



Integrated Personal Commissioning

Emerging Framework



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Version number: 1.1

First published: May 2016

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Contents

Introduction	3
About the programme	4
The emerging IPC framework	5
Proactive coordination of care	9
Community capacity and peer support	11
Personalised care and support planning	13
Choice and control	15
Personalised commissioning and payment	17
NHS England and the LGA's approach to the programme	18
Annex 1: IPC product delivery	21
Annex 2: IPC demonstrator sites	22

Introduction

- i. Integrated Personal Commissioning (IPC) is one of the pillars of the Five Year Forward View¹. It empowers people and communities to take an active role in their health and wellbeing with greater choice and control over the care they need. It supports the improvement, integration and personalisation of services, building on learning from personal budgets in social care and driving bold expansion plans for personal health budgets.
- ii. Better integration between health and social care is a priority to address fragmentation between services, and improve people's experience of, and outcomes from care. Other integration initiatives focus at the system, organisational or functional level. Alongside these approaches, IPC provides practical solutions to integration at the level of each individual, harnessing the potential for people and communities to co-ordinate their own health and care.
- iii. In the 18 months since the publication of the Five Year Forward View, a number of national programmes have launched in addition to IPC, which are transforming the health and social care system dramatically. These include the New Care Models Programme, the Better Care Fund (BCF), Transforming Care, further devolution, co-commissioning of primary medical services and most recently Sustainability and Transformation Plans (STPs).
- iv. Empowering people and communities through personalisation and choice are central components of the shared vision that these programmes are making a reality. It is important that the commissioning landscape that underpins the health and social care system in 2020 is characterised as much by the ability to personalise and shape care and support in response to individual needs and preferences, as it is by place-based approaches and new models of care.
- v. In future, IPC and personal health budgets will provide essential counterbalances to whole population commissioning models. Within or alongside overarching place-based models of care, they will enable people who need a more personalised approach to opt out of their local provider for particular services where appropriate, and take increased charge of decision making around their care.
- vi. The IPC Programme will expand in 2016-17 through early adoption of the model by other sites, representing the first stage of national roll-out. Learning from the demonstrator sites so far indicates that IPC could be the mainstream model of community based care for around 5% of the population, including people with multiple long term conditions, people with severe and enduring mental health problems, and children and adults with complex learning disabilities and autism. By 2020, the model will be in place in every locality, planned and delivered in partnership with social care and the voluntary, community and social enterprise (VCSE) sector.

¹ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> Page 3

About the programme

- vii. The IPC Programme was launched in April 2015 as a partnership between NHS England and the Local Government Association (LGA). In 2014, health and care organisations were invited to apply to become IPC demonstrator sites, with nine areas subsequently chosen following a rigorous selection process. Each demonstrator site is developing a new model of care that will expand to cover everyone with complex needs in their area by 2018.
- viii. The programme is aimed at those groups of individuals who have high levels of need, often with both health and social care needs, where a personalised approach would address acknowledged problems in current care provision, helping prevent people from becoming more unwell and enabling people to retain their independence. This includes:
 - Children and young people with complex needs, including those eligible for education, health and care plans.
 - People with multiple long-term conditions, particularly older people with frailty.
 - People with learning disabilities with high support needs, including those who are in institutional settings or at risk of being placed in these settings.
 - People with significant mental health needs, such as those eligible for the Care Programme Approach or those who have high levels of unplanned care.
- ix. Each local demonstrator programme is grounded in knowledge about their particular community, with each site choosing different cohorts of people as their starting point and delivering IPC aligned to local priorities. The national programme is drawing together the learning from demonstrator sites to develop, test and refine common frameworks and solutions wherever possible, whilst removing the barriers and creating the enablers for radical system change. The programme is focused on producing simple, replicable products and approaches designed for wider adoption and spread.
- x. This document is for commissioners in both clinical commissioning groups (CCGs) and local authorities, their delivery partners in education and the VCSE sector, and for local authority and NHS-funded care providers. Over the following pages, the emerging IPC framework is summarised, based on learning from the first year of delivery. Specific components of the IPC model are clarified, with particular emphasis given to those that add the greatest impact and value for people using health and care services. Finally, this document confirms NHS England's commitment to and timelines for producing blueprints to enable replication of IPC by other local systems during 2016-17 and plans for national roll-out.
- xi. A commitment to reducing inequalities between patients in terms of access and outcomes from healthcare services is central to the aims of the IPC Programme, and is reflected throughout this document and the framework it describes. All CCGs are similarly expected to consider and address issues around equality and health inequalities in the design and delivery of local IPC programmes.

The emerging IPC framework

- xii. IPC is a new approach to joining up health, social care and other services (such as education for children and young people) at the level of each individual. It enables people, carers and families to control the resources available and to shape their own care. It also supports people to make the most of the community resources around them and to develop their knowledge, skills and confidence. It does this through targeted peer support, community capacity building and an expanded role for the VCSE sector in preventing or reducing the need for unplanned care.
- xiii. IPC is delivered through enhanced multi-disciplinary teams within care coordination hubs, usually located in primary care and drawing together generalist, social, mental health and specialist care with the voluntary sector. This means a completely different approach to planning and commissioning community, social care and other services, and the adoption of evidence-based approaches to delivering personalisation at scale for target populations.
- xiv. The emerging IPC framework is characterised by five key shifts in the model of care, underpinned by a number of specific service components. Together these drive improved outcomes for people, the system and the tax payer:

1.

