Summative Evaluation of the Integrated Personal Commissioning (IPC) Programme

Process evaluation – second interim report

June 2018

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Contents

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Glossary

CCG – Clinical Commissioning Group

CPA – Care Programme Approach

DP – Direct Payments

GP – General Practitioner

IG – Information Governance

IPC – Integrated Personal Commissioning

IT – Information Technology

MDT – Multi Disciplinary Team

PB – Personal Budgets

PHB – Personal Health Budgets

SRO – Senior Responsible Officer

VCSE – Voluntary, Community and Social Enterprise

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1. Introduction

1.1   Integrated Personal Commissioning (IPC) is an approach to joining up health and social care, and other services where appropriate. The purpose is to enable service users, with help from carers and families, to combine the resources available to them in order to control their care. This is achieved through personalised care planning and personal budgets (PB). IPC also aims to support service users to develop the skills and confidence needed to self-manage their care in partnership with carers, the voluntary, community and social enterprise (VCSE) sector, community capacity and peer support.

1.2   IPC is being tested out in 17 areas in England (see Annex A) where local authorities and Clinical Commissioning Groups (CCGs) are working together with their providers and VCSE partners. The programme was launched in April 2015 and was run in its original format until March 2018. It was focussed on four particular user groups:

- 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 difficulties 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 (CPA), or those who use high levels of unplanned care.

1.3   From April 2018, it is expected that the scope of IPC will broaden out to cover larger geographical areas and more patient groups. It will underpin other activities that take place as part of the personalised commissioning agenda. This new model is still under development by NHS England in partnership with the Local Government Association (LGA) and the teams in the IPC sites.

Summative evaluation of IPC

1.4   In August 2016, the Department of Health commissioned an independent summative evaluation of IPC. The evaluation is being carried out by a consortium led by SQW, in partnership with Bryson Purdon Social Research (BPSR), Social Care Institute for Excellence (SCIE), the Social Policy Research Unit (SPRU) and the Centre for Health Economics (CHE) both at the University of York, and Mott MacDonald.

1.5   The evaluation aims to identify key lessons about the effectiveness of IPC schemes, including how far outcomes for service users improved and the key drivers of any changes. It will also consider the extent to which these changes represent value for money. The evidence is being gathered from across a number of local authority areas. It covers different ways in which IPC has been delivered and a range of different user groups.

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1.6   The evaluation will consider:

- what has been learned about how to implement IPC approaches in different locations (process evaluation)

- the benefits service users and carers gain from the new approach, by developing and implementing a care plan (impact evaluation)

- the costs of developing the new approaches and any extra costs or savings associated with the plans developed (economic evaluation)

- how far IPC leads to demand for different kinds of care and support, and how the market responds.

1.7   The evaluation is planned to run for two and a half years, between November 2016 and May 2019. The main data collection phase is taking place between July 2017 and late autumn 2018, with analysis and reporting by May 2019.

1.8   The process evaluation strand commenced in July 2017. The first round of interviews took place between July and September 2017. These interviews focused on understanding how IPC was being implemented in each site, what changes were made to governance structures and commissioning, and what other changes had been made to services. A second round of interviews took place between February and March 2018. These interviews focused on the progress made in the development of the IPC processes in each site, what IPC pathways looked like in each site, and staff and service users' experience of these pathways.

1.9   To gain a deeper understanding of the experience of the service users and their families, the evaluation will be conducting 60-80 interviews with service users and carers throughout the year until December 2018. These interviews will focus on service users' satisfaction with the IPC process and the extent to which they feel the IPC process is different to what they had experienced before.

1.10   The process evaluation will also include three thematic studies. These studies will each provide key learning about the development of a particular theme. The selection of the themes will be informed by the process evaluation work in the sites.

Report structure

1.11   This report summarises the findings from the second round of the process evaluation interviews. In the next section, we outline the methodology used in the process evaluation strand. In section 3, we discuss the key findings from the site visits, looking at the progress that had been made in establishing IPC processes, including challenges and ways of addressing them. In section 4, we discuss the implications of the findings and next steps for the evaluation.

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2. Methodology

2.1   The process evaluation strand was designed to provide information on the delivery of IPC, including commissioning and contracting issues, changes in the provider market, and organisational and cultural change. The aim of this strand was to improve the understanding of the evaluation of how IPC was being implemented in each site, what has worked well, and what has worked less well. These findings will also feed in to and augment the impact evaluation work.

2.2   The process evaluation is based on primary research using qualitative methods. The design of the process evaluation was informed by the scoping phase that was conducted between December 2016 and March 2017. Following the scoping interviews, the evaluation identified 12 sites which were ready and willing to take part in the evaluation.

2.3   The second round of fieldwork took place between February and March 2018. Ten sites took part as depth case studies. In two sites we conducted lighter touch fieldwork. These included seven Demonstrator sites (which were in the programme since April 2015) and five Early Adopter sites (which joined the programme in December 2016). This included site visits and interviews and discussion groups with key stakeholders, in person and via telephone. The interviews followed a series of topic guides to ensure the consistency of the data collection across the different sites.

2.4   In total, 63 interviews were conducted across all 12 sites. These included:

- 42 interviews with strategic level stakeholders and commissioners

- 12 interviews with frontline practitioners from across the health and social care services

- nine interviews with service provider managers, including health, social care and the VCSE sector.

2.5   All interviewees signed consent forms to confirm that they agreed to take part in the evaluation. The interviews were recorded and summaries of the discussions were written using a template based on the topic guides. The summaries of the interviews were then systematically coded using qualitative data analysis software (MaxQDA) and analysed to draw out common key messages and lessons learnt with regards to what worked well and what worked less well in the implementation of IPC.

