



# INTEGRATED PERSONAL COMMISSIONING PROSPECTUS



Making a Reality of Health & Social Care Integration for Individuals

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Medical Nursing Finance	Operations Policy Human Resources	<b>Patients and Information</b> Commissioning Development
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**Publications Gateway Reference:****2207**

<b>Document Purpose</b>	Resources
<b>Document Name</b>	Integrated Personal Commissioning – Prospectus for A Partnership Programme
<b>Author</b>	NHS England
<b>Publication date</b>	4th September 2014
<b>Target audience</b>	CCG Accountable Officers, Care Trust CEs, Foundation Trust CEs, Local Authority CEs, Directors of Adult SSs, NHS Trust Board Chairs, Directors of Finance, Directors of Children’s Services, NHS Trust CEs
<b>Additional Circulation list</b>	CSU Managing Directors, Directors of PH, Directors of Nursing, NHS England Regional Directors, NHS England Area Directors, Directors of Finance, Communications Leads.
<b>Description</b>	On 9 July, Simon Stevens set out plans for a new Integrated Personal Commissioning (IPC) programme which will, for the first time, blend comprehensive health and social care funding for individuals, and allow them to direct how it is used. This Prospectus sets out more detail and invites the NHS, Local Authorities and voluntary sector partners to apply to be part of the programme.
<b>Cross Reference</b>	N/A
<b>Superseded Documents (if applicable)</b>	N/A
<b>Action Required</b>	Applications from interested areas
<b>Timing/Deadlines (if applicable)</b>	<b>7th November 2014</b>
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## FOREWORD

“Celebrating my son’s 21<sup>st</sup> birthday was a momentous occasion. Without excellent clinical care from the Royal Blackburn Hospital and advances in medical technology, he wouldn’t have reached this special milestone. Mitchell was born with a complex neuro-disability which means he relies on a tracheostomy and long-term ventilation to breathe, a gastrostomy for all his nutrition and 24-hour support to enable him to live a full and active life.



Mitchell’s personal health budget – which began in childhood – has transformed the quality of his care, and helped us to join up services when he became an adult. It has enabled us to build a skilled team around him, using the years of expertise we have developed. It has also transformed the experience of having 24-hour care in the home for the rest of the family. The magic ingredient is trust. We now feel comfortable in our home, supported by people who know us well and can make good decisions about Mitchell’s day-to-day care.

Having consistent, high quality care from people who know him is particularly important when Mitchell is unwell. The excellent relationship between Mitchell’s care team and Intensive Care Staff during Mitchell’s recent hospital admissions meant he was directly discharged from ICU and soon back home doing the things he enjoys. Even though Mitchell has a life-limiting condition, what matters to us as a family is to enjoy our time together and to make the most of every day.

Through the personal health budget peer network I am contacted by people from many different backgrounds and communities. My experience is that families are united in wanting something different out of the NHS. They want to contribute their knowledge and experience of living with a long-term health condition so that the care they receive from the NHS is efficient, effective and fits with their everyday lives. This has made a real difference to our family. As a parent, Mitchell’s 21<sup>st</sup> was one of those moments that perfectly explains why personalisation matters”.

*Jo Fitzgerald – Mum to Mitchell and founder of Peoplehub peer network.*

Mitchell has benefitted from a new approach to person-centred health and social care that puts his family in control, enables him to live well at home, and keeps him and his family connected to his community. The Integrated Personal Commissioning Programme will give many more people like Jo and Mitchell a chance to shape services around what matters to them, rather than driven by the care system.

We firmly believe that with the right support, individuals themselves can often be the best integrators of their care. *Getting serious about personalisation in the NHS*, published alongside this document, sets out the background and makes the case for the changes we will begin to put in place through this new programme.

We are inviting service users, carers, the voluntary sector, providers and commissioners to come together to provide leadership for a new integrated and personalised commissioning approach for people with complex needs. This builds on the best of what is already happening in local areas and the implementation of reforms across England on person-centred care in health, adult social care and children’s services.

