Southwest IPC Evaluation Final Report

Synthesised Case studies of Sites 1 & 2

Summary report

Authors: Debra Westlake, Jon Allard, Ben Fosh and Helen Lloyd.

Acknowledgements:

Introduction

This document reports the summarised findings, conclusions and recommendations of the evaluation of the Southwest (SW) Integrated Personal Commissioning (IPC) intervention.

The research was carried out between April 2016 and April 2017. Key findings are summarised here for two local programmes in the region (Site 1 and Site2) which were active at the time of data collection. The sites have distinct geography and configurations of services, but have implemented IPC with many common intervention features in line with national guidelines. The complete findings are available in the full report available from [link to SW IPC website?] /CPC publications list?

Background

The national IPC programme started in April 2015 as a partnership between National Health Service England (NHSE) and the Local Government Association (LGA). IPC was seen as a way to extend the developing national personalisation agenda by building on and integrating existing health and social service personal budget programmes. While national guidelines about components of the programme were still developing during the first years, key elements of the intervention were a focus on the 'better conversation', establishing 'w*hat matters to you, rather than what is the matter with you*'[5,8] and the development of a shared plan. The plan may include a budget to be spent in ways that have meaning for the individual and produce their desired outcomes. The budget may be from a number of sources including local authority, health, education or an integrated budget from a combination of these sources. The SW was one of the first 9 demonstrator sites enlisted to develop the programme. Learnings from these first demonstrators are intended to be incorporated in programme development going forward.

Summary of Key Findings

The evaluation of IPC is complex. Not only is it important to understand if individuals are gaining benefit and whether their service use is changing, it is also important to understand how models of IPC are interpreted and implemented on the ground in what are evolving, varied and idiosyncratic health, social and voluntary care systems. To support this understanding, the SW evaluation defined the aims shown in figure 1. This summary will report on findings addressing aims 3,6,7,8. Both qualitative and quantitative data were collected through collection of survey data from participants and practitioners and observations and interviews with managers, practitioners and participants. Qualitative data were collected by an embedded researcher at one of the sites who co-produced research findings with participants and practitioners. A complete description of methods and findings addressing all the research aims are available in the full report.

Figure 1: SW IPC Evaluation aims

> ***The SW IPC Evaluation aimed to :***
> 1. Characterise how IPC is defined in the local context (qualitative data)
> 2. Explore how IPC was being delivered (described through local qualitative case studies)
> 3. Compare the local delivery of IPC with the principles of delivery specified in the national guidelines (the OM) (formative evaluation using qualitative process data)
> 4. Measure outcomes of IPC for individual participants, those who care for them, and the practitioners delivering IPC (quantitative metrics data)
> 5. Calculate the cost and service activity levels for those in receipt of IPC using a before and after design to detect change (quantitative activity level data)
> 6. Assess if person centred care was being implemented (synthesis of qualitative and quantitative data)
> 7. Evaluate if individuals' health and wellbeing improved and if IPC helped support independence (synthesis of qualitative and quantitative data)
> 8. Describe the enablers and challenges to the delivery of local IPC models within distinct geographical areas and unique systems of care within the SW (synthesis of data).

Formative evaluation of process measures: do the local models of IPC resemble the national guidelines proposed in the Operating Model (OM)?

The NHS England Operating Model (OM) was introduced by the national programme team in July 2016 during the course of the study (Appendix 1). The model sets out key features of what IPC means in practice to firstly, people and secondly, to local systems. The programme team at NHS England (NHSE) monitors the progress of demonstrator sites through quarterly structured conversations, in which sites evaluate their development against the process measures ('*key shifts*' or '*enablers*') of the OM. As part of the evaluation we analysed the key themes of the OM shifts and examined our evidence against these themes. This analysis is summarised in table form (Table 1).

