

This is a repository copy of *Summative Evaluation of the Integrated Personal Commissioning (IPC) Programme : Interim report – Process Evaluation November 2017*.

White Rose Research Online URL for this paper:
<http://eprints.whiterose.ac.uk/127112/>

Monograph:

Agur, Maya, Thom, Graham and Baxter, Catherine Rachel orcid.org/0000-0002-3094-9546
(2018) *Summative Evaluation of the Integrated Personal Commissioning (IPC) Programme : Interim report – Process Evaluation November 2017*. Research Report. SQW

Reuse

Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.

Summative Evaluation of the Integrated Personal Commissioning (IPC) Programme

Interim report – Process Evaluation

November 2017

SQW

Contents

Glossary 2

1. Introduction 3

2. Methodology 5

3. Key findings..... 7

4. Implications for the evaluation 16

Contact: Maya Agur Tel: 0207 391 4111 email: magur@sqw.co.uk

Approved by: Graham Thom Date: 17/11/2017
Director

Glossary

1. CCG – Clinical Commissioning Group
2. CHC – Continuous Health Care
3. CMHT – Community Mental Health Team
4. COPD - Chronic Obstructive Pulmonary Disease
5. CPA – Care Programme Approach
6. CPM – Combined Predictive Model
7. CYP – Children and Young People
8. DP – Direct Payments
9. GP – General Practitioner
10. ICM – Intensive Case Management
11. IG – Information Governance
12. IPC – Integrated Personal Commissioning
13. LD – Learning Disabilities
14. LTC – Long Term Condition
15. MDT – Multi Disciplinary Teams
16. MH – Mental Health
17. PB – Personal Budgets
18. PHB – Personal Health Budgets
19. SEN&D – Special Educational Needs and Disabilities
20. STP – Sustainability and Transformation Plan
21. VCSE – Voluntary, Community and Social Enterprise

1. Introduction

- 1.1 Integrated Personal Commissioning (IPC) is a new approach to joining up health and social care, and other services where appropriate. The purpose is to enable people, 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 people 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 18 demonstrator areas in England where local authorities and Clinical Commissioning Groups (CCGs) are working together with their providers and voluntary sector partners. The programme was launched in April 2015 and is planned to run until at least March 2018. It is 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 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 (CPA), or those who use high levels of unplanned care.

Summative evaluation of IPC

- 1.3 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.
- 1.4 The evaluation aims to identify key lessons about the effectiveness of IPC schemes, in particular how far outcomes improved and what were the key drivers of any change. It will also consider how far the changes that do occur represent value for money. The evidence is being gathered from across a number of local authority areas. It will cover different ways in which IPC has been delivered and a range of different user groups.
- 1.5 The results will consider:
- what has been learned about how to introduce IPC approaches in different locations (Process Evaluation)
 - what benefits service users and carers gain through the new approach from 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.
- 1.6 The evaluation is planned to run for two and a half years between November 2016 and April 2019, with the main data collection phase taking place between July 2017 and autumn 2018, with analysis and reporting by April 2019.
- 1.7 The evaluation launched with a scoping and feasibility phase. It explored the context of sites and the activities that each area is undertaking, to gain understanding of the existing and new interventions, available data, approaches, target groups and scale of IPC and to ensure the evaluation methodology aligns with ongoing work and data collection activities. Following the completion of the scoping phase the evaluation commenced work on the Process Evaluation strand.

Report structure

- 1.8 The following report summarises the findings from the first 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 lessons learned, barriers to and enablers of the implementation of IPC. In section 4, we discuss the implications for the evaluation and next steps.

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 is being implemented in each locality, what is working well, and what is working less well, and so to feed in to and augment the impact work which is its primary focus.
- 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 consultation, the evaluation identified nine sites which were ready and willing to take part in the depth case studies. These included five Demonstrator sites and four Early Adopter sites. An evaluation information sheet was circulated amongst stakeholders in all nine sites ahead of the site visits. The information sheet provided an overview of the summative evaluation of IPC. It covered the background to the evaluation, evaluation partners, activities to be undertaken and timeframes.
- 2.3 The first round of fieldwork took place between July and October 2017. This included site visits and interviews with key stakeholders in person and via telephone and discussion groups. The interviews followed a series of topic guides to ensure the consistency of the data collection across the different sites.
- 2.4 In total, 45 interviews were conducted across all nine sites. These included:
- 28 interviews with strategic level stakeholders and commissioners
 - 13 interviews with frontline practitioners from across the health and social care services
 - four interviews with service providers, including health, social care and the VCSE sector.
- 2.5 All of the 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 developed using a template based on the topic guides. The summaries of the interviews were then systematically coded using qualitative data analysis software (MaxQDA) 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 five members appointed through an open selection process, three SCIE trustees and two SCIE co-production team members, plus a member of the evaluation team.

