

EDITORIAL INTRODUCTION

The NHS Long Term Plan (2019) - is it person-centered?

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Introduction

The UK NHS is in a state of significant institutional distress. Key performance targets are now routinely missed. Waiting times for treatment are long and increasing. Treatment cancellation rates are high and becoming higher. Clinical workloads have markedly increased and are increasing [1–8]. There are rising levels of iatrogenic injury [9]. Scandals in the way hospitals and care homes treat patients continue to be widely reported [10–15]. Financial compensation paid to patients for harm and deaths resulting from treatment delays and clinical errors continues to spiral upwards [9, 16–18]. There is currently an estimated workforce shortfall of approximately 100,000 doctors, nursing and related staff - a figure set to rise to approximately 250,000 at, or before, 2030 [19–21]. Established clinical staff are retiring earlier and the retention of newly qualified professionals has become a major problem [19–25]. Burnout rates among clinical professionals are at an all time high [26–29]. The level of patient and carer satisfaction with the NHS is at an all time low [30–33]. Modern medicine continues to treat patients as complex biological machines, with a relative absence of compassion and empathy, and a relentless focus on factory-style patient throughputs as the highest priority [34–42]. Many commentators, observing all of the same, speak of a sustained existential anxiety within the Service [43–45]. This, then, is the background crisis against which the NHS Long Term Plan (LTP), a document of

considerable ambition, has recently been published [46,47].

What, then, is the NHS Long Term Plan [46] actually for? In general terms, the LTP aims to 'future proof' the NHS by shifting current models of care in the direction of an increased focus on disease prevention, a more functional integration of services within the community setting *via* the mechanism of new primary care networks (constituted by GPs, district nurses, social workers and other related and support staff) and a greater and more visible and viable prioritisation of cancer services, mental healthcare services, maternity services and child health. Health inequalities are an additional focus of the LTP, with an emphasis on addressing the increasing gaps in life expectancy and premature mortality throughout the UK.

These shifts in service models and care delivery systems are seen by the LTP as being dependent on the implementation of novel technologies, including a range of applications (apps), developments in artificial intelligence (AI) systems and the employment of digital healthcare technologies more generally [48]. The use of these tools is envisaged as enabling the creation of a so called 'digital first' primary care model, with expanded telehealth approaches assisting care delivery, particularly for, but not limited to, people living with frailty.

The LTP [46] looks forward a full 10 years, attempting to build pragmatically, indeed technocratically, on an earlier vision set out in 2014 within the *Five Year Forward View* [49]. But what about the status of person-

centeredness of care within the NHS, a necessary improvement in the *essential nature* of service delivery which is so radically overdue [41]? For sure, personalisation of treatment is advanced by the LTP as a key objective. But can the provisions of the LTP really increase the extent of PCC in the NHS, making therapeutic excellence of this nature an operational reality, rather than merely a purely rhetorical aspiration [41]?

In this *Editorial Introduction* to 7 (1) of the *European Journal for Person Centered Healthcare*, we briefly review the core characteristics of the LTP and reflect in outline on how the plan may - or may not - deliver on the personalisation of care that it is right to prize so highly.

The NHS Long Term Plan - a document of high ambition

Without doubt, the LTP is highly ambitious in its scope - but disappointingly limited in terms of the lack of precision with which it addresses the methodological necessities that are indispensable to its successful implementation. As such, the LTP conforms, not unexpectedly, to a very well-recognised tradition in the NHS, where stratospheric visions, characterised principally by a yawning absence of rigorous methodological guidance, are dispensed from 'on high' by government mandarins, first to their obedient NHS minions, then to the clinical workforce [50,51]. It is typically anticipated that *vision* will lead to *inspiration* and that *dynamic transformations* into workable methods, organisational change and quantitatively measurable and politically acceptable outcomes, will all result [50-55]. In reality, governmental and executive 'wish lists' - which is precisely what the LTP is in its current form - rarely generate the types of changes that are recognised as meaningful by clinicians and lauded publicly by patients. Whether the LTP will prove the exception to this rule remains to be seen.

In many ways, the NHS has been, almost from its inception, an 'ideologue's adventure playground', the football pitch of warring party politicians, colonised by managers far more concerned with service efficiency than quality [53]; meaning that mechanical efficiency targets are normatively prioritized over fundamental activities of intrinsic quality development such as, for example, person-centered care (PCC) [34-42]. But the NHS will remain the 'patient processing factory' that it is unless a 'quantum shift' in its attitudes to person-centeredness are made to occur. Such a quantum shift will require a far more developed understanding of what PCC is, and what it isn't, than currently exists at the time of writing. Without such a developed understanding, the LTP [46] will be unable to achieve the nature and extent of the personalisation that it mandates, a point to which we will return later, below.

