ETORKIZUNA
ERAIKIZ
think tank

NEW FUTURES OF THE WELFARE STATE
REPORT OF THE 4th MEETING

26/11/2020

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2. Participants

- Group 1

1.- Maite Peña.
2.- Joseba Zalakain
3.- Adriana Martinez
4.- Josu Gago

- Group 3

1.- Eva Sánchez
2.- Garikoitz Agote
3.- Ander Arzelus
4.- Patxi Leturia

- Group 5

1.- Belen Larrion
2.- Rakel San Sebastian
3.- Iñigo Kortabitarte
4.- Javier Castro

- Group 2

1.- Carlos Alfonso
2.- Iker Uson
3.- Maria Muñoz
4.- Javier Sancho

- Group 4

1.- Xabier Barandiaran
2.- Julian Florez
3.- Andoni Zulaika
4.- Mikel Malkorra

- Group 6

1.- Sebas Zurutuza
2.- Gerardo Amunarriz
3.- Koldo Aulestia
4.- Miren Larrea

3. Introduction and presentation of the workshop

The Deputy for Social Policies welcomed the participants to the session saying that they have adopted a new online methodology and will stick to it because of the ongoing pandemic.

She announced that they would begin the session with a presentation by the Driver on an assessment of the Covid-19 crisis in Gipuzkoa. Teresa Martinez will then give a presentation on the topic for discussion.

She also announced that a shared agenda for deliberation has been established. The topic to be addressed in the session is how to centre care on people and ways in which Person-Centred Care (PCC) can be developed.

"I'd just say that in all these topics we will examine the experimental projects related to each topic in relation to our experimentation in the Think Tank".

She said she planned to conclude the reflection process with the creation of a "*White Paper*" which *" will look at the future of the welfare state and set out recommendations*". She asked them to be patient; "*It was scheduled for June, but it will take time*" because "*we will have to compile all the reflections and recommendations made here and check them over with experts"*

She concluded by saying that simultaneous interpretation facilities were available for anyone who required them. She then handed over to the Driver.

4. Presentation of results "Gipuzkoa in a time of Covid-19"

The Driver set out the results of the Covid-19 impact study in Gipuzkoa. The study seeks to provide an understanding of the Covid-19 crisis cycle, by analysing the emergency, management, impact and lessons learned.

Three activities were implemented: Social Policy crash programme (see slide), a 360 assessment of the impact of the crisis (see slide) and a reflection on the crisis within the framework of Etorkizuna Eraikiz.

He went on to speak about the results of the analysis of the emergence into the crisis. The study found that the system has a poor capacity to anticipate the crisis and a good capacity to react to it.

Turning to management, the main findings relate to a lack of medical supplies, poor socio-sanitary coordination, a large number of different protocols from different institutions, which hinder effective protocolization of procedures, prioritization of people's physical health over their psychosocial health and the great social support during the crisis in the form of solidarity and social drive.

With regard to the impact of the crisis, the economic impact is evident and is by far the greatest impact on organizations. He also discussed the organizational impact, since the crisis has highlighted the emergence of new models and the need for a change in model. The psycho-emotional impact is strong, professionals face a lot of stress and users face a great emotional impact. Finally, he highlighted the technological impact of the rapid transition to digital models, which he considers to be positive.

To conclude, he made a series of recommendations which he classified by urgency:

Urgent:

- Improve the model of governance between the health and social sectors.
- Provide medical supplies to care homes.
- Improve care ratios in care homes. Here there is a conflict; ratios have improved in practise because there are no new users in the homes; although there are also problems related to infections among staff.
- COVID-19 early track-and-trace policy.
- Making the visiting regime in care homes more flexible.
- Developing an adapted communication strategy; especially communication from care homes to families.

Short-term measures :

- Promote the person-centred care model in care homes, "*we need to launch a debate on the model and it needs to be done fairly quickly*".
- Diversify the portfolio of domestic services.
- Draw up the protocol for emotion management.
- Develop a new code of ethics for COVID-19 management.

Long-term measures:

- Develop strategic human capital; larger number of nurses and doctors and equivalence of work model and salary between the private and public sectors.
- Modernize care homes.
- Promote participation of volunteers in care, make the social model more participative.
- Create an Assessment Agency.

5. Person-Centred Care

The Deputy of Social Policies then took the floor. She thanked the Driver and said that the report is *"an external assessment that you are the first to hear about. It hasn't been submitted to the Provincial Assembly, although a request has been issued for a hearing. Alongside this report are a number of measures that have already been put in place or that we will implement. In a few days, when it is official, we will pass it on to you"*.

"*Today Teresa is here to talk about the personalization of rights. She has a PhD in Health Sciences from the University of Oviedo, a degree in Psychology from the Complutense University of Madrid and a Diploma in Social Gerontology from the Spanish Society of Geriatrics. She has also received several awards. Without further ado, I would like to thank you warmly for joining us today and for helping us to focus and opening today's debate*".

