address. It is also vital that the information is accurate; there have been cases where a patient has had the wrong organ removed in an operating theatre. Information should never be passed on in an offensive way, or anywhere where it can be overheard.

Case study

The journey home

Joy works in a residential care home for older people. She has just completed her shift and catches the train home with Rani, one of her co-workers, with whom she has not had a chance to speak to all day. They chat about the shift and Joy mentions that one resident they both work with is becoming confused and the doctor has been called to assess her for dementia. The next day, on her arrival at work, Joy is summoned to the manager's office. The manager tells Joy that a relative of the resident she was talking about was sitting behind her on the train last night and heard what Joy said to Rani. The relative has made a complaint.

Check your knowledge

1 Why did Joy share the information about the resident with Rani?

2 If Joy had not been overheard, would Joy's actions in discussing a service user with Rani, a member of her care team, still be unacceptable? Explain your answer.

3 How could Joy have shared the information in a more professional manner?

4 What do you think should happen to Joy and Rani now?

Codes of practice for care workers establishing the importance of confidentiality

Concern about confidentiality led to the *Caldicott Report*, published in April 2013. It set out seven principles (known as the Caldicott principles). These principles are the following.

▸ Justify the purpose(s): every proposed use or transfer of personally identifiable information within or from an organisation should be scrutinised to make sure it is necessary.

▸ Don't use personally identifiable information unless it is absolutely necessary: only use personally identifiable information if there is no alternative.

▸ Use the minimum that is required: if it is essential to use personally identifiable information, then only the item required should be disclosed. For example, the whole of a person's medical details should not be sent if only one small part is needed.

▸ Access to personally identifiable information should be on a strict need-to-know basis: only those people who need access to the information should be allowed that access.

- Everyone with access to personally identifiable information must understand their responsibilities: anyone, both clinical and non-clinical staff, handling the information should understand the need to respect the service user's confidentiality.

- Understand and comply with the law: every use of personally identifiable information must be lawful, and not go against the principles of, for example, the *Data Protection Act 1998*. There should be someone in every organisation who is responsible for making sure that the organisation complies with the law.

- The duty to share information can be as important as the duty to protect service user confidentiality: health and social care professionals should have the confidence to share information in the best interests of service users, within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

The Caldicott principles were drawn up to guide decisions about the storage and disclosure of confidential information. A new code of practice, based on this report, was published as a working document in December 2014 by the Health and Social Care Information Centre (HSCIC). The HSCIC is committed to building on this code and to updating it regularly.

Relevant aspects of legislation

The *Data Protection Act 1998* and the *Human Rights Act 1998*, have been mentioned earlier. Another important piece of legislation about confidentiality is the *Health and Social Care Act 2012*. The HSCIC was given statutory responsibility under this Act to produce a Code of Practice for processing confidential information, based on the Caldicott principles, and the five confidentiality rules they came up with. In September 2013, the HSCIC published a document called *A guide to confidentiality in health and social care*. The confidentiality rules are the following.

1 Confidential information about service users or patients should be treated confidentially and respectfully.

2 Members of a care team should share confidential information when it is needed for the safe and effective care of an individual.

3 Information that is shared for the benefit of the community should be **anonymised**.

4 An individual's right to object to the sharing of confidential information about them should be respected.

5 Organisations should put policies, procedures and systems in place to ensure that the confidentiality rules are followed.

The Act states that all health and social care bodies in England must have regard to this code, as must any person other than a public body who provides health services, or adult social care, in England.

The role of the Health and Social Care Information Centre (HSCIC)

The UK government website states that the HSCIC is 'the national provider of information, data and IT systems for **commissioners**, **analysts** and **clinicians** in health and social care.' Sponsored by the Department of Health, the HSCIC was set up in April 2013, and has powers to provide advice and guidance 'on any matter relating to the collection, analysis, publication or other dissemination of information'. Health and social care service providers must have regard to any guidance that the HSCIC produces.

II **PAUSE POINT** Can you remember the working practices required to maintain confidentiality?

Hint   Close your book and imagine that you are working in a nursery. Think about all the ways you might try to keep information confidential. List them.

