Title: Can a case lead approach deliver the 'craft and graft' of integrated working?

Abstract

Purpose

The aim of this study was to explore the experiences and outcomes for adults with complex needs over time, within and between two teams that delivered integrated care across different Councils' services. The teams' approach to integration included two key features: a 'case lead' way of working and the team itself operating as a single point of access (SPA) for residents in given neighbourhoods with high deprivation.

Design

The study was designed as evaluation research located in the realist tradition. Two teams acted as a case study to provide an in depth understanding of how the case lead approach and SPA delivered the craft and graft of integrated working in the teams.

Mixed methods of data collection included residents' ratings of their quality of life on five domains in an outcome measure over a 6-month period. Residents and staff working in the teams also participated in semi-structured interviews to explore their respective experiences and receiving and delivering integrated care. The costs of care delivery incurred by residents were calculated based on their demands on public services in the year leading up to the teams' intervention and the projected costs for one year following this.

Findings

The relationship between team context, case leads' inputs and residents' outcomes was mediated through the managerial style in the integrated teams which enabled case leads to be creative and do things differently with residents. Case leads worked holistically to prevent residents being in crisis as well as giving practical help such as sorting depts and

finances and supporting access to volunteering or further education. Residents rated their quality of life as significantly improved over a 6-month period and significant savings in costs as result of the teams' support were projected.

Originality/value

The study used a multi-evaluation realistic evaluation methodology to explore the relationship between team context, case leads' inputs and residents' outcomes in terms that integrated services across different District and County Council Departments.

Keywords

Evaluation research, case study District Council, County Council, single point of access, integrated teams, adults with complex needs

Introduction

Integrated care happens when organisations work together to meet the needs of their local populations. In the UK the growing body of literature on integrated care for adults aged 18 and over reflects a focus on integration between health and social care supported by policy developments such as the Better Care Fund (Department of Health, 2019) and legislation such as the Care Act 2014. Despite these policy developments evidence remains lacking about the effectiveness of the approach (Cameron *et al.,* 2014). In adult care comparatively less well explored than integration between health and social care services, are attempts to integrate public services that influence the social determinants of health more broadly. For example, services that relate to housing, employment, neighbourhoods and the physical environment. The study reported herewith focused on the integration of these public services and the Welsh Assembly Government, (2007 p 24) highlights the need for this,

"Individuals often have needs which are the responsibility of several local authority departments ….this requires joined up planning, commissioning and delivery of services".

Similarly, reflective of the diversity of public services, there are many definitions of integration that span working between services, sectors, settings or professionals (Reed *et al.,* 2005) through to the assimilation of services into single organisations (Maslin-Prothero and Bennion, 2010). Typically, studies take integration as read and so do not define it for the purposes of an investigation. Horizontal integration, as that which occurs across departmental boundaries (Integrated Care Network, 2004) was exemplified in the current study as care services were being integrated between a County and District Council. Many parts of the UK retain these two tiers of local government, with 26 County Councils being responsible for providing services such as education, social care, fire and public safety, subdivided into 192 District Councils that provide services such as rubbish collection, recycling, housing and environmental health (UK Government, 2019).

In 2016, Public Health England and the National Health Service (NHS) recognised the need to improve health and wellbeing through a collaborative use of resources held by these services. Collaboration between Fire and Rescue, social care and health services was highlighted with the aim to provide personalised, integrated support to the most vulnerable and those with complex needs (Public Health England and the NHS 2016). By responding to need in a more holistic way it was intended that multiple demands on these services and the rising costs associated with such would reduce.

The quest for integration is therefore intended as a way of achieving better outcomes rather than an outcome in and of itself. This is reflected in the tendency of studies that focus on integration not to measure outcomes achieved (Integrated Care network, 2004). Similarly,

only a minority of studies include individuals' experiences as part of any evaluation (Maslin-Prothero and Bennion, 2010).

In the absence of evidence relating to outcomes these self-reported experiences albeit obtained from small samples, offer a source of qualitative data that supports the UK policy agenda for change (Department of Health, 2006, 2009). Ethically, those who use services have the right to voice their experiences about the care provided (Department of Health, 2005).