- 2.7 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.
- 2.8 Since the start of the evaluation, four co-production panel meetings were 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 work-plan
 - 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, which are presented in this report.
- 2.9 In addition to these activities, representatives of the panel attended both of the evaluation debriefs, which took place after the scoping phase and the first round of the process evaluation (two panel members attended each of the meetings and then fed back to the panel).
- 2.10 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. Key findings

Introduction

- 3.1 The interviews with stakeholders in the nine sites highlighted that IPC is a highly ambitious undertaking. IPC is a framework of principles which services are expected to follow and implement in the context of local services. Moreover, the change is expected to affect the entire system, covering all levels (i.e. strategic and operational) in health and social care services, including commissioners, service providers and frontline practitioners. This means that IPC is intended to change how services will be commissioned and delivered in the future.
- 3.2 To support the development and implementation of IPC in the different sites, NHS England developed the IPC Operating Model¹. 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 in support of the development of the Five Key Shifts. The interviews highlighted that a great deal of work has been done around understanding IPC and what services should look like on the ground, and in developing the enablers to support the implementation of the Five Key Shifts (mainly workforce and leadership).
- 3.3 This chapter discusses the key findings in relation to the implementation of IPC, covering enablers, barriers and lessons learned. The chapter looks at each of the Five Key shifts separately as well as the enabler elements from the IPC operating framework.

Leadership of IPC

- 3.4 The IPC Operating Model sets out leadership as one of the key underpinning enablers of the programme. This relates to having a clear vision, strategy and action plan for driving the change in the system. The evidence from the interviews suggests that to a great extent, the work around implementing IPC has focused on developing the leadership for, and a clear vision of, IPC. Indeed, a great deal of work took place around developing a shared understanding of integration and personalisation at the strategic level and in encouraging joint working between services.
- 3.5 In different places, IPC was being led by different organisations – the local authority, the CCG, a partnership between the local authority and CCG and in two sites an external organisation that was commissioned to deliver IPC. All sites developed a governance structure for the implementation of IPC, which involved stakeholders from the different services and organisations that provide services to the target population. Many of the site leads commented that to be able to implement IPC it was important to acquire senior buy-in, as the change was expected to happen from the top down. Senior stakeholders commented that it was important that the change be driven from the top down and not from the bottom up, because if senior people are not on board they could block the change from happening. For this reason, a great deal of effort was invested in securing senior level buy-in to the

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

programme. Stakeholders commented that where there was no buy-in, the service was not as engaged with the programme and change could not be generated.

3.6 The stakeholders in the majority of the sites felt that they have established good foundations for the growth of IPC. Across the sites we identified three main structures developing:

- developing a governance structure with a multi-agency steering group, bringing representatives from all different agencies and services around the table to develop one single strategy for IPC
- developing multi-disciplinary teams (MDT) and/or looking into co-location solutions to enable practitioners from different services to work on their case-loads as a team
- mapping and streamlining of pathways to avoid duplication in assessments and service provision.

3.7 Stakeholders mentioned that the key enabler to making good progress was having existing and good relationships between agencies (i.e. the local authority and the CCG). Where there was a history of collaborative working, stakeholders were more willing to take part in meetings and take on the additional tasks involved in the development of IPC.

3.8 In addition, sites mentioned that having a local governance structure that puts integration of services at its centre was another important enabler. For example, in one site the local authority and the CCG jointly created and funded a new role of Director of New Care Models to enable better co-ordination of services across the system. Another site had recently introduced a new role of Director of Service Coordination, a role jointly funded by the local authority and the CCG.

3.9 While investing in multi-agency and multi-disciplinary teams to support the development of IPC seemed to have provided a good foundation for the programme, stakeholders commented that it had required a great deal of time and resources to do well. Getting a large number of stakeholders from different agencies to attend meetings and complete tasks required a high level of admin support and monitoring to ensure the engagement with IPC was maintained.