Extend   How do codes of practice written by bodies such as the HSCIC protect both service users and service providers when dealing with issues of confidentiality?

Managing information

Working practices for managing information

All organisations must have policies and codes of practice for managing information. These policies and codes will include the following procedures.

Identifying why information is needed

Most organisations will need information to formally identify a service user. This is to avoid mistakes, such as the wrong treatment being given or information sent to the wrong address, resulting in delays or the wrong person seeing confidential information. Service providers will also need information about an individual in order to identify, provide and monitor care and support. Records should be legible, factual, **unambiguous**, dated, consistent and accurate. Service users have the right to see their own records.

Identifying what information is needed

A key principle in identifying what information is needed is that a service user's records are made by the service provider to support that person's care. This information will include the service user's name, address, date of birth and maybe a photo. In certain cases, additional data may also be required: for example, a hospital number and NHS number, medical history and medical details, such as images (X-rays, scans).

Searching for the information

When asking for personal information, a service provider should inform the service user that the information will be recorded and that it may be shared, in order to provide appropriate care. In some instances, a service user's personal information may be used to support other work, such as research. The information required should be gained directly from the service user unless they are unable to provide it. For example, an infant or child, an unconsciousness person, or a person with a physical or mental condition that makes them unable to communicate is unlikely to be able to provide the information. In these cases, a family member or other advocate may be asked, usually in the presence of the service user. The service user should also be told where they can find more information to help them understand what is happening to them, such as websites and information leaflets. If a service provider needs information from another provider, such as a doctor, permission should be obtained from the service user to release those records.

Using information ethically and legally

Service users trust service providers to gather sensitive information relating to their health and other matters, so it is legally and ethically essential that the information is kept confidentially. Information should not be used or disclosed in a way that can identify the person without their consent. The extent to which information needs to be shared to meet a service user's needs should also be disclosed to the service user. If the service user decides that they are not happy for their information to be disclosed, for example, to other health professionals involved in providing their care, it should be made clear that this might mean that it will not be possible to offer certain treatment options.

Key term

Unambiguous – clear, no chance of being misunderstood.

However, confidential information can be very useful and provide benefits for society, for example, through medical research. Although using this information does not affect the care of the service user, they should be asked for their consent to share the information, which will usually be in an anonymised form.

The NHS confidentiality model is shown in Figure 5.7. It outlines how patients are to be provided with a confidential service.
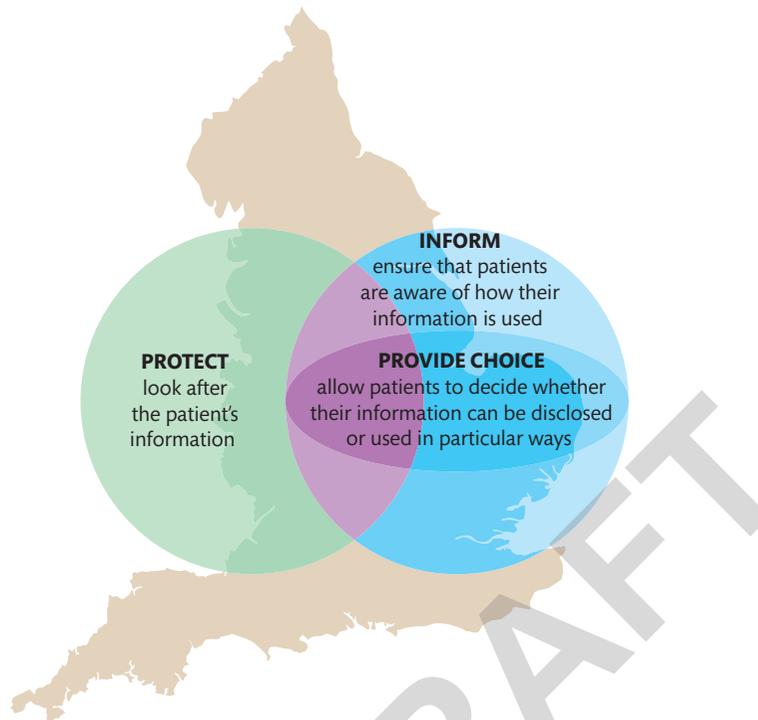
▶ **Figure 5.7:** This diagram is taken from Confidentiality: NHS Code of Practice. Can you see how this would work in other health and social care settings by changing the word patient to service user?

