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Person-centredness - the 'state' of the art

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Person-centredness - the 'state' of the art

Abstract

Background: Person-centred practice is now firmly embedded in the nursing and healthcare discourse. While there is a growing body of development and research activity in the field, there is increased recognition of the need for further advances in the body of existing knowledge. This is reflected in the different approaches to person-centredness being adopted by healthcare systems internationally. **Aims:** To provide an overview of person-centredness and ways in which person-centred practice has been adopted in healthcare systems internationally. **Methods:** A summary review of the evidence underpinning the concepts and theory of person-centredness, incorporating an overview of national strategic frameworks that influence the development of person-centred practice in different countries. **Findings:** While there have been considerable advances in the development of person-centredness, there is a lot of work to be done in the adoption of more consistent approaches to its development and evaluation. In particular, a shared discourse and measurement tools are needed. Internationally, person-centredness is gaining momentum and many countries have strategic frameworks in place to direct its development and implementation. **Conclusions:** Significant developments in the theory and practice of person-centredness in nursing and healthcare have taken place. However, as evidenced by the accounts of in-country developments, internationally there is a need to develop more strategic multiprofessional approaches to the development/implementation and evaluation of person-centred practices. **Implications for practice:** -National developments in person-centred healthcare need to reflect the diversity of strategic approaches internationally -While a common language of person-centredness is emerging, there is a need for clarity over how this is operationalised in everyday practice situations

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Abstract

Background: Person-centred practice is now firmly embedded in the nursing and healthcare discourse. While there is a growing body of development and research activity in the field, there is increased recognition of the need for further advances in the body of existing knowledge. This is reflected in the different approaches to person-centredness being adopted by healthcare systems internationally.

Aims: To provide an overview of person-centredness and ways in which person-centred practice has been adopted in healthcare systems internationally.

Methods: A summary review of the evidence underpinning the concepts and theory of person-centredness, incorporating an overview of national strategic frameworks that influence the development of person-centred practice in different countries.

Findings: While there have been considerable advances in the development of person-centredness, there is a lot of work to be done in the adoption of more consistent approaches to its development and evaluation. In particular, a shared discourse and measurement tools are needed. Internationally, person-centredness is gaining momentum and many countries have strategic frameworks in place to direct its development and implementation.

Conclusions: Significant developments in the theory and practice of person-centredness in nursing and healthcare have taken place. However, as evidenced by the accounts of in-country developments, internationally there is a need to develop more strategic multiprofessional approaches to the development/implementation and evaluation of person-centred practices.

Implications for practice:

- National developments in person-centred healthcare need to reflect the diversity of strategic approaches internationally
- While a common language of person-centredness is emerging, there is a need for clarity over how this is operationalised in everyday practice situations

Keywords: Person-centredness, strategy, international, practice development

Introduction

This opening paper is divided into two sections. In section one we present an overview of the concept of person-centredness and a critique of the way this concept has now become a global phenomenon. We explore how it has been translated into national policy and strategy in a number of countries where we work. Because this is the opening paper of this special issue of the *International Practice Development Journal*, we describe different components of person-centredness and the person-centred

nursing framework of McCormack and McCance (2010). That work continues to be regularly cited in the nursing and healthcare literature as a framework that guides the development and practice of person-centredness in a variety of healthcare contexts – and in many of the projects reported in this special issue. While the framework was originally developed from a nursing perspective, it has been applied in a variety of multidisciplinary contexts. In the second part of the paper, we go on to describe how person-centredness is strategically positioned in the countries in which the authors of this paper work. This overview of person-centredness in these countries will serve as an illustration of advances in this area of work and will also strategically position the papers that follow in this special issue.

Person-centredness – an overview of the concept

The use of the terms ‘person-centredness’ and ‘person-centred care’ has become increasingly common in health and social care services at a global level. A cynic might argue that the term is being used as a ‘catch-all’ for anything to do with high-quality health and social care but we would contend that it is representative of something more significant than this, namely, a movement that has an explicit focus on humanising health services and ensuring the patient/client is at the centre of care delivery. In this context, the body of evidence supporting the processes and outcomes associated with person-centredness in health and social care is constantly growing and becoming increasingly diverse.

