How do older people in receipt of telecare services both utilize and experience these services? Has this changed as a result of Covid-19 and how does this link with their use of ICT generally?

Summary of the Project:

The central aim of this project has been to qualitatively explore how telecare services are experienced by older people as a result of the changes brought into the services as a result of the Covid-19 pandemic. In particular, the research endeavoured to understand how telecare services have supported or replaced usual services. Customers have also been asked about changes in the telecare service they would like to see continue, be discontinued, or introduced in the future. In doing so, the research augments a report produced during 2020 which investigated service level changes; 'Delivering Telecare Services During the Covid-19 Outbreak'.

Another goal of the project has been to evaluate respondents' use of Information and Communications Technology (ICT) during the pandemic. The data was used to assess whether general use of ICT could be used to help people feel connected and to mitigate the effects of the pandemic on experiences of loneliness and social isolation.

Finally, the project aimed to determine the extent of contact with family and significant others prior to, during, and after the Covid-19 lockdown periods, thereby assessing any significant changes in contact/involvement, and the extent to which these correlated with feelings of loneliness and social isolation.

Areas Covered

The project has allowed us to examine and compare the experiences of telecare provision during the Covid-19 pandemic amongst older people from three different regions in Scotland. This has been achieved with the support of three HSCPs. These comprised two city areas in the north and south of Scotland respectively, and a region consisting of both rural communities and small towns. The city area in the south has been labelled area A, the area consisting of both rural communities and small towns, area B and the city area in the north, area C. This has facilitated our better understanding of differences and similarities between customers' experiences of the telecare provision during the pandemic.

Telecare Services

Telecare services can be described as the provision of care services at a distance, using a range of analogue, digital and mobile technologies[1]. Telecare can be provided as a stand-alone service to give a person and their family peace of mind and reassurance, or can be provided as part of a wider package of care and support.

Technologies range from simple personal alarms, devices and sensors in the home, through to more complex devices and systems, such as those which monitor daily activity patterns, home care activity, enable 'safer walking' in the community for people with cognitive impairments/physical frailties, detect falls and epilepsy seizures, facilitate medication prompting, and provide enhanced environmental safety.

Telecare devices relay information from a person's home or community to call handlers in a 24/7 monitoring centre, or an individual responder such as a housing support worker, carer or family member, for it to be acted upon in some way. Telecare services aim to prevent unsafe conditions developing and enable a quick response should an incident – such as a fire or a fall – occur. Many telecare services also offer a telecare responder service, which provides an in-person response to an alert, when required.

Telecare services currently support around 182,000 people in Scotland to live safely and independently. Around 75% of people receive their service from their Health and Social Care Partnership[2], with the remaining 25% receiving a service from their housing provider or an independent organization.

Key Findings:

- Participants:
  Some 29 customers (mean age: 74) were interviewed over zoom or telephone. The mean duration of the interviews was 54 minutes. The sample size comprised 22 females and seven males. 14 of the participants indicated that they lived in area A, eight were from area B and six from area C.

  In line with the TEC report suggestions (2020), all telecare service users in this sample size were recognised as of greater risk of serious illness from Covid-19. Additionally, all participants reported that they were shielding during the lockdown/restriction periods.

  Two main cohorts emerged from the interviewed customers – those living in sheltered housing and those with other forms of tenancies. 14 service users reported that they lived in sheltered housing (all area A residents), whilst fifteen indicated that they had other forms of tenancies (areas B and C). Differences and similarities in the experiences of telecare and other services between these two cohorts will be further discussed in later sections of this report.

  Seven out of the 29 participants reported no close contact with family. In four of the cases, reasons for this were absence of a family. However, these customers reported contacts with/the involvement of significant others, such as friends, former colleagues, personal tutors and communities (e.g., church communities). The other three customers reported that their families lived far away. This report describes the experiences of telecare and other services in this group considering their apparent higher dependency on the telecare service. It appears that these customers are particularly reliant on the responder element of the telecare service due to the lack of an identified contact to provide a response (i.e., no close family or friends nearby). However, this also goes hand in hand with reassurance that assistance could be provided if needed.

[1] A National Telehealth and Telecare Delivery Plan for Scotland to 2016: Driving Improvement, Integration and Innovation - gov.scot (www.gov.scot)
[2] Insights in social care: statistics for Scotland - Support provided or funded by health and social care partnerships in Scotland 2018/19 - Insights in social care: statistics for Scotland - Publications - Public Health Scotland

Ten out of the 29 customers reported receiving a package of care. Only four of these 10 individuals also reported absence of family networks. Frequency of care package provision varied between four times a day to twice a week based on the individual's illnesses and needs. Further details regarding this subgroup will be provided within the following report.

