Evaluation of the IRF test sites
Key findings from the interim review

June 2011

1. Introduction

1.1 Aims and objectives of the IRF test site evaluation

The overall aims of this evaluation are to monitor progress in the test sites; to assess the impact of the work of the test sites; to feed evidence back into the process of change itself; and to draw out implications from the findings for other partnerships moving towards financial and resource integration within and across health and adult social care services in Scotland in the future. The research will also inform further implementation of the IRF across Scotland and will evidence the extent to which such integration could contribute to the Scottish Government’s aim of improving health and social care outcomes for local people by shifting the balance of care.

In April 2010, the Chair of the IRF national programme board wrote to each of the four test sites (Ayrshire & Arran, Highland, Lothian, and Tayside) setting out milestones for progress. These indicated that by April 2011 the pilots should have defined and empowered an integrator to deliver the following:

- Agree/confirm relevant clinical and care pathways and align resource maps to those pathways
- Identify links between changes to care pathways and outcomes
- Agree specific financial mechanisms to be used in the test site
- Define local financial mechanisms to be used e.g. lead commissioner agreements (between health and social care) and/or protocols (for resource realignment within health).
- Amend governance arrangements, if required, to support the test site work
- Amend capacity plan to reflect these new arrangements
- Go live with revised financial arrangements
- Agree a 3 year rolling capacity plan reflecting these arrangements

During the interim evaluation, stakeholders from each of the pilots were asked to report on progress against these milestones as well as share their experience and learning of working in new ways across the health and social care agenda.

2. Key findings from the interim review

2.1 Mapping

The IRF programme set an expectation for each of the test sites to have completed the Phase 1 mapping in 2010. Ayrshire & Arran, Tayside and Highland test sites took a fairly pragmatic approach to the mapping and brought this work to a close in 2010 when they considered the benefits of refining the data further to be outweighed by the cost of undertaking the work. The Lothian site has taken a more ambitious, detailed and comprehensive approach to the mapping and was still refining its mapping information at the point of the interim evaluation. Considerable extra effort has been required by Lothian to attempt to build a patient level costing system and also explore possible software for making this accessible in a user-friendly format to a variety of stakeholders.
**Flexibility or standardisation in approaches to the mapping**

As noted in the baseline evaluation, each of the test sites had used different approaches to map costs across health and social care. Further discussion of this approach during the interim evaluation indicated that flexibility to develop local systems for working out costs was useful in helping test site partners to feel ownership of the mapping process and of the data produced. Discussion of how mapping data could, or should, be used by local stakeholders indicated that acceptance of the validity of the mapping data was very important. Flexibility to build cost data in a way that made sense at a local authority and NHS board level was therefore reported as a positive element of the IRF approach.

However, the flexibility to design local mapping work to best fit the expectations and uses of each test site makes it more difficult to build a consistent picture of cost across the country. This may complicate analysis of activity and costs that cross council or NHS board boundaries and would undermine attempts at national benchmarking. It also requires more resource for each area to build local systems for the mapping if they do not have a template to follow. If the mapping was a one-off exercise then the local approach seems justified. But if the mapping is to be repeated on a more regular basis then the argument for standardisation is strengthened. The Scottish Government may wish to review with the test sites how best to balance the benefits of local mapping design and use with the potential efficiencies of templates and national data standardisation.

**Increased use of the mapping data**

As noted in the baseline report, existing local knowledge and service priorities were more influential than the phase one mapping data in shaping the choice of pilots for the second stage of the IRF. However, many of the pilots have undertaken more detailed mapping focusing on more specific populations of interest or on particular care pathways that they wished to improve. The final round of the evaluation will look to examine any additional uses and lessons from this “drill down” mapping which looked at patient groupings by condition, post code, care setting or care pathway.

Test sites reported that the mapping work undertaken in the first phase of the IRF had been used by partners to prepare Change Fund proposals. This was an unforeseen outcome when the IRF was initially started but was reported as of significant help in creating agreement and clarity for the direction of the Change Fund work in the test sites.

The baseline evaluation reported that most test sites were initially cautious about sharing mapping data with clinicians due to the sensitive nature of the information on variation and concerns about its quality and interpretation. This issue was revisited during the interim evaluation which found evidence of increased efforts to engage clinicians in discussion around variation in costs and activity. Test sites have adopted a variety of approaches in order to disseminate elements of the mapping information to local stakeholders via CHPs and GP locality groups. However, a number of barriers have been identified which were reported as limiting progress:

- Fear of sharing information which makes public the extent of variation between areas.
- Scepticism of the quality of the mapping data.
- Difficulties in understanding the legitimate factors that may underlie variation.
- Recognition that a full discussion should be informed by data on costs, activity and quality of outcomes and not all these data sets are available.

