



National Voices

People shaping health
and social care

A Narrative for Person-Centred Coordinated Care

www.nationalvoices.org.uk

www.thinklocalactpersonal.org.uk

@NVTweeting

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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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