- Telecare:

  Amongst the entire cohort, 19 customers reported having a personal alarm such as a wrist band or a pendant whilst 7 telecare users reported that they have pull cords, most frequently in their sheltered housing. The pull cords are most likely to have been installed by the housing provider, although it is notable that these customers were unclear about their provider and this did lead to some confusion about the overall nature of the service. In seeking further clarification regarding this, the researcher asked customers which service responded to them once the alarm has been triggered. Unfortunately, this did not bring any further clarification. Some customers reported that a housing support worker responded when they used the pull cord system, whilst for the customers who had a personal alarm (i.e., a wrist band or a pendant) in addition to the pull cord system, this was not necessarily the case. This suggests that some of the sheltered-housing respondents might have been provided with more than one telecare service and were unsure about where the responder might come from.

  One customer reported that they had a bed matt, one service user's data is incomplete, and another reported they opted out after seven years of using the telecare service (the individual reported using cords). Finally, five out of these 19 telecare users reported that they had both cords (within their sheltered housing) and a personal alarm, whilst two customers out of the seven participants that reported using cords were initially expecting to receive a personal alarm (pendant/wrist band). However, due to the Covid-19 pandemic the two individuals did not receive the pendant/wrist band/alarm system. Again, although customers were not clear about the supplier of the equipment, it appears that the older cords (probably supplied by the housing provider) were gradually being replaced by newer and more personalised equipment provided by the local Health and Social Care Partnership.

  All interviewed customers stated that they had not used the telecare service more often during the pandemic, consolidating the findings from the report published in 2020 (TEC,2020). The most significant change in the service was the transfer from home review visits to telephone reviews of systems. Customers were also asked by their telecare provider to perform monthly checks of the system by either pulling a cord or triggering their personal alarm. This process was not specifically developed for the pandemic but was a pre-existing standard practice. During the pandemic, however, this practice became increasingly important for the telecare service because of their desire to adequately support customers. This included having confidence that the equipment was working correctly with this being closely linked to the health and wellbeing of the customers.

  Customers in this research reported not formally being informed about any changes in the service or being offered information about additional support services by their telecare provider. As highlighted earlier, many were also unclear about who was providing the service. For those that had two devices, interviewees were unclear whether they had one or two providers, and if the latter, the nature of the link between the two.

  Because two main cohorts (telecare users living in sheltered housing and customers in other forms of tenancy) emerged from the interviewed population, an analysis of telecare use, comparing the two cohorts, appears relevant. The research examined differences in the length of time that customers had used a telecare service. The average duration of usage for customers

accommodated within sheltered housing and using a pull-cord system was found to be 11 years. In contrast to this, HSCP telecare users with a personal alarm had used that service for 4.3 years on average. On occasions when HSCP telecare customers had been using the system for a prolonged period of time (such as over ten years) this was either because of an early diagnosed ill health, or because the customer had used the system to assist a significant other followed by a decision to keep it for their own needs.

Another issue that has been considered within this research is whether telecare service users received any proactive wellbeing calls during the pandemic. Individuals living in sheltered housing reported the most frequent calls. These were usually undertaken by the housing support worker on a weekly basis at the beginning of the pandemic. With the easing of restrictions and lockdown measures, customers were contacted by their housing support worker and asked again how often they would like to be contacted by them – weekly, every two weeks, or once a month. The tendency for most residents of sheltered housing was to request a fortnightly call. This appeared to be because they did not feel the need to be contacted every week. However, the once-a-month call option was reported by the customers to be insufficient. For individuals who reported a desire to be contacted weekly, this was usually related to their needs (e.g., restricted mobility, severe illness, record of frequent falls). All 14 customers who reported that they lived in a sheltered housing accommodation and received calls from the housing support worker were from area A. Importantly, only two of the 14 customers living in sheltered housing also reported that they received care at home services. Various responses emerged when the remaining 15 customers from areas B and C, who reported that they had other forms of tenancy, were asked if they had received any proactive calls. Six out of the eight telecare users from area B reported that they did not receive calls from the service or the council. The remaining two customers from this area either did not report any data in response to the question or said that they had been contacted regularly (twice a week) by a staff member from the telecare service. For the customer reporting the twice a week contact with telecare, the calls terminated once he was no longer shielding. The customer described this aspect of telecare as a "great service" that contributed towards reduced feelings of isolation. Finally, the regular contact by the telecare service was not based on the absence of significant others. Two out of the eight (in total) customers explicitly said that they would not like to be contacted by telecare if the service was not required (e.g., an alarm being triggered). Amongst all interviewed area C telecare users (six customers overall), none received any proactive calls by the telecare service or council during the pandemic. Five out of these six customers would have been happy to be contacted, whilst one reported that they felt they received everything they needed from the telecare service at this stage and no extra calls were necessary. The telecare service report (2020) highlighted that in order to minimise duplicate calls, some areas implemented a red/amber/green system which targeted those in greatest need. Red would be the highest risk group due to no care package being in place and a lack of significant others, leaving the telecare service to provide a response in an emergency. It could be argued that this group could have benefitted from an outbound call during the pandemic. From the service users who reported that they had not been contacted by the telecare service in this research, only three did not have any family/significant others living close by or were receiving a package of care – all these three individuals came from area C.

