

**think local**  
**act personal**

**A Narrative for Person-Centred Coordinated Care**

**National Voices**  
People shaping health and social care

[www.nationalvoices.org.uk](http://www.nationalvoices.org.uk)  
[www.thinklocalactpersonal.org.uk](http://www.thinklocalactpersonal.org.uk)  
NHS England Publication Gateway Reference Number: 00076

@NVTweeting  
@ILAP1

Summary

My goals/outcomes

person centred coordinated care

Information

*"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."*

Transitions

Communication

Decision making

are' means...)

**person centred coordinated care**

## EasyRead guide to the PowerPoint slides



This is an EasyRead guide to the slides you will see on the screen.

It has the slide you will see on the screen at the top of the page and an EasyRead of what it means underneath.





# A Narrative for Person-Centred Coordinated Care

## Slide 1



**National Voices**

National Voices is a large group of health and social care charities in England.



We work together to make sure the things people say are heard by people in power.

We work with:

- patients



- people who use services



- carers



- their families and the voluntary organisations that work for them.



This talk is about **Person-Centred Care**, which means the right care for what each different person needs.



We also use the word **co-ordinated**, this is also about all the different parts of care working well together.

National Voices and TLAP both have web sites and you can follow them on twitter.

## About this Narrative

- Commissioned by NHS England on behalf of the National Collaboration for Integrated Care and Support
- Co-developed with the health and care system by National Voices, a grouping of 130 health and social care charities
- Draft based on: research on what matters most to patients and service users; on survey questions that were fully tested with patients; and on consultations with National Voices members
- Refined at a workshop in September 2012, with service users, charity representatives and NHS and social care leaders
- Second draft published for two months feedback in January 2013
- Feedback from commissioners and providers of care, service user organisations and others was analysed and discussed at a workshop in March 2013, and a final version produced
- This final version aligns with TLAP's 'Making it Real' initiative

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## Slide 2



The NHS has paid us to do this work for a group called the National Collaboration for Integrated Care and Support.



We decided how to do the work with lots of others including health and social care charities.



We wrote a **draft** report.

A **draft** is a report that isn't finished yet, people can read it and ask for changes.



The report was on:

- what matters most to patients and service users
- we asked questions that we had tested on patients
- and we talked to our members.



We changed some things after we asked people at a meeting last September.



We wrote a second draft in January 2013 and asked people what they thought about it.

We heard from:



- people who buy services
- care services
- service user organisations
- and others.

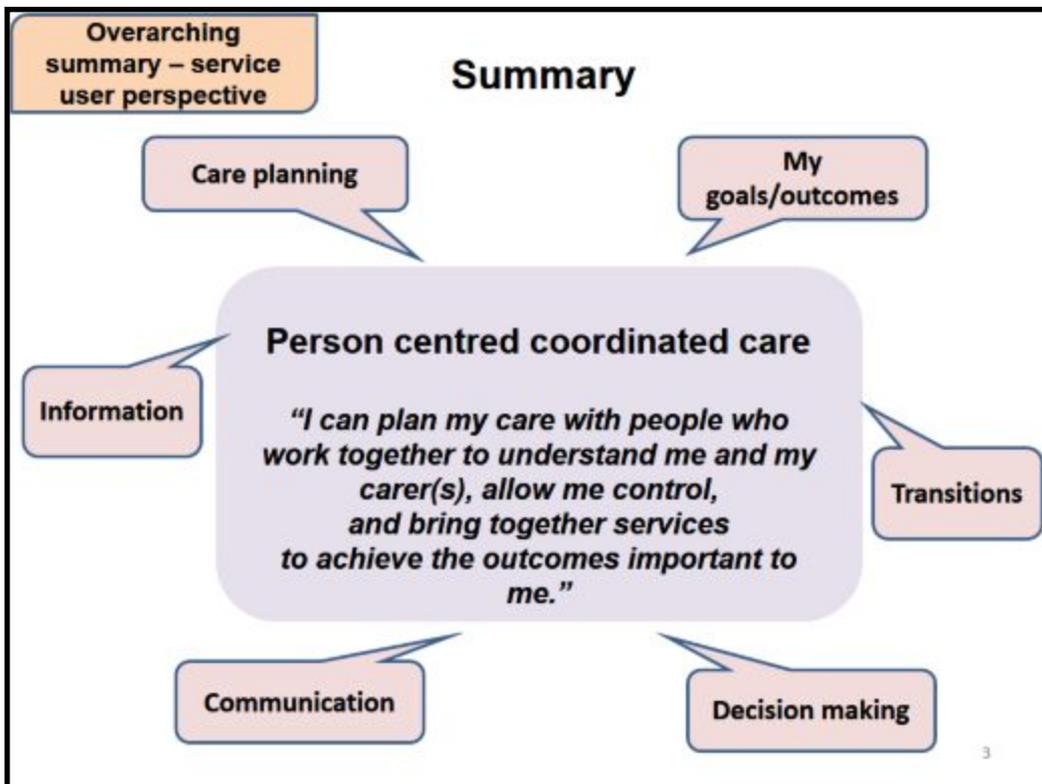


We looked at what everyone said and talked about it at another meeting in March 2013.



