Proactive Telecare Outbound Calling

Evaluation Report

September 2021

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Acknowledgements

Thank you to the members of the steering group who provided their guidance and support to the project.

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A special thank you goes to the staff, customers and managers at Bield Housing and Care, working with Midlothian and Inverclyde HSCPs and with Linstone Housing Association; Edinburgh Health and Care Partnership working with Care Call 24; Dumfries and Galloway Health and Care Partnership; and Stirling Council. Your openness and willingness to share your experience have made this evaluation possible.

Executive Summary

This interim report presents the findings from Phase 1 of the independent evaluation of introducing Proactive Telecare Outbound Calling in four test sites across Scotland:

- Site 1: Bield Housing and Care, working with Midlothian and Inverclyde Health and Social Care Partnership and with Linstone Housing Association
- Site 2: Dumfries & Galloway Health and Social Care Partnership
- Site 3: Edinburgh City Health and Social Care Partnership
- Site 4: Stirling Council (not active)

Purpose

This report appraises the testing of Proactive Telecare Outbound Calling (herein referred to as Proactive Telecare) as an enhancement of existing Telecare services in the four test sites. It retrospectively analyses the approaches applied by the different test sites and factors that are critical for delivering effective and efficient strengths-based person-centred proactive calling. The report describes the experience of people receiving the calls and their unpaid carers, discusses the experience of staff and considers the implications of Proactive Telecare for local health and care services. Finally, it presents options for designing and evaluating the proposed Phase 2 of the Proactive Telecare project.

Methods and Timescale

Following selection by the Digital Health and care Innovation Centre (DHI) and the Scottish Government's Technology Enabled Care (TEC) programme in May 2021, an interdisciplinary and cross sector team with the required expertise commenced the evaluation in June 2021. Ethical approval was granted by the University of the West of Scotland in June 2021 and retrospective data collection was carried out between June and September 2021. Co-design and partnership working with the TEC Learning Collaborative and national stakeholders contributed to successful completion of the Phase 1 evaluation in line with agreed timescales.

Key findings from Phase 1

- Implementation of Proactive Telecare to enhance existing Telecare services was achievable on a relatively small scale as a test of change.
- Three of the four test sites embraced this new way of working and felt optimistic about scaling Proactive Telecare in the future.
- Stirling Council was not able to continue as a Test Site due to increased pressures during the Covid-19 pandemic resulting in staff shortages and reduced resources. However, their experience of proactively managing Telecare customers who were shielding was not dissimilar to the experience of the other three test sites.

- Partnership working is critical for success and enabled a relatively new approach to be rapidly implemented in three test sites in a six months pilot. However, sites underestimated the time required to build relationships and trust, train staff, screen and assess suitable customers, and secure the required permissions to share data.
- The tests sites targeted different customers highlighting the applicability of Proactive Telecare for a wide range of customers from those who have low intensity needs to those with more complex issues who are more dependent on technology.
- Local intelligence is vital to the identification of customers, alongside screening/risk stratification tools. Further research is required to determine the best tool(s) nationally to support local delivery.
- Staff, carers and customers involved valued Proactive Telecare positively. Job satisfaction increased for staff, and customers felt more connected and less isolated.
- Overall, test sites reported low rates of referrals to statutory services and a good balance between referrals to primary care and community services and signposting to local community and voluntary supports.
- The ambition and management support for Proactive Telecare is evident across all three test sites. Continued success and roll out rely on investment in staff time to undertake the role and in training and workplace support/supervision.
- A more robust cost effectiveness analysis will be required if financial investment is to be secured.
- Proactive Telecare may be considered as an additional role to be undertaken by selected trained staff or a more generic approach that all Telecare call handlers can deliver. The introduction of Proactive Telecare presents the opportunity for Telecare providers to consider their skill mix and / or create strategic partnerships for delivery.

Looking toward a Phase 2 Evaluation

- Scale up for individual test sites will be different due to location, population and approach to proactive telecare. This provides an opportunity for test sites to consider the learning from other areas and pitfalls to avoid.
- Scale up is likely to be incremental with individual test sites building on existing approaches or completely revising their target audience.
- Unpaid carers should be considered as a bespoke customer group who may benefit from wellbeing calls.
- Phase 2 Test sites should clarify the purpose of Proactive Telecare within their customer base to better integrate their approach with the anticipatory care actions delivered by local health and care partners.
- A dynamic and flexible approach can be tailored for different customer groups including those who may benefit from a time limited service.
- Evidencing service and system impact may require a considerable lead time in customers who have fewer complex needs and who receive less intensive support from services. Assessment of benefits will be largely qualitative to illustrate personal and relational wellbeing outcomes in this group.

- Phase 2 methodology requires a revision of the measurement indicators for: Proactive call activity; staff contact and non-contact time; customer satisfaction and use of validated quality of life tools that are appropriate for an older population.
- Phase 2 evaluation of costs avoided in the short term may be feasible for selected Proactive Telecare customers with more intensive support needs. Client / patient level linked data will be required to track changes in Telecare, hospital and care home utilisation over time, where possible comparing with a matched cohort who has not received Proactive Telecare. Information on falls and medicines related harms may be useful secondary outcomes.
- The shift from Analogue to Digital nationally has the potential to create a more proactive approach to telecare and opens out the possibilities for further innovative ways to support people to live independently.
- The introduction of a National Care Service and investment in social care provision and workforce will also lead to increase use of proactive telecare as an innovative way to support people.

1. Introduction

1.1. Introduction

Personalising care, digital innovation, and the integration of health and care services have featured highly in multiple strategic documents aimed at reducing social and health inequalities in Scotland (Health and Social Care Scotland 2021; Scottish Government, 2021). Improving the quality of health and care services by revisiting what matters to people has enabled Health, Housing and Social care services in Scotland to innovate and develop initiatives that are anticipatory, proactive and embrace technological advancements to empower people to live longer, healthier lives and be cared for at home or as close to home as possible (Scottish Government, 2013, 2019, 2021). Proactive, digitally enabled anticipatory care is at the heart of the integrated model of care to prevent and manage frailty (Hendry et al., 2018) and is one of the five priorities in Health and Social Care Scotland's Statement of intent and a key ambition of the Digital Health and Care Strategy (Health and Social Care Scotland 2021; Scottish Government, 2021).

A new chapter in health and care has become centre stage in Scotland as a direct consequence of the COVID-19 pandemic. Telecare providers, like all health and care services rapidly employed emergency protocols; reconfigured services and in some instances re-deployed staff to ensure those in need to receive the necessary care and support. Digital delivery of services via virtual consultation methods, telephone and other technologies created more choice on how health and care services were currently designed and delivered (Greenhalgh et al., 2020).

Key research insights on the impact of COVID-19 have shown the benefits of digital delivery of services included improved access, user satisfaction and convenience for people. Collaborative communities, building trust, partnership working, and maximising people's expertise have all been recognised as factors that have contributed to keeping people safe and connected (Healthcare Improvement Scotland, 2020). However, a recent report by the ALLIANCE (2020) has highlighted the challenges of digital poverty and exclusion, poor digital skills, and reduced choice and confidence that digital services could provide the same level of care for some people impacted on Scotland's citizens (Bowyer, 2020, ALLIANCE, 2020). Scotland's Digital Health and Care strategy (2021) describes how digital will play a key role in how services rebuild from the pandemic; maximise opportunities for innovation and support those already marginalised so they are not left behind. The Scottish Government's Technology Enabled Care workstreams on the shift from Analogue to Digital and the scalability of Proactive Telecare make a significant contribution to realising these ambitions.

The move to digital directly influences and shapes Telecare service provision and is essentially the heartbeat of future integrated service delivery. Telecare providers in Scotland have commenced this journey supported by Local Authorities and the Scottish Government. The

availability of the Digital Telecare Playbook and the Security Assessment Scheme has guided the switch over and enabled services to ensure that the technical infrastructure, procurement of equipment and information governance processes are safe and robust (Digital Telecare, 2020). Moving to digital opens out more opportunities for proactive, anticipatory and preventative services to be provided. This is further echoed in the recent consultation on the National Care Service (Scottish Government, 2021) where early intervention and prevention are viewed as crucial to improving outcomes for people. The use of digital is signalled to support integration; inclusivity; interoperability and communication between health, housing and care providers; thus, improving outcomes for people.

1.2. Proactive Telecare defined

For the purpose of this report the Scottish Government (2016) definition of Telecare is adopted as:

> *"the provision of care services at a distance using a range of analogue, digital and mobile technologies. These range from simple personal alarms, devices and sensors in the home, through to more complex technologies 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".*

This highlights a complex social intervention involving the individual and their data; technology and the environment; and the important interconnected role they play in the real time monitoring of individuals to reduce health and lifestyle risks and promote independent living. It is estimated that 180,000 people in Scotland currently use Telecare as a predominantly reactive service to enable them to live independently at home or in a homely setting in their community (Public Health Scotland, 2020). A recent review of Telecare call handling identified that there are 23 Alarm Receiving Centres (ARC) in operation in Scotland and they receive 6.7 million incoming calls per year by service users requiring assistance. These calls are responded to by approximately 343 full time equivalents employed as call handlers (FarrPoint, 2020, 2021).

