NHS England

Integrated Personal Commissioning

Interactive IPC operating model

V14 June 2017

Introduction

- **Integrated Personal Commissioning** will be the main model of care for 5% of a local system's population, including people with multiple long-term conditions or disabilities, people with severe and enduring mental health problems, and children and adults with complex learning disabilities and autism
- The purpose of the **IPC operating model** is to show what we would expect to see if IPC was working successfully
- It provides an overview of how the five key shifts and enablers contribute to IPC as a whole, and provides a means to enable the model to be replicated
- In addition, the **five key shifts** set out what the significant system changes are that are required for IPC to be implemented in health and care. The **key features** set out what a person should expect and experience when IPC is implemented well.

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Integrated Personal Commissioning

About this slide pack

About this slide pack

- This **interactive operating model** supports IPC areas by making clear what the steps are to implement IPC
- It provides an opportunity for areas implementing IPC to describe the approach and provides a basis for developing a local version
- For each key shift and enabler it shares the products available. These products enable sites to put each key shift or enabler into practice
- It provides details of NHS England's delivery support offer
- It also describes how IPC works for carers
- For each of the key shifts and enablers, this pack provides:
  - A summary of what would be seen if IPC is working successfully
  - What to put in place locally
  - The products available to support local areas to put IPC into practice
  - Details of the delivery support offer from NHS England and VCSE partners

How to use this slide pack

This slide pack includes:

- The IPC operating model
- The key features of personal health budgets
- A section about each of the 5 key shifts and the enablers

You can navigate these sections by clicking on the links:

- What this looks like
- What happens for the person
- What to put in place
- The steps to take to put this into practice

Products

- For each of the steps there is an associated product. Click on that product to download

If you have any questions about this slide pack or find any errors please contact:
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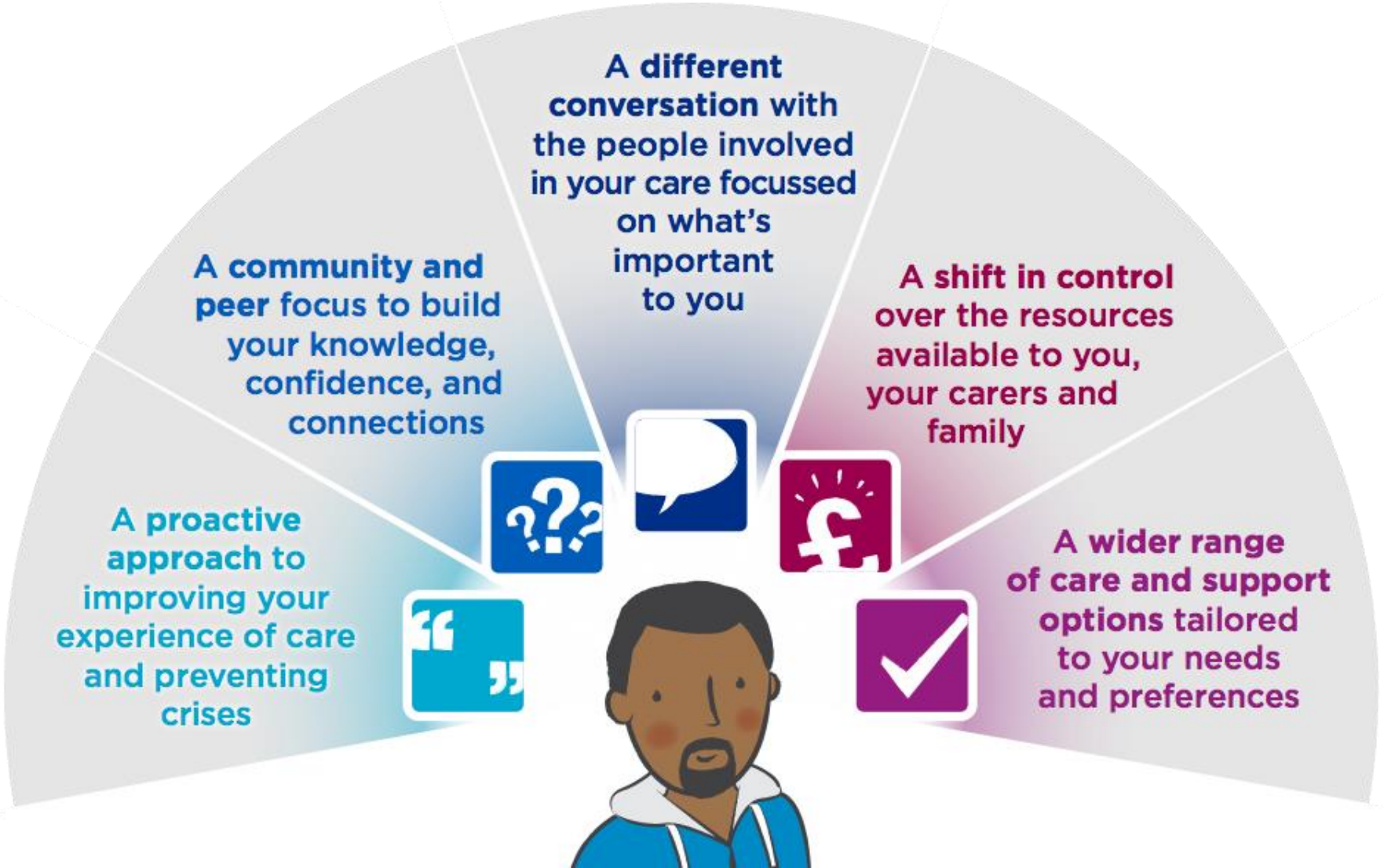
Individual level experience of IPC