The LTP, primary care and person-centeredness

General practice and primary care are fundamentally important in the delivery of person-centered clinical services, with the LTP documenting its commitment to delivering a "higher functioning model of general practice" [56-60]. Such a commitment is welcome if a radical increase in the person-centeredness of care provision is intended to result, an outcome that is perhaps more implicitly, than explicitly, discussed in the plan [46]. Given the monumental strain under which general practice and primary care services are operating at the current time [56-63], it is difficult to see quite how the ambitions of the LTP for primary care are to be driven into practice, especially given the workforce and funding limitations that are currently extant ([64,65] & see below).

The LTP mandates that primary care services are to 'step up' to their responsibilities, ethical and professional, as well as under the political proposals of the LTP [46], to ensure access to properly developed and educationally equipped multidisciplinary teams charged with ensuring that those patients with chronic illness can be guaranteed the nature and level of care that they need. GPs are required to team up with various 'agencies', such as district nurses, social workers and others working within primary care networks. As part of these structural changes, it is intended that access will therefore be afforded to a wide range of specialist services made available in juxtaposition to the 'basic' GP services these patients require, so that assurances can be given that extended access to a GP is guaranteed when it is judged necessary. The availability of a person-centered approach to understanding, care and treatment, is envisaged as becoming an operational reality to be recognised by all as the optimal ethical standard.

So far, so good. But the UK has an acutely worrying shortage of GPs and, it must be noted, the LTP has no direct influence on the GP workforce. Yet the GP workforce, suitably upskilled, is foundational to achieving the LTP's ideas. So, a potentially major problem exists here in terms of LTP implementation within this particular clinical and organisational setting. How the relevant contractual and other intricacies in this context are to be managed should begin to become apparent later in the current year. For sure, we should anticipate significant friction.

The LTP - major considerations

The emphasis in the LTP [46] on shifting hospital care to the community, where appropriate and safe to do so, is an entirely sensible proposition and builds on current health policy. In terms of cancer care, the need to move towards earlier diagnosis is, of course, welcome and will help to alleviate the distress of uncertainty, among much else. But earlier diagnosis, if it is to become a reality, will require significant capital investment in far more of the associated technologies of investigation, such as CT and MRI

scanners, than the UK currently possesses, a spending limited by the need within the NHS to fund its routine functions well before it can think seriously about acquiring more technologies of this type.

The commitment of the LTP [46] to a more rapid and widespread dissemination of good practice, aimed in part at reducing unwarranted variation and productivity, is likewise welcome. However, it will be important for the LTP to recognise that variations in clinical practice, while they can derive from individual practice styles which sometimes diverge eccentrically from established professional guidance, are often and perhaps normatively the result of the personalisation of care which, by its nature, affords different therapeutic approaches to different people. The LTP must be careful, then, not to labour under a misguided assumption that all variation is somehow undesirable and is therefore something to be minimised or eradicated. Such an erroneous tenet would violate one of the principal justifications of the person-centered care approach and would ill serve, indeed militate against, the personalisation mandate of the plan. Indeed, many practice variations are readily explained by case-specific contraindications, patient risk factors, patient preferences and patient choices, and are thus clinically justified by individual patient circumstances [66-70].

Accountability is another issue for the LTP [46]. The plan does not specify the agents that are to be charged with the transformational change and care improvements that the LTP demands. For sure, the LTP envisages that Sustainability and Transformation Partnerships (STPs), working in conjunction with Integrated Care Systems (ICSs), will deliver the required changes. But STPs and ICSs have no statutory authority as such and to empower them executively would require primary legislation, with all of the complexities and time constraints associated with such a process. While the LTP cites the digital health revolution, as we have noted, as an important, if not pivotal means of progressing the implementation of the plan [46,48], it says nothing in terms of how novel digital innovations will, if they are observed to be effective, be properly regulated and more widely disseminated within integrated health and social care systems.

