Monograph:

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Evaluation of the Integrated Personal Commissioning (IPC) Programme

Final evaluation report

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Contents

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Glossary

ASCOT – Adult Social Care Outcomes Toolkit

CCG – Clinical Commissioning Group

CHC – Continuous Health Care

CPA – Care Programme Approach

DP – Direct Payments

EQ5D – Standardised measure of health status

EQ-VAS Scale – a vertical visual scale to measures individuals' perceptions of their health

GHQ-12 – Twelve Items General Health Questionnaire

GP – General Practitioner

HRA – Health Research Authority

IB – Individual Budgets

ICPERG – Integrated Care Policy Evaluation Reference Group

ICS – Integrated Care System

IG – Information Governance

IPB – Integrated Personal Budgets

IPC – Integrated Personal Commissioning

IT – Information Technology

KPI – Key Performance Indicator

LTC – Long-term Condition

MaxQDA – a software package for qualitative data analysis

MDT – Multi Disciplinary Team

MH – Mental Health

MoU – Memorandum of Understanding

OM – Outcome measures

PA – Personal Assistant

PB – Personal Budgets

PB – Personal Budgets

PHB – Personal Health Budgets

PHB – Personal Health Budgets

QALY – Quality Adjusted Life Years

RCT – Randomised Controlled Trial

SEN&D – Special Educational Needs and Disabilities

SRO – Senior Responsible Officer

STP – Sustainability and Transformation Plan

VCSE – Voluntary, Community and Social Enterprise

WEMWBS- Warwick-Edinburgh Mental Wellbeing Scale

WTE – Whole Time Equivalent

YP – Young Person

Executive summary

1. Integrated Personal Commissioning (IPC)[1] 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 and direct the resources available to them and control their care. This is achieved through personalised care and support planning, and personal budgets[2]. IPC was tested in 17 areas in England from April 2015, although six of these areas did not join the programme until December 2016. It was focussed on four user groups with complex needs:

- 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.

Evaluation of IPC

2. In August 2016, the Department of Health commissioned an independent evaluation of IPC. The evaluation ran between November 2016 and May 2019. The evaluation comprised three strands of work: process, impact and economic. The learning from IPC has already informed the development of the comprehensive model for personalised care[3]. This model is one of five major practical changes of the NHS outlined in the Long Term Plan[4].

Analysis and limitations

3. The evaluation faced several key challenges relating to the collection of outcome measures and cost data. The key issues with the outcome measures data were the low numbers and response rates in both the baseline and follow up waves of service user data collection. This reflected the extent of buy-in by sites to the evaluation and variable numbers experiencing IPC. Following on from this it was not possible to generate comparator data, as this process was intended to run in parallel to the outcome measures.

4. With regards to the cost data, response levels were also less than hoped (8 of 17 sites) and in some cases the information provided was insufficient for accurate costing, thus limiting the generalisability of the results. A number of assumptions were made to enable costs to be calculated.

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[1] https://www.england.nhs.uk/ipc/

[2] Personal budgets were available previously for social care services (Personal Budgets (PB)) and health care services (Personal Health Budgets (PHB)). IPC aimed to develop integrated personal budget to cover both social care and health care needs (IPB). In this report, we use the term 'personal budgets' to refer to any type of personal budget. Where the findings refer to a specific type, we indicate this in the text.

[3] https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/

[4] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

5. Despite efforts to seek a broader cohort the vast majority of service users consulted were people with mental health issues, people with dementia, frail older people or people with long-term conditions, and their carers. Based on the process evaluation findings this is probably typical of all those in receipt of IPC.

Overview of the IPC model

6. In May 2015, NHS England launched the IPC emerging framework[5], which set out the "five key shifts" of IPC, to provide guidance to sites in developing their local IPC models (proactive co-ordination of care, community capacity and peer support, personalised care and support planning, choice and control, and personalised commissioning and payment). In June 2017, NHS England published a revised interactive operating model to support the scale and spread of the IPC model. Following the publication of the emerging IPC framework, NHS England set out clear deliverables for the IPC sites, which included target numbers of personalised care and support plans and personal budgets for each of the sites.

7. The sites were operating in a challenging environment for introducing and scaling up a stable model of IPC. At the time of conducting our site visits, none were delivering IPC at scale, although the aim of IPC had been to achieve full maturity of the model by the end of the funding in 2019. However, the programme has been successful in other aspects and sites have contributed a great deal to the learning about personalised care.

Key findings relating to the delivery of IPC

Governance structures and leadership

8. The IPC Operating Model set out leadership structures as one of the key underpinning enablers of the programme. This related to having a clear vision, strategy (including strategic co-production) and action plan for driving change in the system. Sites made good progress in developing and establishing new governance arrangements and a 'system culture change'. In a number of sites, a great deal of resource was invested in workforce development, to enable 'a different kind of conversation' to inform a personalised care and support plan.

9. The findings suggest that greater progress was made where there were pre-existing relationships, which were more amenable for the change. Greater progress was also made in sites where there were existing local governance structures that put integration of services at its centre. However, even in these cases, it required a great deal of time (several years) and resources to develop an effective governance structure to manage a new model of care.

10. One key challenge in the development of the IPC leadership related to the engagement of middle managers, who would need to allow more freedom and flexibility to practitioners to make decisions in order for personalised care and support planning to work well. This will involve greater risk for the middle managers who are accountable for meeting services KPIs.

11. Another challenge was how to maintain the momentum for change. In many of the sites, implementation was on a small scale and short-term pilot basis. At the end of the pilots, things tended to 'go back to normal'. The challenge was one of ownership as well as understanding of

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[5] https://www.england.nhs.uk/wp-content/uploads/2017/06/ipc-emerging-framework.pdf

the personalisation agenda. One way of mitigating this was through the identification of ‘Champions of Personalised Care’ within services and organisations.

IPC processes (delivery of the five key shifts)

12. Progress in the delivery of IPC was mixed across the sites. The majority made slow progress at the beginning, recruiting only small numbers of service users to IPC (with some sites not recruiting any people at all), while they were developing the local model and strategy. However, by March 2018 sites had moved forward, making progress in embedding the new models and beginning to deliver personalised care and support planning sessions.

Proactive co-ordination of care

13. 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 identify those most in need of services, as well as to develop a shared mechanism for recording patient information (i.e. linked datasets). Many of the sites did not have linked datasets in place and were not able to create one; and those that did were not able to use the dataset as a resource to identify and follow-up service users to the IPC cohort. Instead, sites worked with local practitioners to identify service users, a pragmatic but less systematic approach.

Community capacity and peer support

14. The key shift of community capacity and peer support was focused on making the most of services that were available in the community, outside of statutory services. Most sites had made relatively slow progress in the development of this shift. Efforts focused on two main activities: mapping out what local services were available and making plans to fill in identified gaps; and setting up or redeploying local co-production groups. It appeared that the VCSE sector could be a valued partner in developing the community support offer in local systems going forward but delivery at scale would need additional resourcing.

Personalised care and support planning

15. The shift to 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. 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.

16. However, although there has been good progress in this shift, most of the sites were still working at a small scale. Most sites reported very low numbers of plans developed (generally under 50 plans in each site). Therefore, a key challenge remained around scaling up to greater numbers (and resourcing this) and spreading out to other cohorts.

17. Another gap noted was general lack of integration between services. Integration tended to happen outside the personalised care and support planning sessions, with practitioners having

different platforms to ensure that information on personalised care and support plans was being shared and approved across services.

Choice and control

18. The primary objective of the shift of choice and control was the establishment of integrated personal budgets (IPB, a personal budget for both health and social care needs). However, progress around IPBs has remained limited. Activities around this shift focused primarily on developing a system to setting up and deliver Personal Health Budgets (PHBs), reflecting the targets that were set specified PHBs. Feedback from sites on their experience of offering PHBs has been variable so far, reflecting the scale of the change required even before considering how to pool funding from social care and health in to one single budget for the service user.

Personalised commissioning and payment

19. The shift of personalised commissioning and payment comprised the development of the local market of services to enable a greater choice for individuals. Unpacking block contracts remains 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 and were planning to use this information to inform future contracts.

Service users' and carers' experience of IPC

20. The interviews with the service providers and carers highlighted a mixed picture of individuals' experience of IPC.

- Service users had different desires or abilities to exercise choice. Some wanted to exercise choice and took every opportunity to do so whereas others chose not to be involved at all or opted to exercise choice and control in a limited way.
- Some service users and carers particularly good or particularly poor experiences of choice and control appeared to be related to the actions and accessibility of key professionals. Where professionals were hard to contact, offered limited support or gave service users little space to express themselves, experiences were reported as not satisfactory. Where professionals were accessible and engaged service users in the IPC process, especially in support planning, experiences were more positive.
- It appeared that in order to gain the most choice and control, service users needed to be pro-active and push hard within the system to get the results they wanted. Conversely, service users less willing or able to do this tended to experience less choice and control.
- Service users with particularly positive experiences were those who had opportunities to choose what interests and activities to include in their support plan and also control over a budget that enabled them to pursue these activities, with capacity or sufficient support to manage it.

Economic evaluation

21. The economic evaluation collected information on the resources and costs of setting-up IPC and on the differences in resources and costs of running IPC compared to standard care. The findings suggest that IPC was slightly costlier than standard care. The average cost to set-up IPC was approximately £162,000 per site, mostly due to staff time. The additional cost of running IPC compared to standard care was £265 per user. This was driven by the greater number of appointments (+4.2 on average) and contacts between staff members (+2.4).

22. The economic evaluation was not able to collect data on the cost of the new personalised care and support plans. However, survey responses and feedback from service users suggested that for a good number the new personalised care and support plans provided them with more support than before (with over 50% saying that it gave them more support than before, and few reporting less support). This suggests that IPC was also associated with increased resources in the personalised care and support plans.

Impact evaluation

23. Findings relating to the impact of IPC were based primarily on self-completion surveys (collecting data on three standard tools: EQ5DL, WEMWBS, and ASCOT, plus, at follow-up, a short series of additional questions on the user views of the IPC process) completed at baseline and around nine months later by 138 users, plus qualitative interviews with 42 service users and carers.

24. Overall, service users were positive about their experiences of IPC. A quarter felt that their new personalised care and support plan gave them a lot more support than before and 31 per cent felt it gave them a little more support. Analysis of the standardised measures found that there was no statistically significant improvement in health outcomes (measured through EQ5D) and in general wellbeing outcomes (measured through WEMWBS). There was, however, a significant improvement in the social care related wellbeing outcomes (measured through ASCOT).

25. Sub-group analysis found statistically significant change in ASCOT scores for:

- people with mental health issues
- those who had a personalised care and support plan
- those who had a personal budget
- males
- people aged under 65.

26. The statistically significant improvements between baseline and follow-up should not automatically be interpreted as evidence of an IPC impact, especially in the absence of control group data. However, the changes in ASCOT scores (especially) and EQ5D for IPC are in line with those found for PHB evaluation. This is encouraging for IPC, as the PHB study focussed on a similar client group and found no real change in the comparison group scores. Therefore, the impact evaluation, although limited by relatively small numbers, does present some encouraging findings around the impact of IPC.

Recommendations

Recommendations for NHS England and policy stakeholders

- Evidence of the effectiveness of the integrated and personalised care model are vital for securing the buy-in of local commissioners and practitioners. NHS England should look to develop, in collaboration with the local teams, a national framework for recording consistently the outputs of teams and the outcomes for service users.

- NHS England should look at the costs of the new personalised care and support plans to be able to give an accurate estimate of the cost of delivering IPC.

- As the IPC approach continues to roll out on a national level, it is important to create sufficient time and space in the system to provide the number and quality of appointments required for the delivery of effective personalised care planning processes.

Recommendation for local commissioners and operational and delivery stakeholders

- Staff development and support is a vital element in the process of introducing system change and high quality delivery. Any future roll out of the IPC approach should include an element of training for staff to increase their knowledge and confidence in delivering the personalised approach in care and support planning.

- If the IPC approach continues to develop and roll out nationally, it would be beneficial to focus resources in increasing the engagement of middle managers across all sites, giving them the role of the primary change agents.

- If the IPC approach continues to roll out nationally, local systems would need to ensure that they have procedures and support systems in place to address inconsistencies in the quality and standards in the care and support planning processes across services.

- While service users were generally happy with their new care and support plans, they struggled to realise their plans due to an apparent lack of awareness of IPC on a system wide level. Going forward, local systems must ensure that all local services and agencies are aware of the IPC models that are being implemented and the outputs that they might produce (i.e. what a personalise care and support plan looks like) to help ensure the agreed plans are implemented.

- In addition, there was general lack of awareness of what services were available in the local market, which meant that service users could not be signposted to suitable services. Local organisations should be in a position to offer support to service users in commissioning their services through developing directories of local services.

- The personalised care and support planning process should include a single contact for the service users and their carer to approach for any queries or advice required about realising their plan.

1. Introduction

1.1 Integrated Personal Commissioning (IPC)[6] 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 from across statuary bodies, in order to control their care. This is achieved through personalised care and support planning, and personal budgets[7]. Based on conversations about what matters to the service user, IPC also aims to support service users in developing 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 was tested in 17 areas in England (see Annex A) where local authorities and Clinical Commissioning Groups (CCGs) worked 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 groups of service user:

- 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 to May 2019, the scope of IPC broadened to cover larger geographical areas and more service user groups.

1.4 The learning from IPC has already informed the development of the comprehensive model for personalised care[8]. This model, which is one of five major practical changes of the NHS outlined in the Long Term Plan[9], is now being rolled out across the country to ensure personalised care becomes business as usual.

Summative evaluation of IPC

1.5 In August 2016, the Department of Health commissioned an independent summative evaluation of IPC. The evaluation ran between November 2016 and May 2019 and was 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.

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[6] https://www.england.nhs.uk/ipc/

[7] Personal budgets were available previously for social care services (Personal Budgets (PB)) and health care services (Personal Health Budgets (PHB)). IPC aimed to develop integrated personal budget to cover both social care and health care needs (IPB). In this report, we use the term 'personal budgets' to refer to any type of personal budget. Where the findings refer to a specific type, we indicate this in the text.

[8] https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/

[9] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

1.6 The evaluation aims were 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 also considered the extent to which these changes represented value for money. The evaluation comprised three strands of work.

- **Process evaluation**, which was designed to understand the delivery of IPC, commissioning and contracting issues, changes in the provider market and organisational and cultural change.
- **Impact evaluation**, which was designed to quantify the level of impact IPC had on individuals. The evaluation was based on the assessment of key outcome metrics, utilising data collected on IPC participants via data collection tools set up by NHS England.
- **Economic evaluation**, which was designed to find out if IPC was more effective than standard care (i.e. the care received by people in the absence of IPC) and good value for money to manage individuals with complex health and social care needs.

1.7 The evaluation considered:

- what has been learned about how to implement IPC approaches in different locations
- the benefits service users and carers gained from the new approach, by developing and implementing a personalised care and support plan
- the costs of developing the new approaches and any extra costs or savings associated with the plans developed
- how far IPC led to demand for different kinds of care and support, and how the market responded.

Co-production Panel

1.8 A co-production panel has been recruited to assist and inform the evaluation. This strand of the evaluation was being led by SCIE. The aim was 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, were heard, and could shape evaluation activities.

1.9 The panel was made up of eight members appointed through an open selection process, three SCIE Trustees, two SCIE co-production team members, and a member of the evaluation team.

1.10 The co-production panel met quarterly throughout the lifetime of the evaluation. Their inputs informed each of the three strands of the evaluation (process evaluation, impact evaluation, and economic evaluation). This included co-production of research tools, review and co-development of interviewing protocols, and contribution to interview data analysis.

Structure of this report

1.11 This report summarises the findings from three strands of the evaluation. In the next section, we outline the methodology used in each of the evaluation strands and discuss the limitations of the analysis. In section 3, we provide an overview of the IPC model and summarise the key findings from the process evaluation. In section 4, we discuss the lessons from the implementation of IPC. Section 5 summarises the findings from the economic evaluation and section 6 summarises the findings from the impact evaluation. Finally, in section 7 we draw out our conclusions from the evaluation and discuss the implications and recommendations for any further work in this area.

1.12 The report concludes with a series of supporting annexes:

- IPC sites – a list of the 17 IPC sites
- Questionnaire on the costs of setting up and running IPC
- Additional information on economic analysis (Annex tables)
- Service users experience of IPC – summary of the findings from the service users and carers interviews
- Personalised care and support planning process – thematic case study
- Development of the local market - thematic case study
- Sustainability and scalability – thematic case study.

2. Methodology

2.1 This chapter outlines the methodological approach used in the study. This approach evolved over time in response to changing circumstances, as explained below.

The original proposal

2.2 The evaluation was planned to run for two years between September 2016 and October 2018, with the main data collection phase taking place between July 2017 and June 2018, and analysis and reporting between July and October 2018. The initial approach was informed by:

- A scoping study that had been undertaken by RAND Europe[10]
- Interim evaluation from PIRU
- The research specification provided by the (then) Department of Health.

2.3 Given the focus of the programme on four very different service user groups it was planned that quantitative data on experience and impact would be collected from each group, at a scale which would enable disaggregated results to be reported for all four groups. This data was to come through a data collection process led by NHS England which would collect:

- Activity data – projected and actual numbers of the IPC cohort
- Outcome measures (OM) from individuals receiving IPC – baseline and follow-up waves[11]
- Cost data – direct and possibly some indirect cost data of care packages in IPC compared to non-IPC.

2.4 The outcome measures used standard tools that had been selected by NHS England, namely EQ-5D, ASCOT and WEMWBS, and matched those used in the previous PHB evaluation. The OM data was planned to be collected through self-completion questionnaires (consisting of the three selected tools) that were intended to be disseminated to service users via practitioners and other service providers during a routine appointment.

2.5 A parallel process was planned for a comparison group drawn from IPC sites, to be led by the SQW team. The intention was to collect data from within IPC on at least one of the four IPC target groups that the site was not focussed on. In that way, treatment and comparison data would come from the range of IPC sites. This was expected to be more efficient and consistent than seeking to draw in non-IPC sites.

2.6 Other data to be collected included:

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[10] RAND Europe (2015) *Future evaluation of the Integrated Personal Commissioning Programme: mapping the logic and assessing evaluability.* Available online: https://www.rand.org/content/dam/rand/pubs/research_reports/RR1300/RR1350/RAND_RR1350.pdf

[11] The protocol for collecting outcome measures from individuals was set up by NHS England to provide an infrastructure for sites to monitor their outcomes in a way which could continue beyond the evaluation period.

- A light-touch process evaluation through two sets of 10 area case studies, each involving 6-8 interviews with key staff
- Three thematic case studies
- Data on the costs of IPC to be collected through a self-completion tool on set up and running costs, augmented by site workshops on the costs of delivery
- Qualitative interviews with 60-80 service users and carers who had experienced IPC
- A staff work and satisfaction survey.

2.7 The original evaluation design included plans to apply for a research ethics approval from the NHS Health Research Authority (HRA). However, following a consultation with the HRA enquiry team, SQW was advised that based on the evaluation plan and design, the project was considered a 'Service evaluation' rather than 'Research', and therefore did not require a HRA ethics approval.

2.8 SQW developed a research protocol document including a set of participant information flyers, consent forms and consultations topic guides (for professional staff, service users and carers). The research protocol document was circulated amongst all IPC sites and was followed by a conversation with each of the site leads to answer any queries and agree the way forward for the evaluation activities in the site. IPC site leads were asked to inform their local information governance (IG) teams about the research, and SQW offered to attend IG board meetings and answer any queries as required (this took place in two of the 17 sites).

The outcome of the scoping study

2.9 The study began with a scoping study, which reported in March 2017. It included the following key activities:

- Consultations with key stakeholders at the strategic and operational level at NHS England
- On-going liaison with NHS England, especially the internal evaluation team, to ensure our approaches to data collection dovetail to make best use of the evaluation resource and to minimise the burden on sites
- A review of IPC documents, including the NHS England IPC Process Evaluation background documents and sites' Memoranda of Understanding (MoUs)
- Visits to 16 of the 17 sites that were implementing IPC to conduct in-depth scoping consultations with the local IPC team
- Follow up calls with a selected group of sites, to discuss in further detail their outcomes measures data collection activities.

2.10 The scoping study highlighted issues with the progress of NHS England monitoring and evaluation activity, and identified several issues with the delivery of the programme that would impact on the readiness and capacity of sites to engage with the evaluation. Across all sites there appeared to be a much slower start to the programme then initially anticipated, with all sites working on a small (often pilot) scale.

2.11 Of most immediate concern was the low number of OM questionnaires returns, which would impact on planned quantitative analysis. The report commented that there was a significant risk that the sites would not deliver a sufficient number of completed questionnaires to allow any meaningful analysis to be conducted. The local teams fed back that they found it challenging to engage both service providers (for the dissemination of the questionnaires) and individuals with the outcome measures tools. This was because it was not clear to sites who should be invited to complete the OM questionnaires (those with a personalised care and support plan only or those with the personal budget as well). Stakeholders were also dealing with many competing demands and were finding it challenging to find the time to disseminate the questionnaires, which did not appear to be a priority. In addition, it emerged that the sites had deployed different approaches in distributing the questionnaires to individuals (e.g. posting questionnaires out to individuals, handing out the questionnaire during the IPC conversation, or handing the questionnaires out during meetings).

2.12 As a result, it was decided to exclude the staff survey from SQW's design (to reduce the burden on sites) and focus those resources on working alongside NHS England to collect OM and explore the collection of counterfactual data. It was recognised in the scoping report that gathering counterfactual data would be challenging given the wider issues around the outcome measures.

2.13 Two other risk mitigation measures were adopted:

- The study was extended by six months to allow more time for outcome measure data collection
- The baseline outcome measure questionnaires were amended to collect contact details for service users. This was done so that service users could be followed up by NHS England at a later date as data collection was not expected to run beyond the funding of the programme.

2.14 In addition, as the evaluation progressed, it emerged that information on the cost of the care package which NHS England intended to collect was not available through the finance team. Therefore, the economic evaluation does not include the cost of the IPC care package.

The approach adopted

2.15 The approach adopted around the light touch process evaluation, thematic case studies, qualitative research with service users and the costs of IPC broadly followed the plan as set out in the proposal. Each is described below.

2.16 The challenge throughout remained the collection of outcome measures and the related counterfactual. The study encountered two significant difficulties:

- The volume of baseline OM questionnaires completed by service users who have experienced IPC was, and would remain, much less than anticipated despite considerable efforts by NHS England and SQW to encourage sites

- The collection of data from a comparison group within the same sites was not successful, as it sought to follow and build on the OM process, which did not work. The lack of comparator data means that the study was not able to assess attribution as it had planned.

2.17 Helpful discussions were then held with the Department of Health and Social Care, NHS England and selected members of ICPERG[12], to agree a way forward, focussed around what focus might be useful given the changing policy context and methodologies that had been used elsewhere. It was agreed that the focus would be on user experience, which fitted the current policy position. **The key research question to answer would be: how far has IPC been a positive and different experience from 'normal' care and support planning?**

2.18 To enable this focus, it was agreed that:

- The follow-up survey of OM should proceed. It would be important that a good response rate is achieved. This work was led by NHS England, with SQW continuing to support.
- The survey tool would be changed in two ways:
    - ➢ The questions around wider cost use, which were added by SQW to the OM pack (due to sufficiently accurate information not being available from the NHS England finance team) would be dropped. These questions were only in the follow-up surveys and without a comparison group any responses could only be used to provide descriptive analysis
    - ➢ A small number of additional questions would be asked about the user experience.

2.19 In terms of the economic evaluation the revised objectives were specified as:

- First, to estimate the difference in costs between IPC and standard care (i.e. the care received by people in the absence of IPC). This difference in costs includes the costs of setting up the IPC service and the differential costs (whether savings or added costs) of delivering IPC compared to delivering standard care. This is described under *Additional costs of IPC compared to standard care*.
- Second, to estimate the minimum amount of quality of life benefits, or minimum amount of cost savings that IPC would need to achieve to be cost-effective, or cost-neutral given its additional costs. This is described under *Scenario analysis: Implication for outcomes and wider costs.*

Final methodology

Process evaluation

2.20 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 design of the process evaluation was informed by the

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[12] A group convened by DHSC to bring together officials from DHSC and NHS England with researchers working on a range of integrated care research studies.

scoping phase that was conducted between December 2016 and March 2017. The work took place in two rounds of fieldwork (July to October 2017, and February to March 2018). It involved depth case-studies with 12 selected IPC sites, and an additional light touch evaluation in three sites. The light touch sites were intended to serve as a confirmatory exercise, to check that the findings from the depth case-study sites were representative across the IPC programme. The process evaluation was led in each site by the evaluation team member allocated as the site lead.

2.21 The process evaluation also included three thematic studies. The aim of these studies was to provide key learning about the development of key themes:

- The IPC personalised care and support planning process (involving four sites)
- The development of the local market (involving three sites)
- Sustainability and scalability of IPC (involving three sites)

2.22 The work for the three thematic studies came after the second round of fieldwork and took place between July 2018 and January 2019.

2.23 The data was gathered through semi-structured depth interviews with a number of sources:

- Strategic level stakeholders / commissioners (from the local authority, local CCGs and other local health authorities).
- Operational / frontline staff (from health and social care services, including Voluntary, Community and Social Enterprise (VCSE) organisations where relevant).

2.24 Service providers (from health and social care services, including VCSE organisations where relevant).

2.25 In total we conducted 108 interviews across the two rounds of fieldwork. The interviews followed a series of topic guides to ensure consistency across sites and team members. Specific topic guides were developed and updated for each round of fieldwork and for each thematic study.

Qualitative user experience

2.26 IPC sites were each asked to approach 10-20 service users who had experienced the IPC process in the previous three to six months, at least as far as the development of a personalised care and support plan and ask for permission for the evaluation team to contact them with further information about taking part in a research interview about their experiences. The IPC site leads provided the evaluation team with contact details and preferred method of contact for those service users who gave permission.

2.27 The number of potential interviewees offered by each site varied. For example, although one site provided details of 51 service users, many offered less than 10. One of the reported difficulties in supplying details of potential interviewees was the time needed for IPC staff to identify suitable candidates and contact them for permission to provide the evaluation team with their details. This appeared to be done retrospectively, with staff members going back over case notes rather than during routine contacts, therefore adding to workload. Data collection through these qualitative interviews also overlapped with outcome measures collection through structured questionnaires. This occurred because the time period for collecting outcome data was extended due to slow progress. As a result, there was some confusion in some sites about the different strands of data collection. Senior level staff changes in some sites also affected progress with data collection.

2.28 There were also challenges associated with contacting potential interviewees and arranging interviews. Potential interviewees were contacted by email or letter and followed up with a telephone call. Some responded before the call that they were not interested in taking part or were too busy. Typically, potential interviewees were, or cared for someone who was, very frail or had complex needs; some felt unable to spare the time for an interview. In one site, for example, only three of 10 potential interviewees agreed to take part; those who declined were all frail older people who had no recollection of experiencing IPC or did not know what it was, felt too tired to take part or they/the person they cared for had been admitted to hospital.

2.29 Members of the evaluation team then contacted the IPC service users/carers by their preferred means, sending further information about the research interview and subsequently arranging a time to undertake the interview face-to-face if agreed. The majority of interviews were conducted face-to-face, but some were undertaken by phone as preferred by the interviewee.

2.30 A total of, **42 interviews took place throughout 2018**[13]. Interviewees were from eight IPC sites[14]. Eleven interviewees were from one site, four sites provided between five and seven interviewees, and three or fewer interviewees came from the remaining three sites. Twenty interviewees or their carers fell into the long-term conditions IPC cohort, 19 had mental health needs and three were young adults with complex needs. Twenty-six service users were interviewed, alongside 16 carers. Carers were interviewed about their experiences but also offered their views on the involvement in and impact of IPC for the person they cared for.

2.31 All interviews followed a topic guide covering the following areas:

- Initial experiences of IPC such as how the interviewee first became involved in IPC and experiences of the initial IPC conversation
- Experiences of personal budgets and control over resources, including whether or not the interviewee had any form of personal budget
- Care and support options, covering how and why care and support options were chosen and how they were different to pre-IPC
- Involvement with local community and peer groups
- Overarching changes resulting from the IPC approach, such as changes in health and well-being or relationships with professionals.

2.32 Interviews typically lasted about 45-60 minutes although some were less than 30 minutes. Interviews were recorded and transcribed verbatim. A summary of each interview, including verbatim quotations, was written from the transcripts. Summaries were systematically coded

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[13] The evaluation initially set a target of 60-80 interviews from across all 17 sites. However, the evaluation faced considerable challenges in getting names of service users from a number of sites, because of limited numbers recruited to IPC, people were not willing to take part or because they did not have the capacity.

[14] Interviews with service users and carers were conducted in the following sites: Gloucestershire, Islington, Lincolnshire, Luton, Nottinghamshire, Sheffield, Stockton and Tower Hamlets.

and analysed using a qualitative data analysis software (MaxQDA). The coding frame was developed with the assistance of the evaluation co-production panel, to ensure that the researchers did not overlook any themes or trends that were emerging from the interviews. An example of the co-production panel's involvement was in undertaking thematic analysis of extracts of the interview transcripts. Panel members, including those who share characteristics with IPC users, arranged extracts into themes and sub-themes. They also commented on whether further themes should be added. This contributed towards the write up of the findings.

Impact evaluation

2.33 The impact evaluation was focussed around the outcome measures. It was anticipated that services users would complete a questionnaire containing EQ-5D, ASCOT and WEMWBS at baseline and a follow-up point. Additional questions were added to the follow-up questionnaire to capture the user experience. However, as explained above this element faced considerable difficulties.

2.34 The baseline questionnaires were distributed by local sites. The sites also led on the follow-up element. The method of distributing and administrating the surveys varied across sites and included administration via practitioner at scheduled appointments, commissioning a third party to administer the survey in personal meetings and via post. To assist, they were provided with an option whereby NHS England would distribute postal questionnaires. This offer was taken up by eight sites and involved both an initial mail out and a reminder when the full questionnaire pack was sent for a second time.

2.35 Overall, 499 service users completed a baseline questionnaire, from across 15 sites. A follow-up questionnaire was completed by 138 of these, giving a follow-up rate of 28%, from 11 sites.

2.36 The interval between the baseline and follow-up varied considerably from three months to 16 months (measured from the 5th and 95th percentiles to exclude outliers many of which will be simple data entry errors). The median interval was nine months.

Economic evaluation

2.37 The amended approach with respect to the economic evaluation comprised:

- Asking sites to complete a questionnaire on the set-up costs of IPC and the difference in running costs of IPC compared with standard care
- Conducting workshops with three sites on the process, resources and costs of running IPC
- Using the cost data from the questionnaire and the findings from the workshops to estimate the differential impact on costs, that is the difference between the average costs of delivering IPC and the average costs of delivering standard care
- Conducting a scenario analysis to calculate the minimum differential impact on outcomes that would need to be expected for IPC to be cost-effective from the commissioner perspective, assuming that IPC and standard care have similar wider social and health care resource use impacts.

2.38 Data on the resources required to set-up and the differential use of resources to run IPC compared to standard care were collected through a questionnaire. The questionnaire was developed by our research team based on previous work on the costs of the personal health budget (PHB) programme[15], and is provided in 8.Annex D:. The questionnaire included three sections.

- The first section asked for general IPC service information including the name of the site, and the expected and actual number of IPC users between 2015/16 and 2017/18.
- The second section covered information on the differential use of resources for delivering IPC compared to standard care for the average (or typical) user. It included questions on whether IPC, compared to standard care, required a different number of appointments with the user and a different number of contacts between staff, and if so, what the difference was. Also, it asked about the differential number of user appointments and staff contacts, and some details about the staff involved, including job title and salary (or grade).
- The third section covered the set-up of IPC from 2015/16 to 2017/18 in terms of staff and non-staff resources. Information on staff asked about the whole time equivalent (WTE), salary (or grade), number of months in the year worked, and funding organisation. Additionally, there were questions on the number and value of non-staff resources, which might include, for example, travel (by staff), computers, room booking, etc.

2.39 Through the questionnaire on set-up and running costs, our objective was to obtain a measure of *opportunity* costs rather than *actual* costs. The opportunity cost captures the value of the alternative use of resources, and it is the cost measure used for economic evaluations. For simplicity, our assumption was that the opportunity cost of a resource was its actual cost. This implied that, for example, set-up costs included the actual cost of a laptop even if the latter was not purchased through IPC funding.

2.40 Data on total running costs of IPC (excluding the cost of the IPC personalised care and support plans) were collected for three sites through a workshop. In each workshop, a member of the research team facilitated a discussion with a number of people involved in the delivery of IPC. The IPC process was mapped out and the time inputs to each stage were identified for different staff members. The time taken was then summed up and converted to a cost using sites' salary bands. This approach followed previous work on Education Health and Care plans.[16]

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[15] Forder J, Jones K, Glendinning C, Caiels J, Welch E, Baxter K, Davidson J, Windle K, Irvine A, King D, Dolan P. 2012. Evaluation of the personal health budget pilot programme. Discussion Paper 2840_2. Personal Social Services Research Unit. University of Kent. Canterbury.

[16] Thom et al (2015) The Special Educational Needs and Disability Pathfinder Programme Evaluation Final Impact Research Report, DfE

Analysis

Additional costs of IPC compared to standard care

2.41 The perspective of interest was that of the commissioner. This might include the NHS (via the local Clinical Commissioning Group), the local authority, or both (if, for example, the two were integrated through a pooled budget). This perspective excludes patient costs (e.g. travel time).

2.42 The information collected on the set-up and differential resource used to run IPC were used to calculate the:

- total costs of setting up IPC at a local level (but excluding the NHS England support team)
- costs per user of setting up IPC, calculated by dividing the total costs of setting up IPC by the number of IPC users
- differential costs per user of running IPC compared to standard care
- differential costs per user of setting up and running IPC, as the sum of set-up costs per user and differential running costs per user.

2.43 Costs were calculated as the sum of the quantity of resources involved multiplied by the relevant unit cost.

2.44 Set-up costs refer to the resources committed in the short-term to implement IPC. Running costs are incurred recurrently in delivering IPC.

2.45 The first year of IPC in each site was defined as year 1; costs in subsequent years were discounted to their present value (i.e. to year 1) using a discount rate of 3.5%, in line with current guidelines[17]. Capital costs were not annuitised as they only represented a small proportion of set-up costs for most sites.

2.46 Data from the workshop were used to calculate the total costs and the costs per user of running IPC in an average financial year. A number of assumptions were made in order to carry out these calculations, as detailed in table C-4 in Annex C. Where data on resource use and related costs were unknown (e.g. identification of eligible IPC patients, ongoing discussions during the planning phase), these were excluded from the calculation. This implies that the total and per user running costs that were calculated are likely to be an underestimate of the true running costs. This may however be a minor concern since most sources of costs are known.

Scenario analysis: Implication for outcomes

2.47 In the absence of information on user outcomes and on the wider use of resources, the costs calculated as described above were used in two scenario analyses. The first scenario analysis estimated the minimal health- (H-) or social care- (SC-) quality-adjusted life years (QALYs) that IPC would have to achieve to be cost-effective. The second scenario analysis estimated the minimal number of unplanned hospitalisations that IPC would have to achieve to be cost-

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[17] National Institute for Health and Care Excellence (NICE). 2018. Developing NICE guidelines: the manual. National Institute for Health and Care Excellence, Manchester, England.

neutral. The second scenario analysis does not imply that the sole objective of IPC is to reduce unplanned hospitalisations or that commissioners should aim to achieve cost-neutrality.

2.48 A first scenario analysis estimated the minimal differential H- or SC-QALYs per user that IPC would need to achieve compared to standard care to be cost-effective as follows:

$$\begin{aligned}&\mathit{Minimal\ differential\ QALYs\ per\ user} = \\ &= \frac{\mathit{Differential\ costs\ per\ user\ of\ IPC}}{\mathit{Cost\text{-}effectiveness\ threshold}}\end{aligned} \qquad (1)$$

2.49 In using the differential costs per user of setting up and running IPC (the numerator), this scenario analysis assumed that IPC and standard care had the same impacts on the wider use of social and health care resources.

2.50 Multiple cost-effectiveness threshold values (the denominator) were considered to assess how results changed under different assumptions on the opportunity costs (i.e. the forgone benefits), including £13,000 per QALY,[18] £20,000 and £30,000 per QALY,[19] and £50,000 per QALY.[20]

2.51 A second scenario analysis estimated the minimal reduction in unplanned hospitalisations per user that IPC would need to achieve compared to standard care to be cost-neutral, as follows:

$$\begin{aligned}&\mathit{Minimal\ reduction\ in\ unplanned\ hospitalisations\ per\ user} = \\ &= \frac{\mathit{Differential\ costs\ per\ user}}{\mathit{Cost\ of\ an\ unplanned\ hospitalisation}}\end{aligned} \qquad (2)$$

2.52 This scenario analysis assumed that the use of other hospital services (e.g. day cases, long-stay elective admissions) remained constant to produce cost-neutrality. The cost of an unplanned hospitalisation is the average unit cost of a non-elective inpatient admission (excluding excess bed days) of 2015/16, 2016/17 and 2017/18 at £1,600.67.[21]

2.53 Unplanned hospitalisations are an example of an impact which integrated care interventions, such as IPC, may aim to reduce because of their high costs. To date, however, the empirical evidence base available is mixed and uncertain as to whether integrated care does reduce admissions to hospital. Examples from the recent literature suggest that integrated care does not necessarily reduce admissions to hospital, and that it may increase admissions (e.g. Parry et al, 2019, BMJ Open; Stokes et al (2019) Social Science and Medicine; a report by Georghiou and Keeble by the Nuffield Trust).

2.54 Two approaches were taken to calculate the minimal differential QALYs and the minimal reduction in unplanned hospitalisations needed for IPC to be considered either cost-effective or cost-neutral.

2.55 Approach 1 considered a time horizon of a year. Under approach 1, the minimal differential QALYs per user (or the minimal reduction in unplanned hospitalisations per user) comprised

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[18] Claxton K, Martin S, Soares M, Rice N, Spackman E, Hinde S, Devlin N, Smith PC and Sculpher M, 2015. Methods for the estimation of the National Institute for Health and Care Excellence cost-effectiveness threshold. Health technology assessment (Winchester, England), 19(14), p.1.

[19] National Institute for Health and Care Excellence (NICE). 2018. Developing NICE guidelines: the manual. National Institute for Health and Care Excellence, Manchester, England

[20] Forder J, Malley J, Towers AM and Netten A, 2014. Using cost-effectiveness estimates from survey data to guide commissioning: An application to home care. Health economics, 23(8), pp.979-992.

[21] DEPARTMENT OF HEALTH 2018. NHS reference costs 2017/18: highlights, analysis and introduction to the data. Department of Health, London.

the average effect of IPC per user per year. The calculation consisted of taking the average of the differential costs per user of IPC across sites for each of the three years of implementation.

2.56 Approach 2 considered a longer time horizon of three years (i.e. the three years of data collection since the start of IPC). Under approach 2, the minimal differential QALYs per user (or the minimal reduction in unplanned hospitalisations per user) comprised the average effect of IPC per user over the whole three year-period. The calculation consisted of adding up the average set-up costs over each year, discounted to their present value, to obtain the total average set-up costs of IPC over the three-year period. The same procedure was followed to calculate the differential running costs over the three-year period. To obtain the differential costs per user of IPC over the whole three-year period, the sum of the set-up costs and the differential running costs of IPC over the entire period were divided by the total number of IPC users over that time (see Annex Table C-3 in Annex C).

2.57 An additional scenario analysis was run to test the sensitivity of the results to the timing of implementation of IPC since this might affect the costs of setting up and running IPC. In our sample, early adopters introduced IPC in 2015/16 (our first year of data collection), while late adopters introduced IPC in 2017/18 (our last year of data collection). Early and late adopters were compared in terms of both minimal differential QALYs per patient and minimal reduction in unplanned hospitalisations per patient during the first year of implementation of IPC.

Analysis challenges

Quantitative

2.58 The evaluation faced a number of key challenges relating to the collection of outcome measures and cost data.

2.59 The key issue with the outcome measures data was the low numbers and response rates in both the baseline and follow up waves. This reflected on the overall low numbers in the programme, the uncertainty around who had been included in the IPC cohorts, the expectations of the sites to have limited involvement in the collection of data (despite their commitments in accessing funding), and the sites' reservations about the tools that were chosen (particularly for those under 13 and for individuals with learning difficulties). The tools that were chosen were not suitable for all four target groups in IPC. Sites also reported capacity issues despite the evaluation being one the items for which additional funding was provided.

2.60 The evaluation teams at NHS England and SQW have made considerable efforts in engaging with teams at the sites and supporting them in collecting the outcome measures data, but there was still limited response from service users in sites. The data collection process that was set up by NHS England was an ambitious one, with the purpose being to encourage sites to embed data collection within local systems. The challenge associated with this was that it meant there was less control at the centre over the approach and scale of data collection. This meant that the control of the evaluation team over the consistency of data collection was limited.

2.61 With regards to the cost data, only 8 of the 17 sites responded to the questionnaire, thus limiting the generalisability of the results to all IPC sites. Moreover, some answers to the questions in the survey questionnaire provided insufficient information for accurate costing. A number of assumptions were made to enable costs to be calculated. The accuracy of the information provided is unclear and depends on the information available to the respondent in each site.

2.62 If a similar evaluation is to be repeated, greater resources should be allocated to the collection of quantitative data, to ensure the consistency of data collection, the quality of the data and the good level response rate. This would include the extent to which sites were engaged in agreeing the tools and approach to be used. That said, the evaluation would still have faced issues given the issues with overall numbers.

Qualitative

2.63 As the evaluation progressed it became apparent that the quantitative outcome data for the learning disability and young people's cohorts were weak. A supplementary aim of this qualitative element was therefore to provide some insights into the experiences of those user groups. However, we were unable to recruit more than a small number (2) of young adults with complex needs or their carers. The vast majority of service users consulted were people with mental health issues, people with dementia, frail older people or people with long-term conditions, and their carers. Based on the process evaluation findings this is probably fairly typical of those in receipt of IPC overall.

2.64 Some of the sample were involved in IPC co-production groups and so had an insight into IPC that other users would not have had. They are therefore not necessarily representative of typical IPC users.

3. Overview of the IPC model

Introduction

3.1 The IPC programme was announced by Simon Stevens, Chief Executive of the NHS, in July 2014.

> *Our aim in this radical initiative is to end fragmented like-it-or-lump-it health and social care, by giving high-need individuals the power for the first time to decide on the blend of support they themselves want. Integrated Personal Commissioning gives families the chance to make a reality of person-level health and social care integration, as the NHS moves beyond just asking "what's the matter with you?" to "what matters to you?"*
>
> (Simon Stevens, Chief Executive of NHS England)

3.2 Shortly after, in September 2014 the prospectus for sites was published, along with the bids applications process. By December 2014 the first eight IPC sites were selected, with four additional sites selected by the launch of the programme in April 2015. This was the first round of 12 Demonstrator IPC Sites. At this stage of the programme the concept of integrated personal commissioning was not defined. The expectation set out by NHS England and the Local Government Association was that sites would transform the care of the most vulnerable and high needs service users by blending comprehensive health and social care funding for individuals and allowing them to take control of how it is used. The IPC prospectus listed a number of aims for sites, including making a long-term commitment to setting up, testing and implementing new integrated funding models, embedding personalised care and support planning (including personal budgets) within local organisations, and providing clear and more intensive, pro-active support targeted at those who need it the most[22]. However, no clear deliverables were set out for the sites.

3.3 In May 2015, NHS England launched the IPC emerging framework[23], which set out the "five key shifts" of IPC, to provide guidance to sites in developing their local IPC models (proactive co-ordination of care, community capacity and peer support, personalised care and support planning, choice and control, and personalised commissioning and payment). During the first year of the implementation of IPC, the focus for the 12 Demonstrator Sites was on defining what IPC would look like on the ground. As such, activities were centred around design and planning and not on delivery. In June 2017, NHS England published a revised interactive operating model to support the scaling up and spread of the IPC model. At this stage, the emphasis moved away from linked datasets and market development towards personalised care and support planning[24].