Co-production panel

2.6   A co-production panel has been recruited to assist and inform the evaluation. This strand of the evaluation is being led by SCIE. The panel is made up of: seven members appointed through an open selection process; three SCIE trustees; two SCIE co-production team members; and a member of the SQW evaluation team. The aim is for the panel to work collaboratively with the evaluation team to ensure that the views of the public, particularly those that share characteristics with IPC users, are heard and can shape evaluation activities and test findings.

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2.7   Since the start of the evaluation, six co-production panel meetings have been held. These included:

- an introductory meeting, which included a detailed briefing on the IPC programme and an exercise in qualitative research tools design

- a meeting to discuss the findings from the scoping phase and next steps for the evaluation workplan

- a meeting to discuss additional questions that were developed to measure the economic impact of IPC. Panel members provided feedback on the questions and assisted in the design of the tool, which is intended to be used in the follow up wave of the outcome measures data collection

- a meeting to discuss the findings from the first round of the process evaluation

- a meeting to discuss approaches to the analysis of qualitative data from the various interviews. The meeting included a brief demonstration of the analysis methodology using MaxQDA

- a meeting to discuss the progress of the evaluation and a continuation of the planning of the qualitative data analysis. The meeting included a training session for panel members on qualitative data coding.

2.8   In addition to these activities, representatives of the panel attended all three of the evaluation debriefs, which took place after the scoping phase and the two rounds of the process evaluation (two panel members attended each of the meetings and then fed back to the full panel). These full day meetings were aimed at drawing together the emerging findings from the interviews of various stakeholders in each of the sites and identify headline findings to inform the analysis and reporting of the evaluation.

2.9   It is planned that the co-production panel will meet quarterly throughout the lifetime of the evaluation. Their inputs will inform each of the three elements of the evaluation (process evaluation, impact evaluation, and economic evaluation).

3. Summary of findings

Introduction

3.1 IPC is a framework of principles which services are expected to follow and implement in the context of local services. It is intended to change how services will be commissioned and delivered in the future. To support the development and implementation of IPC in the different sites, NHS England developed the IPC Operating Model[1]. This model sets out the Five Key Shifts of IPC, which detail the organisational and service changes that are expected to take place for IPC to work well. In addition, the model sets out a number of enabling factors that sites need to put in place to deliver the Five Key Shifts (these include workforce development, governance structures and leadership).

3.2 This report summarises the findings from the second round of interviews for the process evaluation. Findings from the first round of interviews were summarised in a report that was published in February 2018[2]. The evidence gathered in the first round of interviews highlighted that the sites had spent considerable time during the first year of IPC developing project leadership across a range of services, believing that governance structures, and a shared understanding of priorities, were required before operating at scale. This meant that in the first year to 18 months of the programme, the majority of the sites had not made as much progress as they had hoped in shaping the IPC processes and in working with service providers and practitioners. Stakeholders commented that it had taken much longer than they had anticipated to reach a shared vision and understanding in relation to IPC amongst strategic level professionals.

3.3 This chapter discusses the key findings from the second round of interviews, looking at the progress made in the implementation of IPC since the previous report. This chapter also discusses the culture change delivered by IPC in terms of changes in practice and mindset of commissioners, service providers and practitioners.

Summary of progress

3.4 The interviews found that in the six months since the first round of the process evaluation, IPC sites' progress in delivering IPC was mixed. The majority of sites had made moderate but steady progress, while one site had made significant progress and three sites have not made any real progress in the delivery of IPC.

3.5 The evidence gathered through the interviews suggested that when it came to developing processes for the implementation and delivery of IPC, many of the sites had come to perceive IPC as a set of principles of practice, rather than a specific, prescribed intervention that needed to be delivered. This was a change from what appeared to be the initial aim of IPC, of setting up a new service model. As such, commissioners were reported to have focused, in the months since the previous report, on mapping out current practices and then comparing them to the IPC principles. Where local practice could be improved to better align with the IPC principles,

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[1] https://www.england.nhs.uk/wp-content/uploads/2017/06/IPC-operating-model.pdf

changes were being made, taking a pragmatic approach to enable changes to be implemented rapidly. In most cases these were changes related to making the process more person centred[3] (rather than improving service integration).

3.6   Where sites were still struggling to make progress, it appeared that the main barrier was that stakeholders focused on personal health budgets (PHBs) as the required outcome of the IPC process for every user. These sites were facing considerable challenges with the implementation of PHBs. These included developing local understanding of how PBs would work in health services (given there might not always be a choice available for alternative health care), and gaining buy in from practitioners, convincing them that PHBs can be applied with the appropriate risk assessment and safeguarding measures in place.

3.7   Sites were struggling to move beyond these issues to look at developing an integrated process for person-centred care planning. These sites did not appear to be working in a co-ordinated way across the different services. Rather, each service was working in isolation, each focusing on delivering their targets within their remit. Furthermore, a number of sites experienced high levels of personnel churn in the local site team as well as in local services, which caused delays as new staff members got up to speed.

3.8   Many sites continued to report fairly low numbers, in terms of both care plans completed and PBs. The majority of the sites that were willing to provide numbers reported completing around 50 care plans (or under) via the new care planning process, although two sites reported completing over 1,000 plans. The number of PBs tended to be lower than the number of care plans completed, with two sites reporting under 10 PBs, others reporting in the range of 20-60 and one reporting having around 300 PBs.

3.9   It is worth noting that there were considerable discrepancies between the number of IPC care plans and PBs that sites reported to the evaluation team, and the activity metrics sites reported to NHS England. This could have been a result of the uncertainties amongst sites in what they should have included in their count. A number of sites commented that their care planning processes for service user groups outside of the IPC cohorts were following the same principles as IPC, and so they were inclined to include these user groups in their activity metrics. However, as these groups were not specifically part of the IPC cohort they were not in scope for this evaluation. It was not possible to determine whether the process for care planning with these groups was following the IPC principles.