Proactive Telecare augments a Reactive Telecare approach by expanding and developing *a deeper relationship with its service user, gathering insights into patterns of behaviour and preferences over time, enabling a more tailored, anticipatory and preventative service that supports wellbeing resilience (Technology Enabled Care, 2020).* Integration and partnership working are central to this delivery of Proactive Telecare with outcomes focussed and strengths-based models of care promoted. A proactive, anticipatory and integrated approach to care has been shown to be effective in preventing or delaying the onset and consequences of frailty in older people by identifying early decline in functional ability or wellbeing in order to trigger appropriate interventions (Hendry et al., 2018; WHO, 2017). Strategies employed

may include signposting to a range of digital Information, advice or supports for wellbeing and self-management; referral to third sector supports such as community link workers or befriending services; and escalation to local health, social care and housing services such as falls, housing, rehabilitation or equipment services.

This evaluation of Proactive Telecare is timely and the findings from this report should be considered against this strategic landscape. The Scottish Government's Technology Enabled Care programme aims to advance its intelligence gathering on the unique challenges of delivering Proactive Telecare to ensure future developments are sustainable, cost effective and fit for purpose. This report provides an overview of the factors that have made this new way of working feasible within three local systems and to understand how the learning from this test of change can be used to scale up Proactive Telecare in Scotland.

2. Methodology

2.1. Mixed Methodology

The aim of this evaluation was to appraise the introduction of Proactive Telecare in a six-month Test of change initiative across four test sites in Scotland, leading to an assessment of the value, impact and scalability of the approach. Stirling Council was not able to continue as a Test Site due to increased pressures during the Covid-19 pandemic resulting in staff shortages and reduced resources. Therefore, the evaluation focused on the three active test sites.

A two-phase sequential design was guided by the following areas of inquiry:

1. To describe the contribution of Proactive Telecare across the four tests sites and map this to National health and wellbeing outcomes.
2. Appraise how Proactive telecare is integrated with the test sites and identify learning from and factors influencing change
3. To portray the experiences of customers, staff and providers receiving and implementing Proactive Telecare
4. To appraise the options for scaling up in Phase 2 of the evaluation

Phase 1 of this two-phase sequential project drew primarily upon qualitative methodologies to document the experiential journey of all those involved in the tests of change. Objective 1 was partially achieved however it is noted that quantitative analysis was more limited as the test of change was near completion when the evaluation commenced, and the number of participating customers was lower than anticipated. In addition, the three test sites focused on customers with differing levels of complexity and the duration of their participation also varied considerably. Therefore, it was not possible to collect comparable standardised data to support robust statistical analysis. Based on this limited data, the report sets out the options for evaluation methods and timescales to be considered for Phase 2.

2.1.1. Data collection

Secondary data was collected and analysed from each test site to summarise the process of implementing Proactive Telecare; call activity; partnership working; successes and challenges. This data informed the inquiry questions used by the evaluation team as they carried out a descriptive, exploratory qualitative study. Individual interviews were used to elicit a deeper exploration of the complex needs of the customers/unpaid carers and their experience of receiving Proactive Telecare. This approach was deemed appropriate to allow for expression of personal views and feelings on a topic without being influenced by, or feeling intimidated by, other people's (potentially different) perspectives (Silverman, 2011). Focus groups were used to support the elicitation of the views of staff delivering calls as a group within the individual sites to share their experiences and aspirations in relation to the delivery of Proactive Telecare.

The evaluation team co-produced and co-delivered a Learning Collaborative event to inform the next phase of the Proactive Telecare project and related evaluation. This event supported sharing of experiences between the test sites and facilitated the transfer of learning and good practice across the sites and with national partners. This event added value to the evaluation by connecting all involved in the tests of change with strategic partners and influencers to consolidate and compare learning as well as shape the direction of Phase 2 for each site.

2.2. Ethics, Permissions and Privacy Impact Assessment

Ethical approval was granted by the University of the West of Scotland Ethics Committee. A privacy notice was included in the Ethics application and a Privacy Impact Assessment (UWS PIA 29) produced to assure customers, staff and the multiple agencies involved of how data would be accessed, stored and managed. All participants received an information sheet about the evaluation and consent was gathered prior to data collection. Permissions to access customers and staff was facilitated by a named person at each test site. Covid-19 restrictions remained in place during the period of data collection therefore all contact with participants was facilitated via Microsoft teams video calls and the telephone. To protect the anonymity of service, staff and customers in this report no names, locations or services have been identified in the quotations used.

Sampling and Recruitment

A convenience sampling approach was used to recruit available staff, customers and unpaid carers to this phase of the evaluation. As stated, recruitment was facilitated via a named manager at each test site. The project was driven by a collaborative approach and several initial (Getting to Know You) meetings were arranged to establish working relationships with the Telecare providers across the test sites. These conversations are included in the data analysis.

Table 1 illustrates the breakdown of participants by test site and data collection approach. In total, 25 participants were involved across five focus groups and seven interviews. Data collection totalled 523 minutes or 8 hrs 43mins. Individual interviews ranged from 11mins to

63mins (average: 29mins) and focus groups ranged from 30mins to 90 mins (average: 52mins) in length.

Table 1: Breakdown of participants

Role	Test site	Number of participants	Data collection method
Customers/carers	Bield D & G Edinburgh	N=2 N=1 N=4	2x Interviews 1x Interview 4x Interviews
Staff	Bield D&G Edinburgh	N=3 N=4 N=5	1x Focus group 2x Interviews + 1x Focus group 1x Focus group
Getting to Know you Meetings	Bield D&G Edinburgh Stirling	N=2 N=1 N=2 N=1	1x Focus group 1x Interview 1x Focus group 1x Interview

Discussions were facilitated and the topic areas standardised with the use of semi-structured interview schedules including trigger questions and prompts. Dialogue with Proactive Telecare customers explored:

- general experience of Telecare
- likes, dislikes, preferences and suggestions for improvement of Proactive Telecare.

Conversations with staff investigated:

- how Proactive Telecare was implemented
- issues concerning customer screening and assessment
- approaches to signposting to support and escalation of concerns
- staff training and supervision
- benefits experienced, challenges encountered and suggestions for improvement

All interviews and focus groups were recorded and transcribed verbatim. A thematic framework analysis (Ritchie, Spencer & O'Connor 2003; Gale et al., 2013) was applied to analyse and interpret the information in terms of the person receiving the service and those providing the service.

An online Learning Collaborative event was co-designed and co-delivered with the four test sites and national stakeholders on 9th September 2021 (Appendix 1). The Learning Collaborative event reflected on the Phase 1 experience and considered lessons to inform Scale up of Proactive Telecare. Discussions were facilitated by inquiry questions to consider:

- Partners involved
- Customer screening, selection and call activity
- Processes for staff training; recording calls; signposting/ referrals; staff supervision

- Benefits experienced, challenges encountered and suggestions for improvement

3. Findings

3.1. Analysis of Three Test Sites

This section of the report provides a descriptive overview of the three test sites that recruited customers to receive Proactive Telecare. It highlights some important differences and similarities in their approaches. Table 2 provides a summary of each test site drawn from their project submissions, final reports, presentations at the Learning Collaborative event, and the series of interviews and focus groups with staff.