Table 1. Process measures of IPC: summary of evidence

Key shifts	Progress on key indicators from both sites in SW. Where there is variation between sites this is described by labelling Site 1 and Site 2.			
Proactive coordination of care	**Cohort identification** Up to three cohorts (mental health and LTCs) trialled with IPC and found to benefit. Some difficulty experienced with recruiting frail elderly to programme. Current cohort (site 1 n =14, site 2 n = 17) were people who typically 'fall through the gaps' of services and whose needs are difficult to identify. Site1: new strategy for cohort identification being developed to identify the pre-frail (JFDI) and high users of emergency services.	**Local offer and implementation**: This was not yet a widely advertised local offer but an individual offer to a restricted cohort. **Recruitment** Site 1: Offer made by practitioner known to individual (GP or community matron) Site 2: Participants recruited directly by IPC practitioner. **Delivery** Site 1: A community and primary care MDT; Site 2: Single handed practitioners	**Clarity of programme and eligibility** Some confusion persisted among participants and practitioners about what IPC is and who can benefit from IPC but was gaining clarity as a local model is developed.	**Clarity of process**: Site 1: A co-production group reviewing the process and expected to be involved in development with new cohorts. Site 2: Some of the cohort was elderly and experiencing confusion. Participants not consistently aware of programme steps.
Personalised care and support planning	**Training to deliver a conversation on 'what matters to you'**: Practitioners were trained in delivering a 'different' conversation. Most people report experience of a better conversation. Some participants find the conversation 'empowering'.	**Integrated planning and single point of contact**: Most people have a single point of contact. A common care planning framework developed but not always helpful to the flow of 'conversation' or 'owned' by participants. Plan is not currently integrated with other services.	**Goal identification and meaning to participants** Site 1: 61% of goals achieved with some pending. Site 2: 88% of goals achieved in the sample. Unfamiliar language means participants do not always recognise their 'goals'. High participant satisfaction with goals achieved.	**Review framework**: Mechanism in place but in practice a fluid process not transparent to participants. **Information about support and services**: Site 1: co-produced database of resources developed by MDT including VCSE. Site 2: lone practitioner sourcing and information giving.
Choice and control	**Clarity about who can get an integrated personal budget and what money can be included.** Currently no mechanism for identifying an individual statement of resources and for calculation of an indicative budget for these cohorts. Personal budget comes from health alone.	**Options for managing budget**: notional budgets at Site 2. Site 1 uses direct payment method. Lack of transparent rationale for accepting or refusing funding of goals. Slow/complex system for release of funds caused frustration to practitioners and participants.	**Freeing up of money for personal budgets by changing of contractual agreements**: Lack of strategic support for IPC made it difficult to change contractual arrangements and gain sustainable funding for IPC. Concern about future of funding for individual budgets caused programme stalling.	**Personal budget is individualised and personalised to meet outcomes in ways and at times that make sense to people** A budget is not always needed to provide identified resources (50% of goals funded by IPC, the rest by other provision including self-funding and existing VCSE, council and NHS sources.
Community capacity and peer support	**Community navigation options**: Site1: Community navigation and coordination, including sourcing and brokerage, provided by the VS members of MDT. Site2: strong focus by	**Self-management of health encouraged in ways that 'matter to you'**: Site1: talks and demonstrations by complementary therapists and health	**Range of peer support options and ways to connect**: Site 1: - Co-production group builds relationships between participants. Members invited to	**Building community capacity** Site1: generation of demand for local therapies and activities is likely to stimulate the VCSE market. Site 2: Close

	lone practitioner on signposting of community resources.	practitioners identified by the participant group.	join national strategic co-production groups and Implementation groups for local programme.	working relationship with a local branch of a national VS organisation.

The demonstrator projects at Sites 1 and 2 in the SW were offering many of the characteristics of IPC defined in the OM and which are consistent with personalised care to a cohort of individuals selected largely by practitioner knowledge as those with high needs who fall through the gaps of services.

The sample size across both sites was 20 people. Chief characteristics of the cohort were multiple conditions, frequently combined with a self-reported mental health disorder, either diagnosed or sub-clinical. At Site 1 age range was 51-79 years, mean 62 years. Participants reported that their conditions were not always easily identified initially (fibromyalgia, MS, Parkinson's). Participants for whom IPC was beneficial were typically not in receipt of extensive packages of care from other services and most were willing and motivated to try new initiatives.

At Site 2, the sample population was older (range 58 – 90 years, mean 72). Two individuals, aged 88 and 90 years, were experiencing a variety of complex physical health problems (related to comorbidities and age) meaning that a significant improvement in physical health was unlikely. These individuals had some difficulty engaging with the IPC process. These findings resonate with findings at Site 1 where attempts to recruit participants for the first cohort from the frail elderly population were unsuccessful. It is unclear whether age, number of health conditions or complexity of existing care arrangements are the most significant variable in engaging with the IPC process but this small sample could illustrate how the individualised IPC process may not be suited to everyone. Further research is recommended on this area.

> **Commented [DW1]:** Should this section go to conclusions and recs?
>
> **Commented [HL(2):** No I think it is fine here

At Site 1, IPC was coordinated by the multi-disciplinary team (MDT) with an embedded voluntary sector (VS). The team had a strong history of working together which allowed them to see IPC as an extension and adaptation of their team working and which was mutually supportive. At Site 2, a lone practitioner with significant expertise in care planning and integrated working was developing the programme.

Both sites were developing an innovative model of IPC on the ground in an organic way that was self-reliant, flexible, and courageous, given the lack of national guidelines on how to deliver many of the features of IPC and lack of designated funding to deliver the programme. The 'better conversation' was at the heart of the local offer for IPC, and care and support planning encouraged participants to identify choices which matter to them. At Site 1, a co–production group of practitioners and participants had been given the opportunity to feed back its experiences. A co-produced method of research impact was adopted to enable an iterative process of improvement, which was welcomed by the MDT and managers (see Appendix 2). There remained some lack of clarity about what can be defined and counted as a genuine 'IPC' intervention and how this will be funded.