Governance structure and leadership of IPC

3.10   The previous report highlighted that most of the sites focused their efforts during the first months of IPC in developing a governance structure to support the delivery of the IPC approach. In most cases the governance structure engaged stakeholders from health, social care and community services at high seniority strategic levels. This was to gain senior buy-in and generate a change from the top down. In three sites there were jointly funded posts for directors to lead on the integration of services. They acted as the IPC senior responsible

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[3] When referring to the care planning process sites were following the guidelines set out in the IPC model developed by NHS England. This entailed conducting a 'different kind of conversation' with the service users, focusing on their goals and aspirations in life and being led by their needs and wishes.

officers (SRO) for the site. Stakeholders in these sites commented that they felt this helped to promote the IPC agenda of integrated and person-centred services amongst services.

3.11   During the six months since the previous round of interviews, efforts had focused on embedding the governance structures to sustain integration between services at senior levels. In many sites the stakeholders commented that they felt that the new structures[4] were working well and provided a good platform for making decisions and moving things forward in developing the IPC processes.

3.12   The interviews suggested that the next step would be to engage the middle management (who are directly managing the practitioners on the ground) and gain their buy-in and support to implementing the change in practice on a system wide scale. Stakeholders commented that to successfully deliver IPC and to scale up the work they would need strong leadership to structure, co-ordinate and drive the change forward. This would require the engagement of professionals at all levels. The challenge in gaining the buy-in and support of personnel in middle management was that this would require a significant change in culture. While IPC was still operating on a small scale this appeared to have been less of an issue. System change was very localised and focused on small teams working with small cohorts. However, stakeholders commented that this would not be as straightforward when scaling up as many more people would will need to be engaged. Managers would need to allow more freedom and flexibility to practitioners to make decisions, in order for the care planning and budget setting to work well. Stakeholders commented that this was a challenge that they were still grappling with. A number of sites noted that the middle managers still required the backing of their directors to drive the culture change. They hoped that examples of where this has worked well, albeit on a small scale, would help to 'sell' the benefits of the change to middle managers.

> *There is a culture change that needs to happen if this is to continue. Yes this is ideal and wonderful, but that culture change needs to come from a higher level, because there's pressure to meet your targets still, unfortunately. And it's a very real pressure as well* (Practitioner)

3.13   Two of the IPC sites were led by an external organisation that was commissioned to manage and coordinate the delivery of IPC. Three other sites were working with an external organisation to deliver certain elements of IPC (mainly in piloting processes for care planning), and a further site was considering commissioning an external organisation to manage the care planning process. While it appeared that working with an external provider enabled sites to achieve greater initial progress in the development and delivery of IPC (in three of the five sites), there was a question about the sustainability of this approach in the long term as it required additional funding for the external organisation.

3.14   In the two sites that were led by an external provider, the focus up to March had been on embedding the new structures and processes that had been developed in to local systems, shifting responsibility for the implementation of the new processes from the external body

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[4] Governance structured included multi-agency steering groups and multi-agency workstreams focused around specific topics for development (such as workforce, development of the market and integrated budgets). We describe in detail the activities around the development of the IPC governance structures and leadership in the first interim evaluation report, which can be accessed in the following link:
http://www.sqw.co.uk/files/8215/1818/6800/SQW_first_process_evaluation_report.pdf

and on to local stakeholders (commissioners and directors of services), who were in turn expected to make it 'business as usual going forward'.

3.15   In one site, impetus had been created by bringing in an external organisation to pilot IPC processes. The external input had since ended and the local teams were attempting to keep the momentum of the new processes going. Local stakeholders commented, however, that this was proving to be quite challenging, because the external team had created momentum and there was now a gap due to the limited inputs of middle managers locally. The challenge was also one of ownership / understanding, as the managers who were now expected to take forward the changes had not driven their initial development. Without these inputs practitioners were unsure about which actions they should prioritise and a hoped for adjustment of workloads, caseloads and targets had not happened. This highlighted that in working with an external provider in delivering change, there needs to be a transition plan in place, moving on from external to internal leadership.

Delivering culture change

3.16   Although in most of the sites the delivery of IPC was occurring on a small scale, in terms of service users, the changes that it introduced to the local systems were still considerable. Stakeholders discussed the changes that were introduced through IPC in terms of 'system culture change'. In a number of sites, a great deal of resource had been invested in workforce development, through providing training sessions on managing 'a different kind of conversation' (provided by a contractor commissioned by NHS England) and in developing a person-centred care and support plan. Commissioners and practitioners who received the training commented that the training had been very effective in changing their perceptions and their practice in managing care planning with services users.

3.17   For example, where in the past they would come prepared with a notional budget and a list of services they can provide based on the service user's condition, now they came open minded, ready to listen to the service user's needs and wants first, and then develop a care package together with them. The extent of change was perceived to be greater on health professionals than on social care professionals (because social care practitioners were more familiar with the person-centred approach), although practitioners from both services commented that they benefited from the training a great deal. Practitioners commented that the training changed the way they were thinking about the service users they were working with, seeing them more as people and not just patients.

> *We were all so programmed into this kind of medical way of working… It is a mind-shift. And I think you have to go through something to help you, like this event, to create this mind-shift to challenge yourself and challenge the way we work and to understand it could be better* (Practitioner)

3.18   The interviewees also highlighted that in many of the sites, services were giving thought to developing more holistic and personalise care planning which would hold across services. The key barriers were the different KPIs that services had and the various boundaries between services, which determined the remit of each service. Stakeholders commented that for integration to work well, some of these boundaries needed to be lifted, to allow a seamless experience for the service user. However, it was acknowledged that this would require consistent information

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sharing and a high level of coordination amongst services. This also required the buy-in from middle managers (as noted above).