Table 2: Overview of Proactive Telecare (PT) in Three test sites

	BIELD	EDINBURGH HSCP	DUMFRIES & GALLOWAY HSCP
Telecare Provision	13,114 alarm units	9,500 customers	3,900 customers
Aim	To test Proactive Telecare for health promotion, prevention and earlier intervention to increase a tenants/ service users' ability to be independent and remain active, healthy and socially connected.	To test Proactive Telecare in supporting self-management and wellbeing of citizens and unpaid carers by identifying their interests and concerns; providing tailored advice, support, equipment and digital solutions to enrich their quality of life, autonomy and safety at home; reduce social isolation; prevent deterioration; prevent or delay dependence on formal services.	To test models for Proactive Telecare as an enhancement of an existing Telecare, identify all costs and benefits to establish desirability, sustainability and scalability, identify practicalities, challenges and enablers and identify how the findings will be used to further develop a Proactive Telecare service delivery model
Partners and Governance	Programme Board involved all partners: Bield Housing, Inverclyde HSCP, Midlothian HSCP and Linstone Housing Association	Weekly Implementation Team meetings led by ATEC24 Assistive Living Team (ALT) with key contacts from Edinburgh HSCP and Care and Repair Edinburgh	Aligned with new operational structures as Care Call Service moved to HSCP Single Access Point for HSCP community services. Close links with Council Shielding team
Target Customers (M=Midlothian; I=Inverclyde; L=Linstone)	M – Bield sheltered housing residents, early Life Curve, Limited TEC reliance I - Later in Life Curve, TEC dependent, social housing L - mixed group in sheltered housing	Frequent callers, who do not have regular access to care and support services. Also engaged their unpaid carers	Existing Care Call Clients with limited support network except family and no Care Package. Clients have 'capacity' to make daily independent decisions
Customer Recruitment	M- Intelligence from Bield local housing managers on suitability I–ARC information, Care Records and intelligence from local housing provider	Jontek call records triangulated with SWIFT care records to identify target group	Customers with no record of manually triggering their alarm were chosen. Tunstall Risk Assessment Tool and 9

	L- Proactive 'push' from sheltered housing provider		screening questions were triangulated with HSCP care records to identify those who may benefit from wellbeing calls
Customers offered PT	86 Midlothian 25; Inverclyde 50; Linstone HA 11	345	18
Customers accepted PT	48 (56 %) Midlothian 80%; Inverclyde 26% and Linstone 100%	139 (40%)	4 (22%)
Customers received PT	44 (4 early drop outs) Midlothian 20; Inverclyde 13; Linstone 11	131 (8 referrals not received by C&R)	3
Customers dropped out	4 – all early drop outs	55 (42%)	1 (25%)early drop out
Number of PT calls delivered	613	527	46
Duration of PT service	Customers called by same assigned staff member, initially weekly then more flexibly for a period of 22 weeks (M); 20 weeks (I) and 13 weeks (L)	Customers called weekly for 5 – 7 weeks by rotating member of staff from Care and Repair (Edinburgh)	Customers called weekly for 12 weeks by a single member of staff
Staff making the calls	Bield BR24 staff conducted initial screening calls and the Proactive Telecare wellbeing calls	ATEC24 staff conducted initial screening calls and customer surveys. Care and Repair Edinburgh staff made the wellbeing calls	Care Call staff carried out all calls – different members of team undertook the screening, wellbeing calls and customer satisfaction reviews
Additional Training	Good Conversations (Thistle Foundation); safeguarding; vulnerable adults. Proactive Telecare resources accessible on MS Teams channel	Edinburgh HSCP's 3 conversations, safeguarding and complaints, and escalation processes	No additional training but call handler was experienced and had worked in shielding team
Staff Supervision	Weekly buzz meetings with PM and regular feedback on call recordings	Escalation pathway to Assistive Living Team inbox for Care and Repair staff. Learning log and staff satisfaction surveys	Regular reflection meetings with team. Monthly customer satisfaction calls
Information flow and Data Sharing	No direct links between BR24 and HSCP records. Audio recording in Jontek	Required a new data sharing agreement. Manual notes of Proactive Telecare	Proactive Telecare notes / actions recorded on client records in Mosaic Social

	supplemented by Microsoft Form notes.	scanned to insert in CharityLog system, but this information was not linked with Jontek or SWIFT.	Work system accessible as per HSCP agreement.
Other Resources /additional costs	2 additional Jontek licences		Access to Tunstall's Risk assessment tool

The following sub-sections describe the success factors for building readiness, implementing and effectively integrating Proactive Telecare with local health and care services.

3.1.1. Aims and Scale

The aims and scale of the three tests of change were slightly different. Dumfries & Galloway's test of change was specifically framed as a discovery project focused on understanding the practical challenges and enablers of introducing Proactive Telecare to enhance their Care Call telecare service. Both Bield Housing Response 24 (BR24) and Edinburgh Assistive Technology Enabled Care (ATEC24) aspired to deliver intermediate outcomes for customers in terms of improved wellbeing, quality of life and independence. Edinburgh also aimed to prevent or delay dependence on formal services, an important system outcome but perhaps unlikely to be realised through this short-term prototype project.

3.1.2. Partners and Governance

Bield's project involved a complex collaboration between health and care services and three housing associations in Midlothian, Inverclyde and Renfrewshire HSCP areas. Edinburgh ATEC24 developed a new alliance with Care and Repair Edinburgh, an independent charity that is part of the Age Scotland Age Scotland Independent Living services and has an established telephony system and call handlers. The Dumfries & Galloway test of change operated entirely within HSCP structures following relocation of the Care Call Service and Contact Centre from Council Business and Transformation Services to a newly created Single Access Point for community health and care services.

3.1.3. Strategic Fit and Readiness

All three sites secured senior sponsorship and established the alliances required to progress their tests of change. Their project submissions and proposals were well aligned with the corresponding strategic plans and priorities for their organisations. However operational managers in all sites commented that they had not been directly involved in these submissions. With hindsight, they considered the original aims were overly ambitious in the short timescale. They highlighted the significant lead time needed to build relationships and trust with new partners and new staff.

For the Dumfries & Galloway site, the challenge of building readiness was compounded by ongoing organisational change. The previous hosting of Telecare services within Business and

Transformation services had helped with the technical aspects of preparing for Analogue to Digital (A2D) shift and upgrade of Care Call and ARC platforms, but was not an ideal fit for a 24/ 7 service for vulnerable people that brokers responder services from a mix of personal emergency contacts, private providers, and community health and care professionals. The strategic move of Care Call to the developing Single Access Point (SAP) for all health and social care enquiries streamlined access to support for issues raised during calls. This move was welcomed and described as "*bringing Telecare in from the cold"*. However, expediting this change during the six-month project resulted in some loss of organisational learning and management capacity as some key staff members did not move with the Care Call service.

Edinburgh's Test of change established an Assistive Living Team (ALT) and a weekly ALT Panel that involved ATEC24 staff with Alarm Monitoring and Response team, Sheltered Housing Support Workers Service, Falls Practitioners and direct links to locality hub services including social work assessment and reviews. The ALT Panel was an engine room for the project and a point of engagement with Care and Repair Edinburgh staff but had a much wider ripple effect as a forum for communication and mutual upskilling across teams to improve the coordination of enhanced Telecare. Partnership working and clear lines of communication were echoed as key learning at this test site.

3.1.4. Target population

All test sites were similar in the aims of the test of change, i.e. to reduce frequent alarm activations and demand on statutory services. To some extent, all teams adopted a preventative, anticipatory approach and included people with limited contact with the service. Each test site recalls debate about what type of caller to target and as the test of change commenced, they refined this further using risk stratification tools and local intelligence on call activity and service use. One site commented

"We flipped it. Our biggest learning was to move upstream and establish a relationship with those who don't call".

Both the Edinburgh and Dumfries & Galloway teams focused on telecare customers who may have family support but do not receive other statutory care and support services. Edinburgh also engaged with the unpaid carers of this cohort. Dumfries and Galloway targeted customers who had not manually triggered their alarm and then used risk stratification tools and local intelligence to determine those suitable for wellbeing calls. Bield's test of change addressed three different cohorts: residents of Bield's sheltered housing in Midlothian who were still largely independent in the Life Curve and had limited reliance on TEC; residents of Linstone's sheltered housing in Renfrewshire who had a similar profile to the Midlothian group; and older people living in social housing in Inverclyde who had more complex support needs, were TEC dependent and had average age of 88 years, some 20 years older than the other two Bield cohorts. Overall, a key strength of this project has been the opportunity to explore Proactive Telecare in different customer cohorts both across test sites.

3.1.5. Screening and Consent

The project provided useful insight into the complex process of engaging customers in a new service. In Midlothian, Bield staff could readily identify potential customers based on long established relationships between residents and sheltered housing managers. Managers commented:

"We can chap doors of our own tenants rather than send a letter seeking interest from our partners".

Similarly, Linstone Housing Association came forward with a readymade list of suitable and interested customers, having heard about the project in a news article and through social media.

Recruitment in Inverclyde proved more challenging as call staff recruited customers at 'arm's length'. Selection of potential customers was based on alarm data and review of social care records. Once again, local intelligence from another housing provider helped recruitment. Buy-in with local partners is necessary. Staff commented that

"Need someone in the partnership who is passionate to sell this as a best hope service".

In Edinburgh, triangulating data from ARC records and social work records generated a list of customers for more detailed screening calls. These were undertaken by ATEC24 staff who reported that many of the care records were not up to date on current circumstances, functional ability and support network. Although there was no consideration at the outset of project to include unpaid carers, the offer of involvement was welcomed at pre-screening conversations with customers. This quickly became embedded in their local approach to Proactive Telecare.

Dumfries and Galloway secured permission to use Tunstall's Risk Stratification Tool and nine screening questions. This was considered a reliable and robust approach as it has been used by Delta Connect in their scale up of Proactive Technology Enabled Care in Wales. The project lead adapted the screening questions to apply to their local context and customer group.

