

An Evaluation of Person-Centred Care and Partnership Working in Health and Social Care

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Table of Contents

1. Introduction	1
2. Defining Person-Centred Care: Benefits and Limitations	2
3. Theoretical Foundations: The Gothenburg Model of Person-Centred Care	3
4. Ethical Fundamentals in Health and Social Care	3
5. Evaluating Partnership Working	4
6. Partnership Working in Practice: The Washwood Heath Neighbourhood Hub	4
7. Policy and Legislative Context	5
8. Recommendations for Future Development	6
9. Conclusion	7
10. Reference List	7

1. Introduction

Person-centred care (PCC) and partnership working (PW) are key priorities in UK health and social care policy, as individuals with complex needs often require coordinated support across multiple services (Glasby, 2017).

However, practical barriers including workforce shortages, limited funding and historically fragmented services often restrict the effective implementation of PCC and PW, highlighting a persistent gap between policy goals and everyday practice.

This approach shifts away from fragmented care models by placing the individual's preferences, experiences and strengths at the heart of decision-making. While the approach is designed to

enhance autonomy and personalised support, evidence suggests that in many settings, disease-focused practices continue and individuals with low health literacy or complex social needs often have limited influence over care decisions. The Health and Care Act 2022 supports this shift through the introduction of Integrated Care Systems (ICSs) which promote collaboration between NHS organisations, local authorities and other partners. This report evaluates PCC and PW critically, drawing on academic literature, policy and legislation. It examines the benefits and limitations of PCC, analyses the Gothenburg model, explores ethical principles, evaluates partnership working, reviews a practical example in Birmingham and discusses relevant legislation before presenting recommendations for future development.

2. Defining Person-Centred Care: Benefits and Limitations

PCC represents a move from traditional disease-focused models towards one that prioritises the individual's values, preferences and aspirations in care. Unlike patient-centred care which can sometimes maintain professional control, PCC recognises individuals as equal partners with unique strengths (The Health Foundation, 2016). Four core principles underpin PCC: treating individuals with dignity, compassion, and respect, providing coordinated care, offering personalised support and helping people develop strengths to promote independence (The Health Foundation, 2016).

2.1 Benefits of Person-Centred Care

Research increasingly supports the benefits of PCC. A systematic review of 44 studies (1986-2021), mainly involving patients over 60 with long-term conditions, found PCC was often cost-effective or cost-saving with 26 studies reporting better outcomes at lower costs compared with usual care (Vassiliev et al., 2025). Clinically, PCC improves patient confidence in managing conditions as shown by Gothenburg Centre research (University of Gothenburg Centre for Person-Centred Care, 2025). In chronic wound care, PCC addresses not only the clinical problem but also the individual's broader needs and expectations which may enhance adherence and improve healing outcomes (Panfil et al., 2025).

2.2 Limitations and Challenges

Despite its benefits, PCC faces practical challenges. Health services remain focused on acute, short-term care, often limiting patient involvement through inconsistent communication and persistent disease-focused attitudes (Panfil et al., 2025). Equity remains a major concern, 19 of 32 economic evaluations excluded patients based on disability, language or ethnicity and none assessed whether benefits were distributed fairly (Geethani et al., 2025). This raises justice issues as PCC risks favouring those easiest to engage, potentially reinforcing existing health inequalities rather than reducing them.

3. Theoretical Foundations: The Gothenburg Model of Person-Centred Care

The Gothenburg model, developed at the University of Gothenburg Centre for Person-Centred Care (GPCC), provides a clear framework for applying PCC. Established in 2010 as Europe's first interdisciplinary PCC research centre, the GPCC has produced strong evidence from trials involving over 1,000 patients (University of Gothenburg Centre for Person-Centred Care, 2025).

Based on Paul Ricoeur's "little ethics", "aiming for the good life, with and for others in just institutions", the model frames PCC as an ethical practice, treating patients as equal partners. It operationalises partnership through three stages: initiating collaboration via active listening, jointly creating a health plan integrating patient narrative and clinical data and safeguarding through ongoing support (University of Gothenburg Centre for Person-Centred Care, 2025).

A limitation is its assumption of equal partnership as professionals hold institutional power and resources. Patients with low health literacy or socioeconomic challenges may struggle to engage fully, making staff skills in addressing power imbalances essential (Sørensen et al., 2025).