Proactive coordination of care:

A proactive approach to integrating care at individual level around adults, children and young people with complex needs

2.

Community capacity and peer support:

A community and peer focus to build knowledge, skills and confidence for self-management

3.

Personalised care and support planning:

A different conversation about health and care focused on what is important to each person, through personalised care and support planning

4.

Choice and control:

A shift in control over the resources available to people, carers and families, through personal budgets

5.

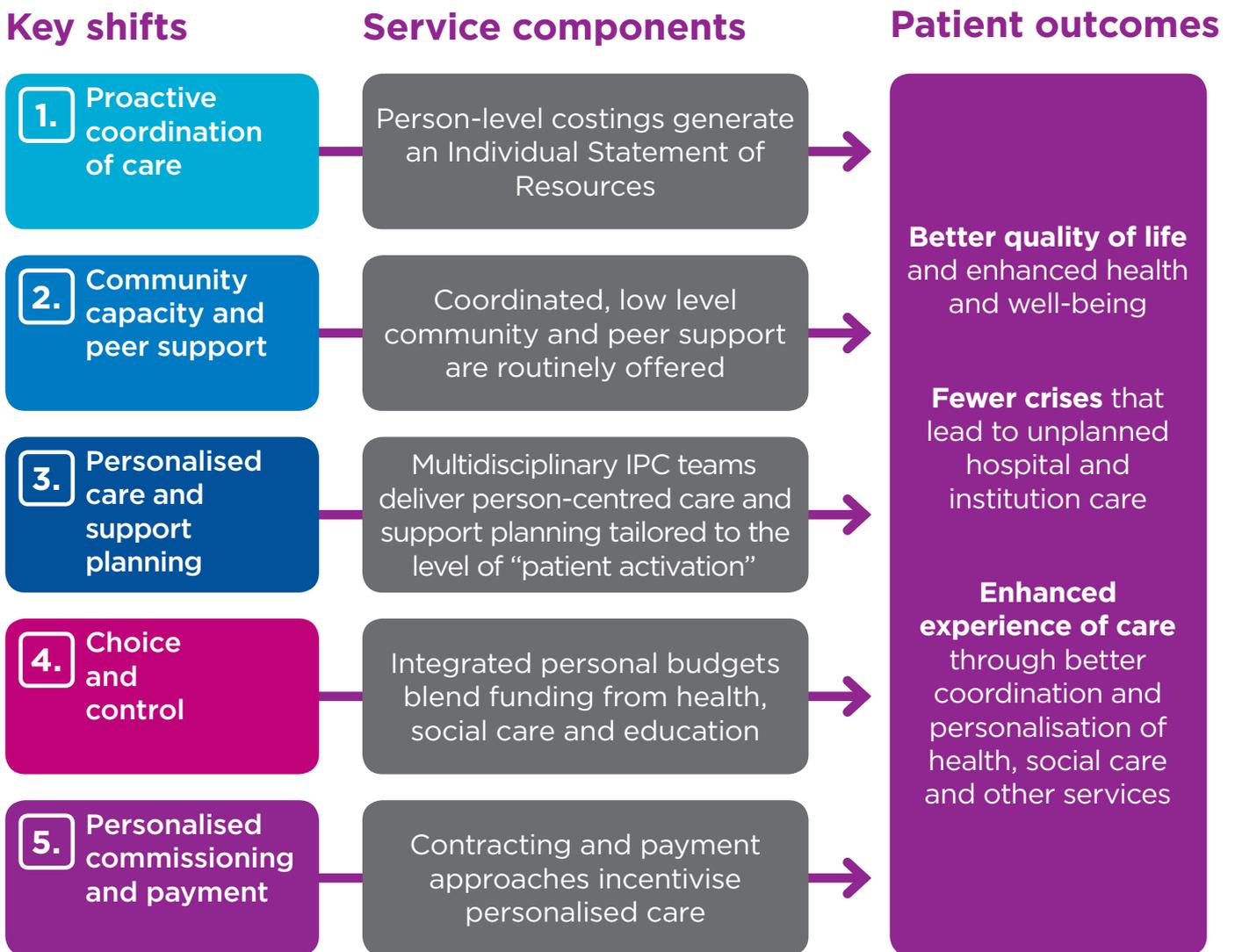
Personalised commissioning and payment:

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

Emerging Framework

- xv. This emerging framework is based on learning so far from the demonstrator sites and will evolve further as the programme progresses. The detail of the model is being co-produced in partnership with demonstrator sites through a collaborative development process, supported by rapid cycle implementation and evaluation. A series of products from this work will be published in early 2017 (see Annex 1).