Integrated Personal Commissioning Operating Model

5% OF POPULATION
Cohorts identified on the basis of local priorities and need

PROACTIVE OR REACTIVE REFERRAL ROUTES

- GP referral (proactive – by population risk stratification)
- GP referral (reactive – by person presenting who could benefit)
- Specialist or acute health services
- Hospital discharge and intermediate care
- Social care (childrens and adults)
- Education
- Voluntary, community and social enterprise (VCSE) organisations
- Self-referral

PROACTIVE COORDINATION OF CARE

People proactively or reactively identified and offered information about IPC.
Multi-disciplinary IPC hubs with single points of coordination for each person.

COMMUNITY CAPACITY AND PEER SUPPORT

Make the most of what's available through Local Area Coordination and systematic access to peer support.

PERSONALISED CARE AND SUPPORT PLANNING

Have a different or better conversation to identify what matters, and capture this in one place.

PERSONAL BUDGET

A personal budget brings together resources to achieve health, wellbeing and learning outcomes.

FINANCE ENABLERS:
- Cohort ID.
- IG solutions.
- Linked data.

WORKFORCE ENABLER (underpins everything):
- Workforce capacity planning.
- Workforce development plan.

LEADERSHIP, CO-PRODUCTION AND CHANGE ENABLER (underpins everything):
- Clear system leadership.
- Vision, strategy and action plan for change.
- Communication strategy.

MAKING IT HAPPEN

Accessing a wider range of care and support options tailored to individual needs and preferences.

REVIEW

Part of personalised care and support planning. Check how well everything is working and adjust the plan and budget. Explore other elements of IPC offer, and repeat.

COMMISSIONING ENABLERS:
- Releasing money.
- Personalised contracting and payment.
- Market shaping.

IPC key shifts (colour coded)

- Proactive coordination of care
- Community capacity and peer support
- Personalised care and support planning
- Choice and control
- Personalised commissioning and payment

Key features of personal health budgets and Integrated Personal Commissioning

Where someone is part of IPC or has a personal health budget, they will:

- be able to access information and advice that is clear and timely and meets their individual information needs and preferences
- experience a coordinated approach that is transparent and empowering
- have access to a range of peer support options and community based resources to help build knowledge, skills and confidence to manage their health and wellbeing
- be valued as an active participant in conversations and decisions about their health and wellbeing
- be central in developing their personalised care and support plan and agree who is involved
- be able to agree the health and wellbeing outcomes* they want to achieve, in dialogue with the relevant health, education and social care professionals.