A variety of responses also emerged regarding the provision of new equipment such as key safes and personal alarms. One service user from area C reported that they needed new equipment (a bed mat), which was immediately provided by the local telecare provider. From area A (sheltered housing), two customers reported that they were due to receive a personal alarm, in addition to the installed system, within the sheltered housing complex. However, due to the pandemic this was postponed. They were not clear if the personal alarm would be provided by the housing provider or by the Health and Social Care Partnership. It is also worth noting that many telecare services had to prioritise referrals early in the pandemic (TEC,2020) which could be the reason for the

delays sheltered housing customers experienced, with those living in non-sheltered housing being given priority. One service user living in sheltered housing in area A also reported that they had been waiting for a key safe to be delivered, however this too was postponed due to the pandemic. Another area A sheltered housing resident reported that they had been provided with a key safe but were reluctant to use it due to the negative experiences of a neighbour (someone broke in and robbed her flat). As customers were often unclear as to who the provider was, the reported differences in time taken to provide equipment could stem from the fact that telecare services were not the only providers of equipment.

With the ease of restrictions, five customers from sheltered housing reported that three month/annual checks were performed via a physical visit rather than over the phone. It was only customers living in sheltered housing (area A) that reported these physical visits. On these occasions, one individual entered the premises, wearing the adequate PPE required, and executed the check. It is likely that the physical check of the pull cord systems was executed by a housing support worker as usually the interviewed customers referred to the individual performing the checks as a "warden" or "someone from the council". All these customers described this event as one that had just recently restarted.

The TEC Report (2020) found that prior to the pandemic, a review of personal information and health status was performed by the telecare provider on a yearly basis. All the interviewed non-sheltered-housing customers reported that yearly reviews have not been performed since the beginning of the Covid-19 pandemic as a result of the imposed lockdown and social distancing restrictions. Instead, it was customers' responsibility to report any changes of circumstances, their health status or personal information.

In relation to monthly tests of the telecare systems, customers reported no changes with a continuation of a pre-existing practice where customers activated their alarms to perform monthly checks of the system. Nevertheless, area B made additional efforts to ensure customers remembered to perform this task. Service users, specifically those in sheltered housing (area A), were also asked by the housing providers to pull a cord that triggered the alarm system every time they were leaving their home. This, however, was once again perceived with mixed feelings by the service users. On some occasions this resulted in feelings of higher safety, although in others it generated feelings of lack of independence and even service termination (for one service user).

Most of the service users in this research described the telecare call handler response to alarm triggers as 'nice' and 'friendly'. However, some said that they felt the responses were short and slightly formal. This suggests that perhaps some telecare users did not view the service as an emergency response but had expectations of a more proactive, befriending role from the service.

The move from review visits to telephone calls for those in sheltered housing also received a mixed response. Some service users reported that they were more than happy for the telephone checks to continue as this saved on material resources and time for the services. It also provided more independence for the service users. However, others said they would prefer physical visits and more human contact. Finally, the resumed housing support worker maintenance calls and visits were described by some as short and formal compared to those carried out previously. According to the interviewed customers, this stemmed from the fact that many housing support workers were no longer living in the residential premises and lacked consistent contact with the service users. Two customers reported that the frequency of housing support workers' calls was regulated by the council and not based on individual needs and requests. These individuals reported that they used to get weekly visits/calls from the housing support worker and now only received calls once a fortnight. For one customer this resulted in inconvenience because of the assistance the housing support workers used to provide, namely assistance with correspondence. It

is notable that most sheltered housing residents viewed the absence of a housing support worker living on the premises in a negative manner.