Across all three sites screening calls to recruit customers to the test of change ranged from 15 – 22.5 minutes in addition to 5 – 40 minutes for preparation and updating of customer records ranged from 5-40mins. Despite these screening efforts, overall only 40% of Telecare customers offered Proactive Telecare went on to accept the service. The approaches to recruitment using the established relationships and intelligence of local housing staff resulted in 80% uptake in Midlothian and 100% uptake in Linstone Housing Association. This highlights the need for a data driven approach to recruitment that combines intelligence of local partners with information from telecare and Health and social care records as test sites prepare to scale up. Recruitment of customers has shown to be resource intense across all test sites and reliant on good marketing skills of call handlers/administrative staff to sign up customers.

Overall, 178 customers commenced the Proactive Telecare test of change. Dropout rates were low but varied across the sites. One of the four consented customers in Dumfries & Galloway dropped out early due to a change in his health circumstances and life priorities. 8% of Bield Proactive Telecare customers discontinued their service. Edinburgh's high rate of

customers drop out (42%) may be indicative of the lengthy delay between screening and consent. Care and Repair staff stated that customers

"…forgot why we were calling … lots of hang ups and confusing first calls"

The delays were compounded by waiting on data sharing agreements to allow the external service Care and Repair Edinburgh to begin the Proactive Telecare service. Several members of staff commented that the consent process and supporting materials for customers could be simplified. Bield developed an Easy read letter and pre call planning questions in line with good Health Literacy practice. Their customers were invited to sign a Proactive Telecare service agreement that set out mutual expectations from the service.

3.1.6. Duration, Frequency and Continuity

Call times and duration were personalised, and person led. Edinburgh customers commenced Proactive Telecare in waves from March – June and were called weekly for five – seven weeks by staff from Care and Repair Edinburgh. These calls averaged 13.5 (range 6-21) minutes and customers were not assigned to a specific staff member. Dumfries and Galloway's customers were called weekly for 12 weeks by a single member of staff for an average of 20 minutes.

The Bield Proactive Telecare test of change also offered continuity of caller over five months (Midlothian and Inverclyde) and over 13 weeks for Linstone residents who came on board at a later stage. Bield's Proactive Telecare calls were weekly but then calls to their Midlothian customers reduced as Covid-19 restrictions lifted and people began to resume their previous activities. Weekly calls remained at Inverclyde and Linstone Housing Associations. The average duration of Bield Proactive Telecare calls was 24 minutes. Calls with the older customers in Inverclyde were longer in call duration than those with the two younger adult cohorts in Linstone Housing and Midlothian. One explanation for the increased call duration in Inverclyde was that those customers had more complex needs in comparison to those receiving wellbeing calls at other sites.

3.1.7. Referrals and Signposting

Managers discussed a perceived risk that the project could increase demand for services in the short term if call handlers uncovered considerable unmet need in the Proactive Telecare customers. However, this was viewed as a positive outcome if referrals enabled earlier intervention to improve wellbeing, reduce dependency and improve longer term system outcomes. Linked to this perceived risk was concern that customers may be escalated to statutory services rather than offered strength-based support to self-manage and identify their own solutions from local community assets. It was acknowledged that this risk may belikely if staff had limited experience and confidence in supporting people to draw on a range of options for self-care; or limited awareness of local resources. To mitigate this risk, two of the test sites offered their staff training on self-management and outcomes-based approaches. This was complemented by training in safeguarding and development of escalation processes to manage emerging concerns.

Bield referred 25% of Proactive Telecare customers to primary care, but staff reported many of these were customers who had been reluctant to approach their general practice team about their health issues during the peak of the pandemic. They did not make any direct referrals to community health and care services. Edinburgh staff referred only 4% of Proactive Telecare customers to primary care, but 8% were referred to community services and 11% had a change in their Telecare package. Around one third of Edinburgh's Proactive Telecare customers and almost a quarter of Bield's cohorts were signposted to non-statutory sources of community support. There was no systematic follow up information collected on the uptake and outcomes of this signposting.

Working with Midlothian Community Links practitioner, Bield developed a directory of local knowledge and community resources available to tenants, drawing on the ALISS resource. They said "*This became our go to resource"* for signposting customers to community networks and support. The Dumfries and Galloway site referred one customer to a community service, signposted two to community support and changed one individual's Telecare package.

Overall, test sites reported low rates of referrals to statutory services and a good balance between referrals to primary care and community services and signposting to local community and voluntary supports.

3.1.8. Information Flow and Measurement

The three sites shared challenges in accessing data from multiple systems that lack interoperability resulting in duplication of work to navigate across many IT systems. As Edinburgh HSCP contracted with a Third sector partner, their test of change required the approval of a new data sharing agreement. This resulted in a delay of three months between initial screening by ATEC24 and Care and Repair commencing Proactive Telecare. Once the outbound calls commenced, manual notes of the calls were scanned into Care and Repair Edinburgh's CharityLog system, but this information was not able to be linked with ATEC24's Jontek system which has no interface with social care SWIFT records. Similarly, although Bield developed a Microsoft form data spreadsheet and summary of Proactive Telecare conversations and wellbeing data to supplement the audio records in BR24s Jontek system, there was no direct linkage with the care records held by the HSCPs. Despite good partnership working and clear lines of communication this approach was resource intensive and impacted on the collection of data. Dumfries & Galloway developed a Proactive Telecare template that allows notes / actions to be recorded on client records in their Mosaic Social Work system. This data is then accessible to health and care partners as per their local data sharing agreement.

Bield staff adapted and tested the Wellbeing Wheel adapted the Delta Connect programme in Wales to identify and describe the impact of Proactive Telecare on the wellbeing of their customers. They reported that initially participants painted a positive picture however as relationships developed after the first 4 -5 calls, conversations became more 'honest' and participant scores were probably more realistic. They considered the tool was too detailed to be useful for every call and that it may work better when used at intervals over a longer time period. The Edinburgh test site applied the principles of the Delta Connect project to

develop a framework for personalised wellbeing plans with goals and outcomes clustered around three themes: Staying healthy; staying connected; staying active.

All test sites and associated partner organisations recorded calls, and this was viewed as a protective element for both staff and customers as well a quality checking process. Staff also had some non-contact time scheduled before and after making their Proactive Telecare calls to allow them to reflect on previous calls, prepare their script and make notes of the latest conversation. BR24 and Care Call staff estimated this non-contact time was 15 - 20 minutes per call and Care and Repair Edinburgh staff estimated it was around 5 minutes per call.

Prior to, and running parallel to this project and in line with the TEC workstreams, the test sites were supported to develop a comprehensive measurement framework that considered customer outcomes, balancing indicators and system outcomes. At present, this remains in its infancy and no reliable and consistent dataset has been established. Establishing the data set is a significant challenge compounded by multiple IT systems that are not linked, requiring significant manual work to interrogate systems and collate data. A sense of frustration exists across the sites that there remains no standard approach to monitoring customer experience and personalised outcomes. To promote the value of Proactive Telecare, additional data and capacity for data linkage are required to inform the business case and to complement the narrative around delivery and customer satisfaction.

3.1.9. Staff Training and Development

Role preparation and support was evident across the three sites in terms of providing additional training on the art of a conversation. The four BR24 call staff participating in the Proactive Telecare test of change undertook ''Good Conversations'' training provided by the Thistle Foundation. Care and Repair Edinburgh's staff members joined ATEC24 staff in two development sessions and some training on 3 conversations - an asset orientated, strengths-based approach that focuses on capabilities of people, families and communities. The Dumfries & Galloway staff member making the wellbeing calls did not undergo specific additional training but was an experienced Care Call handler who had also worked in the Council's Covid-19 shielding team.

All staff involved had experience of working as a call handler/operator dealing with reactive calls and had undergone a degree of training for that role. All staff identified that they initially found the new role challenging. They acknowledged that this was about changing custom and practice and moving away from a 'find out and fix' approach to relaxing and waiting for the person to talk. One participant said

"It was a shift to sit on your hands and listen. We've a lot of customer experience but we learned to listen more and not assume situations".

All agreed that the preparation for the calls helped them in other aspects of their job role and personal life. Several highlighted that the good conversation skills developed and influenced their approach to customers when dealing with reactive calls. This participant commented:

"You know, and it's helped me, you know, being a team leader as well and people managing. You know, listening to people, listening to others and not just jumping in. Making the

difference, obviously, at the start, you know, I found it a wee bit, just a little bit challenging, because we were told to sit back and have a good conversation and we were allocated, you know, an average time of forty-five minutes was, you know, … quite good".

