

Principles of Health and Social Care Practice

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Introduction

Person-centred care (PCC) and partnership working (PW) are the key developments influencing the present-day health and social care practice in the UK. PCC is concerned with the knowledge of individuals as the owner of his or her life experience with emphasis on the autonomy, respect, choice and dignity within the care settings. Meanwhile, PW proposes the need of the collaboration between the professionals with the service users, families and other organisations in order to offer safe, effective and holistic care. Combination models of care incorporating both PCC and PW have become a matter of increased interest as the pressure on the health and social care set-ups, such as increased demand, staffing shortages, and the demographic trend changes, continues to increase (Hallgren et al., 2021).

The present report is a critical evaluation of both PCC and PW, and analysis of their merits, drawbacks, ethical theories, and practice. PCC has a particular theory that is examined to provide a theoretical background to the study on the person-centred practice. The partnership working concept is also checked in terms of the service quality, communication and results. Finally, the report suggests how the issue of PCC and partnering in health and social care in UK could be enhanced.

2. Person-Centred Care

2.1 Definition of PCC

The model is person-centred care in which every decision made on care is centred on the individual in the light of his or her profiling of preferences, values, needs and circumstances (Alderwick et al., 2021). Rather than considering the service user a passive receiver of care, PCC considers him/her an active partner, and whose opinions and experiences characterize the assessment, planning, delivery, and evaluation. PCC involves listening, joint decision-making, empathy, holistic care and putting into consideration autonomy. PCC has a strong presence in the policy of UK and it is incorporated in the professional standard, which articulates their topicality in the context of safe, quality, and experience improvement in health and social care. It is used in a wide field of application such as in the hospitals, nursing home, mental clinics and community services. Lastly, PCC is focused on raising the degree of satisfaction between the service and the users, encourage autonomy, encourage health as well as building trustful relations between the specialists and people.

2.2 Benefits of PCC

The benefits of PCC are inclusive among service users, staff and organisations. PCC is also effective in assisting service users to increase their well being and satisfaction in that care is

provided according to their tastes and culture, as well as individual goals. When individuals feel that they are listened to and respected, they feel assured to become more trusting professionals and they will be involved in care plans (Tetzlaff et al., 2023). PCC also enables a higher degree of safety as personalised communication enables to discover the concerns earlier and reduces the possibilities of misunderstanding, the threat of negligence.

PCC clinically and organisationally leads to significantly a greater utilisation of resources in the form of the enhanced care planning, complaints and continuation of care. Self-management by empowering people to participate in decisions making improves self-management and reduced unnecessary hospitalization and better outcomes particularly in matters regarding long-term condition people. PCC facilitates reflective practice, caring and better relationships with service users and job satisfaction and productivity to employees.

Overall, PCC enhances the quality of care due to its holistic, coordinated, and responsive essence with regard to dynamic needs.

2.3 Limitations of PCC

Despite the advantages, PCC has several flaws. Time pressure is also identified in busy surroundings or in a situation where employees are overworked as one of the greatest problems as they have minimal time to find appropriate ways of meaningful communication. The fact of individualizing the care plans can also be lowered by a large caseload and this causes a discrepancy between the policy expectations and actual delivery. In other, the organisational designs assign efficiency high priorities when compared to a personalised interaction, a characteristic that inhibits the implementation of PCC (Schmüdderich et al., 2024).

The other weakness is linked with communication barriers. Cognitively impaired offenders, mentally ill ones, or those with poor communication skills may find it difficult to express their likes and preferences, may require the use of additional equipment, or the assistance of an expert. PCC also may lead to tensions in which a professional judgement contradicts the desires of the service user in specific instances of cases of safety. It may also become even harder to comprehend preferences due to cross-cultural discrepancies that may arise between employees and patients.

Moreover, PCC requires the well-trained professional workforce on the topic of communication-empathy-shared-decision making. Without this then PCC may not be applied in a manner that is thorough or uniform. These limitations create the need to sustain the system, staff adequately and lead it efficiently.