Figure 1: The emerging IPC framework



- xvi. The schematic below illustrates how IPC interventions could be implemented per a notional figure of 1000 individuals in a typical CCG population. Demonstrator sites have projected their core programme activity for 2016-2018 for their target populations, in line with this model.

Figure 2: Projected implementation of IPC per 1000 people in a typical CCG population

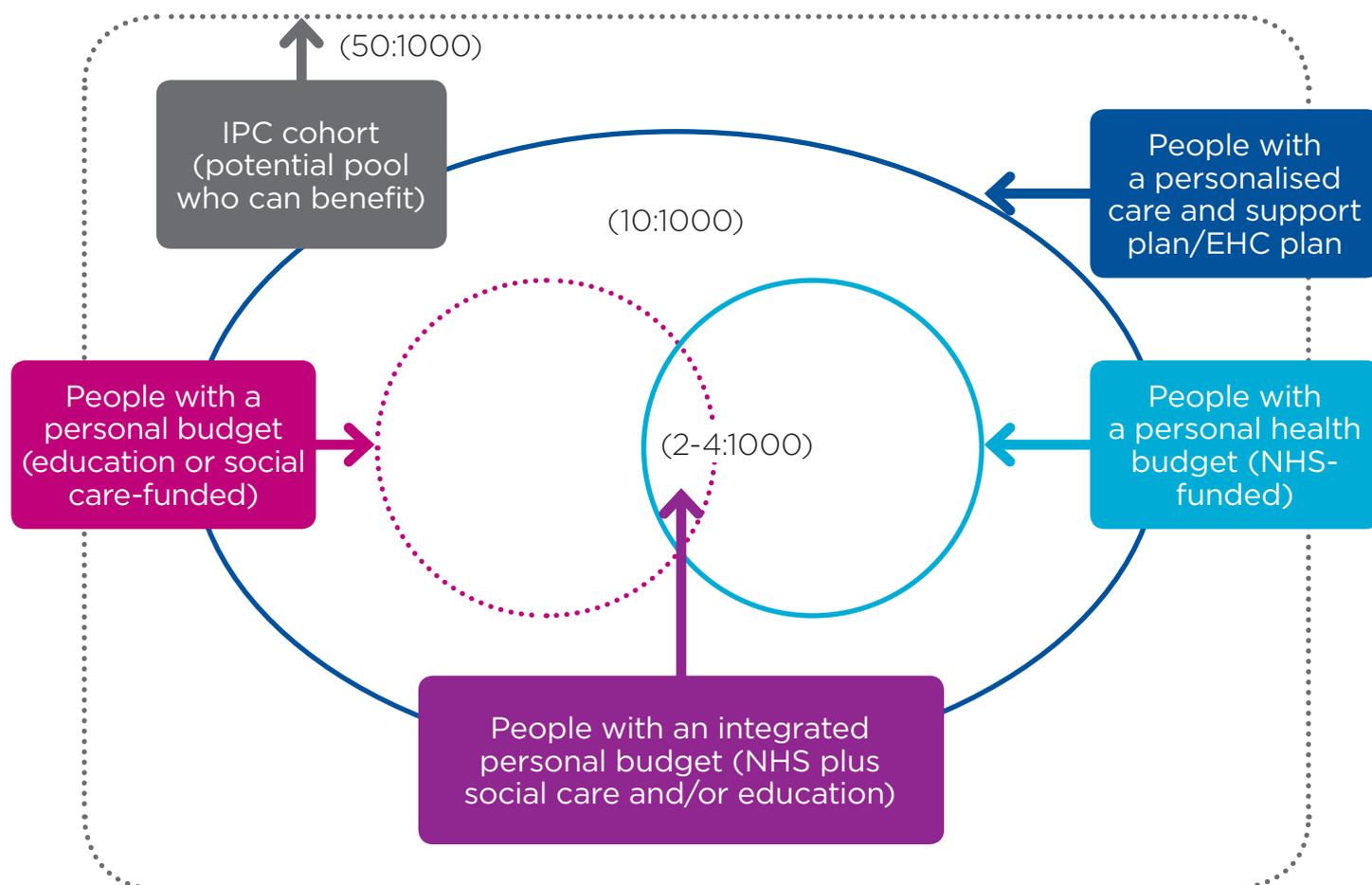


Figure 2 above addresses the following areas:

- xvii. **The IPC cohort:** The largest likely proportion of the CCG population who could benefit from IPC. This is usually around 5% of the general population, including people who benefit from low level interventions and community centred approaches, as well as those who go on to get personalised care and support plans and personal budgets.

People with a personalised care and support plan/education, health and care (EHC) plan: People within the IPC cohort who have a completed personalised care and support plan, amounting to around 1% of the general population.

People with a personal budget for social care or education: People within the IPC cohort who have a completed personalised care and support plan/EHC plan and personal budget in place that includes only social care or education funding.

People with a personal health budget: People within the IPC cohort who have a completed care plan/EHC plan and personal budget in place that includes NHS funding.