Dickinson (2014) contends that studies have been overly concerned with identifying factors that facilitate or hinder integration at the expense of investigating the working practices (or the 'craft and graft') of those delivering it, an observation shared by Glasby et al. (2013). This is important as the 'mechanics' of integration differ with some integrated teams being co-located while others are not. Teams also differ in the way referrals into services are managed with some operating a customer service centre as a single point of access (SPA), while others manage referrals through a triage system involving care coordinators (Bailey et al 2017). As Edwards, (2019, p 2) explains, integrated care models are complex systems" and it is the "nature of the relationship between the actors in the model that is important for its overall success".

Demonstrating integration effectiveness is therefore challenging, what Kodner, (2009) describes as a multiple simultaneous equation. In the light of the above the aim of this study was to explore the experiences and outcomes for adults with complex needs over time, within and between two teams that delivered integrated care across the different Councils' services.

Establishment of the integrated teams was led by the District Council supported by a Strategic Partnership Board (SPB). The SPB was Chaired by Chief Executive of the County Council with membership made up of local councillors, the Chief Fire Officer and the Police and Crime Commissioner. Importantly the SPB sanctioned the human resourcing of the teams, including the secondment of posts from the County Council and monitored the demand on the teams compared with non-integrated services.

The integrated teams were created to provide targeted support for adults aged 18 and above who were making simultaneous demands on multiple agencies, typically over protracted periods of time with no demonstrable resolution of their presenting needs. The approach was informed by the Troubled Families Programme, a targeted approach adopted with whole families in deprived communities in the UK to help reduce service demand and public costs (Department for Communities and Local Government, 2017).

Demand for support from the teams related to inappropriate housing, debt, rubbish accumulation, environmental health issues, and unemployment. Poor mental health, substance misuse and related child or adult safeguarding issues were common. Each team was based in a neighbourhood with high deprivation and the only criteria for accessing support from the team as residency in the given neighbourhood. For this reason, we adopt the term 'resident' throughout the remainder of this paper to refer to people who accessed support from the teams.

The teams' approach to integration included two key features: a 'case lead' way of working and the team itself operating as a single point of access (SPA) to mobilise services to meet

the needs of the individual. This contrasts with previous studies where single points of access have been employed at a service (Dickinson and Neal, 2011) or project level (Moore, 2015) to integrate access points to community health and social care services across the statutory and third sectors.

Residents could access support by visiting the team premises or the team would contact residents brought to their attention by external agencies or by other residents directly, usually through a home visit. The teams were an example of horizontal integration, what Reed et al (2005) refer to as integration between organisation types; in this case the County and the District Councils. Team members were co-located from the outset and employed directly by the District Council or seconded from the contributing County Council departments including Fire and Rescue, Department for Work and Pensions (DWP), and the Police.

Each resident was assigned a team member as a case lead who worked with them to set goals and mobilise all aspects of their support. Case leads were assigned during weekly team meetings when residents' needs were considered and reviewed by the whole team. It was the case lead's responsibility to draw on the collective skills and expertise of team members and their respective agencies as necessary, to coordinate support in response to residents' multiple needs. Case leads would undertake joint visits with other team members as necessary to address residents' interrelated needs simultaneously; for example, concerns about noise and anti-social behaviour alongside inadequate housing, and poor mental health.

Method

Design

The study aimed to explore the experiences and outcomes for adults with complex needs over time, within and between two teams that delivered integrated care across the different Councils' services. The study was designed as evaluation research located in the realist tradition, guided by Goodwin (2013) to adopt a tried and tested, multi-level evaluation framework. The framework combined levels developed by Warr et al. (1970) [context and inputs] and Kirkpatrick (1994) [outcomes]. By combining these levels and testing them through previous research (Bailey, 2002, 2007; Bailey and Littlechild, 2001), the framework has proven suitable for exploring the links between programmes of change and improvement in health and social care outcomes in a range of settings (Bailey & Kerlin, 2012 & 2015 and Ward & Bailey 2016).

The realistic evaluation framework adopted allowed for an exploration of how the context in which the integrated teams worked and the inputs they delivered were experienced by residents' in supporting changes in their quality of life. In this study the teams' inputs are akin to what Pawson and Tilley (1997) consider as the resources offered by a social programme and the evaluation approach supported the exploration of what Pawson and Tilley refer to as "the different layers of social reality which make up and surround programmes of change" (2004 p4). In this instance the social realities of residents receiving; and case leads delivering, more integrated support to address residents' multiple needs.