The value of peer support was evident from the focus groups and the sharing of resources in teams helped the day to day delivery. This led to teams connecting and working together across organisations. The project leads developed conversations scripts with prompts and tips for those undertaking the screening and wellbeing conversations. The ATEC24 service has now been positioned as an innovation site for Edinburgh HSCPs work to spread adoption of the 3 Conversations approach. Bield named their project *Inspire* to reflect the purpose of the calls and to help motivate their team. Managers offered some level of individual and / or group supervision to reflect on calls, address concerns and support staff to manage their emotions as some customers shared intimate, complex, sensitive information.

3.1.10. Transition from Proactive Telecare

All test sites are now in a period of transition. Customers and staff were aware from the outset that the project was time limited. Accordingly, there was proactive discussion about transition to usual care and the need to identify those who required some follow up support for wellbeing. Bield Customers received a thank you letter at the end of the project and follow up was through local housing staff in Midlothian and Renfrewshire or through referral to Age Scotland befriending support for the Inverclyde cohort. The Edinburgh test site sent a follow up letter with a contact number for self-referral to Age Scotland's friendship line. There was no specific follow up planned for Dumfries Care Call customers, but staff suggested the new locality Home Teams would be the best forum for identifying appropriate transition support for their customers.

None of the staff wished to give up the new approach and returning to previous work practice was expressed as failing the project and the efforts made. One participant captures this stage well and says

"I think if we don't [move forward] we're kind of failing the pilot anyway. You know, you either believe in what we're doing here, and I do, so therefore you want to try and see where that moves on to"

Several staff highlighted that to move forward more clarity is required on the scope and purpose of Proactive Telecare as there is potential for it to be further expanded and better tailored to specific local needs and context. One senior manager reflected current ambiguity around the purpose of Proactive Telecare.

is it to prevent customers needing alarm calls in future or is it to reduce the number of frequent callers now?

Another senior manager suggested in future we may no longer view Proactive Telecare as an intervention for selected customers but consider it as an approach that can be tailored and personalised for all Telecare customers.

proactive Telecare has to be part of how we do our business as usual with all call handlers trained in proactive calling and have this as part of their job descriptions.

It was generally acknowledged that Proactive Telecare is not a befriending service – rather it aims to empower people and build their confidence and understanding of how to draw on their own strengths and access a wider range of community supports to live their best life.

3.2. Staff (Call Handler) Experience

The call handlers' experiences of delivering Proactive Telecare calls were explored through a series of focus groups and interviews. The findings from these focus groups and staff interviews revealed two main themes of job satisfaction and relationship building.

3.2.1. Job satisfaction

All call handlers found the new role rewarding and all agreed that they had gained a lot from participating in the project. They all shared individual stories of working with customers and reflected on the contribution they made to supporting and motivating others to stay healthy, stay connected and feel less isolated. One participant reflects:

"So, for me, it's been lovely to get to know people and, … the stories that people tell you and the things that people want to open up about, is amazing. So, the trust that you gain from that is just, for me, it just makes me feel like, 'Yeah, I am doing my job".

One participant said that they felt proud of the feedback they received as it showed that the customers "really enjoyed speaking to us, getting to know us".

Another *remarked that "It went right to my heart and felt as if I was doing something good".* As previously stated, staff began to see the benefits in other areas of their work. Talking about this issue, a participant remarked:

"I actually got feedback the other day from a team leader, that my emergency calls, I'm a lot more confident on them. So, and that can't be a coincidence that it's the project and then this. So, I think they've—both sides have helped me massively, I think. So, I like both".

3.2.2. Relationship building

A common view amongst the call handlers who participated was that their role in Proactive Telecare involved them building relationships with the customers. Only through this did they discover the unmet needs of the customers and the complexity of their lives. All agreed that calls were longer and more challenging and in one area they felt it would be "too intense to do every day". One participant succinctly said, you need to get into a 'mindset' when doing proactive calls.

It was also viewed as emotionally draining especially if the customer and or carers was upset or distressed. They viewed the training on developing conversation skills as standing them in good stead and some were in continually impressed with the 'power of silence' and using open questions to encourage people to talk. All agreed that it took time to build trust with

their customers. Once they had achieved this, they identified a range of unmet needs that the customer did not want to bother other professionals with, e.g. GP.

All reported they had underestimated the personal impact of developing a professional relationship with the customers. They described experiencing the highs and lows working alongside the customers and spoke of 'laughing and crying' at different times. Many staff found it difficult to let go and cope with some of the content shared; and all identified that they worried about the customers.

"On a normal call all I could do is case note it and send it on. I listened. Came off the call quite tired…I've taken a lot home… I think about them"

All staff felt unprepared for ending the relationship with the customers and expressed a range of emotions about how they felt, e.g. 'I feel sad'; 'I will struggle to let go'. Notably, they all worried about how the customer was going to cope as the Proactive Calls for some had been their only contact with the outside world. Balanced against this was the view that they felt they had begun to equip the customers with the skills to be more resilient.

3.3. Customer Experience

The customer experience was central to this project, not only in terms of their satisfaction with the service but for the test sites to consider whether they recruited the right customers to benefit from Proactive Telecare. The themes of satisfaction, value, community connections and isolation are explored.

Proactive Telecare customers all expressed the value of the calls to their lives. All customers interviewed reported enjoying the social aspect of connecting with the caller and the value of 'knowing someone was there'. Two of the customers expressed that they felt they benefited from referral onwards as a result of their conversations with call handlers. One man (Bield) explained how the call handler had helped him negotiate services to find new and accessible housing. He felt that without the calls he would not have been able to access the correct services and would remain in a top floor flat which prevents him leaving without support to go down the stairs.

I was just sitting, like I'm stuck in this house and I'm not going to get out. Nobody seems to be doing anything for me and then, along came [call handler], started the ball rolling, so that kind of cheered me up a wee bit.

Another customer (Edinburgh) described the support of the call handlers as she experienced poor health and felt that the support she received helped to fill a gap left by not having a social worker.

"I used to have a social worker and when there was a problem, you'd tell the social worker and they'd help sort it. Now we don't have that, so you know, we've got no one to off load to….so the calls helped."

Throughout the Covid-19 lockdown, the customers valued the social connection and expressed how the calls could be a 'highlight of their week'. They felt that the calls provided

an outlet for them to speak to someone out with their family. This allowed them to have a general chat, build a relationship with the call handler and offered an opportunity to discuss concerns and worries that they would not be comfortable talking about to their families. A customer (Dumfries and Galloway) described Proactive Telecare as providing her with a sense of security, finding it reassuring knowing that the service was there.

"Well… they show that they're caring that if anything happened between last Friday and this Friday… you're able to talk to them about it or, and they're more than willing to listen. And anything they can do to help, they will do it. So, it's a security thing as well, isn't it? When you live yourself"

She looked forward to the interaction as she lived alone and valued the regular contact as the calls helped orientate and anchor her to the day of the week. She found the call handlers warm and genuinely interested in her life.

"Well, I think they actually worry about the old people. They don't just… It's… They never leave you so that you feel lonely for too long. I get a phone call once a week from XXX or if he's on holiday, there's someone else phones instead and I have a talk to them for ten, fifteen minutes and you always feel better when they go off the phone"

She reported that call staff took the time to ask how she was and chat about her life over the course of a 20-minute telephone call and felt this was invaluable to her at a time when her usual social contact was very limited.

Although revisited several times during interviews with two carers (Edinburgh), a proactive element to the Telecare service appeared unfamiliar to them, even though they were the customer's next of kin. They did not recollect call handlers making scheduled calls to their loved ones, and rather, described the benefits of the conventional reactive Telecare service. They expressed their gratitude to this service and described the positive difference it made to their relatives. This included the peace of mind it gave them knowing someone was available if there was an accident as they were not always able to be there.

The five customers interviewed all expressed disappointment at the pilot project finishing and would be keen to continue with the calls. They all said they would recommend the service to someone in a similar situation to themselves.

This positive view is supported by the feedback from 26 (59%) of Bield's 44 customers. All felt the service was beneficial and 23 / 26 (88%) would like to see the service, or a similar service, continue in future.

3.3.1 Case studies / Personal Stories

Staff from the three test sites were invited to provide short case studies that illustrate the impact of Proactive Telecare on their customer's wellbeing and quality of life. Three stories have been selected to illustrate the range of positive outcomes experienced from a blend of practical advice, signposting to support and referral for equipment and services.