- xviii. Demonstrator sites have already made significant strides in developing their operational capability and in growing momentum for scaling up IPC. There are a number of examples of this, including:
- In Portsmouth the programme has built a strong community navigation service as an integral part of their pathway for older people with multiple long term conditions, in partnership with Age UK.
 - In Luton a Care Banking IT system is being developed to manage integrated personal budget payments.
 - In Lincolnshire a countywide approach to coproduction has been established, which underpins the design of the local care model.
 - In Tower Hamlets a comprehensive health and social care linked dataset is in place that will be used to derive personal budget allocations for IPC participants.

IPC service components:

Each key shift in IPC is delivered through specific service components, which are the changes that need to take place at a service level. These elements of the IPC model are being taken forward by demonstrator sites, using common frameworks and approaches, informing the development of specific products that will support wider replication and spread. These components are described in the remainder of this framework, alongside descriptions of further enablers that are important to delivery. A full set of the service components and example products is listed in Annex 1.

1. Proactive coordination of care

A proactive approach to integrating care at individual level around adults, children and young people with complex needs

Delivering the change:

- 1.1. IPC is aimed at improving the experience of care for people with complex, ongoing physical, social and mental health needs and those who are at high risk of crises leading to unplanned or institutional care. Evidence shows these groups have the poorest experiences of and outcomes from care in the current system. In future, it is anticipated that IPC could be the predominant model of community-based care for around 5% of the population, including people with multiple long term conditions, frailty, severe and enduring mental health problems and children, young people and adults with complex needs, including learning disabilities and autism.
- 1.2. Demonstrator sites have taken a number of approaches to identifying their cohorts, including risk stratification using primary and acute care data (e.g. through the Avoiding Unplanned Admissions: Proactive Case Finding and Care Review for Vulnerable People Enhanced Service²), local intelligence gathering and screening, and using “at risk of admission registers” deployed for Transforming Care. Further population segmentation within “at risk” groups has helped to define and identify specific cohorts of people with similar needs who could benefit from IPC.
- 1.3. IPC uses person-level costing, costs defined at the level of the individual, to understand current service use and plan how resources can be used differently in accordance with individual needs and preferences. Demonstrator sites are gathering and linking cost and activity data across health, social care and education where appropriate, and putting in place information governance solutions to enable data sharing and linking. This work is designed to accelerate the adoption of IPC by other systems in the future by providing reference costs for different population groups.
- 1.4. People within target cohorts are proactively approached, identified through GP referral or through an established review process (e.g. for people with mental health problems who under the Care Programme Approach (CPA)). In future, people will be able to opt in to IPC where they could benefit from a bespoke package of care rather than remain with their existing provider.

² <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/03/avoid-unplanned-admissions-03-15.pdf>

Core service components:

- **1A: Cohort identification and person-level costing** informed by a common framework for how groups of people likely to benefit from IPC have been identified and defined, and the link between these cohorts and wider local health and care economy challenges. This component also includes the information governance solutions that have been deployed locally to enable data sharing and linking for these populations.
- **1B: An IPC Individual Statement of Resources** showing the average expenditure across all services for someone with an equivalent profile. This includes an indication of the amount that can be taken as a personal budget and information on community based and universal services. Statements are provided annually, building in retrospective detail regarding actual service use over time to inform future care and support planning.

Further enablers:

- **Tailored information and advice** regarding IPC and its potential benefits, provided to patients in a variety of formats, including digital information and the option of face-to-face advice. Whether directly approached or identified through routine appointments with primary medical services, people are offered an introduction to a community connector for initial assessment and care planning.
- **An enhanced advocacy offer** aimed particularly at those with low levels of health literacy, i.e. those who might not understand information they are provided with about health, and with a key role for VCSE organisations. Independent advocacy services assist individuals in accessing information, understanding choices and having their wishes understood. These services are central to the initial care planning process for key groups and in resolving problems as they arise in the delivery of the plan.

2. Community capacity and peer support

A community and peer focus to build knowledge, skills and confidence for self-management

Delivering the change:

- 2.1. IPC takes an asset-based approach to helping people build their knowledge, skills and confidence, viewing patients as active co-producers of health and wellbeing, rather than passive recipients of services, and explicitly valuing the potential in communities. It does this by harnessing peer and community capacity to support self-management and through improved networking of formal care services with neighbourhood and community resources.
- 2.2. IPC is adopting the learning from Realising the Value³ and working together with NHS England's emerging Self Care Programme, to promote the use of evidence-based approaches including health coaching, self-management programmes, peer support, group activities and asset-based community development. IPC supports a bottom-up process to identify, align and coordinate existing community-centred approaches in each demonstrator site, and to enhance these through the adoption of common frameworks and principles. In some instances access to these interventions is coordinated outside formal care processes to prevent people from entering the system, while in others it is facilitated through personalised care and support planning.