Published evidence so far has clarified the meaning of the terms personhood and person-centredness (Dewing, 2004; Slater, 2006; Edvardsson et al., 2010), offered insights into the cultural and contextual challenges associated with implementing a person-centred approach (McCormack et al., 2008; McCormack and McCance, 2010; McMillan et al., 2010; McCance et al., 2013; Yalden et al., 2013), and monitored the development of frameworks such as the authentic consciousness framework (McCormack, 2003), the senses framework (Nolan et al., 2004) and the person-centred nursing framework (McCormack and McCance, 2006; 2010) alongside the application and testing of these frameworks in practice (Ryan et al., 2008; McCormack et al., 2010a; 2010b; McCance et al., 2010; McCormack et al., 2011). In addition, much more emphasis has been placed on outcome evaluation and the development of tools to evaluate the relationships between person-centred processes and outcomes (Slater et al., 2009; McCormack et al., 2010b; Smith et al., 2010; Slater et al., 2015). There is however, still much to be achieved in furthering outcome evaluation and this need was highlighted by the Health Foundation (de Silva, 2014) when the existence of 176 validated tools for evaluating person-centred care were reported, few of which were direct measures and all of which were proxies for person-centredness. Alongside these advances in the research and scholarly literature, there has been a proliferation of policy- and strategy-focused publications supporting the need for and development of person-centred cultures in healthcare. While these will be referred to in the second part of this paper, the Health Foundation has been instrumental in influencing many of these strategies and for ensuring that, at least at the level of health systems, people are at the centre of care:

‘We want a more person-centred healthcare system, where people are supported to make informed decisions about and to successfully manage their own health and care, and choose when to invite others to act on their behalf... We want healthcare services to understand and deliver care responsive to people’s individual abilities, preferences, lifestyles and goals’ (Health Foundation, 2015a).

The foundation has produced a range of resources to enable an increased understanding of person-centred care and to support its development in organisations (Health Foundation, 2015b). However, its work on person-centredness continues to focus mainly on ‘care’ and less on how organisations create person-centred cultures.

The World Health Organization has also promoted a person-centred approach, with a global goal of humanising healthcare by ensuring that it is rooted in universal principles of human rights and dignity, non-discrimination, participation and empowerment, access and equity, and a partnership of equals:

'The overall vision for people-centred health care is one in which individuals, families and communities are served by and are able to participate in trusted health systems that respond to their needs in humane and holistic ways...' (World Health Organization, 2007, p 7).

Despite these notable advancements in the area of person-centredness, health and social care cultures still need to evolve further so that they truly place people at the centre of their care in order to achieve effective and meaningful outcomes. Richards et al. (2015, p 3) suggest that it is 'time to get real about delivering person-centred care' and argue that this requires a sea change in the mindset of health professionals and patients/clients alike. We would argue that a significant part of this change is the need to shift the discourse away from person-centred 'care' per se and to promote a unified discourse of person-centred 'cultures'. Person-centredness can only happen if there is a person-centred culture in place in care settings that enables staff to experience person-centredness and work in a person-centred way. With a focus on person-centred culture, we adopt the following definition of person-centredness:

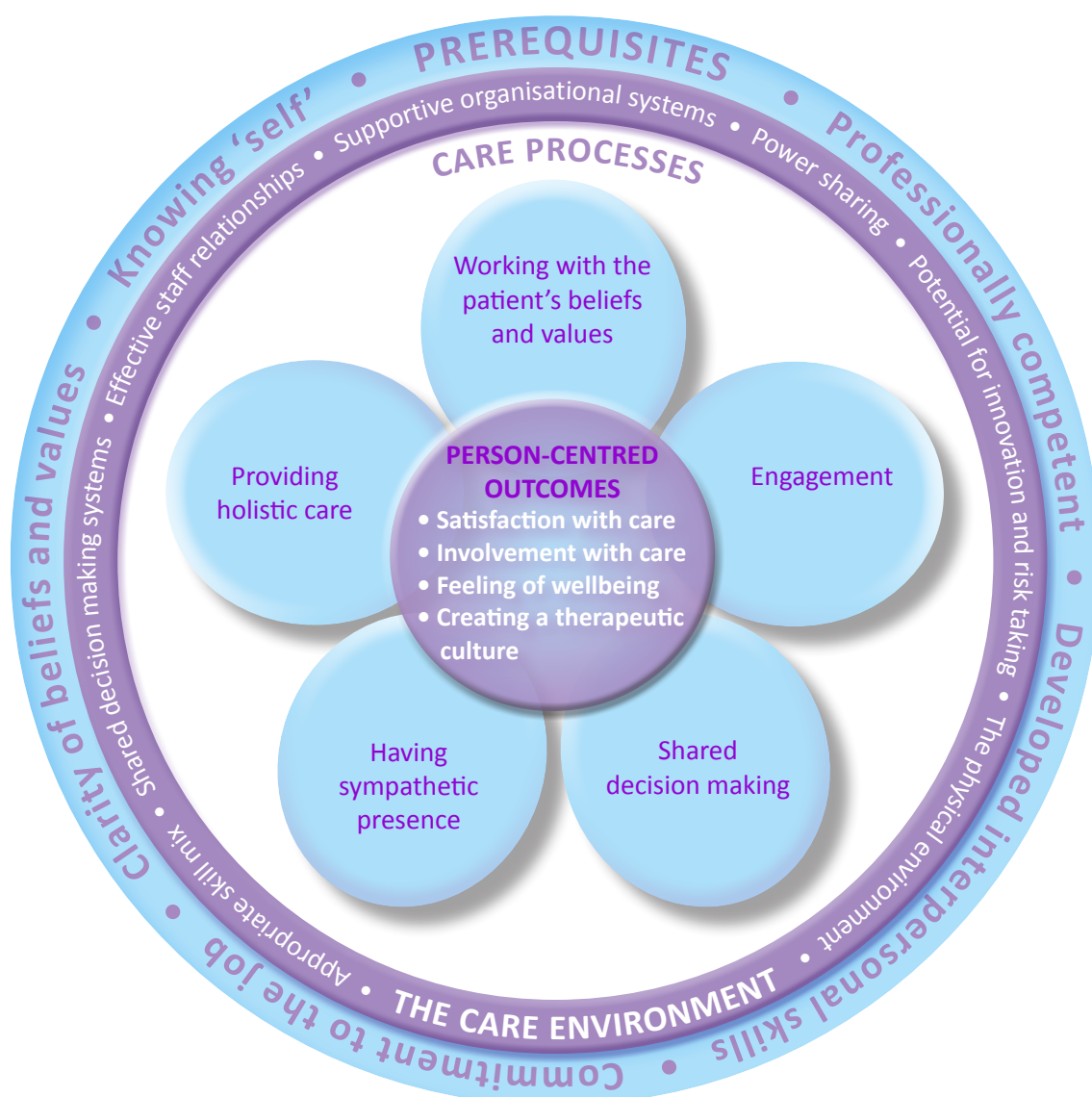
'...An approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development' (McCormack et al., 2013, p 193).

Establishing a person-centred culture requires a sustained commitment to practice developments, service improvements and ways of working that embrace continuous feedback, reflection and engagement methods that enable all voices to be heard. In the body of work published in this special issue of the *International Practice Development Journal*, the use of frameworks to inform such work is important, and the one most often cited is that of McCormack and McCance (2010). The framework has been published extensively, but in summary the framework comprises four constructs:

- **Prerequisites** focus on the attributes of the nurses and include: being professionally competent; having developed interpersonal skills; being committed to the job; being able to demonstrate clarity of beliefs and values; and knowing self
- **The care environment** focuses on the context in which care is delivered and includes: appropriate skill mix; systems that facilitate shared decision making; effective staff relationships; organisational systems that are supportive; the sharing of power; the potential for innovation and risk taking; and the physical environment
- **Person-centred processes** focus on delivering care through a range of activities and include: working with patients' beliefs and values; engagement; having sympathetic presence; sharing decision making; and providing holistic care
- **Outcomes**, the central component of the framework, are the results of effective person-centred nursing and include: satisfaction with care; involvement in care; feeling of wellbeing; and creating a therapeutic environment

The relationship between the constructs of the framework is indicated by the pictorial representation (Figure 1). To reach the centre of the framework, the prerequisites must first be considered, then the care environment, which is necessary in providing effective care through the care processes. This ordering ultimately leads to the achievement of the outcomes. It is also acknowledged that there are relationships within and across constructs, some of which are currently being tested through further research.