- Other Telecare issues:
  Across the whole population, customers from both sheltered and non-sheltered accommodation (16 service users in total) described the telecare service received as excellent and did not raise any further issues. One customer (not sheltered accommodation) reported that they had no experiences of the service as they had not used the service at all. Another customer's data was missing due to an incomplete interview.

  Amongst the cohort of 14 customers living in sheltered housing, 10 reported having no issues with the responses provided. They described the service as friendly and supportive when the cord system was pulled and assistance was needed. Additionally, it became evident from the interviews that customers did not only use the service as an emergency response but also for advice and general assistance (e.g., on some occasions customers pulled the cord to support a neighbour's needs; in other situations, the cord was used as a mean to complain to the housing support worker regarding an issue such as a neighbour feeding foxes; finally, the cords were also used when assistance with a housing issue was required, such as heating problems). From this sheltered housing cohort, four customers reported issues with the housing service and the cord system in place. For instance, one of these four service users described an issue with "not seeing the purpose of the cord system if there is no warden on the premises". It became clear from the interview that the housing support worker had been absent from the premises during the entire lockdown period. This resulted in one customer stating that "I feel like we pay a lot of money for nothing or very little service." Another service user from these four raised the issue of lack of independence because one sheltered housing scheme required customers to pull the cords every time the service user left their home. One customer also shared that for her this housing requirement once resulted in a "frantic call from a family member panicking she is missing as reported by the sheltered scheme" as she had forgotten to pull the cord on the way out of the house. After this occasion, the customer decided to opt out of the cord pull facility. This decision was made on the basis of a couple of factors: 1) a family member lived in close proximity to the customer, and 2) good health status of the customer. The other two customers raised issues in relation to the nature of calls, with one stating that "they can be not very polite sometimes if you speak to the wrong person. Sometimes you pull a cord and you think they are not really interested". A customer also questioned the efficiency of the support provided, stating that having pulled a cord to get assistance with her heating the service was "not very helpful". A general observation from the responses, as stated above, was also that the absence of a housing support worker on the premises was generally regarded as problematic, not only in relation to emergency situations, but with regard to general feelings of security, well-being and support.

  In response to the question about other issues related to telecare, customers not living in sheltered housing (15 in total) provided more consistently positive responses. In particular, three customers did not raise any issues in relation to telecare, four described it as an excellent service (e.g., "The most reliable of all services"; "Excellent service when required"; "A godsend to me"; "Amazing service. It makes me feel as there is somebody else in the house at night"). Of the remaining customers, one reported that the service had not been used and one customer's data was missing due to early termination of the interview. Only three customers raised issues with the service. One of these three service users (area B) described having problems with the attitude and behaviour of the night service call handler and the emergency responder. The customer further stated that the issue had been previously raised and reported to a telecare service manager responsible for the area. Because of the nature of the interview (very short and agitated) and the early termination of it by the customer, the interviewer was unable to further explore the circumstances. The second

customer from the three individuals reporting issues with the service related the problem to a lack of independence (area C). However, from the interview with the customer it was clear that the alarm was falsely activated, and as the telecare service could not contact the individual by phone an emergency response was initiated. For this reason, staff had been sent out as a response. Consequently, although this scenario might have resulted in the customer feeling a lack of independence, the service was clearly operating normal emergency provision. The last customer raising an issue with the telecare service lived in area C and described feelings of "disillusion" with the service and compared it to service provision in the past. They stated: "I am very critical of it at the moment. At the same time, I appreciate how much help it can be and has been". In this instance, the interview revealed that the telecare service was previously used to assist the customer with her husband. The customer found it extremely helpful and also reported that "it could have been a double tragedy" if they did not have the service due to her husband's health condition. The customer's feelings of "disillusion" with the present telecare service appeared to be related to the service being of less importance to the service user compared to the past, and to an occasion when the service was used by the customer not as an emergency response but for assistance with an issue relating to her central heating. Perhaps the most substantial and consistent telecare issue raised amongst users of this cohort was the cost of the service, a point made by four customers, all of whom were from area B. One of the four service users only briefly reported the issue. Another customer explained that "a lot of people let go of the service for this reason" but he thought that this decision was not rational considering old age and health issues. The third user who raised the issue stated that "I don't mind it because I can afford it but there are people that cannot". Finally, the last customer explained that the state benefits provided are insufficient to cover the care package and the telecare service. For this reason, these customers generally believed that the telecare service should be universally provided free of charge.