Is personalised care occurring?

At the strategic level, IPC was seen as a vehicle for the delivery of personalised care and support across a number of programmes and was incorporated in the new models of care and Sustainable and Transformation Plan (STP) at sites. A 'better' or 'different conversation' was regarded as fundamental to delivery of the programme. Training programmes for practitioners were being developed at Site 1 and written into workforce planning for coming years.

Sites were offering many of the characteristics of IPC consistent with personalised care. Participants perceived that they were being treated as equals with respect and dignity and that they were making shared decisions about what matters to them. For some, particularly at Site 2, this new way of working was seen to shift the balance of power in participant-practitioner relationships and was described as 'empowering'.

All the participants that took part in the evaluation had identified goals that were recorded in their care plan and these covered a wide variety of choices. 61% of participants at Site 1 and 88% at Site 2 had accessed services or resources identified by care planning by the end of data collection. Small numbers were awaiting decisions or funding, and a small minority of identified wishes had been denied by the decision-making panels. Participants found the decision-making process was unclear and were concerned that decisions were being made about them without their presence or right of appeal. Practitioners were active in identifying potential, suitable, and accredited treatments or activities for participants. A database of available resources to meet care planning goals was being developed by the administrator of the MDT at Site 1. The co-production group members and taster sessions organised by the team were important sources of information for participants in identifying potential resources. The co-production group also identified the next step is for participants to have more ownership of the care planning process by defining the language and format of the plans.

Local models of finance currently did not allow for full choice in budget type or payment mechanism. Zero budgeting processes (Site 1) and fixed, capped budgeting (Site 2) were not completely understood by participants, but this was outside of the control of practitioners and identified by the sites as an area for development.

In summary, participants in the study perceived the conversation and ongoing support and relationships they had from practitioners to be person centred. Care planning was becoming person centred, but lacked a common understanding. To promote personalisation, a shared language of planning and goal-setting, and the handing over of ownership of the plan and process to participants, needs to be fostered. Practitioner-participant relationships of trust and practitioner training are fundamental to this process, since it represents a shift in traditional roles for both in a health interaction. This will take time to develop; co-production has already begun to encourage the process. Both participants and practitioners were frustrated that mechanisms for budget calculation and release were system-focussed rather than person-focussed.

SW IPC Summary report draft 1 210917

Is IPC improving people's health and wellbeing?

IPC identified resources and IPC key elements, such as the better conversation and care and support planning, were found to have beneficial outcomes for participants at both sites in a number of key areas.

Participants and carers reported limited, but personally significant, improvements in mobility, weight loss, and sense of independence. Reduction in pain and increased mobility allowed some people to reduce medication levels or eliminate certain medications. There was improvement in sleep for some, particularly where aids were provided to support comfortable rest. Participants and their families identified the link between these factors and sense of wellbeing.

The resources provided by IPC, such as exercise programmes and complementary therapies, were found to lift mood, restoring self-worth and sense of personal identity for a number of participants. Involvement in the IPC programme was reported to have positive impact on people's motivation and enthusiasm to achieve goals. This appeared to be key to the positive outcomes for people.

For a number of the participants, the experience of the guided conversation, relationship with the IPC practitioners, and involvement with the co-production group were as important as the resource funded by the programme. Being in the IPC cohort allowed people to feel '*part of something'*. Being listened to and '*heard'* by practitioners and by other people with lived experience gave acknowledgment and credibility to often invisible conditions. Community resources, such as befrienders and social groups, also increased social inclusion and promoted wellbeing.

The needs and outcomes of carers and family members were inextricably linked so that helping the person meant helping the carer. Carers' wellbeing was also improved by seeing psychological benefits for participants who were enthusiastic and motivated by the programme. Carers had some respite time for themselves when participants were engaged in activities. Increased independence for their family member meant increasing freedom for the carer. Recognition of carer stress, by providing a budget for a spouse had great impact on both members of the couple. While the co-production group at Site 1 provided peer support for a small number of carers, it was suggested that a carers' group would be beneficial and that IPC could possibly see carers as a potential cohort for support.

What are the enablers and challenges to the delivery of IPC models?