Strengths include adaptability across settings, including remote care. The Gothenburg model's structured three-stage approach differs from relational frameworks like the Senses Framework (Nolan et al., 2006) and Kitwood's dementia care model (1997), which emphasise emotional reciprocity. While Gothenburg ensures consistency, relational models may better reflect the dynamic needs of patients especially in dementia care, showing PCC effectiveness depends on context.

4. Ethical Fundamentals in Health and Social Care

Beauchamp and Childress's four principles (2019) dominate health and social care ethics, yet their application in PCC reveals fundamental limitations that the framework itself cannot resolve.

Autonomy respects patients right to self-determination. Tensions can arise when individual choices conflict with welfare state objectives. Resolving these requires discussion and reasoned deliberation, aligning closely with PCC by promoting shared decision-making rather than professionals acting unilaterally (Sørensen et al., 2025).

Beneficence is the duty to act for patient's wellbeing. In PCC, this extends beyond clinical care to supporting personal goals, ensuring care truly centres on the individual.

Non-maleficence requires avoiding harm. Ethical dilemmas arise if patients refuse care, forcing interventions can cause distress and undermine trust, potentially conflicting with legal protections such as Article 8 of the Human Rights Act 1998. PCC demands balancing guidance with respect for choice.

Justice ensures fair, equitable treatment. With growing focus on social determinants of health, frameworks like Daniel's accountability for reasonableness (A4R) help organisations discuss fairness systematically (Taylor et al., 2025).

These principles highlight tensions in PCC, autonomy vs beneficence, justice vs resource limits. Professional standards (NMC, 2020) guide practice but cannot fully resolve conflicts. Partnership models mitigate this by fostering shared deliberation and collaboration.

5. Evaluating Partnership Working

Partnership working involves organisations collaborating to combine expertise, resources and shared decision-making to improve service quality and efficiency (Glasby, 2017). Although interagency working has been central to health and social care policy since 1997, Dickinson and Glasby (2020) argue that its effectiveness remains insufficiently evaluated.

5.1 Benefits and Challenges

Effective partnership working offers multiple benefits. At a system level, it reduces fragmentation and enables coordinated support for people with complex needs (Glasby, 2017). Partnerships can improve experiences and outcomes for service users, avoiding repeated storytelling to multiple practitioners.

However, evaluation remains a major challenge. Many initiatives are not designed with assessment in mind and evaluations often occur retrospectively (Dickinson and Glasby, 2020). NHS merger studies from 1998-99 show delays in patient improvements of at least 18 months, unmet savings and no gains in staff recruitment or retention (Glasby and Dickinson, 2014).

Charles (2022) highlights how COVID-19 further disrupted services, constraining planned innovations and affecting health equity despite positive collaboration.

Dickinson and Glasby (2020) highlight that evaluation outcomes depend on who conducts them. Partnerships co-produced with service users tend to succeed (Dickinson and Glasby, 2020), whereas purely administrative assessments often report failure. This reveals a key limitation, measuring 'success' using narrow metrics, such as reduced admissions, can overlook important outcomes like trust-building and improved service user experience, both central to effective PCC and genuine partnership working.

6. Partnership Working in Practice: The Washwood Heath Neighbourhood Hub

The Washwood Heath Health and Wellbeing Centre in East Birmingham is a great example of partnership working within an Integrated Care System. Established as a locality hub, it offers

integrated, community-based care through multidisciplinary teams, reflecting NHS England's neighbourhood health approach (NHS England, 2025).

6.1 Service Integration and Impact

The East Birmingham Hub operates within the Birmingham and Solihull Integrated Care System Community Care Collaborative, linking primary care, community services, mental and physical health services, social care, acute services and voluntary sector partners (NHS England, 2025). Six locality hubs across the region form a coordinated care network.

The hub provides integrated services including urgent and diagnostic care, district nursing and intermediate care (NHS England, 2025). Co-location enables collaboration with GPs, care homes and hospitals while same-day urgent appointments help reduce admissions and repeat contacts.

Evaluation data from December 2023 to December 2024 shows significant impact: GP appointments fell by 47%, emergency department attendances by 5%, inpatient spells by 22% and hospital stays shortened by 1.8 days. Outpatient visits decreased by 41%, while community physical health contacts dropped by 49%. In contrast, mental health contacts increased by 148%, suggesting integrated PCC can improve outcomes, reduce acute demand and address previously unmet mental health needs (NHS England, 2025).