If this leads to a personal budget, integrated personal budget or personal health budget, a person will:

- get an upfront indication of how much money they have available for healthcare and support
- have enough money in the budget to meet the health and wellbeing needs and outcomes* agreed in the personalised care and support plan
- have the option to manage the money as a direct payment, a notional budget, a third party budget or a mix of these approaches
- be able to use the money to meet their outcomes in ways and at times that make sense to them, as agreed in their personalised care and support plan.

* and learning outcomes for children and young people with education, health and care plans.

Where someone has a personal health budget, they should experience all the key features listed above, not just those specifically listed under the personal budget section.

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Key shift:
Proactive coordination of care

Go back to operating model

Go back to operating model

Proactive coordination of care

People proactively or reactively identified and offered information about IPC

What this looks like

What happens for the person?

What will sites need to put in place?

What to put in place

The steps to take to put this into practice	Product
	Product
	Product

What information is available

Plain English guide to personalised health and care

What is IPC film

Proactive coordination of care film

Proactive coordination of care

What this looks like

What happens for the person?

- The person can find out about IPC from council and NHS websites, their GP, other health practitioners, education, social services, or the voluntary sector
- It will be clear about what IPC offers the person, and how to get information and support to help the person achieve what is important to them
- The IPC cohort includes people who are poorly served or may experience health inequalities. People are actively offered IPC, with clear information provided in a range of formats
- It is clear who can benefit from IPC in an area and who can get an IPC budget
- If a person is in this group, the CCG will contact them to offer the chance for a better conversation – or people can ask for this themselves

What will IPC sites need to put in place?

- Identifying the cohort: working out who is suitable for IPC and PHBs and who is likely to benefit
- A clear communication strategy so that all people who could benefit from IPC know what it is, who it is for and what difference it will make
- Linked datasets and information governance solutions for the identified cohorts

How to put this into practice?
What to put in place

Proactive coordination of care

What to put in place

These are the steps to put this shift into practice

- Identifying the cohort: working out who is suitable for IPC and PHBs and who is likely to benefit
- Identifying any potential information risks through completion of a privacy impact assessment
- A clear communication strategy so that all people who could benefit from IPC know what it is, who it is for and what difference it will make
- Linked datasets and information governance solutions for the identified cohorts

Proactive coordination of care summary — Click to download

Finance and commissioning handbook — Click to download

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Key shift: Community capacity and peer support

Go back to operating model

Go back to operating model

Community capacity and peer support

Make the most of what's available to you through local area coordination and systematic access to peer support

What this looks like

What happens for the person?

What will sites need to put in place?

What to put in place

The steps to take to put this into practice	Product
	Product
	Product

What information is available

Plain English guide to personalised health and care

What is IPC film

Community capacity and peer support film

Community capacity and peer support

What this looks like

What happens for the person?

- People and their families know what's available locally to help them achieve what they want from life
- People will be encouraged to develop their knowledge, skills and confidence to manage their health to enable them to do what matters to them
- People will have the chance to connect with other people who have similar experience to learn more, and build their confidence to take up the IPC offer
- Everyone in the IPC cohort has access to VCSE organisations, peer support networks and community groups
- Community capacity and peer support options are geared to meeting the needs of everyone in the local community including people with diverse backgrounds

What will IPC sites need to put in place?

- A range of community capacity options, including Local Area Coordination
- A range of peer support options, including one-to-one, group and online support
- A clear understanding of existing community assets and gaps, through an asset map showing what is available and a plan and business case to invest in developing what's on offer

How to put this into practice?
What to put in place

Community capacity and peer support

What to put in place

These are the steps to put this shift into practice

- A range of community capacity options, including local area coordination
- A range of peer support options, including one-to-one, group and online support
- A clear understanding of existing community assets and gaps, through an asset map showing what is available and a plan and business case to invest in developing what's on offer

Summary guide

Click to download

This includes:

IPC and local area coordination

Peer support framework

Mapping tool for local communities

Business case for community capacity

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Key shift: Personalised care and support planning (PCSP)

Go back to operating model

Go back to operating model

Personalised care and support planning

Have a different or better conversation to identify what matters to you, and capture this in one place

What this looks like

What happens for the person?