Data from Local Lead, practitioner, and patient interviews at both sites were synthesised to identify the following key enablers and challenges to IPC in the SW:

National Level Challenges:
- Unclear guidelines on key elements of the programme and communication about its rationale had led to scepticism from practitioners and patients about the national agenda/rationale for IPC
- Shifting outcomes/ targets - e.g. initial emphasis on reduction of activity in broad areas of service use, including primary care (PC), re-focussed onto acute and secondary care (SC)
- Emphasis on quantity of returns shifted the focus away from the quality of the intervention
- Collection of new national metrics superseded local evaluation

Local System Level Enablers:
- Provider trust, leadership, and management of programme

- Management support and encouragement for Site Leads
- Flexibility and risk-taking at system level/commitment to funding
- Flexibility and willingness to consider person centred and integrated solutions to complex problems
- Local support (e.g. Academic Health Science Network - AHSN) for developing an evidence-based predictive model

Local System Level Challenges:
- Lack of integration into long-term plan – including specification of activities and funding levels – not written into contract with provider organisation or wider offer to the general public
- Limited or no shared understanding of IPC across systems, managers, and other practitioner groups – no integration of the programme
- Unclear statement of local IPC rationale to population
- Resources focussed on NHSE and local system requirements detract from supporting those delivering IPC and recognising challenges (over-emphasis on success stories)
- A financial system that did not understand IPC or is not set up for IPC payment – e.g. lack of efficient process for making direct payments to providers
- No mechanism for calculating indicative budget (Zero based budgeting restricts choice and control where participants are not aware of what the limit and capacity of their budget is)
- Lack of risk stratification or evidence-based mechanism for cohort selection
- Under developed VS - limited market for voluntary, community, and social enterprise (VCSE) options and limited capacity for VS to act as coordinator or broker
- Recognition of implications for VS in both delivering, sourcing and brokerage and in providing community resources

Management level (includes health and VS) Enablers:
- Leadership by example of working alongside practitioners and participants encouraged self-reflective practice
- Refinement/co-production of process aligned the programme with person centred principles
- Passionate leadership at provider and VS level (champions)
- Strong commitment to practitioner development and training – safe space for practitioners to become reflective of their practice and to acknowledge shortfalls
- Commitment to the programme aims despite lack of core funding
- Established relationships between health, local authority, and VS organisation

Management level (includes health and VS) Challenges:
- No local process developed which integrates services with IPC
- Lack of development of clear narrative of IPC that can be explained simply when making an offer to individuals
- No transparent team mechanism for allocation of individual budgets/decisions about participant choices/communication of this to individuals
- Manager uncertainty about future funding

Practitioner/Team Level Enablers:
- Embedded and enthusiastic VS, willing to challenge established sectoral/statutory working patterns and beliefs

- Co-location/close working relationships between key champions across sectors (VS, social care, health)
- Presence of a team to support each other and monitor the progress of the programme – team composition, cross-sectoral, and professional and with experience of working with MLTCs and complexity
- Practitioner knowledge of potential participants and their capacity to accept the programme
- Enthusiastic and committed champions who were willing to 'sell' the programme to colleagues, to challenge their practice, and learn new ways of working by taking risks
- Practitioners willing to engage in research process and iterative learning about innovative practice
- Team prepared to deliver IPC in parallel to other roles, if they were not given dedicated time to the programme
- Administrative support to maintain patient database, input measures, and care plans and to ensure reviews are planned

Practitioner/Team Level Challenges:
- Lone health practitioners working in isolation without team support or integration with VS and other services
- Feeling unable to influence change - which needs to happen higher up in the organisation
- Clarity about roles/responsibilities within the team and allocation of case manager role to individuals
- Lack of clear evidence-base for practitioner decisions on cohort identification
- Lack of designated time to work on IPC – including patient contact time, meetings and decision-making, sourcing, and administration
- No process for handing over care of IPC participant to identified case worker in other organisations
- No integrated IT systems (with multiagency input or even access) meaning IPC care plans were not on patient's health or social care records
- Practitioner fears about future funding caused stalling of programme
- Format of care planning documents were not experienced as helpful and could impede development of a meaningful collaborative narrative and relationship with participants

Participant Level Enablers:
- Communication explaining delays and obstacles to progress could improve participant experience and uptake of the programme
- Co-production promoted participant understanding of the innovative, trial nature of the programme and increases tolerance of process lags
- Co-production of materials and process potentially aids clarity for new cohorts
- Peer support groups provided information about IPC and enabled participants to identify choices based on lived experience
- Tentative suggestions about cohorts where IPC works best: cohort of people who have fallen through the gaps of care and feel their condition is not easily defined or acknowledged
- Regular review of identified choices allowed for modifications and adaptation to resources provided such that they continue to meet person centred goals

Participant Level Challenges:
- Poor understanding of the rationale and philosophy of IPC, and reason for participant selection to the programme could lead to suspicion and doubt about motives and candidacy, such that the offer may not be accepted

- A national media narrative of NHS scarcity and cuts to services led to feelings of guilt and doubts about eligibility for a programme where individual funds are allocated
- Lack of clarity about point of contact (case manager) where there was a team
- Plan has limited meaning to individuals, even when they have a copy
- Patient Knows Best (PKB) as an online portal could be a barrier to ownership of planning records where participants are not regular internet/computer users
- Process of empowerment and self-determination of goals in a healthcare conversation was not familiar to many participants; they also needed to learn how to achieve the maximum from this experience
- Lack of budget definition and rationale for acceptance or denial of their choices by panels led to frustration; many participants could not afford to self-fund their chosen resources