The importance of sharing information

It is important that relevant information is shared with colleagues and other health and social care providers to make sure that a person gets the care and support they need. For example, if a GP decides that a service user has a problem that needs more specialised care, the GP will need to share information with a hospital consultant. It is also important to share as much information as possible with the service user and their family. This ensures that everyone is informed and reassured that the best possible care is being given, and helps them to prepare for what happens next. However, there should always be **protocols** in place that set out the principles and procedures for sharing confidential information. If someone telephones or appears in person asking for information about a service user, the service provider must check that the person asking is who they say they are, and that they have the right to access the information.

Impact of new technologies on managing information

The impacts of advances in technology, such as electronic patient records (EPRs), are:

▶ improved and faster communication
▶ increasing quantities of data available
▶ more detailed information.

Key term

Protocols – procedures following specific guidelines.

However, care must be taken to make the means of transferring information, such as emails, faxes and surface mail, as secure as possible.

The HSCIC's vision is that, by 2020, there will be full service user access to national and local data, for the user to view and manage their own records, communicate with care providers and increasingly manage their own health, care and wellbeing. Service providers will also have access to the information and support systems they need to deliver safe and effective care. The HSCIC has set out a strategy with five objectives towards achieving this vision.

1   Ensure that every citizen's data is protected.
2   Establish shared architecture and standards so that everyone benefits.
3   Implement services that meet national and local needs.
4   Support health and care organisations in getting the best from technology, data and information.
5   Make better use of health and care information.

▶ Information about a service user is not made up of only words and numbers. What other forms of information can you think of?

> **Research**
>
> Read the HSCIC document *Information and technology for better care*. Produce a summary that explains clearly and concisely what each of the HSCIC objectives above is actually promising.

⏸ PAUSE POINT   Do you remember the working practices for managing information?

Hint   Think about a time when you have been in a health or social care setting as a service user. What information were you asked for and why was it needed? How was it collected?

Extend   In what ways has new technology both helped and hindered the safe management of information?

Bodies that control the management of information

The National Adult Social Care Intelligence Service (NASCIS)

The NASCIS has been developed by the HSCIC to provide a single national online resource of relevant, useful and up-to-date information for social care services across England. It is made up of a collection of tools and resources designed to meet the

needs of, for example, those who plan services, manage services, carry out research and write policies. One such tool is an analytical processor, which allows easy access to a wide range of health and social care data against which a service provider can compare their performance.

Legislation and codes of practice that relate to the storage and sharing of information in health and social care

There are many examples of legislation and codes of practice relating to the storage and sharing of information, such as the *Confidentiality: NHS Code of Practice*, mentioned in Figure 5.7. Some of the most important are explained in Table 5.10.

▶ **Table 5.10:** Legislation and codes of practice that relate to the storage and sharing of information in health and social care

Act or code of practice	Notes
Data Protection Act 1998	• The main piece of legislation that governs the protection of personal data in the UK • Controls how your personal information is used by everyone responsible for using data, by providing rules called data protection principles • Provides legal protection for more **sensitive personal data** • Gives you the right to access to your own personal data • Enables health and social care providers to share information with other professionals directly involved in providing clinical care, for example transferring case notes when you change GP
The Freedom of Information Act 2000	• Provides public access to information held by public authorities in England, Wales and Northern Ireland, and UK-wide public authorities based in Scotland • Does not give access to your own personal data • Makes public authorities **accountable** for their actions. Allows public debate to be better informed and, therefore, more productive
Mental Health Act 2007	• Allows people in England and Wales to be admitted to hospital, detained and treated against their consent, for their own health and safety and for that of others, so allows the storing and sharing of their personal information without their consent
Mental Capacity Act 2005	• Requires professionals to consider a person's mental capacity to consent to share information • Outlines correct procedures for making decisions in the best interest of a person who lacks the mental capacity to consent