Figure 1: Person-centred nursing framework (McCormack and McCance, 2010)



While the person-centred nursing framework of McCormack and McCance (2010) has influenced practice, education, evaluation and policy development, it is clear that person-centredness and person-centred care is a global movement. As Richards et al. (2015, p 3) argue, ‘the challenge remains one of overcoming “system” inertia and paternalism’.

International perspectives

In the second part of this paper, we look at how the different countries in which the authors of this paper work are responding to the challenges of developing person-centred health and social care systems. We do not suggest this is a comprehensive representation of the global development of person-centred healthcare, as it is biased by the work locations of the authors. It should be noted when reading these perspectives that some descriptions of ‘whole countries’ are provided (such as the US) while for others, such as Australia and the UK, details of activity in particular geographical regions are outlined. This reflects the different stages of person-centred healthcare in these countries. In the UK, for example, progress has varied across the different nations. Australia’s states have approached their person-centred healthcare strategies differently, and in the US the most significant developments have been made in residential long-term care for older people.

Australia

Reviewing person-centred practice, person-centred care and person-centred initiatives in Australia, there seems to be an abundance of strategies and activity at the micro (for example, practice initiatives), mezzo (support resources) and macro (national standards) levels throughout most states of the country. The terms person-centred and patient-centred seem to be used interchangeably; this can confuse those trying to understand what person-centredness means in terms of policy documents, models of care, educational support and evaluating practice. In this brief overview, it is not possible to outline the breadth, depth or outcomes of the work so the aim is to provide a snapshot of how person-centred practice is taking shape in Australia.

There is evidence in most states that a person-centred approach informs services across a variety of sectors. For example, Perth Home Care Services in Western Australia (Perth Home Care Services, n.d.) and Quality Healthcare in New South Wales (Quality Healthcare, n.d.) take a person-centred approach to providing homecare services for a range of clients such as those with disability or requiring dementia care. In Tasmania a person-centred approach is used in delivering consistent palliative and end-of-life care (Tasmanian Government Department of Health and Human Services, 2014). In New South Wales, the Essentials of Care initiative is a statewide nursing and midwifery programme aimed at improving person-centred practice using a practice development approach (New South Wales Government Health, 2015). In Victoria, the Department of Health has led the way in developing a guide and toolkit for implementing and evaluating person-centred approaches to caring for older people (Victoria State Government Department of Health and Human Services, 2012). The guide includes the philosophy of person-centred practice, and how to improve it through assessment, objectives, action planning and evaluation, as well as providing links to useful resources. These strategies have informed work in other states, such as Impact NSW in New South Wales (Impact NSW, 2012), a programme designing support for older people and those with disability. In addition, the seven signposts of person-centred care is an excellent resource developed to help patients and families through a series of cues/questions (what you see, what you hear and what you feel) when choosing a nursing home that meets their needs (BUPA Australia, n.d.).

In South Australia, a strategic statewide approach has been undertaken with the release of *Caring with Kindness: The Nursing and Midwifery Professional Practice Framework* in September 2014 (South Australia Health, 2014). The framework aligns with the National Safety and Quality Health Service Standards (NSQHSS) (Australian Commission on Safety and Quality in Health Care, 2012), especially standard 2, which highlights patients being placed at the centre of their own care and working in partnership with healthcare professionals. The framework recognises the practice development work already occurring in the state (South Australia Health, 2014), including the work being undertaken at the Women and Children's Hospital in Adelaide as part of the International PINS study (Wilson and McCance, 2015), reported in another paper in this special issue.

While many programmes or projects have been implemented in Australia, there is limited evidence about their outcomes. Queensland (Queensland Government Metro South Health, 2014-15) is measuring person-centred care through outcomes at the organisational level (for example, using validated tools), through services (workforce tools) and individuals' real-time feedback (stories). Victoria is benchmarking person-centred care throughout the state via a statewide survey (Victoria State Government Department of Health and Human Services, 2014a; 2014b). These initiatives are similar to the work that is occurring in PINS. The challenge for those working in Australia as we grow and expand person-centred practice is the pressing need to produce outcomes from this work that hold meaning for patients, their families, staff, healthcare and educational organisations, policymakers and funders.