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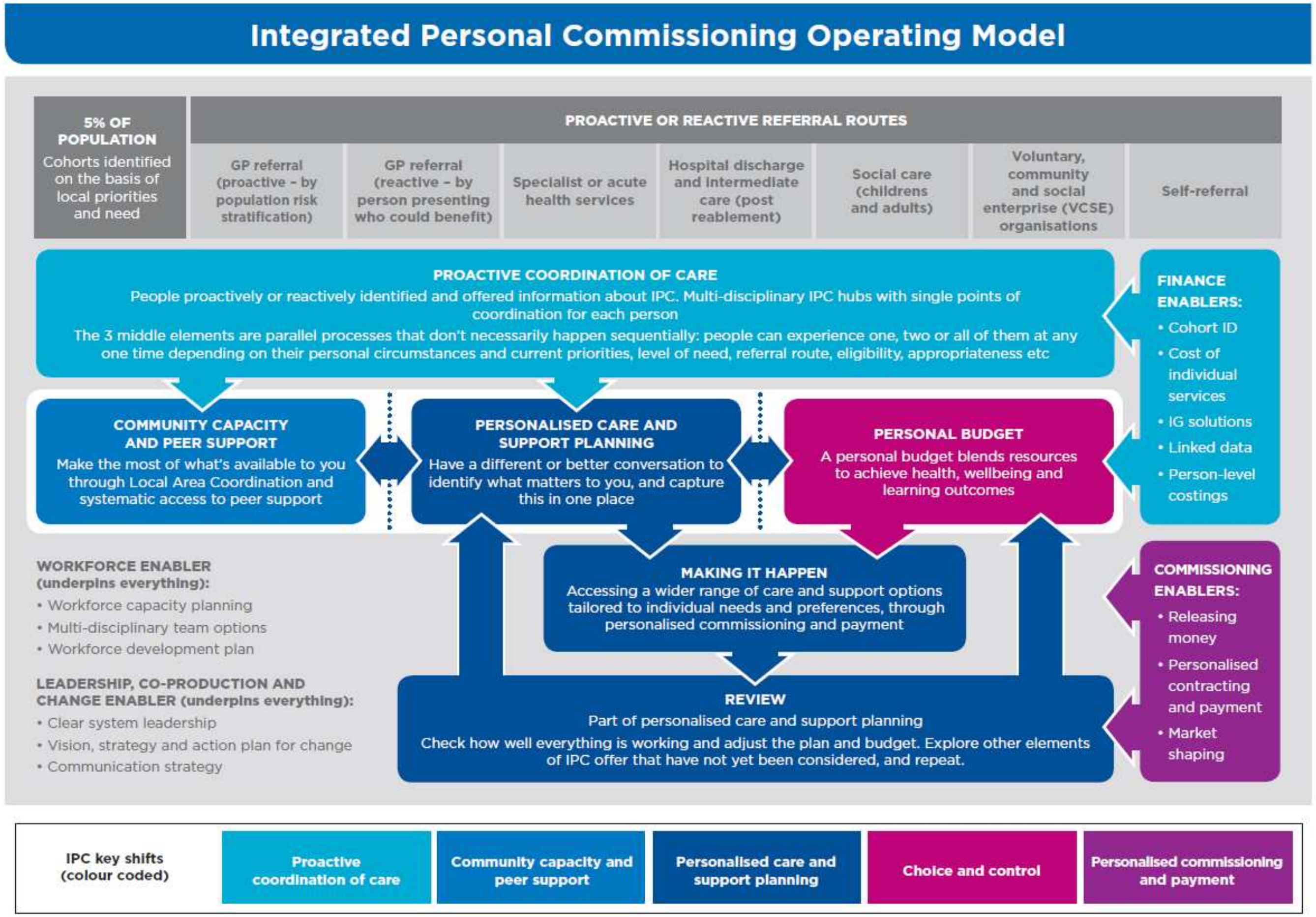
[22] Integrated Personal Commissioning Prospectus https://webarchive.nationalarchives.gov.uk/20160605034527/https://www.england.nhs.uk/wp-content/uploads/2014/09/ipc-prospectus-updated.pdf

[23] https://www.england.nhs.uk/wp-content/uploads/2017/06/ipc-emerging-framework.pdf

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

Figure 3-1: IPC Interactive Operating Model



Integrated Personal Commissioning Operating Model

5% OF POPULATION
Cohorts identified on the basis of local priorities and need

PROACTIVE OR REACTIVE REFERRAL ROUTES
- GP referral (proactive – by population risk stratification)
- GP referral (reactive – by person presenting who could benefit)
- Specialist or acute health services
- Hospital discharge and intermediate care (post reablement)
- Social care (childrens and adults)
- Voluntary, community and social enterprise (VCSE) organisations
- Self-referral

PROACTIVE COORDINATION OF CARE
People proactively or reactively identified and offered information about IPC. Multi-disciplinary IPC hubs with single points of coordination for each person

The 3 middle elements are parallel processes that don't necessarily happen sequentially: people can experience one, two or all of them at any one time depending on their personal circumstances and current priorities, level of need, referral route, eligibility, appropriateness etc

COMMUNITY CAPACITY AND PEER SUPPORT
Make the most of what's available to you through Local Area Coordination and systematic access to peer support

PERSONALISED CARE AND SUPPORT PLANNING
Have a different or better conversation to identify what matters to you, and capture this in one place

PERSONAL BUDGET
A personal budget blends resources to achieve health, wellbeing and learning outcomes

MAKING IT HAPPEN
Accessing a wider range of care and support options tailored to individual needs and preferences, through personalised commissioning and payment

REVIEW
Part of personalised care and support planning
Check how well everything is working and adjust the plan and budget. Explore other elements of IPC offer that have not yet been considered, and repeat.

FINANCE ENABLERS:
- Cohort ID
- Cost of individual services
- IG solutions
- Linked data
- Person-level costings

COMMISSIONING ENABLERS:
- Releasing money
- Personalised contracting and payment
- Market shaping

WORKFORCE ENABLER (underpins everything):
- Workforce capacity planning
- Multi-disciplinary team options
- Workforce development plan

LEADERSHIP, CO-PRODUCTION AND CHANGE ENABLER (underpins everything):
- Clear system leadership
- Vision, strategy and action plan for change
- Communication strategy

IPC key shifts (colour coded)
- Proactive coordination of care
- Community capacity and peer support
- Personalised care and support planning
- Choice and control
- Personalised commissioning and payment

Source: NHS England

3.4 The interactive model set out IPC as a framework of principles that services were expected to follow and implement in the context of local services. It built on the Five Key Shifts of IPC, which described the changes that were expected to take place for IPC to work well. Alongside the shifts, the interactive model set out a number of enabling factors that sites needed to put in place to deliver the Five Key Shifts (these included workforce development, leadership, co-production and finance enablers).

3.5 Following the publication of the emerging IPC framework, NHS England set out clear deliverables for the IPC sites, which included target numbers of personalised care and support plans and personal budgets for each of the sites. It was reported to us by local sites and NHS England that the development of the local IPC models picked up momentum once the Interactive IPC Operating Model was published in Summer 2017. Setting a target number of personal care and support plans and personal budgets appeared to move the sites from testing ideas to being more focussed on achieving their targets. This was especially noted amongst stakeholders in the health services, who were focussed on achieving their mandatory targets for the number of Personal Health Budgets delivered (see also Annex G).

3.6 In December 2016, six new sites that were awarded funding to implement IPC in late 2016. These sites were selected to implement IPC as they were considered to be further ahead in terms of personal health budgets and integrated services. The new Early Adopters sites came in to the programme when the IPC Operating Model was already set out and well defined. During the process evaluation interviews and site visits it emerged that the Early Adopters Sites tended to be clearer on what IPC should look like and were setting up local models closer in line with the NHS England IPC Operating Model.

3.7 Whilst funding for the IPC programme ended March 2019 the development of integrated personalised care continues to evolve as the policy landscape continues to move forward using the learning from the programme[25]. As such, the sites were operating in a challenging environment for introducing and scaling up a stable model of IPC. At the time of conducting our visits with the sites, none were delivering IPC at scale, although the aim of IPC was to achieve full maturity of the model by the end of the funding in 2019. However, the programme has been successful in other aspects and sites have contributed a great deal to the learning of what is possible in personalised care.

Delivery of the key shifts

3.8 In this section we summarise the progress achieved by the IPC sites against the Key Shifts in the IPC Operating Model. We discuss the challenges the sites faced and the ways in which some of the sites addressed them in the next section. The findings are based on two rounds of site visits and interviews with stakeholders, which were conducted in July-October 2017 and February-March 2018 on findings gathered through a set of three thematic studies[26], and on a series of depth interviews with service users and their carers about their experience of IPC,

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[25] The latest policy development was the NHS Long Term Plan, published in January 2019, which set out a clear priority for personalised care across the system, with the development of the comprehensive model for personalised care published in Universal Personalised Care https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/

[26] The evaluation conducted three thematic studies focussing on key topics of interest for the development of IPC: The IPC personalised care and support planning process, The development of the local market and The sustainability and scalability of IPC. These thematics were developed as standalone documents and are provided in the annexes in this report.

which were conducted throughout 2018. As such the findings do not refer to any further progress that sites may have achieved since December 2018[27]. The findings from the process evaluation have been summarised in two previous evaluation reports, which are available on the SQW website[28]. A detailed narrative of the findings from the depth interviews with service users is provided in Annex D.

Governance structures and leadership of IPC

3.9 The IPC Operating Model set out leadership structures as one of the key underpinning enablers of the programme. This related to having a clear vision, strategy (including strategic co-production) and action plan for driving the change in the system. During the first 18 months to two years of the programme, the sites focussed their work around developing the leadership for, and a clear vision of, IPC. Indeed, sites stated 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.

3.10 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 provided services to the target population. In most cases the governance structure engaged stakeholders from health, social care and community and voluntary sector services of high seniority. This was to gain senior buy-in and generate a change from the top down. Senior stakeholders commented that it was important that the change was driven from the top down and not from the bottom up, because if senior people were not on board they were likely to block the change from happening.

3.11 In many sites, by March 2018, stakeholders commented that they felt the new structures[29] were being embedded and were working well. They felt that they had established good foundations for IPC with the new governance structures providing a good platform for making decisions and moving things forward in developing the IPC processes. This notion aligned with the findings of the third thematic 'The sustainability and scalability of IPC', provided in Annex G.

3.12 Across the sites we identified two main structures developing:

- a governance structure with a multi-agency steering group, bringing representatives from the different agencies and services in health and social care around the table to develop one single strategy for IPC (in a number of sites this included representatives from the VCSE sector as well)

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[27] It is important to note that the end date of the IPC programme in its original format was March 2018. However, all sites received additional funding up to March 2019 to support embedding and scaling up their model.

[28] Two evaluation interim reports, summarising findings from the process evaluation are available online in the following links: First interim report- http://www.sqw.co.uk/files/8215/1818/6800/SQW_first_process_evaluation_report.pdf
Second interim report-
http://www.sqw.co.uk/files/1615/3114/9921/IPC_process_evaluation_second_interim_report_Final.pdf

[29] Governance structured included multi-agency steering groups and multi-agency workstreams focussed 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

- multi-disciplinary teams (MDT) (either new or pre-existing) and/or looking into co-location solutions to enable practitioners from different services to work on their case-loads as a team; teams tended to focus on specific target groups in terms of health conditions

3.13 Five sites also invested resources in mapping and streamlining of pathways to avoid duplication of assessments and service provision.

3.14 The interviews suggested that the next step would be to engage middle management (who were directly managing practitioners on the ground) and gain their buy-in and support to implement 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 engaging professionals at all levels. The key task would be to generate a sense of ownership and a good level of understanding of the IPC processes to sustain a stable model of integrated and personalised care.

3.15 One challenge noted by a number of sites was how to keep the momentum for change. This was mostly apparent in sites where external organisations were deployed to set up and run IPC in the first two to three years. While it appeared that working with an external provider enabled sites to achieve greater initial progress in the development and delivery of IPC, there was a question about the sustainability of this approach in the long term, as once the external organisation exits that leaves a gap in the leadership of IPC. 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.

3.16 Findings relating to the governance structures developed through IPC and the challenges around the sustainability and scalability of the models have been reviewed in more detail in a thematic study 'The sustainability and scalability of IPC', available in Annex G. The study found that:

- Sites have made good progress in developing and establishing new governance arrangements
- Key enablers to the development and delivery of IPC in sites were the high level of commitment amongst stakeholders and the identification of Personalisation Champions to drive the change in practice and maintain momentum within organisations
- Integrating health and social care services has been a key challenge, but there are a few examples of successful integration in sites
- Block contracts with service providers has been a key barrier to the sustainability of IPC. In most cases sites did not have a solution to this issue.

IPC processes

3.17 Progress in the delivery of IPC was mixed across the sites. The majority made slow progress at the beginning, recruiting only small numbers to IPC (with some sites not recruiting any people at all), while they were developing the local model and strategy. However, by the time of the second round of interviews (February-March 2018) sites had moved forward, making progress in embedding the new models and beginning to deliver personalised care and support planning sessions. In the sub-sections below, we summarise the progress that has been observed in each of the five Key Shifts of the IPC Operating Model.

Proactive co-ordination of care

3.18 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 identify those most in need of services, as well as to develop a shared mechanism for recording patient information, to enable all service providers who were 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 was offered and provided to the service user.

3.19 The evaluation found that the goal of linking health and social care datasets to identify individuals across both has been difficult to achieve in many places. 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 the information governance (IG) issues mentioned above. Stakeholders mentioned two key challenges in achieving this. The first was IT issues, mainly services using different systems that did not communicate with each other. This meant that service users' records could not be updated by different services and fed in to the same database. The other key challenge was related to IG. Without the appropriate consent from service users, service providers and commissioners were not able to access the datasets for identifying users to invite to IPC and to monitor their progress. Instead, most sites have reverted to operating at a smaller scale, using less systematic and less integrated approaches. The programme provided support in dealing with IG issues, however, this remained a key challenge and barrier to having shared datasets.

> *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)

3.20 The interviews with stakeholders suggested that not having a linked dataset was not initially 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 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.

3.21 However, this pragmatic approach, being more ad hoc, tended to identify just a small number of users each month in the majority of the sites. Another issue was that the lack of consistency across practitioners and across services in how they identified and selected service users to invite to the programme. It also risked embedding health inequalities.

3.22 The lack of systematic approach in recruitment appeared to cause confusion amongst the service users who were invited to be part of IPC. During our interviews with service users and carers, many struggled to remember when and how they heard about IPC (or the local branding of it) and many were not quite clear whether the support they received was part of IPC or other services. Feedback from the interviews suggested that typically a support worker, the service user themselves or a family member proactively pursued any initial offer of IPC. A couple of interviewees also commented that they took the initiative and contacted their GP practices after hearing of IPC elsewhere.

3.23 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 personalised care and support planning process.

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

Community capacity and peer support

3.25 The key shift of community capacity and peer support was focussed on making the most of services that were available in the community, outside of statutory services. Activities in this shift focussed 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 of the sites interviewed had worked with 'Community Catalysts', a social enterprise and community interest organisation, in mapping their local community services and developing a mechanism to disseminate information across stakeholders.

3.26 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 tended to stay with their existing services).

3.27 On the other hand, feedback from the service users suggested that what they appreciated the most was receiving information on what services were available to them and, in particular, information on services that they were not aware off and were not using before. It appeared that the number of service users who took up new services was relatively small at the time of the interviews. Nonetheless the feedback from service users suggested that learning about new services was important to them, perhaps because they may want to add/change in future.

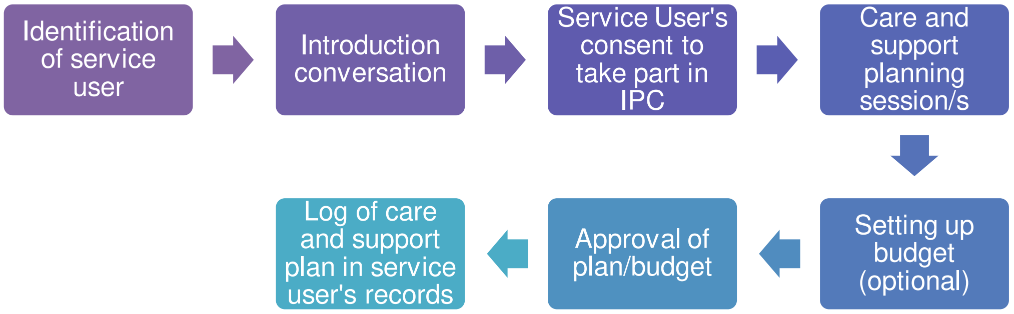
3.28 Another activity that most sites engaged with in relation to this shift was the development of a co-production panel to support the shaping of the IPC processes. Six of the 12 sites we spoke with developed (or re-deployed) a co-production group involving people with lived experience and carers. Stakeholders commented that the work with the co-production group was invaluable, in particular in relation to the development of the personalised care and support plan template and in gaining 'hearts and minds' amongst practitioners to the new approach through engaging with people with lived experience and hearing their stories and experiences.

3.29 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 was reasonable to expect in terms of availability to attend meetings, comment on outputs and respond to requests, and the extent to which the group was going to take part in the decision making.

Personalised care and support planning

3.30 The shift to 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 concept received strong support from stakeholders at all levels in the IPC sites. 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 3-2: Emerging IPC process



Source: SQW based on evidence from interviews

3.31 Once service users were identified and their eligibility for IPC was confirmed, the service user was invited to take part in the personalised care and support planning process. This was done by a letter, a phone call or a meeting in person. The invitation included details about the personalised care and support 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.

3.32 The time from initially being invited to take part in the IPC process to the IPC conversation and support planning was variable. While it could be quick and easy for some, others reported delays of months from the initial invitation to the first conversation. Even after the conversation began, the support planning and budget setting process itself could be prolonged (with the process in some sites taking up to 4 months). The reasons for prolonging the process varied across sites. In a number of cases this was due to the time required: to gather different practitioners to get their views on the plan; to authorise the plan; and due to workload of practitioners, who were not able to follow up on cases immediately after referrals.

3.33 The IPC personalised care and support 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 personalised care and support plan that would address these needs. The number of sessions that were held for the personalised care and support 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. In most cases the IPC personalised care and support planning process was based on existing processes, with the primary changes being: the 'different kind of conversation' focussing on the individual's long term goals and aspirations, rather than addressing immediate needs; and the emphasis of developing a holistic personalised care and support plan, involving practitioners from across all services to input in to the one plan.

> *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)

3.34 The personalised care and support planning sessions usually 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.

3.35 All the sites developed a new personalised care and support 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.

3.36 While in most cases just one practitioner was involved in the personalised care and support planning sessions, the discussions in the sessions, as well as the personalised care and support 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 personalised care and support plan. This approach enabled the sharing of information between the relevant services and practitioners, while not requiring a large number of personnel to free up time to take part in the personalised care and support planning process. However, it meant that the person who managed the personalised care and support planning needed to take the time to speak with services, which added to their workload and had a risk of introducing delays to the process. In addition, the discussion with the different services could have generated conflicts between what was been put in the plan and what services felt they could deliver.

3.37 All agreed personalised care and support plans were sent to a multi-agency panel, which was set up as part of the new personalised care and support planning process, for final approval and sign off. The personalised care and support 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. In most of the sites, the new personalised care and support plans were in addition to existing care plans.

3.38 In most sites there was great focus on ensuring that the personalised care and support planning was person-centred, with the service user actively involved in shaping and making decisions about their personalised care and support plan. Service users and carers who had a positive experience of the personalised care and support planning process spoke about how helpful their support planners were and how different their approach was to anything they had experienced before. Service users and carers valued positive relationships whereby the care co-ordinator listened attentively and understood the IPC user's care needs.

3.39 At the same time, there appeared to be less emphasis on the integration of services in the process. In the best cases there was a single plan, which although developed mainly by a lead professional from one service, was applied to all and was signed off by a multiagency panel. However, in other cases multiple plans were still being used. Service users and carers also noted a general lack of integration across the IPC approach and specifically a lack of awareness of the IPC principles amongst practitioners outside the programme.

3.40 Practitioners'/care co-ordinators' pro-activity and helpfulness were cited by many service users and carers as key contributors to their positive experience of the personalised care and support planning process. Some of the most positive experiences of care and support were reported to be due to the individuals involved. Where the experience was positive, service users mentioned the patience and friendliness of the care planner. In particular, they liked it when planners helped with practical things, for example, filling in forms, making inquiries and accompanying service users to their first appointment in a new service.

3.41 In sites where voluntary organisations were helping to deliver IPC, service users and carers on the whole praised them for their level of knowledge about things such as benefits, council tax reductions, and local groups. In most cases these voluntary organisations also made applications for such benefits or arranged other services or support for service users. Usually once the benefits or support were in place, the co-ordinators stepped back and had no ongoing contact, but service users and carers reported feeling comfortable that the door had been left open for them to get back in touch if they wished. This may have been because these individuals were particularly helpful people, or it may have been that the IPC process introduced a more personalised approach in which key individuals played a role. It is likely to have been a combination of both.

3.42 The majority of the professional stakeholders interviewed also felt that the new approach was better than previous practice, in particular in meeting service users' needs, based on the feedback they received from service users and carers. However, there still remained considerable challenges to delivering this approach at scale. In the majority of sites, teams were still working on a small scale, either with small cohorts or were still seeing the model as a pilot rather than business as usual, at the time of the interviews in March 2018. The key challenge mentioned by stakeholders was the length of time that it took to conduct the different conversations and personalised care and support

> *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 focussed*
>
> (Commissioner)

planning sessions. Each personalised care and support planning session took place over at least one hour, and in most cases more than one session was required. The length of the process was also a barrier to getting some practitioners on board. Therefore, it appeared that discussions around resources for the delivery of the personalisation agenda will be central to the continuation and scaling up of the work going forward.

3.43 The IPC personalised care and support planning process has been reviewed in more detail in a thematic case study, which was published as a standalone document, available in Annex E.

Choice and control

3.44 The primary objective of the shift of choice and control was the establishment of integrated personal budgets (IPB, a personal budget for both health and social care needs). IPBs were intended to give service users greater choice and control of the services they accessed in both health and social care. The evaluation found that progress in this shift had been slow-to-moderate across all sites. The numbers of IPBs achieved was small (generally under 50 plans in each site), but this was in part because sites have worked on a small scale at the time of the interviews. The interviews indicated that this shift proved to be a great challenge for the majority of the sites because it required the development of new systems for setting up IBPs. In addition, resources for funding the IPBs were tied up in block contracts (see section on personalised commissioning and payments below). This was a key barrier to delivering personal budgets.

3.45 When considering IPBs it is important to note that in social care the concept and delivery of PBs is well-established, while in health, Personal Health Budgets (PHBs) were much newer. As such, while social care practitioners (and users of social services) felt fairly comfortable working with PBs, many health practitioners were reported as still grappling with the concept of a PHB for health services. The differences in maturity between the services posed significant challenges when it came to creating a new system of IPBs, jointly funded by health and social care. This meant integrating a mature system with a relatively new one, which added to the complexity of integrating two systems and two budgets. Stakeholders commented that 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.

3.46 It appeared that the activities in this shift often focussed on developing PHBs rather than IPBs. Stakeholders commented that as PBs in social care were already established, it was easier (and potentially an essential first step) to first develop a system for setting up PHBs, with the intention that setting up IPBs would then follow as the next step.

3.47 Where budgets were set up through IPC 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 as directly. 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. At the time of the interviews in March 2017, five of the 12 sites we spoke with offered an option of direct payments (DP) around IPC, which meant money was put in a bank account or a pre-paid card that the service user controlled. 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.

3.48 Two sites described delivering IPBs and one had systems in place to pool funds from the health and social care services in to one fund for setting up IPBs for service users. Stakeholders in these sites commented that working with an IPB had benefits for both service users and the system. They felt that having an IPB increased the flexibility of the resources that were available for the service user. This was because instead of having two pots of money, with 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 personalised care and support plan, because in setting up the budget the services took a holistic view of the personalised care and support 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.

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)

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)

3.49 The feedback from service users and carers about personal budgets (whether PB, PHB or IPB) was mixed, and it was apparent that there was a high level of confusion around the type of budgets service users received, who funded it and what the budget could be used for. Just under half of the service users we interviewed (17 of 41) said that they did not have a personal budget. Many of these had never heard of a personal budget or personal health budget. For those who knew they had a PB or PHB, some were large and flexible, but others were small annual budgets for use with only a limited range of activities, described as one-off payments as part of IPC. These one-off payments were perceived as helpful for purchasing equipment or paying annual gym memberships, for example, but interviewees were concerned that they would be unable to afford continued membership once the payment ended. Uncertainty about whether a budget would be available the following year was a concern for service users and carers, especially if they felt they were benefiting from the activities they were accessing and feared they may not be able to continue to do so.

3.50 Commissioners and practitioners in health services commented that working on IPC increased their understanding of PHBs, 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. The knowledge and understanding of how personal budgets worked and what they could be used for was valued greatly by service users and carers. 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 sense of control and independence that having a budget gave them.

3.51 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', instead posing various restrictions on what budgets could be used for.

3.52 Service users did not always want to take up a budget, either because they were happy with their services or because they were worried about having to manage a budget and commission services in a complex system. These concerns tended to come from service users who had high frailty, dementia or severe learning difficulties. The evaluation of the Personal Health Budget Pilot Programme[30] found similar feedback from service users, suggesting that this was not unique to IPC and is likely to be observed in wider integration policy work.

Personalised commissioning and payment

3.53 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'.

3.54 The primary challenge that sites faced in developing the local market was around unpicking existing block contracts with the NHS providers. A key issue that was mentioned was that as 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.

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

3.56 A number of sites commented that their activity around IPBs encouraged the commissioners to review their local offer. The choices that service users were making helped to highlight gaps in the local market of services. 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 into the local market alongside the statutory services, providing more flexible services and filling gaps.

> *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)

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[30] Forder J, Jones K, Glendinning C, Caiels J, Welch E, Baxter K, Davidson J, Windle K, Irvine A, King D, Dolan P. 2012. Evaluation of the personal health budget pilot programme. Discussion Paper 2840_2. Personal Social Services Research Unit. University of Kent. Canterbury.

3.57 The development of the local market has been reviewed in more detail in a thematic case study, which was published as a standalone document, available in Annex F.

3.58 From the point of view of the service users and carers, there were additional challenges, unrelated to the quality of the local offer. IPC intended to empower service users to self-manage their care through managing their own personal budgets and self-commissioning services to meet their needs. However, the service users and carers that we interviewed felt that the processes introduced through the IPC model did not provide a sufficient framework for them to do so. Many were not able to identify any positive effect of IPC on their care and support. Four key issues were apparent:

- Service users were concerned about the longevity of budgets and therefore support services and activities purchased with those budgets. This was a particular issue for service users who had been given one-off budgets for a limited time period or for specific items
- There were frustrations around the use of budgets, with many service users complaining that they were not allowed to use their budget in the way they felt addressed their needs best. Service users also found it frustrating that they were not allowed to top up their budgets in order to purchase better quality equipment such as a wheelchair.
- Service users noted a general feeling of a lack of coordination. They felt that they lacked a single point of contact to act as a central hub for questions or help with arranging care and support. This was evident in service users' concerns over infrequent meetings with care co-ordinators, lack of clarity from such meetings, the absence of face to face discussions and the apparent lack of interest from some professionals. In particular, many service users commented that no one followed up on initial meetings by offering ongoing support. Even if there was ongoing contact, contact by telephone only without any visits to service users' houses left them feeling disappointed and unsure of the professionals' commitment. Numerous interviewees pointed to the high level of responsibility they were taking in arranging their care and support and felt this was a lot to expected given the lack of help from professionals.
- Related to the lack of co-ordination, many service users felt that they were left alone to implement their personalised care and support plans. Service users reported a range of experiences which appeared to be based in part on their very different needs but also the extent to which they were able to utilise sources of support such as friends and family. A common thread throughout interviews with both service users and carers was that they felt they had to be pro-active in seeking and arranging care and support. In some cases, this meant that service users were not able to realise their plan as they lacked the capacity or means to navigate the system without support.

Delivering culture change

3.59 In most of the sites the delivery of IPC was occurring on a small scale, in terms of service users and practitioners involved. However, 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 personalised care and support plan. Commissioners and practitioners who received the training commented that the training had been very effective in changing their perceptions and practice in managing personalised care and support planning with services users.

3.60 For example, where in the past they would come prepared with a notional budget and a list of services they could provide based on the service user's condition, since the training they came with an open mind, ready to listen to the service user's needs and wants first, before developing 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. Many commented that they changed their practice following the training.

> *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)

3.61 The interviewees highlighted that in many of the sites, services were giving thought to developing more holistic and personalised care and support 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 sharing and a high level of coordination amongst services and buy-in from staff (as noted above).

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

- setting up MDTs to manage and deliver the personalised care and support planning process, to facilitate greater integration, information sharing and coordination across services
- testing the personalised care and support planning processes in small scale pilots and identifying champions to promote the scaling up of the process across the system
- the establishment of co-production groups with service users and carers, giving service users a greater voice in shaping the services that are provided to them.

4. Lessons from the implementation of IPC

4.1 The process evaluation highlighted that IPC is a highly ambitious undertaking. IPC sought to generate change in the entire system, covering all levels (i.e. strategic and operational) in health and social care services, including commissioners, service providers and frontline practitioners. The findings of the evaluation indicated that sites have made slow but steady progress in developing their local models for delivering this change. Progress focussed mostly on the establishment of leadership and new local governance structures to drive the change, and on developing new processes for the delivery of personalised care and support plans and personal budgets and piloting these processes on a small scale.

4.2 Progress in the actual delivery of personalised care and support plans and personal budgets was largely limited and, in most sites, did not progress beyond localised pilots and small-scale delivery. At the time of the interviews (in March 2018) none of the IPC sites we visited were delivering IPC at scale. The majority were still piloting processes with small groups or just one cohort and a few were starting to think about testing the processes with a second cohort (of a different IPC target group). The next step if IPC was to continue would be to scale up the delivery to larger numbers of service users and to different target groups (albeit these would be hard to identify in the absence of a systematic approach) and so secure and expand delivery of the IPC model in each local area.

4.3 The evaluation identified several key barriers and enablers that sites faced during the development of their local IPC model. These may provide helpful lessons for NHS England and current and future local systems in any continuous development of the integrated personalised care approach. We discuss these below.

Governance structures and working relationships

4.4 We noted above that there appeared to have been good progress across all sites in establishing new local governance arrangements for the management and delivery of the IPC model. The findings suggest that greater progress was made where there were pre-existing settings that were more amenable for the change. For example, 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. Greater progress was also made in sites where there were existing local governance structures that put the integration of services at their centres. This included agencies creating and co-funding new roles, which enabled better coordination between services and across the system; and investing in the development of multi-disciplinary teams to oversee the design and delivery of services.

4.5 In sites where there was not a history of good relationships, the stakeholders found it challenging to make good progress in this area, and indeed in a number of sites progress with the development of the IPC model could not be made until joint multi-agency working groups had been established. This suggests that the context of local systems, and in particular having good relationships between agencies and openness to integration of services, was a key enabler for the successful development of the new model. Where good relationships did not pre-exist, building them was possible, but it introduced considerable delays in progress.

4.6 Even where relationships were good and there was general buy-in to the change, it required a great deal of time (several years) and resources to develop an effective governance structure to manage a new model of care. 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. This means that, if IPC were to be rolled out and the aim was for the change to be observed on a whole system level (e.g. STP footprint) ongoing attention and likely resources would be required (e.g. a named SRO and funding to cover the cost of time of stakeholders)

Leadership

4.7 One key challenge in the development of the IPC leadership relates to the engagement of middle managers. We noted above that sites focussed primarily on engaging stakeholders in the senior strategic levels and frontline practitioners in developing the governance structures and delivery model of IPC. Stakeholders commented that the next step would be to recruit the buy-in of the middle managers to develop a strong leadership to enable the scaling up and sustainability of the IPC model.

> *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)

4.8 Stakeholders commented that the challenge in gaining the buy-in and support of middle managers was that this would require a significant change in culture. Managers would need to allow more freedom and flexibility to practitioners to make decisions, in order for the personalised care and support planning and budget setting to work well (for example, using the resources available to them in a flexible way to develop care and support plans that suit the service users' specific needs, or devote more time to individual cases). This was less of an issue while IPC was working on a localised and small scale. However, with scaling up, a larger number of teams and practitioners would need to be involved, as well as the need for a larger population size to be covered. This will involve greater risk for the middle managers who are accountable for meeting service's KPIs. At the time of the interviews (March 2017) completed for this report, in many sites the middle managers were still apprehensive about taking this risk. Stakeholders commented that this was a challenge that they were still grappling with. It appeared that at this stage, middle managers still sought the approval of their directors to drive the change.

Workforce development and support

4.9 It is generally good and necessary practice to include an element of workforce training and support in the process of system change. Frontline practitioners are important change agents in ensuring the sustainability of a change because they have the role of implementing and delivering the new processes. Training can both upskill staff by teaching new skills and practices and providing the support and knowledge for utilising existing skills to implement changes in workforce practices.

4.10 Recognising this, stakeholders across all sites encouraged frontline staff in their areas to take part in training that was provided by the programme. The training focussed on the personalised approach to service provision and provided practical sessions in conducting 'a different kind of conversation' in care planning. The training was received well by practitioners.

4.11 Workforce development through training was included as a key enabler in the IPC Operating Model. The challenge going forward would be for local systems to continue to provide training sessions to new staff. During IPC the training was provided by NHS England. Going forward local systems will need to find the resources to fund the training themselves. A number of sites provided 'train the trainer' sessions to key staff members, with the hope of developing a system of cascading the training internally within organisations. It might be beneficial for NHS England and local systems to follow up with these sites, in order to gain any learning from their experience and assess both whether this approach was effective and whether it could be replicated in other areas to support any further roll out.

Maintaining momentum and sustainability

4.12 One challenge noted by a number of sites was how to keep the momentum for change. Because in many of the sites, implementation was only done on a small scale and short-term pilot basis, at the end of the pilots, things tended to 'go back to normal'. This was mostly apparent in sites where teams deployed external organisations to enable the pilots of IPC (such as Catalyst Stockton or Nesta). Where external organisations were deployed, they appeared to have been successful in gaining momentum by engaging frontline practitioners to deliver the pilots. However, once the pilots ended and the external organisations exited, that left a gap in local systems as it was not clear who should pick things up and maintain momentum.

4.13 In a number of sites the expectation of the senior commissioners was that middle managers would take on the task of delivering the change. However, in reality their engagement in the programme was limited, as noted above. The challenge was one of ownership as well as understanding of the personalisation agenda. The managers who were expected to take forward the changes had not driven their initial development and had not received the relevant training in the personalisation approach.

4.14 One way of mitigating this was through the identification of 'Champions of Personalised Care' within services and organisations (implemented in five sites). These were frontline practitioners who were fully bought-in to the approach and who showed high levels of commitment to the change. The intention was that the 'Champions' would assist in keeping the momentum for change. They received additional support from their organisation to help them with their role. The motivation for staff to become Champions appeared to have been their high level of commitment to the personalisation agenda and their sense of responsibility for the welfare of service users under their care. While this appeared to have been an enabler in starting momentum within services, this solution still bypassed the middle managers (unless the Champions are middle managers), which could be considered a barrier to long-term sustainability of change going forward.

Service users' and carers' experience of IPC

4.15 The interviews with service providers and carers highlighted a mixed picture of individual experiences of IPC. The wide range of experiences relating, in particular, to individual's feeling of having choice and control over their care appear to be attributed to four main reasons.

4.16 First, service user's different desires or abilities to exercise choice. Some wanted to exercise choice and took every opportunity to do so, whereas others chose not to be involved at all or opted to exercise choice and control in selected areas only. For the latter, having support to manage the tasks they were not interested or comfortable with assisted them in feeling autonomous and independent.

4.17 Second, some service users and carer's particularly good or particularly poor experiences of choice and control appeared to be related to the actions and accessibility of key professionals. Where professionals were hard to contact, offered limited support or gave service users little space to express themselves, experiences of choice and control were unsatisfactory. Where professionals were accessible and engaged service users in the IPC process in an empowering way, especially in support planning, experiences were more positive.

4.18 Third, it appeared that in order to gain the most choice and control, service users needed to be pro-active and push hard within the system to get the results they wanted. Conversely, service users less willing or able to do this or to challenge decisions tended to experience less choice and control. This raises the risk that the less able may not be able to access these opportunities, which returns to the issue of support raised above.

4.19 Finally, it may be that service users with particularly positive experiences were those who had capacity or opportunities to choose what interests and activities to include in their support plan and also had control over a budget that enabled them to pursue them, with capacity or sufficient support to manage it.

Conclusions in relation to the five key shifts

4.20 An overview of the evidence against each of the five shifts highlight a number of key conclusions.

Proactive co-ordination of care

Progress in this shift has been limited, with the majority of the sites not having linked datasets, and those who did were not able to use the datasets for the purposes of IPC.

4.21 Many of the sites did not have linked datasets in place, and those that did, were not able to 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. If this remains an area for development for the future, then NHS England and NHS Digital may want to consider offering support to areas in developing an IG Policy to address the various issues that have arisen.

Community capacity and peer support

Progress in this shift has been slow, although it emerged that VSCE agencies could be valuable partners in delivering services in the local offer.

4.22 Most sites had made relatively slow progress in the development of community capacity and peer support. Efforts focussed on two main activities: mapping out what local services and providers were available for health and social care and making plans for filling in identified gaps and setting up or redeploying local co-production groups. Feedback from the service users and carers that we interviewed suggested that service users valued greatly the service and support they received from third sector organisations. They appeared to be knowledgeable about the local offer and were set up to provide practical support to service users in managing their care (e.g. assist with applications forms and claims). It would seem that the VCSE sector might be a valued partner in developing the community support offer in local systems going forward, but this will need resourcing.

Personalised care and support planning

Sites have made the most progress in this shift, and an IPC personalised care and support planning model is emerging and appears to be working well, although still on a small scale.

4.23 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 users as part of the personalised care and support planning process. This is very much 'as intended' by the programme. However, although there has been good progress in this shift, the majority of the sites were still working on a small scale. Most sites reported very low numbers of plans developed (generally under 50 plans in each site). Therefore, a key challenge still remains around scaling up to greater numbers and spreading out to other cohorts.

4.24 The aspect of service integration tended to happen outside the personalised care and support planning sessions, with practitioners having different platforms to ensure that information on personalised care and support plans was being shared and approved across services. In a number of sites this included single approval panels, and MDTs discussing the personalised care and support 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.

4.25 Service users commented about the feeling of a general lack of integration between services and described a feeling of 'piggy in the middle' or being 'passed from pillar to post' when going through the personalised care and support planning process between health and social care.

The challenge for local systems going forward will be to develop processes that not only have personalisation at their core, but also include integration of services in their approach.

Choice and control

Progress in this shift was limited with challenges relating mostly to the difference in experience of personal budgets between health and social care and difficulties around pooling together budgets to create integrated personal budgets.

4.26 Progress around IPBs has remained limited. Activities around this shift focussed primarily on developing a system to set up and deliver PHBs. As we have seen elsewhere, gaining the understanding and trust of providers and service users around the benefits of personal budgets 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.

Personalised commissioning and payment

Block contracts were cited as the key barrier to offering greater choice and flexibility in commissioning services, and a key challenge in scaling up IPC.

4.27 Unpacking block contracts (see Annex G: Sustainability and scalability – thematic case study) remains 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.

5. Economic evaluation

Introduction

5.1 This chapter contains the findings about the two objectives of the economic evaluation:

- First, to estimate the difference in costs between IPC and standard care (i.e. the care received by people in the absence of IPC). This difference in costs includes the costs of setting up the IPC service and the differential costs (whether savings or added costs) of delivering IPC compared to delivering standard care. This is described under *Additional costs of IPC compared to standard care*.
- Second, to estimate the minimum amount of quality of life benefits, or minimum amount of cost savings that IPC would need to achieve to be cost-effective, or cost-neutral given its additional costs. This is described under *Scenario analysis: Implication for outcomes.*

Background

5.2 This section briefly outlines IPC and the evidence base on cost-effectiveness prior to IPC that informed our analysis. This research aimed to explore, from the commissioner perspective, whether IPC and standard care has delivered better outcomes in terms of enhanced care and health outcomes, given the investment in IPC and associated service use compared to 'standard' care without IPC. The aim was to consider whether IPC achieved better outcomes for users at a cost that was worth paying.

5.3 Although an economic evaluation of IPC had not been undertaken before, IPC has similarities with earlier initiatives in England, which have been assessed for cost-effectiveness, comprising individual budgets (IBs) in social care[31] and PHBs[32]. Like these initiatives, IPC supported the user, on the basis of a personalised care and support plan, to identify their own care needs, and provided users with a budget to obtain services to meet those needs. An economic evaluation of both of the earlier initiatives was undertaken and the methods used and results found both informed our analyses.

5.4 Glendinning et al (2008) compared the cost-effectiveness of IBs with standard care based on an RCT with six month follow up from a health and social care perspective, social care (-related) outcomes based on the Adult Social Care Outcome Toolkit (ASCOT), and psychological wellbeing based on GHQ-12. They examined costs and impacts across IBs and standard care for all participants in the study. They found that, from the social and health care perspective across the full sample, there was some evidence that IB users used fewer resources than non-IB users, although the costs were not statistically significantly different at the ten per cent level. Social care costs were similar across the two groups, health care costs appeared to be higher in the IB group, driven by inpatient use. In terms of benefits, IBs were associated with slightly higher social care outcomes and very slightly higher psychological wellbeing, compared to

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[31] Glendinning C, Challis D, Fernandez J-L et al. Evaluation of the Individual Budgets Pilot Programme. Final Report. SPRU, University of York, October 2008.

[32] Jones K, Forder J, Caiels J et al. Personalization in the health care system: do personal health budgets have an impact on outcomes and cost? Journal of Health Services Research and Policy. 2013; 18 (suppl. 2) 59-67.

standard care. Results about the effect of IBs on social care outcomes were mostly driven by people with learning disabilities, while older service users, who are the larger group of social care users, were found to have lower social care outcomes. Overall, IBs appeared more likely to be cost-effective in achieving overall social care outcomes but offered no advantage in psychological well-being.

5.5 Jones et al (2013) compared the cost-effectiveness of PHBs with standard care based on a controlled trial with a pragmatic design over a 12 month follow up period. Health care costs were included as well as the costs of the PHB package of care, which could include social care costs and costs of services from a broad range of sectors. Health outcomes were assessed using EQ-5D, social care outcomes based on ASCOT, general life happiness and satisfaction using a subjective global scale, and psychological wellbeing based on GHQ-12. They found that social care outcomes and psychological wellbeing were statistically significantly different (better) for PHB users vs. standard care users. There were no statistically significant differences in health outcomes nor subjective wellbeing across the two groups.

5.6 PHBs did not appear to have a differential impact on costs across the two groups. Based on social care outcomes, the PHB group appeared more cost-effective having, on average, a greater ASCOT value and lower cost, compared to standard care. Using a hypothetical threshold of £10,000 to £40,000, based on social care outcomes, net monetary benefit ranged from £1,520 to £2,690, and based on health care outcomes using EQ-5D, net monetary benefit ranged from £1,020 to £700. At a hypothetical threshold of £30,000 and above, PHB had a statistically significant net benefit for social care outcomes, but not for health care outcomes.

5.7 As a care model, and as suggested by its' name, IPC focussed on the user personalising their own care and support needs through the personalised care and support planning process, sometimes with a personal budget, to integrate this social care and health care support, compared to IB and PHBs. Given that the cost-effectiveness of IPC and standard care has not been assessed before, this study aimed to address this gap by comparing the outcomes and costs of IPC and standard care on users compared to standard care that is available to users. The findings of the present study might inform the design and implementation of an evaluative study and could provide an indication for commissioners on whether IPC is better/better value than standard care from the commissioner perspective.

Analysis

Additional resources and costs of IPC compared to standard care

5.8 The additional resources and costs of IPC compared to standard care depend on how IPC is implemented. If IPC replaces standard care, any additional costs (or savings) are those that were only incurred due to IPC and would not be incurred if standard care was delivered. These additional costs can be calculated from the information collected through the questionnaire, which covers the resources of setting up IPC and the differential resources to run IPC compared to standard care.

5.9 If IPC is added on to standard care, all the costs incurred in IPC are additional costs compared to having standard care alone. These additional costs correspond to the costs of the resources of running IPC, which were collected through the workshops. The limitation is the workshops could only be conducted in three sites, and only two of these sites answered the questionnaire. On this basis, the estimates on differential running costs of IPC vs standard care obtained using data from the questionnaires might represent a lower bound of the differential running costs. In contrast, the estimates on the total running costs obtained using data from the workshops might represent an upper bound of the 'known' differential running costs. The term 'known' reflects that there were other costs which could not be quantified in the workshops, or for which there was insufficient information to allow for a cost to be estimated. Conversely, we did not cost delivery beyond a maximum of three years. Therefore, the costs do not account for any potential long-term costs or cost savings.

Resource use

5.10 The questionnaire on setting up and running IPC was distributed to 15[33] IPC sites. Eight sites answered the questionnaire and provided additional clarifications.

5.11 The top panel of Table 5-1 summarises the data on resource use for setting-up IPC collected via the questionnaire, where set-up costs are the cost of the resources used to establish IPC. **On average, 2.6 WTE staff were involved in setting up IPC in the first year of implementation and 3.4 in the second and third year of implementation**. The average WTE comprised the contributions of several staff members working part-time on the set-up of IPC.

5.12 Table 5-1 Table 5-2 also reports the typical resources used to set-up IPC per site over time. Across IPC sites in the implementation year, there was substantial variability in the number of WTE staff who set-up IPC. For example, site 6 employed 0.3 WTE staff members only for setting up IPC, while site 1 employed 6.3 WTE staff members.

5.13 The bottom panel of Table 5-1 includes a summary of the data on the differential use of resources for running IPC, compared to standard care. **On average, IPC required 4.2 more appointments per user compared to standard care**. There was substantial variability across sites. Site 1 delivered IPC using the same number of appointments per user compared to standard care, whilst site 3 required 13 more appointments for the delivery of IPC compared to standard care.

5.14 In addition, IPC typically required more contacts between staff, although this varied across the eight sites that responded to our survey. **On average, IPC required 2.4 more contacts between staff per user**. Site 2 and 4 ran IPC with no further contacts between staff per user compared to standard care, while site 6 required six more contacts between staff per user.

5.15 Table C-1 in Annex C shows information about the resources used to run IPC in site 3, 8 and 9 collected through the workshop. The information collected in the workshop suggests that the three sites went through an identification and recruitment, preparation, and delivery phase to run IPC. These three phases, however, varied substantially across sites in the type of tasks carried out or the resources employed. This large variation might be due to a pilot effect. As a service beds in, resources might be used more efficiently, and the costs may reflect increases in efficiency.