A welcome feature of the LTP is the creation of a Chief Improvement Officer (CIO). While the specific terms of reference and powers of the CIO have not yet been, at the time of writing, fully clarified, the CIO will, through general executive oversight, play a pivotal role in the allocation of resources and the evaluation of local NHS service performance against the expectations of the LTP, assessing difficulties in progress articulated from those working at the coal face and taking the necessary actions to successfully address them. One function of the CIO is to audit the progress of the implementation of the LTP and in this he/she should be joined by patients themselves. Yet the LTP is strangely silent in terms of precisely how patients, family and professional carers, and a number of voluntary organisations, are to be involved in a meaningful, and not a tokenistic manner, in delivering the changes the plan proposes. Certainly, the UK Patients Association is less than impressed with the LTP, arguing that the plan highlights the Government's complete lack of

any strategic approach to stewarding the health and wellbeing of the nation [71].

The commitment of the LTP to address the mental health of NHS staff is especially welcome, given the current statistics on the extent of ill health and burn out within NHS employees [26-29]. A person-centered approach to care inevitably concentrates on the care of clinicians, as well as that of patients - sick clinicians are of no use to patients or themselves - and the NHS has a duty of care to all who work within it as well as those who access its services [72-74]. The accumulating evidence that an inverse correlation exists between the extent of person-centeredness of a clinician and his/her susceptibility to burn out, is of certain relevance to the aspirations of the LTP in this regard [75-82].

In the absence of definitive methodologies to underpin a definitive strategy, should pilot studies be constructed and undertaken to directly enable the formulation of mapping exercises to take the implementation of the LTP forward? We answer in the affirmative - this is, surely, a sensible thing to do. However, the LTP withdraws from proposing pilot studies of this nature, circumventing such a sensible approach to moving forward in favour of a less rational, wholesale rush to policy implementation. The proverb 'more haste, less speed' is of relevance here - short term gains can result in longer term political losses.

Despite the aspiration of the LTP for more personalisation of services, no comprehensive training programmes for clinicians in how to increase the person-centeredness of the care they provide have yet been identified and commissioned by government or local agencies. When commencing the educative function of the LTP, its architects, together with NHS Trusts and commissioning authorities, should note that novel training programmes for person-centered care need not necessarily be designed *de novo*, as notable examples already exist. The recently developed Master's degree programme in person-centred health and social care (with its diploma, certificate and individual module options), pioneered by the European Institute for Person Centred Health and Social Care at the University of West London (UWL) UK, in partnership with the European Society for Person Centered Healthcare (ESPCH), functions as a prominent example in this context [83,84]. Moreover, the UWL-ESPCH partnership has indicated its interest in co-working with government and individual NHS Trusts, to develop bespoke short training courses that are tailored to the specific needs of individual organisations, but with direct reference to the broader strategic imperatives set out within the LTP [46].

The LTP and the question of resource and workforce

If the LTP is to be successful in its general implementation of all of the above and, importantly, to satisfy its own mandate to increase the personalisation of care, then it is axiomatic that the adequate resourcing of the LTP is, and remains, of fundamental importance. It is far from clear,

however, that the extent of the plan's ambitions will be matched with the resources necessary to realise them, given that the additional monies allocated in principle to the NHS by 2023/2024 are set to be consumed by current operational necessities - so called 'everyday firefighting'. Moreover, the current resource constraints which directly threaten the successful implementation of the LTP include the impacts of the incremental cuts in public health funding - in the 'core public health grant'. These particular resource reductions collectively constitute a 25% reduction in public health funding per person during the period 2015/2016 - 2018/2019, with additional planned reductions in expenditure for 2019/2020 seeing a further cut of approximately £240M [44,47,85].

With the long term, chronic, socially complex illnesses specifically in mind (see below), given their clinical complexities and financial costs, and the projected increases in their incidence and prevalence, there is therefore a real danger that the £20.5 billion allocated for investment in the NHS by 2023/2024 will be consumed as a function of the inexorably growing ordinary demands of NHS frontline services and that comparatively little may be left to fund the ideals of the LTP [44,47,85,86]. Whether the 1.1% productivity target anticipated by the LTP will be met is not yet clear. Given the current demands on the NHS, and those that are fully anticipated, such efficiency gains appear unlikely at the time of writing.