Core service components:

- **2A: The establishment of community connecting roles (e.g. Local Area Coordinators)** that play a vital part in “bridging” between people, services and the community. Coordinators embedded in IPC teams offer a range of support, including initial “guided conversations” to help IPC participants identify goals and actions, making connections to community based resources and facilitating further referrals (e.g. for social care assessment). Coordinators may also signpost to local VCSE organisations and groups with a defined role in improving health literacy or linking people to each other to enhance their social connections.
- **2B: The systematic use of peer support** through IPC involves routinely linking people into peer groups, networks and online forums to support self-management. This happens through a clearly defined process that enables people to better understand the range of peer support options available to them and explore the alternatives. By providing people with relevant information and enabling them to make connections, people can determine which approach best fits their circumstances. Demonstrator sites are testing different peer support models, depending on their initial target populations, each within a common framework of organisational support and training.

³ <http://www.nesta.org.uk/project/realising-value>

Further enabler:

- **A strategic approach to community capacity building** underpins IPC in each area, with clear and enhanced roles for community and VCSE organisations in service planning and delivery being an explicit goal of the programme. Demonstrator sites are using a variety of evidence-based methodologies tailored to local circumstances, within a common high-level framework and with a shared commitment to coproduction with people and families.

3. Personalised care and support planning

A different conversation about health and care focused on what is important to each person, through personalised care and support planning

Delivering the change:

- 3.1. At the heart of IPC is personalised care and support planning. The approach being adopted models the principles of collaborative care, through consistent application of a number of evidence-based steps in the care planning process. The process is holistic, covering all health and wellbeing needs and leading to a coordinated assessment and a single personalised plan, owned by each individual and geared towards maximising their personal potential for self-management. The purpose of personalised care and support planning is to enable people to develop the knowledge, skills and confidence to manage their own health and social care needs, to anticipate and take steps to manage setbacks and to know who to contact in times of need.
- 3.2. Personalised care and support planning is offered to everyone in the IPC target population, whose needs are not fully met through the community connecting service, and is also managed through the IPC team. Planning is designed to be proportionate, tailored to each person's level of "activation," and reflecting the full spectrum of input, from light-touch, technology enabled support for self-planning, through to more intensive one-to-one support, with simple tools deployed to tailor the approach accordingly. For children and young people with special educational needs and disability (SEND), this is aligned with the local EHC planning process.
- 3.3. Whilst local delivery arrangements vary, demonstrator sites are testing a number of standardised components of delivering personalised care and support planning.

Core service components:

- **3A: Common planning methodology and resources** to support defined stages of planning, aligned to the Think Local Act Personal (TLAP) framework described in the Personalised Care and Support Planning Tool⁴ and adapted for children with SEND. This includes the routine offer of personal budgets, a common outcomes framework and use of the Patient Activation Measure (PAM)⁵. PAM is a simple measure of a person's knowledge, skills and confidence, which is used in IPC to enhance planning by tailoring information and support to each individual's needs and

⁴ <http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/>

⁵ <https://www.england.nhs.uk/ourwork/patients/patient-participation/self-care/patient-activation/>

circumstances. The evidence^{6 7} shows a strong association between increased activation, better outcomes and lower costs. IPC embeds PAM as standard practice for cohorts where there is established evidence and is adapting the measure for testing with other groups, including people with dementia and people with learning disabilities.

- **3B: IPC support teams** deliver planning and care coordination functions, combining staff with a range of clinical and professional expertise (including GPs, nurses, social workers and mental health specialists), with vital input from the voluntary and community sector, peers and volunteers. IPC support teams operate within wider multi-disciplinary care coordination hubs usually located in primary care and are explicitly designed around the delivery of community connecting services and personalised care and support planning for IPC cohorts.

⁶ <http://www.ncbi.nlm.nih.gov/pubmed/23381513>

⁷ <https://www.england.nhs.uk/ourwork/patients/patient-participation/self-care/patient-activation/pamlearning/>

4. Choice and control

A shift in control over the resources available to people, carers and families, through integrated personal budgets

Delivering the change:

- 4.1. Through IPC, all adults, children and young people with a personalised care and support plan have the option of a personal budget for all or part of their care. Personal budgets are a commissioning tool that give people more control over the care they receive and more choice over how their needs are met. The evidence from health and social care shows that, when implemented well, personal budgets are cost effective, improve people's quality of life and experience of care, whilst promoting self-management and reducing reliance on acute services.^{8,9}
- 4.2. Demonstrator sites are implementing a new integrated process that will become the single delivery model for personal health budgets in the NHS, personal budgets in social care for people with complex needs, and personal budgets for children and young people with an EHC plan in the future.
- 4.3. Each IPC participant receives an early estimate of their budget and how it is made up through their IPC Individual Statement of Resources. The detail of how the personal budget is used is set out in the personalised care and support plan agreed between the participant and the IPC team. Participants have the flexibility to choose the degree of control that is right for them with the support they need.

Core service components:

- **4A: An integrated approach to budget setting** underpinned by common principles and methodologies and adapted for particular groups. Whilst a variety of transitional models are being deployed to enable quick progress, ultimately IPC sites will use linked datasets to derive annual, average costs for their cohorts, including banded funding levels for cashable components of care. This informs a bottom-up process for costing care plans, for each individual. In future, this new process may inform national reference costs to fast-track IPC's adoption in other systems.
- **4B: Three personal budget deployment options** for people to choose how their funding is managed. A direct payment option (where all or part of the personal budget is paid directly to the person or a carer to commission services directly for the support they need); a third party personal budget (where funds are placed with an organisation that buys the services the person needs and accounts for the money to the commissioner); or a notional personal budget (where the CCG or local authority commissions and coordinates care on the person's behalf).

