HOME TRUTHS
HAVE WE FOUND THE KEY TO INTEGRATION?
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INTRODUCTION

This document introduces an evaluation report from the Health Services Management Centre and the Institute of Local Government on wave 1 of the Home Truths programme.

Reflecting on the evaluation and the insights from Home Truths leads us now to assert that unless NHS England the LGA, plus councils and CCGs immediately focus on trust, the £3.8bn Integration Transformation Fund will be wasted.

“Integration” is now clearly defined as the success measure for sustainable health and care. The focus of change efforts in the short term are on developing plans for the Integration Transformation Fund by March. The LGA and NHS England’s Statement on the health and social care Integrated Transformation Fund1 references a definition of integrated care2.

“I can plan my care with people who work together to understand me and my carer(s) allowing me control, and bringing together services to achieve the outcomes important to me.”

The definition is followed up with 38 descriptors, very few of which are currently measureable. The challenge is now to work out how you measure and then deliver the vision in reality. We have found that trust is the key. Ultimately the question becomes “do citizens trust care”. This will be the most powerful measure of successful integration.

Importantly this reflects the financial pressures facing the NHS and Councils. The public need to trust the new health and care “offer”. As Sandie Keene (President of ADASS) points out “somehow the high public expectations will have to be managed down towards a new realism” and there are “precious few signs that the task of informing the public is truly in hand”3.

Setting out to increase trust is a complex, but achievable thing. It requires an understanding of the complex nature of trust, which include purpose (overlapping objectives, Do patients think that what is success for them is success for you), planning (has communication worked, have you built a shared understanding and discussed options?), performance (perception of delivery of quality services).

Part of the power of the concept of integration is it then implies a flow of trust. Home Truths has identified the importance of, the lack of and the need for an understanding of trust between professionals. A trust audit offers a powerful evaluation framework for the ability to maximising integrated care.

This approach moves us away from exclusively looking at large structural changes and instead builds a brand new foundation upon which the former can succeed. By focusing on trust and subsequently, behaviours, we believe that we can bridge the gap between failure and success. Care Minister, Norman Lamb MP, said in May 2013 that “unless we change the way we work… the care system is heading for a crisis.”4 We agree with this analysis but assert that our success will have as much to do with the relationships between professionals as it does with the structures we create to house them.

2 https://www.gov.uk/government/publications/integrated-care
Our premise is clear. Without trust, integration will fail. From our research and analysis (Home Truths – this is a programme of both research and projects) there is an appetite from citizens and professionals to develop closer and better working relationships but there is still a pronounced trust deficit. Our work explored the relationship between GPs and Social Care professionals in particular. We found that because of limited trust the information flow was severely hampered. As a result professionals were either unaware of the range of potential options open to service users or actively predisposed to make recommendations that reinforced the existing trust deficit.

There is much talk about the cultural change required to deliver integration. But this is seen as an intangible peripheral factor rather central as it too often ignored that it is individual behaviour – of citizens and professionals – that drives the care system. Accepting that to make integration work we have to change behaviours, off both professionals and citizens, changes the way you measure and deliver your integration approach.

We call for a new national and local conception of integration, with trust at the centre.

“The best way you can find out if you can trust somebody is to trust them.” Ernest Hemmingway

‘The Home Truths work has revealed some stark findings about the level of knowledge and understanding between health and social care professionals. It is clear that to make a reality of integrated support for vulnerable people, we need to accept and address some challenging issues about knowledge, understanding and perhaps ultimately trust between the health and social care sectors’. Catherine Mangan, Senior Fellow, INLOGOV
THE HOME TRUTHS PROGRAMME

Home Truths began life as a combination of quantitative research and sector discussions culminating in a report in Sept 2012 exposing the dysfunctional relationship between GPs and social care and highlighting the opportunity to reduce care demand and save £600m by improving it. Since December 2012, 11 areas (CCGs and councils) have been gaining more in depth evidence on relationships and impact and then implementing plans to change this situation and save money.

In each area the insight and opportunities have gone beyond just the GP and social care relationship. What has emerged is a new approach to Health and Care integration.

The Home Truths programme has helped us to develop;

- The Home Truths philosophy of change
- The Home Truths model of change for delivering integrated care.