Teresa Martínez then took the floor. She thanked the organisers for the invitation and saying that "*it is a pleasure to share my thoughts in this space for generating ideas"*. She congratulated them for the initiative, "*because it is important and it is not always what happens. After talking to Carlos, I have selected some ideas and reflections on PCC*".

Beginning with the conceptual aspects, she said that *"there is no agreed definition of PCC. I've put some definitions up as an example, but we need to be aware that we are dealing with a concept that is not exactly precise*".

"It is interesting to note that the term is used in three different ways in the literature and in general discourse. The first relates to the approach — a philosophy that governs interventions. The second refers to the model. And the third is when we talk

about interventions and methodologies related to this type of care model. The meanings often get blurred".

Teresa said that in the literature there is "*general agreement amongst experts in the field: PCC is a fundamentally ethical approach to care. It starts from a very positioned vision about the groups that need care or support and it is something essential on which we have to base the interventions. I want to show you the ideological map of PCC. It refers to the values. The person is at the centre; those around them have to align themselves with the conception of the person at the centre*".

With regard to the elements surrounding PCC, she said, "*this vision involves the people who work in PCC because it affects their vision of the person and it impacts the way services are organised in a specific way*".

"*PCC is fundamentally ethical because it seeks moral correctness in the values that govern it. Scientific evidence is relevant, but it gives us concepts to explain how to implement it. It has to go hand in hand with PCC, but the justification is ethical*". She said that rights set limits: not everything legal is ethical.

She went on, "*PCC is very much in fashion at the moment, but it is more than just a fad. It is not a new approach; even the classical philosophers talked about ways of giving people a good life. Why is it so fashionable? I would point to two issues that have aroused interest in Spain: we are emerging from models that focused on people's deficiencies, which saw people as a "disvalue", or failed to assign any value to them; at the same time, there is an excessive prevalence of targets centring on services rather than people's needs. We have put a lot of interest and effort into the means, which are fundamental, but they must be coherent with the ends. I think at times there has been a usurpation and the means have become the ends. These two issues have led to the need for a rethink*".

PCC is internationally recognized as a strategic axis for improving service quality. One of the key concepts in PCC is Self-Determination. "*It has to be properly understood. It is a central feature of PCC in whatever field. This process is implemented with the opportunities and resources available. It involves more than just giving people a choice. It needs to be seen as a capacity that is exercised directly with personalised opportunities and support. It is also a right that is exercised indirectly. It is very important to take into account the element of representation through others. This can be addressed by*

identifying the elements of the person's identity and well-being, by working with indicators of well-being to provide support for enjoyable and meaningful lives".

"*In short, what does what we have been doing contribute? It is vision (not new, but recovered) that highlights the values that sometimes get lost in the dynamics. It requires a professional praxis that gets away from the "disease paradigm"; that generates services and organizations that are flexible and open to change. It generates benefits in the quality of life of people and professionals, greater satisfaction, less stress and burnout; as well as bringing about changes in the organizations*".

She concluded by saying that PCC provides support in defining models and services. This process needs to take different values into account:

1. Definition of Guiding Values: vision of the person
2. Definition of care
3. Definition of planning, design, management of services and interventions.

She then moved on to the next theme, referring to some common misconceptions and deviations related to PCC:

- Paying lip-service to the idea; this says a lot about an organization
- Trivialising PCC; this is a central issue
- Thinking that it is only relevant who have the capacity to make their own decisions. In fact, PCC seeks self-determination either for autonomous self-direction and for self-direction with support.
- Disassociating it from the scientific evidence.
- Equating personalised care with individualised care.
- Interpreting that a search for unlimited personal care.
- Seeing it as an approach that advocates deprofessionalizing care.

"*We must not forget that it is a cultural-organizational change; these changes must therefore be progressive, consistent, organized and planned*".

For this, changes are required at different levels:

- Organizational development in services and organizations.
- Attitudes/roles/treatment (from the point of view of recognition).
- Professional practices and methodologies.
- Flexibility in supports and interventions.
- Impact on the everyday and the important

- Role of the actors (individuals, families, community, professionals).

She stressed the importance of assessment and the need for defined value-driven models that have a place in interventions.

She then went on to discuss the challenges linked to personalization. "*The aim is quality of life, protection of rights and support for self-determination*". Where self-determination is seen as going one step further and allowing life projects that are worth living. These challenges are:

- Recognizing that the starting point "*must be to look at and relate to others as people at all levels, including in the design of organizations; you have to invest in it*".
- Creating enabling environments.
- Properly using methodologies that are valuable for PCC, *"I think they are applied without an underlying reflection on PCC"*.
- Limits and difficulties when there are conflicts between values. *"When there is a clash between a person's autonomy and health and safety, now more than ever, we need to start a debate. We need environments that help facilitate a balance, make rules and protocols more flexible and go beyond physical harm. There is psychosocial, emotional and moral harm that is related to the restriction of freedoms. Sometimes autonomy comes into conflict with a fair distribution of care and resources"*.

