Person-centred Outcomes

The ‘I’ statements below are examples of person-centred outcomes. They are not an exhaustive list, however they are valuable as a start point in guiding new thinking about integrated service design.

The design of new integrated caring services does not start with the skills/competences which are available, it starts with the outcomes that are important to people, which is why they are at the core of the framework.

Overview
- I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.

<table>
<thead>
<tr>
<th>My goals/outcomes</th>
<th>Communication</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>All my needs as a person are assessed.</td>
<td>I tell my story once.</td>
<td>I have the information, and support to use it, that I need to make decisions and choices about my care and support.</td>
</tr>
<tr>
<td>My carer/family have their needs recognised and are given support to care for me.</td>
<td>I am listened to about what works for me, in my life.</td>
<td>I have information, and support to use it, that helps me manage my condition(s).</td>
</tr>
<tr>
<td>I am supported to understand my choices and to set and achieve my goals.</td>
<td>I am always kept informed about what the next steps will be.</td>
<td>I can see my health and care records at any time. I can decide who to share them with. I can correct any mistakes in the information.</td>
</tr>
<tr>
<td>Taken together, my care and support help me live the life I want to the best of my ability.</td>
<td>The professionals involved with my care talk to each other. We all work as a team.</td>
<td>Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand.</td>
</tr>
<tr>
<td>My care plan is clearly entered on my record.</td>
<td>I always know who is coordinating my care.</td>
<td>I am told about the other services that are available to someone in my circumstances, including support organisations.</td>
</tr>
<tr>
<td>I have regular reviews of my care and treatment, and of my care and support plan.</td>
<td>I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time.</td>
<td>I am not left alone to make sense of information. I can meet/phone/email a professional when I need to ask more questions or discuss the options.</td>
</tr>
</tbody>
</table>

Care planning
- I work with my team to agree a care and support plan.
- I know what is in my care and support plan. I know what to do if things change or go wrong.
- I have as much control of planning my care and support as I want.
- I can decide the kind of support I need and how to receive it.
- My care plan is clearly entered on my record.
- I have regular reviews of my care and treatment, and of my care and support plan.
- I have regular, comprehensive reviews of my medicines.
- When something is planned, it happens.
- I can plan ahead and stay in control in emergencies.
- I have systems in place to get help at an early stage to avoid a crisis.

Decision making including budgets
- I am as involved in discussions and decisions about my care, support and treatment as I want to be.
- My family or carer is also involved in these decisions as much as I want them to be.
- I have help to make informed choices if I need and want it.
- I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it’s my own money, direct payment, or a ‘personal budget’ from the council or NHS).
- I am able to get skilled advice to understand costs and make the best use of my budget.
- I can get access to the money quickly without over-complicated procedures.

Transitions
- When I use a new service, my care plan is known in advance and respected.
- When I move between services or settings, there is a plan in place for what happens next.
- I know in advance where I am going, what I will be provided with, and who will be my main point of professional contact.
- I am given information about any medicines I take with me – their purpose, how to take them, potential side effects.
- If I still need contact with previous services/professionals, this is made possible.
- If I move across geographical boundaries I do not lose me entitlements to care and support.

Source:
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Part of ‘Making it real’ – referenced in ‘Integrated Care & Support: Our Shared Commitment’ NCICS May 2013