In the coming months;

- We will publish more information on the philosophy and model of change
- We are starting a final group of CCGs and councils on the original HT programme (wave 3)
- CCGs and Councils will see benefits from implementing changes in the first 11 Home Truths projects (wave 1 and 2) – captured in a further report in April 14
- We will publish a report in November including an exploration of the potential to reducing A&E attendance based on understanding the drivers of behaviour
- We will launch further piloting programmes testing the approach in specific areas (details and expressions of interest to be published in November/December)

‘A positive relationship between general practice and social care is clearly vital if we are going to support vulnerable people in maintaining their health and well-being and it is surprising therefore how little we know about this relationship works in practice. The Home Truths programme has helped to shed a light on the current arrangements and provides a springboard to strengthening this in future’. Robin Miller, Senior Fellow, HSMC)
An example – trust impacting social care

The Home Truths programme has explored the impact of trust.

**The knock-on effect of low trust and risk aversion**

**Low trust environment**
Partner relationships, knowledge of how local services work and the level of confidence in local services is misaligned/uneven or poor

**Low tolerance to risk**
In a low trust environment, professionals will assess risks more cautiously and will view pathways which require trusted assessment and a high degree of coordination riskier than more simple, linear options

**Protective behaviour**
GPs will seek to transfer clinical responsibility to another clinician and ensure that the patient is placed in a ‘place of safety’
Other staff will go for the safest option

**Negative pathway decisions**
Risk aversion caused by low trust, poor knowledge and weak relationships disrupts pathways. Practitioners decide that community support that requires a high degree of partnership coordination are too risky and so seek simple options with a low level of complexity that remove risks, sometimes to the detriment of the patient

**High trust environment**
Partner relationships, knowledge of how local services work and the level of confidence in local services is aligned and generally positive.

**High tolerance to risk**
In a high trust environment, professionals will assess risks more positively as they have a higher level of assurance that risks can be managed for complex cases by involving multiple agencies

**Enabling behaviour**
Professionals will seek to take calculated risks to enable the patient to stay in the community, communicating with local partners to ensure that risks are managed

**High trust environment**
Practitioners will choose pathway options that promote independence and that treat risks as manageable and balanced/counteracted by tangible benefits. In particular, options that involve high levels of coordination and trusted assessment become viable

We found a lack of trust leads to a trend towards acute settings away from community based solutions
How trust and attitudes to risk affect demand and cost

**Low trust/‘risk averse’ response examples**
- Ambulance called; A&E attendance and hospital admission
- Medication: GP begins discussions with family about residential care options
- Respite (residential setting) GP contacts ASC ‘recommending’ long stay solution as carer can’t cope
- Family runs out of money. Council steps in to fund placement

**Health & social care pathway**
- **First Fall (minor)**: Fall pendant triggered – rapid response; referred to falls service
- **Early signs of dementia**: Pre-diagnosis support for patient & carer; respite & other support options discussed
- **Second Fall**: Identified by GP-led MDT; referred to ASC – pre-emptive respite (home-based or non-residential setting); light-touch homecare
- **Pressure from family for long term care**: Older adult moves into mixed need extra care accommodation

**High trust/‘risk tolerant’ response examples**
- Rapid response team; Support to self-administer meds
- OP calls 999. Call diverted falls response vehicle or rapid response team attends and treats in the home followed by reablement/rehab
- Carer support: Peer support signposted by council. Free emergency respite made available

Jeremy Cooper, Director, iMPOWER
HOME TRUTHS EVALUATION – BY INLOGOV

Summary
The Institute for Local Government Studies and the Health Services Management Centre at the University of Birmingham worked with iMPOWER as a critical friend to support the development of the Home Truths programme. As part of this we were asked to carry out an evaluation of the work of the programme for the Wave one sites. This involved carrying out interviews with officers who were involved in implementing the Home Truths programme in the six sites.

We found that the programme has raised challenging issues for the sites about the key relationships between health and social care professionals and the implications this has for the integration of health and social care systems, and ultimately user experiences and outcomes.

The incentive for joining the programme varied between the sites. Although some joined explicitly to reduce (or at least delay) the numbers of older people entering residential care, others saw it more as an opportunity to improve relationships between GPs (and hospital consultants) and social care or for improving the integration of health and social care more generally.