She ended her talk by stressing the need for spaces for decision-making and deliberation and advance planning in order to solve the issue of autonomy.

The Deputy for Social Policies thanked Teresa for sharing her wisdom with them: "You've brought up a lot of issues. Taking on person-centred care is a highly complex area". She then gave the floor to the Driver.

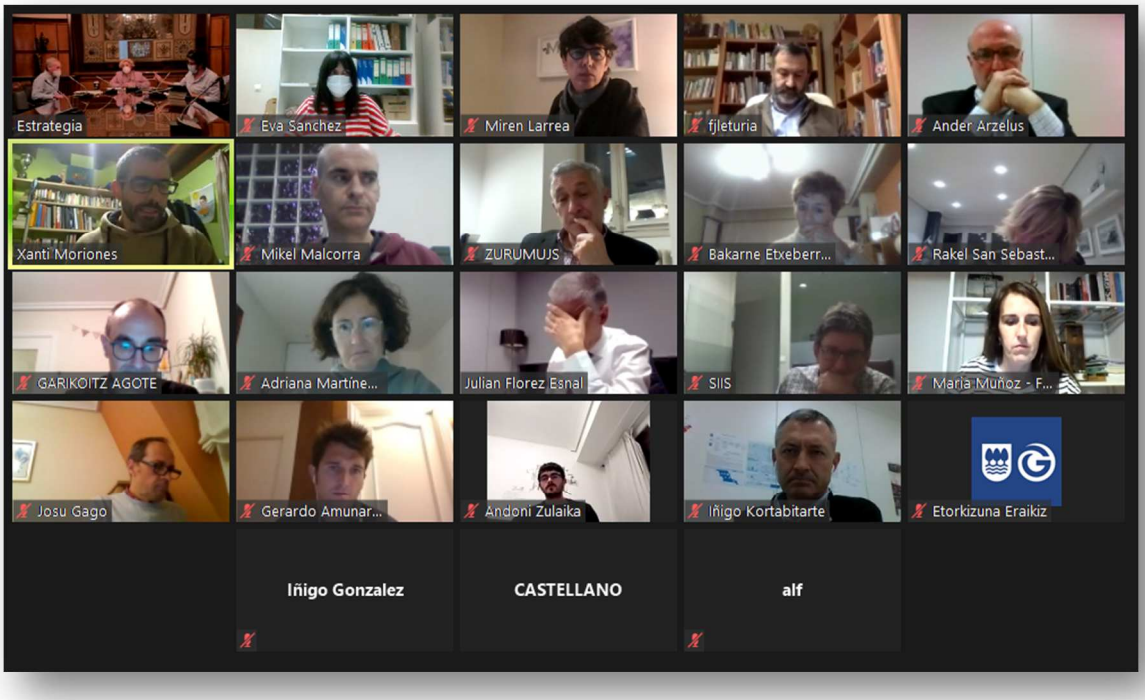
6. Dynamics of reflection and debate

DFG4 took the floor and gave a brief introduction to the Think Tank methodology. *"We always send out a questionnaire before these sessions; in the last one we asked what it means to personalize, what resources it requires and what the*

repercussions are”. He said that he would prepare a report which *"I will complete with the results of the deliberation and send out to you later”*.

He went on to explain *"the dynamics of the debate, which consists of prioritizing three social policy actions that could be implemented in 2021-2022 to promote PCC. After discussing them , each group will propose three. And with that we will have a list of potential actions to be implemented in 2021-2022 which will feed into the White Paper”*.

Following the explanation, the participants began deliberating in groups.



After the deliberation session, the participants came back to the full group and the Driver gave the floor to the spokespersons from the groups, who shared the conclusions of the deliberation process.

DFG6 said that "it has been interesting to tackle the difficult task of prioritizing, each based on his or her own personal experience". The actions that the group has identified and prioritized are as follows:

(1) "*Set up a reference figure for each case so that anyone coming in under the support of the basic or secondary Social Services has a reference person specified in their care itinerary. This could be the same person for all their needs in the system*”. (2) "*Focus more, not on inspecting how things are done or on regulations, but on implementing the care model and also on assessing it. Make some changes in the classic model of*

inspection, which focuses on regulatory aspects, and implement a model of care and assessment of results". (3) "*Work towards giving more freedom of choice to people joining the system . Allow them to choose their care home, caregiver, etc.*".