CHALLENGES	ENABLERS
National level	
Unclear definitions of key elements of the programme and communication about its rationale had led to scepticism from practitioners and population about national agenda/rationale for IPC	
Lack of national guidelines on process of delivery of IPC (organic and uneven development of local programme)	
Shifting outcomes/ targets - eg initial emphasis on reduction of activity in broad areas of service use , including primary care, acute and secondary care	
Emphasis on quantity of returns shifted focus away from quality of intervention	
Collection of new national metrics superseded local evaluation	
Local System level	
Limited or no shared understanding of IPC across systems, managers and other practitioner groups – no integration of the programme.	Provider trust leadership and management of the programme
Unclear statement of local IPC rationale to population	Management support and encouragement for Site Lead
Lack of integration into long term plan – including specification of activities and funding levels – not written into contract with provider organisation or offer to the general public	Flexibility and risk taking at system level
No local mechanism for calculating indicative budget (Zero based budgeting restricts choice and control where participants are not aware of what the limit and capacity of their budget is)	
A financial system that did not understand IPC or is not set up for IPC payment – eg lack of efficient process for making direct payments to providers	Flexibility and willingness to consider person centred and integrated solutions to complex problems
Lack of risk stratification or evidence based mechanism for cohort selection	Local support (eg AHSN) for developing an evidence based predictive model
Resources focussed on NHSE and local system requirements detract from supporting those delivering IPC and recognising challenges (over emphasis on success stories)	
Under developed VS - limited market for VCSE options and limited capacity for voluntary sector to act as coordinator or broker	Strong VCSE structure and history of collaborating with VS organisations
Recognition of implications for VS funding in both delivering sourcing and brokerage and in providing community resources	
Management level (includes health and voluntary sector)	
No local process developed which integrates services with IPC	Passionate leadership at provider and voluntary sector level (champions)
	Leadership of development process that suits local system configuration - co-production with participants and practitioners and quality improvement team

Lack of development of clear narrative of IPC that can be explained simply when making an offer to individuals	Leadership by example of working alongside practitioners and participants to encourage self-reflective practice and
	Iterative refinement of process aligning the programme with person centred principles
	Strong commitment to practitioner development and training
No transparent mechanism for allocation of individual budgets/decisions about participant choices/communication of this to individuals.	Practitioner or co-production person presence on operational board to represent the cohort
Manager uncertainty about future funding led to stalling of programme	Established relationships between health, local authority and voluntary sector organisation
	Commitment to the programme aims despite lack of core funding
Practitioner/team level	
Lone health practitioners working in isolation without team support or integration with VS and other services.	Embedded and enthusiastic voluntary sector, willing to challenge established sectoral /statutory working patterns and beliefs
Feeling unable to influence change - which needs to happen higher up in the organisation.	Co –location/ close working relationships between key champions across sectors (integrated team of VS, social care, health)
Lack of clarity about roles within the team and allocation of case manager role to individuals	Presence of a team to support each other and monitor the progress of developing the programme – team composition cross sectoral and professional and with experience of working with MLTCs and complexity – administrator position is key
Referral into the programme from multiple routes and criteria not clearly defined.	Practitioner knowledge of potential participants and their capacity to accept the programme
Lack of clear evidence base for practitioner decisions on cohort identification	Enthusiastic and committed champions who were willing to 'sell' the programme to colleagues, to challenge their practice and learn new ways of working by taking risks (pushing from the ground up)
Use of national/regional explanatory materials that were not tailored to local circumstances	Practitioners willing to engage in research process and iterative learning about innovative practice
Lack of designated time to work on IPC – including patient contact time, meetings and decision making, sourcing and admin	Team prepared to deliver IPC in parallel to other roles, if not given dedicated time to the programme
No process for handing over care of IPC participant to identified case worker in other organisations	Administrative support to maintain patient database, input measures and care plans and to ensure reviews are planned
No integrated IT systems (with multiagency input or even access) meaning IPC care plans were not on patient's health or social care records.	

Practitioner fears about future funding cause stalling of programme	
Format of care planning documents were not experienced as helpful and could impede development of a meaningful collaborative narrative and relationship with participants.	
Participant level	
Poor understanding of the rationale and philosophy of IPC, and reason for participant selection to the programme could lead to suspicion and doubt about motives and candidacy, such that the offer may not be accepted	Communication explaining delays and obstacles to progress could improve participant experience and uptake of the programme
	Co-production promoted participant understanding of the innovative, trial nature of the programme and increases tolerance of process lags
A national media narrative of NHS scarcity and cuts to services led to feelings of guilt and doubts about eligibility for a programme where individual funds are allocated	Co-production of materials and process potentially could aid clarity for new cohorts.
Lack of clarity about point of contact (case manager) where MDT operationalised programme.	Peer support groups provided information about IPC and enabled participants to identify choices based on lived experience
Plan had limited meaning to individuals even when they have a copy.	Tentative suggestions about cohorts where IPC works best: Cohort of people who have fallen through the gaps of care and feel their condition is not easily defined or acknowledged.
Electronic online portals may be a barrier to ownership of planning records where participants were not regular internet /computer users	
The process of empowerment and self-determination of goals in a health care conversation was not familiar to many participants; they also needed to learn how to achieve the maximum from this experience,	Practitioner guidance will still be necessary when this is a new process, particularly information about available resources
	Regular review of identified choices allowed for modifications and adaptation to resources provided such that they continue to meet person centred goals
Lack of budget definition and rationale for acceptance or denial of their choices by panels led to frustration; many participants could not afford to self-fund their chosen resources	