3.10 The majority of sites had not achieved as much progress as they had expected at this point of the programme in working with providers, practitioners and service users. Stakeholders commented that this was because it took time to get to the point where they had a shared understanding and common vision of IPC. They noted that the messages that go out to providers and practitioners need to be well thought through to ensure positive buy-in. The communications campaign needs to be tailored to different audiences in the different services, depending on where the services are in terms of person-centred and service integration policies.

I sometimes feel that we should have delivered more IPC but actually, the time we've taken in the last six months to get that strategic level on board... means that actually we're getting to a point now where I think we can really start to implement this integrated way of working

IPC site Project Manager

3.11 It is worth noting that the two sites that were led by an external organisation appeared to have made the most progress, having recruited a number of individuals to IPC already. Other sites

who used external providers to implement several elements of the programme, including pilots of new pathways, also commented that working with an external organisation was a key enabler in gaining momentum and pace in delivering the work.

- 3.12 External bodies are tasked with delivering a contract, and as such are able to focus on monitoring progress and ensuring good time keeping. The local authority and CCG as leaders of the programme need to generate change within their own system, while maintaining services as usual while the change takes place. This is a complex and delicate task to undertake. It therefore appears that there are benefits in deploying external organisations to lead on the generation of change, at least for the initial stages of the process. Leadership from the local authority and CCG is still required for embedding the change in the system in the long-term.

We need a cultural change to embed this within the system. We need leaders to say - this is what we are doing, and this is how we are going to do it and we expect you to comply

Local authority senior staff member

Proactive coordination of care

Four of the nine sites have linked datasets between health and social care services. Two of these sites were able to use the linked data set to identify individuals for IPC. The key barrier to the development of local linked datasets mentioned was Information Governance.

- 3.13 The shift of proactive coordination of care involves cohort identification and personal level costing of services and care packages. Activities in this shift focused around exploring ways of developing a mechanism for sharing data across services on individuals' use of services and the costs associated with these.
- 3.14 Establishing a linked dataset that follows an individual's use of services across health and social care was stated by NHS England as a primary enabler for the proactive coordination of services. At the same time, this was mentioned by all sites as a key challenge. To date, more than half of the sites have not yet succeeded in establishing a linked dataset across their services. In four sites, there were linked datasets between social care and health services (three were pre-existing and one was developed by the IPC programme). In three of the sites the dataset was used to identify individuals to invite to join IPC. In one site, the linked dataset could not be used to identify individuals to the programme and could only be used for direct care unless the patient gave their consent for secondary use of the data (e.g. for research and evaluation).
- 3.15 Where the IPC teams could use the dataset for recruitment to the programme, they identified the services that individuals were using to identify those most suitable for IPC. Sites targeted individuals based on different criteria (highest costs of services, integrated funding, or use of services from multiple agencies). Even in these sites the process did not always work as had

[IPC project is enabling the CCG and council] to talk about a much more pro-active sharing of data on a regular basis, rather than an ad hoc way, so a much more formalised sense of data sharing

Local authority senior staff member

been hoped. For example, in one case, although the cohort could be identified and invited, a tracking mechanism could not be put in place to see who had taken up the offer or track any change in outcomes that followed.

- 3.16 In the other sites, stakeholders mentioned that information governance (IG) issues posed the main barrier for establishing the linked dataset.
- 3.17 That said, four of sites mentioned that working in MDTs and in particular having co-located teams allowed some degree of sharing between services. This is because the MDTs work on their caseloads together, and each team member needs to be able to understand the case, be familiar with the individual's history and know the details of their care package. While this solution enables the coordination of care at the individual level, there was still a gap in service coordination at the system level. For this reason, it is important that sites do achieve a linked dataset to enable better coordination of care going forward.

Community capacity and peer support

Sites are at in the early stages of developing this shift. The focus was to deliver this shift in the VCSE sector, with plans to upskill providers in this sector to deliver community services. Three sites mentioned working with local peer support groups and carers advocacy panels to develop peer support activities.