In relation to telecare, most customers did not pinpoint any particular examples of what they would like to see continuing or discontinuing in the future. In two cases, however, customers spoke about telephone reviews as something they would like to see continuing as a way for the service to save resources. Other opinions, however, differed and individuals reported that they would like to go back to the physical reviews and visits. This was particularly relevant for individuals in sheltered housing, but it also featured for other telecare users. Additionally, customers (two from area B and one from area A) reported that they would like to see more consistency in the staff responding to the triggering of an alarm. This was again related to feelings of uncertainty, safety and security during the pandemic. It is worth noting here that in many areas staff from other services were drafted in to provide response services, due to telecare staff shortages caused by Covid-19 related illness and safety precautions (TEC, 2020).

Overall, in terms of customer satisfaction, it is possible to summarise that customers were generally happy and satisfied with the telecare service. On the occasions when issues were raised it was usually related to either individuals living in sheltered housing, thereby issues with the housing service and not telecare per se, or with the individual context such as the customer's feelings of independence. From all interviews, and predominantly from the ones with the sheltered housing customers, it could be concluded that there is a clear desire for a more proactive and sociable service. This could relate to the continuation and extension of regular short 'monitoring' calls with proactive befriending contact, where an organisation such as Age Care, Scotland, follows up a monitoring call and actively contacts individuals who have indicated that they would like such an approach to be made, being used.

- <u>Experiences of scam calls</u>
  Generally, most of the participants (22) experienced scam calls. All service users in area B experienced scam calls, including the two service users that mentioned having a screening service. The number of scam calls, however, depended on the screening services customers had in place

and on whether the users received scam calls on additional electronic devices. For this reason, customers with screening services in place reported significantly lower number of scam calls. In area A, some of the sheltered housing participants paid for the service (a mobile ban), had a landline ban provided by the housing service, or both, and thereby received fewer or no scam calls. There were no differences in the number of scam calls reported by customers using call blocking technology provided by the local authority. However, that the majority of the interviewed customers reported a significant increase in scam calls during the pandemic. The customers described the number of calls as: “doubling during the pandemic”; “a lot”; “plenty”; “constant” and “multiplied enormously during the pandemic”. Most service users easily recognised the scam calls and in response hung up on them and/or blocked the number. Only two of the 29 interviewed customers explicitly reported that they felt less safe using other services because of the scam calls they received, whilst one stated that they had “never really thought about security and if it makes me feel less secure…I suppose not.”. Indeed, one of these two individuals also stated that his generation “is victimised by scam calls”. Furthermore, in relation to ways of handling the scam calls, one individual reported that a friend advised her how to manage the calls, whilst another (from sheltered housing) reported that a representative from Santander came to the sheltered housing scheme and provided support for the residents in handling the issue. There is also the matter of the difference between ‘cold calls’ and ‘scam calls’ to consider. Most of those interviewed used the terms interchangeably. This raises questions about how calls relating to well-being checks could be treated as scam calls and ignored.

- <u>Use of Technology:</u>
  Some 21 out of 29 participants confirmed that they used technology. Six of the remaining participants reported that they did not use technology, whilst two did not discuss the topic with the researcher as the conversation was terminated at an earlier point. In their responses, customers reported the use of various technology devices. The devices reported varied from iPads/tablets, computers, and smartphones to smart speakers (Alexa). The customers explained that they used technology predominantly for emails, google searches, online banking, communication (e.g., video calls and photo exchange), and online shopping. A wide variety of social platforms were also mentioned as a way to maintain communication with significant others, for instance, Zoom, WhatsApp, Facetime, Messenger, Facebook, mobile phone, landline.

  The customers who reported not using technology provided reasons such as no interest in technology, limited available time, and most importantly, lack of access to a device or the Internet. Two customers had a device but no access to the internet as a result of financial concerns. The following phrases emerged from the data in support of the aforementioned: “I am not a tech person. My daughter taught me just how to text”; "I am a complete technophobe. Computers are just alien to me"; “Could not afford it”; “I have access to internet, but I am not an enthusiastic computer user”. The six individuals who reported not using technology to any extent lived across each of the three areas included in this research. Accordingly, no regional pattern of lack of technology use was observed, and the majority of those interviewed used technology.