ECO16 set out the three priorities chosen by his group: (1) "*One thing that is clear is that there is no clear consensus on the definition of PCC. A definition of our own based on the literature and the territory would provide a good foundation".* (2) "*cohabitation units, training, flexibilization: in Gipuzkoa the disability model is very advanced and we could use it as a basis. The spaces, at the moment are designed for doing; we need to be able to have time to work on certain capacities; if we want to innovate and advance, we need to learn*". (3) "It could be helpful to make outcome-based assessments". In Germany, they do this with external agencies, even awarding prizes. They also believe it is important to get to know the people well, to investigate their life stories, from the *Individualised Care Plan* and from an adequate information system.

ECO9 mentioned three priority actions: (1) "*defining what PCC means. Just as there are different concepts of PCC, there are also different concepts of values and ethics*". He said there was a need to objectively assess how they are measured and what they mean and to review the standards by which they are measured. (2) "*we should consider PCC at home and not only in care homes*". (3) "*the people who are linked to measurement and assessment should also be assessed: the assessment process should be monitored. There was also talk of exchanging information silos between the health and social-health care sectors*".

ECO4 said that "to conclude, we coincided with many of the issues mentioned; one of the elements we emphasized is related to breaking down the institutional silos, the competencies of each one, and focusing care from a more comprehensive point of view. We talked about PCC in long-term care and we think that from basic social services to the institutions we could work collaboratively on freedom of choice in the long-term care model. One issue that has not been mentioned so far is the need to set up projects linked to PCC. Not just to identify them, but also to set up projects based on horizontal inter-institutional and inter-systemic collaboration".

The Deputy for Social Policies said that "*this is a good opportunity, it is essential to share a definition of what we want to achieve*". And she thinks it would be interesting for the White Paper.

The floor was thrown open to the participants.

ECO3 wanted to add that including the definition of PCC in the white paper should mean including all groups. She shared her concerns: *"there have already been pilot schemes on PCC practices. Don't we have any experience in Gipuzkoa that we could use to work faster? We run the risk of going from one pilot scheme to another and not getting anywhere*".

ECO14 said that "*we need more than one single model; we need to define, review and implement different models in different areas and in each one the systems, departments and other things are different. The one-size-fits-all model doesn't work; we have to roll out a different model for each area. I don't think a general definition will work*".

ECO7 answered, "*I think it would; if the person is at the centre, what surrounds them may vary, but the basis is the same. I think doing it area by area would entail a risk*".

ECO13 said that "*there are areas that have already developed an approach which is very close in some aspects to what we have been discussing. In others, it remains to be seen. There is no PCC in the Child Care Service or at least I have found very little. I think it is a very interesting debate. The moulds we have in Child Care are similar, but we use different terms to describe them*".

ECO7 believes that this should be clarified and consensual.

7. Assessment and end of session

The Deputy for Social Policy. "*This is great; it really has been great listening to you. I think it is worth delving into this further. Discussion and debate is essential*". She proposed "changing the script a bit and working on this in the first part of the meeting and continuing with the agenda in the second part. "*Because it is essential to be clear about the criteria we are going to use*".

There was widespread agreement.

She took her leave of them saying that it had been a pleasure, "*as always*". She spoke about the importance of filling in the assessment sheet and reminded them that the next session would be on 14th December. She undertook to draw up the map of the implementation of PCC in Gipuzkoa; "let's see if we have time".

8. Appendices

a. Working Document No. 4

DOCUMENT No. 4

Etorkizuna Eraikiz Think Tank:

EMERGING AGENDA

DATE	THEME:
26 November	People at the centre: Personalisation, rights and quality of life
14 December	From the centre to the home: how to de-institutionalise the centres and how to provide sufficient support at home
28 January	Uncomplicating matters: territorial organisation, structure of powers and inter-institutional coordination
25 February	Collaborative governance: building ecosystems (Third Sector, companies, universities and institutions and connected and participating users)
25 March	Sustainability of the System (benchmarking): trends and experiences
29 April	The Digital Platform (ecosystems) and digital transformation (organisations)
27 May	Models for managing and evaluating person-centred care and assistance
15 June	White Paper. The Futures of Social Policies

Results of the agenda-setting workshop

1. Promoting the PCC (Person-Centred Care) model

The PCC model has been seen as the "umbrella" model on which to base the future development of social policies in the Historical Territory of Gipuzkoa. The Think Tank generally believes that it is necessary to explore and promote a conceptual exploration of the PCC model and its link to Social Policies.

1.1. Develop the conceptual approach of the PCC model

The PCC model has different aspects and fields of application. This is a multidimensional model that does not offer a single perspective. To promote this development, the following axes are proposed for the development of the Think Tank's agenda.

Theme 1. Conceptualize the PCC Model and its applications to social policies.

This emerging theme refers to examining the dimensions of the PCC model further. The main question posed by the Think Tank can be phrased as follows: What does it mean to personalise care in the different areas of Social Policies when the PCC model is applied?