We will support areas that want to take part to develop a new approach to deliver integration at the individual level. Key elements include delivering person-centred care for key groups at scale, with innovation around payment approaches to support this. Within this model it is expected that increasing numbers will choose to hold their own integrated personal budgets.

If we get this right, people's lives will be transformed and we will also achieve much better use of public money. However we know that there are many problems to overcome, including structural, financial and cultural barriers that get in the way of change happening at scale. We also know that the NHS and local authorities are stretched, and money is tight. We are committed to working together in a way that supports innovation and experimentation, then scaled to ensure wide input and improvement.



***Simon Stevens,  
Chief Executive,  
NHS England***

A handwritten signature in black ink, appearing to read 'Simon Stevens'.



***David Pearson,  
ADASS President***

A handwritten signature in black ink, appearing to read 'David Pearson'.



***Cllr Isobel Seccombe, Chair,  
Community Wellbeing Board,  
Local Government Association***

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# 1. INTRODUCTION

Successive governments have worked to improve integration and personalisation across both health and social care. Local authorities and the voluntary sector have led the way in many areas, for example with the large scale use of personal budgets in social care and peer support models. The NHS Mandate also commits the NHS to greater personalisation, including rolling out personal health budgets and improving person-centred care.

Building on this, Simon Stevens, Chief Executive of NHS England, in a speech at the Local Government Association annual conference, offered that the NHS would work to develop a people-powered commissioning programme in partnership with local authorities and the voluntary sector. Since then NHS England has worked with its partners to outline proposals for a new Integrated Personal Commissioning (IPC) programme. IPC is for those areas who share our ambition to make change happen at pace for key groups with significant health and social care needs. Partners have also developed a sister document, *Getting serious about personalisation in the NHS*, which provides detail on the background, evidence and delivery approach for the programme.

The IPC proposal will make a triple offer to service users, to local commissioners and to the voluntary sector:

- Service users will be offered power and improved support to shape care that is meaningful to them in their lives.
- Local authorities and NHS commissioners and providers will be offered dedicated technical support and regulation and financial flexibilities to address systemic barriers to change.
- The voluntary sector will be a key partner in designing effective approaches, supporting individuals and driving cultural change.

## 2. WHAT IS INTEGRATED PERSONAL COMMISSIONING?

Integrated personal commissioning is a new voluntary approach to joining up health and social care for adults with complex needs and also health, social care and education for children. It consolidates a shift in power to people who use these services to help them shape care that is effective and meaningful to them in their lives. It builds on and brings together work that has already started to explore new funding models and places that have taken the lead in implementing personal budgets in the NHS.<sup>1</sup> It aims to bring health and social care together, identifying the totality of expenditure at the level of the individual, giving people more control over how this is used and enabling money to be spent in new ways to achieve the three programme goals.

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 and their families** through greater involvement in their care, and being able to design support around their needs and circumstances.
- **Prevention of crises in people's lives that lead to unplanned hospital and institutional care** by keeping them well and supporting self-management as measured by tools such as 'patient activation'<sup>2</sup> – so ensuring better value for money.
- **Better integration and quality of care**, including better user and family experience 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. This will include:

- 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 use high levels of unplanned care.