⁸ <http://php.york.ac.uk/inst/spru/research/summs/ibsen.php>

⁹ <https://www.phbe.org.uk/>

Further enabler:

- **A single administrative process** that allows participants to access their personal budget quickly and efficiently, regardless of how it is funded. Depending on assessed need, participants can access personal health budgets, personal budgets for social care (reflecting any amount the person must pay following a financial assessment) or personal budgets that blend funding from both, including education where applicable. This single, robust process enables combined payment and administration and is designed to support the inclusion of other funding streams in future.

5. Personalised commissioning and payment

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

Delivering the change:

- 5.1. Creating a health and care system driven by people and communities and incentivised to achieve the outcomes most important to them requires a different approach to commissioning, contracting and payment. Demonstrator sites are setting clear commissioning intentions (including regarding the expansion of personal health budgets), designing personalised service specifications and quickly shifting towards payment methods that enable resources to follow IPC participants.
- 5.2. This shift requires taking a strategic approach to facilitating local health and care markets so that IPC participants can access a wider range of personalised care, including from the VCSE sector. This work is underpinned by developing a common framework that builds on the market shaping duty in the Care Act 2014¹⁰, and looks beyond conventional services and tariffs towards stimulating the provision of new types of service in response to individual needs and preferences.

Core service components:

- **5A: Unlocking funding from block contracts** to manage the financial risk of implementing personal health budgets at scale beyond the defined frameworks of NHS Continuing Healthcare and social care. Demonstrator sites are working with NHS-funded providers to identify opportunities for contract variations that enable more personalised working and for resources to be released for personal budgets. This involves moving away from block contracts, unbundling tariffs, setting local unit costs and adapting services in response to changing demand.
- **5B: An IPC Contract Framework** is being developed to enable consistent implementation at scale and to ensure ultimate compatibility between IPC and the New Care Models Programme, in particular with multispecialty community providers (MCPs) and primary and acute care systems (PACS). The national team is working closely with demonstrator sites and the vanguards to define and test approaches and explore new payment mechanisms to minimise local administrative burden.

¹⁰ <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

Further enabler:

- **Individual Service Funds (ISFs)** are being established within existing contracts through the incremental increase of an element of the contract earmarked for personal budgets. ISFs are notional personal budgets, managed by a provider in accordance with the person's individual requirements and include the option to buy services elsewhere, insofar as is possible and where the services fulfil the identified need(s) for which the funds have been allocated. This enables providers to take on the responsibility for the combined costs of a group of IPC participants, offering personal budget management and provision with a clearer accountability for spend to the individuals covered by the contract.

NHS England and the LGA's approach to the programme

IPC is a highly ambitious programme requiring demonstrator sites to work at a fast pace to implement wide ranging transformational change. NHS England and the LGA are committed to ensuring that local ambition is matched by national support to enable the change to happen. This support is strongly underpinned by four key principles:

- **Collaborative leadership:** that shares the ownership and responsibility for programme delivery between the national team and local areas,
- **Common approaches:** so that the active ingredients of IPC are co-designed with sites to build the simplest, standardised approaches,
- **Strong external partnerships:** to ensure the right expertise is on hand, including through a national VCSE strategic partners programme,
- **Modelling an approach to coproduction:** to ensure all our work nationally and locally is grounded in delivering the changes people want to see.