Theme 2. Offering a methodological guide that can be applied to social policies

This theme refers to the development of the experimental and methodological field of the PCC Model in the different areas of Social Policies. The question that has been asked can be structured as follows: How should the PCC model be managed in different areas of Social Policies?

Theme 3. Evaluating the PCC Model

This topic refers to the tools and technologies for assessment of the PCC Model. The question that has been asked in this area is: How should the PCC model be assessed and with what technologies in the different areas of Social Policies?

1.2. Fostering collaborative governance of the PCC model

Theme 1. Multidimensional collaborative governance

This theme refers to the need to integrate the two levels of governance. Vertical governance, which refers to coordination of the municipal, provincial and regional levels for development of the PCC model in social policies. Horizontal governance, which refers to sectoral coordination of policies (health system, employment, housing and social policies). The question that has been asked in this area is: How should Multidimensional Collaborative Governance be developed based on the PCC Model?

Theme 2. Encouraging greater integration of the Third Sector

This theme refers to the need to break down compartmentalisation and foster greater alignment between social organizations at a provincial level. The question that has been asked in this area is: Can the PCC model align (connect) the Third Sector and modernize it?

2. Diagnosis, volunteers and training

2.1. Diagnosing the extent to which the PCC Model has been implemented in the province of Gipuzkoa

This topic refers to the need to evaluate the degree of implementation of the PCC Model in the province of Gipuzkoa both in social services and in third-sector organisations. The question that has been asked in this area is: To what degree has the PCC Model been implemented in the province of Gipuzkoa?

2.2. Boost volunteerism to sustain the PCC model

This theme refers to the need to promote volunteering as a key dimension of the PCC model in domestic and residential care. The question that emerges from the Think Tank: How do we promote and articulate the role of volunteers in the development of the PCC model?

2.3. Promoting a PCC training strategy in Gipuzkoa

This theme refers to the need to improve and boost the level of knowledge and training for implementation of the PCC model. The question that has been asked in this area is: How should a strategy for training in the PCC model be developed?

3. Developing a Digital Platform

3.1. Promoting digitalisation in the third sector

This topic refers to the need to promote digitization in the third sector in order to improve its person-centred management models. The question that emerges from the Think Tank: How to link new information technologies to management of the PCC Model?

3.2. Development of a digital information system

This theme refers to the need to develop an information system based on digital technologies at a provincial level that will allow information to be exploited (a Data Lake), experiences and organizations to be connected, and social policies to be developed. The question that emerges from the Think Tank: What strategies can be developed to promote the creation of a Digital Platform capable of supporting development of the PCC model?

4. Sustainability of Social Policies

4.1. Making an international diagnosis on the sustainability of social policies.

This topic refers to the need to assess the sustainability of the PCC Model based on the European experience. The question that emerges from the Think Tank: What are the best innovative experiences for developing sustainable social and health care models?

4.2. Relational assessment of the costs and benefits in social services and health services

This theme refers to the need to assess health and social services in a holistic and interrelated manner. The question that emerges from the Think Tank: How do PCC-based social policies save costs for health and social services?

b. Presentation used by the Deputy for Social Policy

Work group on the Futures of the Welfare State

26 November 2020

DATE	THINK TANK AGENDA
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15 June	White Paper. The Futures of Social Policies

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White Paper: The futures of the Welfare State

The White Paper is the Think Tank's principal output. It arises from a deliberation process, with stimulus from expert opinion.

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White Paper: The futures of the Welfare State

How is this process being performed?

STEP 1: Before each meeting of the Think Tank, information is collected on the participants' view of different matters on the agenda (online form)
STEP 2: During the meetings, the agreed agenda is discussed and working documents are generated
STEP 3: These working documents, which summarise the debates, are the basis on which the White Paper is constructed.
STEP 4: An editorial team draws up the first draft of the White Paper
STEP 5: This draft version is discussed and validated in the Think Tank
STEP 6: Dissemination and discussion with provincial agents

THANK YOU

c. Presentation on COVID-19

Gipuzkoa in a

time of Covid-19

Purpose

To understand the COVID-19 crisis cycle:
emergence, management, impact and lessons learned.

Three types of activity were launched:

A. A crash programme with 50 measures for dealing with the emergency
B. A 360º study on the impact of the Covid-19 crisis
C. A reflection on the COVID-19 crisis within the framework of the Etorkizuna Eraikiz Think Tank.

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1. CRASH PROGRAMME: 3 central lines

LINE 1: ADAPTING SOCIAL INTERVENTION TO THE NEW CONTEXT

A. Recommendations and protocols
B. Organize a crisis management and coordination team
C. Develop coordination with the Health Dept
D. Develop a data monitor (continuous information)

LINE 2: COVERAGE OF NEW NEEDS

A. Open new centres to cope with the emergency
B. Purchase and distribute medical supplies
C. Reinforce inspection of care homes and individual homes

LINE 3: MONITORING

A. Design of a citizen information system
B. Design of a system for weekly monitoring of situation in care homes
C. Analysis of information and projection of the pandemic, based on data on infections.