Canada

The past decade has seen the emergence of the concept of person-centred care in healthcare research, practice guidelines and policy documents in Canada. There is however no unified national vision for, or definition of, person-centred healthcare. Evolution of the concept has proceeded in a somewhat fragmented way, with limited coordination across sectors or specialties. Most often, person-centred care is positioned somewhat synonymously with the more familiar concepts of client-centred/focused or patient-centred/focused care. That is, the central emphasis is on partnering with patients and ensuring their individual values, preferences and needs guide the clinical decision making process. While this is a welcome focus, there has been limited consideration of how best to structure the care environment and equip the healthcare provider with the requisite skills to be person-centred in their practice. It is this that appears to differentiate the discourse on person-centredness from patient-centred/focused care in countries such as the UK where the concept has benefited from more theoretical and empirical attention (see for example McCormack and McCance, 2010).

Dementia care has benefited the most from focused efforts to promote person-centred care, having the seminal work of Tom Kitwood (1997) on personhood as a springboard. The Alzheimer Society of Canada has initiated a 'culture change initiative' aimed at improving the experience of long-term care for people living with dementia and their families, and working with others to provide useful strategies, tools and tips that can help put the principles of person-centred care into practice (Alzheimer Society Canada, 2014). The work includes federally and provincially funded collaborative projects focused on education and training related to the principles and practices of person-centred care within home care and residential long-term care settings. Following dementia care, the cancer care specialty has a national profile of working systematically towards enhancing person-centred practices. Starting in 2007 the Canadian Partnership Against Cancer initiated a large-scale project to embed a person-centred perspective throughout the 'cancer journey' from diagnosis, treatment and care to survivorship, and palliative and end-of-life care (Canadian Partnership Against Cancer, n.d.). Although not specialty specific, the Registered Nurses Association of Ontario is in the process of updating its client-centred care best practice guideline to a person- and family-centred care guideline (Registered Nursing Association of Ontario, n.d.).

Within academia, person-centredness appeared in a report from a national nursing education summit in 2013 co-led by the Canadian Association of Schools of Nursing and the Canadian Nurses Association. The report outlines a shared vision for nursing education, including programmes that:

'Enable learners to develop emotional intelligence and self-awareness, an understanding of cultural, social and organizational contexts, an orientation toward safe, person-centred care, and the ability to create partnerships with patients and families to achieve optimal outcomes' (Canadian Association of Schools of Nursing, 2014).

Finally, there are individual researchers and research collaboratives across universities in Canada exploring person-centredness within practice and academic settings (see for example Dr Jasna Schwind at Ryerson University in Ontario, who explores humanness of care within person-centred education and practice). The work shows promise for advancing the status of person-centredness in the Canadian healthcare context.

England

There is a movement to mainstream ideas associated with person-centred care in England. This can be seen at micro, mezzo and macro levels in the healthcare system. For example, at the macro level, the National Institute for Health and Care Excellence (2011) begins its guideline 136 on service user experience in adult mental health by stating that best practice is to promote person-centred care. In this context, the guideline frames person-centredness as being about service users' needs, preferences and strengths. As referred to earlier in this paper, the Health Foundation has attempted to define and influence measurement of person-centred care in England (Health Foundation, 2015b). This organisation cites the 'personalisation agenda' (Department of Health, 2010) in health and social

care as a driving force. It seems to construct person-centredness as being founded on compassion, dignity and respect, shared decision making and collective patient and public involvement (The Health Foundation, 2015b). Person-centred support, as of April 2015, is certainly a core of the new national care certificate (Health Education England, 2015) .

At the mezzo level, it is the focus on developing an effective culture, albeit still being centred on organisational culture rather than workplace cultures, that is coming through in policy, local strategy and also via social media. Specifically, staff wellbeing and engagement between managers and staff seem to be most influential foci at this time (Maben et al., 2012). By way of example, the NHS annual staff survey has several indicators designed to measure staff engagement, an attribute of culture necessary for effective care. Although results are improving slowly, in 2013 in response to the survey statement 'the care of patients/service users is my organisation's top priority,' two-thirds (66%) of staff agreed, meaning that about a third of staff are saying it is not the top priority. This is certainly a significant proportion. Further, only 57.7% would recommend their organisation as a place to work, indicating that person-centred cultures remain from being an established reality.