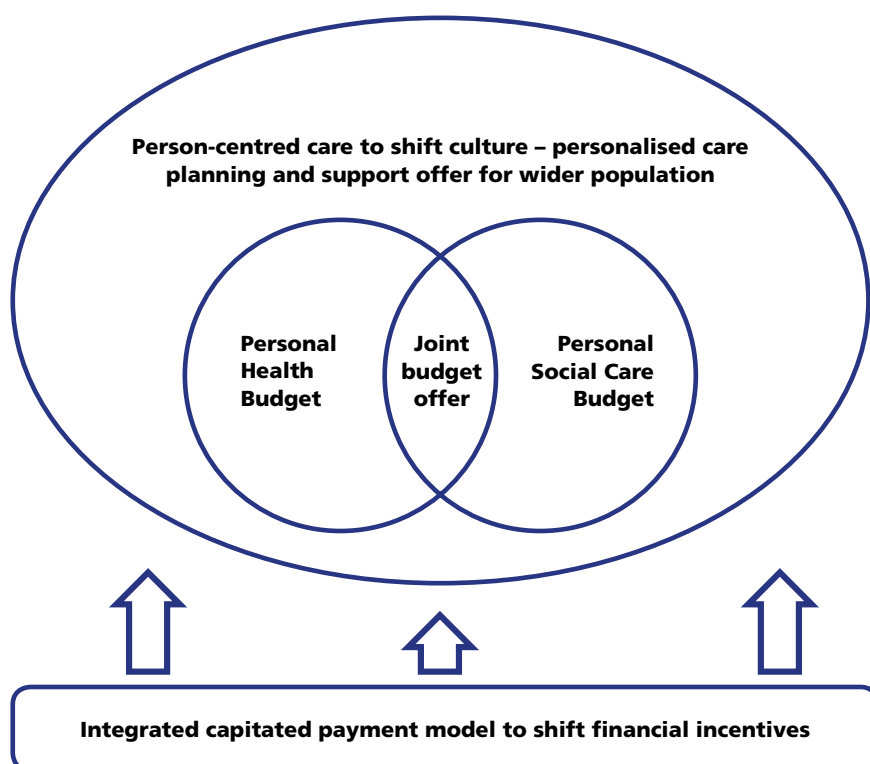
Integrated Personal Commissioning is based on two core elements:

- **Care model: Person-centred care and care planning, combined with an optional personal health and social care budget:** The proposed care model will include personalised care and support planning, independent advocacy, peer support and brokerage. People will be able to take as much control as they want including a clear offer of integrated personal budgets for those who will benefit. Care planning will be based on the strengths and preferences of individuals, instead of a service offer driven by the care system. Where people take up a personal budget this could be managed by the council, the NHS, or by a third party provider (e.g. a voluntary sector partner); or by the person themselves through a direct payment. The proposed care model is based on the premise that with the right support, individuals with significant health and care needs are often better placed than statutory bodies to design and integrate their own care. Further detail is outlined at Annex One.

1 For more information about personal budgets in health and social care, including the ways to manage the budget, see the personal health budgets website [www.personalhealthbudgets.england.nhs.uk](http://www.personalhealthbudgets.england.nhs.uk)

2 <http://www.kingsfund.org.uk/publications/supporting-people-manage-their-health>

- Financial model: An integrated, “year of care” capitated<sup>3</sup> payment model:** The IPC financial model attempts to shift incentives towards prevention and coordination of care, by testing an integrated capitated payment approach. The attraction of a capitated payment is that it can align financial accountability and the outcomes that matter to people. Current financial models can tend to reward NHS and social care activity and crisis services. With capitation, providers have a much stronger incentive to proactively understand who is at risk, and take early action to prevent deterioration and coordinate services, which, to be effective involves working in partnership with the patient and their carer. Capitation will also be developed and tested to support indicative, average personal budget setting for individuals. The IPC financial model aims to remove existing financial barriers to prevention and integration, as well incentives for unnecessary activity that drive up costs. However, financial risk will continue to be pooled across individual and populations by commissioners so no individual service user would face an arbitrary cap on the unplanned service they needed. This is sometimes also referred to as a “year of care” budget.



As the diagram shows, the scope of the care and financial elements of the model include people with complex health needs who are not receiving state-funded social care, for example people eligible for entirely NHS funded mental health aftercare services. Also at certain points people shift between entirely social care or NHS funded services, for example in transition to adult services. These people may not need an integrated personal budget, but may shift from a social care personal budget to a personal health budget, for example. The IPC Programme will align the two personal budget systems and make integrated budgets possible. People would be offered personalised care planning and support whether or not they take up the option of a personal budget across health and/or social care. Partners have also developed the sister document *Getting Serious about Personalisation in the NHS*, which provides background, evidence and delivery insights for the IPC Programme. In all circumstances, NHS care will remain free and provided on the basis of need not ability to pay.