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2. 360 assessment of the impact: OBJECTIVES AND METHODOLOGIES

GENERAL OBJECTIVE

To identify the main impacts of the COVID-19 crisis from the perspective of care home managers and organisations, users, family members and professionals.

METHODOLOGY

A. 93 online surveys of care homes and third sector organisations
B. 2 workshops with family members (care homes with and without COVID-19)
C. 1 workshop with staff
D. 18 interviews with elderly people, care home managers and policy managers

TOPICS EXPLORED

A. Emergence of the Crisis
B. Managing the Crisis
C. Impact of the crisis
D. Lessons learned

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2.1. 360 assessment of the impact: RESULTS

A. **Emergence of the Crisis**
   - Poor capacity for anticipation
   - Good capacity for reaction

B. **Managing the Crisis**
   - Lack of medical supplies
   - Weak socio-sanitary coordination (too many protocols)
   - Major level of social support during the crisis

C. **Impact of the crisis**
   - Major economic impact for care homes and organizations
   - Major organizational impact (new models of care and human resource management)
   - Major psycho-emotional impact on staff and users (stress and visitor management)
   - Major technological impact (rapid transition to digital models)

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2.2. 360 assessment of the impact: RECOMMENDATIONS

URGENT MEASURES

1. Improve the governance model
2. Provide medical supplies to care homes
3. Improve care ratios in residential homes
4. COVID-19 early track and trace policy
5. Making the visiting regime in care homes more flexible
6. Developing an adapted communication strategy

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2.2. 360 assessment of the impact: RECOMMENDATIONS

SHORT-TERM MEASURES

1. Promote the person-centred care model
2. Diversify the portfolio of domestic services
3. Draw up the protocol for emotion management
4. Develop a new code of ethics for COVID-19 management

LONG-TERM MEASURES

1. Develop strategic human capital (nursing)
2. Modernize care homes (new model)
3. Promote participation of volunteers in care
4. Create an Assessment Agency

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GIPUZKOA ETORKIZUNA ORAIN

Thank you

8

d. Presentation by Teresa Martinez

Person-Centred Care

Some thoughts and reflections on the concept and challenges in implementing the model

Teresa Martínez Rodríguez
PhD (University of Oviedo)
Gerontological psychologist
Expert in Person-Centred Care

1

Person- Centred Care.
Conceptual Aspects

Conceptual and terminological diversity

Patient-centred Care
Patient-centred Medicine
Person-centred Medicine
Person-centred care
Person dementia-centred care
People-centred Care
Person-directed Care
Personalised Care or Practice
Individualised care
Humanised Care
Client-practice centred
Person-Centred Planning
…

PCC: definitions

Person-Centred Care: an approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that carers are able to attain maximal function within a supportive working environment. People-centred care is broader than patient and person-centred care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services.

WHO, 2016

PCC: definitions

"Person-centred care means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their care, supporting their realistic health and life goals."

The American Geriatrics Society Expert Panel on PPC, 2016

PCC: definitions

"Integral and person-centred care is care that promotes the necessary conditions for achieving improvements in all aspects of the person's quality of life and well-being, based on full respect for their dignity and rights, their interests and preferences and enjoys the effective participation of that person"

Rodríguez, 2013

PCC, meanings

1) APPROACH

2) MODELS

3) INTERVENTIONS

PCC, an ethical approach

Vision of people requiring care/support

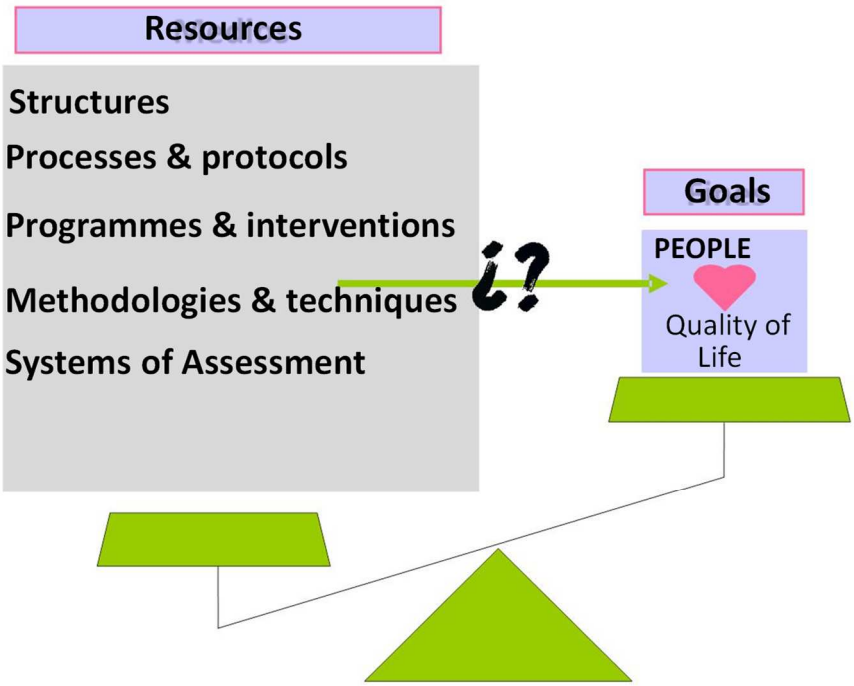
Mission and vision of the services, professional roles and guiding values of professional/organizational praxis