2.4 Theory Underpinning PCC

Among the schools that can offer an appropriate foundation of PCC, it should be mentioned the Model of Personhood by Kitwood as this theory is quite popular in dementia care but can be applied to any practice environment (Kitwood, 2022). On the one hand, such identity is related to cognitive possibility, on the other hand, relationships and social interactions, Kitwood thought that both of them along with emotional experience make the identity of a person. His model also gives so much emphasis to respect, trust, individuality and positive interactions that promotes value of the person as a human being.

The necessity to live in comfort, attachment, inclusion, identity and occupation are some of the significant aspects of the theory by Kitwood. Kitwood indicated that negative responses, such as regulation of behaviour, ignoring the person or the absence of attending to feelings can constitute the negative effects on personhood whereas the positive responses turn around the well-being and dignity. This is extremely accommodating to the PCC values because it lays stress on empathy, validation, and comprehensive understanding of the individual.

Practicability of this theory will assist the professionals put their eyes off the symptoms or task and focus on meaningful engagement. This aids in comprehending the user of the service in a more effective manner so that their experiences can be put into consideration leading to more personalized care. This model by Kitwood is also relevant because it recognizes relevance of emotional and relational aspects of care as a theoretical foundation of PCC provision to different health and social care settings (Lichtwarck, 2025).

3. Ethical Fundamentals in Health and Social Care

Ethics is the greatest issue in defining agency to carry out PCC and partnership working towards dignity, rights and fairness. Principles of main ethics include autonomy, beneficence, non-maleficence, justice, confidentiality and honor of dignity. The autonomy in the PCC is particularly important because it is the person-focused approach, and a person is allowed to make his or her decisions related to his or her treatment. A sense of autonomy is encouraged through provision of enough information, informed consent, and empowerment to get a chance to express the views (Curnow et al., 2021).

Beneficence and non-maleficence go around an act that is, of benefiting and benefiting a person or an individual, not harming him or her. Now, the professionals must consider these principles and especially where risk is capable of disclosure by personal decision. It should be noted that the concept of justice plays a central role in facilitating justice, equal access and non-discrimination, which is important given the fact that the people that use services across health and social care in the UK are heterogeneous.

Trust lies on confidentiality and saving of sensitive information and decency will ensure that persons are taken into consideration and they are treated with respect. The most ethical decisions made are normally the ones that require dealing with complex situations where there is a conflict of principles. The problem of autonomy respect can also be a challenge to the professional conception of safety in order of example. The ethics also concern the relationships between professionals and hence the different professionals are also accountable, transparent and reasonably professional.

Overall, ethical principles are a moral rule that guides the decision-making process, which safeguards the service users and enhances the quality of PCC and PW. The inclusion of ethics into practice will also strengthen connections, safeguard rights and advance quality and caring care (Bassul et al., 2024).

4. Evaluation of Partnership Working

4.1 Benefits of PW

Partnership working implies that the professionals, agencies, families and service users collaborate and strive to achieve mutual goals. The biggest benefit of PW is improved care coordination. By providing and receiving information and sharing of duties, the professionals will be able to develop synchronized care plans to meet the physical, emotional, and social needs. This will reduce duplication, enhance communication and continuity particularly when such individuals have complicated or chronic conditions.

PW helps enhance better decision making because of diverse knowledge; there is better evaluation and intervention. PW empowers service users to the service user and the voice of service users is manifested on planning and delivery. It is also efficient in enhancing the security, in that it guarantees on the increased security measures and early warning on the danger.

At the organisational level, PW assists in making the resources utilised in a more efficient way, reducing the amount of time wasted on the longevity, and encouraging creativity in the service design. It is needed in delivering quality, effective, and person-centred care.

