

NOTTINGHAM
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NTU

INTERIM REPORT

**Prepared for the LGA Care and
Health Improvement Programme
as Commissioned by
Nottinghamshire County Council on
the Evaluation of the Social Care
Role in Nottinghamshire**

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1. INTRODUCTION

The purpose of the evaluation is to explore possible savings, efficiencies and other benefits for social care and health by comparing the social care role in integrated and district teams.

In particular, the purpose of the evaluation is to determine:

- the benefits of social care interventions by integrated teams compared with district teams
- the extent to which integrated teams can deliver efficiencies by social workers being incorporated within them
- how integrated teams can achieve savings through managing demand and reducing costs by promoting independence and keeping people in control of their care and health
- how integrated teams can deliver a better individual experience with more effective, personalised and independent outcomes.

In order to inform the design of the evaluation and learn from previous research on how to measure the social work contribution to the provision of integrated care, the research team carried out an extensive review of the literature on the integration of health and social care in the UK since 2000. This review reveals three, key themes.

The Social Work Contribution to Integrated Care

The first theme is a lack of focus on the social work contribution. Studies focusing on the social work role within integrated care teams are scarce (only three identified to date) and provide no robust evidence that enables us to understand how social workers operate in integrated care teams and to quantify the contribution they make. Despite this lack of evidence, recent advice from the Department of Health, Adults Principal Social Workers' Network and the Association of Directors of Adults Social Services (ADASS) asserts that social work is an 'essential' component in the integration of health and social care provision:

Social work is essential to integration, to support the social model and social care alongside the medical model and treatment. Social work enables people to be included in work and communities. It safeguards their rights when doctors are considering compulsory admission or treatment, when they may be at risk of deprivation of their liberty or when they have experienced abuse or neglect. (p. 4)

Assessing the Effectiveness of Providing Health and Social Care

The second theme is bias in the conceptualisation of effectiveness. Whilst many studies and reports refer to different care outcomes that should be quantified to answer questions about the relative cost effectiveness of providing care through integrated and non-integrated approaches, most studies conceptualise and measure effectiveness qualitatively by asking service users and staff about their experiences of delivering and receiving care. Whilst it is important to capture service users, carers and staff's experience of receiving and delivering care, any study of effectiveness needs to capture whether the delivery of care is cost effective, as this is of particular concern to local authorities, if they are to

achieve targets relating to service improvements as detailed in sustainability and transformation plans (STPs) (NHS, 2015). Therefore, although the body of literature relating to assessing health and social care effectiveness tells us something about the consensus regarding what outcomes to measure if we want to understand what a good, cost-effective experience of receiving care should look like, they tell us little about tried and tested ways to measure these outcomes.

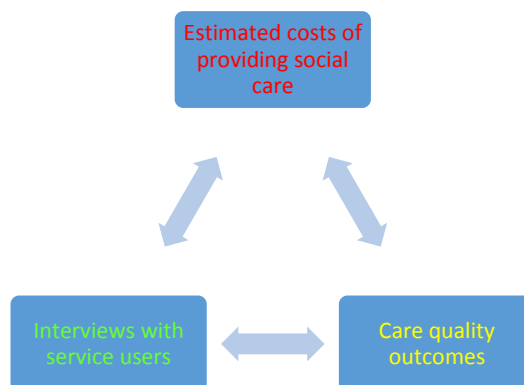
Goodwin (2013) suggests that the way researchers should respond to these gaps in the research and grey literature is to deploy multi-level evaluation frameworks and/or realistic evaluation methods. The tried and tested realistic evaluation approach that we have adopted for this evaluation (Bailey, 2002 & 2007; Bailey and Kerlin, 2015; Ward and Bailey, 2016) is an example of such a framework since it combines the collection of qualitative and quantitative data from a number of sources across a range of levels (see Appendix 1).

Facilitating or Delivering Integration

The third key theme in the literature is that, despite an exponential increase in the body of research on health and social care integration, studies continue to be concerned with what Dickinson (2014) refers to as the 'science' of the approach (the factors that facilitate integration) rather than the working practices (the 'craft or graft') of those delivering it (p. 190), an observation previously offered by Glasby et al. (2013). Using the combination of data sources and methods set out below, the research team for this study attempted to understand and quantify the contribution of the social work role to the integration of health and social care provision from both perspectives by focusing on the **context** in which integration is supported or hindered as well as the **inputs** and expertise that social workers contribute.

The way in which we are combining the respective sources of data to meet the objectives of the evaluation is represented diagrammatically in Figure 1. To the best of our knowledge, this is the first time in any study that quantitative and qualitative data sources have been combined in this way.

Figure 1: Data Sources for Measuring the Social Work Contribution to Integrated Care in Nottinghamshire



For the purposes of the evaluation we have used the following statement from National Voices (2013) as our definition of integrated care: ***"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"***.

Humphries (2015) cites this definition as the foundation of current policy because it comes from a coalition of health and care charities and so reflects the lived experience of those receiving and delivering integrated care.

We have used the term 'service user' rather than patient throughout this report in recognition of the term that is generally used in social care policies and the research literature to refer to people who use social care and health services. Exceptions occur in direct quotations where health and social care practitioners interviewed refer to individuals as patients.

2. DATA COLLECTED AND ANALYSED TO DATE

To date the following data have been collected:

- 30 fully costed cases, 10 from Newark West Integrated Care Team, 10 from Newark and Sherwood District Team and 10 from Broxtowe Primary Integrated Community Services (PICS) Team (see Appendix 2 for details of how costs have been calculated)
- care quality outcomes for 20 cases to compare Newark West Integrated Care Team with Newark and Sherwood District Team (see Appendix 3 for breakdown of outcomes measured)
- 3 focus groups/interviews with staff in Newark West Integrated Care Team (n=8) and 1 focus group with staff in Newark and Sherwood District Team, including Social Workers and Community Care Officers (CCOs) (n=8)
- 2 interviews with service users and their carers (3 carers in total) from Newark West Integrated Care Team and 1 interview with a service user from Newark and Sherwood District Team
- 2 interviews with GPs who relate to both Newark West Integrated Care Team and Newark and Sherwood District Team.

Analysis of the qualitative data is still underway and at least one GP interview is pending rearrangement.

Data Collection Tools

The care quality outcomes have been identified from our review of the literature on the integration of health and social care, including research papers and relevant reports. This literature reveals a degree of consensus about which outcomes are indicators of more effective, integrated care – for example, hospital admission avoided – and which outcomes are indicators of less effective, integrated care – for example, an unplanned hospital admission or delayed discharge because of the lack of a care package.

The social care activities costed for each of the individual cases have been identified through observations of virtual ward rounds in Newark West Integrated Care Team and discussions with the Social Worker in the Newark West Integrated Care Team and the Social Worker and Community Care Officer (CCO) in Rushcliffe PICS Team. These observations and discussions have helped us to understand the main types of social care activities that service users and their families experience.

Peopletoo, our expert reference group, have been involved at each stage of the collection of quantitative data by

- giving guidance and reaching agreement on which activities should be costed and how this can be achieved in a standardised way
- agreeing indicators of care quality and how these might be measured
- reviewing the emerging cost data with the Research Assistants (GM and DH) to ensure that the data is robust and can be compared across the Integrated and District Teams with confidence.

The topic guides developed for use in the focus groups/interviews with social and health care professionals were piloted with a social worker and CCO from an integrated care team not included in the evaluation (Rushcliffe PICS Team). After the initial focus groups took place in the Newark West Integrated Care Team, the topic guides were refined further to reflect the discussions that arose and to ensure that the similarities and differences of social work involvement between integrated and district teams would be explored fully in the evaluation.