PCC a fad?

This is not a new approach, but it arouses great interest, mainly due to an awareness of two departures from best practise:

- A vision focusing on lack, disability or illness (i.e. on absence of value or "disvalue").

- Targets focused on services rather than people (needs/capacities/preferences).



PCC, axis of quality

Person-centred care is an **internationally recognised strategic axis for improving the quality** of health, disability care and long-term care services.

PCC in Health

Medicine

Patient-Centred Medicine (Balint, 1950)
Patient-Centred Communication Model (Stewart & Roter, 1989; Stewart et al., 1995)
Mead & Bower (2000)
International Network for Person-Centered Medicine (Mezzich, 2010)

Occupational Therapy

Canadian Occupational Performance Measure (C.A.O.T., 1991, 1997)
Model of Human Occupation (Kielhofner, 2004)

Nursing

Mc Cormack (2004)
The Senses Framework (Nolan, 2001)

Communication skills
Shared decision-making
Improved patient experience
Self-care
Accessibility of services
Prevention
Comprehensive and coordinated care

Capacities
Meaningful activities
Support from the surroundings

Biography in care
Emotional wellbeing
Interaction between person/professional/family needs

PCC-Gerontology Model

Martinez 2013, 2018

Dimension 1: Person-centred practices

1) **Knowledge of the person**
2) **Autonomy**
3) **Communication**
4) **Individualization/Independence/ Wellbeing**
5) **Privacy**

- **Practices**
- **Interaction/communication**

Dimension 2: Enabling environment

6) **Daily activity**
7) **Physical space**
8) **Family and Friends**
9) **Community**
10) **Organization**

Personalization, beyond individualized care

*"Personalised care seeks to **support each person's life project through respect for their uniqueness and exercise of their self-determination,** placing the focus on what is important to them and providing support to allow them to **keep control over their life and an active role** in their care. It is based on a deep conviction that each person should receive care that will help them to live a full life and self-managing life in which all human dimensions are included."*

Martínez, T., Salgado C., Fraile R., Sánchez, J.M., and Rodríguez, A. (2019). *Guía para activar el proyecto de vida de personas mayores que viven en entornos residenciales*. Valladolid: Gerencia de Servicios Sociales. Junta de Castilla

Self-determination, a process

- Decision making
- Motivation
- Enjoyment
- Self-knowledge
- Perception of control
- Self-regulation
- Personal realization

Self-determination: capacity and right

a) Direct exercise
Personalized opportunities and supports

b) Indirect exercise
representation from identity + well-being

What does PCC contribute to what we have been doing?

A "restored" view of individuals

Values as the starting point

Professional praxis

- Removed from the disease/deficit/lack paradigm (uniformity and paternalism)
- Consistent with explicit guiding values and highly involved

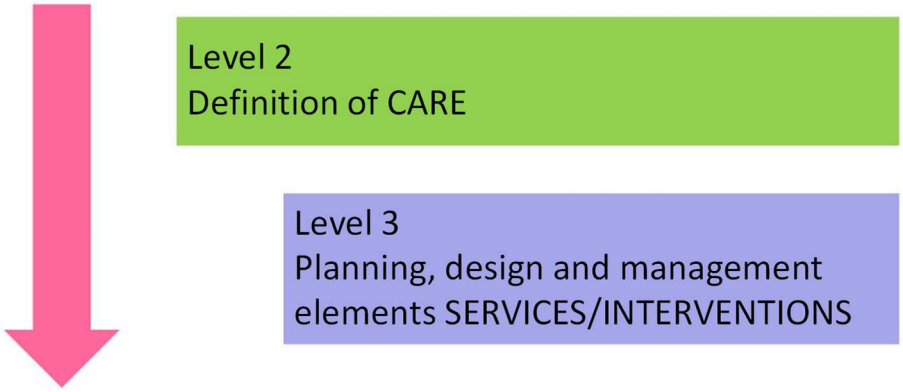
Services and organizations

- Flexible, more horizontal and open to change
- Enable people to develop

Benefits

- In people's quality of life
- Amongst staff (satisfaction, stress, burnout)
- In organizations

Contributions of PCC to the definition of models and services



2

Person-Centred Care.