At the micro level, person-centredness is mostly seen in care settings for older people, including dementia care, learning disabilities and to some extent mental health services, both in acute and long-term care. Although there are exceptions and pockets of person-centred practice appearing in other fields of practice, person-centredness here tends to be presented fairly generically by teams of practitioners as core to shared values and beliefs, or as part of a team philosophy. It is less likely that these teams will have a specific model or framework to direct person-centred practice as risk assessment and predetermined electronic documentation systems take over. It is less likely still that person-centred practice is being evaluated other than through the traditional measures of metrics and satisfaction. There appears to be a gap between the ideals of policy and practice as experienced by staff and service users. In addition, the intentions of education/learning strategies and programmes of delivery appear to be misaligned. Therefore, unsurprisingly, the diffusion of ideas about person-centredness is slow and inconsistent across different fields of practice, services and organisations.

Netherlands

Person-centred care as a concept has only recently emerged on Dutch national policy agendas, even though academics at the University for Humanistic Studies referred to it decades ago in their critique of the market model for healthcare, increasing bureaucratisation and narratives of patient-centred and demand-driven care, instead calling for 'present care' or 'generous care' (University of Humanistic Studies, n.d.). The broader attention being paid to person-centred care in the Netherlands coincides with concerns about an increasingly ageing population, calls for lean management and budget cuts. The focus on quality of care relationships, so prominent in a person-centred approach to care, differentiates it from the individualistic and instrumental stance taken by other approaches.

Vilans, a Dutch centre of expertise for long-term care in Utrecht, has produced a white paper on person-centred care in the past two years (Vilans, 2013). The centre's goal is to help professionals improve care for people living with long-term conditions, vulnerable older people and those with disabilities, by providing practical guidelines and toolkits for person-centred care as well as offering advice and workshops/training programmes for staff. The centre focuses on stimulating self-management, care plan development and models of shared decision making. The Radboud University Medical Centre's model for personalised care (Radboud University Medical Centre, n.d.) also makes the person central by customising care so that it fits the specific biological (including genetic), psychological and social make-up of the person. Although Vilans has recently identified the influence of organisational and financial contexts on person-centred care, in general, models claiming to foster person-centred care often fail to address specifically the role that context, leadership and workplace learning have in creating conditions conducive to person-centred care.

At least two Dutch universities of applied sciences are working with McCormack and McCance's (2010) person-centred nursing framework: Windesheim Knowledge Centre for Innovation in the Care for Older People (Windesheim University of Applied Sciences, 2015) and Fontys Knowledge Centre for Person-Centred and Evidence Based Practice in Healthcare and Welfare (Fontys University of Applied Sciences, n.d.). The Fontys centre now has a four-year research programme exploring three areas of person-centred practice in line with current developments in care and welfare provision:

- The use of technology to enhance person-centred practice
- Person-centred community care
- Professional and workplace development for person-centred practice

The central premise is that person-centredness is a relational concept that can enhance the wellbeing of service users and providers in supportive contexts, and such contexts can be created when service users and professionals are included in their development. As well as a core concept for knowledge centre research and development projects, person-centredness is a core value in the nursing faculty's vision statement and it receives explicit attention in all bachelor and master programmes. In this way, Fontys hopes to both promote and role model the value of person-centred practices for care and educational professional practice and organisations in the Netherlands.

Northern Ireland

In Northern Ireland there has been a significant and sustained effort to develop person-centred practice spanning more than a decade. A key driver in progressing this agenda has been the focus on practice development, described as an approach to sustainable change that has as its core purpose the development of effective person-centred cultures. A priority has been the growth of practice development knowledge and expertise through the implementation of a strategic framework to achieve a regional, cohesive approach to the development and evaluation of practice development learning programmes that reflect strategic priorities and organisational needs. This strategic direction builds on the ongoing contribution of leaders within Northern Ireland to the practice development evidence base (McCormack et al., 2008; McCance et al., 2013).

Within nursing and midwifery, there has been an explicit focus on person-centredness at strategic level (Department of Health and Social Service and Public Safety, 2010). The theoretical development of a model for person-centred practice, which emerged from original research undertaken in Northern Ireland (McCormack and McCance, 2006; 2010), has influenced the discourse on developing person-centredness in practice. This has been further enhanced through a strategic shift in the country to an increased focus on improving the patient experience. One key initiative that has shaped this agenda was the development of a set of standards aimed at improving the patient and client experience and a framework for measurement (Department of Health and Social Service and Public Safety, 2008). The focus on improving the patient experience is now recognised within the national commissioning directions as a priority for care delivery. This has provided increased impetus to embed a positive care experience at organisation and practice levels that reflects principles of person-centredness.