The integrated teams involved in the study offered the opportunity to provide a case study (Stake 1995, Yin 2014) for evaluating integrated working across the Councils'

departments. The realistic evaluation design included a mix of qualitative and quantitative data collection methods as advocated by Stake (1995) as valuable in case study research. Mixed methods allowed for the complexities and uniqueness of how the teams operated and how this was experienced by the residents who accessed support, to be captured. Data collection spanning the four levels of the evaluation framework necessitated different sampling strategies as outlined in Table I below. Quantitative data in the form of self-reported, quality of life ratings were collected from residents. Rating data were augmented by narrative data from semi-structured interviews that captured residents' experiences of their quality of life changing as they made progress towards achieving their goals. Narrative data relating to staff's experiences of working with residents and with each other in the teams were similarly captured using semi-structured interviews.

Quantitative data were also collected in the form of projected costs for supporting residents, with and without the team's involvement. Yin (2009) refers to converging lines of enquiry when multiple data sources are brought together through multiple methods and highlights the importance of this for case study research.

[Insert Table I here]

Table I: Levels of the Evaluation Framework with Associated Methods and Sampling Strategies

Level of Evaluation	Data Sources	Sampling
Context in which the teams were created.	Qualitative data collected from: • Semi-structured interviews with staff	Purposive sample of the total number of case leads at the time of data collection 10 case leads (Team 1 n = 5; Team 2 n = 5) and the Team Manager
Inputs that residents and staff deemed	Qualitative data collected from:	As above

important in terms of support solutions that helped residents achieve their goals	- Semi-structured interviews with staff - Semi-structured interviews with residents	Self-selecting 40 residents (Team 1 n =23; Team 2 n =17)
Outcomes for residents relating to achievement of goals and quality of life	Quantitative data collected from: Outcome measure at T1 and follow up T2 after 6 months	Opportunistic sample of residents who had completed the outcome measure at both T1 and follow up
Outcomes for residents relating to their experiences of accessing support from the team	Qualitative data collected from: Semi-structured interviews with residents	Self-selecting – 40 residents as above
Outcomes for the teams and the Councils	Quantitative data from: - Cost data calculated using recognised databased of unit costs Qualitative data from: - Semi-structured interviews with staff	Purposive sample representative of residents with complex needs - 35 residents (Team 1 n =18; Team 2 n =17) Purposive sample as above

Participants

<u>Residents</u>

At the time of the evaluation the integrated teams had worked with 270 residents aged 18 and over of whom 82% presented with multiple support needs. All residents who were approached to take part in the evaluation were drawn from this group. Typically, needs related to not being in education or employment, a reduced life expectancy resulting from one or more physical or mental health conditions, childcare concerns and/or family violence and living in inadequate housing/low income households. Residents were not approached to take part in the evaluation if they presented with a single need for support; for example, assistance to get bins emptied or to deal with rent arrears. Of the 270 residents at the time of the evaluation, 18% fell into this category.

The Integrated Teams

All staff working in the teams at the time of the evaluation were approached to take part in a semi-structured interview.

Integrated Team 1 was located in a terraced house, in a neighbourhood with 1,200 properties and included 5 case leads one of whom acted as Team Leader.

Integrated Team 2 was located in a parade of shops, in a neighbourhood with 1,400 properties and included 5, case leads one of whom acted as Team Leader. At the time of the evaluation there was also student on placement with the team.

Both neighbourhoods featured in the top 10% of the most deprived in the UK (Department for Communities & Local Government, 2019) and were predominantly White British.

Four case leads were employed directly by the District Council as well as both Team Leaders and a Team Manager who was responsible for both teams. The four remaining case leads were seconded to the teams from the respective Departments of the County Council, either

on a full or part-time basis and included staff from Fire and Rescue, Department for Work and Pensions (DWP) and the Police.

Data collection tools

Outcome measure

Residents self-reported ratings of their quality of life across five core domains was captured on the 'Outcome Star' (www.outcomesstar.org.uk) as a recognised, simple to use benchmarking tool. The 5 domains included housing, health, community, finances and employment and were rated on a scale of 0 -10. Residents completed the ratings at the start of case lead involvement (T1) and at follow- up (T2) after a 6-month time period.

Interview guides

A semi-structured interview guide informed by the 5 domains on the outcome measure, captured narrative data from residents. The guide was designed to capture how residents experienced the team's involvement (inputs) and how this led to changes in the 5 domains. The guide was piloted with a resident and their case lead prior to use to check relevance of questions, ease of understanding and completeness.