3.19   Other common activities used to drive change in the culture of service delivery were:

- setting up multi-disciplinary teams (MDTs) to manage and deliver the care planning process (6 sites), to facilitate greater integration, information sharing and coordination across services

- testing the care planning processes in small scale pilots and identifying champions to promote the scaling up of the process across the system (3 sites)

- the establishment of co-production groups with service users and carers, and working in partnership with them in developing the care planning processes (7 sites), giving service users a greater voice in shaping the services that are provided to them.

The IPC processes

3.20   As noted above, in the six months since the previous round of interviews many of the sites had been successful in moving on from focusing on the establishment of the IPC governance and leadership to making progress in the development of the IPC processes (based on the Five Key Shifts). We summarise below the progress that has been made in each of the five shifts.

Pro-active coordination of care

3.21   The shift of proactive coordination of care involved cohort identification and personal level costing of services and care packages. The main purpose of this shift was to develop a shared mechanism for recording patient information, to enable all service providers who are involved in their care to review the service users' use of services, monitor their health and social care progress and proactively co-ordinate the care that is offered and provided to the service user. The findings in the previous report indicated that the goal of linking health and social care datasets to identify individuals across both has been difficult to achieve in many places. Instead, most sites have reverted to operating at a smaller scale, using less systematic or integrated approaches.

3.22   Six of the IPC sites we interviewed had a shared dataset between health and social care services (with one of the sites having a shared dataset for just one cohort). Most of these datasets existed prior to IPC. None of the sites used the dataset for cohort identification or personal level costing and monitoring of service use. This was due to information governance (IG) issues, which meant that without the appropriate consents from individuals, service providers and commissioners were not able to access the datasets for these purposes. In four of these sites the dataset was anonymised, which meant that stakeholders were not able to identify individual service users at all. But even when the datasets were not anonymised, commissioners were required to have IG consents to use the data for cohort identification.

3.23   The interviews with stakeholders suggested that not having a linked dataset was not posing a challenge for cohort identification. The most common approach to addressing this issue was recruiting service users to IPC through frontline practitioners (GPs, nurses, social workers), care co-ordinators and case workers. Stakeholders commented that this turned out to be a much quicker and more stable approach for cohort recruitment, as the practitioners knew the

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service user the best, held a great deal of information about their medical and care needs, and were perceived by service users as trusted personnel. However, the risk associated with this approach was that the practitioners might not necessarily be focusing on all of the high cost users or those with the most complex needs (as defined as the primary target of IPC). Another issue was the possible loss of consistency across professionals in their approach to identifying and nominating service users to the programme. This pragmatic approach, being more ad hoc, tended to identify just a small number of users each month in the majority of the sites, largely based on who was known to professionals.

3.24   In a number of sites, stakeholders commented that the activities used to develop ways for identifying individuals for IPC helped in raising awareness amongst service providers about IPC and to gain their buy-in to the programme. This resulted in service providers, and mainly VCSE organisations, referring individuals they know to IPC.

3.25   This suggested that the primary need for the linked dataset was coming to be seen as providing a shared mechanism for services to monitor the progress of the service user (i.e. their service use and change in needs) and to review service options in a coordinated way across services (i.e. services are able to see what has been offered to the service user, what has been taken up, and are able to identify gaps that they can fill). To be able to do this the sites would need access to a shared linked dataset between services, which is not anonymised, and which is updated on a regular basis.

> *To understand touchpoints of where people are, and cohorts of people to see averages and what is the cost of their pathway, what are the normal places people go, could we do some services differently…. There is not a way to identify people and target them and say let's do something different with them* (Commissioner)

3.26   Stakeholders mentioned two key challenges in achieving this. The first was IT issues, mainly services using different systems that do not communicate with each other. This means that service users' records could not be updated by different services and fed in to the same database. The other key challenge was IG agreements. This challenge appeared to be the most difficult to address, as it required legal, ethical and safeguarding considerations. Stakeholders commented that they required more support from NHS Digital to help unpick the IG issues and to make progress with developing their shared datasets. These challenges were still ongoing at the time of writing this report.

Community capacity and peer support

3.27   The shift of community capacity and peer support was focused on making the most of services that are available in the community, outside of statutory services. The findings in the previous report indicated that sites had taken a range of approaches to engaging community capacity and peer support. The variation in part seemed to reflect the different starting points in each area.

3.28   In the six months since, activities in this shift have focused primarily on mapping the local services that were available (including statutory, private and VCSE) to ensure both service users and practitioners were aware of the different options that were available for individuals. Five sites worked with 'Community Catalyst', a social enterprise and community interest organisation, in mapping their local community services and developing a mechanism to

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disseminate information across stakeholders. One commissioner commented that they now viewed the VCSE organisations as partners and not just as contractors.

3.29   Stakeholders commented that on reflection, the activities to develop IPC did not necessarily increase the level of service provision or lead to new services being commissioned. Rather, they have increased practitioners' and service users' awareness as to what existing services were available (including non-statutory) and how they could access them, although most tend to stay with their existing services. In many cases people would continue to choose the same services as before, but some (a minority) were changing their choices.

3.30   Another activity that most sites engaged with in relation to this shift was the development of a co-production panel to support the shaping of the IPC processes. Six sites developed (or re-deployed) a co-production group involving people with lived experience and carers. Stakeholders commented that the work with the co-production group was invaluable, in particular in relation to the development of the care plan template and in gaining 'hearts and minds' amongst practitioners to the new approach through engaging with people with lived experience and hearing and promoting their stories and experiences. A number of sites mentioned that they were planning to deliver training to their co-production group members in peer support. They hoped to engage people with lived experience in facilitating peer support groups and delivering peer support interventions. That said, stakeholders commented that the professionals and the co-production groups were still learning how best to utilise this resource. The key challenge was around managing expectations on both sides with regards to the level of participation of the group, what is reasonable to expect in terms of availability to attend meetings, comment on outputs and respond to requests, and the extent to which the group will take part in the decision making.