Conclusions and Recommendations

- Lack of clarity from the national programme team about the core components of IPC, the process by which it can be delivered locally, and what can be counted as IPC has been unhelpful to local development of the programme. While national programme guidelines, expressed through the OM, were that not all elements of IPC may be experienced at any one time and that a budget would not be designated in all cases, participants found the disparity

between what was provided locally and expressed nationally puzzling in the narrative of IPC. *A clear national narrative is needed to support localities to develop their local offers. Practitioners should be supported in developing a meaningful and clear narrative that explains both the process and rationale of the programme to people who may be sceptical when first introduced to the programme.*

- While there is support for the principles of personalisation across the systems, *the CCG building IPC into their contract with the provider organisation, with an expectation regarding numbers experiencing the different elements of IPC would be a helpful lever.*

- Site 1 is an interesting model; it is driven by the Provider organisation and led by key practitioner champions, which has resulted in an operationally strong and authentic model. The Site has delivered a tangible, experimental IPC project with a small cohort of people. *This model could be considered at other national sites.*

- Another key feature is the role of the voluntary sector (VS). At Site 1, the VS manager was a central driving force in introducing IPC. VS Link workers have delivered conversations and care planning and supported sourcing and brokerage and the development of peer support groups. They are an essential link between services. *The Voluntary Services Organisation played a key role in delivering resources identified in care planning. This is an important learning point and potential model for other sites.*

- IPC is delivered via a pre-existing MDT at Site 1. Established cross-sector relationships and a commitment to team working facilitated the model of programme delivery. There was an expectation of practitioner willingness to develop a new way of conceptualising their relationships with clients and to give up their own time, in many cases, for a new role alongside their existing position. At Site 2, the lone practitioner model was adopted. Practitioners were passionate about the programme and proud of the demonstrator; however, by the end of the evaluation, they began to feel this initial goodwill arrangement was being taken advantage of and momentum was starting to be lost. *Funded time for certain key roles as well as cross-sector support for practitioners is likely to ensure the continuation of local programmes.*

- This small sample at two sites tentatively suggest that IPC may not be an attractive or feasible offer for elderly people who have multiple long-term conditions, complex packages of care, and who are quite unwell. *How IPC is offered or tailored to older people with long-term conditions needs to be carefully considered and evidence-based.*

- Testing of the use of a frailty measure/risk stratification (frailty index) may show that IPC can be a preventive programme model. It is hoped that the measure will enable early identification of individuals who are likely to have increasing needs from the services. This requires further investigation. *Early introduction of IPC care planning and support could prevent crises and admissions to secondary care by establishing appropriate local support networks and taking into account the whole person and their needs at a time when they are able to engage in the process of IPC.*

- IPC represents an important shift in behaviour for practitioners and participants. It reconstructs the patient-professional relationship and interactions. The 'better conversation' should provide space for the narrative development of attributes such as information about personal meaning of the condition, the context for the person (their current situation and resources) and discussion about what they want to get from life (what matters to you), as well as relationship development with the practitioner and other peers[9]. A person centred

15

approach through communicative practice is core to creating a relationship that is collaborative between the person and the practitioner[9,10,11]. ***The utility of current care planning tools with formulaic questioning to enable collaborative relationships and person centred communication, should be examined.***

- Practitioner confidence and skill in delivering the conversation is key and is developed over time. It may be that VS workers, who have not been constrained by statutory sector training on delivering a professional agenda, are well-placed to conduct the conversation, but the evaluation did not directly investigate this question. ***An existing relationship with a practitioner is helpful, and reduces time taken in introducing IPC, but does not in all cases lead to an open conversation. It may be that some practitioners have more personal skills enabling them to offer this type of conversation.***

- To embed system-wide person centred interactions, and population-wide acceptance of IPC, it is suggested that training and organisational development is required. For sustainable cultural shift to occur, it is important that people experience consistency of approach, wherever they touch the system. ***Identifying similarities of skill and behavioural requirements across different programmes, such as IPC and Making Every Contact Count (MECC), and weaving these in together as part of system-wide or specific training, will assist the adaptation of the system as a whole and enable people to become accustomed to being true and equal partners in their health and care journeys.***

- A 'plan' can have a shared meaning for people and practitioners but needs to be negotiated early on in the process. The IPC plan at this site was currently additional to other plans a person may have in place, for example PC pain management plans, social care plans, or end of life plans, rather than acting as a single, coordinated plan defined by the three indicators of IPC developed in the research protocol and described as a key element of person centred care[12]. Amalgamating or streamlining plans would create a greater sense of coherence for practitioners and patients. However, the conversation (identifying wishes and choices) should inform the plan(s) and the resultant care planning being developed. Establishing agreement for a shared summary plan based on 'what matters to [the individual]' across the health and care system is suggested as a next step and would support shared ownership, responsibility and personalisation.