<sup>3</sup> Capitation is a prospective payment method on a per-person basis for a range of services for a fixed period of time. Budgets are adjusted to take account of people’s different needs. In this case it would be a holistic payment across health and social care.



### 3. HOW DOES IPC FIT WITH EXISTING INITIATIVES?

The new IPC programme is a natural evolution from current arrangements. Personal budgets in the NHS and Social Care began under the last government and have continued under the current government. Under successive governments, the NHS, public health and social care have started to join-up the commissioning of health and social care at a population level, through pooled budgets, the work of health and wellbeing boards, and the Better Care Fund. The IPC gives further impetus through new co-commissioning arrangements between NHS England, CCGs and local authorities at the level of individual service users.

Local authorities and the voluntary sector have led the way with the development of more personalised approaches, the large scale use of personal budgets in social care and peer support models. More recently, the NHS has started to introduce personal health budgets, following evaluation of the pilot programme. The Special Educational Needs and Disability (SEND) pathfinder sites are aiming to join up services through the use of education health and care plans. However, wider progress in developing personalised approaches that consider NHS and local government expenditure as a whole have been limited. The IPC approach aims to address this in developing better person centred support for individuals, for example through peer support that builds people's confidence and skills to manage their own health and care more effectively.

There are a number of key roles voluntary and community sector (VCS) organisations could play in the programme. VCS partners could represent the local VCS collectively, co-designing the IPC programme with CCGs and Local Authorities. They may provide advocacy and brokerage support for individuals covered by a local IPC programme. They have a role to play in supporting Local Authorities and CCGs to genuinely co-produce this new approach and support those groups who are less often heard. Voluntary sector initiatives, such as social prescribing, have also shown the impact of VCS provision in building community capacity and providing alternative approaches that boost the health and care economy.

In taking forward IPC, we will build on existing development work on new financial models, for example through the long term conditions year of care early implementer programme, and NHS England and Monitor payment innovation sites. The IPC programme will now significantly widen this activity to include local authority services, and substantially accelerate its use. 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 and we don't have all the answers nationally. Indeed the IPC Programme is based on the opposite assumption – that local solutions are needed and it is individuals and families themselves who are best placed to shape effective and meaningful care.

## **Integrated Personal Commissioning in practice: using a financial model to free up resources**

Rita, a retired college lecturer is eight-five years old and lives alone. She has multiple health problems which fluctuate. She is seen regularly by a range of health professionals. However when her condition gets worse the GP feels that it's best to admit her to hospital. Rita has been assessed by the council for social care and separately for NHS Continuing Healthcare but is not eligible for either at the moment.

The NHS and the council have agreed a financial model which identifies the money typically spent across health and social care for people with Rita's level of need (4 or more long-term conditions). Rita has been offered a personal health budget which includes the cost of community health services, and part of the cost of unplanned admissions. Her GP referred her to a voluntary sector brokerage scheme, which helped Rita and her family to work out a care plan and get it agreed. Rita uses part of her budget as a direct payment to employ two friends as personal assistants who can look after her if her condition gets worse, and take the occasional trip away.

A volunteer helps her get to a weekly U3A English Literature class. The rest of her budget is managed by the NHS and pays for weekly physio and a monthly district nurse visit.

## 4. WHAT WILL BE EXPECTED OF SITES JOINING THE IPC PROGRAMME?

The programme will run for a minimum of 3 years beginning in April 2015. Sites will need to have person-centred planning support and personal health budgets in place (beyond continuing care) from April 2015, and they will also be expected to contribute to a national evaluation. Sites taking part will be expected to include the following in their commissioning and financial plans:

- Make a long-term commitment and set a clear ambition to develop, test and implement new integrated funding models;
- Make clear information and support offer available to the population identified, but with more intensive, pro-active support targeted to those who need it most, and
- Embed personalisation and person-centred care and support planning, including personal budgets within their organisation, including the significant cultural shift associated with this.

As part of the programme interested areas would be involved in developing and testing models which link what matters to people – person-centred outcomes as reported by patients/carers – to financial reimbursement. This would aim to use financial incentives for providers to help drive improvement in personalisation and quality of care.