What will sites need to put in place?

What to put in place

The steps to take to put this into practice	Product
	Product
	Product

What information is available

Plain English guide to personalised health and care

What is IPC film

Personalised care and support planning film

Personalised care and support planning (PCSP)

What this looks like

What happens for the person?

- People will have a different or better conversation with practitioners which focuses on what matters to them and what is working and not working in their life
- This will be done in a way that builds on their skills, knowledge and confidence
- People will experience an integrated process coordinated by a single, named coordinator and a single care and support plan developed in partnership and owned by them
- People will have the chance to regularly review their care and support plan
- It's easy to find out what support and services are available
- Plans take account of each person's situation in a holistic way, so that care and support is tailored to their culture and background

What will IPC sites need to put in place?

- A common framework and integrated, proportionate process for personalised care and support planning
- IPC hubs are in place
- A single summary care and support plan
- Training, mentoring and support for all parties delivering better conversations
- Positive approach to choice, risk and decision making

How to put this into practice?
What to put in place

Personalised care and support planning (PCSP)

What to put in place

These are the steps to put this shift into practice

- A common framework and integrated, proportionate process for personalised care and support planning
- IPC hubs are in place
- A single summary care and support plan
- Training, mentoring and support for all parties delivering better conversations
- Positive approach to choice, risk and decision making

PCSP summary guide

Click to download

This includes:

PCSP framework

IPC hubs and single, named coordinator

Single summary care and support plan

Positive approach to risk and choice

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Key shift:
Choice and control

Go back to operating model

Go back to operating model

Choice and control

A personal budget blends resources to achieve health, wellbeing and learning outcomes

What this looks like

What happens for the person?

What will sites need to put in place?

What to put in place

The steps to take to put this into practice	Product
	Product
	Product

What information is available

Plain English guide to personalised health and care

What is IPC film

Choice and control film

Choice and control

What this looks like

What happens for the person?

- It's clear from the start of the process who could get a personal budget, and what money can be included
- Personal budgets become the mainstream approach for people who are eligible for them
- The personalised care and support plan makes clear what the budget can be used for and what outcomes are expected
- People and families get the same, joined-up experience regardless of where the money comes from
- People and families can get advice with arranging care and support, recruiting personal assistants and with managing direct payments
- People have access to support that is tailored to their situation and background, and are actively offered all three options for managing the money

What will IPC sites need to put in place?

- All three options for managing the money are in place with access to direct payment support services and third party budgets
- A joined-up process for personal budget implementation and review
- An individual statement of resources for the people who can have a personal budget, which provides an indicative budget

How to put this into practice?
What to put in place

Choice and control

What to put in place

These are the steps to put this shift into practice

- All three options for managing the money are in place with access to direct payment support services and third party budgets
- A joined-up process for personal budget implementation and review
- An individual statement of resources for the people who can have a personal budget, which provides an indicative budget

Personal budgets summary guide — Click to download

Options for managing the money — Click to download

Finance and commissioning handbook — Click to download

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Integrated Personal Commissioning

Enabler: Personalised commissioning and payment

Go back to operating model

Go back to operating model

Personalised commissioning and payment

Accessing a wider range of care and support options tailored to individual needs and preferences, through personalised contracting and payment

What this looks like

What will sites need to put in place?