From our interviews we found similar themes emerging from the research across all the sites:

- a lack of knowledge and understanding amongst GPs about social care services. Where GPs do know about services there is a view from some GPs that these services are not good quality
- Relationships between GPs and social care are seen as poor, but GPs want to learn more and improve links, as they recognise the potential of social care services to keep older people out of residential care
- GPs have a significant influence on older people’s decision-making about care options; this is made more significant by the finding that older people don’t pre-plan their entry into residential care
- there are problems with communication around referral and assessment processes

We found that sites have begun to implement action plans to address these findings through a variety of approaches which aim to:

- Improve communication about social care referrals
- Improve access to information about social care services
- Train GPs and consultants about social care services and processes
- Embed joint working between social workers and GPs
- Influence the influencers of older people’s decisions about care

The implementation of initiatives to respond to the findings are at an early point and impacts on user experience, practitioner behaviour and use of resources will not be achieved until a later point. However, sites are confident that the interventions being developed will deliver benefits and have the potential to make longer term savings through reducing or delaying older people’s entry into residential care. One site in particular has committed to making a large budget saving through its plans.
Sites were positive about the value of working with an external organisation to implement the programme; reporting that access to unbiased, robust evidence had facilitated conversations between people that might not have been possible before; useful cross fertilisation of ideas from other sites and bringing a priority and focus to the agenda.

For the sites involved, the Home Truths programme has acted a useful catalyst and provided a focus around which health and social care professionals can begin to converge. It appears to have been an important first step in understanding and addressing the relational challenges of integration that lie ahead. It also suggests that areas could benefit from developing different approaches to integration that focus on these relationship issues in addition to the structural and service approaches being developed.

**Overview of the Home Truths programme**

The original Home Truths report was published in September 2012 and suggested that GPs were inflating demand for residential care because they don’t understand the alternatives and that by failing to address this issue, local authorities are failing to manage demand for residential care.

iMpower started working with six sites as part of Wave 1 in December 2012 to test out their findings and develop strategies for addressing the issues raised. The sites involved in Wave 1 were: Barnsley, Croydon, Hertfordshire, Redcar and Cleveland, Wiltshire and Wolverhampton. A second wave of sites were recruited in June 2013 (findings from these areas are not included in this evaluation report). An interim report was published in July highlighting some early findings from the sites. This final report builds on that and reports findings from the sites. A follow up report evaluating impact of the interventions will be published in April 2014.

The Home Truths programme consisted of three stages:

- **Stakeholder Engagement**: Engagement with stakeholders across the care pathway including social care staff, GPs, older people, the acute sector and VCS representatives.
- **Quantitative and qualitative research collected from GPs, older people and other stakeholders in the system**;
  - Older people’s survey (in 5 sites) to understand their influencers
  - GP survey to understand their relationship with social care.
  - Interviews with social workers, hospital discharge teams, acute sector staff, GP surgery staff, hospital management and third sector representatives.
- **Development of initiatives to address the issues raised**

“A man who trusts nobody is apt to be the kind of man nobody trusts.” Harold MacMillan
**Aim of evaluation**

The evaluation aimed to explore:

- what sites had hoped to gain from their involvement with the programme;
- what issues the programme had raised for them,
- the impact of working with the Home Truths programme
- what interventions sites were planning to implement to address the issues raised, and
- what, if any, impact there has been from their involvement with the programme.

**Evaluation Methodology**

Semi-structured Interviews were held by the evaluation team during August and September with key stakeholders who had been closely involved in the Home Truths programme in each of the six sites. Interviewees from health and social care were nominated by the Home truths team and those who chose to participate consisted of:

- 6 in local authority roles
- 3 in CCG roles
- 2 in a public health role
- 1 in a joint health/social care role

The evaluation was carried out once the final actions plans had been discussed and agreed with sites (in all but one site). At the time of interview the implementation of the action plans were at an early stage of development.