At the start of the inspire project one customer advised that everything was going really well and that he was living the best life he could be. Through good conversations, building mutual trust and respect, the customer opened up in terms of how he was really looking after himself. Within three conversations the customer was comfortable and confident enough to disclose that he was not taking as good care of himself as he could be, and this was having an effect not only on his mental health but also his physical health. Following an honest conversation, the customer disclosed that he was in fact struggling with finances and as a result was eating 1 x microwave meal split over two days. Whilst the proactive call handler would normally sit back and empower customers to take control of the situation this was ringing alarm bells and in this instance the operator switched hats slightly to take on a more assertive approach to support the customer to get the help he needed at that point in time. Through effective conversation and sign posting, the customer gave permission for the operator to contact and refer him on to the local food bank and citizens advice for a review of income. Within 24hrs the local foodbank had contacted the customer and provided food parcels to ensure the customer did not go without proper nutrition. Within two weeks the customer had a full benefits review which resulted in an increase in weekly payments and a backdated payment. The customer is now receiving the income he was entitled to. This allowed him to move away from receiving the short-term support of food packages and not only purchase proper food, but also treat himself to a take away once a month. The customer advised this had a positive impact on his mental health, he was able to sleep easier and felt a "weight had been lifted"

Figure 1: Case study example 1

Mr X is a 62 year old gentleman with a complex medical history affecting his mobility (diabetic neuropathy and removal of 2 toes). His 27 year old son lives with him and he has a diagnosis of Autism. No formal care package in place. During outbound call conversations Mr X explained he has been housebound for the past year and feeling isolated. He recently moved to a ground floor flat due to mobility and falls issues and had not yet met his new neighbours at the time of the first call as he has been unable to go out due to his limited mobility and pain levels. During the subsequent conversations he indicated he started to settle into his new flat and noticing a decrease in falls. His son continues to assist him with personal care tasks, shopping and taking him to appointments but Mr X felt this is a big responsibility and commitment on his son and feels dependent on his help. He was keen to regain some independence but continued to experience pain. With his consent, the following plan was agreed for ATEC24 staff member to:

- *Contact GP to raise awareness of current pain levels and enquire re the possibility of review of his pain management plan*
- *Referral for Home Care assessment for personal care to alleviate the stress on son. Home Care contacted Mr X to obtain further information on current needs. He is currently waiting for assessment as it was identified they can manage tasks between them in the short term and this is not a crisis situation.*
- *Referral to Physio for falls and indoor/outdoor mobility assessment to enable him to independently mobilise to his outdoor mobility scooter, and therefore access the community i.e. local shops and meet local residents.*
- *Phoned daughter who is in contact, but has her own family to look after. She was happy to input into any planning around care to meet the needs of both her father and brother. She*

expressed relief that Mr X was opening up as he is very proud and not known for asking for help.

- *Agreed with Mr X that ATEC24 will follow up in 4 weeks to review progress*

Figure 2 Case study example 2

Mrs X`s daughter and main carer initially participated in the outbound call service and Mrs X joined after a number of conversations also. Mrs X lives on her own as her husband moved to a Care Home approx. 1 year ago. Mrs X was the main carer for her husband and felt it took its toll on her own health. The property is over 2 storeys, but Mrs X lives solely on the ground floor where the bedroom and bathroom are located. She suffers from a number of long term medical conditions affecting her mobility and continence. Her daughter attends to all shopping and cooks meals for Mrs X to heat up. Strong family support with Mrs X`s daughter visiting weekly and her son also in regular contact. During the series of conversations, the family was adjusting to Mr X living in a care home and a change in his temper to more aggressive nature as part of his deteriorating health. Mrs X explained she would still wake up during the night listening out for her husband. When they were able to start to visit him Mrs X would go with her daughter and son in law every week. Mrs X doesn`t go out very often due to Covid, but she was very pleased when she received both her vaccinations.

Daughter enquired re provision of a grab rail by the bath as her mother has been washing by the sink as struggles to transfer in/out of the bath, and the request was directed to an ATEC staff member who carried out a phone conversation initially to gather info around Mrs X general function before completing an assessment. The agree assessment outcome was:

- *Mowbray toilet frame and seat already in situ and in use*
- *Replacement of bath board with bath hoist and provision of commode, Rutland trolley and a bed lever to facilitate independent transfers*
- *Request for fitting of handrail at front door as Mrs X for easy access and she enjoys gardening/greenhouse*
- *Advice and signposting for benefits check including carer`s allowance*
- *Referral made by daughter and placed on Social Work Team waiting list cancelled as no longer required.*

The planned review visit has been deferred as Mrs X`s husband sadly passed away but ATEC24 staff member will contact the family as agreed in a few weeks' time.

Figure 3: case study example 3

3.4. Planning for Scaling Up and Phase 2 Evaluation

The programme for the Learning Collaborative event included presentations on the context for the Proactive Telecare project and the approach to the Evaluation. In addition to Proactive Telecare test site staff and operational managers, participants included representatives from the national Telecare programme, DHI, and key strategic partners such as Healthcare Improvement Scotland and the Care Inspectorate. In total, 42 people participated in the event. The report of the interactive half day session is attached as Appendix 1.

The evaluation team supported the test site leads to prepare snapshot presentations summarising the key messages from their Test of Change and facilitated reflection and

discussion to inform the approach to Phase 2. There was consensus that the tests of change across the three sites has raised the profile of Proactive Telecare and changed ways of working and thinking about Telecare delivery. However, the ability to achieve scale up is limited at present as implementation to date has been relatively small scale.

The ambition and management support for Proactive Telecare is evident across all three test sites. This qualitative evaluation has further shown the value of the intervention from a staff and customer perspective, thus supporting important elements of a business case. However, participants acknowledged that the Proactive Telecare model requires more robust cost effectiveness analysis if financial investment is to be secured. A key message from the event was to refrain from simply scaling up the Proactive Telecare activity as delivered in Phase 1 and to take time to clarify the purpose and further refine the optimal local approach. Key considerations when designing the next phase of Proactive Telecare are identified as:

- Adopt a more dynamic and flexible approach tailored for different customer groups but with clarity on…. Who this is for? When do they need it? For how long? At what frequency?
- Consider how Proactive Telecare can be better integrated with anticipatory care by local health and care partners – What is the contribution of Proactive Telecare to the emerging system approach to anticipatory care? What relationships need developed further so Proactive Telecare adds value to a local network of care and support?
- Ensure appropriate information governance and data sharing protocols are in place across the required health, social care and industry partners.
- Track benefits and costs over a reasonable period, noting that evidencing service and system impact may require a considerable lead time in customers who have fewer complex needs and who receive less intensive support from services.
- Consider if Proactive Telecare is an additional role to be undertaken by selected trained staff or a more generic approach that all Telecare call handlers can deliver?
- What is the optimal grade, expertise, training and supervision required as these factors will influence the required staff costs in the business case?

3.4.1. Phase 2 Approach and Evaluation

The approach to evaluation of Phase 2 must be fully aligned to the nature of the intervention being implemented. An options appraisal has been constructed to enable test sites to explore their preferred approach to the second phase of Proactive Telecare. The four options are adapted from the Tiered Model described in the Telecare Business Case, 2021 (Appendix 2).

Option 1 – Maintain the status quo as a Reactive Telecare service

This would involve stopping Proactive Telecare activity albeit services would be free to progress other Telecare developments in conjunction with another TEC workstreams.

The potential advantages are:

- likely to require no additional new resource in the short term
- returning to previous reactive Telecare activity can be achieved quickly

Potential disadvantages are:

- difficult to meet the changing needs of customers now or in the future
- lack of innovation could threaten the long-term sustainability of the service
- reduced value for money from a customer perspective
- loss of organisational memory from Phase 1 and reduced staff motivation

Implications for Phase 2 evaluation – no prospective monitoring and evaluation proposed

Option 2 – Proactive Telecare Wellbeing Calls

Proactive Telecare would specifically target customers who live alone but have low levels of support or reliance on TEC and infrequently activate their community alarm. The Proactive calls could be an enhanced, relational approach to the routine equipment checks with structured conversations that offer advice to support self-management, participation and wellbeing. Proactive calls could be complemented by SMS text messaging to identify changes in self-assessed wellbeing and functional ability.

Potential advantages are:

- telecare intervention is low cost, light touch, infrequent and not time limited
- could be scaled with minimal set up costs and training
- identify changing needs of customers early on before they require formal support
- opportunity to gather intelligence for other sectors to target early intervention
- improved targeting of system resources and delaying dependency over time
- enhanced security, wellbeing, self-management and participation for customers

Potential disadvantages are:

- requires a creative and flexible approach to scheduling calls for those still active
- risk of reverting to a 'tick box' check in service with loss of personalisation.
- risk of dependency on the service if open ended and not strengths based
- requires risk stratification, screening and local intelligence to identify the appropriate customers who do not require a more intensive Proactive Telecare approach
- significant impact on Telecare service demand and the local health and care system are unlikely to be realised in the short term.

Implications for evaluation – need for a standardised approach to measuring monthly proactive call activity and the related staff contact and non-contact time. Assessment of benefits will be largely qualitative to illustrate personal and relational wellbeing outcomes. The test sites will agree to use a common set of simple but well validated quality of life measurement tools that are appropriate for an older population, such as SF36, EQ5D, or OPQOL-brief. A consistent approach to measuring staff satisfaction is recommended.