7. Policy and Legislative Context

Legislation plays an important role in supporting person-centred care (PCC) and partnership working. The Care Act 2014 promotes PCC through six key principles, including wellbeing and personal budgets. However, implementation varies significantly across services (Glasby, 2017). This highlights a key limitation of legislation, while laws like the Health and Care Act 2022 mandate structural changes (e.g., ICSs), they cannot enforce the cultural shift PCC requires. As Panfil et al. (2025) note, disease-focused practices persist, suggesting legislation without workforce investment may produce 'policy-practice decoupling' where formal compliance masks continued traditional care.

The Health and Care Act 2022 introduced Integrated Care Systems (ICSs) across England, creating a legal duty for NHS bodies, local authorities and partners to collaborate in service planning and delivery. Although the Act aims to improve outcomes, reduce inequalities and increase efficiency, integration across ICSs remains uneven with some regions experiencing delays and unclear accountability (Dickinson and Glasby, 2020). This raises questions about whether legislation alone can achieve the cultural change required.

Other legal frameworks also support PCC. The Human Rights Act 1998 requires public bodies to respect Convention rights, including Article 8 (respect for private and family life) and Article 3

(freedom from inhuman or degrading treatment), both closely linked to involvement and dignity in care. The Mental Capacity Act 2005 provides a framework for decision-making that supports PCC, although inconsistent capacity assessments can limit participation for some vulnerable groups (Sørensen et al., 2025). Similarly, the Equality Act 2010 promotes inclusive care by prohibiting discrimination and requiring reasonable adjustments.

8. Recommendations for Future Development

Based on the evidence presented, the following recommendations are proposed.

Recommendation 1: PCC outcome measurement should include equity stratification, as economic evaluations often exclude vulnerable groups (Geethani et al., 2025). National bodies should therefore require outcomes to be reported by protected characteristics to identify inequalities in PCC implementation. However, this may increase pressure on already stretched services and without dedicated funding for data collection could unintentionally divert resources from direct care.

Recommendation 2: Organisations should invest in long-term cultural change programmes as disease-focused attitudes require sustained effort and protected time for staff development (Panfil et al., 2025). However, cultural change is difficult to measure and may become a performative 'box-ticking' exercise if not supported by genuine leadership commitment and staff engagement.

Recommendation 3: Partnerships should adopt co-produced evaluation frameworks, as evaluating initiatives only after implementation limits learning (Leathard, 2021). ICSs should therefore agree on evaluation methods, indicators and timelines collaboratively from the start. However, genuine co-production requires time, resources and skills that may not exist in all partnerships, meaning it risks becoming tokenistic if these capacity gaps are not addressed.

Recommendation 4: Neighbourhood hub models should be expanded with protected funding as evidence from the Washwood Heath hub shows improved outcomes (NHS England, 2025). Policymakers should therefore support wider development of locality hubs. However, rapid expansion may reduce quality and responsiveness to local needs if funding is linked to rigid national targets. Uneven rollout could also create postcode inequalities in access to services.

Recommendation 5: Ethical governance should be strengthened as healthcare organisations take on greater social care responsibilities (Taylor et al., 2025). ICSs could establish ethics committees that include service user representation to guide decision-making. However, these committees may become disconnected from frontline practice, meaning their recommendations could be difficult to implement. Their effectiveness therefore depends on having real influence over organisational decisions.

9. Conclusion

This report has examined person-centred care and partnership working in UK health and social care, showing how they are connected and support each other. Evidence suggests that PCC, when used effectively can improve outcomes and reduce costs, although more attention is needed on equity. The Gothenburg model offers a clear framework for partnership through initiation, working and safeguarding stages. Both approaches rely on ethical practice, with the four principles of biomedical ethics guiding decisions in complex situations. The Washwood Heath hub shows how partnership working can make a real difference, improving service use. Legislative frameworks also support integrated, person-centred care. To fully realise these benefits, ongoing cultural change, careful monitoring of equity, co-produced evaluation and expansion of neighbourhood hubs are essential. This report is limited by its reliance on published evaluations, which may present more positive outcomes than routine practice reflects.

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