The semi-structured interview guide for staff was informed by observations of two integrated team meetings. This allowed the guide to be designed to elicit information about the context in which the team worked and how case leads intervened with residents to achieve change. The interview guide for the Team Manager was also developed iteratively, informed by the interviews with all case leads and several residents. This ensured that questions could explore further and from a management perspective, how the context in which the team operated, and the integrated way of working related to the experiences narrated by residents. This iterative process was intended to support the face validity of the narrative data.

Cost data

The projected costs relating to six services (District Council, Police, DWP, Social Care, Fire and Rescue Service and the NHS) were calculated for each resident. Unit costs from the New Economy Manchester Unit Cost Database (version 1.4) were used in calculations. A project manager from the District Council examined resident's case notes and calculated the costs of services' involvement in the one year prior to the involvement of the integrated team. The continuing costs for services likely to continue with the resident in the one year prior to the team's intervention were similarly calculated for comparison.

Data analysis

Ratings from the outcome measure and the projected costs relating to service utilisation were analysed in IBM SPSS statistics (version 23) and were subjected to an analysis of variance (ANOVA) to identify any significant differences.

The interviews with residents and staff were audio recorded and transcribed verbatim. The complete set of interview transcripts were analysed thematically to identify patterns and themes in the data (Braun and Clarke, 2006) that reflected links between the teams' context, support to residents and residents' self-reported outcomes. The analysis followed the steps described by Braun and Clark; familiarisation with data, generating initial codes, searching for themes, reviewing themes and defining and naming themes. The analysis was conducted by 1 member of the research team (GM) and by an independent researcher. Both researchers then shared and checked themes to reach a level of consensus.

Findings

Of the 270 residents with whom the teams had worked at the time of the evaluation 56 residents had outcome data at T1 and at follow up. All 56 residents were approached to take part in an interview, of whom 28 self-identified as female and 19 as male. 9 residents did not disclose their gender. 40 residents, (28 female and 12 male) agreed to be interviewed. All residents were White British reflecting the ethnic profile of the neighbourhoods in which the teams were located.

Relationship between context, inputs and outcomes

The relationship between team context, case leads' inputs and residents' outcomes (C-I-O) was reportedly mediated through the managerial style in the integrated teams which enabled case leads to deliver the craft and graft of integrated working. This was typified by being creative and doing things differently.

> *"As long as you run through, ideas, through ****[Team leader] he's quite open for you to do what you think's necessary cos you know that individual better than anyone else in the team and he's quite happy for you to go forward with your ideas and if they fail they fail, trial and error really". CL5)*

Case leads were supported by managers to draw on their specialist knowledge and skills acquired in their respective departments (craft) to try different and creative ways of integrated working (graft),

> *"I like the fact that you can do anything. There's no policy book there saying this is how we do, deal with this situation because every resident that you have they're all different…I go to my team leader and I say I want to try this and he'll go yeah try that and I like the fact the he'd never push down for an idea." (CL8)*

> *"I think there's more freedom to change things…. I think single discipline working when I managed at DWP, it was very dull, it was very much a case of we need to deliver this for this statistic and that's it. I think erm that single approach is less person centred". (CL11)*

The teams operated as a single point of access, maintaining contact with residents by phone, text messaging or home visits. Alternatively, residents would drop into the shop premises for Team 2 and knock on the door of the premises for Team 1.

"Phone or text. xxx [case lead] will text me when she's coming and then I'll text back saying yeah it's fine". (R11)

"There's always somebody there if xxx's [case lead] not in there is the option of having someone else so that's always been good to know…you're never left in the lurch and if there ever is a problem there is always someone at the other end of a phone". (R8)

The case leads worked to prevent crises for thirteen residents who talked of having been on the brink of criminal activity or experiencing homelessness. Prior to the team's involvement many residents reported not knowing who turn to for help or being turned away by services. Eleven residents said that the team's intervention had prevented them from attempting suicide.