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[33] Two of the 17 sites were not engaged in the evaluation throughout, and so we made the decision not to send them the cost questionnaire.

Table 5-1: Resources used for setting up and running IPC.

		Site								Summary	
Variable	**Year**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Mean**	**Std dev**
						Set up of IPC					
Total staff WTE	1	5.4	3.1	2.3	-	1.2	0.3	2.7	3.0	2.6	1.6
	2	6.7			-	2.0		2.6	2.3	3.4	2.2
	3	6.7			-	2.5		2.2	2.3	3.4	2.2
	Av	**6.3**	**3.1**	**2.3**	**-**	**1.9**	**0.3**	**2.5**	**2.5**	**2.4**	**1.8**
Total non-staff sources of costs	1	0	3	3	1	4	6	5	1	3	2
	2	0			1	0		7	0	2	3
	3	0			0	0		7	0	1	3
	Av	**0**	**3**	**3**	**1**	**1**	**6**	**6**	**0**	**3**	**2**
						Delivery of IPC					
Diff appointments per patient		Same	More	More	More	More	More	More	More	88%	
		0	+ 2	+ 13	+ 2.5	+ 6	+ 3	+ 3	+ 2	+4.2	4.0
Diff contacts between staff per patient		More	Same	More	Same	More	More	More	More	71%	
		+ 3	0	+ 2	0	+ 4	+ 5	+ 3	+ 4	+2.4	1.8

Year=year of implementation, **Mean**=either proportion of sites with "More" answer or average of the available information across sites, **Std dev**=standard deviation, **IPC**=integrated personal commissioning, **WTE**=whole time equivalent, **-** =missing value, **Av**=average year of implementation, **Diff**=differential (vs standard care)

Source: IPC evaluation set-up and running costs questionnaire

5.16 For example, all sites identified and recruited IPC users through the work of GPs, health and social care professionals, multi-disciplinary team (MDT) coordinators and project managers. However, sites 3 and 8 recruited users through direct contacts (e.g. phone calls, letters), while site 9 organised and ran a more resource-intensive market place event.

5.17 Similarly, concerning the delivery of IPC, site 3 employed a peer coaching approach (i.e. a lay person having meetings with the IPC user) with the support of locality navigators. In contrast, site 8 and 9 delivered IPC mostly through the work of community matrons, district nurses, and GPs.

Costs

5.18 The top panel of Table 5-2 shows the set-up costs calculated using the data from the questionnaire. **On average, the set-up of IPC cost £151,586 across sites in the first year of implementation for both staff and non-staff costs. In the second and third year of implementation, the set-up of IPC costed £162,348 and £146,240 across sites, respectively. For the average year of implementation, set-up costs varied between £81,471 (site 5) and £246,777 (site 6)**. In the average year of implementation, non-staff costs were generally a small proportion of the total set-up costs varying between 0% (site 1 and site 8) and 20% (site 7), except for site 6 in which non-staff costs were 94% of the total set-up costs. Site 6, for which 2017/18 was the first year of implementation, reported that £231,710 was spent on developing the infrastructure and processes to support IPC (including co-production strategy development, resource allocation system and e-marketplace development/asset mapping), whilst the staff involved consisted only of senior staff at 0.33 FTE.

5.19 The middle panel of Table 5-2**.** shows information about the differential costs per user of running IPC compared to standard care. **On average, running IPC cost £265 per user more than running standard care with differential costs varying between £121 per user (site 4) and £486 per user (site 3)**.

5.20 The bottom panel of Table 5-2 indicates the number of users of IPC in each site. In the average implementation year, typically sites delivered IPC to 602 users, with the number of users varying between 21 (site 5 and 6) and 2,050 (site 1).

5.21 Table C-2 in Annex C illustrates the running costs of IPC for three sites calculated using the data collected through the workshops. Site 3 had total annual costs of running IPC of £460,215, which were much greater than the total annual costs for site 8 (£127,363) and 9 (£31,882).

5.22 Taking the number of users into account, again, site 3 had greater total annual costs per user (£2,301) compared to site 8 and 9. In turn, site 9 had greater total annual costs per user (£1,594) compared to site 8 (£535), although the former had lower total annual costs, as discussed above. The variability in running costs is due to the differences in the number of additional appointments and contacts between staff.

Table 5-2: Costs of setting up and running IPC and volume of patients.

		Site								Summary	
Variable	**Year**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Mean**	**Std dev**
Set up of IPC											
Total staff and non-staff costs (£)	1	147,215	166,016	152,423	84,699	59,196	246,777	180,871	175,494	151,586	58,222
	2	219,721			138,616	82,291		222,358	148,752	162,348	59,267
	3	219,712			114,394	102,926		145,350	148,818	146,240	45,541
	Av	**195,550**	**166,016**	**152,423**	**112,570**	**81,471**	**246,777**	**182,860**	**157,688**	**161,919**	**50,430**
Delivery of IPC											
Diff costs of running IPC (£ per patient)		135	131	486	121	426	402	174	248	265	150
Volumes of IPC patients											
Diff contacts between staff per patient	1	470	36	35	-	12	21	20	238	119	174
	2	2,024			-	28		987	300	835	890
	3	3,657			-	22		2,652	1,947	2,070	1,535
	Av	**2,050**	**36**	**35**	**-**	**21**	**21**	**1,220**	**828**	**602**	**801**

Year=year of implementation, **Std dev**=standard deviation, **IPC**=integrated personal commissioning, **WTE**=whole time equivalent, **-** =missing value, **Av**=average year of implementation, **Diff**=differential (vs standard care)

Source: CHE analysis of the IPC evaluation set-up and running costs questionnaire

Scenario analysis: Implications for outcomes

Estimating the minimum differential QALYs

5.23 This section illustrates the minimal differential H- or SC-QALYs per user that the average IPC site would need to generate to be cost-effective compared to the average site delivering standard care, following approach 1 and approach 2 described above and in Table C-3 in Annex C. Both approaches are summarised in Table 5-3 below. Table 5-4 shows minimal differential H- or SC-QALYs per user calculated using multiple thresholds including £13,000 per QALY, £20,000 per QALY, £30,000 per QALY and £50,000 per QALY. For simplicity, **in this section, only the results corresponding to the £13,000 per H- or SC-QALY cost-effectiveness threshold are discussed**, but similar interpretations apply to the other cost-effectiveness threshold values. As the cost-effectiveness threshold increases, the monetary value placed on 1 QALY increases, and the minimal differential QALYs needed for IPC to be cost-effective decreases.

Table 5-3: Short recap of the comparison between approach 1 and approach 2.

Approach 1	**Approach 2**
Time horizon	
1 year	3 years
Interpretation	
The minimal benefits either in terms of QALYs (or unplanned hospitalisations) for IPC to be cost-effective (or cost-neutral) in each year. The minimal benefits depend on the costs incurred in each year and the number of users receiving IPC: • Year 1: greater set-up costs and fewer users, hence greater benefits would need to be achieved; • Year 2: smaller set-up costs and more users, hence smaller benefits would need to be achieved; • Year 3: set-up costs between year 1 and 3 and more users; hence benefits between those estimated for year 1 and 2. This implies that considering the first years of implementation separately is likely to generate large differential costs per patient and, in turn, large minimal effects.	The minimal benefits either in terms of QALYs (or unplanned hospitalisations) for IPC to be cost-effective (or cost-neutral) over three years. This allows the set-up costs to be spread over a period of three years as well as throughout of users to be accumulated over the same time period. The difference in costs per patient over a three-year period, therefore, are likely to be lower than the difference in costs per patient in a single year. In turn, this implies that minimal effects calculated over a three-year period are likely to be smaller compared to minimal benefits calculated in a single year.
Implications for policy	
Minimal benefits which would need to be achieved if IPC needs to reach cost-effectiveness (or cost-neutrality) in each year that it operates. *Note that this is based on the differential cost of setting up IPC and delivering IPC only. It does not include the differential costs for IPC vs standard care on the associated care packages, nor the wider costs relating to associated health and social care use.*	Minimal benefits which would need to be achieved if IPC needs to reach cost-effectiveness (or cost-neutrality) over a three-year time period. *Note that this is based on the differential cost of setting up IPC and delivering IPC only. It does not include the differential costs for IPC vs standard care on the associated care packages, nor the wider costs relating to associated health and social care use.*

5.24 The top panel of Table 5-4 shows the minimal differential QALYs per user, when only set-up costs of IPC are considered and separately for each year of implementation. If IPC needs to achieve cost-effectiveness in year 1 of implementation, IPC would need to generate on average no less than 0.393 QALYs per user. For IPC to be cost-effective in year 2, IPC would need to generate on average no less than 0.072 in that year. Considering only year 3, the minimal differential QALYs are 0.094 QALYs per user.

5.25 The middle panel of Table 5-4 shows the minimal differential QALYs per user, when only differential delivery costs of IPC are considered. IPC would need to generate on average no less than 0.020 QALYs per user to be cost-effective compared to standard care.

5.26 Finally, the bottom panel of Table 5-4 shows the minimal differential QALYs per user, when both set-up costs and differential running costs of IPC are considered. **For IPC to be cost-effective at each year, it would need to generate at least 0.415 QALYs per user in year 1, 0.091 in year 2 and 0.113 QALYs per user in year 3**.

5.27 Table 5-5 includes the calculation of the minimal differential H- or SC-QALYs per user that the average IPC site would need to generate to be cost-effective compared to the average site delivering standard care, following approach 2 which covers a time horizon of three years. More details about the calculation of actual number of users, set-up and differential running costs were reported in Table C-4 in Annex C.

5.28 The top panel of Table 5-5 shows the minimal differential QALYs per user, when only set-up costs of IPC are considered. In the whole three-year period of implementation, IPC would need to generate on average no less than 0.011 QALYs per user to be cost-effective compared to standard care.

5.29 The middle panel of Table 5-5 shows the minimal differential QALYs per user, when only differential running costs of IPC are considered. In the whole three-year period of implementation, IPC would need to generate on average no less than 0.019 QALYs per user to be cost-effective compared to standard care.

Table 5-4: Minimal differential QALYs per patient using differential costs per patient per year for each of the three years of implementation (approach 1).

		Minimal differential QALYs per patient			
Year	**Differential costs per patient for the average site (£ per patient)**	**λ=13,000**	**λ=20,000**	**λ=30,000**	**λ=50,000**
		Set-up of IPC			
1	5,106	0.393	0.255	0.170	0.102
2	942	0.072	0.047	0.031	0.019
3	1,217	0.094	0.061	0.041	0.024
		Delivery of IPC			
Av	265	0.020	0.013	0.009	0.005
		Set-up and delivery of IPC			
1	5,392	0.415	0.270	0.180	0.108
2	1,188	0.091	0.059	0.040	0.024
3	1,463	0.113	0.073	0.049	0.029

λ=cost-effectiveness threshold, **Av**=average year of implementation

Source: CHE analysis of the IPC evaluation set-up and running costs questionnaire

Table 5-5: Minimal differential QALYs per patient using differential costs per patient over the three-year period (approach 2).

Year	Actual number of patients of the average site	Set-up costs of the average site (£)	Set-up costs (£) per patient of the average site	Differential running costs (£)	Differential running costs (£) per patient	Differential costs (£) per patient of IPC	Minimal differential QALYs per patient			
							λ=13,000	λ=20,000	λ=30,000	λ=50,000
Set-up of IPC										
All	3,023	444,961	147			147	0.011	0.007	0.005	0.003
Delivery of IPC										
All	3,023			757,983	251	251	0.019	0.013	0.008	0.005
Set-up and delivery of IPC										
All	3,023	444,961	147	757,983	251	398	0.031	0.020	0.013	0.008

λ=cost-effectiveness threshold, **All**=whole three-year period

Source: CHE analysis of the IPC evaluation set-up and running costs questionnaire

5.30 Finally, the bottom panel of Table 5-5 shows the minimal differential QALYs per user, when both set-up costs and differential running costs of IPC are considered. Over three years, **IPC would need to generate on average no less than 0.031 QALYs per user to be cost-effective compared to standard care**.

5.31 Table C-5 and Table C-6 in Annex C include the results of the sensitivity analysis based on the timing of implementation of IPC. Early adopters always had lower differential costs per user in a typical year, compared to late adopters during the first year of implementation. Therefore, IPC implemented by late adopters needed to achieve a greater differential effect in terms of both QALYs and unplanned hospitalisations to be considered cost-effective and cost-neutral, respectively.

Estimating the minimal reduction in unplanned hospitalisations

5.32 Table 5-6 shows the minimal number of unplanned hospitalisations per user that the average IPC site would need to prevent to produce savings equal to its additional costs (i.e. to be cost-neutral) compared to standard care, following approach 1.

5.33 The top panel of Table 5-6**.** shows the minimal reduction in unplanned hospitalisations per user, when only set-up costs of IPC are considered. In the first year of implementation, IPC would need to prevent on average no less than 3.2 unplanned hospitalisations per user to be cost-neutral compared to standard care. In the second and third year of implementation, IPC would need to prevent on average no less than 0.6 and 0.8 unplanned hospitalisations per user, respectively, to be cost-neutral compared to standard care (equivalent to 6 and 8 unplanned hospitalisations per 10 users).

5.34 The middle panel of Table 5-6 shows the minimal reduction in unplanned hospitalisations per user, when only differential running costs of IPC are considered. In the average year of implementation, IPC would need to prevent on average no less than 0.2 unplanned hospitalisations for each user to be cost-neutral compared to standard care (i.e. 2 unplanned hospitalisations per 10 IPC users).

5.35 Finally, the bottom panel of Table 5-6 shows the minimal reduction in unplanned hospitalisations per user, when both set-up costs and differential running costs of IPC are considered. To be cost-neutral in each year of implementation, IPC would need to prevent, per user, 3.4 hospitalisations in year 1; 0.7 in year 2 and 0.9 in year 3 compared to standard care.

Table 5-6: Minimal reduction in unplanned hospitalisations per patient using differential costs per patient over each of the three years of implementation.

Year	Differential costs per patient of the average site (£ per patient)	Minimal reduction in unplanned hospitalisations per patient
	Set-up of IPC	
1	5,106	3.190
2	942	0.589
3	1,217	0.761

	Delivery of IPC	
Any year	265	0.166
	Set-up and delivery of IPC	
1	5,392	3.369
2	1,188	0.742
3	1,463	0.914

Av=average year of implementation

The unit cost of an unplanned hospitalisation was £1,600.67, which is calculated as the average unit cost in 2015/16 (£1,609), 2016/17 (£1,590), and 2017/18 (£1,603)

Source: CHE analysis of the IPC evaluation set-up and running costs questionnaire

5.36 Table 5-7 shows the minimal number of unplanned hospitalisations per user that the average IPC site would need to prevent to be cost-neutral compared to the average site delivering standard care, following approach 2. More details about the calculation of actual number of users, set-up and differential running costs are reported in Table C-4 in Annex C.

5.37 The top panel of Table 5-7 shows the minimal reduction in unplanned hospitalisations per user, when only set-up costs of IPC are considered. In the whole three-year period of implementation, IPC would need to prevent on average no less than 0.1 unplanned hospitalisations for each user to be cost-neutral compared to standard care (this is equivalent to 1 unplanned hospitalisation prevented per 10 users of IPC).

5.38 The middle panel of Table 5-7 shows the minimal reduction in unplanned hospitalisations per user, when only differential running costs of IPC are considered. In the whole three-year period of implementation, IPC would need to prevent on average no less than 0.2 additional unplanned hospitalisations for each user to be cost-neutral compared to standard care (this is equivalent to 2 unplanned hospitalisations prevented per 10 users of IPC).

5.39 Finally, the bottom panel of Table 5-7 shows the minimal reduction in unplanned hospitalisations per user, when both set-up costs and differential running costs of IPC are considered. **Over the three years of implementation, IPC would need to prevent on average no less than 0.2 additional unplanned hospitalisations for each user to be cost-neutral compared to standard care (this is equivalent to 2 unplanned hospitalisations prevented per 10 users of IPC)**.

Table 5-7: Minimal reduction in unplanned hospitalisations per patient using differential costs per patient in the three-year period.

Year	Actual number of patients of the average site	Set-up costs of the average site (£)	Set-up costs (£) per patient of the average site	Differential running costs (£)	Differential running costs (£) per patient	Differential costs (£) per patient of IPC	Minimal reduction in unplanned hospitalisations per patient
Set-up of IPC							
All	3,023	444,961	147			147	0.092
Delivery of IPC							
All	3,023			757,983	251	251	0.157
Set-up and delivery of IPC							
All	3,023	444,961	147	757,983	251	398	0.249

All=whole three-year period

Source: CHE analysis of the IPC evaluation set-up and running costs questionnaire

Discussion

5.40 The costs of IPC may differ from the costs of standard care in that (i) setting-up IPC may require additional resources; (ii) the delivery of IPC may involve a different amount of resources compared to standard care; (iii) IPC may result in a different care package and (iv) IPC may result in different usage of health and social care resources compared to standard care alone.

5.41 **For this study, it was possible to collect some information on (i) and (ii) but not on (iii) and (iv)**, although the impact chapter does contain some descriptive data on (iii). Data on (i) and (ii) were collected through a questionnaire, across eight of the 17 sites that implemented IPC. Additionally, information on the total amount of resources required to run IPC was collected across three sites (two of which also returned the questionnaire) via workshops with site leads.

5.42 Concerning (i), the total staff WTE dedicated to the set-up of IPC varied from 0.3 WTE (site 6 year 1) to 6.7 WTE (site 1 years 2 and 3). The cost of setting up IPC per year varied from £59,196 (site 5, year 1) to £222,358 (site 7, year 2), and the **average cost was £161,919 per year during a typical year of implementation (i.e. the average cost per year over year 1, 2 and 3). The majority of set-up costs related to staff time**.

5.43 Concerning (ii), the delivery of IPC required on average 4.2 more appointments with users (varying between zero and 13 more appointments across sites) and 2.4 more contacts between staff members (varying between zero and 5 more contacts across sites) compared to standard care. This greater use of resources might be due to the greater personalisation of the personalised care and support planning process introduced by IPC compared to standard care. As a consequence, **IPC had on average £265 greater running costs per user compared to standard care**, varying from £121 (site 4) to £486 (site 3). This variability in differential running costs was mostly driven by the differential resource use, since the salary of IPC professionals was similar across sites. Part of the variability might also be explained by the pilot effect since some sites were in the first year of implementing IPC when our survey took place, although this would require longer term tracking to assess if costs do in fact decline in time.

5.44 Using the information collected at the workshops, the annual total costs were £2,301 per user in site 3, £535 per user in site 8, and £1,594 per user in site 9. For comparison, the questionnaire's differential running costs per user were £486 in site 3 and £248 in site 8, while site 9 did not complete the questionnaire. As discussed above, IPC was in some cases an additional intervention on top of standard care. The workshop's running costs per patient might therefore represent an upper bound of known costs (ii) while the questionnaire's running costs could represent a lower bound. **This suggests that the workshops might have collected more detailed information on the differential resources involved in running IPC**, reflecting the opportunity to identify and cost different stages of the process.

5.45 In addition, the workshop data suggested high heterogeneity in the approach to running IPC, and this is supported by the findings from the process evaluation. This could explain the substantial variability in the resource use and, in turn, costs of IPC across sites, which were observed after analysing the questionnaire data.

5.46 Overall, our findings suggested that IPC might be, on average, costlier than standard care to set up and implement. Such findings differed from those from studies evaluating other support or personalised care and support planning programmes such as IB and PHB. These studies indicated that the new interventions were cost saving, i.e. the IB and the PHB reduced costs by £16 and £1,120 per user compared to standard care, respectively. These results were however not comparable with our results due to the different definition of costs. The IB and PHB did not consider set-up costs and focussed on cost differences in a broad set of social and health care services including (iii) and (iv). As discussed, the collection of these data turned out to be unfeasible in our study.

5.47 Given the additional costs of setting up and running IPC compared to standard care, IPC needs to deliver additional benefits in terms of QALYs or generate savings in the form of reduced hospital activity. **If the costs of setting up IPC and the additional costs of running it are considered, IPC would need to generate 0.031 additional QALYs per user to be cost-effective <u>over the three years</u> of implementation** at a cost-effectiveness threshold of £13,000 per QALY. If IPC continued to run over a longer period of time, and if the set-up costs were not required on a recurrent basis, the additional total cost of IPC per user compared to standard care would tend towards the additional running cost. Hence, **if only running costs were considered, IPC would need to generate between 0.020 additional QALYs per user <u>per year</u> to be cost-effective,** similar to the differential QALYs achieved by the IB and the PHB[34]. The minimal additional QALYs reduce if a greater cost-effectiveness threshold is used. For example, at a cost-effectiveness threshold of £20,000/QALY, IPC needs to generate an additional 0.013 QALYs; 0.009 at a cost-effectiveness threshold of £30,000/QALY and 0.005 at a cost-effectiveness threshold of £50,000/QALY.

5.48 Finally, an alternative scenario calculated the minimal reduction in unplanned hospitalisations for IPC to be cost-neutral keeping constant other hospital activity. Given the additional costs of IPC and the cost of unplanned hospitalisations, **IPC would be cost-neutral over three years if it could prevent 20 unplanned hospitalisations per 100 users compared to standard care.** Whether IPC, or other personalised/integrated care interventions, can reduce unplanned hospitalisations has not yet been demonstrated. For example, recent empirical evidence on an intervention similar to IPC showed an increase in hospital use due to better identification and assessment of health and social care needs compared to standard care.[35]

Table 5-8: Summary of the findings on costs and outcomes.

Summary of the findings on costs
Questionnaire
Set-up of IPC
• The total staff WTE dedicated to the set-up of IPC varied from 0.3 WTE to 6.7 WTE
• The cost of setting up IPC per year was on average £161,919
• The majority of set-up costs related to staff time
Delivery of IPC

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[34] Forder J, Jones K, Glendinning C, Caiels J, Welch E, Baxter K, Davidson J, Windle K, Irvine A, King D, Dolan P. 2012. Evaluation of the personal health budget pilot programme. Discussion Paper 2840_2. Personal Social Services Research Unit. University of Kent. Canterbury.

[35] Georghiou, T. and Keeble, E., Age UK's Personalised Integrated Care Programme: Evaluation of impact on hospital activity.

- The delivery of IPC required on average 4.2 more appointments with users compared to standard care
- The delivery of IPC required on average 2.4 more contacts between staff members compared to standard care
- IPC had on average £265 greater running costs per user compared to standard care

Workshop

- The annual total costs were £2,301 per user in site 3, £535 per user in site 8, and £1,594 per user in site 9
- The questionnaire's differential running costs per user were £486 in site 3, £248 in site 8, while site 9 did not complete the questionnaire

Summary of the findings on outcomes

Approach 1 with a time horizon of one year

- Considering both set-up and delivery costs, IPC would need to generate 0.072-0.393 additional QALYs per user per year to be cost-effective at a cost-effectiveness threshold of £13,000 per QALY. At a highest threshold of £50,000/QALY, the minimal additional QALYs are 0.019-0.102.
- If only running costs were considered, IPC would need to generate between 0.005 - 0.020 additional QALYs per user per year to be cost-effective, depending on the cost-effectiveness threshold.
- Considering both set-up and delivery costs, IPC would need to prevent 59-319 unplanned hospitalisations per 100 users to be cost-neutral at each year of implementation.

Approach 2 with a time horizon of three years

- Considering both set-up and delivery costs, IPC would need to generate 0.031 additional QALYs per user per year to be cost-effective over the three years of implementation at a cost-effectiveness threshold of £13,000 per QALY. At a highest threshold of £50,000/QALY, the minimal additional QALYs are 0.008.
- If only running costs were considered, IPC would need to generate between 0.005 - 0.019 additional QALYs per user per year to be cost-effective, depending on the cost-effectiveness threshold.
- Considering both set-up and delivery costs, IPC would need to prevent about 25 unplanned hospitalisations per 100 users to be cost-neutral over the three-year period.

Strengths and limitations

5.49 This is the first evaluation of the IPC programme. Information was collected on resources required for the set-up of IPC and on the additional resources for running IPC on an individual user basis compared to standard care. Additionally, information was collected on the resources required to run IPC. These were used to calculate the costs of setting up IPC, the additional running costs of IPC compared to standard care and the (absolute) costs of running IPC. This is reported per site, per year, per user and in total over the three years since IPC was launched. These estimates represent the expected cost of implementing IPC in any new sites, which, with all the caveats noted, might be used as a basis for decisions around budgeting.

5.50 Our estimates assumed that the differences in costs were only those in the set-up and the additional running costs of IPC. If, however, IPC resulted in different usage of health and/or social care resources, the minimal differential benefits would be biased. The impact evaluation evidence suggests that this may indeed have happened, as described in the next Chapter.

6. Impact evaluation

Introduction

6.1 This chapter reports on the impacts of IPC as experienced by service users. It draws on the:

- Self-completion surveys of service users, which provided data in response to three standard tools (EQ5DL, WEMWBS and ASCOT) and some additional subject specific questions
- Qualitative interviews with 42 service users and carers from eight sites. These are used to illustrate and amplify points from the survey data.

Characteristics of the service users

6.2 Overall, 499 service users completed a baseline questionnaire, from across 15 sites. A follow-up questionnaire was completed by 138 of these, from 11 sites, giving a follow-up rate of 28 per cent.

6.3 The interval between the baseline and follow-up varied considerably from three months to 16 months (measured from the 5th and 95th percentiles to exclude outliers many of which will be simple data entry errors). The median interval was nine months.

6.4 Table 6-1 below shows the profile of service users completing the baseline and follow-up questionnaires, with the final column showing the follow-up percentage per group. **Overall the profile of service users in the follow-up data-set was very similar to that of the baseline**, suggesting that the fairly low follow-up rate did not introduce major biases. The only very marked differences were that White service users were more likely to complete the follow-up than those from black and minority ethnic groups, and those where the personalised care and support plan field had been completed at baseline (whether it be yes or no) were more likely to complete a follow-up than those where this field was left blank.

6.5 In terms of the profile of service users completing the baseline, there were very few completions by users in the Child/YP with complex needs or Learning Disabilities groups (3 and 16 respectively), so the analysis of change between baseline and follow-up can only be considered to represent change for the Long-Term Health Condition and Mental Health Needs groups.

6.6 Beyond this, most notably the population was relatively elderly, with 49 per cent retired, 47 per cent over the age of 64, and 13 per cent over the age of 84. The mean age is 62. The age distribution was highly correlated with condition: 57 per cent of those with a long-term health condition were aged 65 and over (mean age of 66), compared to just 20 per cent of those with mental health needs (mean age of 51).

Table 6-1: Profile of service users completing the questionnaires

	All at baseline	Those completing follow-up	*Percentage completing follow-up*[36]
Baseline characteristic	%	%	*%*
Condition			
Child/YP with complex needs	1	0	-
Long term health condition	65	64	*29*
Learning disabilities	3	4	-
Mental health needs	51	47	*26*
Gender			
Male	56	57	*27*
Female	44	43	*29*
Age			
Under 24	3	1	-
25-34	8	7	*27*
35-44	11	7	*17*
45-54	17	17	*29*
55-64	15	18	*33*
65-74	15	17	*31*
75-84	19	25	*36*
85 and over	13	9	*19*
Ethnic group			
White	78	86	*31*
Asian/Asian British	6	2	*7*
Black/Black British	9	5	*16*
Mixed	3	4	-
Other/not stated	4	3	-
Employment status			
Retired	49	52	*31*
Unemployed	25	23	*27*
On benefits	16	15	*28*
Other/not stated	11	10	*27*
Budget status at baseline			
Council funded PHB	1	1	-
Direct payment	22	23	*28*
Notional budget	2	6	-
Third party payment	1	2	-
No budget allocated	36	37	*29*
Not known	39	32	*23*
Care plan at baseline			
Yes	47	56	*33*
No	4	5	*33*
Not stated	49	39	*22*

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[36] Only calculated where the base is greater than or equal to 2036

	Mean (sd)	Mean (sd)
Baseline WEMWBS	41.2 (13.5)	42.1 (12.2)
Baseline EQ-5D-5L	2.6 (1.1)	2.7 (1.0)
Baseline EQ-VAS	46.5 (23.8)	49.8 (22.7)
Baseline ASCOT	0.62 (0.30)	0.64 (0.28)
Base:	*499*	*138*

Source: BPSR analysis of the IPC outcome measures questionnaire

Service users' experience of IPC

6.7 At the follow-up stage, service users were asked to complete a set of questions about their views and experiences of the IPC process. Seventy-one service users completed the questions and their responses are summarised in Table 6-2. Reporting on differences in views across sub-groups is limited by the small sample sizes, but we have provided a breakdown for those with mental health conditions and those with long-term health conditions. The pattern of results was very similar across both sub-groups, and so the text below focusses on all service users replying to the questions. There was a high proportion of 'prefer not to say' on all questions.

6.8 Overall, service users were positive about their experiences. **Over half (55 per cent) agreed or agreed strongly that the conversation to develop their personalised care and support plan was different to before**. Most others did not agree or disagree (30 per cent), with only seven per cent disagreeing or disagreeing strongly. In turn, a majority felt that the conversation they had was better than before, with 35 per cent saying it was a lot better and a further 24 per cent saying it was better. Only four per cent said that it was worse. Over half (52 per cent) of service users agreed strongly with the statement "My views were fully taken in to consideration in developing my personalised care and support plan", with a further 20 per cent agreeing slightly.

6.9 The majority of service users were also positive about their new personalised care and support plan in comparison to their last. A quarter (26 per cent) felt that it gave them a lot more support than before and 31 per cent felt it gave them a little more. Four per cent felt that it gave them less support than before and 19 per cent preferred not to answer the question, which might be interpreted as negative. Most felt that the care package they had was different to before: 30 per cent thought it was very different and 29 per cent thought it was a bit different. A fifth (22 per cent) felt that it was the same as before.

6.10 The respondents to our qualitative work also reported improvements in care and support since involvement with IPC. Some of these improvements included access to new services; specific examples were physio sessions, gym membership, dieticians, counselling and weight management advice. Access to new groups and activities were also cited as benefits of IPC.

6.11 These new services were often provided by the voluntary sector or community groups and included events such as breakfast clubs, dementia cafes and singing groups, and typically, but not exclusively, related to people with dementia. In one site, people with mental health issues identified a long-standing local support centre as key in providing them with help in a variety of ways, ranging from housing repairs to employment support. Although the centre had been in existence for a long time, respondents reported that since IPC it had been able to fund and offer a wider range of activities. Many participants who had made contact with these organisations or joined local groups did so because they were signposted to them as part of the IPC process. In these cases, although the organisations and groups existed pre-IPC, respondents had not accessed them, most likely because they did not know about them or did not know how to approach them.

6.12 Improvements also came from more flexible responses from professionals responsible for assisting with care arrangements. Service users also spoke positively about the level of financial support available, particularly people with CHC funding.

6.13 When asked how long they had had the care package, service users provided a range of responses, from within the last month (22 per cent) to within the last six months (22 per cent). However, a third (33 per cent) said that they were still waiting for their new care package.

6.14 For a quarter (27 per cent) of service users, this was the first time they had had a Personal Budget, while, for 41 per cent, it was not.

6.15 There was a range of responses when service users were asked whether there had been joint or separate planning across the different health and social care services, with 21 per cent saying that it was done jointly, 24 per cent saying separately and the remainder not knowing or preferring not to say. This level of uncertainty regarding the sources of funding was replicated in the qualitative work.

Table 6-2: Service user views of the IPC

	Total	Mental health condition	Long-term health condition
	%	%	%
“The conversation to develop my care plan was different to those I’d had before”			
Agree strongly	41	40	38
Agree slightly	14	19	11
Neither agree nor disagree	30	21	36
Disagree slightly	3	5	2
Disagree strongly	4	7	4
Prefer not to say	8	7	9
“The conversation to develop my care plan was”			
A lot better than those I had before	35	36	31
Better than those I had before	24	29	22
The same as those I had before	22	14	24
Worse than I had before	3	5	4
A lot worse than I had before	1	2	2
Prefer not to say	15	14	17
“My views were fully taken in to consideration in developing my care plan”			
Agree strongly	52	52	51
Agree slightly	20	26	15
Neither agree nor disagree	11	5	13

Disagree slightly	0	0	0
Disagree strongly	4	7	6
Prefer not to say	13	10	15
"My new care plan provides me with:"			
Overall a lot more care and support than before	26	24	20
A bit more care and support than before	31	32	33
About the same amount of care and support	19	20	20
A bit less care and support than before	1	2	2
A lot less care and support than before	3	2	2
Prefer not to answer	19	20	24
"My new care plan provides me with:"			
A very different package of support to that I had before	30	27	25
A slightly different package of support to what I had before	29	34	33
The same support as I had before	22	24	19
Prefer not to answer	19	15	23
"If you have a new care plan, when did you start receiving your new care plan?"			
Within the last month	22	20	21
Within the last 3 months	9	10	8
Within the last 6 months	20	29	17
Still not receiving the new care plan	16	20	13
Prefer not to answer	33	22	40
"If you have a personal budget, is this the first time that you have had a personal budget?"			
Yes	27	29	16
No	41	37	43
Prefer not to answer	38	34	41
"Thinking about the different health and social care services that you require did the conversation and support planning take place jointly across all services or was each service dealt with separately?"			
Jointly	21	20	20
Separately	24	18	25
Don't know	34	43	33
Prefer not to answer	21	20	22
Base: service users answering perception questions	*71*	*42*	*53*

Source: BPSR analysis of the IPC outcome measures questionnaire

Reported number of new personalised care and support plans and budgets

6.16 At the baseline and nine-month follow up practitioners recorded whether service users had a personalised care and support plan in place. They also recorded the status of any budget they had. In order to look at change in the proportion of service users with personalised care and support plans and personal budgets at the nine-month follow-up, we have restricted our reporting to those 138 service users who completed a follow-up questionnaire (Table 6-3). **At baseline, 56 per cent of service users had a personalised care and support plan in place and 23 per cent had a personal budget. By the follow-up, the proportions had risen to 67 per cent (a 12 percentage point increase) and 41 per cent (a 17 percentage point increase) respectively**.[37]

6.17 When we focus on those with mental health and long-term health conditions (as recorded at baseline), the proportion of users with personalised care and support plans is a few percentage points higher, at baseline and follow up. Sixty-three per cent of service users with a mental health condition had a personalised care and support plan at baseline, rising to 80 per cent at follow up. Likewise, 61 per cent of those with a long-term health condition had a personalised care and support plan at baseline and 74 per cent had one at follow-up.[38]

6.18 Considering personal budgets, those with mental health condition were more likely than those with a long-term health condition to have a personal budget, both at baseline (28 per cent compared to 19 per cent) and follow up (52 per cent compared to 45 per cent).

Table 6-3: Personalised Care and support plans and Personal Budgets

	Total	Mental health condition	Long-term health condition
	%	%	%
Personalised Care and support plans			
Already had at baseline	56	63	61
Had by nine-month follow up	67	80	74
Personal budgets			
Already had at baseline	23	28	19
Had by nine-month follow up	41	52	45
Base: service users completing follow-up questionnaire	*138*	*65*	*93*

Source: BPSR analysis of the IPC outcome measures questionnaire

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[37] Where service users were reported as having a personalised care and support plan at baseline but not at follow up, these have been coded as having a personalised care and support plan (on the assumption that this is due to miscoding and they would not have a personalised care and support plan removed). So, having a personalised care and support plan at follow up has been derived as having personalised care and support plan at either baseline or at follow up. Those with missing data at both baseline and follow up are assumed not to have a personalised care and support plan. The same approach has been taken to calculating the proportion of service users with personal budgets at follow up.

[38] There was no condition code for 15 of the 138 service users. None of these are reported as having a personalised care and support plan at baseline or follow-up, which explains why the percentages are lower among all service users than among those with a mental health or long-term health condition. The pattern is very similar for personal budgets – only one service user with no condition code was reported as having a personal budget.

Change in health, well-being and social care outcomes

6.19 Service users were asked to complete a short questionnaire that included three standardised tools, each involving a series of questions designed to measure health, well-being and social care outcomes. By comparing service users' scores on each of these three scales at the start and end of the process, we could measure how far they changed over the period. Again, we restricted our analysis to the 138 service users who completed both the baseline and the follow-up questionnaire. As discussed in Chapter 2 on methodology without a comparison group of similar service users who did not go through the IPC, we cannot attribute with certainty any changes in health, well-being or social care outcomes to the IPC. However, we have reported on the statistical significance of any individual-level changes, testing for whether the change is statistically greater than zero at the 5% significance level.

6.20 The sections below report on changes in outcomes approximately nine months after starting IPC support. Within each section, the first table (i.e. Table 6-4, Table 6-6 and Table 6-8) sets out the distribution of outcomes at the baseline and follow up, allowing us to look at the aggregate change across the service users providing baseline and follow-up data. The later Table 6-5, Table 6-7 and Table 6-9in each section, detail the proportion of service users whose outcomes improved, deteriorated or remained static across the two time points.

Changes in health outcomes (EQ5DL)

6.21 The EQ5D-5L is a standardised measure of health status.[39] It comprises five questions, each of which asks about a different aspect of someone's health, as shown in Table 6-4. Focussing on how they feel today, service users are asked to use a five-point scale to rate themselves as having no problems or issues (1), or to it being debilitating (5). As well as being used as individual variables, responses to the five questions can be aggregated to provide an overall health score from 1 to 5, where a higher score denotes worse health. An additional question, the EQVAS, asks service users to rate from 0 to 100 how good or bad their health is on that day, with 0 denoting the worst health they can imagine and 100 denoting the best health.

6.22 Table 6-4 shows the baseline and follow-up scores for the service users who completed questionnaires at both time points. **The mean score of their self-reported health (the EQVAS scale) was 50 (out of a possible 100) at baseline and 52 at follow-up. Likewise, the mean score on the EQ5DL scale (the aggregate score across the five questions) was in the middle of the scale at baseline (2.8 out of 5) and follow-up (2.7).**

6.23 Assessing the responses to the five EQ5DL questions where service users report severe or extreme issues, service users often reported mobility problems and pain, at both baseline and follow up. For instance, 10 per cent of service users reported they were unable to walk and a further 29 per cent said they had severe problems in walking about at baseline. Seven per cent of service users reported extreme pain or discomfort at baseline and a further 26 had severe pain or discomfort. Three in ten service users reported difficulties in doing everyday activities (five per cent unable and 25 per cent with severe difficulties at baseline). In addition, a quarter reported extreme (11 per cent) or severe (14 per cent) anxiety and depression at baseline. The health dimension reported by the fewest service users at baseline was issues with self-care, where five per cent reported being unable to wash and dress themselves and 12 per cent reported severe problems at baseline.

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[39] The numbers of young people completing the youth version were too small to report on.

Table 6-4: EQ5DL health rating at baseline and follow-up

	Baseline	Follow-up
EQVAS health score (0 to 100, higher score better), mean	49.8 (sd 22.7)	52.2 (sd 23.6)
Base: service users answering EQVAS	*130*	*131*
EQ5DL scale (1 to 5, higher score worse), mean	2.8 (sd 0.8)	2.7 (sd 0.9)
Base: service users answering all EQD5L items	*132*	*131*
Mobility	%	%
I have no problems in walking about	16	16
I have slight problems in walking about	19	18
I have moderate problems in walking about	27	28
I have severe problems in walking about	29	29
I am unable to walk about	10	9
Base: service users answering EQD5L mobility item	*134*	*134*
Self-care		
I have no problems washing or dressing myself	34	41
I have slight problems washing or dressing myself	25	23
I have moderate problems washing or dressing myself	24	15
I have severe problems washing or dressing myself	12	10
I am unable to wash or dress myself	5	11
Base: service users answering EQD5L self-care item	*134*	*134*
Usual activities		
I have no problems doing my usual activities	8	17
I have slight problems doing my usual activities	26	24
I have moderate problems doing my usual activities	36	32
I have severe problems doing my usual activities	25	15
I am unable to do my usual activities	5	13
Base: service users answering EQD5L activities item	*133*	*135*
Pain/discomfort		
I have no pain or discomfort	14	16
I have slight pain or discomfort	18	20
I have moderate pain or discomfort	34	31
I have severe pain or discomfort	26	26
I have extreme pain or discomfort	7	8
Base: service users answering EQD5L pain item	*134*	*133*
Anxiety/depression		
I am not anxious or depressed	21	17
I am slightly anxious or depressed	23	28

I am moderately anxious or depressed	30	37
I am severely anxious or depressed	14	10
I am extremely anxious or depressed	11	8
Base: service users answering EQD5L anxiety item	*133*	*135*

Source: BPSR analysis of the IPC outcome measures questionnaire

6.24 Table 6-4 shows that there were no statistically significant improvements, or deterioration, between the baseline and the (median) nine-month follow up. The change in mean score for the EQVAS and EQ5DL scales is simply the difference between the baseline and follow-up scores reported in Table 6-4, with positive change for the EQVAS, and negative change for the EQ5DL, denoting that things are better at follow-up than baseline. The mean difference on the EQVAS score was 2.34 (on a scale from 0 to 100) and it was -0.08 for the EQ5DL score (scale 1 to 5), neither of which are statistically significant improvements.

6.25 Table 6-5 also groups service users into those whose scores deteriorated, stayed the same or improved from baseline to follow-up, not only for the EQVAS and EQ5DL score but also for the five individual EQ5D questions. None of the changes were statistically significant. Although substantial proportions reported improvements across each of the dimensions, the proportions reporting deterioration, or no change meant that overall there were no significant differences between the distribution of responses at baseline and follow-up. For example, 44 per cent of service users scored higher on the EQVAS scale at follow-up than they did at baseline. However, 39 per cent scored lower and 17 per cent stayed the same. Across the five individual EQ5DL questions around half of service users reported that their issues were the same at follow-up as at baseline (e.g. 51 per cent gave the same rating for their mobility issues at baseline and follow up; 46 per cent did so for their level of pain or discomfort). Between a quarter and a third of service users rated their issue at follow up as more or less severe than at baseline (e.g. 26 per cent reported improvement in their mobility issues and 23 per cent reported deterioration).

Table 6-5: EQ5DL health rating, individual level change from baseline to follow-up

	Change	**P-value**
Mean difference in EQVAS health score (positive change is improvement)	2.34 (sd 24.11)	0.278
	%	
Deteriorated	39	0.497
Stayed the same	17	
Improved	44	
Base: service users completing EQVAS at baseline and follow up	*128*	
Mean difference in EQ5DL scale (negative change is improvement)	-0.08 (sd 0.64)	0.173
	%	
Deteriorated	41	0.351
Stayed the same	11	
Improved	48	
Base: service users completing EQ5DL at baseline and follow up	*138*	

Mobility		0.711
Deteriorated	23	
Stayed the same	51	
Improved	26	
Base: service users completing EQ5DL mobility at baseline and follow up	*132*	
Self-care		0.387
Deteriorated	22	
Stayed the same	50	
Improved	28	
Base: service users completing EQ5DL self-care at baseline and follow up	*130*	
Usual activities		0.367
Deteriorated	27	
Stayed the same	40	
Improved	33	
Base: service users completing EQ5DL activities at baseline and follow up	*131*	
Pain/discomfort		0.475
Deteriorated	25	
Stayed the same	46	
Improved	29	
Base: service users completing EQ5DL pain at baseline and follow up	*130*	
Anxiety/depression		0.727
Deteriorated	27	
Stayed the same	45	
Improved	29	
Base: service users completing EQ5DL anxiety at baseline and follow up	*132*	

Source: BPSR analysis of the IPC outcome measures questionnaire

Changes in wellbeing outcomes (Warwick Edinburgh Mental Wellbeing Scale)

6.26 Service users' well-being was measured using the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS). This is a 14-item scale which measures positive well-being (that is, all items are worded positively). Service users score between 14 and 70, with a higher score indicating greater levels of well-being.

Below are some statements about feelings and thoughts.
Please tick or circle the box that best describes your experience of each over the last 2 weeks

a. I've been feeling optimistic about the future
b. I've been feeling useful
c. I've been feeling relaxed
d. I've been feeling interested in other people
e. I've had energy to spare
f. I've been dealing with problems well
g. I've been thinking clearly
h. I've been feeling good about myself
i. I've been feeling close to other people
j. I've been feeling confident
k. I've been able to make up my own mind about things
l. I've been feeling loved
m. I've been interested in new things
n. I've been feeling cheerful

Response codes:
None of the time
Rarely
Some of the time
Often
All of the time

6.27 Table 6-6 shows the mean scores of service users at baseline (42 out of a possible 70) and follow-up (43). We also grouped service users based on their scores into low (score 14 to 41), middle (42 to 57) and high (58 to 70) well-being. At both baseline and follow up half of service users are categorised as having low well-being (48 per cent at baseline and 49 per cent at follow up), four in ten are in the middle category (39 per cent at baseline and 40 per cent at follow up) and around one in tend are categorised as having high levels of well-being (13 per cent at follow up and 11 per cent at baseline).

Table 6-6: Warwick Edinburgh wellbeing rating at baseline and follow-up

	Baseline	Follow-up
WEMWBS score (14 to 70, higher score better), mean	42.1 (sd 12.2)	43.3 (sd 11.5)
	%	%
Low well-being	48	49
Middle well-being	39	40
High well-being	13	11
Base: service users completing WEMBWS	*127*	*130*

Source: BPSR analysis of the IPC outcome measures questionnaire

6.28 Comparing well-being scores at baseline and follow-up in Table 6-6, we see no statistically significant change. Half (54 per cent) of service users had a higher score at follow-up than at baseline, but for 43 per cent it was lower and for seven per cent it was the same. Given 'notable change' is sometimes measured as change of three points or more[40], Table 6-7 also shows these proportions: 41 per cent saw an improvement of three points or more, 35 per cent saw a deterioration and 24 per cent saw no change. Again, overall, this is not a statistically significant level of change.