Questions were raised about the skills required by managers and clinicians to analyse and interpret mapping information. The evaluation identified four factors which may influence the skills required: (i) clear definitions of financial terminology; (ii) agreement on the data sources and data manipulation processes; (iii) simplification and standardisation in the presentation of data; (iv) different levels of data for different forums. For example, if the purpose of sharing the mapping data

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1 For example, Lothian have undertaken additional work to develop a more detailed level of costing and lessons could be learned from this rather than repeating the full exercise in all other areas.
is to raise awareness of variation then simple data could be presented on a few slides to groups of GPs with the opportunity for general discussion. Alternatively, if the purpose is to understand and resolve the factors which cause the variation then more complicated spreadsheet analysis may be required and smaller working groups may need to spend more time looking at the detail. The evaluation team will look to work with test sites and the IRF Programme team to develop simple guidance on this topic.

A recent King’s Fund report, *Variations in Health Care*, highlighted increased interest in addressing variation: “local health organisations – both providers of care and commissioners – (should) be required to publicly justify and explain in a consistent way their relative position on key aspects of health care provision.” However, where mapping data has been openly shared with clinicians in the test sites it was reported that consideration of the data alone was insufficient to instigate change in behaviours. There was recognition across sites that improved data was helpful but this was balanced by the realisation that good quality data was only part of the picture and that mapping information was always open to challenge or interpretation. The IRF has produced improved mapping information for each of the sites. However, it is the interplay of this information alongside existing political structures as well as competing priorities and agendas which require to be negotiated in order to recognise the complex nature of decision making. It was reported that variation in cost or activity was likely to be explained away unless there was an additional incentive to consider variation in detail, and pressure applied to address outliers. The interim evaluation identified three potential drivers for change:

- Create an explicit link between variation in costs/activity and financial incentives for GP practices.
- Create positive peer pressure by encouraging groups of GP practices to consider mapping data in a safe environment and ask questions of the information and of the practice which lies behind it.
- Undertake additional work to add mapping data on the quality of care for patients to existing data on activity and cost so that a more complete picture of variation can be considered.

### 2.2 Efficiency and transfer of resources

*Increased efficiency in part of the system has not necessarily led to savings.*

Stakeholders reported that where new ways of working may be starting to reduce demand in one part of the system this was quickly being filled by demand from other parts of the system. For example, in Highland, it was reported that integration of occupational therapy services could reduce duplication and help improve the efficiency, however, the re-ablement model may increase the demand for OT services. More efficient use of resources may result in more appropriate care or in better demand management but at the interim stage of this evaluation there remains a lack of evidence of IRF leading to cost savings or system wide resource transfer. It was reported that gathering more detail about overheads and all associated costs would be of limited value unless it is clear how these costs would be reduced or released if activity was changed. The situation was summarised by one stakeholder in the statement: “Everything you take out of (an acute hospital) makes what’s left in (the acute hospital) more expensive”.

To measure the impact of new ways of working in the IRF pilots, it will be necessary to take a longitudinal look at indicators such as hospital admissions and hospital length of stay in order to track changes in activity associated with more integrated working. The IRF pilots are at different stages in developing and agreeing the metrics for measuring these changes but indicated that it may be some time before changes in activity can be tracked accurately enough to justify real shifts in

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2 King’s Fund, 2011, *Variations in health care: The good, the bad and the inexplicable*, King’s Fund: London, p.viii
resources. The pilots are not working in a static environment and even where change in activity can be evidenced it will be very difficult to attribute the cause of this.

**Realising the benefits of integrated working is limited by definitions of fixed costs**

The IRF pilots have started to identify ways of delivering health and social care services more efficiently. We have defined two broad approaches to improving efficiency through integrated working:

1. Assume the level of work as fixed and attempt to redesign services to reduce the cost of delivering this work.
2. Assume the cost base is fixed and attempt to redesign services to increase the amount of work that can be delivered.

Where test sites have attempted to take the first approach to increasing efficiency they have come up against problems in varying definitions of fixed costs. “The big barrier that is starting to be acknowledged by stakeholders is that the reality of shifting resources is being hampered by different definitions of fixed costs. If beds, consultants, wards and ward staff are all regarded as fixed costs, then the options for shifting the budgets associated with the improvements aspired to in shifting the balance of care are unlikely to be achieved.”

The mapping data and the work undertaken by IRF pilots has started to identify areas where integrated working could create improved ways of working and changes in the demand structure across the health and social care system. However, stakeholders reported that fixed costs form a significant barrier in shifting towards more integrated ways of working. Three main areas were identified: (i) a negative public perception of changes which lead to a reduction in physical resources such as hospital wards or day care centres, although a change of use may be less contentious; (ii) political commitments to protecting changes in staffing levels; (iii) an historical mindset which defines the majority of costs as fixed.