Northern Ireland has also been at the heart of developments in person-centred practice research and development on an international stage, led by researchers in Ulster University. The Person-Centred Practice Research Centre was developed as part of the Institute for Nursing and Health Research. A research programme has been established within the centre and currently focuses on three workstrands (University of Ulster, n.d.):

1. Person-centred practice development
2. Evidencing person-centredness in practice
3. Caring for older people and their families

Significant work has also been undertaken within curriculum development, with the delivery of the preregistration nursing programme within Ulster University underpinned by the person-centred practice framework (McCormack and McCance, 2010), alongside a research strand evaluating its impact.

While leadership for the development of this agenda in Northern Ireland has come from within nursing and midwifery, there is increasing engagement across other professional and organisational boundaries, which is a key focus for future developments.

Norway

The development of person-centredness in Norway lies in the series of challenges that health and welfare services are faced with, particularly the changes in population demographics and the numbers of people with long-term health needs. Recommendations in recent decades in several national policy documents in the mental health and substance abuse fields, as well as in health promotion, rehabilitation and innovation of healthcare services, have supported person-centredness. As in other Western countries, the Norwegian health and social care services have been influenced by the global economic downturn in the sense of being remodeled and redesigned, and having an overall focus on primary care and public health. These reforms have been driven by the Norwegian government's coordination reform strategy (Norwegian Ministry of Health and Care Services, 2009). There are two central tracks for developing person-centredness and person-centred care in Norway: services for older people and services for persons with mental health and substance abuse problems. In care for older people, the context has primarily been nursing homes and secondly community services. In the nursing homes, nursing staff have increasingly integrated the principles and practices of person-centred care in collaboration with other professionals. There has also been a greater focus on person-centredness in the curriculum frameworks for nurses and other health professionals. Over the past decade, research in the area of person-centredness and older people has increased, with the MEDCED-study (Testad et al., 2015) at the Centre for Care Research at Bergen University College being an ongoing example.

Within mental health and substance abuse services, there has been a greater emphasis on person-centredness and person-centred care since the late 1990s. Human rights, recovery, empowerment and collaborative partnerships have been central areas of theoretical and practice development. The focus has been on user involvement, community support and tailored services and this has influenced practice development, the curriculum frameworks for health and social care professionals and the areas and contexts of research. In developing person-centredness and person-centred mental health and substance abuse care, three focal points have emerged:

1. The perspective and involvement of service users
2. Recovery orientation of services
3. A multiprofessional and interdisciplinary context

Finally, we can mention a new PhD programme in person-centred healthcare being provided by the Faculty of Health Sciences, Buskerud and Vestfold University College (Buskerud and Vestfold University College, 2015). The aim of the programme is to support graduates who can carry out high-level research, professional development and evaluation of person-centred healthcare service provision within the area of health sciences.

Scotland

Person-centredness and person-centred care are at the heart of government health and social care policy in Scotland. The healthcare quality strategy for NHS Scotland (The Scottish Government, 2010) set out a clear vision and strategy for the development of a health service that is world leading and built on principles of care and compassion:

'What will make Scotland a world leader will be the combined effect of millions of individual care encounters that are consistently person-centred, clinically effective and safe, for every person, all the time...' (Scottish Government, 2010, p 1).

This strategy set the direction for an ongoing programme of work that has focused on developing services that meet the needs of patients as persons and ensuring that care systems prioritise individual

need. The Person-centred Health and Care Collaborative has been a key platform of this activity, managed through the Government body Healthcare Improvement Scotland. This is a key part of a Scotland-wide programme of work aimed at improving health and care services so that they are focused on people, their families and carers. The collaborative aims to bring together people from every part of the health service in Scotland to:

- Raise the profile of person-centred approaches to care across Scotland, including staff health and wellbeing
- Develop and test a range of evidence-based interventions and approaches designed to improve person-centred care
- Focus on what can be done now to improve services
- Provide reliable opportunities to personalise support for every person all of the time
- Encourage sharing of ideas and approaches between people who use services and people who provide them
- Promote the use of approaches for obtaining feedback from people who use services
- Use feedback from people who use services to drive improvement
- Provide a framework to measure improvement (Healthcare Improvement Scotland, n.d.)