  Most of the interviewed customers also reported that they had acquired technological skills with assistance from a significant other. On more rare occasions, older people learned how to use technology by attending technology classes as part of a previous occupation, or with the help of assistance provided in sheltered housing.

  Older people who used technology did not generally mind using it for communication purposes but also expressed a clear preference for physical human contact. This was evident in their responses: “You live in a community and have to be part of the community. This has been missed.”; “Technology might bite humanity back at some point.”; “I don’t think social media helps, it tells you to do this and that with friends and family, but what about the ones that do not

have them. It makes you even lonelier." The preference for human contact over technology was also described as an "age thing". It is also noteworthy that some customers did not feel very efficient using technology because this was something that "came very late into their lives." Nevertheless, for six of the participants, technology had played a very positive role during the pandemic: "I do not feel as disconnected as I would without technology"; "It has become an essential". Use of technology sometimes even resulted in an increased social contact.

Generally, based on the information reported in this research, it could be concluded that the emerging data stands in contrast with recent US and UK research reporting concerns about older people being less likely to have skills and resources to deal with digital communication and maintain social contact via technology (Van Jaarsveld, 2020).

Conclusions

This project allowed us to gain insights into the experiences of older people in receipt of telecare services during the pandemic. These experiences included telecare service changes and feelings of increased loneliness and isolation. Findings demonstrate that in line with the previous TEC (2020) report, older people did not report increased use of telecare services during the pandemic. Similarly, in relation to the question whether, or how, telecare services have supported or replaced usual services, there were no significant aspects reported by the customers. However, based on narratives shared with the researcher, it could be concluded that telecare provision has been used as a first instance provision for not only medical issues but also for everyday life support on many occasions. For instance, customers were sometimes referring to telecare in order to seek advice and help with matters such as electricity supply, medical issues such as access to GP practices, health centres and medications, general household maintenance and as a source of information for other support services. This once again highlights that although telecare is by design an emergency service, it is often used and seen by customers as a trusted and valuable means of support.

In relation to changes that telecare service users would like to see continuing or discontinuing in the future, it appears that the respondents often did not aspire for any substantial change, whilst the overall level of customer satisfaction was excellent. It is of note that respondents often expressed various opinions about the replacements of physical reviews and visits to telephone ones. Some customers were entirely satisfied with the telephone reviews/checks, whilst others, who had previously had home visits, expressed a clear desire for the service to return to the physical reviews/checks. Importantly, the customers experiencing and valuing physical visits most were predominantly amongst the sheltered housing community. This raises the important question of whether customers within sheltered housing exhibit a preference for physical visits due to potential closer community relations and the habituation to more frequent visits by the housing support worker. Indeed, this has been echoed in our findings, suggesting that most sheltered housing residents viewed the absence of a housing support worker living on the premises in a negative light. It can also be highlighted that with regard to potential changes, a small number of customers (2) emphasised a desire to see more consistency in the telecare provision of staff responding to an alarm trigger. This is a response that could again be linked to heightened feelings of insecurity and uncertainty amongst some respondents during the pandemic. Considering the increased telecare staff shortages caused by the pandemic and the subsequent safety precautions (TEC, 2020), this could be a relatively challenging change for consideration and mitigation by the service.

Customers reported mixed responses when asked if the telecare service performed any proactive outbound calls to enquire into their health and wellbeing during the pandemic. The responses

varied based on location and accommodation, with individuals in sheltered housing being contacted most frequently, mostly by a housing support worker. Most individuals valued proactive calls although this could be related to overall expectations of the service. There were also comments related to the increased cost of telecare services with some expressing the view that the service should be free.