Care Quality Commission (CQC) codes of practice	• CQC is an independent body that speaks up for the rights of people who use care services, their families and carers, and checks that services stick to the *Health and Social Care Act 2008*
	• One example is the 2010 code of practice for health and adult social services in England, which:
	  • sets out the practices to be followed in obtaining, handling, using and disclosing confidential personal information
	  • is based on a set of nine principles
	  • includes a necessity test to decide whether it is necessary to obtain, use or disclose personal information

The Health and Care Professions Council (HCPC) codes of practice	• HCPC is a regulator set up to protect the public, by keeping a register of health and social care professionals who meet HCPC standards for training, professional skills, behaviour and health • Confidentiality – guidance for **registrants** 2008, slightly amended in 2012, sets out the standards of conduct, performance and ethics expected from the professionals it regulates, including management of information

Key terms

Sensitive personal data – information about a person's physical or mental health.

Accountable – has to justify actions.

Registrants – a person who is registered.

A canine partner

Edi is a 49-year-old woman. Edi suffered a brain injury at the age of 20 that left her unable to function without daily help. She spent almost 30 years relying on others for help, until someone told her about Canine Partners. This charity trains dogs to assist with practical tasks, enabling people with a disability to regain independence. Canine Partners have recently provided Edi with a dog called Molly. Molly helps with a range of tasks, from helping Edi to dress and retrieving the remote control to loading the washing machine. Trainers from Canine Partners are visiting frequently to start with, to help Edi and Molly get into a routine.

Check your knowledge

1 What sort of information will the charity have about Edi?

2 What are some of the things that could happen to Edi if the information got into the wrong hands?

3 Research the *Data Protection Act 1998*. How does this Act protect Edi?
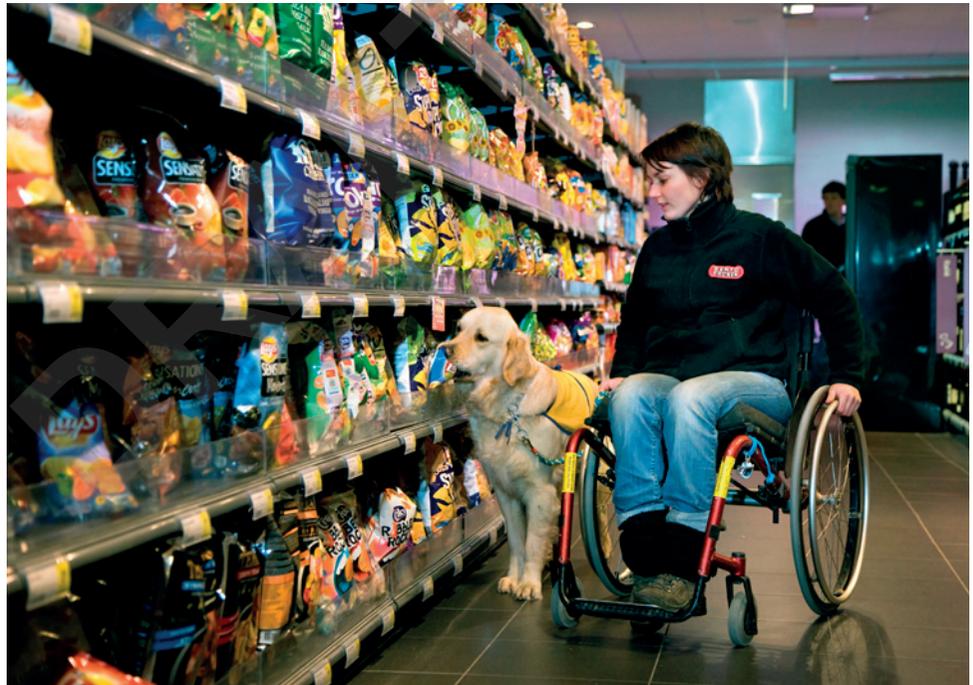
▶ Do you know of other ways in which animals are being used in health and social care to meet the needs of service users?