Table 6-7: Warwick Edinburgh wellbeing rating, individual level change from baseline to follow-up

	Change	p-value
Mean difference in WEMWBS score (positive change is improvement)	0.82 (sd 11.97)	0.454
	%	
Deteriorated	43	0.399
Stayed the same	7	
Improved	50	
Deteriorated by three points or more	35	0.406
Stayed the same within three points	24	
Improved by three points or more	41	
Base: service users completing WEMWBS at baseline and follow up	*121*	

Source: BPSR analysis of the IPC outcome measures questionnaire

Changes in social care outcomes (ASCOT Scale)

6.29 The Adult Social Care Outcomes Toolkit (ASCOT) is designed to measure the aspects of an individual's quality of life that can be affected by social care. It includes nine questions, the responses to eight of which (excluding 'having help') are used to form an overall ASCOT scale, scoring quality of life from 0 to 1, with higher scores denoting better quality of life. The questions and answers categories are phrased in the language of capabilities at the high end of the quality of life spectrum, and in terms of functioning when reflecting low quality of life.

6.30 Table 6-8 shows the mean score of the ASCOT scale at baseline and follow up (0.64 and 0.68 respectively, on a scale from 0 to 1), together with the baseline and follow-up responses to each question.[41] The areas of life where the greatest proportion of service users report issues are in how they spend their time (12 per cent report not doing anything they enjoy or value) and 51 per cent say they do some but not enough); their levels of social contact (11 per cent report having little social contact and feeling socially isolated and 32 per cent have some but not enough); and their control over daily life (seven per cent report having no control and 40 per cent report having some but not enough).

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[40] https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/about/wemwbsvsswemwbs/

[4141] The numbers of service users completing the ASCOT Easy Read version were too small to report on.

Table 6-8: ASCOT social care rating at baseline and follow-up

	Baseline	Follow-up
ASCOT scale (0 to 1, higher score better), mean	0.64 (sd 0.28)	0.68 (0.24)
Base: service users completing all items of ASCOT scale	*125*	*120*
Control over daily life	%	%
I have as much control over my daily life as I want	30	26
I have adequate control over my daily life	22	33
I have some control over my daily life, but not enough	40	38
I have no control over my daily life	7	4
Base: service users completing control item	*129*	*125*
Clean and presentable appearance		
I feel clean and am able to present myself the way I like	47	50
I feel adequately clean and presentable	32	34
I feel less than adequately clean or presentable	19	14
I don't feel at all clean or presentable	2	2
Base: service users completing cleanliness item	*129*	*124*
Food and drink		
I get all the food and drink I like when I want	53	58
I get adequate food and drink at OK times	24	29
I don't always get adequate or timely food and drink	18	12
I don't always get adequate or timely food and drink, and I think there is a risk to my health	5	2
Base: service users completing food and drink item	*131*	*125*
Safety		
I feel as safe as I want	39	42
I feel adequately safe, but not as safe as I would like	43	41
I feel less than adequately safe	14	14
I don't feel at all safe	4	3
Base: service users completing safety items	*130*	*125*
Social contact		
I have as much social contact as I want with people I like	27	29
I have adequate social contact with people	22	29
I have some social contact with people, but not enough	32	30
I have little social contact with people and feel socially isolated	18	12
Base: service users completing social contact item	*130*	*125*
How spend time		

I'm able to spend my time as I want, doing things I value or enjoy	19	23
I'm able to do enough of the things I value or enjoy with my time	18	18
I do some of the things I value or enjoy with my time, but not enough	51	50
I don't do anything I value or enjoy with my time	12	10
Base: service users completing spending time item	*130*	*125*
Clean and comfortable home		
My home is as clean and comfortable as I want	57	58
My home is adequately clean and comfortable	24	30
My home is not quite clean or comfortable enough	16	10
My home is not at all clean or comfortable	2	2
Base: service users completing home item	*129*	*125*
Having help		
Having help makes me think and feel better about myself	53	51
Having help does not affect the way I think or feel about myself	24	24
Having help sometimes undermines the way I think and feel about myself	19	22
Having help completely undermines the way I think and feel about myself	4	2
Base: service users completing help item	*128*	*123*
How helped and treated		
The way I'm helped and treated makes me think and feel better about myself	50	55
The way I'm helped and treated does not affect the way I think or feel about myself	26	23
The way I'm helped and treated sometimes undermines the way I think and feel about myself	20	20
The way I'm helped and treated completely undermines the way I think and feel about myself	3	2
Base: service users completing treatment item	*129*	*122*

Source: BPSR analysis of the IPC outcome measures questionnaire

6.31 In contrast to the change scores for health or well-being, there was a statistically significant improvement in service users' social care-related quality of life, with a positive mean score difference of 0.05 within the 0 to 1 scale (Table 6-9). For six in ten (60 per cent), their follow-up mean score was higher than their baseline score, compared to 38 per cent for whom it was lower and three per cent where it was the same. Across all measures, there was no change between baseline and follow-up for around half of service users (from 42 per cent in relation to social contact, to 66 per cent in relation to having a clean and presentable home).

Table 6-9: ASCOT rating, individual level change from baseline to follow-up

	Change	p-value
Mean difference in ASCOT score (positive change is improvement)	0.05 (sd 0.22)	0.021*
	%	
Deteriorated	38	0.019*

Stayed the same	3	
Improved	60	
Base: service users completing full ASCOT scale at baseline and follow up	*109*	
Control over daily life		0.812
Deteriorated	29	
Stayed the same	41	
Improved	30	
Base: service users completing control item at baseline and follow up	*119*	
Clean and presentable appearance		0.347
Deteriorated	21	
Stayed the same	53	
Improved	26	
Base: service users completing cleanliness item at baseline and follow up	*117*	
Food and drink		0.074
Deteriorated	17	
Stayed the same	55	
Improved	28	
Base: service users completing food and drink item at baseline and follow up	*119*	
Safety		0.190
Deteriorated	20	
Stayed the same	51	
Improved	29	
Base: service users completing safety item at baseline and follow up	*119*	
Social contact		0.280
Deteriorated	25	
Stayed the same	42	
Improved	33	
Base: service users completing social contact item at baseline and follow up	*119*	
How spend time		0.190
Deteriorated	20	
Stayed the same	51	
Improved	29	
Base: service users completing spending time item at baseline and follow up	*119*	
Clean and comfortable home		0.529

Deteriorated	15	
Stayed the same	66	
Improved	19	
Base: service users completing home item at baseline and follow up	*118*	
Having help		0.380
Deteriorated	30	
Stayed the same	45	
Improved	24	
Base: service users completing help item at baseline and follow up	*115*	
How helped and treated		0.682
Deteriorated	22	
Stayed the same	54	
Improved	24	
Base: service users completing treatment item at baseline and follow up	*115*	

Source: BPSR analysis of the IPC outcome measures questionnaire

6.32 Many service users, interviewed in the qualitative work, spoke about improvements in opportunities for social engagement, including opportunities to get out of the house, meet people and make friends. People with mental health problems spoke about feeling comfortable joining clubs and sporting activities specifically for people with mental health issues; one woman commented that in these groups she felt she was among people she could trust. Sometimes service users talked about improved well-being and reduced social isolation as a direct result of having a PHB. For example, a young man used part of his CHC PHB to employ PAs his own age; this helped him to join in everyday activities for people his age, such as trips to the local town. He also joined a new tennis club which enabled him to make new friends and build confidence by helping others. These benefits are, of course, dependent on the resources available, but in other ways link to the wider social prescribing agenda.

Differential change in outcomes across different subgroups

6.33 The section below reports on the changes reported by particular sub-groups of service users: those with and without Personal Budgets and personalised Care and support plans; those with Long-term Health Conditions and with Mental Health conditions; men and women; and service users under and over the age of 65.

6.34 The modest numbers of service users providing both baseline and follow-up data meant that our ability to look at change across different population sub-groups was limited. However, in the sections below, we report on differences in terms of:

- Health conditions - those with a mental health condition and those with a long-term health condition
- Whether or not they have a personalised care and support plan
- Whether or not they have a personal budget
- Gender
- Age.

6.35 We concentrate on change in the aggregate scales rather than the individual items of the EQ5DL, WEMBWS or ASCOT.

6.36 Two sets of p-values are presented. The first (labelled 'p-value for test of change being different to zero') shows whether, within the particular sub-group, there is evidence of change between baseline and follow-up. The second (labelled 'p-value for test of difference between groups') shows whether there is evidence that the change is significantly different between the groups. It is possible for change in one group to be significant and not in the other but for there still to be no significant difference between the groups.

By health condition

6.37 Table 6-10 shows the mean score change in self-reported health (EQVAS), health (EQ5DL), well-being (WEMBWS) and social care-related quality of life (ASCOT) for those with mental health conditions and those with long-term health conditions. Note there is a large overlap in these two groups with 58 per cent of those recorded as having a mental health condition also being recorded as having a long-term health condition, and 41 per cent of those recorded as having a long-term health condition also being recorded as having a mental health condition. Inevitably any differences between these groups will be relatively small, as a result of this overlap.

6.38 Nevertheless, while there are no significant changes for the service users with long-term health conditions, those with mental health conditions exhibited statistically positive improvements in their ASCOT quality of life scores, with 69 per cent scoring better at follow-up than baseline, 29 per cent scoring worse and two per cent remaining the same. The difference between the two groups is statistically significant on this measure. Furthermore, although not shown in the table, for the individual EQ5DL questions there is a significant improvement for the mental health question on anxiety and depression (36 per cent improved, 48 per cent stayed the same, and 16 per cent deteriorated, p=0.033).

Table 6-10: Individual level change from baseline to follow-up by health condition

	Mental health condition		**Long-term health condition**		
	Change	**p-value for test of change being different to zero**	**Change**	**p-value for test of change being different to zero**	**p-value for test of difference between groups**
Mean difference in EQVAS health score (positive change is improvement)	2.51 (sd 21.43)	0.381	0.30 (sd 22.77)	0.903	0.371
	%		%		
Deteriorated	35	0.252	43	0.728	0.387
Stayed the same	16		17		
Improved	49		40		
Base: service users completing EQVAS at baseline and follow up	*57*		*88*		

Mean difference in EQ5DL scale (negative change is improvement	-0.09 (sd 0.65)	0.300	-0.04 (sd 0.66)	0.526	0.421
	%		%		
Deteriorated	39	0.341	44	0.912	0.395
Stayed the same	10		10		
Improved	51		46		
Base: service users completing EQ5DL at baseline and follow up	*59*		*90*		
Mean difference in WEMWBS score (positive change is improvement)	1.13 (sd 13.03)	0.498	-0.48 (sd 11.60)	0.706	0.164
	%		%		
Deteriorated	37	0.147	49	0.738	0.081
Stayed the same	8		5		
Improved	55		46		
Deteriorated by three points or more	29	0.182	37	0.899	0.330
Stayed the same within three points	27		27		
Improved by three points or more	44		36		
Base: service users completing WEMWBS at baseline and follow up	*62*		*83*		
Mean difference in ASCOT score (positive change is improvement)	0.08 (sd 0.24)	0.014*	0.01 (sd 0.19)	0.538	0.009*
	%		%		
Deteriorated	29	0.002*	43	0.302	0.065
Stayed the same	2		3		
Improved	69		55		
Base: service users completing ASCOT at baseline and follow up	*58*		*77*		

Source: BPSR analysis of the IPC outcome measures questionnaire

6.39 Reports of improvements in mental health and well-being were very common across the qualitative interviews, providing some greater confidence in the quantitative results. Sometimes these improvements resulted from sporting and other activities described above. For example, people experiencing weight loss also reported feeling more confident. Confidence also came from speaking regularly with different professionals about care and budgets. The use of PHBs to employ PAs and manage large care packages also contributed to people's sense of worth and self-esteem. In addition, social engagement activities (described above as increasing) added to people's mental well-being.

6.40 Related to mental well-being, service users reported that the care and support they received assisted them to feel 'normal' or to lead a 'normal life' by taking part in everyday activities, such as going to the cinema or meeting friends. Partly this was because of the flexibility of employing PAs rather than care agencies that offered only fixed hours, and partly it was about taking part in activities with like-minded people. Empowerment, control and flexibility featured strongly, with service users also talking about being able to take a more holistic view of their lives in the personalised care and support planning process. A mother spoke about her disabled son's motivation for life increasing again through the IPC process after a decline in well-being following his transition from children to adult's services.

By whether or not have a personalised care and support plan and by perceived quality of the personalised care and support plan

6.41 Service users with a personalised care and support plan (at either baseline or follow-up) scored statistically significantly better at follow-up compared to baseline on the ASCOT quality of life scale, with no such significant change for those without a plan (Table 6-11). Conversely, the well-being scores of those where there is no record of them having a personalised care and support plan improved significantly from baseline to follow-up, with 61 per cent scoring better, 31 per cent scoring worse and eight per cent scoring the same. There was no significant change in well-being among those with a personalised care and support plan. The differences between the two groups were, however, statistically significant.

Table 6-11: Individual level change from baseline to follow-up by whether or not have a personalised care and support plan

	Have a personalised care and support plan		Do not or not answered		
	Change	p-value for test of change being different to zero	Change	p-value for test of change being different to zero	p-value for test of difference between groups
Mean difference in EQVAS health score (positive change is improvement)	4.07 (sd 23.37)	0.106	-0.166 (sd 25.60)	0.692	0.222
	%		%		
Deteriorated	41	0.500	34	0.850	0.051
Stayed the same	11		29		
Improved	48		37		
Base: service users completing EQVAS at baseline and follow up	*88*		*38*		
Mean difference in EQ5DL scale (negative change is improvement	-0.04 (sd 0.63)	0.566	-0.17 (sd 0.69)	0.133	0.292
	%		**%**		
Deteriorated	44	0.825	33	0.173	0.534
Stayed the same	10		13		
Improved	46		54		
Base: service users completing EQ5DL at baseline and follow up	*89*		*39*		
Mean difference in WEMWBS score (positive change is improvement)	-0.38 (sd 12.55)	0.783	3.64 (sd 10.09)	0.037*	0.092
	%		%		
Deteriorated	48	0.825	31	0.054	0.199

Stayed the same	6		8		
Improved	46		61		
Deteriorated by three points or more	40	0.807	22	0.048*	0.170
Stayed the same within three points	22		28		
Improved by three points or more	38		50		
Base: service users completing WEMWBS at baseline and follow up	*85*		*36*		
Mean difference in ASCOT score (positive change is improvement)	0.04 (sd 0.21)	0.091	0.07 (sd 0.23)	0.108	0.485
	%		%		
Deteriorated	38	0.043*	37	0.247	0.941
Stayed the same	2		4		
Improved	60		59		
Base: service users completing ASCOT at baseline and follow up	*82*		*27*		

Source: BPSR analysis of the IPC outcome measures questionnaire

6.42 Those with a personalised care and support plan were asked to rate the care and support this gave them relative to before IPC. The sample sizes were very small, but the table below compares change scores for four groups:

- those saying the personalised care and support plan provides 'overall a lot more care and support than before' (n=18)
- those saying the personalised care and support plan provides 'a bit more care and support than before' (n=21) or 'about the same amount of care and support' (n=13, n=34 overall)
- those saying the personalised care and support plan gave less care and support than before (n=3) or who chose not to answer the question (n=13, n=16 overall)
- those with no record of having yet received a personalised care and support plan (n=33)[42].

6.43 The differences in change scores between these four groups is significant for EQ5DL and for well-being (WEMWBS). The general pattern is that there was marked improvement in scores for those saying their personalised care and support plan gave them a lot more care and support, whereas scores deteriorated for those saying the personalised care and support plan gave less care and support or those who declined to answer the question. This suggests that to drive improvements in health and well-being the personalised care and support plans must be considerable improvements on any pre-IPC plans.

6.44 Notably, the change scores for those where there is no record of a personalised care and support plan being in place are most similar to the change scores for the group saying their personalised care and support plan gave them a lot more care and support. It is not clear what

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[42] Note this is a slightly different sample to those without a personalised care and support plan in the table above, because a small number of those without record of a personalised care and support plan answered the personalised care and support plan questions.

was behind this, but it is possible that the personalised care and support plans for this group are taking longer to put in place giving more time to meet the needs of patients.

Table 6-12: Individual level change from baseline to follow-up by health condition

	A lot more care and support than before	**A bit more or same care and support as before**	**Less care and support or declined to answer**	**No personalised care and support plan recorded**	**p-value for test of difference between groups**
Mean difference in EQVAS health score (positive change is improvement)	0.36	2.53	-12.56	0.25	0.156
	%	%	%	%	0.095
Deteriorated	36	44	63	32	
Stayed the same	21	6	25	29	
Improved	43	50	13	39	
Mean difference in EQ5DL scale (negative change is improvement	-0.27	0.04	0.34	-0.23	0.013*
	%	%	%	%	0.023*
Deteriorated	21	44	63	35	
Stayed the same	0	19	19	7	
Improved	79	38	19	59	
Mean difference in WEMWBS score (positive change is improvement)	2.75	-2.94	-8.82	6.40	0.000*
	%	%	%	%	0.057
Deteriorated	38	55	73	24	
Stayed the same	6	7	7	4	
Improved	56	39	20	72	
Deteriorated by three points or more	31	45	73	16	0.004*
Stayed the same within three points	25	32	13	20	
Improved by three points or more	44	23	13	64	
Mean difference in ASCOT score (positive change is improvement)	0.02	0.04	-0.04	0.09	0.252
	%	%	%	%	0.867
Deteriorated	33	38	50	39	
Stayed the same	0	3	7	6	
Improved	67	59	43	56	

Source: BPSR analysis of the IPC outcome measures questionnaire

By whether or not have a Personal Budget

6.45 We found a similar pattern in terms of those with and without a Personal Budget (at baseline or follow-up) (Table 6-13). **There was a statistically significant improvement in ASCOT quality of life scores among those with a Personal Budget**, with the scores of 62 per cent improving, 34 per cent getting worse and four per cent remaining the same. No such significant change in quality of life was observed among those without a Personal Budget. The difference between the two groups is not, however, statistically significant.

6.46 Comparing those with a personal budget with those without, there is a significant difference between the two on EQ5D and WEMWBS change categories, with the 'no personal budget' group being most likely to have improved. This was very similar to the pattern of findings for those with and without a personalised care and support plan, and given the association between personalised care and support plans and personal budgets (nobody having a personal budget without a personalised care and support plan), it seems to be the case that the same explanation holds. That is, the personalised care and support plan group, and hence the personal budget group, included a mix of those whose experience of the personalised care and support plan was very good and whose outcomes were improved, and others with poorer experiences whose outcomes worsened. However, the very small sample sizes mean it was difficult to test this formally.

Table 6-13: Individual level change from baseline to follow-up by whether or not have a Personal Budget

	Have a Personal Budget		Do not or not answered		
	Change	p-value for test of change being different to zero	Change	p-value for test of change being different to zero	p-value for test of difference between groups
Mean difference in EQVAS health score (positive change is improvement)	4.58 (sd 20.21)	0.109	0.77 (sd 26.53)	0.803	0.385
	%		%		
Deteriorated	44	0.883	35	0.305	0.526
Stayed the same	13		19		
Improved	42		46		
Base: service users completing EQVAS at baseline and follow up	*52*		*74*		
Mean difference in EQ5DL scale (negative change is improvement	-0.03 (sd 0.63)	0.726	-0.11 (sd 0.66)	0.147	0.494
	%		%		
Deteriorated	38	0.761	42	0.349	0.043*
Stayed the same	19		5		
Improved	42		53		
Base: service users completing EQ5DL at baseline and follow up	*52*		*76*		

Mean difference in WEMWBS score (positive change is improvement)	0.02 (sd 10.36)	0.989	1.42 (sd 13.10)	0.371	0.526
	%		%		
Deteriorated	54	0.489	35	0.075	0.044*
Stayed the same	2		10		
Improved	44		55		
Deteriorated by three points or more	40	0.416	30	0.080	0.122
Stayed the same within three points	29		20		
Improved by three points or more	31		49		
Base: service users completing WEMWBS at baseline and follow up	*52*		*69*		
Mean difference in ASCOT score (positive change is improvement)	0.05 (sd 0.19)	0.057	0.05 (sd 0.24)	0.157	0.888
	%		%		
Deteriorated	34	0.034*	41	0.228	0.645
Stayed the same	4		2		
Improved	62		57		
Base: service users completing ASCOT at baseline and follow up	*53*		*56*		

Source: BPSR analysis of the IPC outcome measures questionnaire

By gender

6.47 Table 6-14 shows that there was no statistically significant change in outcomes among female service users across each of the three measures. However, there **was a statistically significant improvement in ASCOT quality of life scores among male service users**, with the scores of 63 per cent improving, 35 per cent getting worse and two per cent remaining the same. The difference between men and women was not, however, significant.

Table 6-14: Individual level change from baseline to follow-up by gender

	Men		Women		
	Change	p-value for test of change being different to zero	Change	p-value for test of change being different to zero	p-value for test of difference between groups
Mean difference in EQVAS health score (positive change is improvement)	4.09 (sd 23.46)	0.206	2.56 (sd 23.15)	0.359	0.716
	%		%		
Deteriorated	31	0.172	43	1.000	0.387
Stayed the same	20		14		
Improved	48		43		

Base: service users completing EQVAS at baseline and follow up	*54*		*70*		
Mean difference in EQ5DL scale (negative change is improvement	-0.12 (sd 0.67)	0.187	-0.07 (sd 0.61)	0.321	0.665
	%		%		
Deteriorated	39	0.659	40	0.275	0.215
Stayed the same	17		7		
Improved	44		53		
Base: service users completing EQ5DL at baseline and follow up	*54*		*72*		
Mean difference in WEMWBS score (positive change is improvement)	0.54 (sd 12.06)	0.745	1.29 (sd 11.79)	0.380	0.731
	%				
Deteriorated	44	1.000	42	0.260	0.166
Stayed the same	11		3		
Improved	44		55		
Deteriorated by three points or more	39	0.878	31	0.201	0.613
Stayed the same within three points	24		25		
Improved by three points or more	37		45		
Base: service users completing WEMWBS at baseline and follow up	*54*		*65*		
Mean difference in ASCOT score (positive change is improvement)	0.07 (sd 0.24)	0.052	0.03 (sd 0.20)	0.206	0.415
	%		%		
Deteriorated	35	0.042*	40	0.192	0.755
Stayed the same	2		3		
Improved	63		57		
Base: service users completing ASCOT at baseline and follow up	*49*		*60*		

Source: BPSR analysis of the IPC outcome measures questionnaire

By age

6.48 There was no statistically significant change in outcomes among service users aged 65 and over across each of the three measures, as shown in Table 6-15. However, **there was a statistically significant improvement in ASCOT quality of life scores among service users aged under 65**, with the scores of 64 per cent improving, 32 per cent getting worse and three per cent remaining the same. Again, this was not a statistically significant difference between the two age groups.

Table 6-15: Individual level change from baseline to follow-up by age

	Under 65		65 and over		
	Change	**p-value for test of change being different to zero**	**Change**	**p-value for test of change being different to zero**	**p-value for test of difference between groups**
Mean difference in EQVAS health score (positive change is improvement)	3.56 (sd 24.04)	0.240	1.08 (sd 24.31)	0.728	0.566
	%		%		
Deteriorated	38	0.289	40	0.888	0.313
Stayed the same	13		21		
Improved	50		39		
Base: service users completing EQVAS at baseline and follow up	*64*		*62*		
Mean difference in EQ5DL scale (negative change is improvement	-0.06 (sd 0.62)	0.426	-0.10 (sd 0.67)	0.267	0.769
	%		%		
Deteriorated	40	0.435	41	0.597	0.984
Stayed the same	11		11		
Improved	49		48		
Base: service users completing EQ5DL at baseline and follow up	*65*		*63*		
Mean difference in WEMWBS score (positive change is improvement)	1.52 (sd 11.84)	0.304	0.00 (sd 12.18)	1.000	0.488
	%				
Deteriorated	42	0.443	45	0.684	0.853
Stayed the same	8		5		
Improved	51		50		
Deteriorated by three points or more	34	0.568	36	0.551	0.831
Stayed the same within three points	26		21		
Improved by three points or more	40		43		
Base: service users completing WEMWBS at baseline and follow up	*65*		*56*		
Mean difference in ASCOT score (positive change is improvement)	0.07 (sd 0.23)	0.024*	0.02 (sd 0.20)	0.406	0.274
	%		%		

Deteriorated	32	0.011*	44	0.481	0.431
Stayed the same	3		2		
Improved	64		54		
Base: service users completing ASCOT at baseline and follow up	*59*		*50*		

Source: BPSR analysis of the IPC outcome measures questionnaire

Difference in EQ5LD and ASCOT index scores

6.49 It is possible to convert responses to both EQ5DL and ASCOT in to utility scores[43]. These were referred to in Chapter 5 in terms of the extent of change that would be required to justify the additional costs of delivering IPC. In this section, we draw on the survey responses to consider what changes have been observed.

6.50 As would be expected given the findings reported previously in this chapter, **the change score for ASCOT is significant and positive**, while EQ5DL, although showing a positive change, is not statistically significant.

Table 6-16: Change in ASCOT

	Mean	Standard deviation	N	p-value (for change scores)
Baseline (all sample)	0.621	0.299	419	
Baseline (all those with follow-up)	0.624	0.282	110	
Follow-up	0.678	0.237	110	
Change scores	0.053	0.213	110	0.01*

Source: BPSR analysis of the IPC outcome measures questionnaire

Table 6-17: Change in EQ5DL

	Mean	Standard deviation	N	p-value (for change scores)
Baseline (all sample)	0.467	0.320	466	
Baseline (all those with follow-up)	0.460	0.285	128	
Follow-up	0.490	0.303	128	
Change scores	0.030	0.229	128	0.140

Source: BPSR analysis of the IPC outcome measures questionnaire

6.51 As explained in Chapter 2, it was not possible to develop a counterfactual group as part of the evaluation. Therefore, we have looked at previous studies to understand what type of change might have been expected in a control group. Table 6-18 sets out the changes reported in the Personal Health Budget evaluation[44] and IPC. The PHB evaluation is a useful comparator as it was a similar intervention, with an evaluation conducted at larger scale (the follow up survey

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[43] The ASCOT calculation is based on Netten, Ann and Burge, Peter and Malley, Juliette and Potoglou, Dimitris and Towers, Ann-Marie and Brazier, John and Flynn, Terry and Forder, Julien (2012) Outcomes of social care for adults: developing a preference-weighted measure. Health technology assessment, 16 (16). pp. 1-166.ISSN 1366-5278'; and the EQ5DL calculation follows from Devlin, N et al (2016). Valuing health-related quality of life: An EQ-5D-5L value set for England. Health economics

[44] Forder et al Evaluation of the personal health budget pilot programme. PSSRU. 2012. Research commissioned by the Department of Health

covered over 1,300 people split between treatment and control). Although the PHB evaluation did include people with long term health conditions and mental health issues (around one third of the achieved follow-up survey), it also covered a wider group with issues from strokes, diabetes, COPD and neurological issues. As such the two groups are not entirely comparable, but it does provide a useful indicator.

6.52 Table 6-18 shows a very similar set of ASCOT results for the two treatment cohorts. This perhaps reflects the similarities in the two programmes, with PHB delivery being a key focus in several IC sites, but also provides reassurance around the IPC findings despite the smaller numbers. Given that the PHB evaluation went on to report a statistically significant net change for ASCOT, this is an encouraging benchmark for IPC and suggests (bearing in mind our data limitation) that IPC may have had a positive impact'.

Table 6-18: Comparing IPC and PHB evaluation

Change in	IPC		PHB treatment group		PHB Control group	
	Mean change	SD	Mean change	SD	Mean change	SD
ASCOT	0.053	0.213	0.057	0.233	0.018	0.221
EQ-5D	-0.030	0.229	-0.011	0.221	0.000	0.207

Source: BPSR analysis of the IPC outcome measures questionnaire

Discussion of findings

6.53 The data, albeit limited by relatively small numbers, do present some encouraging findings around the impact of IPC, although it should be borne in mind that these are changes only in the target group and not set against a counterfactual. While there was no statistically significant change in EQ5DL or WEMWBS, there was a small but significant improvement in ASCOT score following receipt of IPC.

6.54 Sub-group analysis found statistically significant change in ASCOT scores for:

- People with mental health issues
- Those who had a personalised care and support plan
- Those who had a personal budget
- Males
- People aged under 65.

6.55 As above, the lack of a counterfactual necessitates some caution in the interpretation of this data.

Summary

6.56 This chapter has reported on the impacts of IPC as experienced by service users. It draws primarily on self-completion surveys completed at baseline and around nine months later by 138 users, plus qualitative interviews with 42 users and carers.

6.57 The self-completion questionnaires collected data on three standard tools: EQ5DL, WEMWBS, and ASCOT, plus, at follow-up, a short series of additional questions on the user views of the

IPC process. The number completing the additional questions about the process was however small, at just seventy-one.

6.58 Overall users were positive about their experiences. A quarter (26 per cent) felt that their new personalised care and support plan gave them a lot more support than before and 31 per cent felt it gave them a little more support. This was broadly replicated in the qualitative work.

6.59 In terms of the standardised measures, looking across the whole sample of 138 users who completed the baseline and follow-up, there were no statistically significant changes in EQ5D scores or on WEMWBS. There was, however, a significant improvement in the ASCOT score.

6.60 The all-group findings mask a number of differences in the change scores across sub-groups:

- Firstly, comparing those with mental health conditions with those with long-term health conditions, there were no significant changes across the tools for the service users with long-term health conditions, but those with mental health conditions exhibited statistically positive improvements in their ASCOT quality of life scores.
- Service users with a personalised care and support plan (at either baseline or follow-up) scored statistically significantly better at follow-up compared to baseline on the ASCOT quality of life scale, with no such significant change for those without a plan. However, rather surprisingly, the WEMWBS scores of those where there was no record of them having a personalised care and support plan improved significantly from baseline to follow-up. The general pattern was that there was a marked improvement in scores for those saying their personalised care and support plan gave them a lot more care and support, whereas scores deteriorated for those saying the personalised care and support plan gave less care and support or those who declined to answer the question.
- There was no statistically significant change in outcomes among female service users across each of the three measures. However, there was a statistically significant improvement in ASCOT quality of life scores among male service users.
- There was no statistically significant change in outcomes among service users aged 65 and over across each of the three measures. However, there was a statistically significant improvement in ASCOT quality of life scores among service users aged under 65.

6.61 The statistically significant improvements between baseline and follow-up should not automatically be interpreted as evidence of an IPC impact. Some improvement might well have occurred even if IPC had not been introduced for these users, and we had no comparison group data. However, the changes on ASCOT (especially) and EQ5D for IPC were in line with those found for the treatment group in the Personal Health Budget evaluation. That evaluation concluded the PHBs had significantly improved ASCOT scores relative to a comparison group. This *suggests*, although falls far short of strongly demonstrating, that IPC may have a similar size and pattern of impact to PHBs.

7. Conclusions and implications

Introduction

7.1 The findings set out in this report highlight that the implementation and delivery of IPC has been a highly complex and challenging task and a difficult journey for all the stakeholders involved. Good progress has been made in establishing the foundation for the IPC approach to continue to develop and grow at the sites, although there has been slower progress than expected.

7.2 A key strength of the IPC programme was the level of flexibility that was built in the Operating Model, enabling sites to develop a model that was the most suitable for their local context in terms of geographical footprint, demographic characteristics and services systems and processes. This flexibility is apparent in the wide variety of models and approaches across IPC sites regarding the implementation of the IPC.

7.3 While this flexibility has been important to ensure suitable models were being developed, it posed challenges to the evaluation in assessing the impact and cost effectiveness of such a diverse and complex programme. While it was recognisably a programme, it was less apparent that it was a consistent intervention, and the evaluation findings need to be interpreted in that light.

7.4 The evaluation identified some positive signs that IPC might be beneficial to service users and their carers, and with fairly limited cost (in so far as they were measured by the evaluation, longer term costs and benefits are not clear at this point). However, the evidence exists on a relatively small scale still, and the quality and standards of data available were mixed. In this section we summarise our conclusions from the findings of the evaluation and discuss the implications and recommendations for any continuation of the IPC approach going forward. We have included a discussion around key learning for future evaluations at the end of the section, reflecting on the challenges and limitations that the evaluation faced.

Process evaluation

7.5 Acknowledging that developing a new model of care with the IPC approach would require a whole system culture change, sites focussed their efforts primarily on establishing a local leadership to drive forward the change. The process evaluation found that sites appeared to have made good progress in developing and embedding new governance structures to facilitate integrated commissioning of services and to promote a personalised approach in care and support planning and service provision. The strength of these new governance structures was that they tended to be multi-agency, bringing together representatives from health, social care, and VCSE and third sector organisations.

7.6 These new structures have the potential to form the foundation for any roll out and scaling up of the IPC approach to wider geographical footprints. However, many challenges and uncertainties remain with regards to identifying effective approaches for rolling out and indeed for ensuring the sustainability of IPC. Strategic stakeholders were concerned in particular about maintaining momentum to continue the implementation of change and about moving from a small to large scale.

7.7 The sites appeared to have effectively engaged the most senior stakeholders to design and develop the local IPC model, and the strategy to the commissioning and delivery of services under the IPC approach. This implies that the key decision makers within the local services have taken responsibility and ownership for the implementation of the IPC approach in the local system, which was a key strength of the local models. Another strength was that sites have focussed resources on workforce development by providing training to frontline practitioners on the personalised approach to care and support planning, and by encouraging frontline staff to adopt the personalised approach in their practice. A number of sites also appeared to have been successful in identifying and recruiting Champions of Personalised Care within local services, to drive the change amongst colleagues.

7.8 Workforce development was identified as a key enabler of the personalised approach for care and support planning. It is generally good practice to include an element of workforce development and training in the delivery of change. **We recommend that any future roll out of the IPC approach will include an element of training, for staff to increase their knowledge and confidence in delivering the personalised approach in care and support planning**.

7.9 However, a key gap remained with the engagement of middle managers. In many sites, the development of the local model did not include the engagement of middle managers to the same level as senior stakeholders or frontline staff. Middle managers usually have direct line management roles and as such are responsible for authorising changes in processes, procedures and practice of frontline staff. They are also directly accountable for achieving their services' KPIs. A great deal of the risks involved in introducing changes to the systems lie with the middle managers, and for this reason they are a key element in the change process.

7.10 In several sites, the IPC boards and working groups have started engaging the middle managers in the change process, however these were still at very early stages and in most cases the middle managers still sought the approval of senior managers to authorise the change in processes and practice. **Going forward, it might be beneficial to focus resources in increasing the engagement of middle managers across all sites, giving them the role of the primary change agents.**

7.11 Another challenge associated with the rolling out and sustainability of IPC was the lack of sufficient evidence of the benefits of IPC. The majority of the work around IPC focussed on the development of the strategy, which took a great deal of time. Because most of the resources and activities were focussed on the development of governance structures and strategies, actual delivery of services with the new approach had been limited and was achieved only on a small scale (with many sites only delivering short-term small pilots to test the model and processes).

7.12 Furthermore, several sites delivered their IPC offer through third parties. While working with third parties has been effective in getting things going off the ground relatively quickly, it was not straightforward to maintain the momentum and scale up once the pilot finished. Once the third parties exited at the end of the pilot, in most cases the systems were not set up to take on managing the delivery themselves.

7.13 As a result of these challenges, sites were not able to generate compelling evidence of the effectiveness and benefits of IPC, which stakeholders felt was needed to sustain the buy-in of local commissioners, service providers and frontline practitioners for IPC, and in particular to gain the buy-in of their local finance teams. While a comprehensive model for personalised care is being developed on the national level, as part of the Long Term Plan, it was felt that this local buy-in would be vital for the successful implementation of this model as part of 'business as usual' for services.

7.14 It is likely that if there is any further delivery of IPC, sites will be able to generate more evidence of the effect and outcomes of IPC. Several sites have been looking to develop linked datasets between local services to enable them to monitor activity and outcomes for individuals in their care. **We recommend that NHS England, in collaboration with the local teams, build on this work and look to develop a national framework for recording consistently the outputs of teams and the outcomes for service users and carers.**

7.15 When speaking to service users and carers about their experience of IPC, it was apparent that there was a great level of confusion amongst them about what IPC was. Many either did not hear about IPC (or the local branding of IPC) or were not sure if the services that they received were part of IPC or not. Even so, the majority of service users we spoke with said that they noticed a difference in the service that they received, and mostly the change was positive. Service users mentioned that the care and support planning process felt more personalised, and that they felt they had greater choice and control over their care. However, it appeared that the experience for service users was very much dependant on the individual practitioner or care planner who was involved. That is, the experience tended to be positive when the care planner was positive and knowledgeable about the process, what could and could not be included in the plan, or how the budget could be used.

7.16 There appeared to be some level of inconsistency in the quality of the personalised care and support planning within local services. This level of inconsistency is to be expected when new practices are introduced. These inconsistencies could be addressed by: developing standard processes; providing training and ongoing workforce development to develop/reinforce skills and new practices; and by developing support systems for the workforce to receive advice, coaching or mentoring when required. **If the IPC approach continues to roll out and scale up across wider geographical areas, local systems would need to ensure that they have these procedures and support systems in place**.

7.17 A key gap that was identified in relation to the experience of service users and their carers was around the element of empowerment. One of the aims of IPC was to support service users to develop the skills and confidence needed to self-manage their care. The feedback from service users and carers suggested that this remained a gap in the local models. Many of the IPC models did not include an element of support to the service user following the development of the personalised care and support plan, and service users were left on their own to realise their plans. Where service users or their carers have been proactive in pursuing services, the personalised care and support plans were realised successfully. However, service users who lacked the capacity to navigate the system and self-commission services, did not feel any benefits from the new plans. The survey evidence supports this qualitative view.

7.18 To add to the challenge, in many sites it appeared that there was a general lack of awareness about IPC on a system wide level. Indeed, it appeared that there was less emphasis across the board on the integration of services in the personalised care and support planning process. Integration of services may have happened at the senior levels (through the multi-agency working groups), however the integration agenda did not appear to trickle down to the frontline staff levels. Integration of services in the personalised care and support planning process was not fully reached. 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. In addition, personal budgets were not integrated budgets in most sites, with budgets still being funded by each service separately, with elements of the budgets being allocated specifically for health or social care services. Organisations and personnel who were not directly involved in the IPC process were not aware of it and did not recognise the plans when service users approached the organisation in an attempt to commission a service. This was because IPC was still working on a small scale in the localities.

7.19 **Going forward, local systems must ensure that all local services and agencies are aware of any IPC models being implemented locally and the processes and outputs that have been developed through it.** Local organisations should be in a position to offer support to service users in commissioning their services. Furthermore, **the personalised care and support planning process should include the provision of a single contact for the service users and their carer to approach for any queries or advice required to realise their plan**. Putting in place processes for the development of personalised care and support planson its own, is not enough. Enabling service users to realise their plan should be the primary priority for local systems.

Economic evaluation

7.20 The economic evaluation collected information on the resources and costs of setting-up IPC and on the differences in resources and costs of running IPC compared to standard care. The findings suggest that IPC was costlier than standard care. There was a high level of variation in the costs between sites that responded to our survey, which might reflect variation between the IPC models. The available data, which are limited, suggest that there are differences in costs between IPC sites. For set-up costs, these differences were driven by differences in staff time and costs, while the differences in running costs were driven by differences in the number of appointments and contacts between staff. It is uncertain whether the resources and costs collected by the questionnaire are an accurate representation of the costs incurred by the sites and whether they are generalisable to the sites that did not respond to the questionnaire.

7.21 The average cost to set-up IPC was approximately £162,000, mostly due to staff time. The additional cost of running IPC compared to standard care was £265 per user. This was driven by the greater number of appointments (4.2 more on average) and contacts between staff members (2.4 more on average). The greater number of appointments and contacts between staff members may lead to increased demand on personnel time, in particular frontline practitioners, in an already overloaded system. Whether the local systems created the time and space for these additional appointments in the current structures is unclear.

7.22 In the sites involved in the evaluation, IPC was mostly delivered on a small scale or as a short-term pilot. This may have helped manage the workload due to the additional appointments for IPC. Since IPC was provided in addition to standard care, there might have been duplication of effort in the system. **Wide-scale implementation of IPC may benefit from further consideration about identifying sufficient time and space in the system to provide the number of appointments required for the delivery of effective personalised care planning processes.** There might be opportunities for reducing the number of appointments needed, when IPC is rolled out, which it would be useful to identify.

7.23 The economic evaluation was not able to collect data on the cost of the new personalised care and support plans. However, survey responses and feedback from service users suggested that for a good number the new personalised care and support plans provided them with more support than before (with around a quarter saying it provided them a lot more support than before). This suggests that a positive impact of IPC was also associated with increased resources in the personalised care and support plans alongside the new approach. This, in turn, means that the additional cost of delivering IPC might have been underestimated in this evaluation, due to the gap in data about the cost of personalised care and support plans. **We recommend that NHS England should look at the costs of the new personalised care and support plans, in order to be able to give an accurate estimate of the cost of delivering IPC**.

7.24 When discussing the findings from the economic evaluation strand it is important to highlight again the challenges that we faced and therefore the limitations of the economic evaluation analysis. We noted above the four elements in which the cost of IPC may differ from standard care. These were

- setting-up IPC may require additional resources
- the delivery of IPC may involve a different amount of resources compared to standard care
- IPC may result in a different care package
- IPC may result in different usage of health and social care resources compared to standard care.

7.25 For this study we collected information on the first two elements for a group of eight IPC sites. Such a small sample size generates uncertainty about our results. Moreover, we collected some anecdotal reporting on the third point. However, we were not able to collect information of the changes in the use of health and social care services. This element is key in understanding the impact of IPC on the system, which might manifest in a change in levels of use or patterns in terms the type of services that service users opt for. These types of changes might introduce cost savings in the system. **We therefore recommend that if IPC is to be rolled out that NHS England invest in gathering data about the use of services by IPC service users, to identify if changes are evident and if these changes suggest savings in costs on the system level.** That said, the experience of this evaluation showed that embedding a process for collecting measures from service users can be challenging and needs to be carefully thought out to ensure it is feasible within local systems context.

Impact evaluation

7.26 The impact evaluation found that there was no statistically significant improvement in health outcomes (measured through EQ5D) and in general wellbeing outcomes (measured through WEMWBS). There was, however, a significant improvement in the social care related wellbeing outcomes (measured through ASCOT). Given that the only data available is at entry to the IPC service and six months later but with no comparator data, it is not possible to know if the improvement reflects the impact of the IPC service or whether it is due to other causes.

7.27 Sub-group analysis found statistically significant change in ASCOT scores for:

- people with mental health issues
- those who had a personalised care and support plan
- those who had a personal budget
- males
- people aged under 65.

7.28 The statistically significant improvements between baseline and follow-up should not automatically be interpreted as evidence of an IPC impact, especially in the absence of control group data. Some improvement might well have occurred even if IPC had not been introduced for these users. However, the changes in ASCOT scores (especially) and EQ5D for IPC are in line with those found for Personal Health Budget evaluation. This is encouraging for IPC, as the PHB study focussed on a similar client group and found no real change in the comparison group scores. Therefore, the impact evaluation, although limited by relatively small numbers, does present some encouraging findings around the impact of IPC.

7.29 The challenge for IPC if it is to be rolled out, is to further develop the evidence base to see if this initial finding is substantiated when the model is applied at scale. This would enable policy makers to have more confidence in the model if it is rolled out, especially in light of the comments above about the initial model in many areas requiring some changes as it is scaled up.

7.30 Moreover, gathering data at scale would enable the impact to be more fully assessed at sub-group level. The evidence above, while fairly weak, does suggest that not all of the cohorts targeted originally might benefit to the same extent.

7.31 The issue about how the model is delivered as it is rolled out is emphasised by the sub-group analysis. It suggests better results where delivery is closer to the advised model, with a personalised care and support plan and personal budget. The evaluation suggests it is important that any on-going rollout therefore is of high quality. Promoting and monitoring the quality of the process will be important in determining the outcomes achieved in future.

Recommendations

7.32 The evaluation recommendation discussed above are compiled below, highlighting their relevance for different stakeholders.

Recommendations for NHS England and policy stakeholders

1. Evidence of the effectiveness of the integrated and personalised care model is vital to securing the buy-in of local commissioners and practitioners. Sites have been able to generate some evidence, although this was limited in scope and it would be beneficial to build on this work going forward. We recommend that NHS England, in collaboration with the local teams, look to develop a national framework for recording consistently the outputs of teams and the outcomes for service users and carers.
2. The economic evaluation was not able to collect data on the cost of the new personalised care and support plans, although service users' feedback implies

that the new plans provided service users with additional support. So that commissioners can better estimate the cost of IPC, we recommend that NHS England should look at the costs of the new personalised care and support plans to be able to give an accurate estimate of the cost of delivering IPC.

3. It appeared that the difference in costs between IPC and standard care was driven by the greater number of appointments and contacts between staff that were required for the delivery of the new personalised care and support planning process. While IPC was being delivered on a small scale, the local systems appeared to have been coping with the additional strain on resources. As the IPC approach continues to develop and roll out on a national level, it is important to create sufficient time and space in the system to provide the number and quality of appointments required for the delivery of effective personalised care planning processes (assuming this higher level of activity is maintained after pilot effects decline).