"You know they'll pull out all the stops and do all the phone calls and everything and if at the end of the day there's nothing that can be done, then nothing can be done but at least they've tried and I'm not there tearing my hair out… So they have been a big help as I say without them after last year I don't think I'd be here if it weren't for them. So I applaud them". (R10)

"They've give me loads and loads of support. If it wasn't for these I probably wouldn't be alive. I'd have probably just ended it". (R22)

Residents reported that the support from the teams at times of crisis was qualitatively different to other services they had dealt with in the past. Case leads were commended for really listening to what the residents said, being more respectful and far less judgmental than services they had previously encountered.

"They've listened to me and they help…They actually come out and help not just say they can help and not help. I've had other agencies where they've said they can help and they've not bothered coming out or they've just said I don't meet their criteria and stuff." (R24)

Similarly, case leads described how they worked holistically with residents as well as interacting in the teams and more widely with agencies to share distinct and overlapping areas of expertise necessary to support residents. This fits with what Lethard (2003) identifies as interprofessional working.

"I'll pull expertise from some of the other guys here because they've got areas where I've never been. Whatever issues there are we'll always find a way and you know somebody with the experience to deal with it." (CL7)

"We leave the badge at the door, we'll holistically look at a range of issues…we only had the one criteria, they (residents) had to be on the area…we didn't do a lot of work with GPs before but I think we're not as afraid to get into like mental health issues and the and other health issues as we were…now we're pretty upfront with it and we're quite involved with the local GPs". (CL11)

"We sort of built quite a good working relationship with their team (Private Sector Enforcement), so that if they're going to visit a property and they know we're working with that resident they'll contact us as well so we can jointly go to there". (CL9)

Case leads explained the integrated way of working. This involved providing dedicated support within the scope of the case lead's expertise and avoiding duplication by promoting greater coordination when support from multiple services was needed.

"So you're the case lead you own the case, you own that individuals needs and you deal with every aspect or their issues and if you don't have the expertise and the team doesn't you seek it elsewhere be that a referral to family services… I think that's a really good thing to do because it stops that individual having to contact like 10 different agencies. (CL5)

"It gives them (residents) one person that they know they can contact if they need help for anything. So if they've got different things going on in loads of different places, so police officers, council workers, waste, social services, it gives them one person that can draw everything together for them as well which is for a lot of people a much easier way of doing it". (CL9)

"I've got a couple where I'm working with the social workers. There's no point in duplicating a service so we'll do what we can and they'll do, they keep us informed what's going off". (CL7)

Over half of residents (n =24) spoke about how case leads had encouraged them to participate in activities and take steps to learn the necessary skills that would enable them to achieve their goals.

> "She's been brilliant. Just getting me on that right track… and paying bills when they come through instead of ignoring them. That's the main thing. And I'm struggling but I'm doing it so it's brilliant." (R20)

Case lead's 'craft' included giving practical help, informed by their experience in their respective agencies. For example: to sort depts and finances including advice on how to manage money and budget, and to support access to volunteering or further education by helping residents to fill in necessary forms and attend events. Case leads planned practical steps with residents who wanted to reduce alcohol intake or eat a healthier diet. The case lead's involvement provided a sense of structure to the resident's life as well as for some greater financial stability particularly when residents had been supported to gain employment.

> "These guys aren't …just there for a moan, they actually got me an application form to start, a job that I'd really like, so they've worked together with the Jobcentre to try and better you." (R13)

Residents spoke of how receiving support from their case lead and the team had changed their outlook including thinking more positively about their situation which in turn led residents to taking positive steps to further improve their circumstances.

> "I'll give it [college course] a go. It might be good. You've got to try haven't you, do you know what I mean? She hasn't got a magic wand she can't go like that, do you

know what I mean? But she's been brilliant. She has. I'll give it a go. I mean she's

going out her way so I've got to go out my way haven't I?" (R1)

All residents reported improvements in their mental health or general wellbeing; for some brought about by a reduction in alcohol and drug intake (n =8). For others their self-confidence and mood improved (n =19), which led to them going out more and feeling less socially anxious.