Personalised care and support planning

3.31   The shift of personalised care and support planning is in many ways the crux of the IPC approach. It entails having a different kind of conversation with individuals, focussed on what matters to them across health and social care (and education if relevant), and capturing it in a single personalised plan. This shift received strong support from stakeholders at all levels in the IPC sites. As a result, the most progress that had been made in the previous six months was in the development of new and enhanced processes for developing personalised care and support plans and PBs for service users who were targeted for IPC. While each site appeared to have gone about this in a slightly different way, the interviews highlighted an emerging model of the IPC process that was similar in the majority of the sites, as set out in Figure 3-1 below.

Figure 3-1: IPC process emerging model
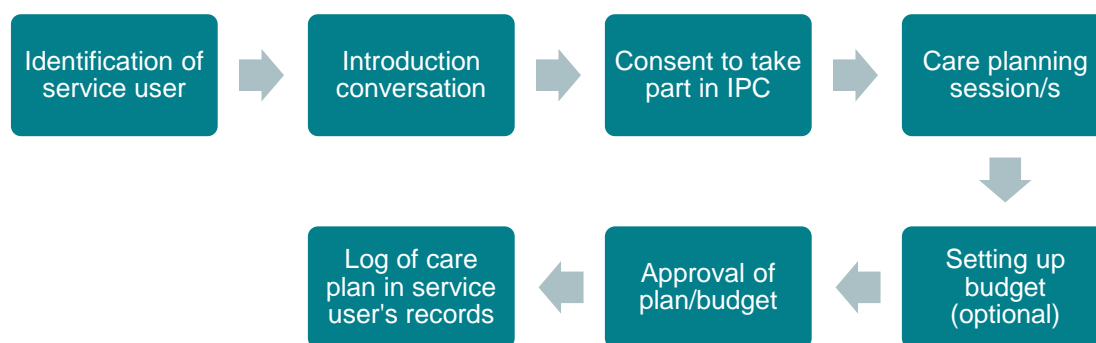
Source: SQW based on evidence from interviews

3.32   Identification of the service user to be invited to go through the process was usually done by practitioners involved in the care of the individual. In a number of sites, the identification happened at their annual review, and for new users at the point of entering the system. Identification included assessing the service user's eligibility to take part and where the process was not led by the practitioner who had done the identification, referring them to the service that was commissioned to deliver the care planning process. Once identified and eligibility confirmed, the service user was invited to take part in the care planning process. This was done by a letter, a phone call or a meeting in person. The invitation included details about the care planning process, explaining that a different approach was being taken by the local services (all sites commented that they were avoiding referring to IPC as a programme). The service user was then asked to sign a consent form if they agreed to take part.

3.33   The care planning process was similar across most of the IPC sites. It usually involved a number of sessions between a lead professional and the service user, in which they discussed the user's aspirations and needs and developed a support plan that would address these needs. The number of sessions that were held for the care planning process varied across the sites and ranged between one and three meetings for most sites (with one site holding up to ten meetings), usually between one hour to 90 minutes in length.

3.34   All the sites developed a new care plan template as part of the new approach. The template was influenced by the personalisation training, and was designed to include information on the service user's life, hobbies and other things that were important to them, alongside the medical and social care needs.

> *It's about not jumping to conclusions i.e. "you've got this problem, therefore you need this solution"; traditionally it would have been "you've got these assessed needs, here's a package of care; we're going to commission this agency to come in and do everything for you". Now it's about stopping and having the conversation with the user* (Site IPC project manager)

3.35   Practitioners commented that the conversations in these sessions had a different focus than the ones they used to have prior to IPC. In the past, practitioners tended to start from the condition that the service user had, then based on that determine what they needed, and then offer them the services that were available locally for their type of condition and need. Since IPC the practitioners took a step back and asked the service user to lead the conversation. Practitioners commented that they focused on the user's strengths, goals and aspirations and co-produced with them a care package that would help them fulfil their goals.

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3.36   The care planning sessions often included the service user and just one practitioner (this would normally be a social worker managing the case or a care co-ordinator). The service user was able to invite family members, carers and any other practitioners that they wished to be involved in the process. Where the service user lacked cognitive capacity, their carer/ guardian was present in the sessions as well.

3.37   While in most cases just one practitioner was involved in the care planning sessions, the discussions in the sessions, as well as the care plan, was then fed back to all the services involved (either via MDT meetings or through discussions with each service separately), allowing them the opportunity to review and comment on the care plan. This approach enabled sharing information between the relevant services and practitioners while not requiring a large number of personnel to free up time to take part in the care planning process. Just one site held multi-agency meetings attended by representatives of all services relevant to the case and the service user as a matter of course in their process. Another site left it to the service user to decide whether they wanted more practitioners to attend the sessions. If they wanted representatives from both health and social care, the care co-ordinator would coordinate the joint meeting.

3.38   In a number of sites, the IPC process included a conversation about setting a PB for the service user. These were either social care funded, health funded, or in just one site jointly funded. The conversation about the personal budget sometimes followed the care planning sessions (with the care plan feeding in to the budget calculations) and sometimes preceded it (to feed in to the care planning process). All agreed care plans and personal budgets were sent to a multi-agency panel for final approval and sign off. The care plans were then logged in the service user's records for relevant practitioners to access as needed. A copy was given to the service user as well, as they were perceived to be the owner of the plan.