4.2 Challenges of PW

Partnership working brings competitors, albeit with the good side. Communication breakdown between professionals or agencies could result in fragmented care and misunderstandings. It is possible that the conflicting or delayed decision-making are because of the difference in the organisational culture, priorities, or professional boundaries. The time and workloads, also, do not allow the frequent cooperation.

There can be cases of lack of information exchange especially between teams because of confidentiality issues. Additionally, lack of professional to professional imbalance can mean the prevalence of some of the voices which will become ineffective in influencing a mutual decision. The service users are also subjected to too many professionals involved in their care.

These challenges demonstrate that there is a need to have a good leadership, well elaborated communication networks, shared policies and respect among the colleagues. Without them, PW will be ineffective or even unreliable (NHS England, 2023).

5. Application of Partnership Working in a Practice Setting

The partnership working adopted in this report is applied in the case of a community mental health team (CMHT) which is a typical and multi disciplinary team. CMHTs commonly consist of a mix of nurses, social workers, psych TH, psychiatrist, occupational therapist, support worker and at times; voluntary organisations. In this respect, PW plays a critical role because mental health care implies the interdependent involvement of different disciplines simultaneously, which will result in safe, timely, and holistic treatment (Dang et al., 2021).

PW also enables intervention of crisis; it has ensured rapidity in crisis team coordination, hospital, GPs, and community providers coordination in Hege. Through the practice, hospitals can reduce the hospitalization and adopt care based on the recovery process. CMHTs have shared decision making as one of the mechanisms that ensures that the service users are included in their care plan and assists the users in managing their condition. The issues in this environment may either be in form of professional outlook differences, work load or resource shortage. However, appropriately, PW in CMHTs promotes safety, recovery, and continuity of care, which justifies the significance of collaboration in people with complicated mental health needs support.

6. Policy and Legislation Relevant to PCC and PW

The policies and laws of UK have a high impact on PCC and PW. The Care Act is oriented on well-being, personalisation, and prevention according to which the local authorities need to involve people in decision-making regarding their support and care. It also provides PCC with legal support and focuses on agency cooperation.

The third program encouraged by the Health and Social Care Act, which provides the opportunity of working across health and social care, is the Integrated care and partnership (Jones, 2023). It challenges organisations to join together in order to improve outcomes, reduce inequalities, and continuity of care. Mental capacity act assists in simplifying the process of PCC by ensuring that whenever it is possible individuals are involved in decision making process and putting in place mechanisms to protect those who are not yet in a position to make decision. The

version of equality Act helps in ensuring equity and non-discrimination, which help eliminate inaccessibility and lack of respect towards care delivery due to diversities in backgrounds.

7. Recommendations for Future Development

There are several recommendations which can help in improving PCC and PW in the UK health and social care. To begin with, the services must invest in the staff training based on communication, empathy, cultural competence and shared decision-making orientation. This will contribute towards the provision of standardized PCC across settings. The staffing level should also be enhanced and the workload of the staff reduced to give the staff an opportunity to make meaningful person-centred interactions.

The digital systems should be enhanced in such a way that encourages the formation of an enhanced information sharing and functioning of partnership. Electronic records sharing, MDT meetings and effective channels of communication can reduce the amount of fragmentation. Instead, respect, transparency, and inter professional collaboration ought to be promoted in organisations.

When the service users and families are involved in the designing of the service, services models can be created basing on the requirements of the people. Co-production tactics give strength to autonomy and build trust. Policymakers should emphasize the importance of personalised care and integrated working so that the resources and support could be directed to long-term implementation (Thorpe et al., 2024).

8. Conclusion

Work partnership and clients-centred care are important factors of quality health and social care in the UK. PCC has the implication of choosing that individuals are handled with humility, respect and compassion, and partnership working involves bonding, combined care and improved results. Although the value of PCC is impressive, time constraints, and communication barriers and organisational pressures are some of the possible barriers to implementation. Cooperation working may also provide the positive results, and suffer by the differences in professional cultures, workload requirements and communication issues (Williams, 2022).