Regarding the respondents' use of ICT, the findings in this report suggest that the majority (21) of customers within this cohort used technology and, contrary to the view of Van Jaarsveld (2020), had the skills and abilities to do this independently. Furthermore, it is evident from the findings that technology has proven useful, at least to some extent, in mitigating the effects of the pandemic on loneliness and isolation, enabling people to continue to feel connected in times of global crisis. There tended to be a preference for verbal systems such as Alexa with linkages to zoom, panic buttons and so on, but on-line social media was widely used as a means of keeping in touch. However, in relation to social care services, the customers reported that whilst useful, they did not feel that technology could ever replace the need for physical human contact. This was particularly evident amongst the cohort of customers within sheltered housing where a sense of community had traditionally been fostered by the wide variety of activities, events and service provision that had now ceased and currently lacked replacement. It is of note that whilst most of the interviewed customers stated that they were able to supply and use the technology needed for maintaining connections, there were individual cases where customers described either a financial inability to afford a technological device and/or connectivity (i.e., internet), or a lack of social support to learn how to use ICT. More particularly, two customers reported that services were suggesting online shopping as an alternative to going into stores and therefore minimising the risk of exposure to the virus. However, one of those customers was only provided with a technological device but no access to the internet, inevitably limiting the impact of accessing ICT. On another occasion, service shortages and prolonged lockdowns prevented ICT assistance from being provided to the customer. This highlights a not unusual contradiction in that whilst service providers generally tend to assume that older people have a problem using technology, technological forms of assistance such as on-line shopping and banking are often recommended. Similarly, assumptions can be made about on- line accessibility without checks being made that the prerequisite resources are in place. However, it can be concluded that ICT has been an incredible assistance to older people in maintaining connections during a particularly acute crisis.

Most interviewed customers (18) reported increased levels of loneliness and social isolation during the pandemic. This was also associated with a recurrence of ill health and greater use of medication. It was also linked with concerns about neighbourliness, in that Covid-19 and the concomitant restrictions were seen to have brought in a new social wariness and a perception that neighbours were not allowed to be neighbourly. Some also reported that the Covid-19 restrictions were the 'new normal' and that they had little time left for a resurgence of community. Many were also aware of the contradiction between Covid-19 shielding and 'lock down' measures being enacted to protect older and 'vulnerable' people, whilst at the same time many older people were being left to manage with much reduced or no support. A frequent comment was that they had been forgotten. Those in sheltered housing appeared to be most affected by prolonged periods of isolation and there appeared to be a push back to older people themselves being left to restart activities such as the 'community hall' and community activities. It is interesting to note that the less contact with support services an individual had, the less likely they were to contact services and ask for support. Poignant comments included "Loneliness is my trouble"; "Nobody is interested"; "You feel like nobody is there. You are totally alone"; "I feel cut off from people.".

The findings also highlight that increased feelings of loneliness and isolation, although linked to the reduction of available services and activities, were also clearly associated with reduced social contact with families, significant others and organisations, such as the church. ICT including social media clearly helped but did not make up for the lack of direct contact and engagement.

Many however referred to the importance of hope and being involved in something, albeit on line or via social bubbles, that generated reciprocity. This was associated with having a purpose, ensuring that there was always something to look forward to and, despite the lack of face to face interaction, connecting in ways that felt meaningful and helpful.

Recommendations

This was a small scale, qualitative study reaching 29 customers. Whilst representativeness cannot be claimed and taking account of sheltered housing considerations, it is notable that many of the older people interviewed in the three very different areas said very similar things. Accordingly, a key recommendation is that older people's views, experiences and expertise are taken fully on board in the further development of telecare provision. This is particularly germane in relation to changes designed to address the shortage of social care workers and developments related to lifestyle monitoring, medication prompting and other forms of responder services. It is also pertinent in the light of the development of the National Care Service for Scotland.

The majority of the respondents in the study reported decreased social contact with significant others and involvement in daily communal activities during the pandemic which exacerbated feelings of loneliness and isolation. A significant tranche of literature stresses the implications of social determinants such as feelings of loneliness and social isolation upon physical and mental health, wellbeing, morbidity and mortality rates (Kuiper et al., 2015; Leigh-Hunt et al., 2017; Valtorta et al., 2016). Taking this into consideration, together with the data gathered, there are implications for telecare as well as for other support services. Telecare is by design an emergency service, but the data indicates that it is often used and seen by customers as a trusted and valuable means of support. One future direction for telecare is to continue to consistently develop a more proactive approach with increased emphasis being placed on 'friendly' calls and possibly home visits with greater links to more intensive social care and health services. However, given resource constraints, another option would be to expand existing collaboration with voluntary and third sector organisations. This would enable those customers wanting greater interaction and/or help with a particular issue to agree to be contacted by 'befriending' schemes run by organisations such as Age (Scotland). This could facilitate telecare, third sector and other services working in partnership to adopt a preventative approach which could in turn ameliorate some of the effects of loneliness and social isolation and the associated escalation of mental and physical ill-health. The development of the National Care Service for Scotland (NCS) could also serve to facilitate additional cohesion between telecare and other social care support and health services in the facilitation of well-being promotion.