Recommendation for local commissioners and operational and delivery stakeholders

1. Staff development and support is a vital element in the process of introducing system change and high quality delivery. We recommend that any future roll out of the IPC approach include an element of training for staff to increase their knowledge and confidence in delivering the personalised approach in care and support planning.
2. Middle managers are a key element in the change process as they have direct line management responsibilities for authorising change on the frontline and at the same time are directly accountable for achieving their services' KPIs. As the IPC approach continues to develop and roll out nationally, it might be beneficial to focus resources on increasing the engagement of middle managers across all sites, giving them the role of the primary change agents.
3. There appeared to be some inconsistency in the quality of personalised care and support planning within local services. If the IPC approach continues to roll out nationally, local systems would need to ensure that they have procedures and support systems in place to address these inconsistencies (such as standard processes, training for staff and coaching and other support mechanism for staff).
4. While service users were generally happy with their new care and support plans, they struggled to realise their plans due to an apparent lack of awareness of IPC on a system wide level. Going forward, local systems must ensure that all local services and agencies are aware of the IPC models that are being implemented and the outputs that they might produce (i.e. what a personalise care and support plan looks like) to help ensure the agreed plans are implemented.
5. In addition, there was general lack of awareness of what services were available in the local market, which meant that service users could not be signposted to suitable services. Local organisations should be in a position to offer support to service users in commissioning their services through developing directories of local services.

6. Service users who did not have the capacity or resources to navigate the system of services found it challenging to realise their new plan. Putting in place processes for the development of personalised care and support plans on its own, is not enough. The personalised care and support planning process should include a single contact for the service users and their carer to approach for any queries or advice required to realise their plan.

Learnings for future evaluations

7.33 As noted above, the evaluation faced a number of significant challenges, which have limited our ability to gather evidence and data to the extent that was originally planned. The evaluation faced challenges in three key areas:

- obtaining sufficient data on outcome measures
- establishing a comparison group
- gaps in data for the economic evaluation.

Outcome measures data

7.34 Data on outcomes for service users was planned to be obtained through the process set out by NHS England. The plan was for IPC sites to collect outcome measure data, which would be processed by NHS England and made available to the evaluation team. The core outcome metrics were introduced to sites in early 2016, prior to the evaluation beginning. The same generic measures (EQ-5D, ASCOT) as used in the 2012 PHB study were chosen, with the addition of WEMWBS.

7.35 NHS England intended that sites would embed the outcome measures in their administration processes so that they would have local on-going data collection. This would provide information on the impact of IPC to support the development of the IPC offer once the Programme finished. The NHS England evaluation and delivery teams have provided on-going support to sites in relation to implementing this process and to build commitment.

7.36 A key issue for the evaluation has been the slow progress in the collection of outcome measures data throughout the lifetime of the evaluation. The issues were:

- Sites have been unsure of who should receive a questionnaire
- The process of collecting outcome measures has been seen by many sites as burdensome and complex in situations where sites were not at the point of having a systematic IPC processes in place
- The measures themselves were seen by some sites as inappropriate for their cohorts
- The number of individuals covered by an IPC offer has been smaller than anticipated.

7.37 The end result was that the number of baseline outcome measures submitted was much smaller than anticipated. In addition, it was known that the tools selected would not be appropriate for high dependency cohorts or young children. The implication of this to the study was that two of the IPC cohorts (children and young people with complex needs and disabilities and adults with learning difficulties) were underrepresented in the outcome measures data.

7.38 The learning for future evaluation projects is the importance of conducting a detailed scoping and feasibility study with the sites, in order to gain an understanding of the expected throughput of sites before beginning the data collection process. If this information is not available or subject to change (as experienced here on throughput), then the key uncertainties and parameters could be set to guide actions as more information becomes available. This is important for planning the sampling strategy and subsequent analysis approach. In addition, co-producing the data collection processes with the teams on the ground is a key enabler to ensuring that the data that is being collected makes sense to them and that the procedures are feasible and do not appear burdensome or complex. And finally, ensuring the collection of outcome measures required a great deal of resource, as teams at the IPC sites required support and a lot of chasing to engage with the task. Any evaluation project taking a similar task on should put in place sufficient resource to enable ongoing and frequent engagement with teams on the ground.

Establishing a comparison group

7.39 The evaluation faced significant challenges in identifying and recruiting a group of service users similar to the service users receiving IPC but who received only standard care, to take part in the evaluation and provide information on their characteristics, outcomes and costs over time. Even where potential comparison groups were identified in a number of sites, the evaluation still faced challenges in establishing a process to collect the data from service users. This in large part followed from the challenges around Outcome Measures described above, as it was anticipated that the process to collect comparative data would follow from that and be based in the same sites.

7.40 One lesson from this issue was that risks should be monitored, and actions taken in mitigation. In this case, we added a small number of questions on users' experience of their care since IPC to the questionnaires at the follow up wave of outcome measures data collection. Through this, the key question we sought to answer was how far has IPC been a positive and different experience from 'standard' care and support planning.

7.41 In addition to the survey findings we conducted a rapid evidence assessment to contextualise the survey findings through gaining a better understanding of what change over time might be expected in the conditions of the key IPC cohorts. This was based on findings from studies with service users with similar characteristics to those of IPC target groups.

7.42 To overcome the challenges of obtaining information from service users who received IPC or standard care, **future evaluations could seek to access routinely collected data such as hospital use data via hospital episode statistics**. For information on the service users who received standard care, **a sample of similar individuals who reside in areas without the new service could be identified from hospital episode statistics data**.

7.43 This was the approach taken by Georghiou and Keeble in their evaluation of Age UK's Personalised Integrated Care Programme [45]. The limitation of this approach is that it

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[45] Georghiou T and Keeble E (2019) Age UK's Personalised Integrated Care Programme: Evaluation of impact on hospital activity. Research report. Nuffield Trust.

considers only the effect of the new service on hospital care, without considering costs of primary care services or other, wider associated service use, nor any impact on outcomes. As we have seen in the main findings, the main improvements are in the ASCOT measures, which would likely not show up in this analysis. Furthermore, the construction of a sample of similar individuals who received standard care relies on the information on user characteristics, which is routinely collected in hospital episode statistics but is not comprehensive. Lastly, this approach depends on users providing their consent for data sharing and having robust data governance processes in place so that hospital episode statistics data can be obtained and analysed in a timely manner.

Gaps in data for the economic evaluation

7.44 A key gap was obtaining information from the service users who received IPC on their characteristics, use of health and social care services and associated outcomes. Without information on the use of health and social care services from the service users who received IPC, it was not possible to know their costs.

7.45 To bypass this challenge, the economic evaluation focussed on the additional direct costs of IPC compared to standard care. These were the cost of setting up IPC (as standard care was already set up and operating); the additional cost of running IPC over and above the cost of standard care per user; and the cost of care package if the service users received IPC or standard care. The rationale was to understand the magnitude of additional investment required to implement and run IPC instead of standard care for some users, to know what this represents in terms of avoided unplanned hospitalisations, and to estimate the magnitude of the benefits that IPC would have to achieve to be considered cost-effective.

7.46 This plan faced challenges as well. It was not possible to obtain information on the cost of the IPC care package; hence this cost was excluded from the analysis. Information on the cost of setting up IPC and the additional cost of running IPC over and above the cost of standard care was collected via a questionnaire to sites. As discussed above, only 8 sites responded to the questionnaires and only 3 sites took part in the workshops. Additionally, some information was insufficient to allow for its inclusion in the calculation of costs.

7.47 Anecdotal evidence from sites suggested that data on resources and costs were not readily available to the person answering the questionnaires, hence it was not provided. Any future studies are recommended to engage with sites early on in the design of the evaluation to collaborate in the development of the questionnaires, potentially embed the collection of resource use and cost data for the new intervention when it is implemented, and allow sufficient lead-time for collection of this information and clarification of queries.

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	Lead organisation	Projected cohort size[46]	Intended cohort	Date joined
Birmingham and Solihull	Early Adopter	Birmingham and Solihull CCG	26,000	Adults and children with multiple LTC Adults with mental health needs	December 2016
Cheshire West & Chester	Demonstrator	Cheshire West and Chester Council West Cheshire CCG Vale Royal CCG	6,640	Adults with learning difficulties	April 2015
Gloucestershire	Demonstrator	Gloucestershire CCG	12,694	Adults and children with multiple LTC Adults with mental health needs Adults with learning difficulties	April 2015
Hampshire	Demonstrator	Hampshire County Council Hampshire CCGs	12,672	People with disabilities and learning difficulties	April 2015
Hertfordshire	Early Adopter	Hertfordshire County Council East and North Hertfordshire CCG Herts Valley CCG	24,000	Adults with multiple LTC and frailty	December 2016
Islington	Early Adopter	Islington CCG	4,760	Adults with multiple LTC and frailty	December 2016
Lincolnshire	Demonstrator	Lincolnshire County Council Lincolnshire CCGs	15,615	Adults with learning difficulties Adults with mental health issues Young people with special needs	April 2015
Luton	Demonstrator	The Disability Resource Centre Luton CCG	3,636	People diagnosed with dementia	April 2015

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[46] Projected cohort size that was expected to be identified in linked datasets, based on NHS England interim evaluation reports.

Site name	Type	Lead organisation	Projected cohort size[46]	Intended cohort	Date joined
		Luton Borough Council			
Northern, Eastern and Western (NEW) Devon	Demonstrator	North East and West Devon CCG	17,847	Adults with multiple LTC and frailty	April 2015
Nottingham City	Early Adopter	Nottingham City CCG	7,310	Adults with learning difficulties Adults with mental health issues	December 2016
Nottinghamshire	Early Adopter	Nottinghamshire CCGs	13,922	Adults with multiple LTC Adults with disabilities	December 2016
Portsmouth	Demonstrator	Portsmouth City Council Portsmouth CCG	23,762	Adults with multiple LTC Adults with mental health needs	April 2015
Somerset	Demonstrator	Somerset CCG	10,880		April 2015
South Devon and Torbay	Demonstrator	South Devon and Torbay CCG	5,720	Adults with multiple LTC	April 2015
Sheffield	Early Adopter	Sheffield CCG Sheffield City Council	11,200	Adults and children with multiple LTC Adults with mental health needs Adults with learning difficulties	December 2016
Stockton-On-Tees	Demonstrator	Catalyst Stockton Hartlepool & Stockton-on-Tees CCG North Tees and Hartlepool NHS Foundation Trust Stockton Borough Council	4,000	Adults with LTC – respiratory conditions	April 2015
Tower Hamlets	Demonstrator	Tower Hamlets CCG Tower Hamlets Council	59.717	Adults and children with multiple LTC Adults with mental health needs Adults with learning difficulties Children and young people with SEN&D	April 2015

Source: NHS England

Annex B: Questionnaire on the costs of setting up and running IPC

Costs of implementing
Integrated Personal Commissioning (IPC)

This questionnaire will be used to help us calculate the cost of implementing IPC. Implementation costs include **running costs of IPC** and **set-up costs of IPC**.

The questionnaire includes three sections. The first section asks to provide general information about the site. The next two sections ask questions on running costs and set-up costs, respectively.

Please answer the questions below as accurately as you can. Best guesses are fine.

We want to take this opportunity to reassure that the information you provide to us will inform our calculations and will not be attributed to your service or locality.

General information on the site

This section asks to provide some general information about your site.

Locality ___________________

How many people were expected to receive IPC?

By expected number, we mean the number of people across all cohorts that you intended to cover that your site had proposed to NHS England at the time of the application to become an IPC site or the numbers that were included in the agreed MoUs.

How many people actually received IPC?

By achieved number, we mean the number of people across all cohorts that your site has actually delivered IPC to.

If you don’t know, please leave blank.

Year	Number expected to receive IPC	Number who actually received IPC
2015-16		
2016-17		
2017-18		

Running costs of IPC compared to standard care

This section asks questions about the **running costs of IPC compared to standard care**.

Running costs are the costs of resources used to operate IPC on an individual user basis. They include the cost of appointments with practitioners that are provided to service users, meetings between practitioners, and meetings between practitioners and service providers to discuss the needs and care of service users.

In terms of the running costs, we are interested to measure the difference in **running costs of IPC compared to standard care.** Standard care is the service that the users of IPC would have received if IPC was not available.

In looking at the differences between the two, the aim is to examine the differences in costs and resources used for the delivery of IPC, i.e. for the agreement and receipt of the care plan, compared with the standard care, i.e. the service that users have received if IPC was not available.

For example, providing IPC to a service user may require more (or fewer) appointments, or longer (or shorter) appointments than standard of care. Providing IPC may require meetings between practitioners to discuss the needs of the service user and to organise their care, which would not have happened had the service user received standard care instead.

Thinking about the typical IPC service user in your site, had this service user received standard care instead, what would be the differences in resources and costs?

1. **Does providing IPC require the same, more or fewer appointments with the service user than standard of care?**
    - Same/more/less (circle what is applicable)

    1.1. If the number of appointments is different with IPC compared with standard care, what is the difference in the number of appointments required? Please specify job title, salary/grade.

1) Job title____
Salary/grade____
Number of times _______ more/less appointments (circle what is applicable)

2) Job title____
Salary/grade____
Number of times _______ more/less appointments (circle what is applicable)

3) Job title____
Salary/grade____
Number of times _______ more/less appointments (circle what is applicable)

4) Job title____
Salary/grade____
Number of times _______ more/less appointments (circle what is applicable)

2. **Does providing IPC require the same, longer or shorter appointments with the service user than standard of care?**
    Same/longer/shorter (circle what is applicable)

    2.1. How much longer or shorter is the average IPC appointment compared to standard care?
    _______________ minutes longer/shorter (circle what is applicable)

3. **Does providing IPC to a service user require more contacts between staff or between staff and service providers than providing standard care?**
    Same / More / Less contacts (circle what is applicable)

3.1. How many more or less contacts by staff member? Please specify job title, salary/grade.

3.2.

1)Job title____
Salary/grade____
Number of contacts ___________ more/less (circle what is applicable)

2) Job title____
Salary/grade____
Number of contacts ___________ more/less (circle what is applicable)

3) Job title____
Salary/grade____
Number of contacts ___________ more/less (circle what is applicable)

4) Job title____
Salary/grade____
Number of contacts ___________ more/less (circle what is applicable)

4. **Are there any other differences in the resources and costs required to deliver IPC to individual service users over and above what you have detailed above? For example, IPC may require more time for staff to fill in forms.**

____

____

8. Set-up of IPC

This section asks question about the **set-up of IPC**.

Set-up costs are the cost of the resources used to set up IPC. They include staff time, equipment, and any additional resource or cash spent in the development of IPC. These are sunk costs in that, if IPC is no longer provided, the investment cannot
be recouped.

The set-up of IPC is not a simple task and this is likely to take time. It may have taken over one year to set up IPC. Our questions on set-up costs are therefore repeated for each year for up to three years since its launch in April 2015. If, within your site, the set-up phase took less time, especially where your site was an Early Adopter, then please only complete this questionnaire for the years in which IPC was operational.

Time to set up IPC

Has your model of IPC now become ‘business as usual’ (i.e. set up completed)?

If yes, when did it become ‘business as usual’?

Staff involved in the set-up of IPC

Through this sub-section, we would like to know about **all staff involved in the set-up of IPC.** This includes staff employed for the IPC service (e.g. project manager), staff seconded or loaned from other services (e.g. occupational therapist seconded from the clinical commissioning group), and staff who helped out on an *ad hoc* or short term basis (e.g. senior staff that take part in project meetings).

The tables below ask: who was involved in setting up IPC (job title)? How much time did it take (% whole time equivalent, or WTE) and for how long? How much did their time cost (annual salary)? And, what is the impact of taking on the role on the existing workload?

The topic of each column is explained in detail below:

- **Job title** refers to the job position held.
- **%WTE time allocated to IPC** refers to the proportion of whole time equivalent time that this person was assigned to work on the set-up of IPC.
- **For how long** refers to the number of months out of the year that the person worked on the set-up of IPC. If the time allocated to the set-up of IPC changed over the year, please calculate the average over the year or include each time period separately as another row in the table.
- **Annual salary/grade** refers to the annual wage of the staff member before taxes but excluding on-costs such as employer’s national

insurance contributions. If you do not know the annual salary, please indicate the grade (e.g. Agenda for Change band 8).

- **Organisation** refers to the organisation in which the person is based at.
- **IPC impact on workload**. Is this role in addition to the existing workload? Please fill in this field using the following 3 options:
  - (1) whether this role of setting up IPC was added to their existing workload (hence their WTE time increased),
  - (2) replaced some of their workload (hence their WTE was the same compared to before IPC), or
  - (3) if the person was employed specifically for setting up IPC.

Please include information in this table about all the staff working on setting up IPC, regardless of whether or not they were paid from IPC monies.

Please also include information about any member of the steering group that was not directly involved in the set-up of IPC but who provided (external) advice during the steering groups. For such members please indicate the total amount of time spent in the steering groups under the "**for how long**" field and the annual salary.

The row in grey shows an example of the kind of information we are looking for.

Set-up costs in 2015/16					
Job title	**% WTE time allocated to IPC**	**For how long?**	**Annual salary/grade**	**Organisation**	**IPC impact on workload**
Example Project lead	*80%*	*12 months*	*£35,000*	*Local authority*	*Employed to set up IPC*
Project lead					

Set-up costs in 2015/16					
Job title	**% WTE time allocated to IPC**	**For how long?**	**Annual salary/grade**	**Organisation**	**IPC impact on workload**
Finance manager					
Commissioning manager					
Care planner					
Team manager					
Other (please specify)					
Other (please specify)					
Other (please specify)					
Other (please specify)					
Other (please specify)					

Set-up costs in year 2016/17					
Job title	**% WTE time allocated to IPC**	**For how long?**	**Annual salary/grade**	**Organisation**	**IPC impact on workload**
Project lead					
Finance manager					
Commissioning manager					
Care planner					
Team manager					
Other (please specify)					
Other (please specify)					
Other (please specify)					
Other (please specify)					
Other (please specify)					

Set-up costs in year 2017/18					
Job title	**% WTE time allocated to IPC**	**For how long?**	**Annual salary/grade**	**Organisation**	**IPC impact on workload**
Project lead					
Finance manager					
Commissioning manager					
Care planner					
Team manager					
Other (please specify)					
Other (please specify)					
Other (please specify)					
Other (please specify)					
Other (please specify)					

Which non-staff items were used in setting-up IPC?

This section is about the non-staff items. By non-staff items, we mean equipment, facilities, or travel arrangements with and without charge.

The topic of each column is explained in detail below:

- **Non-staff item** refers to the equipment, facilities, travel arrangements, training, etc. used for the set-up of IPC.
- **Organisation which funded the item** refers to the organisation (IPC service, local authority, clinical commissioning group, or other) which payed for or provided the item in kind.
- **Number of non-staff items used** refers to the amount of equipment, facilities, travel arrangements, etc. used.
- **Total value if known** refers to the total value of the non-staff items if known.

The rows in grey show examples of the kind of information that we are looking for.

Non-staff costs in 2015/16			
Non-staff item	Organisation which funded the item	Number of non-staff items used	Total value if known
Laptop	*Provided in kind by the local authority*	*5*	*Unknown*
Travel costs	*Funded by IPC service*	*1*	*£1,000*
Training	*Funded by IPC service*	*Not applicable*	*£500*

Non-staff costs in 2015/16			
Non-staff item	Organisation which funded the item	Number of non-staff items used	Total value if known

Non-staff costs in 2016/17			
Non-staff item	Organisation which funded the item	Number of non-staff items used	Total value if known

Non-staff costs in 2017/18			
Non-staff item	Organisation which funded the item	Number of non-staff items used	Total value if known

Do you have any other comments?

____

____

Thank you very much for answering this questionnaire.

The economics team at the University of York will use the information you have provided to calculate the cost of setting-up IPC and the difference in cost of running IPC compared to standard of care. We may get back in touch with you to discuss the information you have provided and ensure that we have interpreted it correctly.

Annex C: Additional information on economic analysis

Table C-1: Resource use to run IPC in three sites.

		Resources				
Row ID	**Task**	**Staff/item**	**Number of staff/item**	**Band**	**Hours per staff**	**Unit of activity**
		Site 3				
1	Identification of eligible IPC patients	General Practitioner	Unknown	Unknown	Unknown	Per annum
2		Health professional	Unknown	Unknown	Unknown	Per annum
3	Referral to the IPC team	Health & social care professional	1	Unknown	0.25	Per annum
4		Project manager	1	Unknown	Unknown	Per annum
5		Project officer	1	Unknown	Unknown	Per annum
6	Other	Room bookings	Unknown	Unknown	-	-
7		Printing leaflets	Unknown	Unknown	-	-
8	Budget setting	Project manager	1	Band 8a	16.00	Per week
9		Project officer	1	Band 6	16.00	Per week
10		Budget	1	-	-	-
11	Peer coaching	Lay person	1	Unknown	10.00	-
12		Training	1	Unknown	Unknown	-
13	Locality navigator	Senior manager	1	Unknown	Unknown	-
14		Locality navigator	2	Unknown	2.50	Per patient
15		Locality coordinator	1	Unknown	Unknown	-
16	Payment processing	Officer	1	Unknown	-	-
		Site 8				
1	Identification of eligible IPC patients					
2	New patients	MDT coordinator	8	Band 5	18.00	Per annum
3		Nurse	1	Band 7 or 8a	18.00	Per annum
4		Coordinator manager	1	Band 6	18.00	Per annum
5		District nurse	Unknown	Band 5	0.07	Per annum

6		General practitioner	Unknown	-	0.07	Per annum
7	Existing patients	General practitioner	1	Unknown	Unknown	Per annum
8		Community matron	1	Band 8a	Unknown	Per annum
9		Coordinator manager	1	Band 6	Unknown	Per annum
10		Social worker	1	-	Unknown	Per annum
11	Collection of information	MDT coordinator	8	Band 5	0.58	Per annum
12	Monthly meetings (i.e. 12 meetings in a year)	General practitioner	1	Unknown	1.00	Per month
13		Community matron	1	Band 8a	1.00	Per month
14		MDT coordinator	1	Band 5	1.08	Per month
15		Social worker	1	-	1.00	Per month
16		Specialist nurse	1	Band 6	1.00	Per month
17	Planning phase					
18	Consent from Intensive Case Management	MDT coordinator	1	Band 5	0.13	Per patient
19	Arrange first assessment	Community matron	1	Band 8a	0.33	Per patient
20	First assessment	Community matron	1	Band 8a	2.00	Per patient
21		Pharmacy technician	1	Unknown	2.00	Per patient
22	Second assessment	Community matron	1	Band 8a	1.50	Per patient
23	Subsequent assessments/visits	Community matron	1	Band 8a	9.00	Per patient
24	Ongoing discussions	MDT coordinator	1	Band 5	0.40	Per patient
25		Other MDT members	Unknown	Unknown	0.07	Per patient
26	DRC referral	MDT coordinator	Unknown	Band 5	Unknown	Unknown
27	DRC support	Information services	Unknown	Unknown	Unknown	Unknown
28		Carer support and case workers	Unknown	Unknown	Unknown	Unknown
29		PHB/direct payment support	Unknown	Unknown	Unknown	Unknown
30	PHB discussion	DRC worker	1	-	6.00	Per patient
31	Finalising care plans	Community matron	1	Band 8a	6.00	Per patient
32	PHB panel review	Panel member	1	Band 8a or 8b	26.00	Per annum

33		Panel member	1	Band 8a or 8b	26.00	Per annum
34		Panel member	1	Band 8a or 8b	26.00	Per annum
35	Approval of the finalised plan	Community matron	1	Band 8a	0.58	Per patient
36	Plan in place					
37	Setting up the plans	Administrator	1	Band 3	1.00	Per patient
38	Conclusion of intensive case management	MDT coordinator	1	Band 5	0.50	Per patient
			Site 9			
1	Setting up list of patients	GP receptionist	1	Unknown	Unknown	Per annum
2		General practitioner	1	Unknown	Unknown	Per annum
3	Confirmation of patients	-	2	Band 6	5.00	Per annum
4		Community navigator	1	Band 4	5.00	Per annum
5	Sending invitations to patients	-	1	Band 6	4.00	Per annum
6		-	1	Band 3	3.00	Per annum
7		X3 sheets of paper	287	-	-	Per annum
8		Envelopes	287	-	-	Per annum
9		1st class stamps	287	-	-	Per annum
10	Market place event organisation	-	1	Band 6	5.00	Per annum
11		-	2	Band 6	0.50	Per annum
12		Community navigator	1	Band 4	3.00	Per annum
14		-	1	Band 7	3.50	Per annum
15		Miscellaneous	1	-	-	-
16		Public liability insurance	1	-	-	-
17	Market place event	Community Physiotherapist	1	Band 6	6.30	Per annum
18		MDT coordinator	1	Band 7	6.30	Per annum
19		Community matron	1	Band 7	6.30	Per annum
21	Confirmation of patient participation	-	1	Band 6	1.00	Per annum
22		-	1	Band 7	1.00	Per annum

23	100 day challenge pilot meetings	Social worker	1	Band 6	48.00	Per annum
24		Community physiotherapist	1	Band 6	48.00	Per annum
26		General practitioner	1	-	96.00	Per annum
27	100 day challenge pilot events	Social worker	1	Band 6	32.00	Per annum
28		Community physiotherapist	1	Band 6	32.00	Per annum
30		General practitioner	1	-	64.00	Per annum
31	Training on personalised care planning	General practitioner	1	-	2.00	Per annum
32		Community matron	1	Band 7	2.00	Per annum
33		IPC project manager	1	Band 6	2.00	Per annum
34		Community Physiotherapist	1	Band 6	2.00	Per annum
35		Mental health nurse	1	Band 6	2.00	Per annum
36		Community care officer	1	Band 4	2.00	Per annum
37		Community navigator	1	Band 4	2.00	Per annum
39		CCG representative	1	Unknown	2.00	Per annum
40	Preparation of meetings with patients	Community matron	2	Band 7	1.00	Per annum
41		-	1	Band 6	1.00	Per annum
42	Development of care plan with patients	-	1	Band 6 or 4	2.50	Per patient
43		-	1	Band 6 or 4	2.00	Per patient
44	Follow-up of patients with Personal Health Budget	General practitioner	1	-	Unknown	Per patient
45		-	1	Band 6	5.00	Per patient
46		-	3	-	-	-

Source: workshop on running costs of IPC

Table C-2: Annual costs and annual costs per patient for the delivery of IPC in three sites.

Row ID	Task	Staff/item	Annual costs	Annual costs per user
Site 3				
1	Identification of eligible IPC patients	General Practitioner	Unknown	Unknown
2		Health professional	Unknown	Unknown
3	Referral to the IPC team	Health & social care professional	Unknown	Unknown
4		Project manager	Unknown	Unknown
5		project officer	Unknown	Unknown
6	Other	Room bookings	£1,000	£5
7		Printing leaflets	£500	£3
8	Budget setting	Project manager	£18,895	£94
9		project officer	£13,104	£66
10		Budget	£170,000	£850
11	Peer coaching	Lay person	£100,000	£500
12		Training		
13	Locality navigator	Senior manager	£139,333	£697
14		locality navigator		
15		locality coordinator		
16	Payment processing	Officer	£17,383	£87
	Number of users: 200 (source: workshop)		£460,215	£2,301
Site 8				
1	Identification of eligible IPC patients			
2	New patients	MDT coordinator	£1,855	£7.79

Row ID	Task	Staff/item	Annual costs	Annual costs per user
3		Nurse	£373	£2
4		Coordinator manager	£283	£1
5		District nurse	Unknown	Unknown
6		General practitioner	Unknown	Unknown
7	Existing patients	General practitioner	Unknown	Unknown
8		Community matron	Unknown	Unknown
9		Coordinator manager	Unknown	Unknown
10		Social worker	Unknown	Unknown
11	Collection of information	MDT coordinator	£60	£0
12	Monthly meetings (i.e. 12 meetings in a year)	General practitioner	£1,800	£8
13		Community matron	£273	£1
14		MDT coordinator	£167	£1
15		Social worker	£708	£3
16		Specialist nurse	£189	£1
17	Planning phase			
18	Consent from Intensive Case Management	MDT coordinator	£383.14	£2
19	Arrange first assessment	Community matron	£1,802	£8
20	First assessment	Community matron	£10,809	£45
21		Pharmacy technician	£4,489	£19
22	Second assessment	Community matron	£8,107	£34
23	Subsequent assessments/visits	Community matron	£48,641	£204

Row ID	Task	Staff/item	Annual costs	Annual costs per user
24	Ongoing discussions	MDT coordinator	£1,226	£5
25		Other MDT members	Unknown	Unknown
26	DRC referral	MDT coordinator	Unknown	Unknown
27	DRC support	Information services	Unknown	Unknown
28		Carer support and case workers	Unknown	Unknown
29		PHB/direct payment support	Unknown	Unknown
30	PHB discussion	DRC worker	£22,118	£93
31	Finalising care plans	Community matron	£22,118	£93
32	PHB panel review	Panel member	£645	£3
33		Panel member	£645	£3
34		Panel member	£645	£3
35	Approval of the finalised plan	Community matron	£13	£0
36	Plan in place			
37	Setting up the plans	Administrator	£9	£0
38	Conclusion of intensive case management	MDT coordinator	£6	£0
	Number of users: 238 (source: questionnaire, financial year 2015/16)		£127,363	£535
		Site 9		
1	Setting up list of patients	GP receptionist	Unknown	Unknown
2		General practitioner	Unknown	Unknown
3	Confirmation of patients	-	£158	£7.88
4		Community navigator	£120	£6

Row ID	Task	Staff/item	Annual costs	Annual costs per user
5	Sending invitations to patients	-	£63	£3
6		-	£28	£1
7		X3 sheets of paper	£10	£1
8		Envelopes	£10	£1
9		1st class stamps	£201	£10
10	Market place event organisation	-	£79	£4
11		-	£16	£1
12		Community navigator	£72	£4
14		-	£66	£3
15		Miscellaneous	£20	£1
16		Public liability insurance	£60	£3
17	Market place event	Community Physiotherapist	£99	£5
18		MDT coordinator	£118	£6
19		Community matron	£118	£6
21	Confirmation of patient participation	-	£16	£1
22		-	£19	£1
23	100-day challenge pilot meetings	Social worker	£756	£38
24		Community physiotherapist	£756	£38
26		General practitioner	£14,400	£720
27	100-day challenge pilot events	Social worker	£504	£25
28		Community physiotherapist	£504	£25

Row ID	Task	Staff/item	Annual costs	Annual costs per user
30		General practitioner	£9,600	£480
31	Training on personalised care planning	General practitioner	£300	£15
32		Community matron	£37	£2
33		IPC project manager	£32	£2
34		Community Physiotherapist	£32	£2
35		Mental health nurse	£32	£2
36		Community care officer	£48	£2
37		Community navigator	£48	£2
39		CCG representative	Unknown	Unknown
40	Preparation of meetings with patients	Community matron	£37	£2
41		-	£16	£1
42	Development of care plan with patients	-	£1,000	£50
43		-	£800	£40
44	Follow-up of patients with Personal Health Budget	General practitioner	Unknown	Unknown
45		-	£1,575	£79
46		-	£135	£7
	Number of users: 20		£31,882	£1,594

Source: Workshop

Table C-3: Comparison between approach 1 and approach 2 for the calculation of the differential costs per patient of IPC.

Approach 1	**Approach 2**
Time horizon	
1 year	3 years
Calculations	
The differential set-up and delivery costs per patient of the average IPC site are calculated as follows:	The differential set-up and delivery costs per patient of the average IPC site are calculated as follows:
Step 1: the set-up costs (total staff and non-staff costs) for each site in each year are divided by the actual number of IPC patients for the same site and year to obtain the set-up costs per patient. For example, for site 1 in year 1, the set-up costs per patient are £313 (=£147,215/470). For site 1 in year 2, the set-up costs per patient are £109 (=£219,721/2,024). The same calculation is carried out for all sites and years.	Step 1: the actual number of patients of the average site is calculated in each year. For example, in year 1, the actual number of patients of the average site is 119 (=[470(site 1)+36(site 2)+35(site 3)+12(site 5)+21(site 6)+20(site 7)+238(site8)]/7). In year 2, the actual number of patients of the average site is 835 (=[2,024(site 1)+28(site 5)+987(site 7)+300(site8)]/4). the same calculation is carried out in year 3. The actual number of patients of the average site in all three years are summed together to obtain the actual number of patients of the average site over the three-year period.
Step 2: the obtained set-up costs per patient for each site in each year, as obtained in step 1, are summed to the differential costs per patient of running IPC to obtain the differential set-up and delivery costs per patient for each site in each year. For example, for site 1 in year 1 the differential set-up and delivery costs per patient are £448 (=£313+£135). For site 1 in year 2 the differential set-up and delivery costs per patient are £244 (=£109+£135). The same calculation is carried out for all sites and years.	Step 2: the set-up costs of the average site are calculated in each year. For example, in year 1, the set-up costs of the average site are £151,586 (=[£147,215(site 1)+£166,016(site 2)+£152,423(site 3)+£84,699(site 4)+£59,196(site 5)+£246,777(site 6)+£180,871(site 7)+£175,494(site8)]/8). In year 2, the set-up costs of the average site are £162,348 (=[£219,721(site 1)+£138,616(site 4)+£82,291(site 5)+£222,358(site 7)+£148,752(site 8)]/5). The same calculation is carried out in year 3. The set-up costs of the average site in year 2 and 3 are discounted to year 1. The discounted set-up costs of the average site in all three years are summed together to obtain the set-up costs of the average site over the three-year period.
Step 3: in each year, the differential set-up and delivery costs per patient, as obtained in step 2, are averaged across sites to obtain the differential set-up and delivery costs per patient of the average IPC site (reported in Table 5-2). For example, in year 1, the differential set-up and delivery costs per patient of the average IPC site is £5,392 (=[£448(site 1)+£4,742(site 2)+£4,841(site 3)+£5,359(site 5)+£12,153(site 6)+£9,218(site 7)+£985(site8)]/7). The same calculation is carried out for each year.	Step 3: the differential running costs per patient of the average site in an average year are £265 (=[£135(site 1)+£131(site 2)+£486(site 3)+£121(site 4)+£426(site 5)+£402(site 6)+£174(site 7)+£248(site8)]/8). The differential running costs of the average site are calculated in each year by multiplying the differential running costs per patient of the average site by the actual number of patients of the average site, as obtained in step 1. For example, in year 1 the differential running costs of the average site are £31,531 (=£265x119). The same calculation is carried out in year 2 and 3 and the resulting differential running costs of the average site in these years are discounted to year 1. The discounted differential running costs of the average site in all three years are

Approach 1	Approach 2
	summed together to obtain the differential running costs of the average site over the three-year period.
Step 4: the values calculated in step 3 are used in equation (1) and (2) for the calculation of minimal differential QALYs per user and the minimal reduction in unplanned hospitalisations per user, respectively.	Step 4: the set-up costs of the average site over the three-year period, as calculated in step 2, and the differential running costs of the average site over the three-year period, as calculated in step 3, are both divided by the actual number of patients of the average site over the three-year period, as calculated in step 1, to obtain the set-up costs per patient and the differential running costs per patient, respectively, of the average site over the three-year period. These are summed together to obtain the differential set-up and delivery costs per patient of the average site over the three-year period.
	Step 5: the value calculated in step 4 is used in equation (1) and (2) for the calculation of minimal differential QALYs per user and the minimal reduction in unplanned hospitalisations per user, respectively.
Interpretation	
The resulting minimal effects either in terms of QALYs or unplanned hospitalisations refer to each of the first three years of implementation of IPC. Minimal effects can be reasonably expected to decrease over time as the number of IPC users increases and as the set-up costs decrease. During the first year of implementation, the number of actual patients is expected to be low because IPC sites are unlikely to run the service at full capacity, and set-up costs are expected to be high because of the initial implementation of the service. This implies that considering the first years of implementation separately is likely to generate large differential costs per patient and, in turn, large minimal effects.	The resulting minimal effects either in terms of QALYs or unplanned hospitalisations refer to a period of three years. This means that set-up costs, which are expected to be higher especially in the first year of implementation, will be spread over a period of three years. Similarly, the number of patients treated over a period of three years is expected to be greater than the number of patients treated in a single year. Differential costs per patient over a three-year period, therefore, are likely to be lower than the differential costs per patient in a single year. In turn, this implies that minimal effects calculated over a three-year period are likely to be lower compared to minimal effects calculated in a single year.

Source: CHE

Table C-4: Calculation of discounted set-up and differential running costs.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Year	Actual number of patients of the average site	Set-up costs of the average site (£)	Discounted set-up costs of the average site (£)	Differential running costs (£) per patient	Differential running costs (£) = (2)x(5)	Discounted differential running costs (£)
1	119	151,586	151,586	265	31,531	31,531
2	835	162,348	156,858	265	221,444	213,955
3	2,070	146,240	136,517	265	549,000	512,497
All	3,023	460,174	444,961	796	801,974	757,983

All=whole three-year period

Table C-5:Minimal differential QALYs per patient comparing early and late adopters of IPC.

	Early adopters					Late adopters				
		Minimal differential QALYs per patient					Minimal differential QALYs per patient			
Year	Differential costs per patient of the average IPC site (£ per patient)	λ=13,000	λ=20,000	λ=30,000	λ=50,000	Differential costs per patient of the average IPC site (£ per patient)	λ=13,000	λ=20,000	λ=30,000	λ=50,000
Set-up of IPC										
1	3,757	0.289	0.188	0.125	0.075	6,906	0.531	0.345	0.230	0.138
Delivery of IPC										
1	221	0.017	0.011	0.007	0.004	339	0.026	0.017	0.011	0.007
Set-up and delivery of IPC										
1	4,003	0.308	0.200	0.133	0.080	7,245	0.557	0.362	0.242	0.145

Table C-6: Minimal reduction in unplanned hospitalisations per patient comparing early and late adopters of IPC.

	Early adopters		Late adopters	
Year	Differential costs per patient of the average IPC site (£ per patient)	Minimal reduction in unplanned hospitalisations per patient	Differential costs per patient of the average IPC site (£ per patient)	Minimal reduction in unplanned hospitalisations per patient
Set-up of IPC				
1	3,757	2.3	6,906	4.3
Delivery of IPC				
1	221	0.1	339	0.2
Set-up and delivery of IPC				
1	4,003	2.5	7,245	4.5

Annex D: Service users experience of IPC

Background

D.1 The quantitative element of this evaluation aimed to measure changes in the well-being and health-related quality of life of service users and their carers who had experienced the IPC approach. The qualitative element described in this appendix aimed to augment the quantitative data by providing more detail on users' and carers' experiences of IPC.

Aims and objectives

D.2 This qualitative part of the evaluation aimed to provide an in-depth understanding of IPC service users' and carers' understanding and experiences of the IPC process, including developing their personalised care and support plans, choice and control over support that could be accessed and how far the support was perceived to have affected quality of life.

D.3 Interviews were planned with a total of 60-80 service users and/or their carers from across the 10 in-depth case study schemes. The aim was to interview 15-20 service users and/or carers who had experience of the IPC approach from each of the four main IPC cohorts: children and young people with complex needs; people with multiple long-term conditions, particularly frail older people; people with learning disabilities; and people with significant mental health needs.

D.4 To ensure a good balance of different service users/carers, we planned to work with the IPC case study sites to purposively sample participants. The recruitment approach and research interview guides were reviewed by the co-production advisory panel and received ethical approval from the University of York Social Policy and Social Work committee.

Methods

D.5 Thirteen IPC sites (the 10 in-depth case study sites plus three light touch evaluation sites) were each asked to approach 10-20 service users and carers who had experienced the IPC process in the previous three to six months, at least as far as the development of a personalised care and support plan, and ask for permission for the evaluation team to contact them with further information about taking part in a research interview about their experiences. The IPC site leads provided the evaluation team with contact details and preferred method of contact for those service users and carers who gave permission.

D.6 The number of potential interviewees offered by each site varied. For example, although one site provided details of 51 service users, many offered less than 10. One of the reported difficulties in supplying details of potential interviewees was the time required for IPC staff to identify suitable candidates and contact them for permission to provide the evaluation team with their details. This appeared to be done retrospectively, with staff members going back over case notes, rather than during routine contacts, so added to workload. There was also confusion in some sites about the different strands of data collection as these qualitative interviews overlapped with outcome data collection through structured questionnaires. This occurred because the time period for collecting outcome data was extended. Senior level staff changes in some sites also affected progress with data collection.

D.7 There were also challenges associated with contacting potential interviewees and arranging interviews. Potential interviewees were contacted by email or letter with further information and followed up with a telephone call. Some responded before the call that they were not interested in taking part or were too busy. Typically, potential interviewees were, or cared for someone who was, very frail or had complex needs; some felt unable to spare the time for an interview. For example, in one site, only three of 10 potential interviewees agreed to take part; all were frail older people who had no recollection of receiving IPC, felt too tired to take part or they/the person they cared for had been admitted to hospital.

D.8 After a slow start, 42 interviews took place throughout 2018. The majority of interviews were conducted face-to-face, but some were undertaken by phone as preferred by the interviewee. Interviewees were from eight IPC sites. Eleven interviewees were from one site, four sites provided between five and seven interviewees, and three or fewer interviewees came from the remaining three sites. Twenty interviewees or their carers fell into the long-term conditions IPC cohort, 19 had mental health needs and three were young adults with complex needs. Twenty-seven service users were interviewed and 15 carers. Carers were interviewed about their experiences but also offered their views on the involvement in and impact of IPC for the person they cared for.

D.9 All interviews followed a topic guide covering the following areas: (1) initial experiences of IPC, such as how the interviewee first became involved in IPC and experiences of the initial IPC conversation; (2) experiences of personal budgets and control over resources, including whether or not the interviewee had any form of personal budget; (3) care and support options, covering how and why care and support options were chosen and how they were different to pre-IPC; (4) involvement with local community and peer groups; and (5) overarching changes resulting from the IPC approach, such as changes in health and well-being or relationships with professionals. Interviews with carers included questions about the cared-for person as well as the carer and covered basic details about the carer's role. Where IPC sites used a local term/branding for IPC, this term was used in the interviews.

D.10 Interviews typically lasted about 45-60 minutes although some were less than 30 minutes. Interviews were recorded and transcribed verbatim. A summary of each interview, including verbatim quotations, was written from the transcripts. Summaries were analysed using a coding frame developed with the assistance of the evaluation co-production panel.

Limitations

D.11 As the evaluation progressed it became apparent that the quantitative outcome data for the learning disability and young people's cohorts were weak. A supplementary aim of this qualitative element was therefore to provide some insights into the experiences of those groups. However, we were unable to recruit more than a handful of young adults with complex needs or their carers. The vast majority of service users consulted were people with mental health issues, people with dementia, frail older people or people with long-term conditions, and their carers. Based on the process evaluation findings this is probably fairly typical of those in receipt of IPC overall.

D.12 Some of the sample were involved in IPC co-production groups and so had an insight into IPC that other users would not have had. They are therefore not necessarily representative of typical IPC users.

Findings

D.13 This section presents findings from the qualitative interviews under six headings: (1) description of the sample; (2) knowledge and understanding of IPC; (3) experiences of the IPC approach; (4) sources of care and support; (5) choice and control; and (6) the impact of IPC.

Description of the sample

D.14 Overall, the group of service users was very diverse. They included: older people with dementia who received no statutory support, had no budget they were aware of and received a single intervention from an age or dementia-related voluntary organisation to assist in accessing benefits and local activities; people with long-standing conditions, some of whom received social care funded-support already, and who were provided with additional help in the form of information and advice from voluntary organisations; people with mental health needs who appeared to be offered one-off/small budgets to assist with social engagement or physical activity; and people of all ages with complex needs already in receipt of continuing healthcare (CHC) funding.

D.15 Service users were very confused about budgets and not always clear about whether they already had a budget before IPC. Personal budgets for social care appeared in many cases to be long-standing and not introduced as a result of the IPC process. At least two service users had a PHB that preceded IPC; both received CHC funding. In addition, three young adults with complex needs all received CHC funding through personal health budgets; all had received CHC funding pre-IPC, but it was not clear whether some or any of the funding was via a PHB. Carer's allowance, attendance allowance and savings from council tax reductions were all cited as key sources of funding to pay for care, including help at home such as cleaning and gardening.

D.16 Carers who were interviewed were family members, especially spouses, parents, daughters and sisters. The most common caring activities revolved around maintaining the home, for example, cooking, cleaning, laundry, ironing, and gardening. These were typically activities that the cared-for person was no longer able to assist with. Additional activities included managing medication and for some service users assisting with feeding, dressing or showering. Some service users had adapted their homes (prior to IPC) to assist with mobility, such as moving bedrooms or bathrooms downstairs, installing stair lifts and wet rooms.

D.17 Carers also acted as advocates or voices for the cared-for person as well as listening on their behalf. This was particularly important when communicating with service providers and other professionals and when arranging care and support.

D.18 Administrative tasks were also a key responsibility; these included managing personal budgets, care packages and personal assistants (PAs); checking care agency timesheets and accounts; and organising activities, hospital appointments and transport.

D.19 The experiences of service users and carers are presented together in the sections that follow. Where there were specific differences in the experiences of service users from that of carers, these are highlighted. Similarly, where service users or carers from one cohort (for example, mental health, older people, long term conditions) appeared to have different experiences to those from another, these are also noted.