We then wrote this final version.

It fits in with the Think Local Act Personal work on 'Making it Real'.



## Slide 3



This slide shows the different parts that need to work together to help plan my care.



We will give you more details about each part in a moment. They are:

- what I want to happen



- talking and listening



- information



- being in control



- making a plan for me



- moving from one service to another.

(‘Integrated care’ means...)

**person centred  
coordinated care**

Slide 4

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There are several different names that are being used to talk about the changes that are happening in health and social care.



One of them is **Integrated Care** it means the same thing as **person-centred coordinated care**, which means planning the right care for what each different person needs.

**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.**

## Slide 5



To plan my care I need people who:

- work together



- understand me and my carers



- make sure I'm in control



- bring different services together



- make the things I want happen.

## My goals/outcomes

All my needs as a person are assessed.

My carer/family have their needs recognised and are given support to care for me.

I am supported to understand my choices and to set and achieve my goals.

Taken together, my care and support help me live the life I want to the best of my ability.

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## Slide 6



To help me decide what I want to happen, I need:

- people who find out what all my needs are
- people to think about my needs in what they do, my carers and family to get support with their needs so they can carry on supporting me
- to understand what choices I have and how to get what I want
- my care and support helping me live the life I want, as well as I can.



## 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.

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## Slide 7



Making my care plan, I need:

- to work with my team to agree my care and support plan



- to know what is in my plan



- to know what to do if things change or go wrong



- to have as much control as I want over my plan



- to decide what kind of support I need, when and how I get it



- my care plan to be in my notes



- to review my plan often to check it is still right for me



- to review my medicines



- to know when something is planned it happens



- to be able to plan ahead and stay in control in any emergency



- to be able to get help early so it stops anything getting worse.

## Communication

I tell my story once.

I am listened to about what works for me, in my life.

I am always kept informed about what the next steps will be.

The professionals involved with my care talk to each other. We all work as a team.

I always know who is coordinating my care.

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.

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Slide 8



Talking to each other, what I need:

- to just tell my story once to one person



- people listening to what things work well for me



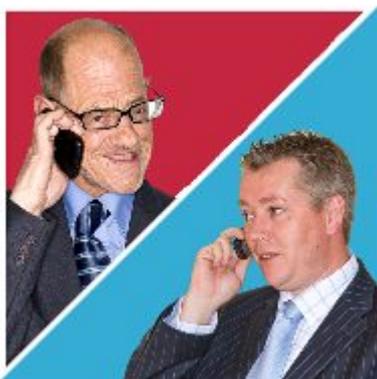
- I am always told what is happening next



- everyone to work as a team talking to each other and including me



- always knowing who is in charge of organising my care



- only having one person to contact



- people understanding me and knowing about my disability



- having someone to go to with questions at any time.

## Information

I have the information, and support to use it, that I need to make decisions and choices about my care and support.

I have information, and support to use it, that helps me manage my condition(s).

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.

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.

I am told about the other services that are available to someone in my circumstances, including support organisations.

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.

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## Slide 9



The information I need:

- having all the information I need to make choices about my care and support in a way I can understand



- having help so I can use the information to help myself



- being able to see my health and social care records



- being able to decide who else can see them



- being able to change any mistakes in them



- having the right information at the right time and in a way I can understand



- being told about any other services and support that might be useful to me



- having the right support to understand what any information means for me



- not being left alone with information that I do not understand



- having someone I can talk to and ask questions.

## 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.

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Slide 10

The things I might want to make decisions:



- being involved in talks and decisions about my care, support and treatment



- having my family or carer involved as well



- having help to make choices that I understand and know about



- knowing how much money is there for my care and support



- having choices on what to spend that money on



- having good support and information to help me spend money in the best way



- getting the money quickly without lots of paperwork.

## 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.

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Slide 11

## Moving to a new service



When I use a new service:

- they need to know all about me and my care plan and want to do what it says



- there needs to be a plan for what happens next when I move to a different service or place



- I need to know where I am going, what I will be getting and who the main person is I should talk to, before I move



- I need to have information about my medicines to take with me, I need to know how to take them and any problems they can cause



- I need to be able to contact my old services if I need to



- I need to have the same level of care and support even if I move to a new area.



**National Voices**

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and social care

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**Slide 12**



**National Voices**

People shaping health  
and social care

## A Narrative for Person-Centred Coordinated Care

[www.nhs.uk/publications/00076](http://www.nhs.uk/publications/00076)  
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**This slide is nearly the same as  
Slide 1 at the start.**





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