Sampling Issues

Six teams have been purposively selected to take part in the evaluation. Newark West Integrated Care Team was selected as the longest running of the integrated teams in Nottinghamshire. Bassetlaw North West Integrated Care Team was selected because it had been running for the shortest amount of time since inception and because Clinical Commissioning Group (CCG) funding changes have meant that social workers have been withdrawn from the team. Broxtowe PICS Team operates a system whereby Care Coordinators refer to the Social Worker for assessment and/or intervention. In each of the areas the three respective District Teams of social care professionals have been included for comparison, giving six teams in total.

The 10 cases for costing in either an integrated or district team were selected using the following criteria:

1. the case has 3 or more professions involved
2. the case has at least 2 health conditions, (more likely 3) and, where there are only 2, there are likely to be other factors such as safeguarding/risk/resisting help issues
3. age is likely to be 70+ (if not, all other indicators 1, 2 and 4 are met)
4. the case meets at least baseline criteria 3 on the workload management tool (see Appendix 4) but is more likely to be 4 in relation to multi-professional input/decision making and risk concerns.

The Research Assistant (GM) worked directly with all the social workers in all the teams to itemise the costing of cases to ensure that costs were attributed to the respective activities in a standardised way.

Data Analysis

The cost data were analysed using an independent samples t test. A t test is a statistical technique used to assess whether two sample means are significantly different from each other (Field, 2009). This technique was therefore appropriate to use to assess the difference in mean costs between Newark West Integrated Care Team and Newark and Sherwood District Team with the type of team acting as the independent variable and social care costs acting as the dependent variable. The analysis was accompanied by the effect size, Cohen's d (Cohen, 1977). Cohen's d is a standardised measure of effect size used to indicate the size of the difference between two means and is often used to accompany reporting of t tests (Cumming, 2012).

The data relating to care quality outcomes are categorical data, which are unsuitable for analysis using inferential statistics. Therefore, simple descriptive statistics were calculated – that is, percentages for each indicator present in the sample were established to compare the difference between the two types of team.

Interviews with service users, carers and GPs, together with the focus groups with staff, were audio recorded and transcribed verbatim. The transcripts were analysed thematically to identify overarching themes and sub-categories (Lincoln and Guba, 1985).

3. KEY FINDINGS

3.1 To what extent has the embedding of social care professionals in integrated care teams been effectively delivered?

County Health Partnerships set out the aims and philosophy for the Integrated Care Teams/virtual wards in Newark and Sherwood and the core membership of the team, which includes a full-time social worker funded by the CCG. The primary aim of the team, which is to prevent unnecessary admissions to hospital and residential/nursing care through proactive care interventions, was echoed by integrated care team staff in the focus groups, who were very clear that this was their remit:

"It was a case of different multi-disciplinary teams coming together including specialist nurses, district nurses, community matron, social worker ... where we have patients on a virtual ward ... that are at risk of hospital admission and support them through any crises that might avoid hospital admission" (FG2).

The social worker/social care role was accepted as part of the team:

"Well patients will get referred to the ward for various reasons because of hospital admissions ... but can also be due to social circumstances have changed i.e. not coping at home or the social care package is not enough or they haven't got one so there are lots of reasons why people are actually on the ward" (FG2).

"I've been in this job for 3 and a half years and they were just setting up the teams at that time ... we've got a community matron, diabetes specialist nurse, heart failure specialist nurse, COPD specialist nurse, OTs, physios, social worker, mental

health nurse, erm, falls team with physios and OTs, we have support workers, erm, and there is the Community Nursing Team, which I suppose sit on the periphery but they do become involved with some of our patients” (FG3).

It was clear from the focus group that the social work contribution to the Newark West Integrated Care Team was highly valued:

“I just, you’ve got a different perspective on things, from social perspective, than what we do have as health providers and so just be, just having you there to be able to talk to you, to bat things off. You know and get your thoughts on it, you know, and it stops us panicking a little bit I think sometimes” (FG1).

*“It may be that **** [social worker] will go to a meeting, a monthly meeting, and one of the GPs doesn’t feel that we need nursing involvement but will say we need to look at the social side of things. So that will just be **** [Social Worker] then. You know they’ve already decided that ... there’s nothing else needed or to ensure there’s no other concern with the patient from a medical point of view; and it’s just from a social so then they refer directly to **** [Social Worker].” (FG2)*

“I’ve come from secondary care. I’ve always been in hospital so I came here and I think it’s great that you’ve got the specialist nurses in the team, district nurses in your team, an OT, a physio, a social worker, mental health ... and ... to get that perspective; and do you know what, communication is key to it and I do think ... it works really well because in secondary ... it’s hard to get a social worker once you’re out of hospital. You don’t know where to go. It’s really hard.” (FG2)

The embedding of the social work role had occurred with the setting up of the Newark West Integrated Care Team in 2013 in that

“there was lots of, lots of, back work before they did it ... and they just identified the biggest threat, the biggest users of A & E were people with multiple health conditions and they just identified that ... that they would need like diabetes, heart failure, COPD, falls ... she was some kind of top dog in setting up this team and she was basically saying in some ways they’re not expecting to save money, but it’s about improved patient care.” (FG1)

One way that the embedding of the social care role was evident in practice in Newark West Integrated Care Team was the common occurrence of joint visits, which were described during the focus groups:

“So ... before the team was set up ... a health nurse would go out, say this person needs urgent respite care, they’re not walking ... They’d do an urgent referral to social services. Social Services will go, ‘They’re off their legs ... that’s a health need really.’ But then they’ll say they’re not acutely unwell ... It’s kind of a waste of a hospital admission but that ... still happens to this day ... but I think there’s been a great ... the common one is me and the community matron going out and doing joint visits ... when there is the potential of somebody needing hospital or residential care and we can sort of identify ... which one’s needed.” (FG1)

There was general recognition amongst practitioners in Newark West Integrated Care Team that they must “work together”, if the benefits of integration (for example, a quicker

response to prevent crises with service users) are to emerge, and this was experienced in practice by service users and carers:

*"They definitely talk because when ****'s [Diabetes Nurse] been or ****'s [Social Worker] been, **** [Social Worker] said, 'Yes, actually I saw **** [Mental Health Nurse]' and we, cos I had to, erm, 'cause, like I say, we had a bit of a wobble at the weekend, so **** [Social Worker] had spoken to **** [Mental Health Nurse] about that and, yeah, so they do liaise with each other definitely." (I1)*

"I think it's great because they're all different people and for a lot of different people to get on together is quite, quite good, isn't it?" (I1)

"I mean, if you hadn't got 'em, then you'd be just like fishing here, there and everywhere; it'd be like hook-a-duck. If you, ooh I can have that but, with them, you know what you can and what is available, you know? So yeah, I mean, like, it's really, I mean what is available, if you want it, have it; if you don't, I mean nothing's, it's not forced on you but at least if you know it's there." (I2)

Comments from the GP and team colleagues echoed that the social worker was very well embedded in the Newark West Integrated Care Team:

*"I can speak directly with **** [Social Worker]. Because I know him well, I can be much more frank about what I expect him to do. Or he can be very frank with me about what he's intending to do and to offer and what might be available to this person than, than I would be necessarily with the District Teams who I don't know so well." (GP1)*

"So yeah, I think that's, the thing that really works is ... having that ... sort of named person that you, that I know well, and I think that's what works for patients as well is having that named team of people that they are going to get to know well rather than lots of different people sort of turning up who they don't necessarily, they're not familiar with." (GP1)

However, achieving effective interdisciplinary working between social care and health within the Integrated Care Team was not without its challenges, particularly when joint visits had not taken place:

"I've got one at the moment ... up at ... North ward. Now she's been put in, it was just a matron who did a spot purchase. So, there's still challenges. I'm not saying it's perfect because the matron's gone out and noticed that they're off their legs and ... they've done a spot purchase bed under health funding. Now I'm going out, the first conversation I've had with the son, who is in his eighties ... the first thing he said to me was ... 'I think she needs to be looked after now.' They've not had no services: there were two caseloads on Framework – that's it. ... so I've got her ... but I wasn't there during that joint visit so it would have been nice to have been there. So, even though we're talking about how good it is, it's not always." (FG1)