In terms of increased feelings of loneliness and isolation, there are also specific considerations relating to the participants in sheltered housing to highlight. These participants appeared to experience greater changes than those living in other forms of accommodation. Many of these participants reported experiencing a diminishing sense of community and connectivity as a result of discontinued services, hobbies and activities, and through the absence of a housing support worker on the premises. These changes appeared to have led to increased feelings of insecurity, uncertainty and abandonment. There were also reports of sheltered housing provision being opened up to a wider variety of societal groups, without existing residents being consulted or having support systems in place to manage resulting issues. A recommendation, based on the survey findings, is that post Covid-19 sheltered housing service provision should look to restoring and replacing services (i.e., access to community halls/rooms, supporting services and networks, trauma informed self-harm projects, bus services etc) that are highly valued and were discontinued as a result of the pandemic. The presence of a housing support worker on the

premises was also highly regarded as the warden not only co-ordinated community activities, but helped with day to day issues and ameliorated feelings of insecurity.

Regarding the use of ICT, data from our respondents suggests that technology may indeed play a key role in developing and sustaining feelings of connectivity and in mitigating increased experiences of loneliness and isolation during and following the Covid-19 pandemic. One of our recommendations for future research and practice is to consider the significant number of respondents, within this project who reported abilities, resources and a desire to use technology as opposed to the existing norms and prejudices deeming older people to be "technophobes" (Oudshoorn, 2011). A small number of individuals appeared to be reluctant or embarrassed to engage with technologies, but in most instances this was related to financial inability to cover expenses for a device/network or an absence of support in terms of learning how to use the device. As highlighted earlier, the paradox of some services providers recommending that customers go on line for their shopping or for other reasons without checking the availability of an appropriate device, connection to the internet and/or support on how to shop on line, needs to be noted. This leads to the recommendation that in order to improve services and networks, those involved in social care should facilitate the availability of accessible technological support with this being linked to assistance to ensure connectivity. Alternative innovative technological approaches which allow individuals to stay connected and remain cognitively active other than platforms such as Zoom, Skype and WhatsApp, could also be considered for customers with particular disabilities such as visual impairment.

Overall, our data suggests the effectiveness of ICT usage in mitigating the effects of the pandemic in terms of feelings of loneliness and isolation as well as for addressing practical day to day needs. However, it needs to be noted that although ICT usage was widely valued, the respondents also emphasised the importance of real-life human contact. For this reason, our long-term post Covid-19 recommendations relate to the importance of the replacement and continuation of services, networks and activities which allow older populations to maximise face to face contact and valued social engagement opportunities.

Considering the emphasis on a person-centred approach within telecare services, an issue that can also be raised relates to the importance that many of the respondents attached to feeling independent. This was highlighted by both sheltered-housing respondents and those from non-sheltered-housing settings. For this reason, two recommendations can be made; one relating to sheltered housing provision and one to the general telecare service. Within sheltered housing provision, in order to maximise feelings of independence and to prevent the risk of installed systems being abandoned because of requirements perceived as restrictive (e.g. residents having to pull the cord every time they leave their accommodation), there can be seen to be a need to take account of individual needs and requirements rather than a blanket approach requiring all service users to observe the same generalised regulations being routinely applied. Alternatively, the need for adherence to a particular practice could be communicated more fully with feedback loops being put in place. With regard to telecare services, more information could be provided on how to avoid the accidental triggering of alarms and how to stop an emergency response following an accidental triggering.

Technological responses are continually evolving and developments related to lifestyle monitoring, medication prompts and other forms of responder service models clearly offer potential efficiency savings for already hard-pressed social care budgets. Lifestyle monitors, for example, can provide insights into service users' daily routines with this information being used to efficiently target individual needs facilitating the already adopted person-centred approach within telecare practice. However, as highlighted it is important that attention continues to be paid

to the views and experiences of service users in informing usage and developments. The significance of independence, which was referred to frequently in this study, needs also to be fully taken into account. It is also important to acknowledge that although the innovative and quickly evolving technological approach embedded within the telecare services can assist in addressing social care staff shortages, be insightful tools in the daily experiences of telecare customers and ensure quick responses to emergency situations, a human presence in social care remains very important (Eccles, 2013; Woolham et al., 2017). Accordingly, our final recommendation relates to ensuring that particularly in times of difficulty, full attention is paid to maintaining an appropriate balance between evolving technology which serves a crucial role and direct face to face interaction. This recommendation can also be associated with the need for greater cohesiveness going forward between health, telecare and social care services.

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