Knowledge and understanding of IPC

D.20 This section describes how service users and carers recalled first hearing about IPC and how it was explained to them; and their understanding of the IPC process prior to experiencing it.

How service users first heard about IPC

D.21 Interviewees often struggled to remember how and when they first heard of or joined the IPC programme. This uncertainty and confusion seems to be related to the multitude of professionals and organisations involved in their care and support, and the many different care initiatives they were experiencing. Paperwork explaining IPC was also reported to be insufficient to enable service users to understand the programme well. In addition, at the time of the evaluation interviews, initial IPC-related conversions were reported to have taken place months, in some cases years, previously, which may have further added to service users' difficulties in recalling events. For example, one interviewee was not able to pinpoint when IPC began for her, commenting:

> *I think that came under IPC at that point [when given CHC funding], but like nobody kinda said that to us. But I think, yeah, I think that was kind of the idea.*
>
> (Service user ID18, LTC, site 8)

D.22 Notwithstanding this confusion, service users reported first hearing about IPC via a wide range of people and organisations. For example, the Alzheimer's Society and Age UK featured highly in some IPC areas, with service users finding out about IPC because they were already in touch with these services or received support from them, but others were referred to these organisations having had no prior contact with them. Many service users first heard about IPC through their GP or an NHS organisation such as the local Clinical Commissioning Group (CCG) or hospital, for instance, people in receipt of CHC funding were often introduced to IPC via their CHC nurses or CCG contacts.

D.23 In many cases, service users became involved with the IPC programme through a referral by or letter from a professional such as a GP or social worker; some letters were invitations to group or one to one meetings with the local IPC lead where there were opportunities to ask questions. Typically, a support worker, the service user themselves or a family member proactively pursued any initial offer of IPC, with a couple of interviewees taking the initiative and contacting their GP practices after hearing of IPC elsewhere.

D.24 Some service users saw advertisements for, or were invited to become involved in, local IPC co-production groups, and from there learned more about IPC, subsequently requesting to join the programme and experiencing the IPC approach as a service user. In a minority of cases, interviewees spoke of learning about IPC through luck and chance encounters, such as one man who had never heard of IPC but contacted Age UK following a suggestion from a neighbour; Age UK were the organisation tasked with delivering the IPC approach to older people in that area.

D.25 This wide range of methods through which service users and carers first heard of IPC reflects the equally wide range of ways in which IPC was being delivered in the evaluation sites and the large number of organisations doing so. It also re-enforces that in many cases the approach was not systematic, as reported in the process evaluation.

How IPC was explained

D.26 Despite hazy memories of when IPC was first introduced to them, service users were able to describe some of the ways in which IPC was explained to them.

D.27 For some, it was explained in terms of its overall aims, using words such as choice, control and tailoring of care and support.

> *[I received a letter] explaining that it's putting it more in your hands, your care, so you can decide about things a bit more and you've got more control over it than if someone else is deciding things for you. Then you have more of a chance to tailor it to yourself as well, tailor it to your needs.*
>
> (Service user ID13, mental health, site 6)

D.28 While some were happy with this explanation, others found such letters vague and uninformative.

> I received a letter in the post saying, talking about IPC, very, quite a cryptic letter, if I'm honest (laughs) but sort of saying that we were going to introduce this thing called IPC and it was going to give you more choice and control over your care and it, you know, it was going to be amazing and that this was our new way of working and it didn't really explain much but it kinda invited you to an evening to explain more.
>
> (Service user ID18, long term condition, site 8)

D.29 More typically, service users reported that IPC was introduced and explained to them in terms of a budget or financial support that would help them with their condition by facilitating access to activities, courses or other support, including from the community. Sometimes these were activities that the service user accessed already but could be paid for from the IPC budget. Most service users remembered the budget being presented as a one-off payment or time limited funding. The exception was people with CHC funding. Although service users did not talk about budgets as additional money, it was evident that in most cases it was, at least as far as service users were concerned as they did not have to forgo any services to be allocated an IPC budget. For some interviewees, for example, IPC was explained in terms of securing funding to continue attending courses and activities at a centre they already attended. One interviewee reported receiving a phone call, but she did not understand who the call was from and initially did not trust the offer of money; she did remember the local brand name for IPC which was used in the call but this did not mean anything to her at the time.

D.30 IPC was also described as an opportunity to access peer support to help with getting out and about as well as to help with deciding how to use the IPC budget. Respondents did not report integration as a key element of how IPC was described but did describe it as an opportunity for people to have a voice.

D.31 Some interviewees reported having no recollection of hearing about IPC, a new approach, integration or personalisation, while others were confused by the acronyms and so conflated IPC and PHB.

> *To be honest, there's so many different abbreviations for so many different things that like, my head gets like a bit full with it. So for me I, I don't, I don't really separate it out that much.*
>
> (Service user ID19, long term condition, site 8)

Confusion and uncertainty

D.32 In the majority of interviews, participants expressed some level of confusion or uncertainty about IPC. This ranged from having no idea what IPC (or the local term for IPC) was, or who any of the organisations delivering IPC were, through to understanding the IPC programme but being uncertain around what the IPC budget could be spent on. It was also apparent that service users could be confused about some aspects of IPC at some points in time but were clear about other aspects or became clearer later in the process.

D.33 One of the reasons service users were confused about IPC was that they were going through a very stressful time when they were first approached about it and felt that they were not in a suitable emotional state to take on board the information. Even where service users felt able to engage, some reported the programme being hard to grasp and that there was insufficient accessible information about it.

> *I think in terms of the communication, I think there's a long way to go. I don't think somebody who's not experienced it has a good mechanism to explain it.*
>
> (Service user ID18, long term condition, site 8)

D.34 Those service users reporting to have no knowledge of IPC were a significant minority. They were characterised by having no recollection of the IPC programme or approach, the organisations delivering IPC, personal budgets or personal health budgets. However, once they found or were shown relevant leaflets, some were able to recollect a meeting about IPC. However, others, although able to describe meetings and support from certain organisations, were not clear whether or not these organisations were delivering IPC.

D.35 For example, in one site, a voluntary organisation was tasked with delivering IPC to people with dementia. The people with dementia and their carers knew the name of the voluntary organisation, the local individuals who were helping them, the local dementia cafes and groups, and had leaflets about these groups, but were not aware that the help they were receiving was part of the IPC programme or was any different to the help that was available pre-IPC.

D.36 Many interviewees had a multitude of people and organisations involved in their care and support and found it hard to differentiate between them all. For example, one man reported receiving physiotherapy but was not sure if this had been arranged by the local voluntary organisation (and was therefore part of IPC) or the district nurse (in which case it wasn't). Another described being unclear about which people at the local breakfast club were volunteers and which were paid members of staff with responsibility for assisting with identifying and resolving wider needs as part of the IPC process.

> *They're all wearing badges with Alzheimer's Society and all that on them, I don't know.*
>
> (Carer ID15, mental health, site 5)

D.37 Even where service users understood the IPC approach or programme in some detail, there was still uncertainty about where the money was coming from, whether it was a one-off budget or would be renewed annually, and how the budget could be used. For example, one woman reported asking if she could use some of the budget for massages to relieve pain and help with mobility in her shoulders; she reported being turned down with no reason offered and felt frustrated that the care and support manager she worked with could offer no explanations and was not in a position to make any decisions on budget use.

Experiences of the IPC approach

D.38 This section details service users' experiences of the IPC approach, including: what happened in their first/IPC conversations; how their personalised care and support plans were developed; and how this was different to pre-IPC.

The focus and function of the IPC conversation

D.39 Initial IPC conversations tended to have a number of functions: to help IPC co-ordinators and service users understand their support needs; to develop a support plan; and to provide practical support in arranging care and support.

D.40 The time from initially being invited to take part in the IPC process to the IPC conversation and support planning was variable. While it could be quick and easy for some, others reported delays of months from the initial invitation to the first conversation. Even after the conversation began, the support planning and budget setting process itself could be prolonged; delays and mistakes in calculating CHC budgets were a particular issue that was raised. One person waiting for a budget to assist with mental health issues commented that the administrative problems in setting up the IPC budget were '*enough to make you feel unwell'* (Service user ID09, mental health, site 13).

D.41 IPC conversations took place with a care co-ordinator or similarly named practitioner. Some interviewees with long-term conditions from one IPC site described 'peer coaches' who helped with developing personalised care and support plans.

D.42 There was typically more than one conversation, and these took place face to face. The focus was on what service users were able to do for themselves, what they wanted to do and where they felt they needed help.

> *All the time they [the care co-ordinator] are taking in all the information and they're building a picture of you, so it didn't feel demanding, at all.*
>
> (Service user ID10, long-term conditions, site 4)

D.43 The purpose of the conversations was to develop and record a support plan and, if relevant, to decide how the budget should be spent. In one IPC site, many of the interviewees spoke about using their budget to continue using a well-being centre they already attended, although they were not clear how it was being funded or how their budgets contributed to its funding. Another popular option across sites was to fund new gym memberships to assist with mental health as well as physical issues.

D.44 Not all interviewees remembered these conversations well or knew whether or not they had a support plan. However, even where this was the case, service users and carers spoke positively about the practical support they had received, particularly from organisations such as Age UK, regarding issues such as identifying and applying for benefits, arranging for aids, adaptations or other equipment in the house, and learning about local community-based groups.

The experience of the IPC conversation

D.45 Relationships between the service user and the IPC care co-ordinator were important but variable. Service users valued positive relationships whereby the care co-ordinator listened attentively and understood the IPC user's care needs. As an example, a daughter of a man with long-term conditions described the relief she felt when an Age UK care co-ordinator visited and listened in a friendly manner:

> *She's such a personable person that I think she just made us all feel like, phew, thank goodness, someone's here, someone's listening to us, someone who talks our language and is just a friendly, ordinary person, not someone who's in authority and seems to be questioning everything, every statement that you make.*
>
> (Carer ID06, long term condition, site 10)

D.46 A mother of a young man with complex needs praised the IPC approach she had received for being less blinkered than traditional medical approaches:

> *I think when you come across somebody that is unable to look outside their blinkers you are reminded about how good the personalised approach and the care and support planning approach is that we receive; it makes me more grateful for that, because the, the gap between the two is huge.*
>
> (Mother of young man ID03, complex needs, site 8)

D.47 Another mother of a young man with complex needs, in receipt of CHC funding, described the efforts she had gone to to select and test an appropriate service for her son to attend on some weekdays. She had done this in preparation for a CHC panel meeting whereby her son's support plan would be reviewed. She reported feeling both listened to and in control.

D.48 Relationships were less positive where care co-ordinators appeared to focus on providing information rather than listening to the service user or helping them to understand the information offered. Examples include a peer support worker who, according to the service user, did not understand the service user's needs and instead focussed on her own issues; and an IPC care co-ordinator who had a more limited relationship with a service user and his daughter than a long-standing social worker with whom the family felt more content. Relationships seemed to be particularly poor with little opportunity for development when the information offered was overwhelmingly on paper rather than verbal. Of course, there were exceptions, with service users also commenting on the difficulty of retaining information that was offered only verbally with no written back up.

D.49 Furthermore, relationships suffered when the care co-ordinator appeared to lack knowledge. For example, a woman with long term conditions reported her support planner not knowing what a PHB could be spent on and not understanding definitions such as 'waking night care'. It seemed that his role was purely about developing a support plan, but the service user felt he should also have been able to advise on if and how a personal budget could be used to meet that plan:

> *He was like "I'm just here to help with like making a support plan." But I don't think it was helpful that he didn't know the answer to specific questions; I think surely people that are helping you make your personalised plan should know these things?*
>
> (Service user ID19, long-term conditions, site 8)

D.50 Practitioners'/care co-ordinators' pro-activity and helpfulness was a recurring theme. In sites where voluntary organisations were helping to deliver IPC, service users on the whole praised them for their level of knowledge about things such as benefits, council tax reductions, and local groups. In most cases these voluntary organisations also made applications for such benefits or arranged other services or support for service users. Usually once the benefits or support were in place, the co-ordinators stepped back and had no ongoing contact, but service users reported feeling comfortable that the door had been left open for them to get back in touch if they wished. There were exceptions to the rule where a few service users reported that local care co-ordinators from voluntary organisations had done nothing for them and nothing about their care or support had changed.

D.51 As reported above, some service users wanted and felt in control of support planning and arranging support and care for themselves or a family member. However, other service users, mainly the older people with long-term conditions or their carers, were grateful that someone else was taking charge at a stressful time:

> *I think she sort of came in and took some of that [stress] away.*
>
> (Carer ID06, long-term condition, site 10)

D.52 The extent of service users' involvement with their personalised care and support planning varied. While service users wanted to have influence, for some this could be challenging, especially if they felt they were receiving insufficient guidance. People with CHC funding and parents of young adults spoke of welcoming the opportunity to write a personalised care and support plan but sometimes feeling alone in the process, creating personalised care and support plans with little idea of what a should go into one. These two groups appeared to be writing support plans themselves, facilitated by support planners; older people typically did not talk about support plans or writing them. What service users felt would have been helpful were prompts to encourage them to consider care and support options they were not aware of or had not used before, to open up the range of opportunities. Also, service users wanted guidance about what budgets could be spent on and what kinds of support were realistic, to avoid setbacks such as requests being turned down, which could be quite demoralising.

D.53 Service users spoke appreciatively of care co-ordinators or support planners who got to know the services users/carers and judged how much help they needed in putting together a support plan.

> *I think there's an understanding [from the case managers] of what we can and can't do and capabilities and, you know, if someone had said, no, we'll do that, that would have annoyed [husband], but I think they understood that [husband] and I could do this [support planning] and present this back, so they gave us that autonomy, which was, you know, really quite welcoming.*
>
> (Carer ID21, long-term condition, site 8)

D.54 These experiences suggest that one size does not fit all and illustrate the importance of personal, not just personalised, relationships.

The IPC experience as an integrated approach

D.55 Many interviewees highlighted a lack of integration between health and social care and other organisations, but there were also examples of improved integration and communication.

D.56 One positive example is of a dementia café acting as the hub from which other support and networks could be accessed:

> *It's almost like the wheel and you can spin off on whichever, they'll advise you on have you thought of going this way and they have leaflets all the time.*
>
> (Carer ID20, long-term conditions, site 8)

D.57 A carer of someone else with a long-term condition felt that services had become better integrated since IPC, citing their 'case manager' as key in taking requests from the carer and her husband to 'the Panel' for approval. Others spoke about good communication between different elements of their health care team but felt health and social care professionals could communicate better. This desire for better communication and integration was widespread, noticeably for people with dementia and their carers who wanted to be able to go and talk to one person who could then suggest and make contact with other services and support.

D.58 Experiences of lack of integration were more evident. One issue was the lack of clarity over which organisation had responsibility for key decisions. This could result in decisions being delayed and service users feeling stressed. An example involved a carer trying to get a wheelchair for her spouse. The hospital wheelchair service had repeatedly said that the chair would be ready the following week, but it never was. When the carer rang to enquire, she was told it was delayed with the contractors. Eventually she rang the contractors who reported that they had the chair but were waiting for an email from the wheelchair service before they could release it. The carer arranged for the email to be sent and the chair was released. The carer had since joined the local wheelchair personalisation group to try and streamline the process. Other service users used the terms '*piggy in the middle*' (Carer ID02, young adult with complex needs, site 10) to describe being stuck between poor relations between local health and social care services, and being '*passed from pillar to post*' (service user ID15, LTC, site 12) to describe an IPC journey between health and social care.

D.59 Another important issue was that there was no single point of contact for people using multiple services. This gap was felt particularly acutely on discharge from hospital when service users could feel '*a bit cast adrift*' (Carer ID06, LTC, site 10), as well as for older people and their carers who were trying to co-ordinate services and support from a range of local groups and voluntary organisations. Some service users had a list of contacts but were unsure if any one person could co-ordinate services; others had a favourite person who had been particularly helpful previously and who they would contact again. Some would default to asking their GP.

D.60 Service users and carers also spoke about a general lack of integration across the IPC approach and a lack of awareness of IPC health and social care workers outside the IPC programme, from not recalling anyone ever speaking about integration, to professionals working in silos, to being classed as having an integrated budget when this was not the case. In the latter example, a woman with long-term conditions received a direct payment from her local council (and had done for years) to pay for her social care needs and, separately, had been given a one-off payment from the NHS as her IPC budget; the one-off payment was made through the local council direct payment mechanism, which she believed meant she was classed by the IPC team as having an integrated budget even though the rules about how each budget could be used were different and so, in her view, not integrated.

Care and support

Personal budgets and personal health budgets

D.61 Everyone in the sample was asked whether they had a personal budget as a result of the IPC process. For some service users, this was a familiar term whereas for others it was not.

D.62 Table D-1: shows the number of service users with and without personal budgets at the time of the interviews.

Table D-1: Number of service users with personal budgets

Type of budget (if any)	No. of Interviewees
No budget	15
Personal (social care) budget	1
Personal health budget	22
Personal (social care) budget and personal health budget	0
Not clear if had a budget	4

D.63 Almost half the sample (15/42) had no budget. Many of these had never heard of a personal budget or personal health budget. Some service users were confused about budgets and when asked about a personal budget, spoke about carer's or attendance allowance, or the mobility scheme. It was apparent in some interviews that the service user did have a personal budget although they were not clear about it. For example, one mental health service user thought she received some form of funding to enable her to attend a local community centre group but was unsure about this; she also reported that her Community Psychiatric Nurse told her she had a personal budget, but the interviewee did not have any more details about it. Another interviewee who attended the same community group thought the budget was paid straight to the community centre to pay for organising the group. Other service users did not know if they had a personal budget of any sort, but did appear to be accessing additional activities.

D.64 For those who knew they had a PB or PHB, some were large and flexible, however, others were small annual budgets for use with only a limited range of activities, described as one-off payments as part of IPC. These one-off payments were perceived as helpful for purchasing equipment or paying annual gym memberships, but interviewees were concerned that they would be unable to afford continued membership once the payment ended. One person with CHC funding commented that his budget was helpful, however, this was because it was not part of IPC; he reported that IPC budgets in his area were limited to £750 which he felt was insufficient for many service users.

D.65 There were also delays in receiving budgets, which were reported to result in delays in accessing care and support or other activities. Occasionally service users mentioned having payment cards to pay for activities such as gym membership or attending football matches.

Positive experiences of budgets, care and support

D.66 Many respondents reported improvements in care and support since involvement with IPC. Some of these improvements were about access to additional services; specific examples included physio sessions, gym membership, dieticians, counselling and weight management advice. These services were not newly developed specifically for IPC but appeared to have been offered to these service users in addition to services they accessed routinely. Access to new groups and activities were also cited as benefits of IPC. These were often provided by the voluntary sector or community groups and included events such as breakfast clubs, dementia cafes and singing groups, and typically, but not exclusively, related to people with dementia. In one site, people with mental health issues talked about a long-standing local support centre as key in providing them with help in a variety of ways from housing repairs to employment support. Although the centre had been in existence for a long time, respondents reported that since IPC it had been able to fund and offer a wider range of activities; these activities were probably being funded from pooled budgets, but respondents were unclear about this. Many participants who had made contact with these organisations or joined local groups did so because they had been signposted to them as part of the IPC process; although the organisations and groups existed pre-IPC, respondents had not accessed them.

D.67 Some service users also spoke positively about the level of financial support available, particularly people with CHC funding. While some with CHC funding were very clear that they felt they were receiving more funding than pre-IPC, others were unsure about this. All but one person with a CHC budget felt that they were able to use the budget a lot more flexibly since IPC. For example, a mother of a young man with complex needs reported that she felt she was receiving quicker and more positive responses to problems with her son's package post-IPC whereas '*before this approach I'd have been told "tough, that's the way it is*"' (Carer ID03, young adult with complex needs, site 3).

D.68 Some of the most positive experiences of care and support were reported to be due to the individuals involved rather than the IPC process. Respondents spoke about named individuals or organisations being very helpful. Examples included Age UK advisers, dementia care workers and CHC nurses. This may be because these individuals were particularly helpful people, or it may be that the IPC process introduced a more personalised approach in which key individuals played a role. It is likely to be a combination of both.

D.69 Some service users reported that formal services, such as home care workers and personal assistants, were more reliable post-IPC. They reported feeling more confident that care workers and PAs would meet care needs consistently and that care packages were more stable. It was often hard for respondents to know whether these improvements were due to IPC or other factors such as starting to receive CHC funding, using a personal budget or having help from care co-ordinators/case managers, some of which occurred simultaneously. Some improvements may have resulted from service users employing PAs or care workers directly through a PB/PHB rather than through an agency, although this was not articulated clearly.

D.70 One respondent with a long-term condition also reported different attitudes to budgets between the health and social care sectors, which subsequently affected service users' ability to spend budgets to meet needs:

> *Health are very much, get on with it, you've gotta live and everything else, and they encourage you to do your best, whereas Social Services are not like that at all. It's about if I can cut you and cut you and cut you.*
>
> (Service User ID16, long-term conditions, site 8)

Challenging experiences around budgets, care and support

D.71 There were also more challenging experiences, with many service users unable to pinpoint any positive effects of IPC on their care and support. Four key issues were apparent.

D.72 First, service users were concerned about the longevity of budgets and therefore, any support services and activities purchased with those budgets. This was a particular issue for service users who had been given one-off budgets for a limited time period or for specific items such as annual gym memberships. Uncertainty about whether a budget would be available the following year was a concern for service users, especially if they felt they were benefiting from the activities they were accessing and feared they may not be able to continue to do so. People with mental health issues in one site voiced concerns about a move from group funded activities to a recovery model that relied on self-management and personal budgets, which they feared in the long term would threaten the number and type of group activities available.

D.73 Second, there were frustrations around the use of budgets, with many service users complaining that they were not allowed to use their budget in the way they felt addressed their needs best. Some service users reported not being allowed to spend their budget on the type of support they wanted, for example a personal trainer to help with motivation and create a personalised exercise programme, whereas they were allowed to spend it on gym membership. Service users were also frustrated at being told that they were not allowed to top up their budgets in order to purchase better quality equipment such as a wheelchair.

> *It was neither use nor ornament […] because what I actually wanted the help and support for wasn't what they gave me the budget for.*
>
> (Service user ID15, long-term condition, site 12)

D.74 A third major challenge was co-ordination. Service users felt that they lacked a single point of contact to act as a central hub for questions or help with arranging care and support. This was evident in service users' concerns over infrequent meetings with care co-ordinators, lack of clarity from such meetings, the absence of face to face discussions or the apparent lack of interest from some professionals. In particular, many service users commented that no one followed up on initial meetings by offering ongoing support. Even if there was ongoing contact, contact by telephone only without any visits to service users' houses left service users feeling disappointed and questioning professionals' commitment. Numerous interviewees pointed to the level of responsibility they were taking in arranging their care and support as evidence of lack of help from professionals.

D.75 Finally, and related to the lack of co-ordination, many service users felt that they were left alone to implement their personalised care and support plans. Service users reported a range of experiences which appeared to be based in part on their very different needs but also the extent to which they were able to utilise sources of support such as friends and family. A common thread throughout interviews with both service users and carers was that they felt they had to be pro-active in seeking and arranging care and support.

> *I know what I'm looking for, and I know that if I want anything to happen I've got to make it happen, nobody else is gonna make it happen.*
>
> (Carer ID14 mental health, site 5)

D.76 Despite families being important and in some cases being chosen as a main form of support, service users also felt that friends and family as well as community and voluntary organisations had no choice but to assist with arranging care and support and in some cases, fill the gaps left by formal services.

Choice and control

D.77 A key aim of personalisation is to facilitate service users to have choice and control over their care and support. This can include choice and control over planning, decision making and care and support options, along with use of budgets and other resources. Some of these issues have been discussed above. These experiences can be positive but service users also experienced constraints. This section explores the positive and less positive elements of choice and control service users felt they had, including lack of choice and control. It then considers possible reasons for variation in service users' experiences.

Positive experiences of choice and control

D.78 Despite many service users reporting being left to their own devices and being confused about how their budgets could be used, others reported that their experience of IPC personalised care and support planning was positive and offered them the opportunity to include their own voices in their personalised care and support plans. They spoke about feelings of autonomy when they were encouraged to write personalised care and support plans and of being given the space to be themselves.

I voice my opinion. I explain what I need and I'm heard. The care plan is geared towards my needs.

(Service user ID02, MH, site 6)

I think because of the way that was done and because of the person that I think came out and his approach it changed our worlds, because suddenly it was like, actually what do you want to do, [son]? Which was radical, for want of a better word, because everything had been, well what you can't have and this means you can't have and you're too complex cos you can't have, whereas suddenly it's all flipped round to actually what would make [son] happy?

(Carer ID03, young adult with complex needs, site 8)

I liked him. "Can we come and talk to you about how we can help your husband?" That's what I liked. It was, "How can we help?" Nobody has ever really asked how they can help.

(Carer ID19, MH, site 6)

I liked him. "Can we come and talk to you about how we can help your husband?" That's what I liked. It was, "How can we help?" Nobody has ever really asked how they can help.

(Carer ID19, MH, site 6)

[The support planner] spoke about my needs and what I needed, why I needed those things, how I felt those things would help me. Actually she took some time to really understand what it is that I wanted.

(Service user ID09, MH, site 13)

I think you feel that people are questioning you for the reason of trying to find out if you're trying to get something that you're not entitled to or giving them some information that's incorrect and that sort of thing, whereas she was just questioning us (sighs) just to help us. I think that was the difference.

(Carer ID06, LTC, site 10)

D.87 The professionals who visited the service users and their carers to discuss support planning were key. Service users who reported positive experiences in exercising choice and control invariably spoke about how helpful their support planners were and how different their approach was to anything they had experienced before. Support planners asked questions to help them understand service users' lives and wants but also listened attentively and responded to what service users were saying in a holistic way.

D.88 Positive experiences also arose from control over budgets, which many service users reported as providing them with very welcome feelings of independence and ownership. Not all service users were quite so positive, but on the whole, if service users had a budget and control over it, they did feel empowered. For example, a mother of a young man with complex needs including mild learning difficulties talked of how the flexibility within his CHC budget had empowered her son to manage his life in the way he wanted.

D.89 Many others used similar terms, such as being enabled to live the lives they wanted or spoke of getting their lives back or getting back their independence. This was evident throughout the interviews but was especially true for carers who spoke of the positive impact of being able to focus on something other than care and of being able to reclaim their identity. For example, a mother of a young man in his 20s commented that:

> *It's nice to be valued for who I am rather than as [son's] mum or his medical diary manager.*
>
> (Carer ID03, young adult with complex needs, site 8)

D.90 Service users often managed the budget themselves, sometimes with their carers, but were able to tailor the level of control they had by opting for external support with some tasks, usually help with employment issues from, for example, recruitment or payroll organisations. This assisted service users who wanted control over the amount, timing and selection of care workers/PAs supporting them but did not want the additional administrative work involved with calculating wages or paying taxes. This form of support was helpful for service users who were simply not interested in administration as well as service users who already had busy lives and no time to dedicate to these tasks.

> *I used to do the monthly what do you call it, the quarterly return, financial return. However, as now I'm now paying them [the payroll company] to pay the PAs and for them to submit the paperwork for the quarterly returns, it just didn't seem to make sense that I was doing that on top of my full-time job, etc.*
>
> (Carer ID21, LTC, site 8)

> *You've got a choice of doing it yourself, getting the timesheets filled in and everything, and sorting out the money, but we said we didn't really want anything to do with that.*
>
> (Joint Service user and carer IDs 20&21, MH, site 6)

Constraints on choice and control

D.91 Not all service users following the IPC approach were able to be involved or interested in having choice or control over their care and support decisions. For example, a young man with complex needs was able to make simple choices about, for example, whether he wanted a drink, but not more complex choices about care arrangements; his mother made these choices. Conversely, a man who had had a stroke was able to take part in conversations about care and support but chose not to because he, according to his wife, found adjusting to a different way of life post-stroke too overwhelming. In both these cases, and others, it was the carers who were experiencing choice and control over decisions.

D.92 Some respondents reported that constraints on how they were allowed to use their budget, or the size of the budget, limited their abilities to exercise choice. For example, a spouse of a man who had had a stroke requested purchasing a specialist toilet to assist her husband with personal care but, despite the best efforts of her case manager, the request was turned down as it was seen to be too expensive; the interviewee was told she could choose something else to buy, but as that was all she could think of that would have helped, they didn't buy anything. In another example, a woman with both mental health needs and physical impairments requested a consultation with an out of area NHS specialist but was refused. As far as she understood this was on the grounds that her condition was mental health not physical; she also requested a personal trainer/tailored exercise programme to assist with mobility but again was turned down because her funding was for mental health needs. Many other service users spoke about the frustration and resulting lack of choice arising from rules and restrictions on how they could spend their budgets.

> *You're not in control because you can only spend it [the budget] on exactly what's agreed.*
>
> (Carer ID20, LTC, site 8)

D.93 A further constraint was that with greater autonomy and control from managing a budget and arranging care and support, typically via PAs, came greater administrative burden and responsibility which in turn could impact on service users' time for and control over other aspects of their lives.

D.94 Practical constraints also had negative impacts on service users' abilities to exercise choice or be in control of their activities. For example, service users might be made aware of community-based groups or activities that they could join but were unable to get there because of poor mobility or a lack of accessible transport. Lack of acceptable respite opportunities also led carers to feel they lacked control over their own lives.

D.95 Those individuals who did not have or did not remember being involved in developing a support plan unsurprisingly felt that the process had not provided them with opportunities to exercise choice or control. Service users also lacked any choice of support planner; this was mentioned specifically in relation to being allocated peer planners.

D.96 The process of approving support plans or spending from budgets was also felt to be somewhat removed from individuals and so limited their control:

> *It's not like you get to go and argue your corner. You say "I want it." They sit in a closed room and say "Don't give it to him."*
>
> (Service user ID20, MH, site 6)

D.97 Carers in particular (other than mothers of young adults receiving CHC funding), felt that they had seen no improvement in their choices and did not feel empowered as a result of IPC. This was usually because they had seen very little change in their own roles or in the lives of the person they cared for. Some also felt they were left on their own with no support in making choices; this may be in part because carers of older people were often provided with information by advisers from voluntary organisations and did not associate this form of help with personalised care and support planning.

Factors affecting variation in experiences of choice and control

D.98 The wide range of experiences of choice and control appear to be attributed to four main reasons.

D.99 First, service users' different desires or abilities to exercise choice. Some wanted to exercise choice and took every opportunity to do so, whereas others chose not to be involved at all or opted to exercise choice and control in selected areas only. For the latter, having support to manage the tasks they were not interested or comfortable with assisted them to feel autonomous and independent.

D.100 Second, some service users' particularly good or particularly poor experiences of choice and control appeared to be related to the actions and accessibility of key professionals. Where professionals were hard to contact, offered limited support or gave service users little space to express themselves, experiences of choice and control were unsatisfactory. Where professionals were accessible and engaged service users in the IPC process in an empowering way, especially in support planning, experiences were more positive.

D.101 Third, it appeared that in order to gain the most choice and control, service users needed to be pro-active and push hard within the system to get the results they wanted. Conversely, service users less willing or able to do this or to challenge decisions tended to experience less choice and control.

D.102 Finally, it may be that service users with particularly positive experiences were those who had opportunities to choose what interests and activities to include in their support plan and who also had control over a budget that enabled them to pursue them.

Perceived impacts of IPC

D.103 The quantitative impacts on service users' quality of life and well-being are described elsewhere in the main report. This section provides softer illustrations of service users' perceptions of their well-being. In interpreting these findings, it is worth noting that a number of service users had a very limited understanding of IPC and were not aware of whether they had received care and support as part of the IPC programme. They also often conflated IPC and PHBs. It is therefore difficult to disentangle the perceived impacts of IPC from those of wider services and support or of having a budget.

Quality of life and well-being for service users

D.104 Service users across the board spoke about improvements in opportunities for social engagement. These included opportunities to get out of the house, meet people and make friends. People with mental health problems spoke about feeling comfortable joining clubs and sporting activities specifically for people with mental health issues; one woman commented that in these groups she felt she was among people she could trust. Sometimes service users talked about improved well-being and reduced social isolation as a direct result of having a PHB. For example, a young man used part of his CHC PHB to employ PAs his own age; this helped him to join in everyday activities for people his age, such as trips to the local town. He also joined a new tennis club which enabled him to make new friends and build confidence by helping others.

D.105 One site utilised peer coaches to help service users identify what was important to them; these relationships were reported as being very helpful in encouraging service users to take up new activities, which in turn increased service users' sense of well-being and in some cases helped service users feel like a valued member of the local community.

D.106 Both physical and mental well-being were highlighted. Physical well-being came from being more active, typically through use of gyms or sports-based activities. Service users felt that because IPC had provided them with more opportunities to get active, it had in turn assisted them to, for example, lose weight or become generally stronger. One person with long-term conditions stated that he had not been hospitalised since starting to use a PHB.

D.107 Reports of improvements in mental health and well-being were very common. Sometimes these improvements resulted from the sporting and other activities described above. For example, people experiencing weight loss also reported feeling more confident. Confidence also came from speaking regularly with different professionals about care and budgets. The use of PHBs to employ PAs and manage large care packages also contributed to service users' sense of worth and self-esteem. In addition, social engagement activities added to service users' mental well-being. The benefits of having a circle of support and a safety net of people to 'keep their eye on me' (Service user ID11, LTC, site 4) were also mentioned.

D.108 Related to mental well-being, service users reported that the care and support they received assisted them to feel 'normal' or to lead a 'normal life' by taking part in everyday activities, such as going to the cinema or meeting friends. Partly this was because of the flexibility of employing PAs rather than care agencies that offered only fixed hours, and partly it was about taking part in activities with like-minded people. Empowerment, control and flexibility featured strongly, with service users also talking about being able to take a more holistic view of their lives in the personalised care and support planning process. A mother spoke about her disabled son's motivation for life increasing again through the IPC process after a decline in well-being following his transition from children to adult's services.

D.109 On the downside, service users commonly reported that dealing with administration, chasing professionals, arranging care and support, and the time taken to effect change were all stressful, and had negative impacts on their well-being and that of their families.

Quality of life and well-being for carers

D.110 Carers also noted improvements in their mental well-being, fuelled by having less to worry about. Again, this related to the ability to employ PAs who service users and their carers felt comfortable with and who fitted into daily routines; service users spoke about a more relaxed atmosphere and feeling of well-being around the home. Some service users noted that it was comforting to have a network of support. Money worries were also lessened for some carers who had been helped to access benefits and other allowances to assist with paying for support.

> *'I think we feel very lucky to live in this day and age where this, this funding is available, because it's enabled [husband's] life to continue, and all our lives to continue in this way, and it'd be very hard if we had to fund every bit of care that we needed, eventually we'd run out of money and that would be very worrying for everybody. We feel very, very fortunate to live in this country and have this opportunity'*
>
> (Carer ID20, LTC, site 8)

D.111 The support that service users accessed, particularly dementia-related cafes or other activities, also reduced the practical pressure on carers and, in particular, gave them opportunities for short breaks from their caring roles. Short breaks that engaged the service users in interesting activities also aided mental well-being through lifting carers' spirits as a result of the person they cared for becoming more content.

D.112 As with service users, carers also noticed that their confidence increased as a consequence of dealing with different professionals. This new confidence came from experience and increased knowledge about the service users' needs and behaviours but also from the re-assurance that key people such as care co-ordinators were available to help out if needed. Some carers gained knowledge from attending specialist courses on dementia; others relied on peer support and learning from people in similar situations who they met at mental health groups, dementia cafes and other activities.

D.113 A key theme for carers, notably mothers of disabled young adults with CHC-funding, was getting their lives back through arranging successful packages of care and support. One mother talked about feeling as if she had become a professional care worker in the two years between the end of her son's time using children's services and the start of IPC; since IPC, although she retained an overview of all of her son's support from PAs, because they assisted him with everyday activities, she felt she was '*back to being a mum' (Carer ID03, young adult with complex needs, site 8)*.

D.114 As with service users, carers also found some of the administrative processes and the difficulty they experienced contacting professionals to have negative impacts. One sentiment that was repeatedly mentioned by carers was the ongoing and relentless nature of their involvement in caring for their relative. Many interviewees highlighted how much they were relied on but also how much they relied on other family members for help. Many of the carers interviewed lived with or quite close to the person they cared for, but some cared at a distance which involved an hour or more travel each way; if carers were daughters or sons, they often also had children of their own to care for. Likewise, parents of disabled young adults had ageing parents who needed their support as well. These demands varied according to the cared-for person's needs but were felt to be having a physical and emotional impact on the carers.

Perceived lack of impact from IPC

D.115 As noted previously, some service users had no recollection of IPC or any associated conversations; these service users likewise were not able to describe any impact of the IPC approach on their care and support. One participant who didn't know when she joined IPC but thought it was mentioned about two years' previously, noted '*all I can say is that the care I've received hasn't altered in any way, it hasn't deteriorated or improved*.' (Service user ID02, MH, site 6)

D.116 It was common, however, for service users to be aware of the IPC process but report no or very little change as a result. The extent to which these interviewees perceived the lack of change to be a problem appeared to be influenced by their level of satisfaction with their existing situation and care and support package. Three very different quotes from service users who felt nothing had changed illustrate this:

> I think the people we had on board were really good case managers and really listened, from the outset, I haven't really noticed a particular shift, and I think our contact who previously helped us set it [the care package] up was involved in the, probably before we got involved in the IPC stuff. (Carer ID21, LTC, site 8)

> *I don't get anything extra, not that I want anything extra, and they just put basically my life upside down with all these meetings and arguments [about PAs and home care agencies], just to keep what I had in the first place.*
>
> (Carer ID02, young adult with complex needs, site 10)

> *IPC is about window dressing to make it look good, thinking yeah, we can do this, we will tweak it here and there, roll it out and it looks fantastic, but actually it's the same, it's dressed up in a different cover.*
>
> (Service user ID16, LTC, site 8)

D.117 Several service users spoke about having insufficient funding or funding only for a limited period of one year; both were felt to restrict opportunities for long-term impact. One person also felt that there was too much focus on money and was concerned that for her and others like her, with emotional issues, money was not the answer.

D.118 Service users also noted the lack of impact in areas described earlier in this report, such as lack of integration between health, social care and other sectors; lack of help in arranging care and support, with much of the 'leg work' having to be undertaken by service users and their families; and lack of availability of professionals or a central contact person.

Discussion

D.119 This appendix has presented findings from interviews with service users and carers who have experienced the IPC approach, and their carers. The aim was to add to the quantitative findings by providing in-depth knowledge of service users' experiences of the IPC process and reflections on its impacts.

D.120 The findings give a mixed picture of experiences. For some service users, the IPC process was clear, involving a personalised conversation, support planning and a long-term budget. For others the process was experienced as disjointed, with variable levels of communication and a lack of clarity regarding budgets. The subjective impact on service users' well-being was also mixed and there was a group of service users who perceived very little change. For some service users who already had a personal budget of some form and were content with their care and support, there was perhaps little room for noticeable improvements from the IPC process and this may have led to some of the frustrations about lack of change. Where service users' situations were fairly typical, the IPC approach, at least for service users in this sample, appears to have fitted well but for service users who wanted something different or where there were difficulties with arranging care and support, the way (or skill with which) the IPC process was delivered was not always helpful.

D.121 As planned, we interviewed around 20 service users and carers of service users who had experienced the IPC approach due to mental health issues and 20 due to multiple long-term conditions or frailty. However, we were only able to recruit three carers of young adults with complex needs, no young people themselves and no people or carers of people with learning disabilities with high support needs. The interview findings therefore offer a limited view of experiences. Nevertheless, this sample aligns broadly to the overall population of service users who have experienced IPC.

D.122 Recruitment of the sample was challenging and relied on IPC case study site managers to identify potential interviewees and ask their permission to be contacted by the research team. As a result, the spread of the sample across sites was not equal; some sites were not represented at all. Recruitment through site managers raised the possibility that service users may be selected because they have a particular view or may be able to articulate their views well. IPC site managers were encouraged to suggest service users they felt had had positive as well as challenging experiences with the IPC approach and the range of experiences identified in these findings suggests this was achieved. The aim was also to interview service users between three and six months after their initial IPC conversation, but for many service users the conversations had taken place a lot earlier and others did not remember such a conversation. There also appeared to be some conflation by the interviewees of the terms IPC and PHB; many found it difficult to differentiate the two. This may reflect the way in which IPC was implemented in some areas and the messages service users heard from IPC managers who, as other parts of the evaluation have shown, used the terms PHBs and IPC interchangeably.

The following highlights key issues

Support planning

D.123 Service users' experiences of support planning, a key element of IPC, were mixed. Some service users reported what may be considered close to the ideal of designing their own plans with support from professionals whereas others felt unsupported and some could not remember the process. These experiences may be related in part to the skills and knowledge of the support planners. Relationships were less positive where support planners or care co-ordinators appeared to focus on providing information rather than listening to the service user or helping them to understand the information offered.

D.124 There were some complaints that support planners did not always know how personal health budgets could be used. Some respondents found the process of developing a support plan difficult without also knowing if the care and support detailed in the plan was permitted via a PHB. There is an argument that support planners should focus on service users' plans and goals rather than budgets, but these concerns by respondents do highlight that lack of knowledge by some support planners about budgets and implementing the plan can make the process more difficult and frustrating.

D.125 Service users also tended to speak about the support planning process and purchasing support via a personal budget as a single process, possibly involving some to-ing and fro-ing with budget panels to gain approvals for spending. These steps were often facilitated by the same people, for example a CHC nurse might assist with support planning, present the support plan to a funding panel for approval and help to arrange subsequent support. For older people with no budget, voluntary organisation advisers took on this role, acting as support planners as well as facilitating take up of benefits and access to local activities. It is therefore not surprising that service users talked about the two processes as one. Some service users reported the lack of a central co-ordinator to assist with all aspects of care and support as a challenge; there may therefore be benefits to these different processes being led by a single person.

Personal budgets

D.126 Having a budget was not essential to the IPC approach. Service users in this sample reported having personal budgets, personal health budgets, no budgets or no knowledge of budgets. Where service users did have a budget, key issues were flexibility in how it could be used and clarity about its longevity.

D.127 Other than people receiving CHC funding, most service users who reported having a budget understood it to be a one-off pot of money in addition to routine care and support. Some had no information on whether or not a budget might be available the following year; others knew they would have to re-apply but were not certain of being awarded the same, or any, level of funding. Those service users using their budgets to fund ongoing support such as annual gym memberships found this lack of information on longevity to be disconcerting and this undoubtedly affected their views of IPC.

D.128 Some respondents reported that constraints on how they were allowed to use their budget, or the size of the budget, limited their abilities to exercise choice. Service users with small budgets, of a few hundred pounds a year or less, reported feeling that there was very little they could do with the budget. In some cases, service users reported that there was a standard level for a PHB in their IPC site, which was the same for everyone regardless of support needs. This suggests that some service users may have perceived that their needs were higher, and they would have benefitted from a larger budget. It also brings into question the purpose of a support plan if the budget is not related to the needs identified in that plan.

Peer support and networks

D.129 It was apparent that some groups of service users, especially people with mental health issues, people with dementia and their carers, and younger adults with CHC funding, felt that they benefitted from peer support and social networks. These subjective benefits arose in a number of ways, for example, from help with understanding conditions such as dementia, opportunities to engage with like-minded people or people with relevant experiences to share, and access to PAs through others' networks. Some service users also spoke of help from peers in developing support plans, although there were reports that such peer supporters may have found it difficult to achieve the right balance between sharing their own experiences and offering support.

D.130 Voluntary organisations were also key for some service users, although this was primarily because they were tasked with delivering the IPC approach in some sites, especially for older people or people with dementia. In contrast to the aims of the IPC programme, to focus on high level needs, assistance from voluntary organisations appeared to be quite low level, such as assisting with claiming benefits and allowances or accessing local activities. Community capacity building also appeared limited for this sample of service users; there were a couple of examples of service users, young and old, getting involved with helping at local groups or arranging their own events, but these were the exception not the rule. Overall, peer and community support and that from voluntary organisations comprised introducing service users to existing services rather than building new capacity.

Understanding of the IPC approach

D.131 Over the course of the evaluation, IPC developed into an approach rather than a defined sequence of events. A substantial proportion of the service users in this sample had never heard of IPC, had a limited understanding of the IPC approach or were not sure that they had been a recipient of IPC. Many of the service users who were not familiar with the term IPC had received help through local voluntary organisations that they did not associate with health or social care and that did not use the term IPC. This raises the question of whether lack of understanding about IPC is important, or whether the terms and labels used are less important than the general approach and ultimately the end point of improved well-being.

Summary

D.132 In summary, there are positive stories which show how the IPC approach can work well for some service users. However, trying to pinpoint why this is the case and what elements of the IPC approach work well and for whom is complex. One possibility is that the process works best for service users with large, ongoing budgets, typically through CHC funding. Another is that the IPC process works best when it is delivered well by knowledgeable support planners or care co-ordinators. It is likely that both are important.

Annex E: Personalised care and support planning process – thematic case study

Introduction

E.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 involvement from carers and families, to combine the resources available to them in order to control their care. This is achieved through personalised care and support planning and personal budgets. 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.

The programme

E.2 IPC was tested out in 17 areas in England where local authorities and Clinical Commissioning Groups (CCGs) worked together with their providers and VCSE partners. The programme was launched in April 2015 and ran in its original format until March 2018. It was focussed on four particular service user groups:

- children and young people with complex needs, including those eligible for Education, Health and personalised care and support 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[47].

E.3 From April 2018, IPC has broadened 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.