Because of these challenges associated with integrated ways of working it was deemed important for the social worker to possess certain skills and qualities:

"But I think ... when they first set this up, they wanted a social worker to do it, they wanted somebody with experience. ... they wanted somebody who ... had more

experience. They didn't want a newly qualified into the team 'cause ... they need to have a lot of pre-existing knowledge 'cause you are on your own. So that is a challenge. I think that's a challenge for anybody in the team." (FG1)

These challenges were reportedly observed by the Integrated Care Team for a new, less experienced social work colleague:

"we've got a new member of staff starting. She's fairly newly qualified, and she's finding that she's going out on visits and she's a bit out of depth. She could do with some help but none of us have got the skills that we need to help her. None of us are OTs; she's a bit on her own. And ... she's finding it quite tough, I think." (FG1)

Another condition for effective embedding of interdisciplinary working between health and social care practitioners in an integrated care team is the sharing of information relating to service users which exists on SystmOne for health practitioners and on Framework for social workers. During the virtual ward rounds in Newark West Integrated Care Team we observed the Social Worker accessing service users' information on Framework and feeding this into the interdisciplinary discussion while the SystmOne case record was displayed on the large screen in the virtual ward round meeting. However, accessibility of information was raised as an issue for effective integration of health and social care in both the Integrated Care Team and the District Team:

"if you were on Framework, you had a file on Framework, I could look on it and see your name and ... see everything we've done with you. On SystmOne people go ... off caseloads, units, and that's stopping me from going into your health records effectively." (FG1)

"I think then that gets recorded on SystmOne which is okay if you're a health professional....it doesn't help us whatsoever cos we can't tell what's been done and what hasn't". (FG4)

"I know they [Integrated Care Team Social Worker] can sit in an NHS office and they can use SystmOne which probably gives them a bit more that they can find something out directly themselves, directly whereas we've got to go through Call for Care". (FG4)

These types of technological constraint also affected health staff:

*"There's three different systems, bearing in mind you know **** [Social Worker] uses Framework, we use the intermediate care system and you use the nursing system."* (FG2)

The effect of this type of constraint was that it prevented health care practitioners from making referrals within the team, as one explained:

"I think, for me, it stops the referral, is the biggest pain in the backside for me because we're supposed to pass to each other but, if patients aren't open on continence unit and the DN unit, then they can't pass over." (FG1)

The degree of embeddedness of the social care role was also influenced by the different geographical boundaries that operated between health (determined by the Clinical Commissioning Groups) and social care colleagues:

"our area covers Ravenshead, which is Gedling. Also, health covers areas of Mansfield, which is not my area – I'm Newark and Sherwood. So, we've got areas of Gedling and Mansfield. Now, when we first started, I did pick up those areas but ... two problems are ... I'm using another budget, which ... it would have to go through another manager ... but at the same time it's ... knowing the services in that area and what it's like and I don't know ... even though Ravenshead is a lot, lot closer than Southwell, I just don't know ... what day services, what homes are good for those people. ... so, we've made a decision that I don't pick up Ravenshead and Mansfield." (FG1)

Different geographical boundaries mean that some service users in the CCG-determined area would be assessed by a social worker from the relevant district team, which brought with it some frustrations for the Social Workers and CCOs in the District Team as well as for health practitioners in the Integrated Care Team:

"If we're on Duty and we think health needs to be input we have to go through Call for Care, we have to do a lot of phoning round, if they're [Integrated Care Team Social Worker] on Duty with us they can simply just phone direct to that person and say can you look on this and they get it straight away". (FG4)

"I've had some cases where I've spent days and days just chasing health professionals about them [service user] ... for us it seems like it's an impossible task just because you can't speak to the, or you can't find out what they're doing and who's talking to who". (FG4)

"They [Integrated Care Team Social Worker] build up a better working relationship with them [Health] because they're sitting in the same office with them". (FG4)

"To say we are the same organisation, there's different things that are going on, so different across, even you know 5 or 6 miles down the road. Yes, totally different" (FG2).

"We literally don't have hardly any contact and it's, it's odd when you know there's heart failure nurses over there, there's Falls Teams over there, we don't integrate across patch in that respect across counties should I say." (FG2)

3.2 What difference has it made, for whom and why?

Care Quality Outcomes

Outcomes of the quality of care were identified using data taken from the case records of the 10 service users purposively selected from Newark West Integrated Care Team and the 10 service users from Newark and Sherwood District Team. For each service user, the presence (Yes or No) of a care quality outcome was identified from these records. The percentage of outcomes present in the sample of service users from both types of team is compared in Table 1. This comparison indicates that Newark West Integrated Care Team has a lower incidence of short-term unplanned admissions to residential/nursing care than Newark and Sherwood District Team. Newark West Integrated Care Team also has no incidence of permanent admission to residential/nursing care compared to Newark and Sherwood District Team, which experienced this in 30 per cent of its sample. Hospital

admissions were present in only 50 per cent of the Integrated Care Team sample compared to 80 per cent of the District Team's sample. However, the percentage for readmission to hospital remained similar between the two teams.

Although hospital avoidance was an outcome originally identified as being a positive indicator of care, this was only being actively measured in the Integrated Care Team and not in the District Team. Therefore, any differences between the rates of hospital avoidance found between the two teams would in part be because staff actively record this in the Integrated Team. For this reason, it was therefore decided not to include hospital avoidance as a care quality outcome in this interim report.

Table 1: Presence of Care Quality Outcomes in Samples of Service Users

| | Newark West Integrated Care Team | Newark and Sherwood District Team |
|---|---|--|
| Use of Assistive Technology | 20% | 20% |
| Maintaining Wellbeing and Independence through Low-Level or Preventative Services | 50% | 10% |
| End-of-life Care at Home | 0% | 0% |
| Short-Term Residential/Nursing Care Placement | 40% | 70% |
| Permanent Admission to Residential/Nursing Care | 0% | 30% |
| Hospital Admission | 50% | 80% |
| Re-admission to Hospital within 90 days | 60% | 62.5% |
| Presentations at A & E | 50% | 70% |
| Ambulance Call-Outs | 50% | 80% |
| Additional Indicators | | |
| Mean number of referrals | 3.8 | 1.3 |
| Mean number of days from referral to assessment | 3.3 | 8.4 * |

*One case was removed from the analysis because it was an outlier (3 standard deviations above the mean).

The number of referrals to and from the social worker was also treated as an indicator of quality of care. These data were analysed using an independent samples t test. The number of referrals made and received by the social worker to and from other professionals and services was found to be significantly higher in Newark West Integrated Care Team, $t(18) = 5.64, p = .00, d = 2.52$, with the mean number per service user being 3.8 compared to 1.3 for Newark and Sherwood District Team. This result suggests that service users in Newark West Integrated Care Team are experiencing referrals to a wider

range of services and expertise and that there may be a greater sign posting of service users to support. Responses to a question in the focus groups about what works well in an integrated team support this finding:

"I think the sign posting of erm patients or the specialities of or we're here."
(FG2)

This was echoed by service users and carers:

"So, he sort of helped us out with all that you know. What was, erm, available. You know systems that we could try that are, obviously not being in this situation before, you don't know that it is there." (I2)

Several of the cases in the District Team already had health professionals involved – for example, Occupational Therapy (OT) – and the focus group discussion alluded to the appointment of new workers (Community Independence Workers) within the Team, whose job would be specifically to signpost service users:

"We've got new workers who do more prevention in our team ... Community Independence Workers. I think they do a lot more things like that, low level." (FG4)

The time period between receipt of a social work referral for assessment and that assessment being completed was also captured and analysed. This was shown to be shorter in Newark West Integrated Care Team (3.3 days) than in Newark West District Team (8.4 days). Although this difference was not statistically significant, $t(17) = 1.238$, $p > .05$, $d = .58$, speed of response was identified as a key theme from the focus group discussions:

"a lot of the referrals are done, they're just done through the week ... we don't say, we don't say, 'Oh, we'll only do referrals once a week' – like at Byron House they'll only except a referral on a Tuesday when they do their Tuesday appointments."
(FG1)

The data suggest, therefore, that the social worker in the integrated care team is dealing with referrals in a more timely way.