If raw financial resource for the LTP, or the lack of it, is of major concern, which it is, then so too is the scale of the clinical and administrative staffing that is required to maintain the routine functions of the NHS, as well as the objectives of the LTP, at a time when acute staff shortages represent one of the biggest current challenges to the NHS. The current scale of staff vacancy in the NHS, calculated to be of the order of 100,000 staff, is set to increase inexorably, as we have cited above, with the deficit projected to reach 250,000 at or within ten years. Staff recruitment and training therefore represents an urgent priority, though little action appears set to address this deficit until the provisions of the 2019 Spending Review are known much later in the current year. The LTP is far from naive on the likely effects of the clinical workforce deficit and recognises their gravity as a major barrier to its operational implementation. Time, then, perhaps, if the LTP is to succeed, for the responsible authorities to engage far more enthusiastically and urgently in workforce planning, staff training, development and retention - a decade of neglect of these responsibilities will almost certainly require a decade of repair and recovery [19-25,46].

Considered collectively, these economic conditions and acute workforce shortages, do not augur well for the smoothest of operational implementations of the LTP that is effective enough - in full, or in part - to generate at least some measurable impacts on individual person-centered care and general population health.

The LTP - and where its personalisation mandate should primarily 'take aim'

Given that the LTP represents a core strategy to "future proof" the NHS for the next decade, one of its surprising deficiencies is surely its failure to advance an *explicit* national strategy to address the current epidemic of chronic, long term, socially complex illnesses. After all, these conditions are among the greatest challenges that face the NHS - and indeed health systems worldwide - causing 73% of current global mortality. It is estimated that in the UK, for example, one in four adults in England are currently living with two or more health conditions, equating to approximately 14.2 million people, with essentially 50% of all primary and secondary care consultations and admissions associated with multimorbid illness [87-96].

These statistics will not remain static. On the contrary, the number of patients and their families living with multimorbidity (and thus with all of the sequelae that form the broader state of illness arising from the primary biological dysfunction(s)), is projected to increase significantly over the 10-year course of the LTP. And while the LTP is right to acknowledge that the population of the UK is, as elsewhere, ageing, with the incidence and prevalence of multimorbidity (and general frailty) increasing in parallel, it is equally important to remember that co- and multimorbid illness is hardly restricted to the elderly. On the contrary, a substantial number of individuals with multimorbidity are beneath the age of 65, with the extent of illness positively correlated with social deprivation [97-99].

If the LTP is as determined to increase the personalisation of care in the NHS as it says it is, then the greatly improved care of the long-term illnesses is precisely where its *primary* focus should fall. And when we speak of these illnesses we do not speak only of the high volume and most 'epidemiologically important' classifications, such as cardiovascular disease, respiratory disease, the cancers, diabetes, *etc.*, but also of the conditions that cause similar, if not greater, human distress and often existential suffering. Here, the neurodegenerative diseases such as Parkinson's Disease (PD), Motor Neurone Disease (MND/ALS) and Multiple Sclerosis (MS) function as immediate exemplars, as do, in equal illustration, HIV and HIV-HCV co-infection, a range of dermatological, musculoskeletal, joint and inflammatory conditions, the rare diseases and also the so called 'medically unexplained' illnesses. Neither must or can we omit a full consideration of those who labour under chronic mental ill health and dementia and those who live with the intellectual disabilities. Likewise, we think also of those who suffer the multiple personal and societal effects of alcohol, drug or other addictions [39].

Why should the LTP focus *primarily* on conditions of these types when addressing the personalisation of services and not on, for example, more acute illness(es) in the first instance? The answer lies in the specific *nature* of the chronic illnesses and thus in the specific nature of the care

that they require. Specific changes in the nature and level of their care have therefore become urgently necessary. Such urgency is required precisely because the current models of care for these patients is suboptimal at least and, as many commentators observe, is in reality not fit for purpose at all; in fact, the typical deficits in the care of these patients is, from a professional and human perspective, ethically unsustainable - which means nothing more than that the *status quo* cannot be sustained. What, then, is the nature of these conditions that make them a first order concern of modern health systems?

A pre-eminent characteristic of the chronic illnesses is that patients who manifest the underlying organic pathologies develop symptoms way beyond the somatic which are typically psychological, emotional, spiritual and existential in their nature. Moreover, such effects are not confined to the individual, but by their nature 'radiate outwards', as it were, to spouses, friends, the family, and to Society at large, causing social and fiscal impacts. When these patients present to health services, seeking assistance and asking for help, they do not present as "a collection of organ systems, one or more of which may be dysfunctional requiring scientifically indicated technical and pharmacological interventions, but rather as integral human beings with narratives, values, preferences, psychology and emotionality, cultural situation, spiritual and existential concerns, possible difficulties with sexual, relational, social and work functioning, possible alcohol and substance abuses and addictions, worries, anxieties, fears, hopes and ambitions - and more" [37-42].