Existing guidance

E.4 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 are commissioned and delivered. To support the development and implementation of IPC in the different sites, NHS England developed the Interactive IPC Operating Model in June 2017[48]. 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. One of the Five Key Shifts is the implementation of personalised care and support planning.

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[47] These four user groups are not mutually exclusive. Service users referred to the programme could potentially meet the criteria of more than one of these four categories (for example, if they had both mental health needs and frailty).
[48] https://www.england.nhs.uk/wp-content/uploads/2017/06/IPC-operating-model.pdf

E.5 The Operating Model sets out several enabling factors that sites need to put in place to deliver the shift to personalised care and support planning. These are:

- Service users will have a different or better conversation with practitioners, which focusses on what matters to them and what is working and not working in their life
- This will be done in a way that builds on their skills, knowledge and confidence
- Service users will experience an integrated process coordinated by a single, named coordinator and a single personalised care and support plan developed in partnership and owned by them
- Service users will have the chance to regularly review their personalised care and support plan
- It will be easy to find out what support and services are available
- Plans take account of each person's situation in a holistic way, so that care and support is tailored to their culture and background.

E.6 In addition, the Interactive Operating Model includes a reference to the summary guide on implementing personalised care and support planning[49]. This summary guide, along with a separate handbook[50], sets out further specific elements of best practice that should be included in the personalised care and support planning process, covering: initial referral; who attends planning meeting(s); the content of discussions at the meeting(s); the structure of the personalised care and support plan; and sign-off/implementation of the plan. These elements are discussed in turn in the relevant sections of this report. Full details are provided in the appendix (on page E-16)0

Progress to date

E.7 Findings from the evaluation of the IPC programme have been formally reported twice to date, in November 2017 and July 2018. Fieldwork undertaken for these reports found that IPC sites' progress in delivering IPC had been mixed. Over the first three years of the programme the majority of sites made moderate but steady progress, one site made significant progress, and three sites did not make any real progress in the delivery of IPC.

E.8 Evidence gathered through 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 model of intervention. There was therefore considerable variation in practice between sites, including in the planning process itself.

This report

E.9 This thematic study was conducted to examine the delivery models adopted by different pilot areas, exploring variations between them and the success/challenges arising from different models. It has also sought to explore the extent to which practice in the IPC pilot sites aligns

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[49] https://www.england.nhs.uk/publication/personalised-care-and-support-planning/
[50] https://www.england.nhs.uk/wp-content/uploads/2016/04/practcl-del-care-support-planning.pdf

with, or differs from, existing guidance on best practice in personalised care and support planning, and the difference any deviation has made to the success of sites' pilots.

E.10 In doing so, this study aims to identify the key ingredients that constitute a successful (or unsuccessful) model of IPC personalised care and support planning, highlighting examples of best practice to inform other areas looking to adopt IPC or roll out existing pilots.

E.11 Four of the 17 IPC pilot areas were consulted for this report. At each site, interviews were conducted with a range of individuals involved in designing and/or implementing the IPC personalised care and support planning process in that site. These individuals included:

- strategic staff involved in designing IPC pathways and/or signing off the plans developed
- staff involved in personalised care and support planning meetings (including advocacy or other support made available to the service user)
- staff who might not be involved in the meeting but who are expected to implement the plan in some way.

The personalised care and support planning process

Referral

Best practice guidelines for the implementation of personalised care and support planning recommend that services include the following key steps as part of their referral processes:

- Participation should be initiated by the health and care services. There should be a system in place for inviting service users to appointments (such as invitation letters, or discussion during routine appointments).
- Service users should be given sufficient information about the planning process to be able to make an informed opt-in decision, at this first engagement.
- The professional who will help with the planning should be given information about the service user's needs and other professionals who should be involved in the planning, prior to meeting the service user.

The guidance does not specify a particular format or method for sharing this information with professionals.

E.12 At each site, referrals took place via a mixture of care practitioners discussing IPC with the service user and then making a referral (if the service user accepted), and self-referral by service users. Self-referral was usually the result of the service user and/or their carer hearing about IPC at a user engagement event. If practitioners (mainly GPs and nurses) made referrals, then this referral was based on that practitioner's own assessment of whether the service user would benefit from IPC. If service users agreed to take part, they were then referred to a planner.

E.13 The level of information supplied to the care planner in advance of their first meeting with the service user varied. In three sites, the service user's details and care records were supplied by the practitioner referring them. In the fourth, a referral form was filled out by the practitioner setting out a list of community services the service user might have already been using, alongside suggestions of services that might be of benefit to the service user if they started to use them. This information was sent to care planners electronically.

E.14 Details of service users' diagnoses and conditions were not automatically shared as part of the referral process. This reflected the fact that the personalised care and support planning process was intended to shift the planning of an individual's care away from a process where a practitioner's care plan was based on the individual's symptoms, towards a process where the individual shaped their care around what mattered most to them. Service users could share details of their condition/diagnoses during planning meetings if they wished to, and in some cases, planners would contact other practitioners to collect information on service users diagnoses, however, this information was not routinely transferred as part of the referral process.

E.15 At each of the four sites, if service users self-referred, then the care planner was required to proactively collect this information themselves. At three sites this was done by requesting it from health and social care practitioners, while at the fourth, care planners relied on service users to provide this information themselves.

Initial meeting

Who attends

Best practice guidelines state that meetings should occur between the service user and a care practitioner (or multiple practitioners, if relevant). Service users may wish to have a carer, family member, friend or other support/advocate with them, and if so then this should be facilitated.

E.17 In all sites, the service user attended the planning meeting and had the option of bringing someone else with them if they wished.

E.18 At two sites, care planners from VCSE organisations were commissioned to deliver the care personalised care and support planning process. At one of these sites, the VCSE planner attended the initial meeting with the service user. At the other site, the service user first met with a peer coach (with lived experience of the service user's condition(s)), before meeting the VCSE planner at a later meeting. These peer coaches and VCSE planners were the only people involved in meetings with the service user.

E.19 At the other two sites, personalised care and support planning conversations were run by practitioners from health and/or social care. The initial meeting was attended by either a multi-disciplinary team (MDT) comprising staff from primary care, social work and nurses, or a single member of that MDT. One site reported that if it was difficult to arrange a time for the service users and all MDT members to meet, the service user was given the choice of whether to hold the meeting sooner (with fewer MDT members attending) or later (with all MDT members attending).

Content and structure of the discussion

Best practice guidelines state that discussions between service users and practitioners should be a two-way exchange of information, to enable shared decision-making. Guidelines recommend that this discussion should cover:

- The service user's needs: in the wider context of their life (e.g. lifestyle, finances and social networks).
- Goal setting: setting goals linked to the service user's desired outcomes, with specific and tangible actions to be taken to address these (including timeframes and responsible parties). These goals should be based on both the professional's expertise and the service user's own solutions.
- Choice: service users should be offered a broad range of choices, rather than a small 'menu'.
- Future planning: there should be future planning and consideration of what might need to happen if the service user's health deteriorates.
- Discussion of risk: the risk of different treatment paths, and how to minimize this, should be discussed. This enables the service user, their carers, and care professionals to jointly consider the risks associated with different support options.

E.20 At three of the sites, the planning process always involved more than one meeting. At the fourth site, practice varied. If the first meeting at this site was attended by an MDT (rather than one single practitioner) then the personalised care and support planning was conducted in one single meeting, covering the entire process from identifying service users' priorities up to writing and agreeing a personalised care and support plan. However, sometimes initial meetings at that site were attended by one single planner; in these instances, the planning process always involved more than one meeting.

E.21 Generally, initial meetings did not advance from a discussion of needs and priorities to setting specific goals or starting to establish a personalised care and support plan. The initial meeting always focussed on 'what matters' to the service user, starting with a discussion of immediate issues and priorities (the service user's health and wellbeing, and factors in their life affecting these), before moving on to thinking about the service user's priorities and goals moving forward (if there was time). Initial conversations were generally around an hour long at each site.

> *"It's about what's important to them, rather than what's important for them."*
>
> *Care planner*

E.22 At each site, only individuals present at the personalised care and support planning meeting(s) gave input to the personalised care and support planning process. At the two sites using VCSE care planners, health or social care staff's role was limited to supplying background information on the service user, or information on the different support services available in the area (for the planner's reference). At the two sites where care practitioners implemented the planning process, only care practitioners present at the meetings gave input to the planning process.

Discussion of risk

Personalised care and support planning guidance states that clear discussions of risk should be held between planners and service users, as these enable both to:

- discuss the risks associated with different treatment options, and how these could be mitigated, and
- identify and record the service user's preferred course of action if a change in the service user's health or condition means one or more elements of their personalised care and support plan can no longer be applied.

E.23 A full discussion of risk and mitigation would help personalised care and support planning to move away from 'risk-aversion' to 'risk-enablement', helping give service users greater scope to design a personalised care and support plan that suits their wants and needs, while still ensuring that any risks taken are proportional and that care given to service users is still safe. However, future planning and discussion of risks were only reported to be features of personalised care and support planning conversations at one of the four sites.

Subsequent meetings

- At the two sites that commissioned VCSE planners, subsequent meetings were run by the same planner (or team of two planners) as the first meeting.
- Where care practitioners ran the meeting, the initial meeting was usually attended by a single practitioner from the MDT. The MDT then met to collectively determine which MDT member(s) were most suitable, based on the needs expressed by the service user during the first meeting, to attend subsequent meetings and continue the planning process with the service user. At one site, multiple staff attended subsequent meetings. At the other, a single member of the MDT identified as the most relevant team member held a follow-up planning session with the service user.
- At three sites, the second and (if needed) third conversations shifted from focussing on service users' needs and issues to developing goals and identifying services that could be used to help the service user meet those goals. At the site that employed both peer coaches and VCSE planners, the same progression was made but over a greater number of sessions (generally up to 10 with a peer coach and 5-6 with the care planner).

- During these later conversations, planners elicited service users' own ideas of support or services that might benefit them, as well as presented service users with other support options they were aware of. They then facilitated a discussion of the pros and cons of these various options, allowing service users to ultimately determine which service or set of services they wanted to include in their plan.
- These subsequent meetings generally each took between 45 minutes and an hour at each site. The length of time it took to progress from holding the first meeting to generating a personalised care and support plan varied considerably across the four sites, and between different service users at the same site. Variation in the length of the planning process was primarily due to variation in the number of conversations taken to produce each plan.
- In general, the gap between one meeting and the next was up to one week. If a greater number of meetings took place, the length of time the planning process took was proportionally greater. At one site, where 1-3 meetings were held, the process took up to two weeks; at the site where up to 10 meetings were held, the process took up to 3-4 months.

Reflections

Successes

E.24 At all sites, service users mostly responded positively to the IPC planning process. Planning conversations at all sites covered the service user's needs, goals and a broad range of choices. Discussions around needs and goals were reported (by all four sites) to be motivating for service users, with many feeling that IPC was the first time some of these priorities and wishes had been factored into the care and support they received, or even discussed with them.

> *"[They] feel very pleased that someone's taken the time to think about what might actually make their life better."*
>
> Care practitioner

E.25 Planners reported that offering a range of different support options to service users helped make them aware of support they might not have considered otherwise. In some cases, this led to service users taking up this support as part of their plan (e.g. exercises classes they wouldn't previously have thought of taking). VCSE planners and MDTs were generally knowledgeable enough to be able to present a wide range of options.

Challenges

Length of the planning process

E.26 One challenge highlighted in each area was the length of time the planning process took. There appeared to be a tension between the desire of commissioners (and some care practitioners) to ensure the planning process put the smallest possible time burden on staff or to minimize the resourcing implications, and planners' views that holistic conversations around service users' needs and priorities were time-consuming if done properly. One commissioner commented that they felt planners spent too much time establishing a relationship with service users before beginning the actual planning process and that in hindsight commissioners should have given planners guidelines on how long they expected the process to take.

Care planners' access to information

E.27 At one site, planning was managed by an MDT comprised of health staff, whose relatively low knowledge of social care support was initially a barrier to providing a full range of options to service users. Similarly, VCSE planners at another site reported instances where they had produced personalised care and support plans with a service user, and then later become aware of a different support service they felt would have been good to be able to offer to that user.

E.28 At three sites, a database of services was therefore produced during the lifetime of the IPC pilots, as a resource to support personalised care and support planning conversations. However, keeping it completely up to date proved challenging. This was partially because (in two sites) the database was produced and updated by the planners themselves, who (as frontline practitioners) had only a limited overview of provision in their areas. While databases like this would be extremely useful tools for care planners to have access to, they need to be produced and maintained centrally (with input from both health and social care teams, and VCSE organisations).

E.29 Some planners and practitioners reported that (in some instances) service users had included support/services in their personalised care and support plan, but when attempting to access them, found they were oversubscribed. This had resulted in the service user needing to independently locate a different, similar service within their area or revise their personalised care and support plan. This might have been avoided if planners had checked the availability of services during the planning process, prior to including them in personalised care and support plans.

Integrating IPC into routine practice

E.30 Across all four sites, the processes for identifying service users and making a referral were mostly additional to existing systems and processes (such as routine check-ups or reviews of other personalised care and support plans). Interviewees at several sites felt this had impacted upon both the volume of referrals made by care practitioners and the level of information practitioners supplied, as not all practitioners were willing to spend time identifying and referring service users for IPC in addition to performing their existing duties.

E.31 One planner reported receiving referrals from some GPs who had simply sent them an email, instead of filling out the referral form they were supposed to. They then had to contact other staff to collect information on support the service user was in receipt of (instead of having it provided to them in the referral form). A commissioner at a different site commented that referral numbers varied between GPs, depending on how engaged and how willing they were to hold conversations with patients about IPC. 'Tightening up' the process – via measures such as integrating referral forms with existing paperwork and holding the initial conversation as part of existing care reviews might help with this.

Dedicated resources allocated to the planning process

E.32 In two sites, planners were recruited for the purpose of undertaking the IPC planning process with service users. At the other two sites, existing members of the health and/or social care workforce set aside dedicated time to undertake the planning process themselves. At these latter two sites, resources were not provided to expand workforce capacity; staff retained their existing caseloads and duties, and simply added IPC commitments on top of these.

E.33 Staff at one of these sites reported that ring-fencing time to dedicate to longer planning meetings with service users had the knock-on effect of causing delays dealing with their regular caseloads, as the increase in the time they spent with IPC service users meant they had a decreased amount of time to spend with others.

The personalised care and support plan

Content and format

Best practice guidelines for the implementation of personalised care and support planning include the following recommendations on the content of personalised care and support plans:

- The plan should capture key information including: details of the service user; a summary of their needs, goals and actions to be taken; the support and service in place or being arranged; and names and contact information for named key individuals, such as their GP or care co-ordinator.
- The plan might include further information on the service user, such as any challenging behaviours, social networks, diet, employment circumstances etc. that care practitioners ought to be aware of.
- The length and complexity of the plan may vary according to the service user's level of need.

E.34 At three sites, the plan created was one joint plan for health and social care. At the other, the plan only covered healthcare. At two of the sites where joint health and social personalised care and support plans were created, funding provided by health and social care services was pooled without any requirements for plans to allocate specific proportions to either service area. At the third site, funding for healthcare elements of a service user's plan was provided by health services, and funding for social care elements provided by social care services.

E.35 At each site, plans were written using a template that followed the structure of the conversations. Planning templates had headings to capture information on the service user's:

- diagnoses and previous use of services (e.g. 'What other support I get')
- values and priorities (e.g. 'My values and what matters to me')

- personal goals/objectives (e.g. 'Things I would like to work on')
- the support/services they intended to access as part of their plan. (e.g. 'What could help me').

E.36 This generally aligned with existing guidance regarding what should be included in a personalised care and support plan. However, none of the sites reported including contact details for key individuals such as GPs or nurses in their plans (one stated that this information was not included in their plans because they did not have consent from those staff groups to do so).

E.37 Two sites created one single document capturing all of this information, while the other two sites captured information on the service user's values, priorities and goals on one document, and details of the care they planned to access on a second document.

Writing the plan

Existing guidance states that the service user and/or their carer should agree to what is written, although does not specify that service users should participate in the actual writing of their plan.

E.38 At one site, the plan was written by the service user and their planner together during a planning session (or across multiple planning sessions, if necessary). At the second, the planner wrote the plan by themselves but then shared it with the service user for sign-off before submitting it to colleagues for their formal approval.

E.39 At the other two sites the planner wrote up the plan after the meeting, based on what they had agreed with the service user. They then sent a copy to the service user and at the same time sent it to other staff for sign-off (instead of sending it to the service user for sign-off followed by sending it to other staff).

Finalising the plan

Best practice guidelines state that all parties (the service user, their carer, and care practitioners) must agree to the final plan, but that exactly who signs off on the plan will 'depend on local processes'.

E.40 At all four sites, the plans created for IPC were additional to service users' existing plan(s) and the support provided by the plan was additional to the support the service user already received. At three sites this was because IPC had been implemented as a pilot programme, rather than as a permanent change to service provision.

E.41 Plans were usually submitted to and signed off by a single individual or team. At two sites, if a joint health and social personalised care and support plan was produced, then this was a team composed of both health and social care staff. If the plan produced only required a health budget, it was signed off by a health practitioner. At the third site, any budgets assigned were for health only and the sign-off team therefore consisted of health staff only. At each of these three sites, it was usually the same teams or individuals signing off plans for all service users. These were staff that had not been involved in the planning process.

E.42 However, at one site there was a different process. The plan was first sent to a social work practitioner who usually dealt with the service user; once they had signed it off, it was then sent to a health practitioner engaged with the service user. The time taken to get plans signed off was longest at this site - some plans only took a day or two, but for others the process had been reported to take up to two or three weeks.

E.43 At each site the individuals signing off personalised care and support plans assessed them based on whether the information they contained about service users' diagnoses and previous service use was accurate, and whether plans gave a clear, convincing argument that the support listed in the plan was likely to deliver better health and/or wellbeing outcomes for the service user.

Reflections

Successes

E.44 The process of writing plans appeared to have been well received by service users at each site. Their direct involvement in the decision-making process and (in some sites) writing and/or signing off the plan themselves ensured the content reflected their wishes. Anecdotal feedback from planners and practitioners suggested that service users were happy with the support they had received through their IPC personalised care and support plans and were adhering to them.

E.45 The content included in plans written at each site covered most of the key information that best practice guidance says personalised care and support plans should (although only some included risk assessments of different treatment options or contact details for practitioners working with that service user, both of which best practice guidance recommends should be included).

E.46 In order to help service users to identify the care and support that will best meet their needs, planners need to be able to present them with a wide range of options that are available to them. It is therefore crucial that planners are fully aware of what services and support are available in their area. In the two sites that had commissioned VCSE planners to undertake the planning process, part of their reason for doing so was to make use of these planners' knowledge of the different provision available in the area. Similarly, in the site where initial meetings were held by an MDT, part of the reason for this was to ensure that staff in the room had a good collective knowledge of the range of services available in the area. Planners at each of these sites generally felt confident that they were able to present service users with a comprehensive 'menu' of options during the planning process.

Challenges

E.47 Some staff reported that, early on, plans were occasionally sent back to the planner with a request they be reworked before a revised draft was eventually signed off. This was perceived to be partially due to planners not always providing clear evidence of how the personalised care and support plan would help achieve better health and/or wellbeing outcomes for the service user, and sometimes due to the staff signing off on plans being hesitant about signing off on 'unconventional' support packages (examples included day trips, a bicycle for travelling to an exercise club and tattoo removals).

E.48 Incidences of this appeared to decrease over time as planners became more familiar with the type and level of evidence needed, and the staff signing off became more comfortable with approving relatively unfamiliar services and support.

IPC process added on top of practitioners' existing duties

E.49 Sites found that referral rates and completeness of referral information varied depending on the practitioner making the referrals. Both the referral of service users and the passing on of supporting information/documentation were dependent on practitioners engaging with IPC at the same time as undertaking their regular day job. This appeared to have meant that some had been less prepared to devote time to identifying and referring service users to IPC than others.

E.50 Similarly, the fact that the sign off process at one site took considerably longer than at others appears to have been partly due to that site's process being something practitioners were asked to do on an ad hoc basis, on top of other existing duties and responsibilities. One practitioner at that site reported that the act of reviewing and signing off a personalised care and support plan was something they could do within 5-10 minutes, meaning they usually reviewed and signed off a plan within a day of receiving it. Where other practitioners at the same site took longer, this was felt to be simply because those practitioners weren't prioritising signing off plans (rather than because of any practical barriers).

E.51 This was in contrast to other sites, where a nominated team met regularly for the purpose of reviewing and signing off plans. They had a dedicated group of staff with time set aside to review and sign off a personalised care and support plans, and as a result the average length of time taken to sign off plans was shorter.

Implementing the plan

Best practice guidance on personalised care and support planning states that the service user themselves and their carer should be given a copy of their plan. A copy should also be stored in their care record so that practitioners can access it.

E.52 At each of the four thematic study sites, the service user was given a copy of their personalised care and support plan. Who else the plan was shared with varied across the sites:

- At one of the sites that created a single document (detailing both the profile of the service user and the support/services they planned to access), this was shared with all health and social care practitioners that worked with the service user.
- At another site, a note was made in GP records that the plan had been created, but the plan itself was not shared with the GP (or any other staff). The service user was given a copy, and whether or not staff saw it depended on whether the service user chose to share it with them.

- At the sites that created two separate documents, the plan itself was sent to the professionals who worked with the service user, but only the service user was given the document capturing information on their issues, priorities and goals.

Responsibility for implementation

E.53 At each site, primary responsibility for accessing the support included in the plan lay with the service user. If a budget was created, service users were generally given the option of a direct payment or having their budget managed as a notional budget[51]. If service users were signposted and/or referred to services without being assigned a budget, responsibility for contacting and accessing these services lay with the service user.

E.54 None of the sites assigned a specific member of staff to ensure that the personalised care and support plan was being implemented once it had been created. At two sites it was reported that a key individual involved in the personalised care and support planning process[52] usually stayed in touch with the service user and different services to ensure that the plan was being implemented, although it was not a formal requirement for them to do so. At the other two sites, implementation appeared to be left to the service user without any routine follow-ups taking place.

Responsibility for reviewing plans

Best practice guidelines state that personalised care and support plans should be reviewed at least annually, with the exact frequency of reviews determined by the service user's level of need, health and circumstances. Topics suggested for discussion during reviews include progress, changes in circumstances, and any new goals.

E.55 At the site where care planners often maintained contact with service users after the planning process had finished, these care planners held 3-month reviews with service users to undertake a more in-depth review of how implementation was progressing. At the other three sites, there was no process in place for reviewing the implementation of the IPC personalised care and support plans[53].

E.56 Staff at one site reported that because the funding for the pilot was not guaranteed to continue, plans had been written as one-off plans that would run for six months. It was anticipated that if funding was not continued, that the plans written as part of the IPC process would not be extended. They had therefore refrained from putting a review process in place, pending a decision about whether the programme would continue to receive funding.

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[51] Although in some cases, if the service user was flagged as too high risk to manage a budget themselves (e.g. due to recent substance misuse issues), it was likely that only a notional budget was made available.

[52] At one site this was the care planner, at the other it was a peer coach with lived experience and/or care planner.

[53] Although one site reported plans to introduce an annual review process, once IPC has been established as business as usual support at that site.

Reflections

Ensuring implementation of the plan

E.57 Three sites did not have follow-up and review processes integrated into 'business as usual' care (e.g. built into routine appointments/reviews the service user would usually have anyway). Staff at one site reported that this was because IPC had been implemented as a pilot and was therefore not guaranteed to continue. This had resulted in follow-ups that were inconsistent or that sometimes simply did not take place. This meant that although sites were recording the allocation and spending of budgets, as well as documenting any visits paid to service users to help them set up new equipment, they were not recording or monitoring whether or not services or equipment were being regularly utilised by service users.

E.58 At one site, the personalised care and support plan was not automatically shared with any health or social care practitioners. Implementation of plans was therefore at particular risk in this site, as this approach put the onus completely on the service user to ensure their plan was implemented. For some cohorts of service users, such as those with dementia or learning disabilities, taking charge of implementing their own plan could be particularly challenging.

E.59 To mitigate against the risk of plans being only partially implemented, or not implemented at all, sites could ensure that practitioners regularly providing support to IPC service users are informed that:

- the IPC planning process is being implemented in their area
- service users could be turning up with a personalised care and support plan (or that the practitioner will be receiving a copy directly), and the content of that plan
- they will need to support service users in accessing the wider services recorded in their plans.

Wider utility of planning documents for practitioners

E.60 The personalised care and support plans produced at each site captured not just a record of the services/support the service user has chosen to commission, but also information about them as a person and how practitioners can best interact with them. This was useful information for the staff engaged with that service user to have access to. It also aligned with the recommendation in the existing guidance on personalised care and support planning that these documents be shared with all practitioners involved in a service user's care.

E.61 At the three sites where this information was not being routinely shared with practitioners, some reported feeling that this was a missed opportunity for useful intelligence on the service user to be shared with the staff who provide support to them:

> *"If someone had this plan throughout their life, when it came to a point of crisis their plan would exist and what we are trying to find out of the point of crisis would be recorded in front of you, rather than spending hours teasing it out."*
>
> Care practitioner

> *"From a clinical point of view the personalised care plan means we are looking at a record that they hold, but some of that information would be really great to have before you meet them. Even if it's just what they want to be called, these simple things can make a real difference."*
>
> Care practitioner

Conclusions and recommendations

E.62 At each site, the broad principles being applied throughout the planning process were correct and in line with good practice. In particular, conversations being held with service users and the plans produced from those conversations appeared to include almost all of the elements recommended by best practice guidance. Conversations focussed on service users' own priorities, wishes and goals, the choosing of services and support was directed by the service user, and the plans produced during the process captured all of this.

E.63 As the processes being implemented were new for each of the sites examined, it is natural that sites were still continuing to develop and refine their approaches. Where ongoing issues or challenges were observed, these were mostly due to sites' approaches deviating from best practice guidelines. For example:

- recruiting service users via self-referral, instead of or in addition to referrals from health and social care practitioners
- not undertaking future planning around what should be done if service users' needs change or if the support they have chosen is not available
- not sharing the full plans (including details of service users' needs and wishes) with the practitioners who work with the service users
- being over-reliant on service users to implement their plans themselves, without formalised support from health and/or social care practitioners.

E.64 The primary action for sites to take is, therefore, to review their existing IPC processes against best practice guidance (in the appendix), to identify which elements of the guidance which they have yet to implement fully.

E.65 Two other notable challenge were seen across most sites:

- The first was that not all of the services whose involvement was required to deliver the IPC pathway (including GP practices and community nurses) were given dedicated resources to do so. This meant that various stages of the IPC process that relied on engagement from health and social care practitioners (e.g. referring service users to the programme, signing off plans, or monitoring that plans were being implemented) were not applied consistently. Three of the sites also had not identified or secured resources for IPC to continue after March 2018, and therefore did not have processes in place for ensuring plans they had produced were implemented and adhered to in the medium- to long-term. As these sites move forward, they will need to consider how they can acquire or free up resources to enable practitioners to dedicate time to the delivery of IPC.

- The second was that care planners in most sites lacked access to a central directory of services in their area. This meant they were unable to be sure they were presenting service users with the full range of options available to them – awareness of which is essential if service users are to make a fully-informed choice about the care they receive. Databases like this would therefore be extremely useful tools for care planners to have access to and need to be produced and maintained centrally (with input from both health and social care teams, and VCSE organisations).

Appendix: Best practice in personalised care and support planning

E.66 This appendix sets out the specific elements of best practice set out by NHS guidance on implementing personalised care and support planning. The full guidance documents that this set of best practice has been compiled from can be accessed here and here.

E.67 This guidance may be updated later in 2019 to reflect the Universal Personalised Care model[54] published by NHS England in January 2019.

Referral

E.68 Participation should be initiated by the health and care services. There should be a system in place for inviting service users to appointments (such as invitation letters, or discussion during routine appointments).

E.69 Service users should be given sufficient information about the planning process to be able to make an informed opt-in decision, at this first engagement.

E.70 The professional who will help with the planning should also be given information about the service user's needs and other professionals who should be involved in the planning, prior to meeting the service user.

Meeting(s) with the service user

E.71 A meeting will occur between the service user and a care practitioner (or multiple practitioners, if relevant). Service users may wish to have a carer, family member, friend or other support/advocate with them, and this should be facilitated.

E.72 The discussion between the service user and practitioner should be a two-way exchange of information, enabling shared decision-making. It should cover:

- The service user's needs: in the wider context of their life (e.g. lifestyle, finances and social networks).
- Goal setting: setting goals linked to the service user's desired outcomes, with specific and tangible actions to be taken to address these (including timeframes and

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[54] Available here.

responsible parties). These goals should be based on both the professional's expertise and the service user's own solutions.

- Choice: service users should be offered a broad range of choices, rather than a small 'menu'.
- Future planning: there should be future planning and consideration of what might need to happen if the service user's health deteriorates.
- Discussion of risk: the risk of different treatment paths, and how to minimize this, should be discussed. This enables the service user, their carers, and care professionals to jointly consider the risks associated with different support options.

The personalised care and support plan

E.73 The plan should capture key information including: details of the service user; a summary of their needs, goals and actions to be taken; the support and service in place or being arranged; and names and contact information for key named individuals, such as their GP or care co-ordinator.

E.74 It may also include further information on the service user, such as any challenging behaviours, social networks, diet, employment circumstances etc. that care practitioners ought to be aware of.

E.75 The length and complexity of the plan may vary according to the service user's level of need.

Sign-off

E.76 All parties (the service user, their carer, and care practitioners) must agree to the plan.

E.77 Exactly who signs off on the plan will depend on local processes.

Implementing the plan

E.78 The service user and/or their carer should have a copy of the plan (either paper or electronic).

E.79 A copy of the plan should also be put in the service user's care record, so care practitioners can access it.

E.80 Plans should be reviewed at least annually, the exact frequency determined by the service user's level of need, health and circumstances. Topics for discussion at the review could include progress, situation changes, and any new goals.

Annex F: Development of the local market – thematic case study

Introduction and background

F.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 and support planning and personal budgets. 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.

The pilot programme

F.2 IPC is being tested out in 17 areas in England 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 run in its original format until March 2018. It was focussed on four particular service 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.

F.3 From April 2018, IPC has broadened out to cover larger geographical areas and more service user groups. It will underpin other activities that take place as part of the personalised commissioning agenda.

Existing guidance

F.4 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 Interactive IPC Operating Model in June 2017[55]. 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. One of the Five Key Shifts is around market development to enable a wider range of care and support options tailored to service users' individual needs and preferences.

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

This report

F.5 Market development is a long-term activity aimed at creating a wider range of care and support options from which service users can choose. Significant and widespread changes in supply were not anticipated within the evaluation timeframe. However, we investigated achievements to date, plus organisational-level activities aimed at improving the range of providers and/or choices available.

F.6 The first interim report from this evaluation, published in November 2017, showed that progress with the development of a more flexible local market for services was variable across the sites. IPC sites were encouraging existing providers to offer more flexible and bespoke packages of care, while working with the VCSE sector to develop new ways of providing services that were person-led and filled gaps in the market. Key challenges included making changes to block contracts, as well as cultural and system changes.

F.7 In July 2018, the second interim report showed activities in relation to market development had focussed primarily on mapping local services (including statutory, private and VCSE). However, there was also acknowledgement that IPC had not increased the level of service provision or led to new services but had resulted in greater awareness of existing services. The key challenge of unpicking block contracts remained. Discussions around how to offer more flexible services were resulting in stronger relations with the VCSE sector in some sites.

F.8 In this thematic report we looked in detail at market development activities. The aim was to describe achievements to date, outline various approaches to market development as well as attempting to explain the following:

- the rationale for the approach taken
- the elements which worked well
- the challenges faced.

F.9 Market development (or market shaping) is a somewhat nebulous concept. Guides from the Institute of Public Care offer definitions of market shaping and provide tools to help deliver change[56]. While these guides relate specifically to adult social care, their summaries of market shaping under two headings are pertinent to other areas of social care and health care as well:

- Market intelligence – activities which seek to understand supply and demand, including collection and analysis of data on provider stability to enable oversight of the 'health' of the market
- Market influencing – a spectrum of activity that seeks to influence the current and future range of care and support available, based on the understanding of the market, including contingency planning or other interventions[57].

F.10 However, the practicalities of moving from understanding care markets to influencing and achieving change are imprecise. Markets are not always easily defined or specific to user groups or localities, nor can different sectors or programmes tasked with developing markets work in isolation. Thus, what follows is an illustration of market development activities taking

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[56] https://ipc.brookes.ac.uk//what-we-do/market-shaping.html

[57] Market Shaping Review What is Market Shaping? July 2016, Institute of Public Care, Oxford Brookes University, page 5 https://ipc.brookes.ac.uk/docs/market-shaping/What%20is%20Market%20Shaping.pdf

place in and around the IPC programme, but not necessarily specific to or driven by that programme.

F.11 Three of the 17 IPC pilot areas are covered in this report. At each site, interviews were conducted with a range of individuals involved in market development activities. These individuals included:

- Strategic staff in health and social care organisations
- Representatives from VCSE sector providers
- Representatives from IPC co-production groups.

F.12 We aimed to interview representatives from local NHS and social care providers or provider fora that might be impacted by market developments, however, we were unable to identify relevant providers in two sites and were asked not to approach an NHS provider in the third site due to difficult relationships.

F.13 It was not easy to identify individuals who had formal responsibility for market development in relation to IPC. As a result, those people interviewed were usually involved in some way with market development or intelligence, but often only as a small part of their role. Some were only peripherally involved in IPC; for others, their market development work was relevant to but not driven by IPC.

Rationale, aims and objectives

F.14 None of the three sites reported formal aims and objectives for IPC-related market development, or a clear IPC-specific rationale for their approach that was independent from existing models of working. Market development was something that was already taking place in the sites under different guises and driven by an array of other factors, often unrelated to but sometimes in parallel with IPC. Some developments were labelled as IPC although they were happening anyway.

Rationale for market development

F.15 None of the sites offered a clear rationale for their market development plans. In one site, IPC was very closely linked with Better Care Fund priorities to develop the market to assist early interventions and enable service users to access alternatives to statutory provision. In the other sites, on-going service reconfigurations, for example in mental health and in children's services, were linked with but not driven by IPC.

> *'What I think the IPC programme helped me to focus on was the need to really understand what was happening in communities; because we were taking a city-wide approach and saying actually this is about what people can access locally to them, let's look at it through that lens, and if somebody's given more choice and more control over what they choose, what is available to them? We decided to focus in on key neighbourhoods; to look at what was actually available and what people were choosing.'*
>
> (VCSE manager)

F.16 Across sites, the voluntary, community and social enterprise sector (VCSE) appeared to be heavily involved in projects related to market development. This could take the form of leading IPC-related market development through to being involved in projects to build trust between the voluntary and statutory sectors that it was hoped would ultimately lead to improved systems for market development. In the site where the VCSE took the lead on market development, the organisation already had a strong market development remit outside IPC, so market development for them was business as usual. The interviewee gave this rationale for involvement with IPC.

Aims and objectives

F.17 Typical responses to requests for market shaping aims and objectives were broad, not always specifically about market development per se and not necessarily driven by IPC. Some tended to emphasise relatively focussed changes around specific services or condition groups whereas others were strategic level aspirations with no stated methods for implementation. Examples are:

- To increase the numbers of personal assistants (PAs) available for service users using direct payments;
- To develop the market and offer early intervention services, social prescribing and access to alternatives to statutory provision as part of the Better Care Fund plan;
- To stimulate the market so that children who have a PHB can explore alternative ways to use it for planned short breaks;
- In mental health, to encourage the health sector to take more risks, to enable service users to test out independence;
- To change the way care is delivered for adults living in the community, moving away from bureaucratic assessments to enable different conversations and types of need;
- To build trust and relationships across the relevant sectors and stakeholders, through conversations, in order to improve future market development opportunities;
- To ensure community-based providers are market ready and have a clear menu of support available;
- To have, as a direction of travel, more individualised services within health: '*it's saying how do we set all this in motion, how do we prepare for that?*'.

F.18 In the site trying to build trust and relationships across the statutory and voluntary sectors, a key driver was to enable the VCSE to make best use of volunteers in the longer term. Small and short-term grant funding for projects had in the past meant that many projects were short-lived or failed once grant funding ended. It was hoped that better working relationships would result in better funding systems and longer lasting projects. Neither of the other two sites spoke about IPC as a driver for market development.

Management and organisation of market development

F.19 Management and organisation of market development activities appeared somewhat fragmented, perhaps as a consequence of not having formal aims and objectives.

Management structures

F.20 All three sites had an IPC Programme market development lead for at least some of the evaluation period. In one site the person occupying this role changed throughout this time but in another a named manager from the VCSE sector held this role throughout the period. In the third site, the VCSE sector IPC partner was commissioned to focus on market development and co-production, however, the market development role was never fully developed and was taken over by another organisation in early 2018. The market development strategy became part of the Sustainability and Transformation Plan (STP) and the original VCSE sector partner felt '*a little bit left out of the conversation.*'

F.21 Having a lead officer for market development was considered significant in achieving and maintaining progress, even if the person in that role changed. Of particular importance, was dedicated time and personal commitment to the role of market development.

> *'It is about getting people in a room, who are passionate and want to change things, to think creatively about how they can do things better together.'*
>
> (Local council senior manager)

Organisation of activities

F.22 Market development was undertaken both unilaterally (for example, by a social care-based LD team) and through approaches shared across councils, CCGs and health providers. Yet, although health and social care may share approaches at a strategic level, it was noted that some healthcare staff and GPs were reluctant to accept alternative models of care delivery that may arise or be suggested as a result of market shaping activities. In addition, even where senior managers held joint health and social care appointments, market development activities were not necessarily undertaken across these boundaries.

F.23 An example from one site illustrated some challenges for partnership working across health and social care boundaries. A CCG and local council both commissioned services for children with complex needs and planned to undertake reviews of them (these reviews ran in parallel with but were not directly linked to IPC.) However, different timeframes and reasons for undertaking the reviews meant that the CCG reviewed their health service offer independently from the local council's offer. The CCG review was completed before the council review had begun. The CCG review provided a clear idea of what the families of children with complex needs wanted and enabled the CCG to go ahead with reconfiguring the services. However, it also gave the CCG confidence that they could assist the council by feeding into their review. The council review had not started at the time of the interviews.

F.24 In practical terms, methods for promoting engagement with market development activities included hosting forums, for example to encourage providers and local council social care teams to collaborate in developing service improvements; involving service users in a range of methods for feeding back views; and carrying out asset mapping exercises in key localities (details below). Key people attending market mapping and intelligence events, or involved more generally in market development activities, included: people from local NHS Trusts, local councils and the VCSE sector; managers at commissioning and strategic level; people representing specific services such as children's services or learning disability teams; and members of IPC co-production groups.

Market development activities

F.25 The main market development activities were market mapping in order to identify gaps in provision. Some market development activities were related specifically to IPC, but others were not. The aims of market mapping were to: '*make sure we are providing what people want rather than what we think they need*' [CCG Clinical Officer].

Market mapping and intelligence

- All three sites had undertaken some form of market mapping. Methods of gauging the extent and diversity of the market varied across and within sites. Some methods used quite specific formats such as workshops with set aims, whereas others were more fluid, for example, relying on a better understanding of individuals' needs through feedback from co-production groups. Two sites held market mapping workshops; in one, they were one-off events to map local assets whereas in the other there was a series of four workshops aimed at identifying gaps through to planning implementation activities to fill those gaps. Terminology varied, with people speaking of market mapping, asset mapping and gap analysis. The following examples show some of the formalised market mapping activities, but there were also examples of more informal processes such as monthly cross-sector meetings with the public to talk through recent issues in health and social care, or tasking teams to identify gaps and solutions using existing information, for example, in education, health and care plans.

- **Example 1:** There were four events across one IPC area, attended by social care, children's services and CCG representatives and the IPC co-production panel. The events looked at transitions, looked after children and support for younger adults, and tried to identify gaps in the market for each. Each event built on the previous one, covering: first, market mapping through group discussions; second, mobilising the community to address gaps; third, planning actions for implementation; and fourth, recapping on challenges and what worked well. The lead organisation (a social enterprise) wanted to find out (a) if there were gaps in provision, (b) if there was provision but it was not well publicised, or (c) if there were process issues around service users not being able to use personal budgets for the services. The findings showed that there was provision, but it was not well publicised. Mapping the market for some groups was reportedly difficult where service users wanted a diverse range of activities not always related to their condition (for example people with mental health problems seeking photography lessons), or where they tended to know what was available locally (for example, young adults), which made market mapping unnecessary.

- **Example 2**: The senior manager of the council learning disability team took the view that a market mapping exercise was unnecessary because it was obvious that the market was not working. Instead, the team took a top down approach, taking key decisions themselves to set the direction of travel. They moved away from what the manager called a '*supermarket model to a high street model'*, meaning that services could be purchased from multiple rather than a single provider. The result was that instead of a 'one service fits all' approach, provision became more personalised. Services were developed around four key outcomes: work, health and independence, relationships, and communities. Each service user had a re-assessment of support based on the four outcomes. Findings were mapped onto financial bands and numbers of days provision for each activity. The learning disability team then commissioned this activity. Where the team felt there were gaps in provision, they worked with providers to enable them to adapt and fill those gaps or identified alternative provision. For example, a service user who had a talent for art was helped to attend an 'outsider art' programme aimed at people with no formal art training; following his attendance on the programme, his behaviour was reported to have improved.

- **Example 3**: The VCSE ran asset mapping workshops in conjunction with local multi-sector prevention partnerships. These workshops fitted with the VCSE prevention agenda, but IPC was the catalyst. One workshop was held in each of five localities. A range of people with local interests were invited, including: local residents, people from the VCSE sector, local council managers, politicians, link workers, and local churches. Workshops lasted for two hours and involved a core of about 15-20 people, with others dropping in for parts of sessions. About a quarter of attendees were local residents; most were the people running the local assets. The workshops used 'planning for real' techniques which involved visual, 3D mapping of local areas onto large polystyrene boards. The workshops were planned around three key issues: what people saw as assets in the areas (buildings, people, parks etc); then what they liked/was available; and finally, what they would like to see more of/felt was missing. The information that was drawn on the map came from existing knowledge of the people who were there plus online searches during the workshops. The intention was that after the workshops, the local VCSE leads would summarise the findings and the gaps and start to work on how best to fill those gaps. In reality, the local leads were so pressured for time that there were delays in writing the summaries and taking plans forward, so at the time of the interviews no further progress had been made.

- **Example 4:** The council team responsible for customer services and community engagement developed a methodology in 2017 to bring together the community, the VCSE sector and the statutory sector. The purpose was to enable discussions around community issues and work together to develop a vision for resolving them. This methodology ran in parallel with IPC, although it was not clear whether it was driven by IPC some links were made around the over-arching principles. Independent facilitators ran each session on a volunteer basis using tasks to help people think outside the constraints of their roles, for example budgetary constraints, and to develop creative solutions. Once groups began to implement their solutions, the local council provided project management, analysis and reporting support to avoid overburdening the VCSE partners. A success story from this project was the development of a new 'sitting service' of volunteers to provide company for a cared-for person while their carer had a break. Group discussions and talks with carers had shown that 'sitters' from the service originally commissioned were in fact performing care tasks rather than providing company. The new service had been running for a few months at the time of the interviews.

Other market development activities

F.26 Aside from market mapping, other forms of market development activities were evident. One was about providing opportunities for capacity building and innovation, including funding, to help stimulate the market. In the two sites offering this form of funding, local organisations were able to bid for start-up or development funding that was small scale and time limited. An example of a project funded through this type of scheme was a club to support fathers to be present and have a role within families. An example of a project that was supported but without innovation funding is a social enterprise cleaning business run by people with learning disabilities. Successful projects were monitored monthly to assess impact, although it was recognised that measuring impact on statutory services was a challenge. Potential pitfalls of these types of funding systems were the development of projects that did not fill existing gaps, and difficulty in enabling individuals to purchase new offers without first releasing funds from block contracts into personal budgets. The latter was a major issue and is discussed further in the section on challenges and facilitators.

F.27 A further market development-related activity involved improving information services and access to them, by bringing multiple information databases into one centralised system or refreshing local databases to make them more user-friendly. While not actually making any changes to the market, this method aimed to improve knowledge about, and therefore use of, existing providers. One of the challenges, however, was internet access; a market mapping exercise in several deprived areas in one site showed that local residents struggled to access the internet via existing community facilities, which suggests that offering more comprehensive information via the internet might have been less productive then intended.

Achievements and future plans

F.28 All three sites were successful in identifying gaps in local markets. Identifying gaps was one of the main aims of market mapping exercises and seen as a first step in developing the market.

F.29 The following table illustrates the kinds of gaps identified:

> *'So we're sort of trying to build that picture up really and in doing so we are supporting organisations to think about filling those gaps.'*
>
> (VCSE Manager)

Table F-1: Gaps in local markets identified through market mapping

Support for young people

- gaps in services for young people with autism transitioning into adult services
- limited provision of early intervention services for young people
- activities for five to 15-year olds
- activities run by groups other than churches

Support for carers

- to assist in spending quality time with the people they cared for
- short breaks enabling the cared for person to spend time with people with similar interests
- short breaks provided by someone other than volunteers
- short breaks outside the family home for children with very complex needs

Social isolation

- activities for older people, especially people with dementia
- activities for people unable to leave their homes
- activities for people with long term conditions

Other

- libraries and community centres offering more computers to access the internet, with better opening times and more technical support
- poor publicity about existing services
- intergenerational activities
- access to formal mental health services
- access to debt crisis/financial advice teams
- insufficient number of PAs to meet demand

F.30 However, despite identifying these gaps, the sites reported limited progress towards influencing the market to fill these gaps. Reasons offered for the slow progress included being in the early phases of the market development journey and still building relations with the VCSE sector.