Care Coordinators to screen cases for social work involvement were not employed in the Newark West Integrated Care Team; rather, potential cases were discussed directly between the social worker and health care colleagues and/or with the virtual ward administrator. Over the time period that the team had been established, this way of working had facilitated an enhanced level of shared knowledge amongst team members about what constituted an appropriate referral to the social worker. This acted as an initial filter, as discussed in the focus groups:

"It's not that it's less visible, it's more understood rather than, we can say to our patients, you know we can answer some of their questions before we actually refer." (FG1)

"you know, so you can explain that to them too so us knowing kind of what the threshold is for them to actually be able to receive some of their care ..."

So, you wouldn't have known that threshold if *****[social worker] hadn't been in your team?

"No, I wouldn't, definitely not." (FG1)

This way of working suggests that the number of inappropriate referrals to the social worker may be lessened because of the enhanced knowledge regarding the social care role in the integrated team. If health care colleagues are filtering low-level social care queries/issues that in their view would not warrant involvement from the social worker, this way of working may be allowing the social worker more time to respond to the referrals that they do receive. It will be important to investigate this further in the Broxtowe and Bassetlaw Teams.

3.3 What is the value for money and cost-effectiveness of having social care professionals embedded within integrated care teams?

Estimated costs for providing social care were broken down as detailed in Appendix 2 and extracted from service users' records by the Research Assistant (GM) in discussion with the Social Worker or CCO responsible for the service user's care package. To ensure consistency in the way that costs were calculated between the Integrated Care Team and District Team, the following parameters were applied.

- For service users in permanent residential/nursing care the cost for one year of care was used in the analysis to reflect the on-going cost.
- For service users in short-term residential/nursing care the cost for the period the service user had spent there was used.
- For service users with a care package at home the cost of the package for one year was used in the analysis to reflect the on-going cost.
- For service users in Newark West District Team we have included 45 minutes of time (£14.39 per hour) spent by the Service Advisor in the Customer Service Centre to reflect the processing and triaging time required before allocation of a case to a CCO or Social Worker in the District Team for assessment. This amount of time (45 minutes) emerged from discussions with individual social workers and focus group participants as the minimum amount of time that would be given to a case before it was scheduled for assessment.
- Referrals in Newark West Integrated Care Team were made directly to the Social Worker in the Team and so were not incurring the costs associated with processing by the Customer Service Centre. The social workers' time costed included their time spent in multidisciplinary team meetings, recording a contact assessment and/or fielding inappropriate referrals.
- Health costs (for example, a Health-funded assessment bed, fully funded nursing care or nursing care contributions paid by Health) were not used in the analyses, as these were not costs incurred to social care.
- Hourly social worker costs were calculated using a standard rate of pay (£23.75), regardless of the pay level of the social worker who dealt with the case.
- The Newark West District Team differs from the Newark West Integrated Care Team in that it employs CCOs whose hourly rate of pay is lower than that of a social worker. At the time of producing this report it was not possible to agree a cost for the additional supervisory time CCOs might incur when working with complex cases.

- The cases in the Integrated Care Team and District Team were selected based on agreed criteria for their level of complexity. According to the focus group discussion with the District Team, cases which involved safeguarding issues would be allocated to social workers and supervised by the team manager. CCOs were supervised by senior practitioners and would not be allocated cases with safeguarding issues. In all other respects cases worked by CCOs and social workers in the District Team were of a similar level of complexity.
- For comparison, we have included an analysis of costs using actual CCO rates of pay (£16.99) for cases in the District Team alongside an analysis of costs using the standard social worker rate of pay (£23.75), in recognition that these cases could have been allocated to a social worker rather than a CCO. These costs were provided by Nottinghamshire County Council finance staff and do not include salary-related on-costs (pension and NI). Neither do they include NCC on-costs such as accommodation and other corporate overheads.

Cost data for 20 service users (Newark West Integrated Care Team, n = 10; Newark and Sherwood District Team, n = 10) were collected and used in the analysis. The mean estimated costs are shown in Table 2 below.

Table 2: Mean Social Care Costs per Service User for Newark West Integrated Care Team and Newark and Sherwood District Team

| <i>Type of Social Care Cost</i> | <i>Newark West Integrated Care Team</i> | <i>Newark and Sherwood District Team</i> |
|---|---|--|
| Short term care placement cost per service user (£) | 3,542.50 | 6,163.03 |
| Care package cost per service user for 1 year (£) | 6,206.20 | 11,802.86 |
| Social Worker/CCO hours per service user | 9 | 18.4 |
| Social Worker/CCO costs per service user (£) | 213.75 | 437 (321.40*) |
| Customer Service Centre costs (£) | 0 | 10.79 |
| Total social care cost per service user (£) | 9,962.45 | 18,413.66 (18,298.08) |

*Mean costs when cases in the District Team were costed at the CCO rate. Not all cases in the District Team were worked by CCOs.

Total Social Care Costs

The cost data (using social work rates of pay) for the teams were analysed using an independent samples t test. The results showed a significant difference in **total** social care costs between the two teams, $t(18) = 2.05$, $p = .055$, $d = 0.92$, with mean total costs per service user (£9,962.45) being lower in Newark West Integrated Care Team than in Newark and Sherwood District Team (£18,413.66). Even when the latter cost was adjusted downwards to take into account the lower rates of pay for CCOs, the difference in costs was shown to be approaching significance, $t(18) = 2.02$, $p = .058$, $d = 0.9$, and still had a large effect size of 0.9, suggesting that overall the Integrated Care Team incurs considerably lower social care costs than the District Team.

Care Package Costs

Comparing specific social care contributions across the two teams, a significant difference in care package costs was also identified, $t(34) = 3.06$, $p = .048$, $d = 0.95$, with care package costs being significantly lower in Newark West Integrated Care Team.

Short Term Care

Although short term care placement costs were lower in Newark West Integrated Care Team, these were not found to be significantly lower, $t(18) = 0.58$, $p > .05$, $d = 0.26$.

