<Patient Name>
<Address 1>
<Address 2>
<Address 3>
<Town>
<County>
<Postcode>

<Date>

Dear <Representatives Name>

Integrated Personal Commissioning
NHS Number:

We are writing to you as a person who is closest to and represents <Patients Name>.

Further to your recent conversation with <Patients Name> care professional/team you feel that <Patients Name> health and wellbeing support could be improved through integrated personal commissioning. As explained IPC puts <Patients Name> at the centre and is about *what matters to you, rather than what is the matter with you* and we need to evaluate how beneficial this way of working is for <Patients Name>. I have attached our IPC leaflet "Is this for you?" which provides further information.

The purpose of this letter is to seek your consent in a "Best Interest Decision" for us to collate and share some of <Patients Name> personal and sensitive information from the past two years and going forward for the next 12 months, which will include:

- Personal information such as <Patients Name> , address, postcode, date of birth, NHS number, (sometimes systems don't have NHS numbers in which case we need to use <Patients Name> NI number and their name);
- Information about which health and care services <Patients Name> use or have used including hospital, GP, community nursing, therapists, domiciliary care, out of hours services, etc
- Information about any voluntary services <Patients Name> use or have used to support your health and well-being;
- Information about any contact <Patients Name> have had or may have with the emergency services; ambulance, fire, police in relation to your health and care;
- Information about <Patients Name> past, present and any future medication.

We will also ask you on behalf of <Patients Name> to take part in some surveys which may be paper based or undertaken by a professional involved in your care.

The information collated will be used to evaluate the care and treatment that you receive to identify any benefits for this way of working i.e. *what matters to you, rather than what is the matter with you.* All information provided will remain confidential and will not be shared with any party not listed on the consent form. No identifiable information will be provided in any evaluations, outcomes or reports from this pilot. Once the time period of 12 months has elapsed all information will be destroyed confidentially. A more detailed information leaflet is contained about our responsibility around keeping your information safe "Your information, your choice".

If you are also a carer of <Patients Name> we will contact you in your own right to explain about how integrated personal commissioning may benefit carers. We will need your consent to gather relevant information about what you do on behalf of <Patients Name> for the evaluation and care planning process.

If after reading the enclosed leaflets and this letter you would like to use Integrated Personal Commissioning to support <Patients Name> and be part of the evaluation for this method of support, could I please ask you to complete the enclosed consent form and return to <Patients Name> care professional or send to [insert address]

If you would like to discuss this further or have any queries about how <Patients Name> information will be used, please contact <?clinical team/commissioning team>.

Yours sincerely

<organisation>

[insert logo]

Integrated Personal Commissioning

Best Interest Decision Consent Form

The Mental Capacity Act 2005 set out the definition of a person who lacks capacity.

Sections of the Act say that a person lacks capacity if he or she has a temporary or permanent impairment of, or disturbance to, the functioning of the mind or brain at the time when the decision needs to be made and as a result is unable to:

- Understand the information relevant to that decision
- Retain that information
- Weigh up information as part of the process making the decision
- Communicate his/her decision (whether by speech, sing language or any other means)

When the person is deemed to be incapacitated under the terms of the Act and unable therefore to give consent, information should only be disclosed in their best interests and then only as much information as it needed to support their care.

For further guidance, see the Mental Capacity Act 2005 Code of Practice on www.dca.gov.uk/menincap/legis.htl and the guidance booklet "Making Decision: a guide for people who work in mental health and social care" on www.dca.gov.uk/legal-policy/mental - capacity/mibooklets/booklet03.pdf.

Mindful of this do you hold any of the following:

Lasting Power of attorney: (*Please tick boxes as relevant to you)*

☐ Finance ☐ Health and welfare

Deputy of court of protection: Name: ……

Date registered:……

Registration Number:……

Enduring Power of attorney: *(Please tick boxes as relevant to you)*

☐ Finance ☐ Health and welfare

Additional information:

……
……
……
……

If <Patients Name> lacks Mental Capacity at this time and no single person is in the legal position to give full consent then the following “Best Interest Decision” must be completed and held in <Patients Name> Health and Social Care records.

If <Patients Name> is deemed not to have capacity to consent to an integrated Personal Commissioning Assessment, Care Plan and evaluation please state the following:

Record of Decision:
We the undersigned agree that it is in the Best Interest of <Patients Name> to proceed with participation in the Integrated Personal Commissioning Program for the purposes of enhancing their quality of life and the full evaluation of the Integrated Personal Commissioning Programme.

Name	Designation	Signature	Date

On What evidence was this decision based:

Under a best interest decision or Power of Attorney I have agreed <Patients Name> should take part in the Integrated Personal Commissioning evaluation within my local area as outlined in the leaflet ‘is this for you?’ and your letter to me dated [insert date of letter]. If you have any queries about completing this form, please contact [insert contact details].

Please tick boxes as relevant to you

- ☐ I understand that relevant personal and sensitive information will be shared with other organisations for the purposes of direct care.

- ☐ I understand that all information will remain confidential and not be shared with any third parties. All reports, evaluations, etc will be anonymised and if you wish to quote something I have said, then you will seek my consent.

☐ I hereby give consent for <Patients Name> information to be collated and shared with the organisations listed below (as I have ✓)as outlined in your letter and in relation to <Patients Name> health and well-being for the purpose of this evaluation.

- ☐ Torbay and Southern Devon Health and Care NHS Trust
- ☐ South Devon Healthcare NHS Foundation Trust
- ☐ South West Ambulance NHS Foundation Trust
- ☐ Devon Doctors Ltd
- ☐ Devon Partnership NHS Trust
- ☐ Torbay Council
- ☐ Devon and Cornwall Police
- ☐ Devon County Council
- ☐ Devon Fire and Rescue Services
- ☐ NHS 111
- ☐ Your GP Practice (please state) ……
- ☐ [Please delete and add as appropriate]

☐ I understand going forward, the evaluation may need to access personal and sensitive information from organisations that may support <Patients Name> health and well-being in the future as part of ensuring *what matters to me, rather than what is the matter with me.*

☐ I consent for care professionals to contact me by telephone as part of this evaluation.

☐ I consent for care professionals to contact me by email as part of this evaluation.

☐ I understand that I can withdraw my consent on behalf of <Patients Name> for the collating and sharing of information as part of this evaluation at any time by speaking in the first instance to a care professional. I note that this will not affect any care or treatment that <Patients Name> is currently receiving but understand that they will not be eligible for Integrated Personal Commissioning.

Signed: …….. Date: ……

Name: ……

On behalf of ……NHS Number: …….
(Please print) (if known)

Date of Birth…….

Address: ……..

……Postcode:…….

Tel No: …….. Email: ……

For Staff Use Only

Please ensure that the referring organisation is removed from the list of options above and any organisations that the patient receives services from is added to the list.

Ensure that a copy is provided to the patient, a copy is stored in the patient's care record and a copy is provided to the Administrative Support of the Group.

Should the above named patient indicate that they wish to amend the organisations that they have consented to share with, please ensure that a new form is completed with the revised choices and then shared and stored as above.

If the above named patient indicate that they wish to withdraw from the evaluation, please use form [need to consider how you want to capture withdrawal – I would suggest that it needs to be confirmed in writing and then copies as above.