**Evaluation findings**

**Participation in the Home truths programme**

The evaluation found that there were three overarching reasons for sites joining the programme:

1. Sites that already knew they wanted to improve relationships or communications between GPs and/or hospital consultants and social care
2. Those that wanted to save money by ultimately reducing the number of people entering residential care
3. Those who saw it as an opportunity for improving integration of health and social care more generally. The development of CCGs, and the national agenda for closer integrated working between health and social care meant that there was enthusiasm from those responding to do something to work more closely together.

‘we had to become authorised as a CCG and I used this joint authorisation as part of our evidence of how we were working collaboratively with local partners (CCG chief officer)

Most sites were looking to achieve a combination of these outcomes.
The initiative to join the programme came from different parts of the system and is reflected in terms of how their participation was funded. In some sites it was funded through the CCG, in others it was from the council and in one it was funded jointly.

‘we were looking for some vehicles where we could get some quick wins, something to develop that relationship with GPs and the CCG and this seems an ideal vehicle...it was commissioned as a joint piece of work, so we jointly paid for it, and I think that’s quite important sort of principle (Local authority Director, adults and community service)

Key findings for the sites
Participants were asked to identify the key issues that arose from the programme in their sites. These insights arose in the main from the survey data and interviews with stakeholders. Sites were given access to their own data and combined data from all six sites as comparator data. We have used data from the combined survey results to illustrate these points where appropriate.

a) There is a lack of knowledge and understanding amongst GPs about social care services.

The sites found that a majority of GPs who responded to the surveys do not have knowledge of the social care, preventative services that exist in their area to keep people living independently in their own homes. For example, 59% of GPs said they knew nothing about telecare services, 31% knew nothing about exercise classes and 27% knew nothing about social support networks (see figure 1 below).

‘GPs know very little about social care and probably feel they don’t need to know much about social care’. (Local authority Head of service, adult social care)

‘I expected to discover that there were gaps in our services and that we needed to… plug those gaps, whereas one of the chief findings was that it’s really more about a perception of gaps more than service gaps so, in other words, GPs are not necessarily aware of all the opportunities, all the services that are out there to keep people independent in their own homes’. (Chief Officer, CCG)

‘Probably one of the things which struck me was…. how many GPs didn’t know what Social Care could do in terms of looking after the patients and you know that’s something I think I from Public Health assumed’  (Director, Public Health)

b) There is a view from GPs that some social care services are not good quality

Where GPs do know about social care services, the survey data showed that there is a perception that some of them are not of a good quality. Figure 1 shows that, for example, 47% of GP respondents rated respite services as unsatisfactory or very poor, 35% rated reablement as unsatisfactory or very poor and 31% rated intermediate care as unsatisfactory or very poor. Hospital discharge was also not considered to be of good quality by nearly half GP respondents, with 49% rating it unsatisfactory or very poor.
Sites also found there was a lack of understanding or wrong assumptions about some of the services:

‘our re-ablement service, which is one of our key services to keep people out of residential care, GPs either aren’t comfortable about what that’s to do with or they’ve even been misinformed to think that it’s oversubscribed and therefore there’s no point applying to it because they won’t be able to get the service’ (Local authority Development Manager, Peoples’ services)

c) More than half of GPs do not think they have a good relationship with adult social care.  
56% of respondents to the GP survey rated their current relationship with adult social care as poor/unsatisfactory.
Interviewees from the sites were in the main not surprised by these findings as they illustrated their ‘gut feeling’ about relationships between health and social care:

‘… it supported a lot of what we originally thought and also about the relationships of viewpoints from social care and GPs, there wasn’t really any surprises but I think what it did was it gave us a bit more evidence!’ (Integration lead, Joint Health and social care appointment)

The survey data provided the sites with hard evidence to share with others in the system, and interviewees were heartened by the positive responses:

‘the GPs’ response was very much that they want to build the relationship with social care and they want to do things differently with social care. So there’s a will to do things differently’ (Local authority Head of service, adult social care)

‘GPs and consultants who’d answered the survey or been part of the focus groups, also said they would like to learn more and be part of a change programme to, you know, resolve those … issues’ (Local authority Director, adult social care)
d) GPs recognise the potential of social care services in keeping older people out of residential care

Interviewees were encouraged by survey findings that showed GPs did recognise the potential of social care services. 92% of GPs agreed or strongly agreed that they would value closer links with Adult Social Care staff to understand local service offers better (see figure 3 below). This also illustrates that 76% of GP respondents said that they agreed or strongly agreed that they could be helped to do more to intervene earlier to delay or avoid the need for residential care admissions. The top three ways they identified of helping them to do this were:

- An easier/ more reliable way to refer patients on to social care
- A wider range of options to intervene earlier
- Having greater faith in referral options having a positive impact

The survey data also showed that 31% of GPs felt that at least some of their patients who had gone into residential care had been admitted before they needed to be, and they felt knowing more about social care services could prevent this happening in future.