3.39   In most of the sites, the new care plans replaced the existing plans that service users had. In just one site the care plans under the IPC process were in addition to existing care plans. This was because the IPC process was still being piloted on a small scale and had not been rolled out to the entire cohort.

3.40   Table 3-1 summarises the variation in the model across some IPC sites.

Table 3-1: Variations in IPC process model

Site	Number of meetings	Service user present	Lead professional / key worker	Wider services involvement	Length of process
Site A	Depends on needs	Care planning and budget	Social worker	During care planning meeting	Depends on needs
Site B	Depends on needs	Care planning and budget	Social care practitioner	Outside care planning meeting	12 weeks
Site C	2-6	Care planning and budget	No	No	Depends on needs
Site D	1-3	Care planning and budget	VCSE IPC planner	No	Up to 2 weeks
Site E	1	Care planning and budget	Care coordinator	Outside care planning meeting	4 weeks

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Site	Number of meetings	Service user present	Lead professional / key worker	Wider services involvement	Length of process
Site F	Up to 10	Care planning only	Peer coacher	No	3-3.5 months
Site G	2-3	Care planning and budget	Practitioner (health or social care, depends on need)	Outside care planning meeting	4-6 weeks
Site H	2	Care planning and budget	No	During care planning meeting	2 months
Site I	1	Care planning only	No	No	Depends on needs

Source: SQW based on information from sites

3.41 In all of the sites, there seemed to be a greater focus than in the previous round of interviews on ensuring that the care planning was person-centred, with the service user actively involved in shaping and making decisions about their care plan.

3.42 At the same time, services had not been fully integrated in a number of the sites. In the best cases there was a single plan, which although developed mainly by a lead professional from one service, applied to all and was signed off by a multiagency panel. However, in other cases multiple plans were still being used, while in others the plans were very much focussed on single services. The latter was particularly prevalent where sites focussed heavily on agreeing PHBs, seeing this as an output. In these cases the main focus was on agreeing this element of the plan, through liaison with health services, with other elements including social care seeming to be secondary and much less likely to be changed.

3.43 It is important to note that although the sites appeared to have made good progress in developing the personalised care planning processes, the majority were still working on a small scale, either with small cohorts or still on a pilot basis. In a number of sites there were variations to the process that was implemented across cohorts, which made these sites feel as though they were delivering separate projects rather than developing a new system-wide approach. This approach again suggests IPC as a set of broad principles to be followed. It may also mean that its rollout is more complex, if new models have to be developed as new groups are engaged.

3.44 The majority of the stakeholders interviewed fed back that the new approach was better than previous practice, in particular in meeting service users' needs. However, there still remained considerable challenges to delivering this approach at scale. The key challenge mentioned by stakeholders was the length of time that it took to conduct the different conversations and care planning sessions. Each care planning session took place over at least one hour, and in most cases more than one session was required. This was reported as being considerably more time than practitioners had been spending in care planning meetings prior to IPC. The length of the process was also a barrier to getting some practitioners on board. Some stakeholders commented that the new care planning process

> *This takes a lot longer than just the assessment and planning process. Preparatory work is required before you have the planning phase. [However,] the planning phase can happen quicker because you've done the preparatory work – it's more focused* (Commissioner)

was perceived as an added task that they did not want to take on. It appeared that discussions around resources for the delivery of the personalisation agenda will be central to the continuation of the work in the next year of the programme.

> **Exceptions to the IPC model**
>
> The interviews highlighted two examples where the IPC process implemented by a site was different to the common emerging model described above.
>
> In one site, the care planning session involved going over a questionnaire about health and social care needs and the completion of a care plan template. The service user was also asked about whether they wanted a personal budget, and whether they wanted to manage the budget or preferred a notional budget instead. The completed care plan template was then taken to a panel for review and risk assessment. Any request to purchase a service through the personal budget also went for review by the risk panel to ensure all other options of services were exhausted before approving the purchase. The service user was not present at the panel meetings.
>
> Another site commissioned trained peer coaches who worked with the service users to develop a care plan. In this site, once the individual was identified and consented to take part, the IPC team at the CCG set up an indicative budget for the service user and referred their case to the peer coaching company. The company conducted a risk assessment to ensure the environment was safe for the peer coach to work in, before the work began. Service users were offered up to 10 one-hour sessions to work with the peer coach in developing their care plan. The complete care plan was sent to the CCG for final sign off.

Choice and control

3.45   The primary objective of the shift of choice and control was the establishment of integrated PBs. PBs were intended to give service users greater choice and control of the services they access. In the previous report it was noted that, in part because sites have started with small cohorts, progress delivering PBs had been limited. The figures reported in the second round interviews indicated that progress in this shift had continued to be slow-to-moderate across all sites. The interviews indicated that this shift proved to be a great challenge to the majority of the sites because it required developing new systems for setting up budgets. In addition, resources for funding the PBs were tied up in block contracts (see section on personalised commissioning and payments below). This was a key barrier to funding the PBs.

3.46   When considering PBs it is important to note that in social care the concept and delivery of PBs is well-established, but in health PHBs have only recently been piloted and not yet embedded nationally. As such, while social care practitioners (and users of social services) feel fairly comfortable working with PBs, many health practitioners were reported as still grappling with the concept of a PB for health services.

3.47   The differences between the services posed significant challenges when it came to creating a new system of integrated budgets, jointly funded by health and social care. Stakeholders commented that the health services needed to 'catch up' to be at the same place as social care, in terms of practitioners' understanding of PBs and having systems in place for PBs.