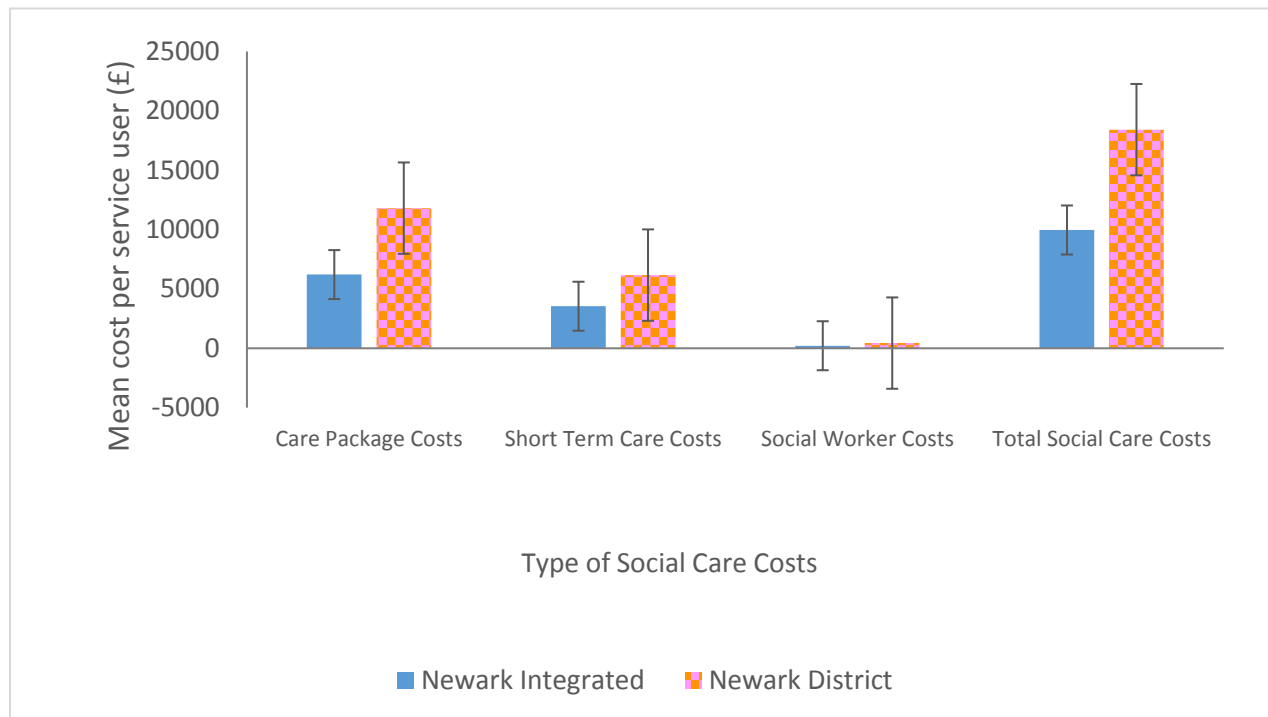
Social Work Time Costs

Social worker's time costs were also lower in Newark West Integrated Care Team but not significantly lower than the same costs in Newark District Team, either when costed using the social worker's pay grade, $t(18) = 1.12$, $p > .05$, $d = 0.5$, or that for the CCOs, $t(18) = 0.74$, $p > .05$, $d = 0.33$.

Detecting a significant effect in such small samples can be difficult; therefore, it will be important to compare costs across the larger sample as data is collected in the Broxtowe and Bassetlaw Teams.

Overall the findings suggest that mean total costs to social care are significantly lower in Newark West Integrated Care Team than in Newark and Sherwood District Team. This is demonstrated in Figure 2, which illustrates the mean costs for both Teams. From Figure 2 it is evident that all costs are higher for Newark and Sherwood District Team. However, from looking at the data it appears that Newark West Integrated Care Team may be achieving greater cost effectiveness through savings on the cost of care packages when compared with Newark and Sherwood District Team. As service users had similarly complex needs across both teams, these cost savings may be due to the Integrated Care Team intervening earlier, having better access to other health professionals and using more sign posting to sources of additional support. This is supported by the finding (see Section 3.2) that a significantly higher number of referrals are made by Newark West Integrated Care Team to other services. Section 3.2 also identified a higher number of service users using low-level preventative services to support self-care in Newark West Integrated Care Team, which may also result in lower care package costs. Despite these cost differences, service user and carer satisfaction with care delivered by the Integrated Care Team is reportedly high.

Figure 2: Mean Social Care Costs presented with Standard Error Bars



There is therefore consistent evidence from all data sources that the integrated approach adopted in Newark West is resulting in cost savings to social care when compared to the standard approach employed by Newark and Sherwood District Team. Care package costs, short term care placement costs, and social worker hours/costs are all lower in Newark West Integrated Care Team. In addition, Newark West Integrated Care Team does not incur any costs in processing cases at the Customer Service Centre/through triage before reaching the social worker/CCO. This more streamlined approach is likely to be contributing in a range of ways to the significantly lower costs of social care that have emerged in Newark West Integrated Care Team.

3.4 How could the care model be improved further? Should it be scaled up and if so, what are the options, with pros and cons?

Preliminary observations suggest that more effective communication, ease of referrals and joint visits between health and social care colleagues may be contributing to a more cost-effective care model characterised, primarily, by more cost-effective care packages in the Integrated Care Team in the longer term. This finding will be explored further as data are captured from the Broxtowe and Bassetlaw Teams.

The way that knowledge is shared between members of the Integrated Care Team in Newark West suggests that learning with and from each other is fundamental to effective interdisciplinary working, and that it may be this shared knowledge that underpins more cost-effective care:

"You're not repeating yourself either with the patient because, because we speak about it then we can go in to the patient knowing things. So, then we look more professional because we know what we're talking about and we know what's being done so there's less to me duplication" (FG1).

"because I've taught them effectively they've learnt, and vice versa it's not a, I learn about all sorts, I've learnt, I've learnt how big catheter tubes are. Erm so sometimes the preamble's kind of already done before they get, before they come to me. Although, although it's all very informal" (FG1).

"I think we have got better at being more holistic as well I think because we all work together we kind of jump outside the box, you know, and we do look differently. You know we don't just look at what we're doing" (FG1).

The Integrated Care Team in Newark West and the District Team in Newark and Sherwood appear to make assumptions and/or know little about how each other operates and how integrated and district teams operate in different areas of Nottinghamshire. This lack of localised knowledge is potentially preventing teams learning from best practice and from informing the introduction of new roles – for example, that of Community Independence Worker – which is a costly investment. Whichever model/s is/are adopted, an opportunity for regular knowledge exchange across teams would seem to be welcomed by practitioners and may help to dismiss myths and stereotypes relating to the pros and cons of integrated versus district teams. This needs to be explored in the toolkit that we plan to accompany submission of the final report of the evaluation in October 2017.

4. CONCLUSIONS AND RECOMMENDATIONS

The limitation of this evaluation lies in the focus on a small sample of cases from two teams in one geographical area. Although cases were sampled purposively by social workers and CCOs in accordance with the given inclusion criteria (set out on page 5), these cases were not matched according to a standardised set of demographic and health care variables which, if this had been possible, would have rendered more robust the comparison between the social work role in integrated and district teams in terms of cost effectiveness.

The strength of this evaluation lies in the combining of data sources to answer the evaluation questions. To the best of our knowledge, this is the first time that both quantitative and qualitative data sources have been combined in this way to produce a robust approach to evaluating the costs of the social care role in integrated teams. This places Nottinghamshire at the forefront in terms of any similar evaluations emerging in future.

By implementing a mixed-methods, multi-level, realistic evaluation design, we have been able to triangulate the results of the statistical analyses of the quantitative data with the results of the thematic analyses of the qualitative data. This has allowed us to deepen our understanding of the different effects on staff and service users of delivering and receiving the social care role through integrated and standard models of care. Because of our small sample size at this stage of the evaluation we accept that our results may lack statistical

generalisability. However, we suggest that our findings are theoretically generalizable in that we would expect to observe similar effects of the social care role in integrated compared with non-integrated teams, if the contextual factors affecting integration were similarly demonstrated. As data emerges from the data collection in Broxtowe and Bassetlaw teams we will be able to say more about this, as we will have a larger sample for statistical analysis of costs and will gain a richer understanding of service users' and carers' experiences of receiving social care across Nottinghamshire as a whole.

It is important that duration data by team is captured wherever possible to assist with this, in addition to any suggested refinements for how we calculate the cost of the CCO input. Interviews with team managers may also provide helpful insights that will allow us to refine our cost model further.

5. NEXT STEPS AND REVISED TIMESCALE

In preparation for the final report (due in October 2017) the following additional data will be provided by Nottinghamshire County Council at team level for the last 12 months. These data will act as valuable contextual data to inform answers to Questions 1-3 as set out on page 5 of *Nottinghamshire County Council's Efficiency Project Bid – February 2016* and replicated in Section 3 above.