### 2.3 Progress made by the test site pilots

**The ambition, rate and scale of integration varies across the test sites**

As noted in the introduction to this report, the milestones set out by the national IRF Programme Board indicated that by the time of this interim evaluation, the test sites should have identified pilot populations and care pathways for which new integrated ways of working were identified and implemented. At the time of the interim review, none of the test sites had gone live with new financial and governance arrangements for integrated working, which is the second stage of the work. However, the test sites have made progress in identifying a range of different processes for integration across different population groups with varying health and social care needs.

Ayrshire & Arran, Lothian and Tayside test sites have each identified focused pilot populations. Each pilot is looking at how to improve integration of clinical and care pathways as well as how resources could be better aligned to match need. The final round of the IRF evaluation will look at the lessons that have been learned from the drill-down mapping in these pilot projects and the potential for improved ways of working.

The Highland test site has taken an ambitious approach by looking at integration on a much larger scale. At the end of 2010, it was jointly announced that there was agreement in principle between NHS Highland and Highland Council to move to establish integrated services for children and for adult health and social care. The planned integration will be based on a lead agency model with NHS Highland acting as lead for adult health and social care services, while Highland Council will act as lead for children’s services. In making this step, the Highland test site have moved beyond the original focused work of the initial phase 2 pilots and have made clear the intent of the two partners to expand the integration approach to all services across the Highland council area.
Slow progress in developing financial mechanisms and governance arrangements

There is no evidence yet of a preferred model for a financial mechanism to facilitate the development of more integrated care in Ayrshire & Arran, Tayside or Lothian. The range of mechanisms under consideration include grant transfer between health and social care organisations, pooled funding, integration of management or provision of services resourced from pooled funding and the development of community budgets at locality level. There is some resistance to a prescriptive approach to financial mechanisms, with a preference for less emphasis on resource control and more on the delivery of an integrated approach which delivers cost-effective care.

The extent of development of new governance arrangements was found to vary depending on the extent of implementation of partnership proposals. Ayrshire & Arran have started to mainstream the IRF governance arrangements by transferring strategic governance back to the Strategic Alliance Group from which the IRF steering group had been created and requiring the CHPs to continue the role of integrator as the IRF pilots are implemented. Highland has also wound up their IRF programme board as governance has been passed onto new structures created to implement lead agency across Health and Social Care.

Lothian and Tayside both recognise the need for senior leadership at the stage of implementing proposals to develop more integrated care. They have made changes to the IRF governance structure to ensure senior leadership at the implementation stage. In the case of Tayside this consists of reframing the IRF Programme Board, which hitherto had oversight of operational planning by the IRF Project Team, to become the IRF Implementation Board which will be chaired by the Chief Executive of NHS Tayside.

Governance arrangements have been strongly influenced by other policy drivers such as the Change Fund. For pilots which are looking at older people under the Change Fund plans, it was reported that governance arrangements should be developed consistently across the IRF and Change Fund. Rather than trying to design new governance structures at the level of individual pilots designed to deliver more integrated care, it may make more sense to ensure that the governance structure designed to support Change Fund implementation supports specific proposals to deliver more integrated care.

Leadership and engagement

Test sites reported that the success of the IRF will be dependent on consistency of vision among partners. Pilots had started to work towards gaining agreement on a common set of outcome indicators between health and social care partners as a vital step in helping to drive this shared vision. The final round of the evaluation will monitor whether the agenda for integrated care is shared at all levels as evidenced in an agreed set of metrics to measure a shared set of outcomes.

The evidence from the interim stage of the evaluation indicated that moves towards more integrated working benefited from strong leadership as well as clear communication with all relevant stakeholders. Test sites reported that leadership could come from different levels within partner organisations but may take time to expand out to broader buy-in across all stakeholders. Two contrasting examples illustrate this point:

- In Highland there was bold leadership evidenced in the decision made by Chief Executives of Highland Council and NHS Highland to set a new direction towards a lead agency model. However, the reasoning or process for making this decision was not clearly articulated by those in the IRF test sites.
- Conversely, in East Ayrshire, the IRF pilot project was taken forward by delivery staff seconded from NHS and local authority services. This practical leadership was reported to have given the pilot credibility amongst other delivery staff. However some stakeholders reported that the pilot was experiencing difficulties in gaining commitment from senior managers when it sought to implement new ways of working.
Throughout the baseline and interim stages of the IRF evaluation, interviewees reported widespread uncertainty about the extent to which clinicians and GPs have, or will, buy-in to more integrated ways of working. The final round of evaluation will look to engage more directly with this particular group of stakeholders to better understand issues such as their attitudes to risk, their views on variation, and their expectations around fixed costs.