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3.48   Stakeholders in the IPC sites commented that activities in this shift focused on developing PHBs rather than integrated budgets. They commented that as PBs in social care were already established, it was easier to first develop a system for setting up PHBs, with the intention that setting up integrated budget would then follow as the next step. Commissioners and practitioners in health services commented that working on IPC increased their understanding of PBs, how they could be used and what benefits they could offer to service users. They commented that they felt more confident having the discussion with service users about setting up a budget and explaining to them how it would work. Stakeholders commented that, in many cases, the service users who took up a budget did not change the services they were using, but often used them more flexibly than before and were pleased with the empowerment that having a budget gave them.

> *Putting people in the driving seat means being open and transparent about the cost to the system, and giving them options that are "real" and not notional. This is a challenge for providers, as people might have the option to choose something other than their services, and this can generate resistance from providers* (Commissioner)

3.49   Nevertheless, setting up the budgets remained a challenge. Although awareness amongst stakeholders increased, there was still resistance from providers as well as service users to taking up budgets. In some cases, providers were worried that offering choice and control to service users through the budgets might mean a loss of business for them. Practitioners were worried about safeguarding and commented that the risk assessment panels were still quite risk averse and were finding it difficult to 'let go'. As a result, a number of sites offered their IPC cohort a very small one off PB to test this process. The budgets were used to purchase products or services outside of their 'normal' use of services, that were identified as gaps during the care planning process.

3.50   Service users did not always want to take up a budget, either because they were happy with their services or because they worried about having to manage a budget and commission services in a complex system. These tended to be service users who had high frailty, dementia or severe learning difficulties. One site (which was an outlier in its scepticism about PBs) commented that they were concerned about issues with fraud and misuse of the budget, which meant further review systems needed to be put in place to monitor service users' use of budgets. They commented that because of the risk of fraud and for reasons of safeguarding, PHBs required close case management and this has meant that professionals need to have greater oversight of services users than previously.

> *It's about reassuring people, people need reassurance, because this is a new system with new processes and we're still trying to figure things out. So if that's not explained clearly at the beginning I think that leads to dissatisfaction from people and they just pull out, because they think 'I can't be bothered with this anymore* (Commissioner)

3.51   Where budgets were set up they tended to be notional budgets, managed by the CCG in most cases. This option provided a greater choice in terms of use of services, but did not offer service users the control over their budget. In a number of sites the CCG posed considerable restrictions on service users in using their budget and on what the budgets could be used for. For example, in one site budgets were loaded on to a pre-paid card that was held by one professional. This person accompanied service users when purchases were made, to pay for the item or service. This added complexity to the

process of using the budget, as a further meeting was needed. In addition, when the person responsible for the card was not available, all requests and purchases were delayed. In another site all purchase requests were reviewed by a risk panel, which meant a delay in the purchase process, and in some cases a refusal of the request.

3.52   Five sites offered an option of direct payments (DP) around IPC, which meant money put in a bank account or a pre-paid card that the service user controlled. This offered both greater choice as well as control over the services they used. Where the DP option was available, the majority of service users opted for this option. Stakeholders commented that this enabled service users to take greater control of the services that they wished to engage.

3.53   Two sites delivered integrated budgets and one had systems in place to set joint budgets for service users. Stakeholders in these sites commented that working with an integrated budget had benefits for both service users and the system. They felt that having an integrated budget increased the flexibility of the resources that were available for the service user. This was because instead of having two pots of money, each one intended to be used on a specific list of services, all the funds were pooled together and could be used in a seamless way, because funds were not ring-fenced around services. Commissioners commented that integrated budgets also helped in preventing double funding of elements in the care plan, because in setting up the budget the services took a holistic view of the care plan, set up the budget and pooled the funds from the relevant services. Previously, each service only reviewed the elements that were relevant for them, and could miss that more than one service was allocating funds to the same element.

Personalised commissioning and payments

3.54   The shift of personalised commissioning and payment comprised the development of the local market of services to enable a greater choice and flexibility for individuals. In this respect, this shift is closely linked to the previous one of 'choice and control'.

3.55   In the first round of the process evaluation interviews the primary challenge that sites faced in developing the local market was around unpicking the block contracts with the NHS providers. For many of the sites, this remained the main challenge six months on. A key issue that was mentioned was that because much of the money was still tied up in block contracts, if a service user decided to go with a different service, the CCG could end up double funding the service. To address this issue, some sites set up small budgets to fund just some elements of the care package, while the rest of the sum was still funding statutory services under contract.

> *This is a very complex and politically sensitive area. This is not something you can just tell the provider to do. Additionally, there are complexities associated with block contracts*
> (Commissioner)

3.56   That said, a number of sites commented that they have shifted some of their focus to thinking about the mechanics of using PHBs (i.e. setting up systems and infrastructure for service users to be able to purchase services and items as they required). Sites were looking in to working with pre-paid cards, setting up personal bank accounts for service users, and, in one site, negotiating contracts with brokerage services.

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3.57   A number of sites commented that their activity around PHBs encouraged the commissioners to review their local offer. The choices that people were making helped to highlight what services were required for the local service user population. Commissioners commented that this would inform the negotiation of contracts when they come up for renewal, in terms of the flexibility they will ask services to exercise and in the introduction of new offers. In a number of sites this promoted the development of stronger relationships with VCSE organisations to integrate them in to the local market alongside the statutory services, providing more flexible services and filling gaps.

3.58   However, this progress was not made in all sites. It appeared that in a number of sites, the IPC teams were primarily focused on the development of a personalised care and support planning process and setting up systems for PHBs, with much less progress being made in this shift.

> *There has been such a push on getting people to have personal budgets that we've not concentrated on what they are going to buy with them* (Service provider, VCSE)

4. Implications of the findings

4.1   The evidence gathered from the selection of sites that have supported the evaluation in the second round of interviews continues to present a rich picture of the implementation of IPC. It demonstrates the progress that some have made and the challenges many have faced.