"Yeah really good, off the anti-depressants, feel great. Really really good. I hold my

head up high when I walk out. I speak to people now. Don't want to be inside

anymore whereas before that was all I did. I was like a hermit. It just got to the point

where I wouldn't leave the house. Whereas now I'm on the garden, shops, here, there

and everywhere." (R4)

Outcomes for residents

The case lead way of working was reflected in improvements on the outcome measure completed by the 56 residents across the teams (Team 1 n = 28, Team 2 n =28). The scores for each of the five domains data were amalgamated to calculate a mean total score for each resident. This data were analysed using a 2x2 mixed design ANOVA with time of testing (time 1, time 2) as a within subjects factor and support team (team 1, team 2) as a between subjects factor. Results showed a significant increase in ratings using the outcome measure from T1 to T2, $F(1,54) = 49.3$, $p < .001$, $\eta p^2 = .48$. There was no significant difference between the two teams, $F(1,54) = .22$, $p > .05$, $\eta p^2 = .004$. and no significant interaction between the time of testing and team, $F(1,54) = .05$, $p > .05$, $\eta p^2 = .001$ This suggests that residents from both support teams are reporting similar, significant increases in outcome ratings from T1 to T2.
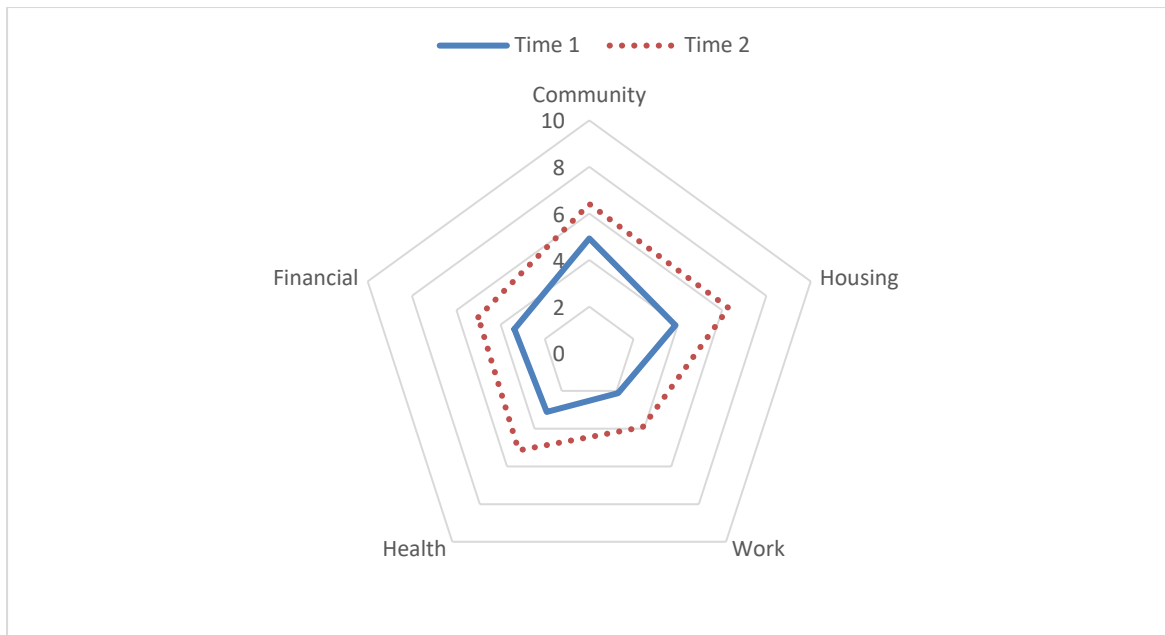
The means and significance level of each individual component of the outcome measure are displayed in Table II and illustrated in Figure 1.

[Insert Table II here]

Table II Mean Score for each Component of the Outcome Measure at Time 1 and Time 2

	Score at Time 1	Score at Time 2	Significance level
Community	Mean = 4.93 SD = 3	Mean = 6.41 SD = 2.87	$p < .001$
Housing	Mean = 3.89 SD = 3.89	Mean = 6.29 SD = 2.44	$p < .001$
Work	Mean = 2.11 SD = 2.92	Mean = 3.91 SD = 3.46	$p < .001$
Health	Mean = 3.11 SD = 2.58	Mean = 5.15 SD = 2.17	$p < .001$
Financial	Mean = 3.38 SD = 2.46	Mean = 5.01 SD = 1.99	$p < .001$
Overall mean Score	Mean = 3.49 SD = 1.85	Mean = 5.35 SD = 1.68	$p < .001$

[Insert Fig 1 here]

Outcomes for the Care System

The projected costs for the integrated teams' involvement were analysed for 35 residents considered representative of adults with complex needs who accessed support from either of the two teams. Analysis took the form of a 2x2 mixed design ANOVA with team involvement (with, without) as a within subjects factor and support team (Team 1, Team 2) as a between subjects factor., The results showed a significant main effect of team involvement on projected costs, $F(1,33) = 23.81$, $p < .05$, $\eta p^2 = .42$, highlighting that mean projected costs were significantly lower with team involvement. A significant interaction between team involvement and support team was found, $F(1,33) = 5.65$, $p < .05$, $\eta p^2 = .15$, suggesting that the difference between projected costs with and without team involvement was greater in team 1. There was no significant main effect of team on projected cost data, $F(1,33) = 1.85$, $p > .05$, $\eta p^2 = .05$.