- Number of referrals.
- Number of assessments.
- Number of assessments that result in a service.
- Number admitted to permanent residential care by service user type: i.e. OP/OPMH and average length of episode.
- Number admitted to nursing care by service user type and average length of episode.
- Number of placements jointly funded by Health.
- Number of packages of care jointly funded by Health.
- Number in extra care.
- Number in receipt of day care only.
- Number in receipt of telecare.
- Number in receipt of community equipment as part of an ongoing package.
- Number in receipt of community equipment with no on-going provision.
- Number receiving a direct payment.
- Number in receipt of domiciliary care by service user type and average number of hours.
- Number of episodes of re-ablement and average length of episode – percentage with no on-going care need.
- Tracked admissions to hospital, and in the absence of a single view of health and social care data, we need to explore whether this could be achieved by capturing the number of hospital assessments and discharge notices on cases which are allocated or closed to review.

In addition to collecting the contextual data above it will also be important to understand in more detail, and refine, the costs for social care, as necessary, to take into account:

- whether and how service users 'cross over' between integrated and district teams or whether the teams are working with distinct populations of service users with social care needs;
- whether having Care Coordinators in the Broxtowe integrated team assists in screening out inappropriate referrals for social care.

It will also be important to determine, where possible, cost implications/potential savings for health care services. For example, where Customer Service Centre costs have been included in our calculations for this interim report in terms of social care involvement, we have not to date quantified these costs for health care colleagues whose time has been taken to make the referral. This needs further investigation/revisiting on a case-by-case basis and so will be included in the next stage of data capture.

6. ACKNOWLEDGEMENTS

We would like to thank Nottinghamshire Council for the funding of this evaluation and all the service users, carers and staff who have given their time to support the collection of data to date.

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8. APPENDICES

| | | | |
|---|--|--|--|
| <p>Outcomes (benefits for service users/families and carers)</p> | <p>Quantitative data collected from:</p> <ul style="list-style-type: none"> • Costs on a case-by-case basis • Types of social care need worked with • Year-on-year demand level comparisons for services • Referral/unplanned hospital admission data where available • Critical incident analyses <p>Qualitative data collected from:</p> <ul style="list-style-type: none"> • Interviews with service users • Interviews with integrated team staff • Stakeholder event 2 | <p>Descriptive statistics of costs and benefits</p> <p>Thematic analysis</p> | <ul style="list-style-type: none"> • What difference has integrated working made to the lives of service users/families and carers with respect to the type of intervention and quality of care that people have received? • What impact has integrated working had on health and wellbeing outcomes for service users? • What impact has integrated working had on health and wellbeing outcomes for families and carers? |
| <p>Outcomes (change in practice at team and organisational levels)</p> | <p>Qualitative data from:</p> <ul style="list-style-type: none"> • Interviews with integrated care Team Leaders • Interviews with integrated care staff • Stakeholder event(s) <p>Quantitative data from:</p> <ul style="list-style-type: none"> • Costs on a case-by-case basis • Types of social care need worked with • Year-on-year demand level comparisons for services • Referral/unplanned hospital admission data where available • Critical incident analyses • Mapping and quantifying service demand data, including workforce efficiencies and costs • Case studies re scaling up | <p>Thematic analysis</p> <p>Descriptive statistics to include value of money, return on investment</p> | <ul style="list-style-type: none"> • Are there any differences in pathways or outcomes, comparing the standard referral route in a district social care team and to an integrated care team? • How can the integrated care model be improved further? • Is the team working differently in terms of eligibility criteria, sign posting, assessment and discharge support? • What is the impact on the sharing of information and communication between different workers/teams/organisations? • Are there any changes in staff satisfaction, confidence and capability? • What is the value for money and cost effectiveness of having social care professionals embedded in integrated care teams? • Can we try to identify/extrapolate the value of integrated care teams for health as distinct from social care sectors? • If the contextual factors suggest the model can be scaled up, what outcomes will result for the teams/organisations? What might be the unintended consequences? |

APPENDIX 2: GUIDANCE FOR SOCIAL WORKERS COMPLETING COST/BENEFIT DATA FOR 10 CASES

Thank you for agreeing to help us with collecting the following important information, which will enable us to estimate, as accurately as possible, the costs and benefits for those in receipt of adult social care via the integrated care and district social work teams in Nottinghamshire. Some of the information below may have already been shared with you. However, we have put it all in one document so that it is easier to refer to.

Gabriella Mutale, who is the Research Assistant for this project at Nottingham Trent University, will be arranging to visit your team to offer further support, should need it. In the meantime, please do begin to collect the data as outlined below and insert it into the spread sheet attached. If you have any queries or need to check anything with Gaby in advance of her coming to visit the team, please send an email to gabriella.mutale@ntu.ac.uk.

Inclusion criteria - we are seeking to find 10 cases in either a district social work or an integrated care team where ...

1. the case has 3 or more professions involved in it
2. the case has at least 2 health conditions (more likely 3) and, where there are only 2, there are likely to be other factors such as safeguarding/risk/resisting help issues
3. age is likely to be 70+ (if not, all other indicators 1, 2 and 4 met)
4. the case meets at least baseline criteria 3 on the workload management tool (see attached) but is more likely to be 4 in terms of multi-professional input/decision making and risk concerns.

Estimated social care costs (for each service user)

- Weeks spent in residential care – we need to know the total number of weeks in residential care irrespective of how many admissions/episodes – [Column B](#). Please also give us the cost per week of residential care – [Column C](#).
- Weeks spent in nursing care – we need to know the total number of weeks in nursing care irrespective of how many admissions/episodes - [Column E](#). Please also give us the cost per week of nursing care – [Column F](#).
- Care package cost per week – this needs to be the actual cost of the care package – [Column K](#).
- Social worker’s hours – estimate the total hours you, the social worker, have spent on the case – [Column H](#).
- Number of referrals:
 - i) from you, the social worker, to other external services/health care professionals etc. – [Column M](#)
 - ii) from other external services to you, the social worker – [Column N](#).
- Date of initial referral to you, the social worker – [Column R](#).
- Date of assessment by you, the assessing social worker – [Column S](#).
- Date care package was implemented – [Column T](#).
- Duration of social worker involvement – this means the number of weeks from when you opened the case to when it was closed (or it may still be open and that’s fine) – [Column U](#).

Indicators of quality of care

The literature on integrated care tells us something about the kind of indicators that Councils like Nottinghamshire are exploring in relation to the quality of care they provide. We are interested in collecting data in relation to the following indicators for the cases that you have selected.

- Avoidable hospital admissions (reasons why a hospital admission has been avoided can be recorded as anything a social worker has done which has helped to avoid an admission to hospital – e.g. any alterations to a care package which may have prevented a hospital admission).
 - Please tell us whether this has happened (either Yes or No) in [Column V](#).
 - If hospital admission has been avoided, please tell us (if you can) the number of times for this case a hospital admission has been avoided in total in [Column W](#).
- If end of life care has been provided at home – tell us (either Yes or No) in [Column Z](#).
- Use of assistive technology (e.g. social worker has set up FLO medication prompt, a pendant alarm, etc.) – tell us (either Yes or No) in [Column X](#).
- The service user is controlling their own health using supported self-care (e.g. social worker has set up a hot meals service for them) – tell us (either Yes or No) in [Column Y](#).
- Hospital admissions – tell us (either Yes or No) in [Column AA](#), and give us the number of admissions since the start of your involvement in [Column AB](#).
- Re-admission to hospital within 30 days of discharge – tell us (either Yes or No) in [Column AC](#).
- A&E presentations (number of) – tell us (either Yes or No) in [Column AD](#).
- Delayed discharge from hospital – tell us (either Yes or No) in [Column AE](#).
- Ambulance call-outs – tell us (either Yes or No) in [Column AF](#).
- Admission to residential/nursing care (temporary/respice) – tell us (either Yes or No) in [Column AG](#) (temporary) or [AI](#) (for respice).
- Admission to residential/nursing care (permanent) – tell us (either Yes or No) in [Column AK](#) (for permanent residential care) or [AL](#) (for permanent nursing care).