4.2   It appears that the governance structures and leadership of IPC are in the process of being embedded into the system in a number of sites, shifting the focus on to developing the IPC offer and processes. Sites have focused primarily on developing their process for personalised care and support planning, putting a greater emphasis on implementing a different kind of conversation, centred around service users and what was important to them. In addition, a great deal of time and thinking has been invested in developing processes for setting up and delivering PHBs as standard for service users. An overview of the evidence against each of the five shifts appears to suggest:

- Although good progress has been made in developing the IPC offer, the majority of the sites were still working on a small scale. The majority of the sites reported completing around 50 care plans (or under), although two sites reported completing over 1,000. The number of PBs tended to be lower than the number of care plans completed, with two sites reporting under 10 PBs, others reporting in the range of 20-60 and just one reported having around 300 budgets. Therefore, a key challenge still remains around scaling up to greater numbers and spreading out to other cohorts.

- Many of the sites did not have linked datasets in place, and those that did, did not use the dataset as a resource to identify service users to the IPC cohort. Instead, sites worked with local practitioners to identify service users, and found this to be a much more pragmatic and stable approach. The value of having a linked dataset was perceived primarily as a mechanism to monitor service users' conditions and proactively offer care and support as appropriate and needed. Going forward, sites would need to resolve IG issues to be able to move forward with developing a local shared linked dataset. NHS England and NHS Digital might need to consider how they can help support the sites in developing an IG Policy to address the various issues that have arisen.

- Most sites had made relatively slow progress in the development of community capacity and peer support. Many spent time and resources mapping out what local services and providers were available for health and social care, and started to make plans to engage new providers, primarily independent, and incorporate the VCSE sector into the local market to offer greater choice for service users.

- Many sites set up or developed a renewed partnership with local co-production groups. These groups contributed to the development of the care planning process and to the development of new care plan templates.

- The most progress was achieved in the development of personalised care and support planning processes. The findings show an emerging IPC process model, that was similar in most sites. The new processes had a greater emphasis on person-centred approaches, with practitioners having 'a different kind of conversation' with service

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users as part of the care planning process. This is very much 'as intended' by the programme.

- The aspect of service integration tended to happen outside the care planning sessions, with practitioners having different platforms to ensure that information on care plans was being shared and approved across services. In a number of sites this included single approval panels, and MDTs discussing the care plan details and developing a care package to support the plan. In other sites this included informing different services of the details of the plan and keeping a copy of the plan in a place where it could be accessed by practitioners from all services.

- Progress around integrated PBs has remained limited. Activities around this shift focused primarily on developing a system to setting up and deliver PHBs. As we have seen elsewhere, gaining the understanding and trust of providers and service users around the benefits of PBs takes time. Feedback from sites on their experience of PHBs has been variable so far, which suggests getting this right will take a considerable amount of time. The additional challenge that sites will face will be developing integrated budgets, pooling funding from social care and health in to one single budget for the service user.

- Unpacking block contracts remain the key challenge for sites in offering greater choice and flexibility in the local market. That said, a number of sites were monitoring how service users were using their budgets (i.e. what service choice they were making) and were planning to use this information to inform the shaping of the local market and any contracts with providers going forward.

Next steps

4.3 In the six months since the first round of fieldwork it appears that some progress had been made across sites, primarily in the development of the care planning processes and in setting up PHBs. That said, in many sites the progress was moderate, as services were working on a relatively small scale or on a trial or pilot basis. At the same time, progress was limited in the development of the local services offer from both statutory and VCSE services. Sites acknowledged where further progress was required and were committed to continuing the development of the model.

4.4 This has important implications for the next phases of the evaluation:

- The evaluation plans to conduct between 60 and 80 interviews with service users and their carers to gather feedback from them about their experience of the IPC model. It is hoped that the sample of service users and carer will provide a good representation of the four IPC target groups. The numbers of people experiencing IPC to date appears lower than originally expected, as progress on the development of the model has been slow going. As the model starts to embed and more people start to go through the process, it should support the delivery of these interviews.

- The evaluation also plans to conduct three thematic case studies, looking in depth in to key topics of common interest to support the learning around the development and implementation of IPC. The three topics are yet to be agreed, but the evidence

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gathered to date suggest that there would be benefits in focusing on areas of common challenges across sites (e.g. sustainability, scaling up, development of the local market, care planning).

- The data for the economic evaluation is planned to be gathered through workshops with a number of sites. The evaluation team will facilitate discussions to gather information on the cost of setting up IPC and of the different element of the care planning process. The progress that has been made in the development of the IPC model in a number of sites will support the work on the economic evaluation.

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Annex A: IPC sites

A.1   The table below lists the 17 IPC sites and the period in which they joined IPC. Sites that joined IPC in April 2015 were Demonstrators sites. Those that joined in December 2016 were Early Adopters sites.

Table A-1: IPC sites

Site name	Type	Date joined
Birmingham and Solihull	Early Adopter	December 2016
Cheshire West & Chester	Demonstrator	April 2015
Gloucestershire	Demonstrator	April 2015
Hampshire	Demonstrator	April 2015
Hertfordshire	Early Adopter	December 2016
Islington	Early Adopter	December 2016
Lincolnshire	Demonstrator	April 2015
Luton	Demonstrator	April 2015
Northern, Eastern and Western (NEW) Devon	Demonstrator	April 2015
Nottingham City	Early Adopter	December 2016
Nottinghamshire	Early Adopter	December 2016
Portsmouth	Demonstrator	April 2015
Somerset	Demonstrator	April 2015
South Devon and Torbay	Demonstrator	April 2015
Sheffield	Early Adopter	December 2016
Stockton-On-Tees	Demonstrator	April 2015
Tower Hamlets	Demonstrator	April 2015

Source: NHS England

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