- At both sites, 50% of goals identified in care planning were funded by the IPC budget; the other 50% were provided by a mixed economy of VS, self-funding, and signposting to existing statutory services (health and social care). Advocacy of the IPC practitioner in legitimising participants' concerns gave them the confidence to make most use of existing services***. It is important for sites to engage with and encourage the VS to come together to be ready to deliver services. The information from the care plans about which services are required is crucial evidence for all sectors.***

- While the budget is not necessary for all goals identified in IPC planning, it plays a very significant role for participants in this sample***. Should the budget be withdrawn, it may have far-reaching consequences on their health and wellbeing, and that of their carers' so implications should be carefully considered.***

- One of the major barriers to the programme's success was lack of an efficient, timely system of payments for IPC resources that was acceptable to independent practitioners and small provider organisations. ***The lack of funding agreement by the organisation, combined with bureaucratic mechanisms of finance release for direct payments, caused frustration and***

embarrassment to practitioners and disappointment and annoyance to participants. The local organisations' commitment to IPC needs to be consolidated.

- For this small sample, health and wellbeing outcomes are very encouraging. One of the most important outcomes was in reduction of prescribed medication. De-prescribing will lead to cost reductions and is important as minimally disruptive medicine gains attention. Participants reported improvements in mobility and in mental health and wellbeing. There were also positive outcomes for carers. *These qualitative outcomes support the programme development and should be considered alongside quantitative outcomes in national evaluation.*

- The co-production of research employed by Site 1 enabled a person centred approach to process development as well as promoting understanding of IPC and what it could achieve. Peer support from this group was key to retaining participants on the programme. It also provided an important social function. *It would be useful to extend this model to other cohorts where possible and to link new cohorts to this group where appropriate.*

Appendix 1. NHSE OM, July 2016
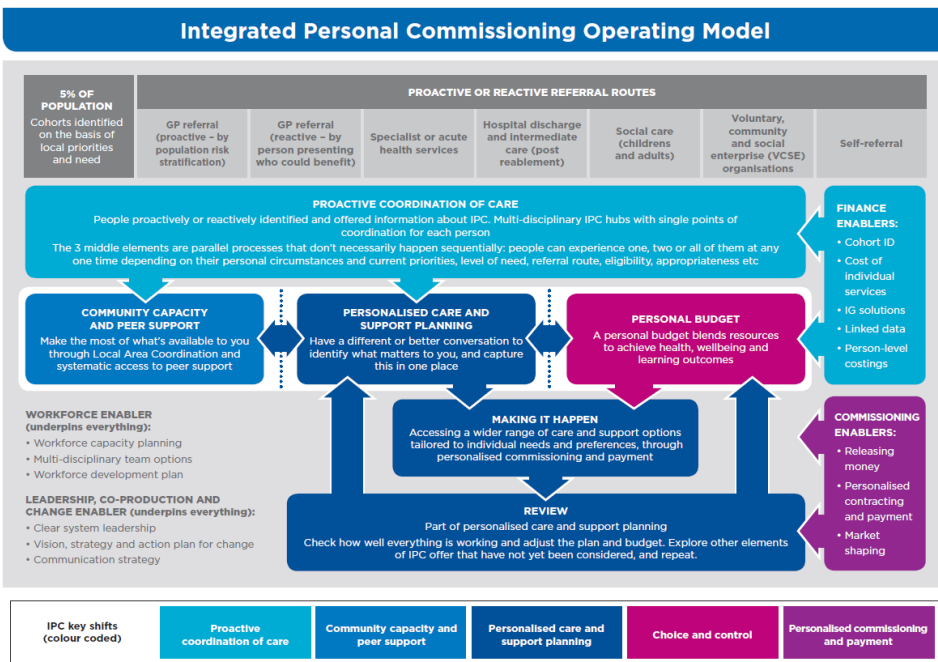
Appendix 2. Working collaboratively: the impact of embedded evaluation and support (Site 1)

The method followed was a qualitative participant observation model in which the researcher engaged with the development process, feeding in observations and analytical points as the intervention evolved. The researcher participated in co-production, peer support, and team meetings and facilitated two research impact meetings – one for practitioners and one for participants. These researcher-led meetings had multiple purposes: to check researcher hunches and observations about findings with respondents (enabling co-production of analysis), to co-produce an agenda for change of the programme following person centred principles, to enable practitioners to engage in an evidence-based discourse with managers and senior leaders about process and outcomes of IPC and influence system-level support for programme delivery.

