

***Evaluating Person-Centred Care and
Partnership Working in UK
Community Healthcare: A Critical
Analysis of Personalised Care
Through Joan's Story***

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32/07/2026

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1. Abstract

Person-centred care (PCC) and partnership working (PW) are key concepts in modern UK health and social care that complement a move away from professional-led care and towards an integrated, personalised and collaborative approach. PCC allows everyone to be involved in decisions affecting their health and partnership working encourages joined up working between patients, health care professionals and other services. The aim of this report is to critically review the personalised COPD care provided in Joan's Story in the community healthcare setting. It explores how PCC helped Joan to become more autonomous, more confident, more self-managing, and how effective care coordination was achieved through a multidisciplinary approach. Ethical issues and relevant theories and UK healthcare policies are explored and recommendations include improvements to the healthcare workforce, digital personalised care and enhanced multidisciplinary working (NHS England, 2019).

2. Introduction

Healthcare in the UK is becoming more complex and upends the conventional model of treating patients for diseases and focuses on personalised care that values the individual and their autonomy in their own care. Person centred care involves respecting patient's preferences, values and experiences and partnership working involves working with patients and their wider support networks, and working with healthcare professionals to improve outcomes. There is evidence that people with long-term health conditions are helped by tailored approaches to their needs that include psychological, social and practical problems (Early et al., 2019). This report concentrates on the community healthcare services for people with COPD where self-management and a coordinated professional response will be important. Joan's Story is used as an illustration of the concept of personalised COPD care, highlighting the interprofessional working of healthcare professionals with the patient. The report is critical of the concepts and theories behind PCC, ethical issues, partnership working and relevant legislation and evidence-based recommendations (NHS England, 2019).

3. Theoretical Foundations of Person-Centred Care

3.1 Carl Rogers' Person-Centred Theory

Person-centred theory developed by Carl Rogers is an important basis for person-centred care as it focuses on the recognition of person's experience, values and abilities, not just on illness. Rogers believed that the key conditions of effective helping relationships are empathy,

authenticity and unconditional positive regard. Healthcare professionals in Joan's COPD care did these things, and did so respecting Joan's needs, preferences and engaging her in decisions about her care. This individualized method fostered trust and confidence and self-management. In healthcare, however, there are certain obstacles to implementing Rogers' approach, such as time pressures, lack of consultation time, and organisational obstacles. For this reason, the staff's skill in communication, training of staffs, and health care environment are important for the effective person centred care (Hlavek, 2022).

3.2 Maslow's Hierarchy of Needs

The Maslow's Hierarchy of Needs is a complementary model to help understand the whole person needs of individuals receiving healthcare. The theory suggests that there are several levels of human needs such as basic, safety, social, esteem, and self-actualization needs. The model was developed in psychology but can still be applied in the healthcare field, as it points to the fact that successful care requires a whole person approach to wellbeing, encompassing physical, psychological and social aspects (Cherry, 2024).

Within Joan's COPD management, the hierarchy can be applied as follows:

Maslow's Need	Application to Joan's Care
Physiological needs	Supporting COPD symptom management, breathing difficulties and physical health needs
Safety needs	Reducing deterioration risks through education and personalised care planning
Social needs	Encouraging support networks and communication with healthcare professionals
Esteem needs	Building Joan's confidence and ability to participate in self-management
Self-actualisation	Enabling Joan to achieve independence and greater control over her condition

This highlights the need to focus on confidence, emotional wellbeing and independence as well as symptom management when planning personalised COPD care. There is evidence that COPD self-management interventions which are patient–healthcare professional collaborative interventions can improve the quality of life and reduce the utilization of healthcare resources.

3.3 Overall Critical Synthesis

The Person-centred Theory of Rogers and the Hierarchy of Needs of Maslow are complementary theories to help understand PCC. Rogers is focused on therapeutic relationships, and Maslow is focused on physical, emotional and social wellbeing. In the context of COPD treatment, both theories account for an increase in autonomy, confidence and self-management. But application demands skilled human resources and integration of services, which may be problematic due to resource limitations, health disparities and organisational challenges (Poot et al., 2021).

4. Ethical Principles in Person-Centred Care and Partnership Working

Ethical principles are central to the safe, respectful and individual care provided to people as it supports professionals to prioritise patients' rights and preferences alongside their clinical responsibilities. In the context of person centred care (PCC), autonomy, beneficence, non-maleficence and justice offer a useful framework for considering decision making in Joan's COPD care.

Autonomy – Respect an individual's right to make informed decisions about their care. For Joan, autonomy was exhibited in her engagement with identifying personal challenges, discussing care options and engaging with action planning in partnership. Shared decision making, where health professionals offer expertise, and patients are active partners. Shared decision making interventions have been shown to enhance patient engagement and health outcomes for people with chronic respiratory diseases (Barradell et al., 2023).

Professionals need to work in the interests of the patient, as required by the imperative of beneficence. The healthcare team provided Joan with support to look after her health, developing tailored strategies to enhance her confidence, self-management and control of COPD symptoms. The principle of non-maleficence is to avoid harming. Supporting Joan's ability to manage her COPD lessened risks of deterioration, poor symptom management and unnecessary healthcare utilization.

Justice is concerned with the fair distribution of suitable care based on health and/or personal needs. Personalised care approaches can help to tackle inequalities by responding to individual needs.

But, there is an ethical dilemma when the recommendations of professionals contradict the preferences of the patient. For instance, a healthcare provider might advise Joan to take medication to minimize health threats and accept her informed decisions about treatment requires respecting her autonomy. So, ethical PCC requires negotiation, effective communication, and

shared decision making, and not the exclusive use of a paternalistic approach (Barradell et al., 2023).