What to put in place

The steps to take to put this into practice	Product
	Product
	Product

What information is available

Plain English guide to personalised health and care

What is IPC film

Personalised commissioning and payment film

Personalised commissioning and payment

What this looks like

What this looks like for the site

- Health and care commissioners have identified shared priorities for IPC within strategic commissioning intentions
- Commissioners can clearly identify the current cost of services at contract, service, cohort and individual level
- Commissioners can clearly demonstrate the contracting shifts to support IPC implementation
- There are clear systems and processes to release funding from current contracts. This can be by cohort, population or individual costs
- Sites have clear strategic plans and can clearly articulate how they will increase IPC at pace and scale beyond current cohorts
- People can influence decisions about commissioning, ensuring that care and support is geared to the needs of diverse groups

What will IPC sites need to put in place?

- A clear plan to identify resource in contracts and appropriate approaches to release it
- As a minimum, joint commissioning arrangements to enable IPC as a local strategic priority

How to put this into practice?
What to put in place

Personalised commissioning and payment

What to put in place

These are the steps to put this shift into practice

- A clear plan to identify resource in contracts and appropriate approaches to release it
- As a minimum, joint commissioning arrangements to enable IPC as a local strategic priority

Personalised commissioning and payment summary — Click to download

Finance and commissioning handbook — Click to download

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Integrated Personal Commissioning

Enabler: Leadership, co-production and change

Go back to operating model

Go back to operating model

Leadership, co-production and change

Strategic endorsement and prioritisation of IPC, with leaders at all levels delivering a coordinated action plan

What this looks like

What will sites need to put in place?

What to put in place

The steps to take to put this into practice	Product
	Product
	Product

Leadership, co-production and change

What this looks like

What this looks like for the site

- We have senior, strategic endorsement of IPC across key partner organisations and a shared vision and strategy for implementing IPC
- We reflect IPC as a strategic priority through key system and organisational planning processes and strategic governance arrangements bringing together IPC and related programmes
- There are a wide range of people at different organisational roles who are actively and enthusiastically involved and demonstrate they understand what IPC is and what it can offer
- There is dedicated organisational capacity to take IPC forward as a significant local change programme
- The local IPC approach takes into account the duties on equality and health inequalities

What will IPC sites need to put in place?

- Use the operating model to design their system and identify actions needed, and get commitment from all relevant people (including people with lived experience) incorporating mapping out key strategic leaders and identify their roles in championing and enabling IPC
- As an underpinning approach, sites must engage with people with lived experience from the IPC cohort who are informed and enabled to influence key decisions on an equal footing with other stakeholders (co-production)

How to put this into practice?
What to put in place

Leadership, co-production and change

What to put in place

These are the steps to put this shift into practice

- Use the operating model to design their system and identify actions needed, and get commitment from all relevant people (including people with lived experience) incorporating mapping out key strategic leaders and identify their roles in championing and enabling IPC
- As an underpinning approach, sites must engage with people with lived experience from the IPC cohort who are informed and enabled to influence key decisions on an equal footing with other stakeholders (co-production)

Co-production summary guide and framework

Click to download

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Enabler: Workforce

Go back to operating model

Go back to operating model

Workforce

A cross-organisation approach to support and develop people's roles, skills, knowledge and the wider culture to deliver IPC

What this looks like

What will sites need to put in place?

What to put in place

The steps to take to put this into practice

- Product
- Product
- Product

Workforce

What this looks like

What this looks like for the site

- We have a local cross-organisational workforce strategy that identifies roles, responsibilities and governance arrangements for IPC delivery. The strategy addresses any role redesign, skills merging or development required.
- We have a plan in place across health, social care and education for developing the skills, knowledge and culture shift necessary to deliver IPC. This plan has clear links with the local workforce strategy and includes statutory, VCSE and relevant provider organisations.
- Workforce development reflects the diversity of the local community, and is geared to the workforce race equality standard and workforce disability equality standard

What will IPC sites need to put in place?