### **Integrated Personal Commissioning in practice: care planning and peer support**

Joe is in his fifties, and is still recovering physically and mentally from the major stroke that he suffered two years ago. The stroke has seriously affected his mobility and speech, and meant that he needed to retire early. As someone who previously led an active, busy life, this has been enormously difficult to adjust to, resulting in severe depression and anxiety. Joe's 'whole life' care plan addresses not just his medical needs, but considers the impact of the social isolation that profoundly affects his wellbeing. Having a care co-coordinator across health and social care makes it simpler for Joe when in crisis. A referral to a local MIND befriending scheme has put Joe in touch with Roger, who helps him to get out of the house to enjoy their mutual interest in music. Being a 'full time patient' has badly dented Joe's self-esteem, and it was important to 'give something back'. Joe now helps run the local Stroke Association self-help group.

### **Integrated Personal Commissioning in practice: personal budgets**

Amal is eight years old and was born with a life limiting genetic condition. She lives at home with her mum Tanya and two older brothers, but requires 24 hour care as she needs a ventilator and is fed through gastrostomy tubes. A personal budget allows Tanya to employ and manage a small team of personal assistants. Tanya previously found the differences between the services offered by the NHS and the local authority confusing and hard to manage. The personal budget means that Amal gets consistent support from one team of people at home and at school. A personalised training package has been set up for Amal's PAs so they are fully trained in all the tasks and interventions needed to keep Amal well and safe. The budget means that the family can take trips away together instead of Amal going to a residential respite unit. Amal suffers from regular chest infections which can become very serious quickly. A management plan has been drawn up with their GP and the practice nurses to ensure appropriate antibiotic treatment can be set up quickly when needed to prevent a rapid escalation resulting in hospital admission.

## 5. WHAT SUPPORT IS AVAILABLE?

The IPC programme aims to model a genuinely collaborative approach between national and local organisations. Successful applicants will benefit from a combination of direct, joined-up senior sponsorship from NHS England, Public Health England and local government, and help on key issues such as the financial model, information governance, risk stratification, care planning, personal budget systems, and evaluation.

We will have planned funding for around 10 demonstrator sites during part of 2014/15 through 2016/17, although this may be higher depending on interest and the quality of applications. We will consider the fairest method of funding demonstrators in the light of their applications.

NHS England will ensure that the work of existing programmes such as the personal health budgets Going Further Faster sites, the Integration Pioneers, Long-Term Conditions Year of Care Commissioning Programme and our payment innovation sites are brought together to support the new integrated personal commissioning sites in a coordinated way. In particular support will be offered to sites to develop and test a blended financial model that brings together all the NHS and local authority funding for a defined target population.

This programme will require major leadership support, and entail significant organisational development. Sites will be supported to develop strong partnerships that can pursue a clear local vision for change, genuinely co-produce their programmes with all parties, including people who use services, and invest in working with staff to understand and adopt new ways of working.

Continued support will be offered to local IPC partners to help improve existing methods of setting individual level personal budgets. Individuals should know how much money is available to meet their needs across the whole year as part of the planning process and be able to spend the money in ways and at times that make sense to them, as agreed in their plan. We will also offer evaluation support in terms measuring the changes we want to see happening, which can be linked to funding and contracting. This will include tracking the difference this has made for people and their carers, as well as the impact on the health and care system.

## 6. HOW CAN WE APPLY?

Applications must be made jointly by one or more CCG and local authorities and at least one voluntary sector partner. They can include other commissioners and providers. Conflicts of interest would need to be managed if providers are included. Other providers should not be disadvantaged by the involvement of the VCS as partners in the programme.

Please email [england.ipc@nhs.net](mailto:england.ipc@nhs.net) by 19<sup>th</sup> September 2014 to make an initial expression of interest, to provide a contact and to obtain an application form. This will ensure that you are invited to any planned events and receive an offer of preliminary advice to make the application process as easy as possible.

