



**National Voices**

People shaping health  
and social care

# A Narrative for Person-Centred Coordinated Care

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# 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

# Summary

Overarching summary – service user perspective

Care planning

My goals/outcomes

**Person centred coordinated care**

*“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.”*

Information

Transitions

Communication

Decision making

## Subject

**(‘Integrated care’ means...)**

person centred  
coordinated care

**Definition - service user  
perspective**

**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.**

**Generic 'I'  
statements**

## **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.

**Generic 'I'  
statements**

# 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.

**Generic 'I'  
statements**

## **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.

## Generic 'I' statements

# 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.

## Generic 'I' statements

# 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.

## Generic 'I' statements

# 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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