Thank you for your time in giving us this information.

Di Bailey and Gabriella Mutale

APPENDIX 3: MEASURING THE QUALITY OF SOCIAL CARE

Outcome Indicators of Care Quality for Fully Costed Cases

Positive:

- hospital admission avoided
- end-of-life-care given at home
- low level or preventative services to maintain wellbeing and independence
- use of assistive technology

Negative:

- unplanned/hospital admissions
- re-admission to hospital within 30 days
- admission to residential/nursing care – temporary
- admission to residential/nursing care – permanent
- delayed discharge from hospital
- A & E presentations
- ambulance call-outs

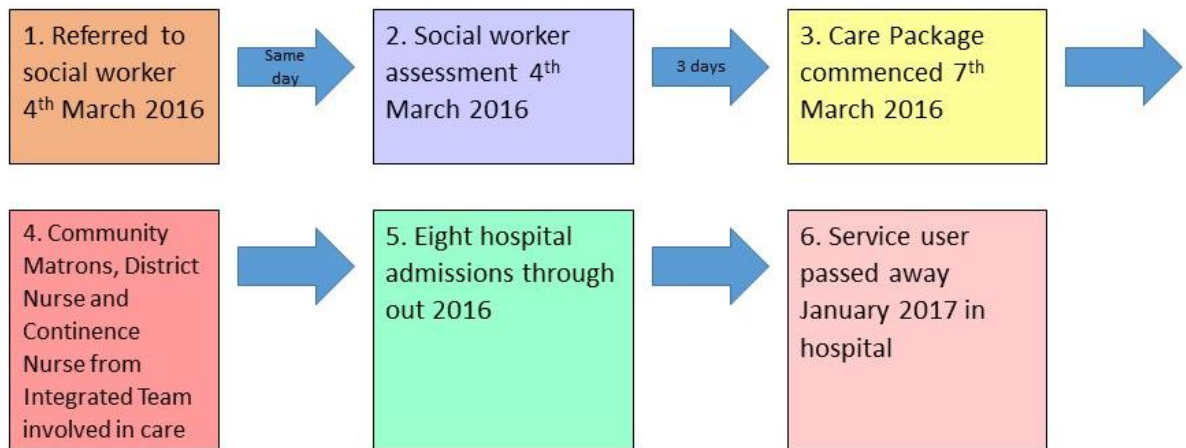
APPENDIX 4: WORKLOAD MANAGEMENT TOOL SCORING GUIDANCE

1. Carer's assessments, non-urgent home care assessments, START referrals, cases awaiting care packages or provision of equipment and cases ready for closure.
2. Non-complex home care assessments, moving and handling reviews, care package and placement reviews where no issues have been identified, Decision Support Tool (DST) meetings, again where no issues have been identified, minor adaptations and major adaptations awaiting completion, moving and handling telephone reviews.
3. **(Baseline)** Non-complex but time-consuming assessments and pieces of work, cases involving self-neglect including working with other agencies to offer support with house clearances and care provision and monitoring of risks etc. also level access showers and ramps and OT rehousing assessments to include property viewings.
4. Multi-agency meetings, capacity assessments, risk assessments to inform panel decision making for long term care, assessments for short term care/respite care and funding for carer's breaks, day care and transport, assistive technology provision.
5. Cases involving assessments of service users living with advanced dementia, high level risks and cases requiring co-working between social work, occupational therapy and other professionals/agencies, moving and handling reviews/assessments, major adaptations and associated risk assessments, provision of specialist and bespoke equipment, hoarding and alcohol related issues, cases involving mental health elements, safeguarding work, long term care applications, financial issues, for example corporate deputyship applications, time consuming and complex work.

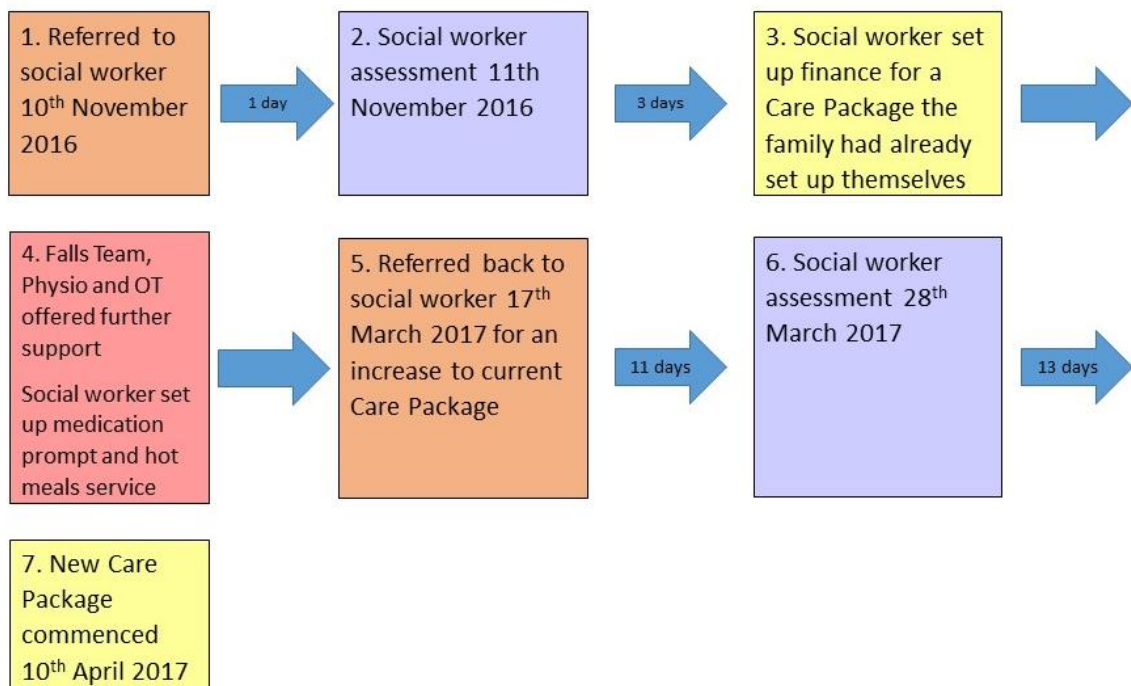
APPENDIX 5: SERVICE USER JOURNEYS THROUGH TIME

