What will be different for people because of the IPC programme?

People who need a variety of support from different organisations will have their:
- assessment of needs better co-ordinated,
- needs captured in one personalised care plan,
- support tailored to meet the outcomes they want for their life,
- choice of how that support is delivered, and if they wish it,
- own budget to control themselves

What is proposed?
- A South West IPC network to support design and implementation of the programme to:
  - Improve outcomes for people
  - Reduce cost pressures
- IPC Programme to run Jan 2015 – Dec 2017

Who will be involved?
- People and their families using services
- CCGs and Local Authorities
- Voluntary and Community Sector
- Providers of care
- Regional support organisations – like SWSCN, ASNs, HESW, SWCSU, Area Teams

Why a regional network, rather than local?

**SUSTAINABILITY** - ‘Looking for learning’ plus the scale of this approach will allow limited resources available both locally and regionally to be used to maximum impact.

**DIVERSE DEVELOPMENT** – different parts of the region are already tackling elements, sharing using the ‘expertise time bank’ will accelerate roll out.

**SCALE** – whole system solutions can be more readily implemented if patient flows are not divided by commissioning boundaries and risk can be effectively shared across all sectors.

How will it work?

1 – Thought leadership change programme – launch conference for senior leaders in January 2015 bringing together the whole system to define scope of system change. Workstreams from April 2015 including: financial modelling, impact on block contracts, risk sharing strategies, market development, growth of peer support and patient activation. Local areas will accelerate implementation by benefiting from each other’s strengths using the ‘regional expertise time bank’.

2 – 1st phase roll out of PHBs/integrated budgets for people who may benefit – support includes training, mentoring, use of quality improvement methodologies and evaluation of impact (outcomes and financial). Series of micro sites in variety of settings working with different groups of patients will provide an achievable, low risk place to start. Findings aggregated across the region will provide robust data to inform application at scale. Sustainability is achieved by willing 1st phase patients and practitioners mentoring 2nd phase roll out sites, and so on.

3 – Social movement for change – communicating the benefits to people, organisations providing care and staff. Programme will promote patient self-management / activation and support the development of peer support networks.

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Regional Support Programme - for more information contact:
- Frances Tippett, SCN Quality Improvement Programme Manager - Frances.tippett@nhs.net 07825 420546
- Liz Little, SW Regional lead, Personal Health Budgets Delivery Team – liz.little@nhs.net 07514 901359
- Ray Heal, Practitioner Advisor – ray.heal@nhs.net
**Why are we doing this? - The National Policy Context**

**NHS FIVE YEAR FORWARD VIEW –**

“We will also introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, “year of care” budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation. (NHS England Oct 2014)"

**Integrated Personal Commissioning**

“In taking forward IPC, we will build on existing development work on new financial models... It will consider the inclusion of all NHS spend including specialised commissioning’ nothing will be ruled out. What counts should be what works for individuals, their families and their carers – not what works best for existing systems and institutions.

The challenge of delivering this approach at scale is significant ... local solutions are needed and it is individuals and families themselves who are best placed to shape effective and meaningful care”.


The goals of the programme are:

- People with complex needs and their carers have better quality of life and can achieve the outcomes that are important to them
- Prevention of crises in people’s lives that lead to unplanned hospital and institutional care
- Better integration and quality of care

The programme is aimed at groups of individuals who have high levels of need, who often have both health and social care needs, where a personalised approach would address acknowledged problems in current care provision, help prevent people from becoming more unwell, and enable people to retain their independence. Including:

- 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 placement
- People with significant mental health needs, like those eligible for the Care Programme Approach or who use a lot of unplanned care

Integrated Personal Commissioning is based on two core elements:

- Care Model: Person-centred care and care planning, combined with an optional personal health and social care budget
- Financial Model: An integrated , “year of care” capitated payment

The new IPC programme builds on existing initiatives e.g. personal budgets www.personalhealthbudgets.england.nhs.uk, Better Care Fund www.local.gov.uk/web/guest/health-wellbeing-and-adult-social-care, The Special Educational Needs and Disability (SEND) www.gov.uk/childrens-services/special-educational-needs and has a number of key roles for voluntary and community sector organisations.

**Strategic Clinical Networks** “will work across the boundaries of commissioning and provision, as engines for change in the modernised NHS” (SCN’s Single Operating Framework – 2013)

**South West Strategic Clinical Network**