How impact was evidenced

Research impact from the first feedback session was identified as a series of actions recorded by a practitioner that addressed changes to be made at different organisational levels – actions for the MDT, for senior managers, and for the Clinical Commissioning Group (CCG). A second researcher feedback meeting with participants identified a number of issues that were summarised as actions by the VS manager. Some of these, such as ensuring people had copies of their own care plan, were outstanding from the practitioner meeting some months earlier. The co-production group have subsequently felt empowered to follow up this request with the team (MDT).

Key impacts were delivered in the following 3 areas:

- On care planning tool and ownership (participant driven requests)
- On process (changes to make process more person centred)
- On management decision-making re workforce employment/release of funding (ongoing negotiations)

The value of research impact was stressed by the Site Lead:

I for one have really valued your support and input into helping me deliver a quality IPC service. I personally do not 'do mediocrity' and therefore having your objective, deep and at times constructively challenging input, helping me see the 'product' from a different perspective has helped me enormously to embed the iterative learning that has occurred into the processes that we follow. I feel that we are still so very early on in this journey and I hope that the wisdom that your work has been able to impart on our local IPC model will continue to shape the service moving forward (Site1_LL01_email communication).

Appendix 3. References

1. Department of Health (2014), Five Year Forward View. London: Department of Health.
2. NHS England IPC website: https://www.england.nhs.uk/commissioning/ipc/ (accessed June 2017)
3. Department of Health (2014) Care Act. London HMSO.
4. Department of Health (2009), Personal Health Budgets: first steps. London: Department of Health (http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_093842, accessed 30/05/17)
5. Department of Health (2010) Equity and Excellence: Liberating the NHS. London: Department of Health. (https://www.gov.uk/government/publications/liberating-the-nhs-white-paper accessed 2016)
6. Salisbury, C., Johnson, L., Purdy, S., Valderas, J. M. and Montgomery, A. (2011) Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study, *British Journal of General Practice,* 61(582):e12–e21.
7. NHS England and Local Government Association (2016) *IPC Operating Model v1*. London. NHSE
8. Think Local Act Personal 2015, Personalised care and support planning tool, online resource (https://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/) accessed on 31/05/17
9. Burton, C.D., Entwhistle, V.A., Elliot, A.M., Krucien, N., Porteous, T. and Ryan, M.(2017) the value of different aspects of person centred care: a series of discrete choice experiments in people with long-term conditions, *BMJ Open*, 2017 (7)
10. Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A. and Brink, E. (2011) Person-Centered Care — Ready for Prime Time, *European Journal of Cardiovascular Nursing*, 10(4):248-51.
11. Ekman, I., Wolf, A., Olsson, L.E., Taft, C., Dudas, K., and Schaufelberger, M. (2012) Effects of person-centred care in patients with chronic heart failure: the PCC-HF study, *European Heart Journal,* 33(9):1112-9.
12. Lloyd, H., Pearson, M., Wheat, H., Asthana, S., Horrell, J., Valderas, J., Bainbridge, M., Witts, L., Britten, N. and Byng, R. (2017) Collaborative Action for Person Centred Coordinated Care (P3C), *Health Services Research and Practice,* (in review)
13. Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J. & Neville, A. J. (2014) 'The use of triangulation in qualitative research'. Oncol Nurs Forum, 41 (5). pp 545-547.
14. Iedema, R., and Carroll, K. (2011) "The "clinalyst": Institutionalizing reflexive space to realize safety and flexible systematization in health care", *Journal of Organizational Change Management*, 24(2):175-190
15. Hammersley, M. and Atkinson, P. (1997) 'Ethnography: Principles in Practice'. London: Routledge
16. Ritchie, J. and Lewis, J. (2003) *Qualitative research practice: a guide for social science students and researchers*, London: Sage
17. Gale, N.K., Heath, G. and Cameron, E. (2013) 'Using the framework method for the analysis of qualitative data in multi-disciplinary health research', *BMC medical research methodology,* 13(1):117
18. Fereday, J. and Muir-Cochrane, W. (2006) 'Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development'. International Journal of Qualitative Methods. 5(1).
19. Charmaz, K. (2006) 'Constructing grounded theory: a practical guide through qualitative analysis'. Thousand Oaks, California: Sage, 2006.

Commented [DW4]: Should we take out only refs for the summary report or include full list from the full report?

19

20. Guest, G., MacQueen K., Namey E.E. (2012) 'Applied Thematic Analysis' Thousand Oaks, California: Sage.
21. Van Mannen, J. (2011) 'Tales of the field: On writing Ethnography'. Chicago: Chicago University Press.