REFERENCES

Books and Journals

- Alderwick, H., Hutchings, A., Briggs, A. and Mays, N. (2021). The Impacts of Collaboration between Local Health Care and non-health Care Organizations and Factors Shaping How They work: a Systematic Review of Reviews. *BioMed Central Public Health*, [online] 21(1), pp.1–16. doi:<https://doi.org/10.1186/s12889-021-10630-1>.
- Bassul, C., Gannon, J., Kelly, Y., Williams, M., Morrissey, D., McKee, J., Niamh O'Rourke and Flynn, R. (2024). How to Achieve Person-Centered Care for People Using Home Care Services: A Narrative Review. *Home Health Care Management & Practice*. doi:<https://doi.org/10.1177/10848223241267874>.
- Curnow, E., Tyagi, V., Salisbury, L., Stuart, K., Melville-Jóhannesson, B., Nicol, K., McCormack, B., Dewing, J., Magowan, R., Sagan, O. and Bulley, C. (2021). Person-Centered Healthcare Practice in a Pandemic Context: An Exploration of People's Experience of Seeking Healthcare Support. *Frontiers in Rehabilitation Sciences*, [online] 2. doi:<https://doi.org/10.3389/fresc.2021.726210>.
- Dang, D., Dearholt, S., Bissett, K., Ascenzi, J. and Whalen, M. (2021). *Johns Hopkins Evidence-Based Practice for Nurses and Healthcare Professionals: Model and Guidelines, Fourth Edition*. [online] Google Books. Available at: <https://books.google.com/books>
- Hallgren, J., Bergman, K., Klingberg, M. and Gillsjö, C. (2021). Implementing a person centred collaborative health care model – A qualitative study on patient experiences. *International Emergency Nursing*, 59, p.101068. doi:<https://doi.org/10.1016/j.ienj.2021.101068>.
- Jones, K. (2023). *A History of the Mental Health Services*. Routledge. doi:<https://doi.org/10.4324/9781003404514>.
- Kitwood, T. (2022). *Disclosures to a Stranger*. doi:<https://doi.org/10.4324/9781003343653>.
- Lichtwarck, B. (2025). Person-centred care and existential health. *Understanding Existential Health for Dementia Care*, pp.47–54. doi:<https://doi.org/10.4324/9781003517733-8>.
- NHS England (2023). *Working in Partnership with People and communities: Statutory Guidance*. [online] NHS England. Available at: <https://www.england.nhs.uk/long-read/working-in-partnership-with-people-and-communities-statutory-guidance/>.
- Schmüdderich, K., Dörner, J., Fahsold, A., Palm, R., Roes, M. and Holle, B. (2024). Current situation, strengths and problems in intra- and interprofessional collaboration in German nursing homes – A holistic multiple case study. *BMC Geriatrics*, 24(1). doi:<https://doi.org/10.1186/s12877-024-05182-z>.
- Tetzlaff, B., Scherer, M., Balzer, K., Steyer, L., Sascha Köpke, Friede, T., Maurer, I., Weber, C.E., Hans-Helmut König, Konnopka, A., Ruppel, T., Mazur, A., Hummers-Pradier, E. and Müller, C. (2023). Development of an interprofessional person-centred care concept for persons with care needs living in their own homes (*interprofHOME*): study protocol for a mixed-methods study. *BMJ Open*, 13(7), pp.e069597–e069597. doi:<https://doi.org/10.1136/bmjopen-2022-069597>.
- Thorpe, D.H., Smith, D., Green, C.J. and Paley, J.H. (2024). *Out of Care*. [online] doi:<https://doi.org/10.4324/9781003501831>.
- Williams, B. (2022). *Social Policy*. Routledge eBooks, pp.124–138. doi:<https://doi.org/10.4324/9781003254393-14>.