Applications will need to demonstrate:

- the population you will target with the IPC programme, including likely number of people covered;
- the intended approach to care and support planning;
- arrangements for information, advice and advocacy including peer support;
- the proposed approach to creating a joined up integrated personal commissioning budget for the target cohort, covering the totality of health and local government spend;
- commitment to supporting the development of a potential national formula with appropriate risk-sharing;
- commitment to supporting the development of a system that rewards high quality, personalised care and self-management;
- the approach to integrated personal budgets including the option of direct payments, showing a strong record of NHS as well as local authority delivery;
- strong involvement from people (and their families) steering, and delivering change;
- strong local partnership and community involvement;
- commitment to adopting common metrics;
- commitment to taking part in a national evaluation including potentially a randomised controlled trial method in one or more geographies; and
- senior leadership support and collaboration across agencies.

We envisage receiving a range of bids focused on specific groups, and implementing different delivery models to support these populations better.

Please return the signed application by 7 November 2014. The full timetable is outlined at Annex Two.

We will aim to respond to you in December.

# ANNEX ONE: FURTHER INFORMATION ON THE IPC CARE AND FINANCE MODELS

## *The proposed care model – Person-centred care and care planning with a strong personal budget offer across health and social care*

- **Person-centred care and support planning:** Person-centred care and support planning sits at the heart of the IPC programme. Access to support to enable people to develop a plan which covers all aspects of life, not just tightly defined health and care need. This should build on existing services, including within social care, general practice and special educational needs for children.
- **Personal budgets:** People can have control over their budget, including the option of a direct payment. Personal budgets<sup>4</sup> will be offered to those who could benefit or who are eligible from within the population. IPC areas will receive support on how means tested social care budgets and health budgets can be combined successfully.
- Areas will have varied starting positions in terms of the different elements of the proposed model. Some will be advanced in terms of delivery of health and social care personal budgets, and will be able to set an ambitious offer of full or part control of funding to a significant proportion of the identified population. Other areas may offer a smaller number of personal budgets, but focus on putting in place highly responsive services for a wide population that can respond to individuals' personalised care planning goals, and are co-commissioned with local people. We would welcome approaches which reflect local starting points and ambitions in different areas.
- **Information, support, advice and advocacy:** Access to good information support, advice and advocacy from a range of sources. No individual who would benefit from the IPC approach should be excluded from the opportunity to take part because of their background. A clear information and support offer should be available to the population identified, but with more intensive, pro-active support and advocacy targeted to those who need it most.
- Areas will need to give due regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way to reduce health inequalities.
- **Peer support:** We want areas to make the most of peer support, developing social capital, supporting carers and investing in the local voluntary sector and community groups. Strong peer support models include trained peer coaches, informal peer support groups, peer-led education programmes and online peer networks. These can be linked to existing networks for example the personal health budget peer network, led by 'PeopleHub'.

## *The proposed financial model – An integrated, capitated payment model*

**Integrated, capitated payments:** Support will be offered to sites to develop and test a blended financial model that brings together all the NHS and local authority funding for a defined target population. In parallel we will work with sites to collect the data necessary to support increasingly refined capitation approaches. In the first stage of the programme, sites will be supported to work through the local payment example being prepared as part of NHS England and Monitor's 2015/16 *National Tariff Payment System*. If needed sites will be supported to establish key building blocks such

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4 This includes budgets which include funding from both the NHS and a local authority, sometimes known as joint personal budgets.

as person level linked data sets and financial models, which can assist in the selection of a target cohort population. Stage 2 is the calculation of a baseline capitation payment value, which can be used in shadow form during 2015/16. Stage 3 is completing the necessary design features of the capitation so that the payment approach can be implemented locally, including quality measures and transition gain/loss sharing arrangements by 2016/7. Finally, Stage 4 involves sharing linked data sets to inform the development of potential national formula for capitation (linked to patient complexity and/or activation), enabling benchmarking across sites and feeding into an evaluation. Sites could receive feedback from how they compare on cost, quality and activity to others trying similar initiatives.

Continued support will be offered to areas to help improve existing methods of setting personal budgets. Individuals should know how much money is available to meet their needs across the whole year as part of the planning process.