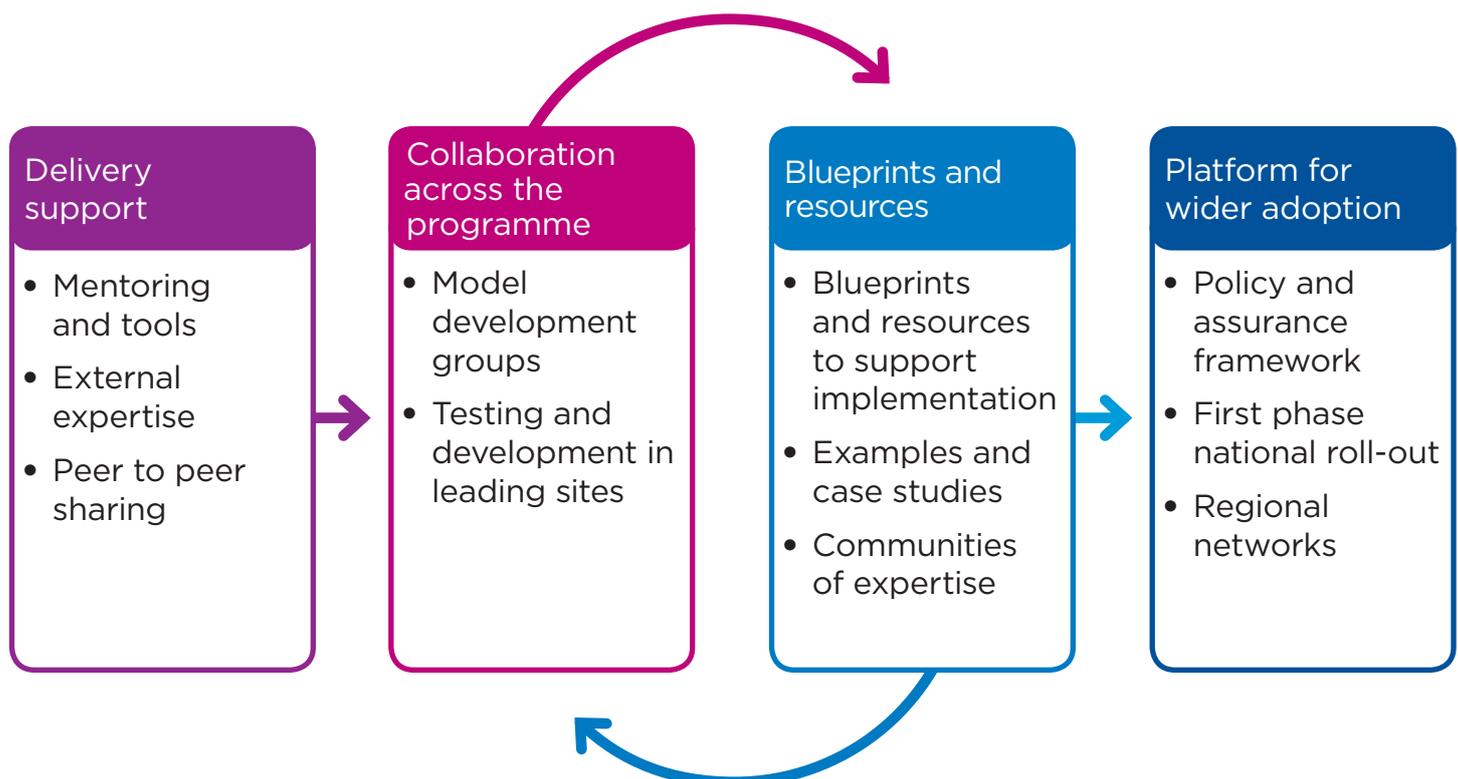
NHS England and the LGA have worked closely with demonstrator sites to determine the focus and scope of national support. So far this has included:

- **Targeted funding** to ensure the right people and programme infrastructure is in place to enable progress,
- **Dedicated support to engage senior leaders** locally and with development of strategic plans for IPC delivery,
- **Opportunities to share learning across sites**, including online and offline networks and mentoring support,
- **Practical tools and training** to support local stakeholder events and enable progress with particular aspects of the model (e.g. personalised care and support planning),

- **Support with coproduction** to strengthen local mechanisms for participation of people with complex needs and their families,
- **Access to national expertise** to provide timely answers to policy questions and technical guidance on implementation issues,
- **Dedicated support on finance** focused in year one predominantly on data collection and development of person-level costings,
- **Up to date advice and guidance on information governance** issues, working in partnership with the Integrated Care Pioneers and Better Care Fund programmes,
- **Development of a national menu of metrics** for core IPC activity and outcomes (in use across the programme in 2016-17),
- **Support with local evaluation** from a dedicated team of analysts.

This support has been provided to lay the foundations for an increased pace and scale of delivery in 2016-17. Raised expectations around the programme are being set out in new Memoranda of Understanding with each demonstrator site, including the commitment to strengthen the support on offer and enhance collaboration across the programme to design, test and refine the core components of IPC. The approach focuses on the development of simple, standardised solutions and the supporting enablers that will underpin their successful adoption.