Option 3 – Time limited Proactive Telecare to enhance Transitional / Intermediate Care

This option promotes the time limited use of Proactive Telecare for customers who are experiencing a change in health status, social circumstances or care setting. For example,

those customers who are transitioning from hospital to home following a period of injury or ill health and who live alone and / or require support as they recover. This aim of this option is to promote confidence and independence at home as the individual recovers, in collaboration with a reablement or discharge to assess approach by a community integrated team. The Proactive Telecare may be able to integrate with other technologies that support self-management such as SMS reminders/Simple Telehealth solutions for medication prompts and calls to remind customers to adhere to their home exercise schedules.

Potential advantages are like Option 2 but include:

- time limited service, likely to be for a period of up to 8 weeks
- positive experience for customers and carers
- reduced risks of re-hospitalisation through early community intervention
- savings in hospital and care home utilisation likely to be realised in the short term
- potential for improved functional recovery, medication adherence and reduced harms resulting from medicines and falls
- adds value and amplifies impact of existing transitional / intermediate care services

Disadvantages are

- relatively intensive intervention involving a high frequency of calls
- increased staff costs for delivery, training and supervision.
- infrastructure and service redesign may be required to successfully integrate with local transitional / intermediate care services in some test sites.

Implications for evaluation – as for Option 2 there is a need for a standardised approach to measuring monthly proactive call activity and the related staff contact and non- contact time. Assessment of benefits will use mixed methods to illustrate changes in functional ability of customers, for example using the community IoRN, and in personal and relational wellbeing outcomes for customers and carers. Quality of life measurement tools and a consistent approach to measuring staff satisfaction will be used as above. Telecare, hospital and care home utilisation at baseline, three months and six months from commencing the service will be compared with a matched cohort receiving transitional or intermediate care without Proactive Telecare. Information on falls and medicines related harms will be recorded.

Option 4 - Proactive Telecare support for Chronic Case Management

This option promotes Proactive Telecare for customers with complex needs who require and currently use enhanced TEC in their home environment. The person may live alone, receive regular support from a carer or family member and may experience sensory or cognitive impairment. The aim is to improve the continuity and coordination of care for customers and carers, reduce demand on the Telecare Service and on local health and care services as part of a person centred, integrated, interdisciplinary and anticipatory approach to chronic care and support for people with complex or frequently changing needs.

Potential advantages are also like Option 2 and 3 and include:

- Early response and intervention for escalating dependency
- Reduced frequency of alarm activation and need for response
- Improved continuity and coordination of care for customers and carers

- Savings in hospital and care home utilisation likely to be realised in the short term

Disadvantages are:

- Intensive intervention over a prolonged period increases Telecare staff costs
- Risk of duplication unless targeted at those without an allocated case manager
- Redesign likely to be required to successfully integrate with local services

Implications for evaluation – as for Options 2 and 3 there is a need for a standardised approach to measuring monthly proactive call activity and the related staff contact and non-contact time. Assessment of benefits will use mixed methods to illustrate personal and relational wellbeing outcomes for customers and carers. Quality of life measurement tools and a consistent approach to measuring staff satisfaction will be used as above. Telecare, hospital and care home utilisation will be assessed for the six months prior to commencing the service and for the following six months. If possible, changes over time will be compared with a matched cohort of customers with similar SPARRA risk or eFI who are not receiving Proactive Telecare. Information on falls and medicines related harms will be recorded.

For example, one of Bield's Proactive Telecare customers in Inverclyde had recently triggered 6 fall detectors (impacts alarms) within a single week. Through the good conversations approach it was identified this was a result of rushing to answer the telephone. The call handler updated the notes on the BR24 file, provided a few hints/tips on avoiding falls and supported the customer to call her family, friends and GP to advise them to let the phone ring out and then immediately call back to allow time for the customer to walk safely to the phone. Over a 3-week period after this advice was implemented the customer only had 2 fall activations and reported feeling more relaxed and less anxious about missing important calls.

4. Strengths and Limitations

The approach taken in phase 1 of the evaluation has yielded a rich experiential data set which captures the reflective learning associated with the tests of change. Such learning is key to informing the planning and delivery of Proactive Telecare within Scotland. Although there was some variability in the test of change processes implemented by the test sites, many common opportunities and challenges were identified.

The different approaches taken by the test sites also offers insight as it highlights the importance of contextualising delivery depending on the nature of the partner, the existing infrastructure and the needs of the client group. As well as appreciating the insights offered, it is important to note the limitations. Firstly, no direct comparison can be made between the test sites due to their different local health and care context; different age and complexity of the customers targeted; widely differing number of customers involved, and intensity of service delivered. Despite this, a key strength of the project is that the test sites have demonstrated that Proactive Calling is feasible for different targeted cohorts from those with low support needs to those with more complex needs.

At the outset of the project there were four test sites, however, Stirling Council was not able to continue due to increased pressures during the Covid-19 pandemic resulting in staff shortages and reduced resources. The test site lead was interviewed to reflect on how they

managed their customers who were shielding. Notably their experience was not dissimilar to the other three test sites and if they remained as an active test site their contribution would have added to the rich insight gained on how existing Telecare services can be augmented.

At the time of writing this report no national dataset exists to compare and extrapolate information about Telecare services. Additionally, each service collated different variables dependent on their Telecare and Health & Social Care provider requirements. The study was also undertaken at a time of significant change at a national level, and several strategic TEC work streams on reimagining Telecare ran parallel to this test of change.

Whilst the interviews were informative, a group discussion with customers may have yielded a wider consensus on Proactive Telecare.

5. Conclusions

This report has captured the findings from Phase 1 of a two-stage evaluation to analyse and appraise the introduction of Proactive Telecare across four sites in Scotland. Phase 1 has explored the test of change process in action and makes numerous noteworthy contributions to understanding how Proactive Telecare has been implemented.

Despite its exploratory nature this phase of the evaluation has shown that Proactive Telecare is feasible on a relatively small scale and has been successfully delivered in three regions of Scotland for a diverse range of customers. The findings have also revealed that managers and staff have embraced new ways of working and were optimistic about the sustainability of Proactive Telecare if financial investment continues.

The different locations and focus of the test sites have been a strength of the work undertaken. It has shown how the approach can involve different targeted population groups from low intensity Telecare users to those with more complex needs.

Partnership working was observed as a key strength of the design of the test of changes across the three sites; the level of partnership working between the TEC programme team and the local test sites; as well as within and between services at a local level. Information governance was vital and necessary for the projects to succeed however, in one area this was more frustrating and limiting in terms of progress due to the data sharing protocols with external organisations. The lessons around information governance and who owns data are relevant to all test sites going forward and require future work to pre-empt these challenges.

Notably, the experience of the customers and unpaid carers is positive, and a clear message was conveyed that the customers valued the service and saw this as improving their connections with others as well as reducing their sense of isolation.

Proactive Telecare builds upon the existing skill set and resources of traditional Reactive Telecare provision, however, in terms of scaling up and continuing to offer Proactive Telecare beyond the test of change period additional investment is required by services. Firstly, investment in time to build a relationship with the customer and signpost them to community supports/services to manage any issues. Secondly, a marked increase in call time is noted with traditional reactive calls averaging 2-3mins and proactive calls averaging 20mins. This changes

the dynamic between the call handler and customer; and was found to be valued by the staff delivering the intervention as a rewarding and worthwhile addition to their job role. Thirdly, the findings highlighted that this new job role will require continued investment in role support and supervision as well as training for new staff. There was no consensus amongst the staff group if the role of the call handler should be a blend of reactive and proactive or whether the two roles should be separate.

This study has also shown that Proactive Telecare is a dynamic intervention that requires a tailored approach for different customers. Indeed, how Proactive Telecare is delivered for an individual may evolve over time as their health and circumstances change. This highlights the need for investment in staff development and opens out the possibility of involving a wider skill mix and or using a mix of community resources to support Proactive Telecare long term. Furthermore, future tests of change could examine the application of Proactive Telecare in a time limited manner, e.g. a person returning home from hospital following a fall.

The findings revealed a range of different approaches on how customers were selected, and staff debated whether the current risk stratification tools were fit for purpose. Not one type of customer emerges as more worthy or suitable for Proactive Telecare. Local intelligence about Telecare customers proved more valuable when used in conjunction with screening tools and methods. The project has highlighted that the intervention is suitable for all customer groups invited to participate and it is now the decision of local services to determine how they wish to target their resources in a preventative and anticipatory manner. Future work may involve the development and or refinement of existing risk stratification tools for use by Telecare providers and locality teams to target customers and resources more cost effectively.

The findings also show that readiness to scale up remains in its infancy at all test sites. Future work needs to support test sites to segment their customer base in terms of their health needs and complexity and to integrate with local health and care teams to understand who the best placed person is to function as self-management coach or care manager.

To scale Proactive Telecare for optimal value, further work is required on local data linkage and to more fully integrate Telecare services with the day to day workflow and information flow within locality health and care teams.