**CCG, local authority and NHS England budgets:** IPC partners will consider which budgets can be aligned at population level. These should be made available to be pooled at an individual level for those people who might benefit from a personal health and/or social care budget. This is likely to involve freeing up resources from contracts with NHS and other providers to enable the money to be spent differently, in line with individual plans, and with the development of new models such as individual service funds.

Areas may also make a case for devolving budgets with NHS England commissioned services too. This may include NHS specialised services for key groups and primary care services including GP Enhanced Services on personalised care planning.

## *Strategic considerations*

- **Identified population/s and targeting methods:** Identifying the broad population group/s where there is a local need for change, involving people and families in the process. Consider targeting approaches within populations, using risk stratification and/or targeting those with low 'patient activation' scores, numbers of long-term conditions together with social care factors (such as isolation), or other suitable methods.
- **Aligned IPC objectives with local strategies:** Local partners should agree IPC objectives and consider how these align with local strategic plans, including the implementation of the Care Act, the Children and Families' Act and the use of the Better Care Fund.
- **Strong local partnership and community involvement:** The local authority, the CCG and VCS should be included as lead partners alongside people who use services and their families. There are a number of roles voluntary and community sector (VCS) organisations could play in the programme. VCS partners could represent the local VCS collectively, co-designing the IPC programme with CCGs and local authorities. They have a role to play in holding local authorities and CCGs to account as to how they genuinely co-produce this new approach and act as advocates for those groups who are less often heard.
- **Metrics and Evaluation:** We will offer support in terms measuring the changes we want to see happening, which can be linked to funding and contracting. This will include tracking the difference this has made for people and their carers, as well as the impact on the health and care system. Those participating in the programme will be asked to build in an agreed common set of measures and participate in robust evaluation with local administration costs met nationally.

## ANNEX TWO: PROPOSED TIMESCALES

Activity	Deliverable	When
Expression of interest	Sites contact NHS England expressing interest and providing a contact name.	19 <sup>th</sup> Sept 2014
Applications	Applications received by NHS England	7 <sup>th</sup> Nov 2014
Site agreed	Decision taken on sites for the IPC programme	Dec 2014
Planning	Have a dedicated project lead in place, working within a clear governance framework for partnership working across the NHS, the local authority and voluntary sector	Jan 2014
Co-production	Have in place a peer network or other means to co-design the local programme.	Feb 2015
Planning	<p><b>Financial model (Stage 1)</b> Use local patient linked data set, or available financial tools to select the initial cohort (within the broad groups already selected as the focus).</p> <p>Agree a project plan with NHS England encompassing local data development plans (covering activity/cost and quality), expected take-up of integrated personal commissioning including personal budgets in 2015–16, 2016–17, and 2017–18, the commissioning funding available, and the evaluation data to be provided.</p>	Feb 2015
Delivery	<p><b>Care model</b> Personalised care planning in place. Begin offering personal budgets to people within the cohort.</p> <p><b>Financial model (Stage 2)</b> Implement a shadow capitation payment for the initial cohort, having calculated an appropriate value using the local payment example and with support from Monitor and NHS England.</p>	Apr 2015  Apr 2015
Evaluation	Provide initial evaluation data on uptake and costs of personal health budgets, and user experience, and use of NHS care across the whole cohort.	Dec 2015
Sharing the learning	Provide partial evaluation learning people with a personal health budgets, policies and plans, and a write-up of progress and lessons learned	Mar 2016
Delivery	<p><b>Financial model (Stage 3)</b> Complete the final design of the capitation payment ready to go live from April 2016. This will include the link to quality and outcomes, how the per person payment will be adjusted year on year, any gain/loss sharing arrangements to be put in place.</p> <p>Participate in national efforts to compare/ benchmark patient level datasets across local areas and to develop a formula for complexity adjustment based on these datasets.</p>	Mar 2016  Mar 2017
Evaluation	Provide follow-up evaluation data on uptake and costs of personal health budgets, and user experience, and use of NHS care across the whole cohort.	Dec 2017 (and ongoing)