A variety of activities have been promoted by the collaborative including learning events, online communities for discussion and debate, conferences and 'innovation cafes' as well as the development of a number of tools for person-centred care, such as the 'Five Must Do With Me Areas' (Healthcare Improvement Scotland, n.d.). The collaborative has been a significant driving force behind many changes across the health system, including patient/client feedback systems, the development of quality standards, the education of all staff about person-centred approaches and of course the influencing of policy and everyday practices. While collaborative has been an important driving force behind the development of person-centred services in Scotland, other significant developments include the leadership in compassionate care programme led by Edinburgh Napier University in partnership with NHS Lothian (Leadership in compassionate care programme team, 2012), a significant research initiative in the field of compassion in nursing and care work. Overall, Scotland is a vibrant strategic environment for the ongoing development of and research into person-centredness. In 2015, Scotland moves towards a fully integrated health and social care system and while this change is in itself a person-centred one, it also creates a range of new opportunities for extending the significance and reach of person-centred programmes of work.

United States

Person-centred care first emerged in the US in the 1980s in response to widespread concerns about the quality of care in the nation's nursing homes. The Institute of Medicine was commissioned to write a report on nursing home regulations that introduced person-centred care as:

'Care that is respectful and responsive to individual preferences, needs and values, and ensures that patient values guide all clinical decisions' (Institute of Medicine, 1986, p 49).

From this, the Nursing Home Reform Act was included in the Omnibus Budget Reconciliation Act of 1987, which established new, resident-focused standards for nursing homes and made explicit the statutory requirement that care be 'person-centred'. Several models of person-centred care have been developed in the US, supported and coordinated by the Pioneer Network, a cooperative network of state- or region-based coalitions of service providers. The Eden Alternative, Well-Spring, and the Green House models for communal long-term care facilities are probably the best-known and the ones that have conducted some evaluative research on outcomes for residents and staff. These models have focused a great deal on the importance of environment and in particular the arrangement of care in small groups – for example, households within traditional nursing homes and purpose-built homes for small numbers of older adults.

Mostly, the development of person-centred care has been with older adults in long-term care but without dementia. This seems to be because of the focus on personal choice and preference and the difficulty of translating those values into the care of those living with dementia. However, with the mandating of person-centred care in all Medicare- and Medicaid-funded nursing homes (Pioneer Network, 2009; 2012), and the passing of the National Alzheimer's Plan Act in 2010 (Department of Health and Human Services, 2015) it is hoped that a more consistent change will be possible. But with only limited resources allocated to care and advocacy in the act, there is greater emphasis developing on person-centred care for all older adults including those living with dementia. Unfortunately, there is a general belief among some providers that person-centred care is not good for the financial 'bottom line' and this persistent belief is seriously slowing down the adoption of person-centred practices. A number of research centres, such as the University of Buffalo Institute for Person Centred Care, have been established recently, which it is hoped will produce the much-needed evidence to support more consistent and widespread adoption.

More broadly, person-centred care has also been a central tenet of care for people living with developmental disabilities. Other pockets of person-centredness can be found in private mental health services using Rogers' person-centred therapeutic approaches (Rogers, 1961). The term itself has gained some popularity and is being used with increasing frequency in health-related businesses. The degree to which these businesses embrace the deeper meaning of person-centredness is debatable, but there seems to be some adoption of the term instead of patient-centred care in a number of places. However, it is in the care of older people that person-centredness is most prominent, not least because of continued policy developments and the persistent advocacy of champions, both individuals and organisations.

Concluding remarks

In this paper we have provided a brief overview of the concept of person-centredness and how this has evolved over time. It is clear that a lot of work in terms of concepts and theory has taken place and there is a growing body of research focusing on implementation processes and the development of outcome measures. The in-country accounts in this paper also highlight the diversity of strategic approaches being adopted across the world and the key influences on these developments. The papers that follow in this special issue of *International Practice Development Journal* further illustrate the development and growth in this field of practice development and research, as well as the influences of the International Community of Practice for Person-centred Practice (ICOP) on these developments.

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