Challenges in application

Misconceptions and deviations

- Paying lip-service to the idea
- Trivialising what this approach and models entail.
- Thinking that it is only relevant to those who have the capacity to make their own decisions.
- Disassociating it from the scientific evidence.
- Equating personalised care with individualised care.

- Interpreting it as the search for unlimited personal care.
- Seeing it as an approach that advocates deprofessionalizing care.

Keys for progress

Understand and accept that this is a cultural/organisational change

Changes must be progressive but planned from a global, harmonic, coherent vision, in the understanding that services are systems in which different actors and elements interact.

Keys for progress

Actions and changes at different levels and dimensions

- Organizational development in services and organizations.
- Attitudes/roles/treatment (from the perspective of recognition).
- Professional practices and methodologies.
- Flexibility in supports and interventions.
- Impact on the everyday and the important.
- Role of the actors (individuals, families, community, professionals).

Keys for progress

Assessment

We need to know the degree of effective application of this approach and its effects through application of **well-defined models**. Value-oriented but developed in components and interventions. Assessable (process and outcomes) in different care settings.

Keys for progress

- ✓ **Leadership:** belief, commitment and participation.
- ✓ **Rigour:** knowledge, training and planning.

Personalization

Objectives

- ✓ QUALITY OF LIFE
- ✓ PROTECTION OF RIGHTS
- ✓ **SUPPORT FOR SELF-DETERMINATION (life project)**
  - Meaningful Life
  - Identity
  - Wellbeing

Personalization: challenges

The starting point

Perspective and relationship based on mutual recognition among individuals.
Possessors of dignity, rights and values.

People who receive care, those who accompany them, decision-makers, the community...

Achieving enabling environments

Physical space, daily and relational activity, community, organizational environment...

Proper use of valuable methodologies

- ✓ Life history
- ✓ Co-participated Support Plans (CPPs)
- ✓ Accompanying figures (support coordinator, reference staff, support groups, assessors, etc...)

Personalization

Limits and difficulties when conflicts arise between values

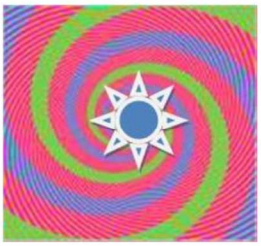
✓ Autonomy in conflict with health or safety (in relation to self and others).

- Environments that facilitate balance.
- Relaxation of rules and protocols.
- Beyond physical harm: psychosocial, emotional and moral damage.

✓ Autonomy in conflict with limited resources and fair distribution of care.

- Shared deliberation and decision-making processes.
- Planning ahead.

Eskerrik asko!
Thank you!



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e. Presentation of the Dynamic

ETORKIZUNA ERAIKIZ

What does PERSONALISATION mean in the PCC model?

26 November 2020

ETORKIZUNA ERAIKIZ

THE QUESTIONS

What does personalisation mean in different sectors?
What resources are required?
What impact does personalization have in different sectors?

ETORKIZUNA ERAIKIZ

Personalization

1. Means making it possible for the needs and preferences of a person receiving care and attention to be incorporated into the way the service, accompaniment and support they receive is designed.
2. Assessing the person's conditions, drawing up an intervention plan, accompanying the person throughout the process by adapting resources to the dynamics of their needs
3. Accompanying them in the design and development of life projects by adapting the necessary resources

ETORKIZUNA ERAIKIZ

What resources should be personalised

1. MANAGEMENT: Promoting new organizational and management models
2. INFRASTRUCTURES: Creating new physical infrastructures (architectures)
3. TECHNOLOGIES: Introducing technologies for accompaniment
4. NEW CATALOGUE: Promoting a new catalogue of services
5. FINANCING: Redefining forms of public funding
6. CULTURE: Promoting change in culture (awareness-raising, training)
7. CHANGE OF MODEL: Promoting deinstitutionalization policies that go beyond the care model

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What impacts

1. Digital: Boost to digitization for management
2. Financing: Increase and new funding models
3. Planning: New management models
4. Scalability: System-wide transfer of good practice
5. Improvements in health: individuals will have better quality of life because they can develop a life project with adapted support
6. Improvement in quality of care and support (quality and relevance)
7. Inclusion: Improves inclusion of people with care needs

ETORKIZUNA ERAIKIZ

HOW WE ARE GOING TO WORK

1. We will separate up into small groups
2. Each group will choose a spokesperson who will take note of the results of the discussion
3. We will then move to the general room to discuss potential priority actions for implementing the PCC (personalization) model, from the perspective of each group.

INSTRUCTION

Prioritise 3 (three) social policy actions that could be implemented in 2021-2022 (next two years) to promote the PCC model in the social services network of Gipuzkoa.

LET'S GET GOING