- 3.18 The shift of community capacity and peer support involves making the most of services that are available in the community outside of statutory services. These services are often fairly 'low-level' but important in enabling self-management. The activities in the development of this shift focused primarily on the VCSE sector. A great deal of work has been taking place to upskill providers in the VCSE. Sites were looking to this sector to provide different and innovative services and in particular a more flexible and bespoke package of care. Stakeholders commented that a great deal of the work with the VCSE sector providers was around encouraging an innovative way of thinking and developing more flexible and bespoke packages of provision for individuals.

- 3.19 The interviews with the various stakeholders highlighted that there was mixed progress made around the development of local peer support services. Two sites mentioned a number of projects that were running, involving volunteers who offered peer support to individuals. For example, in one area the adult social care services operated a volunteer based buddying programme, where volunteers would link up with adults with mental health issues and take them out to social activities (e.g. the local pub or a theatre show). This supported individuals to gain the confidence to enjoy social activities in the community.

If you think about the devolved offer and putting communities much more in charge of own destinies, they will be in control and have better choices and we need to be able to look at this against what the local offer is in general

VCSE sector service provider

- 3.20 However, the majority of the sites mentioned that this area was challenging to develop, in some cases due to lack of local interest from service providers (to develop the offer) and from

the community, and in other cases, due to strains on resources and competing priorities. We return to this issue below.

Personalised care and support planning

The majority of the sites felt that integrated commissioning and person-centred approaches were already in practice in their area, and so expected little change to occur in this shift. That said, the interviews revealed that in many cases services were either working in a person-centred way or in an integrated way, but rarely exercised both. Where examples of good practice of both integrated and person-centred approach were identified, they mostly occurred in specific services or were practiced by a specific team rather than across services.

All bar one of the sites engaged in various activities in developing this shift:

- three sites were running pilots to test the effects of new pathways and new formats of assessments
- four sites were providing training sessions and workshops to staff on the person-centred approach to assessments
- four sites engaged external bodies to manage and run the implementation of the IPC programme or elements relating to the development of this shift

- 3.21 The shift of personalised care and support planning 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. Activities in developing this shift focused on mapping existing ways of working and assessing the extent to which new service pathways and models need to be developed to offer personalised care and support planning for individuals. A number of sites commented that service integration and person-centred approaches have already been high on the agenda for local services for some time.
- 3.22 However, when we delved into the detail of the care planning approach, it became apparent that in many cases the services worked in either a person-centred way or in an integrated way, but rarely in both. Where a person-centred approach was implemented, service users were increasingly involved in the assessment and care planning process, having a greater say in the development of their care plan. In around half the sites, an integrated approach was implemented. This meant that the assessment and planning conversations involved representatives from all services attending one or more meetings, rather than multiple conversations with each service separately. However, in some areas, the service user was not present in the multi-agency discussion and the outcomes of this meeting were discussed with them separately. In areas where person-centred and/or integrated approaches to care planning were used, IPC was perceived as an opportunity to generate momentum and scale up this care model system wide.
- 3.23 All bar one of the sites that engaged in the Process Evaluation started recruiting individuals to IPC from just one cohort. Stakeholders commented that they thought starting small and focusing on a defined group of people was beneficial in helping them to develop the initial

pathways. A number of sites ran small-scale pilots to test new pathways and approaches to services. They hoped that once the pathways were established and bedded they could form the basis from which the new approach could expand and grow.

3.24 The benefit of starting small and piloting their approach was that it allowed sites to move relatively quickly in implementing the new approach and pathways. This also had the potential to generate evidence to show the benefits of the new approach to care planning for the individuals and the services alike. Indeed, some anecdotal evidence from sites suggested that the feedback from service users and practitioners who experienced the new approach was highly positive. Individuals felt listened to and empowered. One family commented that the experience allowed them to start thinking about the future of their child and what they would like her to achieve when she grows up, where previously they focused only on her immediate needs to get her through the day. Practitioners commented that the experience changed their way of thinking around care planning (e.g. focusing on the strengths of the individuals, talking about their goals and aspirations rather than just their needs, and thinking about the long term rather than the short-term and immediate).

I have a good understanding of IPC and it has been great to know that the work I took part in ... has helped sites who are now starting with IPC. Seeing the impact IPC has had on some of the first families has been very satisfying

Operational manager and personalisation lead

3.25 However, stakeholders commented that moving on from the small cohorts and pilots and doing IPC at scale proved to be a great deal more challenging than they initially thought. The key issues were around:

- resources in the system- while they were sufficient for a small-scale pilot they could not be sustained on a larger scale
- different needs for different conditions and groups of people, which meant not all pathways were transferable (and more testing needed to be done)
- readiness of services – health services and social care services were at different levels of readiness in relation to embedding person-centred care planning.