5. Evaluation of Partnership Working in Community Healthcare

5.1 Definition and Importance of Partnership Working

Partnership working means working together with other people and organisations with patients to produce the same health results. In UK healthcare, it is vital to the coordinated and integrated approach to the management of complex long term conditions. Integrated Care Systems (ICSs) provide a way for NHS organisations, local authorities and community services to work together to enhance person-centred care. A multidisciplinary approach to COPD management, which includes the collaboration of GPs, physiotherapists and specialist services, helps to improve continuity of care, self-management and patient outcomes by reducing fragmentation of care (Nici and ZuWallack, 2012).

5.2 Partnership Working in Joan's Story

A Heart and Stroke Foundation initiative, Joan's Story is a testament to the positive impact of team-based care service. Cooperation between Joan, her specialist physio, GP and community health services was involved in her personalised COPD care. Joan was not only a partner in the process of identifying barriers, she was also a partner in the process of developing solutions, and improving her confidence in managing her condition.

Shared decision-making and communication were key to this. A non-standardised intervention was possible through understanding Joan's individual circumstances to allow support to be adapted according to her needs. This is indicative of the strengthening of COPD management when patients and professionals are in a collaborative relationship that promotes patient self-management and involvement (Kruis et al., 2014).

5.3 Benefits and Challenges of Partnership Working

Joint working can enhance continuity of care as it promotes a shared responsibility and consistent provision of care across health and social care settings. It can also support patient empowerment – boost confidence, health literacy and engagement in decision making. In addition, multidisciplinary care can help decrease unnecessary hospitalizations by facilitating early intervention and effective self-management (Deas, Rao and Raghavan, 2026).

But there are problems to partnership working, too. Poor communication with other parties, lack of information sharing and unclear roles/ responsibilities can impact on coordinated care. Also, organisational priorities and limited healthcare resources may hinder effective collaboration. To achieve successful partnership working, good leadership, communication systems and a common drive to achieve patient-centred outcomes are essential.

6. Policy and Legislative Framework Supporting PCC and PW

6.1 Care Act 2014

The Care Act 2014 has an important underpinning to person-centred practice as placing promotion of individual wellbeing at the centre of care services. The law helps professionals take into account their own situation, their choices and their participation when planning for support. This is a principle that was evident in Joan's COPD care, in the sense of personalised planning, taking into account her barriers and enabling more independence.

6.2 Health and Care Act 2022

The Health and Care Act 2022 further enhances partnership working by introducing Integrated Care Systems (ICSs) with the goal of enhancing collaboration between NHS organisations, local authorities and community services. This framework can be used to support coordinated responses like Joan's experience, in which multiple professionals are working together to meet multiple health needs.

6.3 Equality Act 2010

The Equality Act 2010 helps ensure fairness in healthcare for everyone, including people with long-term conditions, who are protected from discrimination. The use of this legislation within COPD care needs healthcare practitioners to be aware of individual circumstances and make reasonable adjustments as required.

6.4 Human Rights Act 1998

The Human Rights Act 1998 is a form of reinforcement to the principles of dignity, respect and individual rights in healthcare. In the context of person-centred practice, it implies that patients are viewed as having the right to be involved in decisions that impact on their lives.

Critical Evaluation

Whilst there is a robust framework in UK legislation that supports PCC and partnership working, there are challenges in implementing this as a consequence of pressures on the workforce, limitations in resources and different approaches to service delivery. Legislation is not enough to ensure person-centred outcomes, however – the organisation must commit, staff must be able, and patients must play a part (Ettinger et al., 2025).

7. Evidence-Based Recommendations

To implement person centred care (PCC) and partnership working (PW) effectively, there is a need for ongoing improvement in the professional skills, healthcare systems and collaborative working. Personalised COPD care is shown to be effective in Joan's Story, but there is a need to tackle the challenges of implementing individualised COPD care in community health services.

One of the recommendations is to increase personalised care training for healthcare workers. Having competence in workforce communication, empathy and shared decision making would help professionals to understand each patient's situation and facilitate meaningful engagement in care planning decisions. There is evidence that education of HPs is crucial to effective shared decision-making because professionals must have the right skills to weigh clinical and patient preferences in shared decision-making. However, constraints to implementation might be the workforce shortage, competing clinical priorities and the economic burden of training programmes.

The second recommendation is to enhance the integration of digital in personalised care pathways. Shared electronic records and remote monitoring technologies via digital platforms may improve communication between patients and professionals and assist with continuity of care. Evidence shows that building patient engagement and collaboration, particularly by effectively integrating technology, can be improved through shared decision making. Yet, there is still a high level of digital exclusion among older people and those with limited digital literacy which is a major obstacle that needs further support (Vaseur et al., 2024).

Lastly, promoting multidisciplinary collaboration is crucial to achieve streamlined care of COPD. Improved communication between GPs, physiotherapists and community services can minimise fragmented care and enhance patient outcomes. However, ineffective collaboration may still be possible due to organisational priorities and information sharing practices, therefore, there is a need for more effective leadership and care without fragmentation (Barr et al., 2017).

8. Conclusion

Person-centred care and partnership working are key ways of enhancing quality of health care, especially for people with complex long term conditions like COPD. Joan's Story illustrates the benefit of personalised support in improving autonomy, confidence and self-management, and the benefit of professionals working together to ensure the delivery of coordinated and effective support. Principles of ethics and UK legislation offer important guidance for safeguarding dignity, equality and involvement of the patient. Sustainable implementation, however, needs to be backed by investments in the development of healthcare systems and in workforce development, as well as in multidisciplinary collaboration. So PCC and PW continue to be essential pillars to a more integrated, responsive and sustainable UK health service.

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