The significant reduction in projected costs in both teams is shown in Figure 2.

 [Figure 2 here]

Discussion

The multi-level realistic evaluation framework applied across both teams as a case study of integrated working across Council departments provides support for the case lead approach as a facet of horizontal integration (Integrated Care Network, 2004).

Case lead craft consisted of a combination of direct work with residents supported by the wider team as necessary, as well as integrating care between agencies such as housing, police and local government. This approach has overtures with care coordination typically used in health and social work (Bailey, 2012). However, in the integrated teams case lead support reportedly included more intensive approaches. These were important to support residents to take small steps towards achieving their goals and go on to achieve outcomes that were significant; such as gaining employment, being rehoused, studying at college and managing their finances. This more enabling way of working with intensive support from the integrated team at times of increased need has overtures with assertive outreach interventions usually provided in specialist mental health services (Williams *et al.,* 2011). The positive change in outcome ratings between time points across both teams were clearly supported by residents' narratives.

Findings point to the importance of the team having 'time' to work with residents and in creative ways, unconstrained by eligibility criteria. These 'ingredients' were identified by Molyneux (2001) as contributing positively to integrated team working. The case leads shared their knowledge of their respective agencies and used their experiences collectively within the team, to address resident's needs simultaneously rather than in sequence. Gregson (1992) describes this as the multiplicative effect of integration which results in a

level of 'magic' or synergy within teams such that the sum of a team's activities become greater than the individual contributions.

The multi-level evaluation framework and mixed methods of data collection used had the advantage of capturing residents' narratives alongside quantifiable data, albeit reflecting self-reported outcome ratings and projected rather than actual costs. While the outcome measure is not sensitised to the integrated care context, utilising rating data alongside residents' narratives begins to address some of the gaps acknowledged in previous research particularly studies that don't include residents' experiences at all as identified by (Maslin-Prothero and Bennion, 2010). The evaluation captured greater insight into how residents' experienced the craft and graft of the case lead way of working, as well as case leads' own reports relating to the 'craft and graft' of delivering it.

The agency make-up of the team reflected the residents' needs in the district but with some key challenges. Housing, police, fire and rescue and DWP staff continued to act as case leads for the duration of the evaluation. However, a social worker from adult services acting as a part-time, seconded case lead had been withdrawn after a year in one of the teams because of workforce pressures in the County Council. The disciplinary make up of integrated teams to reflect population-based needs requires further research, particularly as the UK moves towards integrated care systems (NHS, 2019).

The case study provides rich description of the case lead way of working as one example of the craft and graft of integration in one district. The evaluation took place over a relatively short duration and the sample of residents with outcome data and who took part in interviews were self-selecting residents who had engaged with the teams for longer periods. This raises an unanswered question about whether all residents who engaged with the

teams experienced the case lead approach as positive or only those who remained engaged with support for longer. This requires further investigation.

The design of the evaluation supports Goodwin's (2013) assertion that multi-level evaluation frameworks, employing realistic methodologies have a worthwhile role to play in learning lessons about how care for those with complex needs might be integrated in future.

Conclusions

In conclusion case leads delivered the craft and graft of integrated working across Councils' departments by acting as a single point of contact and coordinator of services for residents with complex needs. A multi-level, realistic evaluation framework suggests that residents benefited from the approach as reflected in their narratives and improved ratings of their quality of life over a 6-month period of case lead involvement. Similar experiences were reported in integrated teams spanning two neighbourhoods, of similar deprivation and with similar need profiles. This suggests that the model of case lead working, in integrated teams may be replicable in communities with similar levels of need and deprivation. A more sophisticated, cost benefit analysis using actual rather than projected costs would be beneficial to evidence the impact that this way of integrated working could have on public funded services.

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