Choice and control

In all of the sites, PBs were already used in social care services prior to IPC. These PBs were mostly notional budgets (managed by the local authority). Three sites were piloting the implementation of PBs for health services. One site was implementing integrated PBs (funded jointly by social care and health services). A small number of DPs were allocated in seven of the sites.

- 3.26 The shift of choice and control primarily involves the establishment of integrated PBs. During the interviews, it was clear that for stakeholders at the strategic level, PBs were a top priority and one of the primary goals of IPC. However, the evidence suggested that sites have made limited progress in developing this shift.
- 3.27 Feedback from stakeholders suggests that while PBs in social care existed for some time, PBs in health services were still relatively new and staff and services were still working out how best to implement them. Stakeholders commented that health professionals tended to be more risk averse and were worried about risk management and accountability around the choices that individuals might take with regards to their health care.
- 3.28 In all of the sites, PBs were already offered to individuals for social services, and in some sites through health services as well. In the majority of the cases, where PBs were set up, they were notional budgets (i.e. managed by the local authority) rather than DPs (i.e. money transferred directly to the individual to manage either to their bank account or via pre-paid cards). Stakeholders commented that they were hoping that the IPC programme would drive progress towards DPs across the system, but this has not happened yet.
- 3.29 Furthermore, integrating PBs with pooled budgets from social care and health services was an even greater challenge to achieve. Stakeholders highlighted three key barriers to implementing integrated budgets:
- Staff buy-in, particularly in health services. Practitioners who did not work with PBs had concerns about risk management and accountability – how to make sure that individuals manage their care safely, make the right choices and manage their budget well
 - Service user buy-in. For some individuals who were happy with their care package and the services they received, the idea of having a PB seemed disruptive and inconvenient. Many of the elderly reportedly did not wish to make changes or to have to deal with the admin that is related to managing a PB and commissioning services. That said, some stakeholders commented that the lack of buy-in from service users might have been due to the way in which PBs and how they function were presented.

PBs only work if they go parallel with developing community capacity, otherwise what they do is they buy the same old services... but what is great is when they can buy things that are quirky and individual and inclusive that we can't provide the services. But actually, what we found was that if we are able to develop the right providers, they do that stuff

Local authority senior staff member

- Security of funds. Stakeholders commented that because IPC is a pilot programme, there was nervousness amongst stakeholders in all levels about the sustainability of PBs. In some sites, the programme funds were used in pilots to test the use of PBs with individuals. Stakeholders were concerned that without achieving system change and pooled funds, they would not be able to guarantee the continuation of the PBs to individuals. For this reason, practitioners were said to be nervous about offering them.

Personalised commissioning and payment

There was limited progress in the development of this shift across all sites. The key barriers that were mentioned included:

- VCSE reservations in using PBs and taking direct payments from service users (services need to appear free at the point of use)
- funding tied up in block contracts, which limits the ability to invite new providers and expand the local offer
- lack of local infrastructure amongst services to work with PBs and DPs (i.e. systems to allow services to received payments through PBs)

3.30 The shift of personalised commissioning and payment comprises the development of the local market of services to enable more choice and control for individuals. In this respect, this shift is closely linked to the previous one of 'choice and control'. Activities in this shift focused primarily on unpicking existing contracts with services and reviewing ways of changing or discontinuing block contracts to allow the introduction of new services and new packages of care to be provided.

3.31 Progress in this shift across the sites was variable. In one site, stakeholders commented that it was not possible for them to change block contracts, and because the contracts would still run for a few years, they were not likely to make changes in the services provided. Other sites attempted to introduce changes to the local market in a number of ways:

There is a missing bit, I think, where we knew we had to disinvest or break down those big NHS contracts and we knew we needed to have a more developed market to offer more choice, and the VCS was the market to do that with, but they weren't ready

Local authority senior commissioner

- Requesting providers to offer more flexible and bespoke packages based on individuals' needs and wants. In a number of sites, these requests were introduced to their existing contracts as a requirement. In a few cases providers objected to the change, and commissioners are engaging in lengthy negotiations to reach mutual agreements.
- Working with providers in the VCSE sector to encourage them to develop new ways of service provision that will enable them to work with person led commissioning and start filling in gaps on the market (i.e. providing services that were not offered

through the statutory services). Stakeholders commented that when working with VCSE sector organisations they faced the challenge that, by and large, the sector was used to working with grants and block contracts. The culture was that services should appear to be free at the point of use and so some service providers in the sector did not feel comfortable receiving direct payments from individuals via DPs. Stakeholders commented that it was still early days and in many cases a great deal more work would be required to bring providers in the VCSE sector to the level of readiness that the commissioners would like.