Figure 3: Approach to IPC programme delivery



Emerging Framework

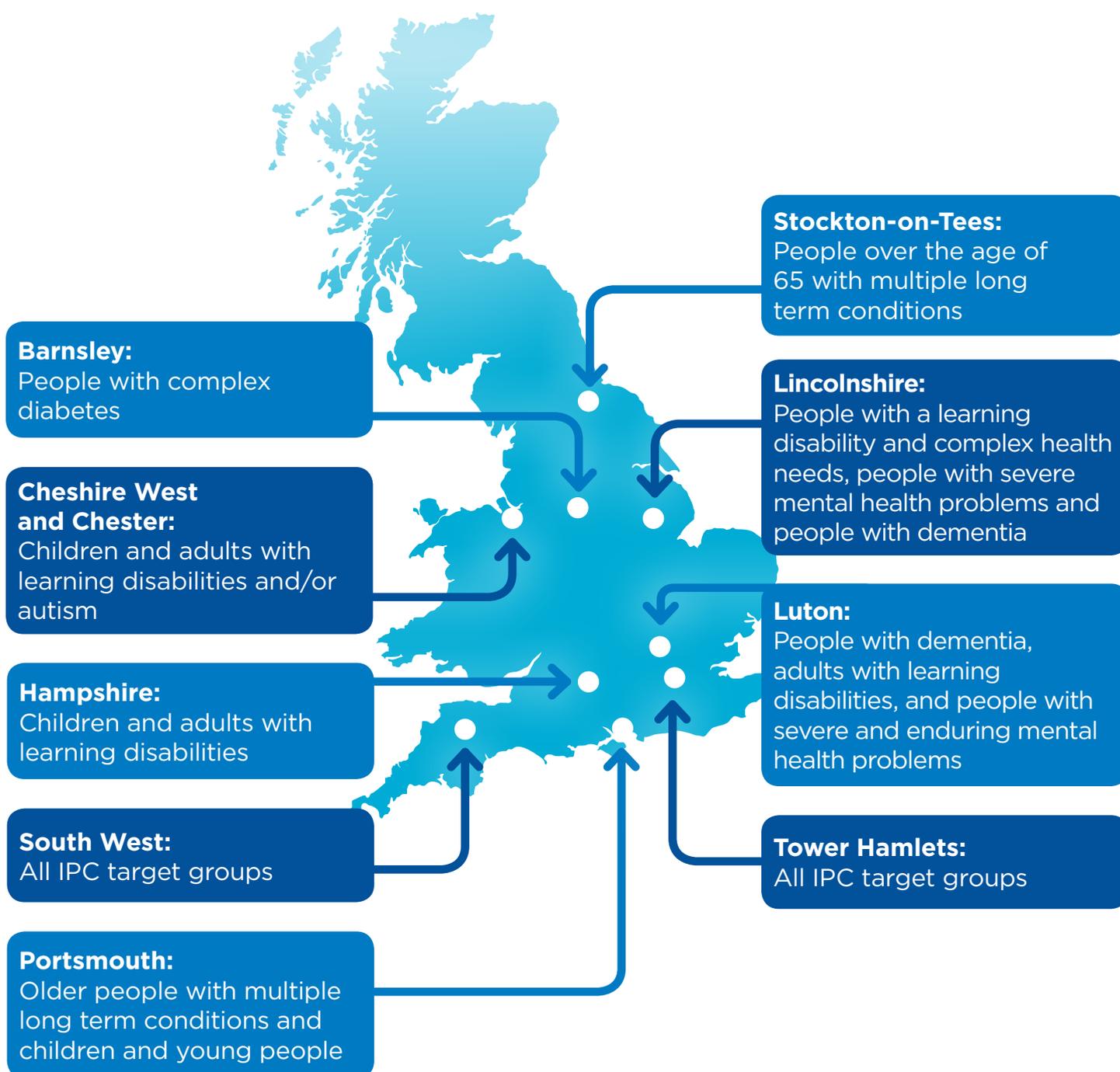
The five collaborative development groups (CDGs) now operational across the programme are geared towards answering key questions that will underpin wider replication of the model. In 2016-17 products from this work will be shared to expand upon the detail of the emerging IPC framework and provide further practical guidance around the concepts and overarching principles discussed in this document. These products will act as blueprints to enable wider replication across the system, supported by expansion in the programme. The timeline for delivery of key IPC products in 2016-17 is set out in Annex 1.

Annex 1: IPC product delivery

IPC collaborative development groups will begin producing early products to support wider adoption and spread of the IPC model from the autumn of 2016. Final products to enable rollout will be published from March 2017.

Key shift		Service component		Example products
1	Proactive coordination of care	A	Cohort identification and person-level costing	<ul style="list-style-type: none"> • Cohort identification methodology • Directory of data sources • Information governance solutions catalogue
		B	Individual Statement of Resources	<ul style="list-style-type: none"> • Indicative personal budget model for each IPC cohort
2	Community capacity and peer support	A	Community connecting	<ul style="list-style-type: none"> • Role definitions • Case examples
		B	Systematic peer support	<ul style="list-style-type: none"> • Peer support framework • Case examples
3	Personalised care and support planning	A	Common planning methodology and resources	<ul style="list-style-type: none"> • Planning framework, tailored to Patient Activation Measure • Monitoring and review guidance • Directory of resources to support practice
		B	IPC support teams	<ul style="list-style-type: none"> • Team design options • Workforce capacity plan
4	Choice and control	A	Personal budget setting methodology	<ul style="list-style-type: none"> • Framework for costing care plans to enable personal budgets to be calculated
		B	Personal budget deployment options	<ul style="list-style-type: none"> • Guidance and case examples on direct payments, prepaid cards, individual service funds/third party budgets and notional budgets
5	Personalised commissioning and payment	A	Releasing funding from block contracts	<ul style="list-style-type: none"> • Guidance and case examples on unlocking funding from block contracts • Service specification inserts for commissioning intentions
		B	IPC Contract Framework	<ul style="list-style-type: none"> • Outline contract methodology • Common metrics

Annex 2: IPC demonstrator sites (2015/16)



IPC empowers people and communities to take an active role in their health and wellbeing with greater choice and control over the care they need



The Integrated Personal Commissioning Programme

www.england.nhs.uk/commissioning/ipc

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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