- Mapping and gapping across the local system (including VCSE) to identify the roles, skills and capacity needed to deliver IPC
- Develop a dedicated workforce development strategy, and dedicated champion roles

How to put this into practice?
What to put in place

Workforce

What to put in place

These are the steps to put this shift into practice

- Mapping and gapping across the local system (including VCSE) to identify the roles, skills and capacity needed to deliver IPC
- Develop a dedicated workforce development strategy, and dedicated champion roles

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Annex: IPC and carers

About carers

- Carers are people who look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid. Carers include adults looking after other adults, parent carers looking after disabled children and young carers under 18

- The Care Act 2014 gives local authorities a responsibility to assess a carer's needs for support, where the carer appears to have such needs. The new provision works alongside other measures in the Care Act 2014 to enable a whole system, whole family approach to assessment and support and bestows a duty of co-operation on local authorities and all agencies involved in public care. The Children and Families Act (2014) gives young carers (and parent carers) similar rights to assessment as other carers have under the Care Act.

- Caring has a significant impact on carers' own physical and mental health and their education and employment potential. This can result in significantly poorer health and quality of life outcomes. Carers are more than twice as likely to suffer from poor health compared to people without caring responsibilities. This in turn can affect a carer's effectiveness and lead to the admission of the cared for person to hospital or residential care.

An integrated approach to carers

IPC supports the delivery of the key principles of the memorandum of understanding between health and social care in “An integrated approach to identifying and assessing carer health and wellbeing” (NHS England, 2016), also supported by ADASS and carers organisations. The principles are:

1. We will support the identification, recognition and registration of carers in primary care
2. Carers will have their support needs assessed and will receive an integrated package of support in order to maintain and/or improve their physical and mental health
3. Carers will be empowered to make choices about their caring role and access appropriate services and support for them and the person they look after
4. The staff of partners to this agreement will be aware of the needs of carers and of their value to our communities
5. Carers will be supported by information sharing between health, social care, carer support organisations and other partners to this agreement
6. Carers will be respected and listened to as expert care partners, and will be actively involved in care planning, shared decision-making and reviewing services
7. The support needs of carers who are more vulnerable or at key transition points will be identified early

IPC and carers

- IPC offers an opportunity to develop an integrated approach to the identification, assessment and support of carers' health and wellbeing needs across health and social care to:
  - Maintain the independence, physical health and emotional wellbeing of carers and their families
  - Empower and support carers to manage their caring roles and have a life outside of caring
  - Ensure carers receive the right support, at the right time, in the right place
  - Respect the carer's decision about how much care they will provide and respect the carer's decision about not providing care at all
- In the following slides is shown how each key shift and enabler of the IPC operating model applies to carers
- For each it is also shown how each key shift / enabler supports delivery of the key principles of the memorandum of understanding between health and social care outlined in "An integrated approach to identifying and assessing carer health and wellbeing"
- For more information, there is also a Carers Quick guide about personal health budgets and Integrated Personal Commissioning

Carers experience of IPC

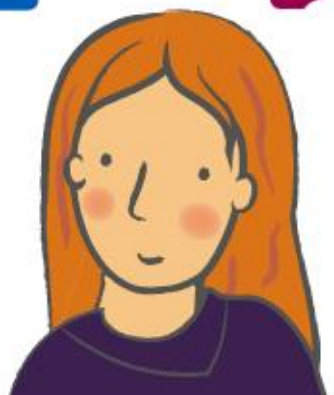
A different conversation that includes you as an expert care partner in care and support planning for the person you care for **and about your needs in your own right.**

A **community and peer** approach to build your knowledge, confidence and connections.

A **shift in control** over any resources available to you, and a joined up approach to make things work well for everyone in the family.

A **proactive approach** to recognising you as a carer and supporting you to maintain your health and well being.

A **wider range of care and support** options for you as a carer to choose to have support with caring, a break from caring and a life outside of caring.