3.32 Progressing this shift was challenging to sites for a number of reasons. Sites' inability to break up the block contracts was a key barrier. If providers were not willing to change the conditions of their contract then commissioners felt limited in what they could do. To address this, in a number of sites the commissioners engaged in conversations with their providers to consider new ways of service provision (in particular allowing bespoke packages of care). One site commented that they aligned the work of IPC with the local service transformation plan (STP). In that way, statutory providers could not refuse to discuss changes to the contract as this was part of the wider local transformation of services. Getting provider buy-in was a lengthy process and contributed to the delay in making progress in the shift.

3.33 Another barrier mentioned by stakeholders in seven of the sites was the need for infrastructure to be set up to enable services and individuals to use DPs once in place. In the majority of the cases the PBs that were set up were notional budgets, so the funding of services was still transferred in blocks between the CCG or local authority to the services. If DPs were to be used in the future, services will need to set up a system to enable accepting payments from individuals. Until this system is in place, DPs cannot be set up for individuals.

The outcomes that an individual wants to achieve then need to be turned into a costed plan- that's a part of the process that we get stuck on because clinicians don't know how to do this.... We then need to set up the direct payments, and this, again, slows the process down, primarily because there are a lot of systems and processes that CCGs need to have in place to do that, which we don't

CCG senior staff member

4. Implications for the evaluation

Emerging evidence

- 4.1 The process element of the evaluation is deliberately light touch, aimed primarily at informing and providing context for the impact work. That said, the evidence gathered from the selection of sites that have supported the evaluation presents a rich picture of the implementation of IPC. It demonstrates the progress that some have made and the challenges many have faced.
- 4.2 The sites have spent considerable time trying to develop project leadership across a range of services, believing that governance structures, and a shared understanding to gain buy-in, were required before operating fully. An overview of the evidence against each of the five shifts appears to suggest:
- The expectation of linking health and social care datasets to identify individuals across both has been difficult in many places. Instead, most sites have reverted to operate at a different scale using less systematic or integrated approaches
 - Sites have taken a range of approaches to engaging community capacity and peer support. The variation in part seems to reflect the different starting points in each area, which has been a positive for some alongside a concern about developing services at a time when resources are constrained
 - Enhanced care and support planning is in many ways the crux of IPC. Sites are supportive of this objective, although a number thought that they already exhibited good practice. Perhaps where most ground remained here was in integrating the two services (health and social care) to deliver both an integrated approach alongside a personalised approach. Most sites have started with small numbers to test new approaches and pathways. They now require to scale up these approaches and apply them to different cohorts
 - In part because they have started small, the progress around personal budgets has been limited. As we have seen elsewhere, it takes time to build confidence and so demand among professionals and service users
 - Many areas have struggled to unpack existing block contracts to offer more personalised commissioning and services. Others have sought to identify specific funds to enable users to purchase their own services, and some sites are considering what sort of market offer they would like to arrive at.

Next steps

- 4.3 Across the sites it appears that progress at the time data was collected was less than might have been expected. In particular, approaches and pathways were still being developed to operate across the target cohorts and at the anticipated scale. The sites were working hard to make progress.
- 4.4 This has important implications for the next phases of the evaluation:

- Further site based interviews are planned for early in 2018 and these will be important in gathering further information about the delivery of IPC, which will inform learning around delivery approaches and means of implementation, and feed in to the impact analysis as to different approaches across the sites which may influence observed impacts
- The numbers of people experiencing IPC to date appears lower than expected and the planned increase should support the development of the quantitative analysis
- The evaluation also plans to gather qualitative data from a range of service users in early 2018. This will be gathered before any quantitative follow up data. It will therefore provide an important view of the types of impact which IPC can deliver and the routes through which impact can arise.