Pick one of the acts mentioned in Table 5.10. Research what the act says about storing and sharing information. Then imagine that you are working at a residential centre for young offenders. What might be the consequences for the young offenders, the centre and for you if you did not store and share the information lawfully? Produce a colourful poster that could be displayed in such a centre to remind staff about what they need to do to stay within the law when they store and share information.

Reflect

Search online for the 2010 code of practice and see what it says about keeping personal information safe. Then find the CQC easy-access document *Our rules for keeping private information safe*. Did you get the same messages from each? Why do you think the code of practice is produced in two different forms?

Now try to write your own version for the HCPC's code of practice *Confidentiality – guidance for registrants*. How successful have you been in completing this task?

Assessment practice 5.4

5D.P6 5D.P7 5D.P8 5D.M5 5D.M6 5D.D3 5D.D4

A serious spinal injury, after a fall from her horse at the age of 17, meant that Josie had to lie flat on her back in hospital for months. She was eventually able to return home, but faced using a wheelchair for the rest of her life.

Tasks

1 Draw up two lists of the professionals and agencies from which Josie will need help:
   • from the moment she arrives at the hospital after her accident until her discharge home
   • for her continuing care on leaving the hospital.

2 Write a report to:
   • explain each of their roles and responsibilities
   • explain why she needs so many service providers to be involved in her care
   • assess, justify and evaluate how these professionals, all working together, can meet her specific needs
   • analyse the arrangements for managing information between the professionals that will reflect the law and current codes of practice.

Remember to try to use all the correct terms, such as multi-disciplinary and multi-agency.

Plan
• Exactly what do I need to include in my report?
• What are the success criteria for this task?

Do
• Have I spent some time planning my approach to the task?
• I understand what to reflect on and what action to take.

Review
• I can explain what the task is.
• I can draw links between this task and prior learning.

Further reading and resources

DK Publishing – *First Aid Manual 10th edition* (Dorling Kindersley, 2014)

Parker L – *The Early Years Health and Safety Handbook 2nd edition* (Routledge, 2011)

Websites

https://professionals.carers.org
The *Carers Trust Professionals* website describes the Triangle of Care for mental health.

www.cyf.govt.nz
The *Child, Youth and Family (New Zealand)* website has information about attachment and resilience.

http://www.compassioninaction.info

Compassion in Action is a charity which helps meet the needs of people in crisis.

www.hscic.gov.uk
The *Health and Social Care Information Centre* provides a guide to confidentiality in health and social care, codes of practice on confidential information and the Caldicott principles.

www.local.gov.uk
The *Local Government Association* has links to Health and Wellbeing Boards.

www.nhs-chaplaincy-spiritualcare.org.uk
The *NHS chaplaincy* service provides information about meeting NHS standards of quality and professionalism and questions of policy and practice relating to the Church's ministry in health care.

www.england.nhs.uk
The *NHS England* website has useful information about the 6Cs, health action plans, personalised care and support, multi-disciplinary and multi-agency working. It also gives guidance for CCGs: for example, *Managing Conflicts of Interest: statutory guidance for CCGs*.

www.scottishhealthcouncil.org
The *Scottish Health Council* was established to listen to the views of users, including through the use of focus groups and to promote public involvement.

www.gov.uk
The *UK government* website contains much information, including the *Adult Social Care Outcomes Framework*.

THINK ▶FUTURE

Laura Hope

Nursing home manager

I've worked with older people for more than 20 years. People are surprised that I still have day-to-day contact with the residents now I'm a manager, but, if an older person needs help, there is no way I wouldn't give it. The residents are usually very grateful for the help, but sometimes they can be bad tempered. I don't mind that because I know it's just frustration as they feel they have increasingly less control over their lives and don't like having to depend on others so much. In a nursing home, the residents are even more dependent on our help than in a care home, as they are all here due to having at least one medical condition they need help with, as well as with day-to-day living. It's good to talk to the residents so that I can hear their preferences regarding their own care, whether that's to do with the food, the type of chair they have in their own room or the time they go to bed.