It therefore stands to reason that attending only to the biological basis of the underlying pathologies in these cases, through immediate amelioration or temporary attenuation using purely bioscientific knowledge, would be an approach potentially rich in technical skill, but, as is often the case, one that is poor in humanity, representing a wholly reductive approach that shortchanges the patient and does little to stabilise, or increase, the patient's quality of life. When, therefore, one looks at the current model of care for people living with chronic illness, in contradistinction to the great value of 'stepped up' models of care which would consider the patient as the whole person that he or she is, it is clear that the gap between such approaches must be narrowed - and surely forthwith. How, then, to progress such important change?

We have previously argued that achieving a higher order of care, which is to say an authentically person-centered model, will require the coordinated action of a variety of stakeholders, including politicians, policymakers, researchers and educators, multidisciplinary clinical teams, social services professionals, family carers, professional carers, chaplains, NHS managers and transformational leaders, patient advocacy groups, media professionals and the pharmaceutical and healthcare technology industries [39,41,100]. These stakeholders, we argued, constituting what has been described as the 'healthcare ecosystem', and acting together in accordance with a joined up National Strategy, are vital to the realisation of PCC. Their role is to promote, and become actively involved in pushing forward, an increasing public awareness of the value of person-centered care, the need

for the person-centered education of clinical professionals (at both undergraduate and postgraduate levels) and the necessity to develop new services and reconfigure existing ones according to the person-centered approach. Such advocacies have the very real potential, we said [100], to drive important and long overdue changes in the way clinical services are delivered to people living with long term chronic illnesses in particular [39,41,100].

In a very real sense, the LTP has taken our previously published principles on board *in toto* and the astute reader will easily see how they have been laid out within the broader focus on the plan, in a way which subsumes our proposals for an increased person-centeredness of care within a broader organisational reconfiguration of services for the NHS as a whole. Indeed, even the National Director for Person Centered Healthcare we recommended as an essential co-ordinator of a national strategy for person-centered care [100] may be seen as assimilated within the overall role of the LTP's Chief Improvement Officer [46], whose function, as articulated by the LTP, we have already touched on above.

Discussion

We have previously posited, and do so here again, that person-centered care, by seeking to apply ongoing technological and biomedical progress within a radically humanistic framework of understanding and delivery, represents the most compassionate and empathetic, yet the most solidly 'fit for purpose' model of care currently conceived [34-42, 100]. If, in the 20th Century, the biomedical model reigned supreme, causing exponential and extraordinary increases in individual and population health, then in 'The 21st Century of the Patient' [101], we have witnessed a growing insistence that medicine and healthcare should begin remembering in earnest all of those things that have been forgotten in over a century of such empiricism. In agreeing that a 'science only medicine' is a fundamentally incomplete account of the care of the sick, and at the same time acknowledging that a 'humanities only medicine' would be positively dangerous, PCC advocates a formulaic, but nevertheless truth-laden descriptor of good care: that good care is constituted by a 'science *plus*' philosophy, where the 'plus' is all about the contextualization of objective science within an overt humanism [34-42, 100].

In consequence of the above, the 'job', as it were, of PCC, is to say 'no' to a false dichotomy between the so called *science* and *art* of medicine and healthcare, where these core components of clinical practice are held apart as polar opposites - and 'yes' to their functional integration in the service of the sick [102,103]. In so doing, PCC acts to raise the bar of clinical professionalism from the lower common denominator of legally acceptable, basic technoscientific competence, to the higher numerator of person-centered excellence [34-42,100]. Indeed, it has been said, albeit controversially in this very context, that the former can only be understood as 'second, or even third rate' care, while the latter is incontrovertibly first rate and

pre-eminent in its nature. We might add, here, with equal controversy, that the provision of second or third rate care is fine - *for second or third raters*.

When considering such high ethical ideals, and noting the criticism of those who fail to adhere to them as 'second or third rate', PCC can easily be described as intuitively the 'right' thing to do. But there is a great deal more than noble 'intuition', 'aspiration' and 'high ethical ideals' to be considered here. There is, in fact, empirical scientific evidence, as well as health economic arguments, to be taken into full account, as our discourse moves inexorably forward. Insofar as the scientific evidence for PCC is concerned, there is a rapidly accumulating empirical research base which indicates that PCC can mediate an increased patient adherence to both simple and complex medication regimens, that it decreases the frequency of primary and secondary care clinical consultations, that it decreases the frequency of disease and illness exacerbations, that it decreases hospitalization rates and length of hospital stay, that it results in increased patient and clinician satisfaction rates, that it negatively correlates with clinician burn out rates and that it acts to reduce malpractice claims [39,41]. In terms of health economic considerations, economic studies of PCH are now necessary - and have commenced - in order to illustrate how PCC-mediated changes in health services utilization and delivery can reduce, contain, or limit the extent of increases in health and social care costs.