Integrated Care Team

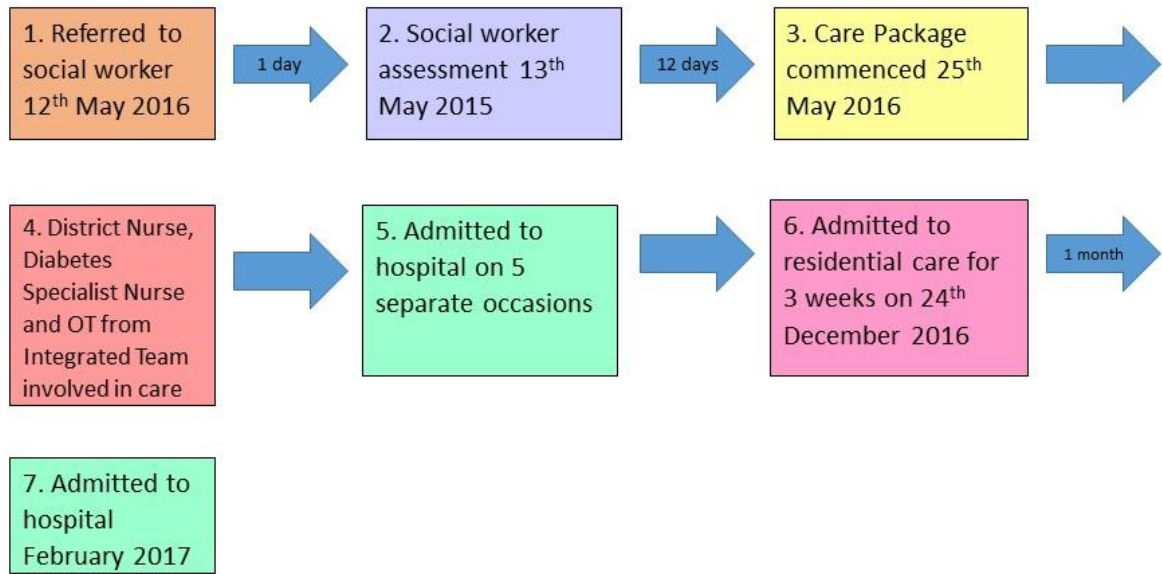
Example 1



Example 2



Example 3

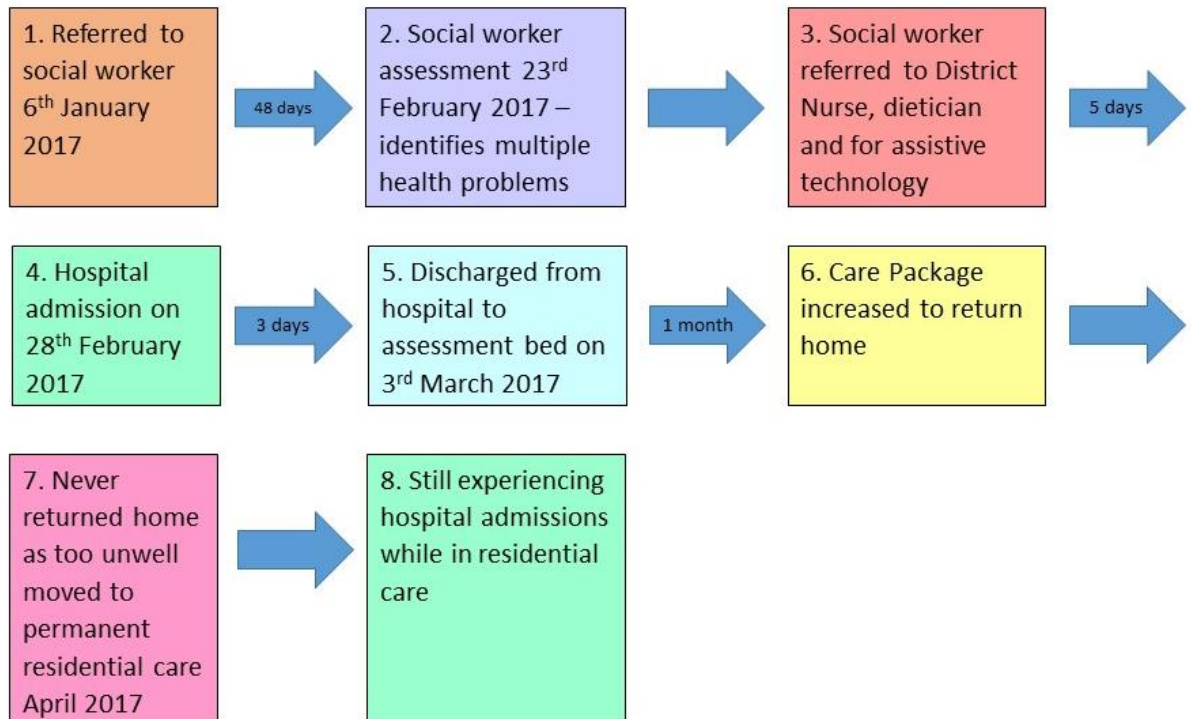


District Team

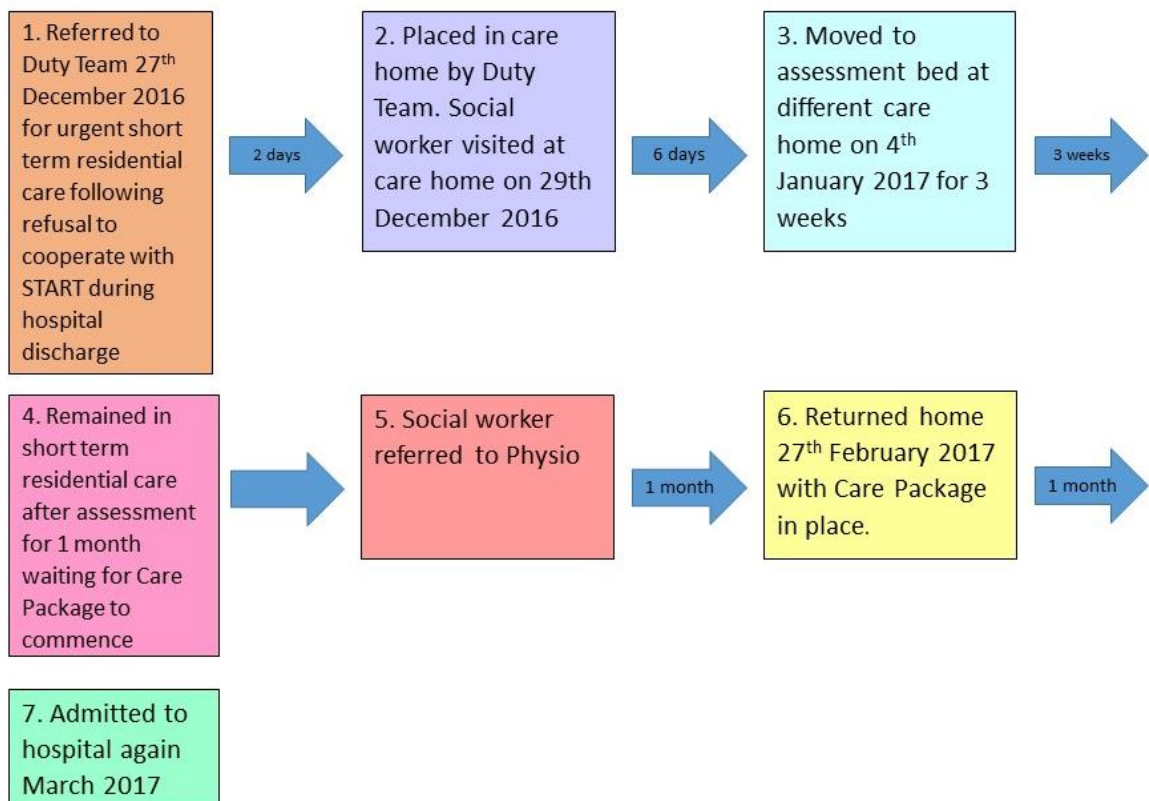
Example 1



Example 2



Example 3



APPENDIX 6: UPDATED TIMESCALE AGREED 25TH APRIL 2017

| | |
|-----|---------------------|
| KEY | |
| | Key Activity |
| | Milestone/Reporting |

| | April 2017 | May 2017 | June 2017 | July 2017 | Aug 2017 | Sept 2017 | Oct 2017 | Nov 2017 |
|---|---------------|-------------|--------------|--------------|-------------|--------------|-------------|-------------|
| Data collection in Newark West Integrated Team | | | | | | | | |
| Data collection in equivalent District Team | | | | | | | | |
| Refine data collection tools | | | | | | | | |
| Data collection in South Nottinghamshire PICS Team (Broxtowe) | | | | | | | | |
| Data collection in North Nottinghamshire Integrated Neighbourhood Team (Bassetlaw North West) | | | | | | | | |
| Data collection in equivalent District Teams | | | | | | | | |
| Interim report for Steering Group Meeting on June 2 nd | | | | | | | | |
| Data analysis and writing up | | | | | | | | |
| Stakeholder meeting to support evaluation tool-kit development | | | | | | | | |
| Evaluation tool-kit produced | | | | | | | | |
| Reconvene Expert Reference Group and involve in reviewing findings | | | | | | | | |
| Final Report | | | | | | | | |
| Follow-up meeting with John Bolton and colleagues | | | | | | | | |