As well as working with the residents, I have to do a whole range of tasks to manage the home. One of these is to write policies and guidelines so that all the staff are informed and know the correct procedures to follow, from administering medicines to keeping records, to addressing the residents respectfully. I also have to make arrangements for various health professionals to visit each resident and make sure that each person receives the care and support they need.

Focusing your skills

Communicating with a person with impaired hearing

It is important to be able to communicate with those who have some form of disability. Here are some tips to help if you think that someone is losing their hearing.

- Do they think the TV is too quiet and keep turning it up? Do they say you are mumbling? If so, they need to have a hearing check with an audiologist.
- In the meantime, always attract their attention before you start to speak. Rephrase things if they don't understand you, as some words are easier to hear than others.
- Use natural hand gestures, but don't over-exaggerate or cover your mouth when speaking to them.
- Finally, be patient! They will feel frustrated and will be grateful that you are willing to work out how to help them.

Observing a person who is unwell

If someone who can't speak is in your care, how will you know if they are unwell?

- Look out for any changes in a person's condition. Try to do this in a room where there is good light.
- Has their colour changed? Is their skin paler, darker, yellow or bluish? Are their lips or insides of their eyelids pale? Do they have a rash?
- Are their lips or fingernails going blue? Is the white part of their eyes normal, red or yellow? Have their pupils become larger (dilated) or smaller (constricted)?
- Are they sweating? Is their breathing faster, more shallow or laboured?

Getting ready for assessment

Ryan is working towards a BTEC National in Health and Social Care. He was given an assignment for learning aim B with the following title: 'Is it right that that some of the UK's biggest charities put pressure on vulnerable people to give money?' The task was to write an article about this issue for *Yours*, a magazine aimed at people in later middle age and older people. The article had to:

▶ include information on the ethics of managing the conflict of interest between the charities needing to raise money and vulnerable people feeling they are being hounded to donate money

▶ discuss how adults can cope with these demands, and how charities could change their approach but still raise the money they need to help others.

Ryan shares his experience below.

How I got started

First I read the assessment criteria for learning aim B, so I knew what I was trying to achieve. While doing this, I made a note of the command words from the criteria. Then I did some research online to see if something had happened recently to make the way in which charities ask for money an issue in the media, before reading all the ethical theories in my textbook several times until I felt I understood them. I was undecided as to what I thought about this issue so I draw a concept map, which included everything I knew and felt about this topic.

I decided to divide the facts for the article into four sections, the first about why and how the charities work to raise money, the second on how this affects people, the third about how charities could change their ways and the fourth about how others could deal with this problem. I intended to finish the article with a few sentences giving my conclusions on the matter.

I arranged to visit a local charity's office to speak to a volunteer about how they tackle asking for donations. They gave me permission to use what they had said in my assignment.

How I brought it all together

I decided to use a variety of fonts and colours to make the work look appealing. To start the article, I wrote a short introduction to the article explaining the dilemma. For each of the four sections I:

▶ wrote a case study based on real-life stories I'd read when researching the problem

▶ included photos to make the article more eye catching and to show different aspects of this situation.

I used comments I'd noted down during my visit to the local charity to help explain the charity's point of view. Finally, I wrote a short summary as a conclusion to the article.

What I learned from the experience

I wish I'd made more notes during my visit to the charity as I didn't have as much information as I would have liked, and forgot some of the points they made. Next time, I'll write a list of questions to ask before my visit. I also wish I'd thought to visit my local newspaper office to talk to them about how they structure articles like these. Another idea, which came to me too late, was to have a proper discussion about the issue with a group of friends or family members to gather more opinions. I felt very undecided as to how the situation should change, seeing both that charities are competing for much-needed funds but also that some people are feeling pressurised into giving money they can't afford to a number of charities.

Think about it

▶ Have you written a plan with timings so that you can complete your assignment by the agreed submission date?

▶ Have you read your course notes on learning aim B, and read the relevant section of the textbook so you are clear on the general subject of ethical issues and approaches?

▶ Is your information written in your own words, and referenced clearly where you have used quotations or information from a book, journal or website?