Figure 3 GP views of the potential of social care services, summarised survey data
e) *GPs have a significant influence on older people’s decision making about care options*

The sites were interested in the data about who influences older people’s care decisions; in particular their decision to enter residential care. Older people were asked to respond to the question ‘If you were thinking about moving into residential care, which one person would you be most likely to go to for advice?’ After family, most older people stated they would go to their GP for advice. (this is the case for all sites except one, where more older people would turn to friends for advice than their GP). The data in Figure 4 has been shown by site to demonstrate the variation between areas.

**Figure 4 Breakdown of older people’s survey data by site: ‘If you were thinking about moving into residential care, which one person would you be most likely to go to for advice?’**

Interviewees found this data quite striking:

‘I think what emerges quite strongly was that after people’s family and friends, the views of your family doctor can be incredibly influential on whether somebody goes into residential care. I suppose that probably actually didn’t surprise me hugely, I know, I mean, family doctors in this country are, you know, kind of vastly respected, still….and are hugely influential, therefore, in terms of the choices that people make, but that emerged very clearly and I have that in the front of my mind as a, kind of, conclusion from Home Truths.’ (CCG chief officer)
Interviewees expressed some surprise at the findings that in most sites social workers had little influence over older people’s decisions:

‘in terms of the findings what was social workers’ ability to influence people’s decisions and I think we came out a zero, but I think that on reflection I think that the reality is that people have made their decisions before social workers get involved, it’s others that will influence the decision and social workers aren’t involved on a day to day basis in people’s lives, they do particular aspects. So, you know, it’s quite a harsh finding’ (Local Authority Director, Adult and community services)

It was not a surprise to interviewees that family members were influential, but it did make sites start to think about how they may need to provide these members of the family who act as decision makers/influencers with early, sufficient information to support informed decision making, prior to a crisis point.

‘one of the things we got from the survey was around the use of families and friends – that people … ask them for information and advice…first, really. So if Betty down the road’s got something, then they might be willing to consider that, but if that’s not their experiences, they’ll do the default and go straight to the GP’ (Local authority Development Officer, People services)

f) Older people don’t pre-plan their entry into residential care

Interviewees reflected that the older people survey data demonstrated strongly that older people do not see moving into residential care as a positive option. 61% of older people surveyed (all in receipt of social care) disagreed or strongly disagreed that they would want to move into residential care in the next three years. 68% of those surveyed were also living alone.

‘It confirmed what we thought which was nobody wants to go into residential care, it’s the last thing on their mind’, (Local authority Head of service, adult social care)

g) There are problems with communication around referral and assessment processes

Sites reported that the programme uncovered a lack of knowledge (often on both sides of the health and social care system) about referral and assessment processes. This was exacerbated by a lack of feedback on referrals that GPs make to social services.

‘GPs reported that they make referrals to social services and then we don’t inform them of the outcome’ (Local authority Director, Health, social care and housing)

Interviewees expressed some surprise at the survey data which showed that 41% of GPs felt they could make a better assessment than social workers about a patient’s need for residential care.