F.31 Despite reporting limited progress, there were several project specific achievements. For example, a new sitting/carers' short breaks service, provided by volunteers, had been commissioned in one site. This enabled carers to have short breaks knowing the person they cared for had companionship. It also highlighted opportunities to fill other gaps, such as carers spending quality time with the person they care for and the cared-for person spending time with like-minded people. For example, a project was underway to develop a companionship service modelled on a dating agency; this would enable cared-for people to connect with volunteer carers with shared interests, to offer companionship for the cared-for person but also to assist the family carer and the person to spend quality time together. In the same site, there was a focus on recruiting volunteers to deliver flexible and bespoke services which linked with the social prescribing scheme, encouraging people who had been prescribed social interventions to continue involvement in the community by becoming a volunteer.

F.32 Opportunities for young people had also been created. These included reconfiguring children's respite services to better meet the desires of children and their parents for flexibility in the timing of respite. Places were also being offered as 'step-down beds' to assist children in early discharge from hospital. In another site, the local police had worked with the youth mental health service to offer a weekly boxing club for looked after children and young people. The aim was to improve mental health and reduce offending.

F.33 To address lack of publicity about available services and activities, one site was in the process of creating a physical information centre where service users could go to ask about and browse local information. Another site had supported a local community to publish a quarterly newsletter.

F.34 These were small steps, however, future plans were ambitious and involved building on progress to date. One site reported more collaborative working between the statutory and

VCSE sectors and plans to continue building partnerships with the local council, bringing on board additional voluntary and community organisations. Another aimed to develop an 'intelligent system' whereby service users could input details of their budget and support needs and receive tailored information about available services, as well as links to vetted suppliers. This website was also intended to help to identify supply and demand. The council hoped to win funding from the Digital Innovation Fund to support the development of this system over the following year to 18 months. In the meantime, the council's website was intended to be populated with a database of available services, although this information was yet to be collected at the time of interview. In the same site, there were ambitions to develop an e-market for healthcare equipment.

F.35 One of the difficulties the sites faced was how to measure achievements and the impact of market development activities. All three sites struggled to articulate how they did or would be able to measure success.

F.36 Of the few examples of hard evidence provided, one was that an initiative to increase the level of volunteering through matching volunteers and service users with common interests had been successful in recruiting more volunteers and a larger support team to manage the system. Increased use of an online directory of services was cited as evidence of success following the updating of the website, but it was not possible to prove why activity had increased. One site discussed measuring the success of joint VCSE sector and local council projects through a Project Board, and software to track money spent, number of people served and outcomes.

F.37 More commonly, sites relied on softer outcomes and anecdotal reports of success. These reports came through formal and informal feedback from service users and project providers. Examples included reports of less challenging behaviour following involvement with new art-based activities and improved parental involvement in families with complex relationships. Success for one VCSE organisation was winning tenders to provide services that filled gaps identified in market mapping exercises.

F.38 Each of the examples offered, which included both hard and soft success measures, was project specific. None of the measures or systems of measuring success related to improvements in the diversity or vibrancy of local markets. However, a team manager for learning disabilities in one site felt the team had moved from a position of trying to gather ideas to drive the market to one in which the team was often overwhelmed with the ideas from the VCSE sector for new services.

Building on existing resources

F.39 As IPC is a shared venture between health and social care, and in some areas education, we explored how these organisations shared and built on existing resources, especially social care market position statements.

F.40 A market position statement is a document which outlines supply and demand of adult social care-related support in a local authority area, signalling to businesses what the opportunities are within the care market. Specifically, a market position statement:

> *'…should give providers a range of information relevant to their business and how it might develop. It should aim to give its readers information they may not already know, but which would be helpful in planning their future businesses, offer a clear picture of what gaps there are in the existing care market and identify what people who need care and support are saying about services.*[58]

F.41 Local councils are required to produce market position statements in order to meet their market shaping duties under the Care Act 2014. Each of the sites had produced a Market Position Statement a year or two before the start of the IPC Programme. Two of these, dated 2014 and 2016, made no mention of IPC, although the latter stated that the council was planning on working closely with the local CCG to deliver personal health budgets. The third, dated 2015, described their planned involvement in the IPC Programme, stressing the challenge of developing services and products where those desired did not already exist, and their hopes for significant stimulation of the market to encourage greater use of personal health budgets.

F.42 None of the three sites reported using market position statements to assist in developing the market around IPC and none had more up to date market position statements available publicly. Interviewees were typically either not aware of, or had not read, local market position statements. This may be a reflection of the roles of the people interviewed. Although they represented multiple sectors in each site, including CCGs, adult social care, specialist services and the voluntary sector, none were local council market development leads. Council market development lead officer roles were considered distinct from and wider than IPC, and so not strictly relevant to this evaluation. One voluntary sector lead had read the local market position statement some time ago, but when interviewed acknowledged it was '*no longer on [her] radar*'. This interviewee felt the local council approach to market development was quite broad and strategic in focus whereas the voluntary sector asset mapping exercise for IPC was built from the '*ground up*'. She felt the two methods could perhaps meet in the middle but there was no evidence of this happening to date.

F.43 In addition to market position statements, we asked interviewees about other existing local resources that were feeding into the market development process for IPC.

F.44 A common theme was building on existing relationships, both formally and informally. For example, local prevention and well-being partnerships, or quarterly meetings between commissioners and providers, served as stepping stones for further development of local services and support; for example, personalised care and support planning, earlier intervention, greater involvement of the voluntary sector and sustainable provision, all key IPC principles, were already being discussed in these fora prior to the set-up of IPC. Other formal developments such as STPs also encompassed key elements such as market development and personalisation.

F.45 The other common theme was further development of existing directories or databases of services; however, e-markets did not feature other than as aspirations to develop databases into online platforms in the future. As an example, one site had created a directory of support services for service users using direct payments. Just before the start of IPC in 2016, a sub-

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[58] Market Shaping Review: Market Position Statement Guidance, July 2016, Institute of Public Care, Oxford Brookes University,page3 https://ipc.brookes.ac.uk/docs/market-shaping/Market%20Position%20Statement%20guidance.pdf

directory of PAs was added to assist service users in finding and increasing the use of PAs. Coincidentally, IPC users benefitted as they were able to spend their PHBs on PAs. The site promoted the PA directory by discussing it with service users during IPC conversations and providing a leaflet about it.

Challenges and facilitators

F.46 We anticipated that the lack of clarity in the aims and goals of market development, or an unclear rationale for the way forward, would be highlighted as a key challenge, but this was not the case; respondents spoke only briefly about market development meetings not being sufficiently focussed and actions not being followed up.

F.47 Instead, perceived challenges and facilitators fell loosely into the following headings: organisation and relationships, funding and investment, and understanding and expanding the market.

Organisation and relationships

F.48 Positive engagement with IPC and the energy to drive forward change were reported to be key in facilitating moves towards market development. Common themes were about networking opportunities, building trust, investing time and having leadership support across health and social care, which helped to end working in silos and open new doors. In a practical sense, having a shared understanding of what a 'good' service looks like and the determination to achieve it were vital. Where there were market development workshops or other networking meetings, interviewees across the sites commented on the importance of independent facilitators, preferably the same facilitator across a series of meetings to enable continuity.

> *'[The lead facilitator] was actually amazing and I believe she's had training, and also having a different face presenting, that makes a huge difference.'*
>
> (VCSE manager)

> *'[The workshop session] was simply one of the most eye-opening days I've had in a very long while.'*
>
> (LA senior manager)

F.49 The involvement and in some instances the drive from the VCSE sector was also important in facilitating relationships that could lead to market development activities. VCSE organisations felt that their vision was aligned very closely with the principles of IPC and that the IPC programme's national meetings that brought together VCSE organisations from different areas assisted in driving their involvement initially.

F.50 One of the practical issues for the VCSE sector was funding; although they wanted to develop bespoke services, they were unable to do so without guaranteed funding. Indeed, VCSE managers reported being under or unfunded to attend market development meetings with local health and social care colleagues and having to balance these commitments with funded work. This underfunding of the sector's involvement also meant that the VCSE sector reported being left out of some conversations and not being involved in strategic level discussions. In some cases, awareness of the VCSE sector's lack of funding had

> *'I think the main challenges have been capacity to do the work; that's been the main challenge for us at [VCSE organisation] and for the people that we've worked with.'*
>
> (VCSE manager)

driven non-VCSE members of multi-sector meetings to make efforts to become more focussed during meetings and better at following up on their commitments, in order to make meetings more efficient and the time commitment of the VCSE sector more worthwhile.

F.51 One of the difficulties in encouraging organisations to become involved in the market development side of IPC was that IPC was seen initially as a discrete activity, meaning that market development and shaping activities that preceded IPC were typically pursued separately. The perceived focus of IPC on personal budgets rather than personalisation also made it appear detached from the VCSE agenda.

F.52 Respondents considered cultural change as key to moving market development plans forward but recognised that this happened slowly for a number of reasons. Some felt that the long-term use of block contracts had solidified thinking across sectors, institutionalising this style of commissioning and distancing people from thinking about promotion of services to individuals. For example, when new services had been introduced in the past, they had failed to thrive because of too few referrals, a result of insufficient buy-in from GPs and other practitioners. There were also cultural challenges in implementing change, in which a 'new' sector was tasked with delivering work traditionally provided by another sector, for example, the VCSE undertaking some tasks that district nurses have previously offered. In essence, people found it difficult to adapt to new ways of delivering services, especially if they were being asked to stop delivery.

F.53 Good relationships were also key to facilitating market development. Relationships can take time to develop but it was felt that developing and maintaining good relations was easier with a smaller number of organisations or people. For example, a local council learning disability team believed they knew all of their providers and service users and felt this enabled them both to foster those relationships and understand how and where the market could be further developed. Working with providers to operate sustainably whilst adapting to changes in demand also facilitated market development by lending security and smoothing changes in provision. In two of the three IPC sites studied, however, there are also examples of service-specific teams forging ahead with market changes unilaterally or with only select partners, mainly delivery partners, as other partner organisations were not in a position to put together plans or make changes at the same time. In one site this was done by a council-led team and in the other a CCG team; both were successful in implementing their plans.

F.54 The linking of strategic and operational roles and plans was seen as a facilitator for market development. Where IPC was able to link with other initiatives such as local well-being projects, which drew funds and partners from across health and social care as well as from ground-level workers through to senior planners, market development activities were enabled to move forwards. Strategic level consideration of practical issues such as how personal budgets could be spent on individual market purchases was also felt to be key in implementing change. Integrating IPC principles into existing strategic plans for a specific site was also perceived as beneficial for market development by enabling IPC to become 'business as usual' and therefore more easily implemented.

Funding and investment

F.55 Funding and investment issues had major impacts on abilities to develop markets. Releasing money from block contracts and decommissioning existing health services to invest in new services and providers was seen as central to market development but was not yet evident.

The reasons for this were reported to be in part about key individuals believing that achieving disinvestment was too difficult; the reasons given for this were inappropriate accounting systems and ill-defined unit costs, making it problematic, for example, to withdraw part of a contract for specific services. As a result, any new provision typically had to be funded from other available budgets. Interviewees felt that the heavy reliance on block contracts acted as a barrier to integration, personalisation and market creativity.

F.56 The risk faced by providers in developing new services was also an issue. Commissioners could see the ideal end point of individually purchasing care and support but getting to that point involved risks and a challenge was how those risks should be shared.

> *'I think the main challenges are that for people to have real choice over provision, that [provision] has to grow and it's how much should we, as an NHS organisation, invest in that, because really, [the ideal] would be that there're arrangements provided out there and we just spot purchase.'*
>
> (NHS commissioning manager)

F.57 Where only a small number of care and support users wanted a different kind of provision, interviewees reported no incentive for providers to develop that service. This was where good relationships and clear market development roles were essential.

> *'And so my role is to work with the providers, to tell them more about what's coming, so that they're prepared to take more risk, and so that they're ready to diversify, where needed.'*
>
> (Joint commissioning manager)

> *'…to encourage a new provider to do something radically different, to do that they require the level of assurance that we're going to utilise them, otherwise they just come at risk, and whilst the private sector and other areas will take risk, they won't take massive risks where there's no guarantee for future work; and I think that's the biggest challenge, development without any certainty.'*
>
> (Joint commissioning manager)

F.58 To limit the risk faced by VCSE providers in moving away from block contracts, one local council learning disability team commissioned a small number of providers, with whom the council would contract exclusively for selected services. Potential providers bid to provide a range of personalised services based on estimates of the number of individuals likely to purchase that service. These estimates were based on the learning disability team's knowledge of their clients, but there were no guarantees that any clients would choose the services offered. The learning disability team noted the financial risks from a move away from block contracts, particularly for smaller VCSE organisations. Despite these risks and the lack of guaranteed service user numbers, providers were reported to be eager to partake in the bidding process. The process was carefully managed by working closely with service users and reporting anticipated levels of demand for specific services to providers. The council team believed strongly that providers should not bear all the risk of market development and that, if they did, there was a danger that small creative providers could be filtered out of the market. A commissioning manager in another site noted that a restriction on using IPC programme money to pump prime the provider market limited the financial support that could be offered in these types of developments.

F.59 The local council in one site shared risks by protecting providers on their framework agreement from financial losses that might result from personal budget users defaulting on payment; whilst this had no direct bearing on the risk associated with insufficient service users using services offered by new providers, it did offer existing providers a degree of security from which they could build additional services. In a different site, a risk sharing agreement was set up between the CCG and the current provider of a specialist short breaks service when personal health budgets were introduced; this agreement enabled the provider to offer services to out of area budget holders as well as offering different services to existing service users, sharing gains and losses with the CCG.

Understanding and expanding the market

F.60 Market mapping and intelligence activities had typically been successful in aiding understanding of specific local markets. However, sufficient funding to carry out these activities and, importantly, to follow them up with concrete developments was a challenge. One area linked up with a local well-being project that spanned a different geographical footprint but was able to contribute funds and people to a mapping exercise. This gave the mapping exercise greater input and a different reach as well as new impetus. Lack of impetus and will after the lead organisation in another area left was reported as a factor contributing to limited progress following market mapping.

F.61 Yet the success of market mapping left some managers concerned that by bringing existing services to service users' attention, without also highlighting their limited capacity to take on new referrals, might lead to service users having their expectations raised at the prospect of newly identified provision only to have them dashed by long waiting times or closed lists.

F.62 A further challenge with asset mapping was 'hyperlocalism', which referred to local populations wanting to focus very much on their immediate locality, such as one side of a valley or river. The timing of market mapping was also crucial; one site reported conducting training for local social entrepreneurs to facilitate new market provision but doing so before fully understanding current provision. The result was that some of the provision developed did not fit well with demand.

> *'I think the danger is the amount of money is so little that it just funds some stuff that then, once the money's run out, stops. [...] We need more funding for both the infrastructure and the activities to really stimulate, in true market development, to develop stuff that's going to be here in five years' time; that kind of vision.'*
>
> (VCSE manager)

F.63 The purpose of market development was to facilitate IPC users to access the care and support of their choice by encouraging additional provision. But sometimes this was not necessary as existing providers already offered relevant services. Whereas some interviewees felt it to be a challenge if personal budget users wanted to purchase services or products available on the high street, as it did not help the development of new services, others felt this was a positive factor as budget holders were able to purchase their choice of care without the need for specialist provision. Urban areas were thought to be better able to facilitate use of existing services simply because there were more options available, not only commercial services but also community groups and neighbourhood events.

F.64 The longevity of newly developed services was raised as a market development challenge; new services or providers risked ceasing once initial development funds ended.

F.65 Limited funds also affected the long-term usefulness of the asset mapping workshops that had taken place; there was the potential for the asset maps to be written up in a way that reached out to multiple organisations, showing what assets existed and where there were gaps. However, limited funds in one site had meant that, even a few months after the workshops, the reports had not been written and there was no guarantee that the lead voluntary organisations had time to commit to it, despite a willingness to do so. Therefore, the initial investment in market development risked not being used to its full potential.

> *'The council like that we have that information and it's there to share but we've not created a document out of it. [...] apart from it informing our services and our development we've not been able to do much else with it recently.'*
>
> (VCSE front line worker)

F.66 A final facilitator, reported by two sites, was the freedom the VCSE sector had to develop and diversify. The public sector was considered to be more constrained. In both the sites, the relevant commissioners had adopted very flexible frameworks with the VCSE, enabling them to respond quickly and passionately to local market changes, despite one site having no steady flow of funding.

Conclusions

F.67 The three IPC sites studied appeared to have made more progress in understanding than influencing local markets. Market intelligence had been collected through market mapping exercises as well as other activities including formal and informal discussions with service providers and users. Each of the sites had identified gaps and had ambitions to try and address those gaps. Achievements to date in terms of influencing the shape of local markets were less clear; while some services had been reconfigured, many gaps remained and there was, in general, little evidence of more vibrant and active markets.

F.68 None of the three sites had measurable, IPC-specific aims and objectives or clear rationales for IPC-related market development. Many of the stated aims and objectives were broad and aspirational, rather than being focussed on deliverables. It is perhaps therefore not surprising that the sites struggled to describe quantifiable measures of success. What is not clear is how the lack of specific aims and objectives affected progress. Lack of aims were not cited as a challenge by any of the interviewees. Progress had been made in building relationships and market mapping, a key first stage to market shaping. It may be that the individuals and organisations involved had clear aims for undertaking market mapping,

> *'The freedom that there's been around commissioning, [the] commissioner is, pretty much just wants to see what outcomes, she doesn't prescribe how we do things, she wants to just see how you're going to meet your outcomes, and then there's quite a lot of flexibility and freedom about how that's delivered; and I think that's very, very important.'*
>
> (VCSE manager)

but there was less certainty about how resulting maps would be used and less direction to market development plans as a whole.

F.69 There were many challenges in understanding and developing local markets, but also many lessons for IPC or similar integrated partnerships attempting to shape care markets in the future. In summary, findings from these three sites suggest that market development can be facilitated through:

- positive relationships that engage a wide range of stakeholders, in particular, treating partners from different sectors as equals and being willing to share financial and other risks;
- positive energy and drive from designated leads able to take responsibility for keeping up momentum and buy-in from local multi-sector partners;
- undertaking market mapping exercises as a first step to understanding local needs;
- making the best of existing resources and providers, whether that be the greater flexibility available through the VCSE sector, the use of 'high street' products and solutions, or more accessible information about care and support options;
- sufficient funding for the VCSE sector to become and remain actively engaged at all levels, from service development and delivery to strategic oversight. National meetings to enable the VCSE sector to share experiences with colleagues in different areas were highlighted to maintain impetus;
- adequate investment to ensure the longevity of newly developed services and support, especially from the VCSE sector.

Annex G: Sustainability and scalability – thematic case study

Introduction

G.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 and support planning and personal budgets. 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.

The programme

G.2 IPC is being tested out in 17 areas in England 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 run in its original format until March 2018. It was focussed on four particular service 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.

G.3 From April 2018, IPC has broadened out to cover larger geographical areas and more service user groups. It will underpin other activities that take place as part of the personalised commissioning agenda.

G.4 focussed

Progress to date

G.5 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, In June 2017, NHS England developed the IPC Interactive Operating Model[59]. 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.

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

G.6 Findings from the evaluation of the IPC programme have been formally reported twice to date, in November 2017 and July 2018. Fieldwork undertaken for these reports found that IPC sites' progress in delivering IPC had been mixed. Over the first three years of the programme the majority of sites made moderate but steady progress, one site made significant progress, and three sites did not make any real progress in the delivery of IPC.

G.7 Evidence gathered through 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 model of intervention. There was therefore considerable variation in practice between sites, including in the development and set-up process itself.

Sustainability and scalability of IPC

G.8 The IPC sites were supported to develop models which could be replicated and build on locally and by others. All of the IPC sites, and five additional new sites (that came from the empowering people and communities workstream of the new care models programme), received funding in the 2018/19 financial year to enable their continued development. This happened at two levels:

- Demonstrators (level one) - 11 demonstrators implementing the full comprehensive model of personalised care at scale across an Integrated Care System (ICS) or Sustainability and Transformation Plan (STP) footprint
- Demonstrators (level two) - 11 demonstrators implementing elements of personalised care at scale within their existing footprint
- In addition, three of the original IPC demonstrator sites are Accelerated Integration Pilot sites, testing an integrated approach to assessment for everyone eligible for a needs assessment under the Care Act 2014.

This report

G.9 This thematic case study was conducted to review what had happened across a range of sites since April 2018 and in particular about **how the ways in which they implemented IPC have been sustained and enabled them to scale up their personalised care offer**.

G.10 Three of the original 17 IPC sites were consulted for this thematic: one Level 1 Demonstrator, one Level 2 Demonstrator and one Level 2 demonstrator that was also an Accelerated Integration Pilot area. The IPC sites were nominated by NHS England to take part, reflecting their and other sites previous engagement with the wider IPC evaluation. At each site, interviews were conducted with a range of individuals involved in the development and setting up of the IPC model in the site. These individuals included:

- the IPC programme managers in each of the sites
- senior strategic level stakeholders who were involved in the development and design of the IPC model in the site

- strategic stakeholders involved in taking forward the implementation of the IPC model in the area.

G.11 Interviews took place between November 2018 and February 2019. The sections below summarise the learning from the experience of the sites.

The IPC models in the case study sites

G.12 This thematic case study was conducted with three IPC sites. Each of the sites developed a different model of IPC, setting up different governance arrangements and utilising different resources in the development of new infrastructure. That said, all three sites noted during the interviews that when developing their IPC model, they were aiming to develop a model that could be embedded as 'business as usual' from the outset.

G.13 In the section below, we summarise the models of the three sites.

Demonstrator Level 1

This site was one of the first round IPC sites (known as IPC Demonstrator Sites) and has been developing their IPC model since 2015. The local authority was the IPC lead for the site. The site was able to build on good working relationships between senior figures at the local authority and the CCG.

The focus of the site in developing the model was on building strong relationships between health and social care and developing integrated systems and infrastructure for the delivery of integrated personal budgets.

The site established an integrated commissioning board, with the objective of bringing together health and social care to develop a shared language and understanding of personalised care. The board developed an electronic payment system for processing payments of integrated personal budgets for service users (with funds being paid in from both social care and health in to a joint pot). This payment system was launched in January 2019.

This site has made progress and begun the delivery of personalised care and support plans and integrated budgets as a universal offer.

The objective for the site going forward is to scale up the implementation of the integrated personal budgets at scale and to reach STP footprint.

Demonstrator Level 2

This site was one of the second round IPC sites (known as IPC Early Adopters), developing their IPC model since December 2016. The IPC programme in this site was led by the CCG.

IPC in this site was developed in a number of separate workstreams. Each was looking in to developing a personalised care offer with personal budgets within their own services and for specific target groups. There was little focus on integration between services.

The work of IPC in this site was focussed on developing the governance structures and infrastructure within each workstream to deliver personalised care. Good progress has been made by the site in this area. However, as the site was just ending their second year of the programme at the time of the interviews, actual delivery of IPC to service users had only been achieved on a small scale and through short-term pilots.

The site had always planned to deliver IPC on the STP footprint. Going forward the objective is to continue to develop their models of personalised care in the different workstreams.

Accelerator Integration Pilot site

This site was one of the first round of IPC sites, developing their IPC model since 2015. The site has faced a number of challenges, with health and social care being very segmented in the area, resulting in limited awareness amongst stakeholders about what local services were available. As a result, and set alongside staff changes, the IPC work in this site is still at the very early stages of planning and set-up of the governance structure.

To mitigate this lack of knowledge, the IPC team invested the majority of the resources during the three years of the programme in developing an integrated governance structure and mapping out the various services and providers in the area. Through this process the IPC team identified a local intervention that worked with the same principles of integration and personalisation as IPC. This service deployed teams of practitioners who visited service users, assisted them in developing a bespoke plan of their care needs and provided them with information and support in accessing local services to meet these needs.

The objectives for the site’s team going forward is to build on the model of work of this local service that is already established, in developing a sustainable offer on the large geographical footprint and to scale up across the STP footprint.

Progress made towards sustainability and scalability

G.14 To understand the progress that has been made in the development of the IPC models in each of the sites, it is important first to review the development of the IPC programme at the national level.

G.15 The IPC programme was announced by Simon Stevens, Chief Executive of the NHS, in July 2014. Shortly after, in September 2014 the prospectus for sites was published, along with the bids applications process. By December 2014 the first eight IPC sites were selected, with four additional sites selected by the launch of the programme in April 2015. This was the first round of 12 Demonstrator IPC Sites. At this stage of the programme the concept of integrated personal commissioning was not clearly defined, and no clear deliverables were set out for the sites.

G.16 In May 2015, NHS England launched the IPC emerging framework[60], which set out the Five Key Shifts of IPC, to provide some initial guidance to sites in developing their local models of IPC (Proactive co-ordination of care, community capacity and peer support, personalised care and support planning, choice and control, and personalised commissioning and payment). During the first year of the implementation of IPC, the focus for the 12 Demonstrator Sites was on defining what IPC would look like on the ground. As such, activities were centred around design and planning and not on delivery. In June 2017, NHS England published a revised interactive operating model (which was developed in collaboration with representatives from sites, local government, representatives from the health sector, VCSE organisations and people with lived experience), to support the scale and spread of the IPC model. At this stage, the emphasis moved away from linked datasets and market development in to personalised care and support planning [61].

> *'It is really difficult trying to implement any of these changes until we move everybody back into one unit'*
>
> (Site VSCE manager)

G.17 It appeared that the development of the local IPC models picked up momentum once the IPC Interactive Operating Model was published in Summer 2017. In addition, the concept of integrated personal commissioning continues to evolve, even today, as the policy landscape continues to develop[62]. As such, the sites were operating in a challenging environment for introducing and scaling up a stable model [63].

G.18 For this reason, we are only able to discuss preliminary findings in relation to sustainability and scalability at this point. However, we would expect further progress and scaling up of activities as the health and social care sectors take forward delivery of the Long Term Plan[64]. NHS England might wish to follow up with additional evaluation at a later stage, to gather learning on the sustainability and scalability process of the IPC model as it develops further across many sites.

G.19 The work on this thematic case study highlighted that the most progress achieved by the sites was in the development of new governance structures. This was the area that all three sites had focussed most of their resources on. The actual commissioning of services was planned as the next stage of the process. One interviewee noted that they felt this was the right focus for ensuring the sustainability of the model, even though they felt under pressure to meet their delivery targets. At the time of conducting the interviews, two of the sites were at the point of starting to look at commissioning, while the third was still at the governance and infrastructure planning and setting up stage.

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[60] https://www.england.nhs.uk/wp-content/uploads/2017/06/ipc-emerging-framework.pdf

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

[62] The latest policy development was the NHS Long Term Plan, published in January 2019, which set out a clear priority for personalised care across the system, with the development of Universal Personalised Care and support plans.

[63] We discussed the issued around the definitions of IPC and the resulted delay in the development of the IPC models in sites in the evaluation first interim report, available online via this link: http://www.sqw.co.uk/files/8215/1818/6800/SQW_first_process_evaluation_report.pdf.

[64] NHS Long Term Plan (2019) available on line: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

'It was a real struggle to try to get people, particularly managers, to understand the worth of IPC at all, because they were saying, well, what is it? I don't understand'

(Site senior manager in social care)

G.20 The concept of the IPC model represented a significant culture change in the way services were expected to be set up and delivered. Traditional governance structures separated health and social care services: each had different sets of KPIs, budgets and ways of working. Bringing the two services together to be integrated under one governance structure was no small undertaking, and it required a great deal of time resource to gain buy-in from relevant stakeholders, bring them together and develop a shared vision of how services would be delivered in an integrated and personalised way in the future. The interviews with the teams at the sites indicated that all sites have been successful in gaining local stakeholders' buy-in and achieved a shift in mindsets.

G.21 In two of the sites the work focussed on achieving both integration and personalisation in service design and provision. In these sites, the programme teams set up integrated boards, bringing to the table representatives from health, social care and the voluntary sector. It was noted that voluntary sector bodies were key to the learning process, as they had a great deal of experience in working across services and pulling together resources from different sources to deliver their provision.

G.22 The boards appeared to have been working successfully, with meetings taking place regularly (in most cases on a monthly basis) and with good attendance. Members of the boards appeared to have had strong commitment to changing how services were commissioned and delivered in their locality. The joint groups contributed to the development of good relationships between stakeholders from different services, so that even where traditionally services were working completely separately from each other, partnerships were beginning to form. For example, in one of the sites the integrated board was looking in to developing multi-disciplinary teams to deliver personalised care and support plans for service users.

G.23 In the third site, the focus of the work was on personalisation rather than integration, and work was done in separate workstreams for each service. Each workstream set up a steering group, bringing to the table senior commissioners, representatives of providers and representative of the voluntary sector, to develop a shared vision in relation to personalisation in the provision of services around the user's needs going forward. The steering groups appeared to have been successful in gaining buy-in from representatives at the senior level, although stakeholders commented that they were still at the very early stages of the process. This limited progress was because a high level of personnel churn, including a merger of the three local CCGs and a complete governance restructuring, which caused significant delays to the work.

G.24 In all three sites, senior stakeholders showed high levels of commitment, and there was confidence amongst stakeholders that the new integrated boards or steering groups will continue to drive the change in services commissioning. Stakeholders believed that the new governance structures would support change and help to ensure the sustainability and scalability of the new models of commissioning.

G.25 In addition to the development of new governance arrangements (in the form of boards and steering groups), two of the sites focussed their efforts in setting up infrastructure for the delivery of the services. This was designed to enable service users and their carer to commission their own bespoke care packages using their personal budgets:

- One of the sites was working on the development of an e-marketplace, which was an electronic local offer. This platform was intended to serve as a directory of services as well as a portal for service users to commission services directly, using their personal health budget. The challenge with setting up this portal was that with most providers the local authority and the CCG were constrained by block contracts. At the time of conducting the interviews the CCG signed a contract with a new provider for CHC, in which they introduced the expectation that the provider would offer tailored packages for service users. The e-marketplace was intended to be launched for the CHC cohort in the first instance, while the steering groups were exploring how to introduce flexibility in to the other services offers which were still bound by the block contracts.
- The second site set up an electronic 'banking system' where funds from health and social care, intended for personal budgets, were pooled and kept in one place. This electronic 'banking system' was managed by the local authority, and they set up processes in place to deliver integrated personal budgets to service users. Setting up a mechanism for the delivery of integrated personal budgets was a significant achievement for the site. The team noted that this was achieved through the development of strong working relationships and trust between the heads of health and social care services in the site. This system was launched in January 2019, and so there was not enough evidence at the time of writing this report to assess how well the system was working.
- The third site noted that they were still at the early stages of mapping out their local services and establishing their integrated board. The integrated board had started meeting regularly and stakeholders commented that the discussions have been going well. They noted that with the new integrated board in place, there is good potential for the integration and personalisation work to gain momentum in the area. The site had not reached the stage of looking in to setting up the infrastructure for the delivery of the new commissioning model at the time of conducting the interviews. However, social care services have been delivering *personalised* care and support plans for service users in the meantime, although these have been on a localised level.

Workforce development and support

G.26 Another element of working towards the sustainability of the IPC model was the consideration of the workforce needs. The integrated boards and joint steering groups helped in gaining the buy-in from senior stakeholders at the senior strategic level. However, stakeholders recognised that to achieve sustainability of the model, the frontline workforce, who will be delivering services, needed to be bought-in to the change as well. In all three sites, the frontline workforce was encouraged to take part in special training that was provided by the programme. The training focussed on the personalisation approach to service provision and provided practical sessions in conducting 'a different kind of conversation' in personalised care and support planning.

G.27 Through the training sessions, senior stakeholders identified those frontline practitioners who were fully bought-in to the approach and who showed high levels of commitment to the change. These practitioners were invited to be 'Champions of Personalisation' in their services/organisations. The intention was that the 'Champions of Personalisation' would assist in keeping the momentum for change. The motivation for staff to become Champions appeared to have been their high level of commitment to the personalisation agenda and their sense of responsibility for the welfare of service users under their care. The Champions received additional support from their organisation to help them with their role. One of the sites provided 'train the trainer' sessions to their Champions, so that the training on the personalisation approach in service provision would continue to cascade locally, even after the funding for the training through the programme stopped.

Conclusion

G.28 Although two of the sites were still at the early stages of the development and implementation of the IPC model, they have been successful in making good progress in gaining the commitment amongst senior stakeholders and in generating momentum around the change in the commissioning approach. Stakeholders during the interviews expressed confidence that the progress that the sites have made in the development of the new governance arrangements and infrastructures has the potential to support the sustainability and scalability of the new model of commissioning going forward.

Enablers and barriers

G.29 In this section we explore the key enablers and success factors in this process and the main challenges and barriers that sites faced.

Enablers and factors of success

G.30 Interviewees at the sites noted that a key driver for local stakeholders to engage with the IPC programme was the **high profile of the personalisation agenda**. They noted, in addition, that for health service stakeholders, a key driver was the targets set out by NHS England for the delivery of personal health budgets (PHBs). For health services, offering PHBs became mandatory for certain target groups (mainly those in receipt of CHC)[65] and that was a primary motivation for the senior strategic stakeholders in health to engage with the IPC programme. Indeed, in two of the sites it was noted that before this it was very difficult to engage health services in discussions of personalisation in care and support planning and delivery. One interviewee commented that making integrated personal budgets mandatory in the same way, with a target of a number of budgets achieved each year, might provide a driver for services to make greater progress in this area.

G.31 The main factor of success for establishing the new governance arrangements, cited by all sites, was the **good relationships between the senior stakeholders at the strategic level in health and social care**. Stakeholders commented that without the good working relationship and trust that was established between colleagues, it would not have been

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[65] Since April 2019 all individuals living in their home who are in receipt of NHS CHC should have a PHB. (https://www.england.nhs.uk/personal-health-budgets/personal-health-budgets-in-nhs-continuing-healthcare-and-continuing-care-for-children/)

possible to develop a shared vision and understanding of what the IPC model should look like in the local context. In one site in particular it was noted that the strong relationship and trust between the senior leads at the local authority and the CCG meant that the health services recognised that local authority and social care services were much more experienced in the development of personalised care and support plans and the allocation of personal budgets than health services; and therefore the CCG was happy to place the lead with the local authority and to learn from their experience in developing an integrated system for allocating personal budgets. The relationships between health and social care have not always been good in all three sites. Stakeholders commented that where necessary they addressed issues through establishing **joint working groups**. Through their collaboration, stakeholders noticed that they had shared goals and started developing a shared language to discuss personalised care.

G.32 In addition to the good relationships, interviewees noted that there was a very **high level of commitment to the personalisation agenda**. The development of the IPC model required senior stakeholders to attend board and steering groups meetings on a regular basis. Regular attendance at these meetings required a substantial investment of in kind resources from the organisations and stakeholders involved, which is not to be taken lightly. Interviewees commented that it was the high level of commitment to change that kept the attendance levels at these meetings high and helped keep the momentum of the change. Stakeholders noted that in part, the commitment was driven by the targets and KPIs set out by NHS England with regards to PHBs. However, stakeholders were mostly committed because they believed that the personalised approached has the potential to improve outcomes for service users.

G.33 The commitment of frontline staff was another key enabler. Experience shows that in order to maintain momentum in a change process, a vital enabler is local change agents. Two of the sites included in their governance arrangement the identification of **Champions of Personalisation within the different providers and organisations**. These champions received additional training and support to cascade down the personalisation approach to service planning and delivery to their colleagues and within their organisation. It was noted that these Champions will assist in sustaining the new commissioning model, as they will continue to practice and advocate for personalisation in care, gradually making this the norm of service provision in their organisation.

G.34 Another enabler cited by the sites was the **training provided to frontline workforce**. It is generally good practice to provide training to the workforce in support of a change in the system. Furthermore, stakeholders thought of the changes that were introduced through the development and in time, the implementation of a personalised care model in terms of ‘system culture change’, which required a change in the mindset and practice of all stakeholders in the delivery of personalised care and support plans. The training sessions focussed on conducting ‘a different kind of conversation’ with service users and provided practical tools in developing personalised care and support plans. It was noted that the training was received well by those who attended the sessions, as it combined theory with practice and helped increase the attendees’ understanding of what personalisation in care and support planning looked like.

G.35 Finally, all the interviewees cited the **NHS England funding** as a vital enabler for the work that has been done. The IPC programme funding enabled the work that was undertaken in setting up the new governance structures, processes and infrastructure as the foundation for the delivery of the IPC model in the area. It funded the post of the programme manager, who was critical in keeping the momentum of the work and in brokering the relationship between the stakeholders at the site and the programme team at NHS England, and it funded admin support and resources for the smooth running of the programme set-up. Sites noted that the costs of setting up the governance structures, systems and processes for generating a system change on this scale should not be underestimated. If this approach was to be replicated in other areas, the lack of external funding to support the set-up stage might become a barrier.

Barriers and challenges

G.36 Interviewees noted a number of challenges and barriers that they faced during the development of the IPC model. The main challenge cited by all sites was the **high level of staff churn within the programme team as well as within the local organisations**. In two of the sites, the IPC programme team members changed a number of times throughout the lifetime of the project. This included a change of the programme manager, evaluation and data leads and admin support. In addition, senior personnel in the local organisations and services (CCG, social services and local providers) changed or their post have been cancelled. One of the sites has seen a merger of their local CCGs, which meant a large number of posts being lost. Interviewees noted that with the change in staff, a great deal of the organisation memory was lost.

G.37 This all caused delays in the progress of the work, as with every change, the programme team felt they needed to take a few steps back, to get everybody on the same page again, before continuing with the model development. In one site in particular, this meant that when the programme manager left, the work needed to start almost from the beginning, as most of the information on the work and planning that had been done before had not been recorded in a consistent or accessible way. To mitigate this issue, the site invested further resources in the mapping of the local services to ensure all stakeholders were aware of what was available andto prevent any duplication of efforts and to build on models that already worked well in the area.

> *I am one of the people who was there right from the beginning all the way through. This has been an advantage. In lots of other sites they have had a big turnover of programme management, and might have lost the lessons learnt. So I've been able to offer support and advice, saying 'no that won't work', or, 'you need this in place'*
>
> (Site Project Manager)

G.38 Another challenge that was noted by all of the sites was the **difference in experience and approach to personalisation and personal budgets between health and social care services**. Interviewees noted that there was a significant gap between health and social care in this area. While social care services were working with a personalised approach and had been allocating personal budgets for over a decade, the idea of personal budgets and personalisation in care and support planning and provision was just recently introduced in to health services. While social

> *'There are organisational barriers as well, just how we work differently and communicate differently…we have got better relationships, but a true embedded integrated health and social care model… we are not there yet'*
>
> (VSCE representative)

care had years to interpret what personalisation in care looked like for services and develop models of personalised care and personal budgets, health services were just at the start of the process. Direct translation of the model and experiences from social care in to a health model was not straightforward, as the medical context was quite different from the context of social care.

G.39 Programme teams at the sites found that they needed to allow health to 'catch-up' with social care in order to be able to develop an integrated model of service planning and provision, and in particular in developing systems for the allocation of integrated personal budgets. The good relationships and trust between stakeholders was the key enabler to overcome this challenge. However, getting all stakeholders on the same page took time and meant that the progress in developing the local IPC models was not as advanced as hoped at this stage of the programme.

> *'It probably took us a good year, possibly more, even two years, for us to get to the point where we were all in the same space where we can all move forward'*
>
> (Site senior manager in Social Care)

G.40 The provision of training to the frontline workforce was cited by the sites as one of the key enablers for the implementation of the IPC model. However, there were a number of challenges associated with the training. The training was provided by NHS England via the IPC programme. It was not clear whether sites would have been able to provide this training to their workforce if they had to develop/fund the training themselves. One of the sites provided 'train the trainer' training to a group of practitioners, who were identified as highly bought-in and committed to the change. This approach will help to ensure that the training continues with little funding required from the local authority or CCG. However, as the personalised care approach will be rolled out across different STPs, the cost of running more and more training sessions might become a barrier.

G.41 Another challenge relating to the training session was the need to free up the workforce to attend the sessions. The training sessions were a full day, and this meant that organisations had to free their staff, fund their pay for the day, and fund the pay for replacement staff to work in their place during the training session. The high levels of commitment from the senior strategic stakeholders meant that organisations and providers invested this contribution in kind. However, it is not clear whether this could be replicated elsewhere, where there are not high levels of commitment for change, nor whether this could be sustained long-term.

G.42 We noted above that the primary factor of success in the development of the local IPC models was the strong buy-in and high level of commitment from senior stakeholders at the strategic level. Additionally, the programme invested in workforce development on the frontline level, to ensure their buy-in and commitment as well, as they will be tasked with the delivery of services under the new models. However, interviewees noted that to ensure the sustainability of the model, the **middle managers would be vital to the process**, as they have the operational responsibility for the delivery of the models of care. In the second interim report of the evaluation we discussed the important role of middle managers in the process of introducing system change and the challenges that the sites faced in engaging them[66]. At the

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[66] SQW (2018) Summative Evaluation of the Integrated Personal Commissioning (IPC) Programme. Can be accessed online via this link: http://www.sqw.co.uk/files/1615/3114/9921/IPC_process_evaluation_second_interim_report_Final.pdf.

time of the interviews for this thematic case study, the engagement of middle managers in to the change process had not yet happened.

G.43 Finally, all sites have made good progress in developing governance structures and infrastructure for the delivery of the new commissioning models. However, in two of the sites, progressing to the next stage of commissioning services in a personalised approach remains a key challenge, as **most of the funding that would be allocated for these services was tied up in long-term block contracts with providers**. While discussions have been taking place with providers to introduce some flexibility in to the care packages that they offered, there was little incentive for providers to change their offer in the short-term at least, as local authorities and CCGs were bind by the contract they had.

G.44 To try and mitigate this issue, one of the sites was looking for other sources of funding to enable them to start the delivery of services with the new model of commissioning, until the existing contracts end or changes to them could be introduced. However, the challenge that they faced was that because delivery under the new IPC model was only on a small scale so far, there was little if any evidence to demonstrate the benefits of the new approach to the individuals and their carers and to the system. At the time of the interviews the stakeholders in these two sites did not have a solution for this issue.

Learning and conclusions

G.45 The summary of the sites' activities highlights that the development of the IPC models in each of the sites that were engaged in this thematic was still at the early stages. Progress in all three sites has not gone much beyond the set-up stage (and in one site the team is still at early stages of set up). Two of the three sites noted that they will face a challenge in delivering IPC (i.e. commissioning personalised care and support planning and care packages) mainly due to financial constraints. However, overall it appeared that the sites have made good progress in developing the foundations for embedding the new model of commissioning as 'business as usual' going forward.

G.46 Although it is too early to discuss outcomes in relation to sustainability and scalability, we can discuss the learning from the activities of the sites and the potential sustainability and scalability of the model.

G.47 All three sites appeared to have been successful in **engaging senior commissioners in the process of designing and setting up the IPC model in the local systems**. As the senior commissioners have the responsibility for managing the contracts with the providers, they are the key stakeholders who will be able to ensure the sustainability of the new commissioning approach.

G.48 In addition, two of the sites appeared to have been successful in bringing together stakeholders from the different sectors to develop a shared understanding about what IPC would look like in their area. This **collaboration between health and social care in the development of the new model** could promote a consistent change across the local system and in turn could support the sustainability of the change, as the engagement will be system wide.

G.49 Two of the sites developed **electronic solutions**, one for managing self-commissioning and the other for managing integrated personal budgets. At the time of conducting the interviews the system in one of the sites has been just recently launched and in the other site was not yet in full operation, so it was not possible to assess their effectiveness. However, the digitisation of these processes has the potential to promote the consistent application of this element of the model and in turn support the sustainability of these processes. It would be beneficial for NHS England to follow up with these sites to review how the electronic systems operate, how effective they are, what benefits they have for service users, their carers and the system, and what learning can be drawn for replicating these solutions in other areas.

G.50 **A key barrier to the sustainability the IPC model in the sites was the financial constraints** that local authorities and CCGs faced. In addition, CCGs and local authorities were bound by long-term block contracts with most of their providers. Although discussions have been taking place with providers to introduce some flexibility in to the contract (to allow for the commissioning of bespoke packages of care), there was little immediate incentive for the providers to make these changes and not all providers agreed. With the money tied up in those contracts, stakeholders faced a challenge to find the finance to fund the implementation of a new commissioning model.

G.51 It was envisaged that the IPC model would introduce savings in the system (as service users manage their health better and as a result require lower use of services), and the money from these savings would be diverted in to supporting the new commissioning approach. However, there was little evidence to show whether costs savings have been achieved, or what the benefits for the service users, their carers and the system were, to build a business case for the development and rollout of the new model. One of the sites noted that they regretted not thinking about the financial sustainability of the model from the outset. Had they done so they could have had a plan in place to gather the evidence required to make a business case for the model.

G.52 The IPC teams at these sites noted that they were determined to continue with the development and implementation of the new model and were looking in to different solutions for financing this. This included looking for opportunities to bid for external funding. This is a testimony for the high level of commitment to the approach amongst the local teams and stakeholders. However, to ensure the sustainability and scalability of the IPC model there will be a need of a long-term financial solution. At the time of conducting this thematic case study, this issue remained a key challenge and a potential barrier for the sustainability and scalability of the IPC model.