6. Recommendations

To achieve the ambition of scaling Proactive Telecare then several options should be explored by the local test sites prior to moving into the next phase of the evaluation. Based on this the following recommendations are made:

1. To continue to examine the process of Proactive Telecare normalising across the three test sites
2. To work with the test sites and TEC partners to agree a consistent approach to prospectively assessing wellbeing, participation and quality of life
3. To work with the test sites, TEC partners and local LIST analysts to agree a Proactive Telecare and linked dataset to permit a cost effectiveness analysis to be undertaken.

4. To reduce delays in access to customers and staff in the next phase of evaluation permissions and access to customers should be reviewed early with all intermediaries and external partners.
5. To work with the test sites to undertake an option appraisal to determine how to approach the next phase of implementing Proactive Telecare
6. To work with the test sites to assess the costs, benefits, impact and scalability of their chosen approach to the second phase of Proactive Telecare.

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APPENDIX 1: Learning Collaborative Event: summary report

Learning Collaborative Event

9th September 2021

Thank you to colleagues who attended the event to showcase, reflect and highlight their progress implementing Proactive Telecare Outbound Calling. This short newsletter highlights the key points from the day, areas of good practice, real time challenges and views on scaling up.

Purpose of the Day

For test site teams, strategic partners and the evaluation team to connect and collaborate

To give time to reflect and share learning on local Tests of Change

To consider the key messages from analysis of the introduction of Proactive Telecare Outbound calling

To contemplate the approach to scale up

Proactive Telecare Defined

Our working definition of Proactive Telecare is:

Proactive Telecare has a deeper relationship with its service-user, gathering insights into patterns of behaviour and preferences over time, enabling a more tailored, anticipatory and preventative service that prevents crises and supports wellbeing and resilience.

Proactive Telecare also provides potential for greater integration with other health and care services, the third sector and communities. This involves:

Targeted & personalised outbound calls.

Signposting for wellbeing.

Escalation to statutory services when required.

Outcomes-focused and strengths-based.

Intelligence-informed.

Snapshot Presentations

Using the 5 P's approach each test site presented the purpose of their Test of change, progress made, personal story, elements they are proud of and pain points identified. Three unique approaches were adopted to capturing customers in need at different points along the life curve. Similarity is noted across the three sites in terms of their overall aim to test out the feasibility and viability of proactive calling. All envisaged improved service delivery for their customers and greater integration with partner organisations supporting citizens.

Table 1: Summary of activity from test sites

Test site	Priority targeted group	No of customers	No of calls	Average time of call
Bield	Early on in the life curve (Midlothian HSCP) (Limited TEC); later down the life curve using TEC assisted living (Inverclyde HSCP) (TEC Dependant); Dynamic telecare service (Linstone Housing Association) (mixed TEC)	44	613	24mins
Edinburgh	Frequent callers, who do not have regular access to care and support services Next of kin`s in their capacity as informal carers	131	527	21mins
Dumfries and Galloway	Existing Care Call Clients who have had limited interaction with the service since taking on the service and they are not overly known to Social Work and/or the partnership	4	12	25mins

Customer voice

Whilst the emphasis of the event was on reflecting on the practical implementation of Proactive Telecare Outbound Calling the voice of the customer was represented by each service and by UWS researchers in their summary of individual interviews. A clear message is evident that Proactive Telecare Outbound Calling was valued by its recipients and unpaid carers. One customer described that it 'changed his life'. Positive behaviour change is echoed throughout the personal stories with comments referring to people being motivated, connected and listened to.

Areas to be Proud of…

Multiple areas were highlighted by the test sites that they were proud of. These are summarised below:

- Partnership working
- Caseload management approach
- Approach to delivery was Person led
- Use of conversation templates/scripts
- Use of ALISS (as a resource (one site)
- Time built in after each call to wrap up and act (if required)

Pain points

Like all tests of change initiatives, roadblocks emerge that delay, disrupt or shape a new path in the process. The areas highlighted by the teams are listed below:

- Data Protection/PIA amongst multiple partners re sharing of information and retrieving data collected
- Duplication of information across multiple IT platforms and between H&SC partners
- Use of Wellness Wheel and other tools for assessment and risk stratification- did not prove to be useful in the short term. Possibly over time this may be more effective.
- Data collection period not long enough

Staff reflections

A few interesting points were raised today and during the interviews with call handlers. The first relates to the unexpected emotional impact of Proactive Telecare Outbound Calling. The shift from reactive to proactive telecare enabled staff to join customers in the highs and lows of what was going on in their life and the call handlers highlighted this as both rewarding and challenging. This theme emerged today again when teams recalled personal customer stories and the time it takes to build trust and relationships with customers. The impact of letting go of these relationships has potentially been underestimated. This needs to be factored into future staffing needs, their support and supervision.

Scaling up

Identified that there are several factors to take into consideration as the teams examine the feasibility, viability and scalability of proactive telecare. These were grouped under the following headings:

- More Data and analysis is needed
- Establish a Proactive Telecare data set as part of Telecare Benchmarking
- Systematic approach to collection of data
- National standardisation of measures and local linkage of data
- Measurements of costs avoided
- Measurements of benefits
- Strategic and financial buy-in
- Need to persuasively articulate the benefits of Proactive Telecare
- Business case development
- Involvement with suppliers of Telecare
- Information governance and data sharing protocols are necessary across multiple H&SC and industry partners.
- Greater emphasis on benefits of Proactive Telecare
- Track and measure benefits and costs over a longer period
- Describe how the benefits are accrued, e.g. a value chain
- Wellness wheel used by one site – not effective but may be due to low numbers and duration of test of change. Need to review what personal outcomes are captured.
- Scalability

Next phase is about increasing volume and being more focussed on a dynamic and flexible approach for different target groups

- Integration with local health and care partners
    - What is the contribution of POC to person centred anticipatory care?
    - What local relationships need developed further?
- Criteria to consider for different cohorts
- Who is this for?
- When do they need it?
- For how long?
- What will it involve?
- Who will we work with?
- Criteria for call handler
- Grade
- Expertise

- Training and supervision
- Cost of a call handler vs volunteer vs link worker

Conclusions and next steps

Consensus was evident from discussion today that the test of changes across the three sites has been effective in raising the profile of Proactive telecare; and changed ways of working and thinking about Telecare delivery. The different location of the test sites has been a strength of the work undertaken. It has shown how the approach can be used involving different targeted population groups from low intensity users to those with more complex needs. It highlights partnership working within organisations and with external partners. The lessons around information governance are relevant to all test sites going forward enabling future work to pre-empt these challenges. Notably, the experience of the customers and unpaid carers is positive, and a clear message was conveyed today that the customers value the service.

APPENDIX 2: Tiered Service Model (adapted from TEC, 2021)

Level	Service Components	Service User Characteristics
Level 1 PREVENTATIVE ANTICIPATORY	• 24-hour monitoring of community alarm service (dispersed/warden call system); • Citizen-own technology; • GP/Emergency Services/Nominated person(s) in the event of an alarm call; • No mobile response service.	Persons living alone, who feel the need for an extra sense of security.
Level 2 PREVENTATIVE ANTICIPATORY INFORMAL/FAMILY CARER SUPPORT	• 24-hour monitoring of community alarm service (dispersed/warden call system); • Personally-owned technology; • GP/Emergency Services/Nominated person(s) in the event of an alarm call; • Mobile response to every alarm call; • Key holding service; • Non-injurious falls service.	Persons living alone, or who have a partner, but are left alone for long periods of time; those, who may not have a personal contact to attend in an emergency.
Level 3 ENHANCED SERVICE ESSENTIAL TO ON-GOING CARE AND SUPPORT INFORMAL/FAMILY CARER SUPPORT	• 24-hour monitoring of community alarm service (dispersed/warden call system); • Telecare sensor installation; • GP/Emergency Services/Nominated person(s) in the event of an alarm call; • Mobile response to every alarm call; • Key holding service; • Non-injurious falls service.	Persons living alone, or who have a partner, but are left alone for long periods of time; those, who have a long-term condition (LTC) or who may not have a personal contact to attend in an emergency.
Level 4 ENHANCED SERVICE ESSENTIAL TO ON-GOING CARE AND SUPPORT INCREASING COMPLEXITY OF NEED	• 24-hour monitoring of community alarm service (dispersed/warden call system); • Telecare sensor installation; • GP/Emergency Services/Nominated person(s) in the event of an alarm call; • Mobile response to every alarm call; • Key holding service; • Non-injurious falls service.; • Enhanced telecare installations – Door Contacts/ GPS solutions etc.;	Persons living alone and who tend to be forgetful or are left alone for long periods of time; those who have a long term health condition (LTC) and who would benefit from a welfare check to ensure all is well, or who may not have a personal contact to attend in an emergency.