‘GPs also thought they could manage social care better than the local authority, and they referred for residential care rather than assessment so we need to change our information to them so that they understand the process’ (Local authority Director, Health, social care and housing)
In one area, interviewees reported that GPs were referring people to social care for inappropriate services:

‘they tend to send inappropriate referrals about, you know, I don’t want to be too glib, but it’s things like housing and potholes and drop kerbs and they send all that to social care’ (Local authority Director of Adult social care)

Summary of findings

In summary, the research and stakeholder engagement elements of the Home Truths programme raised challenging issues for the sites, which supported the findings of the initial Home truths report (add ref). The programme has highlighted for the sites:

- a lack of knowledge and understanding amongst GPs about social care services.
- a view from GPs that some social care services are not good quality
- poor relationships between GPs and social care, but a desire amongst GPs to learn more and develop improved links with social care.
- GPs recognise the potential of social care services in keeping older people out of residential care and want to be supported to make better use of social care services
- GPs have a significant influence on older people’s decision-making about care options
- older people don’t pre-plan their entry into residential care
- there are problems with communication around referral and assessment processes

Planned interventions to tackle the issues raised

Interviewees from all sites told us that they have developed an action plan of interventions to address the issues raised by the Home Truths research and stakeholder engagement. In several of the sites, there are already large health and social integration or transformation projects being taken forward and the specific actions being developed as part of the Home truths work are being subsumed into a larger piece of work. So for some interviewees it was difficult for them to untangle the specific Home truths interventions from the wider integration planning.

The planned interventions split into five areas:

**Improving communication about social care referrals**

Sites have put in place initiatives to improve the prospect of various care and health interventions being integrated through informing GPs about the social care support that has been put in place. In particular they have used processes to ensure that GPs receive feedback on the referrals that they make to social care services and are informed of the outcome of their referral.
• the (acute) trust has got something called e-discharge which sends a copy of the discharge report out to GPs and what we’re now looking at is incorporating the social care information into that’ (Integration lead, joint appointment)

• we are making sure that discharge summaries not only get to the GPs in time but also contain enough information to actually describe the care packages that is being put in place for the older person. So that’s not going to involve a lot of resource (Local authority, Public Health specialist).

• so when people make a referral from a GP, we actually tell them quite quickly that ‘thank you very much for your referral and this is what we’ve done with it’, I mean, we’re not giving them a blow-by-blow daily update, kind of thing, but just that bit of feedback so that if that person came back into their surgery, they at least would be able to see on the system that, ‘Oh, I see Social Services have been in touch and you’ve got this now in place.’ (Local authority Development manager, People services)

**Improving access to information about social care services**

Three sites are developing signposting for GPs so they can more easily access information about services that are available as a way of improving their knowledge. One site is considering setting up a shared portal across the CCG and council so that information about signposting activities can be shared. This was a popular response to the findings, although one interviewee sounded a note of caution: ‘So the signposts must be there but the back-up must be there to actually make the signposting effective’. (Chair, CCG)

**Case study**

One site is embarking on training for GPs and hospital consultants.

The site is considering linking their social work teams to GP practices, with, as part of that deal, the GPs having to undergo some training in what the social workers can do. They are piloting a training scheme for hospital consultants at their General Hospital, which has the biggest A & E pressures. The hospital chief executive has agreed that they can have two half day sessions to train their consultants on what to say and also what not to say. They are recruiting somebody permanently just to train clinicians. Recognising the time constraints the material will be fairly high level and will be kept up to date and supported by an on-line resource that consultants can use after they’ve been trained. The material could be used for other partners, like housing providers.

The site is hoping that once all consultants and GPs have been trained there will be lower numbers of people being admitted to residential care, and they have set expected budget savings accordingly.
Training for GPs and consultants about social care services and processes

Another site is looking to provide internal training for the GP surgeries, involving receptionists so that they have the knowledge about social care options and can use that to help early intervention, ‘so picking people up before they hit the formal crisis points’. (Integration lead, Joint appointment)

Another site is planning to deliver training to GPs and practice staff about the assessment process and how this links into their own demand management strategy.

Embedding joint working between social workers and GPs

One site is setting up a new team of social workers who will link with GP clusters. These social workers will have a role in contributing to the training of new practice staff in social care options and services.

One site has introduced a contractual incentive for their community services provider to look at how their staff deliver whole person care – originally the team was defined as an NHS team but since the Home Truths programme it’s been re-defined as a health and social care team.

One site is mainstreaming closer working; with an interviewee describing it as a dripping tap – ‘making sure that social care is ... equally represented on the agenda for certain things, that we continue the feedback arrangements with GPs, that we know the things that they are aware of that they’re missing or the things that we think they know about but actually they don’t’ (Local authority Development manager, People’s services)

Influencing the influencers of older people’s decisions about care

Following the insights from the survey about older people’s reluctance to consider residential care, two of the sites are considering how they provide timely, pre-crisis information to family members who may influence the care decisions of older people. Sites are considering how to upstream information and help people plan better for their future care options.