Proactive or reactive referral routes

Principle 1: We will support the identification, recognition and registration of Carers in primary care

- Reactive
  - Carers, including young carers, are identified and information recorded wherever contact is made with them or with the person the support, including with health and primary care, social care or voluntary sector and discussions initiated through asking key questions such as:
    - Is there anyone at home who helps you with your care and support?
    - Do you look after someone who couldn't manage without your help and support?
    - Are you willing/able to continue your caring role and what support do you need to do this?
    - Are there any children in the household?
    - Will any of these children be involved in caring?
- Proactive:
  - Approaches such as carers' clinics, annual carers' health checks, carers' drop in services provide opportunities to identify and support carers

Proactive coordination of care

Principle 2: Carers will have their support needs assessed and will receive an integrated package of support in order to maintain and/or improve their physical and mental health

- Carers are recognised and supported through local agencies working together to develop integrated systems and support to meet identified and emerging needs of carers
- This ensures:
  - Carers rights to a formal assessment of their needs in their own right is recognised
  - Assessment and care planning respects the carer's decision about how much care they will provide, including any carer's decision about not providing care at all
  - Carers are listened to and included as expert partners in care and support planning
  - Additional support, either in order to continue their caring role, to continue contributing to their family and social networks or in employment outside of the home, is identified

Delivering care and support

Principle 3: Carers will be empowered to make choices about their caring role and access appropriate services and support for them and the person they look after

Principle 6: Carers will be respected and listened to as expert care partners, and will be actively involved in care planning, shared decision- making and reviewing services

- **Community capacity and peer support**: carers are offered advice and information at an early stage and connected to community support, including carers organisations
- **Personalised care and support planning**: carers (including young carers) are identified and listened to. Their specific needs as a carer are identified and care and support plans are aligned and take a whole-family approach
- **Personal budgets**: are made available to carers where eligible in their own right for support. Small payments enable carers to access breaks, support or items that help achieve their health and wellbeing outcomes

Making it happen

Principle 5: Carers will be supported by information sharing between health, social care, carer support organisations and other partners to this agreement

- Partnership working and cooperation enables a joined-up approach to support carers supported by a local memorandum of understanding between health and social care
- Local data and information sharing processes enable information to follow the carer across their own care and support pathway
- Risk stratification and carer assessment tools allow for predictive modelling to develop preventative and other support resources to meet the needs of carers approaching key transition points
- The needs of carers including young carers are recognised and planned for by commissioners

Review

Principle 7: The support needs of carers who are more vulnerable or at key transition points will be identified early

- Carers are included in the review conversations and their needs are discussed and considered at review stage
- Carers know who to contact if their needs or circumstances change or they have concerns
- Young carers are identified and their needs reviewed including in particular at transition points such as moving school and approaching the age of eighteen
- The needs of parent carers are also reviewed at key transition points for their child

Leadership and co-production

Principle 6: Carers will be respected and listened to as expert care partners, and will be actively involved in care planning, shared decision- making and reviewing services

- Carers are respected and listened to as expert care partners
- Carers are actively involved in the planning of care for the person they care for
- Carers are fully engaged in a co-produced process for planning, redesign and shaping of services
- Carers are identified as champions and leaders in developing IPC

Workforce and carers

Principle 4: the staff of partners to this agreement will be aware of the needs of carers and of their value to our communities

- Workforce development plans across sectors include carer awareness training to develop understanding of how to identify and support carers
- Integrated processes and procedures include a focus on carers and whole family approaches
- Awareness of young carers is raised and practitioners understand their responsibilities in identifying and addressing the needs of young carers
- Understanding is developed of the wide range and scope of caring roles including, for example, older carers, LGBT and BME carers, multiple caring roles, mutual caring, end of life and bereavement for carers

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Further information and contact details

Further information and contact details

The IPC operating model is part of the Personalised health and care framework

The framework provides advice and practical guides for the NHS and local government to support progress with Integrated Personal Commissioning and personal health budgets

Other information about IPC includes:

- What is Integrated Personal Commissioning?
- Information for people, carers and families about Integrated Personal Commissioning
- IPC emerging framework

For further information about the IPC programme contact us at:

england.integratedpersonalcommissioning@nhs.net

Twitter: @IPCEngland, @NHSPHB, #IPCEngland, #FutureNHS

Interactive IPC operating model

www.england.nhs.uk/personalisedcare

Email: **england.integratedpersonalcommissioning@nhs.net**
england.personalhealthbudgets@nhs.net
The information provided in this framework can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact **0300 311 22 33** or email **england.contactus@nhs.net**

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