For sure, PCC is here to stay. It is far from an abstract concept, or a 'sentimental' preoccupation with the history of medicine. Neither is it a form of 'virtue signalling', with an associated moral posturing. Rather, it is a new - indeed an entirely radical - proposition, which rests firmly on a rapidly developing ethical justification, a scientific evidence-based justification and an economic justification [41]. For our part, we hope that the LTP [46] will recognise the same and that the methodological developments that will be central to the success of the LTP will take into full and functional account the ESPCH arguments on the nature of personalisation necessary within modern health systems, and therefore the NHS, fully into account.

Conclusion

Readers who study the NHS Long Term Plan [46] in search of an explicit strategy to drive the LTP into operational action will not find one. In consequence, as a function of the working up at local level of insufficiently guided 'hands on' attempts at action, it is likely that various degrees of confusion, divergences of approaches, and thus a variability of outcomes, will all inevitably result. However, little progress of any type is to be expected until the acute NHS staff shortages are intelligently addressed through proper workforce planning, investment, recruitment and retention, detailed implementation methodologies developed, training packages commissioned and introduced, and sufficient monies allocated to the plan from general funding increases, as well as from those which may or may not derive from efficiency savings. The

UK government's policy failures and lack of executive action in these areas, further complicated by substantial funding deficits in public health and preventive services, when considered collectively, do not augur well for the achievement of early successes in the imbedding of the LTP which would, by their nature, help to galvanise professional enthusiasm and guarantee ongoing support for the plan's multiple ambitions.

The translation of the LTP into meaningful and measurable patient benefits, as part of which an increase in the person-centeredness of care is pivotal, will be a long journey that encounters many difficulties, some of which may well prove intractable in their nature. Within a complex adaptive system such as the NHS, the execution of the plan is likely to take a great deal longer than the decade envisaged and it would therefore be wise for the architects of the LTP to revise their performance standards within the next year in a frank recognition of the same.

We assert that if the LTP understands the personalisation of care in the way we have described and referenced it above, as a 'new way of thinking and doing' in clinical practice, and if it strives to implement these principles in large measure, if not indeed in their entirety, then major improvements in service quality, patient satisfaction and value-based clinical outcomes are, probabilistically, likely to result. Certainly, it is on the basis of these concepts that the European Society for Person Centered Healthcare, together with the newly established European Institute for Person Centred Health and Social Care at the University of West London UK, are formulating, in partnership, a new range of actionable methodologies aimed at providing a raft of non-prescriptive key guidance documents for clinicians, with the aim of assisting them in increasing the person-centeredness of the care that they provide - both as individual clinicians, and within the broader context of the multidisciplinary team and organisational system in which they are employed, more broadly.

It is our fervent hope that the LTP, as it is rolled out and becomes imbedded within day-to-day NHS practice, proves itself capable of delivering, for those who suffer, a desperately needed set of changes. By which we mean a shift away from our current factory-style, assembly-line type system of patient processing, as if patients were statistical units or health record ID digits, towards a model of care that returns to the Service an ambition to treat patients as persons - and attends to them accordingly. If the British NHS wishes to remain the envy of the world, as historically it always has been, then this, surely, would represent *progress* - in name, direction and, above all, outcome.

Note to Readers

Those colleagues who hold interest in the work of the European Society for Person Centered Healthcare and who wish to become involved in, and contribute actively to, the Society's work, are invited to contact Professor Andrew Miles, ESPCH Senior Vice President and Secretary General, *via* e-mail (andrew.miles@pchealthcare.org.uk)

Announcement

The Sixth Annual Conference and Awards Ceremony of the European Society for Person Centered Healthcare (ESPCH6) will take place in London UK on Thursday 5th and Friday 6th December 2019. Further details are available from Professor Andrew Miles, ESPCH Senior Vice President and Secretary General, via e-mail (andrew.miles@pchealthcare.org.uk).

Acknowledgements and Conflicts of Interest

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