‘They don’t want it when they need it and when they do need it, they’re going to ask their daughter who lives down the road for it. So there’s something about how do you make it available, potentially on-line, or in a way that families can access, but that sort of idea of making plans for your social care needs, people generally felt unable to - or that’s not something they wanted to do, they thought it’s something that might happen one day and so they didn’t want to think about it’. (Local authority Head of service, adult social care)

One site has held information sessions in GP practices,

‘almost like mini market place sessions where we set up in a stall in a couple of GP surgeries and answered questions from people as they come in to the surgery and giving them leaflets and talk to the practice staff, which has been quite useful’, (Local authority Head of Service, Adult social care)

However they have found through these sessions that older people do not always want to get their information about social care from the surgery – they would prefer to get it from their
children, so they are considering how to make information available potentially on-line, or in a way that families can access it.

Another site is considering a similar approach:

*I’m thinking that the information that we give out to people, who we might think are aiming at service users, we really need to be telling people’s friends and families, you know, ‘this is available for your mother’, or whatever and a more generic kind of approach so that we should be working more with our neighbourhood community groups and telling them about the services that we offer’* (Local authority Development officer, People’s services)

**Potential savings from the interventions**

Although most interviewees referred to the expectation that they could make financial savings from the interventions, it is too early to be able to judge whether the planned interventions will have an impact on reducing the numbers of people entering residential care. For some sites this was not the prime incentive behind their involvement in the programme and they saw savings as a by-product of improving the integration between health and social care:

‘we’re aware that we can do things differently and make a difference and in the process also make some savings’. (Local authority, Public Health specialist)

However one site has been explicit about the savings they hope to make and has set themselves a target of a net saving of £1.1m (a gross saving of £716K from social care budget and £614k from the health budget). The savings will be achieved through improving the use of social care support so that residential care entry is delayed and health visits reduced.

‘so we think if we ramp this programme up then it might achieve savings that are already in the budget and we should see lower numbers of people being admitted’. (Local authority Director of Adult social care)

**Role of iMPOWER**

As part of the evaluation we wanted to explore the impact of an external programme as a potential agent for change. Most interviewees were clear about the benefits of working with an external organisation in this way. The feedback from interviewees fell into six areas:

- As an external organisation, iMPOWER had no ‘baggage’ and were able to provide an unbiased and robust evidence based view about the issues the sites needed to tackle:

  ‘So iMPOWER directly engaged with them, they went out to locality forums and they went with a, sort of, open mind and just inquisitive, you know, and there was no, they were unbiased and that was very helpful...’ (Local authority Director, adult social care)

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47% of GPs trust their own judgement over social workers in assessing social care need
This also meant that they were better able to engage a wide range of stakeholders than individuals from the specific organisations might have been:

‘the ability to pull everybody together, to have everybody sitting round the table and really looking at some of the issues and having those discussions across the different organisations and I think iMPOWER are a great supporter of facilitating that and getting people to think about things differently’.

As they were involved in implementing the programme in other areas, they were able to provide useful comparisons with other sites (although some interviewees said they would have welcomed more networking with the other sites)

iMPOWER helped the sites to think differently by bringing new ideas to the table

‘Because I think we all came with the impression of, yeah, the GPs don’t really know what social care is and vice versa, but they were able to go into the detail and facilitate those discussions with the GPs, with the social workers and come up with some really good constructive ideas that we probably wouldn’t have come up with on our own’ (Integration lead, joint appointment)

There was a clear and simple methodology, with a definite end point, so the work was completed:

‘what they also brought was a methodology so, you know, a research discipline and a rigour to get it finished because, often, bits of research are started here but then they’re de-prioritised when a crisis happens, but you know we bought them in and they kept to the task’ (Local authority Director, adult social care)

Having an external provider bringing a focus on a particular aspect of the health and social care system meant that the agenda was prioritised, when in reality it may not have been taken forward without this external impetus.

‘whilst if you’d sat me down in the pub and asked me what I thought, I probably would have predicted most of it, but actually it would never have got priority on my list of things to do!’ (Local authority director, adults and community services)

**Suggested next steps**

The Home truths programme has raised significant challenges and insights for the areas involved, which will be of interest to other areas looking to integrate health and social care. We suggest that the sites should continue to measure the impact of their approaches, so that the results and learning can be shared more widely. The networking and learning opportunities offered through the programme could also be continued to create a network of areas which can offer advice to others. Health and Well Being Boards in all areas could usefully consider how these issues might apply within their health and social care systems and initiate a constructive dialogue between partners about the relational aspects of integration.
Conclusion

It is too early to be able to assess the impact of the Home Truths programme on the experiences and outcomes for older people. However, it is clear from our interviews with the sites that the programme has had an impact on their understanding about the challenges they face in integrating the health and social care system. They have found that in order to facilitate an integrated approach they will all need to accept and address some challenging issues around knowledge, understanding and perhaps ultimately trust between the health and social care sectors.

All of the sites had gained insights and new evidence from being involved in the programme. Interviewees spoke about it being particularly useful as a catalyst; providing robust data to underpin anecdotal evidence, and giving health and social care organisations a focus around which to gather.

‘I think it was a very helpful catalyst,……because it was what people themselves had said, it wasn’t just someone else’s view. If I just said it, it would be just my view, but it was corroborated based on, OK it was only a sample but, I mean, basically you could extrapolate some pretty key issues in there’ . (Local authority Director, adults and community services)

Participants welcomed the networking that had taken place so far and were keen to continue to learn from each other.

Perhaps the biggest impact has been simply to aid the health and social care professionals to start a constructive conversation with each other:

‘I think the biggest impact is actually getting people to actually talk to each other and think about an integrated approach. I think that is really the most important thing that I think we’ve got out of this’ CCG Chair

50% GPs don’t trust hospital discharge teams to make decisions in the best interest of their patients
HOME TRUTHS
HAVE WE FOUND THE KEY TO INTEGRATION?

Quotes
‘The Home Truths work has revealed some stark findings about the level of knowledge and understanding between health and social care professionals. It is clear that to make a reality of integrated support for vulnerable people, we need to accept and address some challenging issues about knowledge, understanding and perhaps ultimately trust between the health and social care sectors’. Catherine Mangan, Senior Fellow, INLOGOV

‘A positive relationship between general practice and social care is clearly vital if we are going to support vulnerable people in maintaining their health and well-being and it is surprising therefore how little we know about this relationship works in practice. The Home Truths programme has helped to shed a light on the current arrangements and provides a springboard to strengthening this in future’. Robin Miller, Senior Fellow, HSMC

Biogs
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Robin Miller is a Senior Fellow at Health Services Management Centre and the health and social care delivery lead at the Third Sector Research Centre. His research focuses on integrated delivery between public, third and private sectors, and joint commissioning of community based services. He is the co-editor of the Journal of Integrated Care.

Organisational biogs
The Institute of Local Government Studies (INLOGOV) is the leading UK centre for the study of local public service management, policy and governance. With over 40 years of experience working within local government and the public sector, the Institute of Local Government Studies creates the latest thinking for public servants. It delivers policy and management research, continuing professional and management development and consultancy work for central government and other national and local agencies. One of its strengths is its close links with the world of practice in local government, the voluntary sector and other public service agencies.

The Health Services Management Centre, based in the School of Social Policy, is one of the leading centres specialising in policy, development, education and research in health and social care services in the UK. HSMC’s prime purpose is to strengthen the management and leadership of these services and to promote improved health and well-being.
FURTHER INFORMATION AVAILABLE

**The Home Truths white paper**
Available to download here:
http://www.impower.co.uk/public/upload/impowerdemandmanagementhometruths.pdf

**Home Truths – Information for GPs**
Two page summary of the prototype programme. Available from iMPOWER

**ADASS Spring seminar presentation**
Home Truths presentation from the 2013 ADASS Spring Seminar

**Media coverage of Home Truths**
Via websites: Guardian, MJ, localgov, Government opportunities, local government executive, practice business, GovToday, Community Care, Kings Fund, Active Care Thinking, Health Matters

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