Bield Response 24 (BR24) Proactive Telecare

BR24 Overview

- TSA accredited Alarm Receiving Centre
- Fully digital enabled alarm receiving centre & disaster recovery site
- On average 1782 incoming alarm calls are managed on a daily basis
- Service delivery includes, but not limited to, personal alarm monitoring, Asset monitoring, proactive telecare and emergency out of hours repairs
- 2,208 (and growing weekly) digitally connected alarms including personal alarm units and developments
- 48 external partnerships including local health and social care partnerships & housing associations
- NHS24 Scotland partnership working to improve pathways for Alarm Receiving Centres to connect effectively

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Overview of Proactive Telecare – Project Inspire Phase 1 & Phase 2 progress

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Phase 1 – The Purpose

- **Aim**

To engage with up to 50 tenants/service users will have engaged on a test of change programme to observe (and learn) the impact on Bield & partner services; specifically, with a view to evaluating the prioritisation of health promotion, prevention and earlier intervention to increase a tenants/ service users' ability to be independent and remain active, healthy and socially connected. The overall ambition is to maintain or improve people's abilities and support independent living.

- **Priority Target Group(s)**

Initially to work with three cohort's:
Beneficiaries who are early on in the life curve (Midlothian HSCP) (Limited TEC)
Beneficiaries who are living in the community who are later down the life curve1 using TEC assisted living (Inverclyde HSCP) (TEC Dependant)
Dynamic telecare service due to late addition (Linstone Housing Association) (mixed TEC)

- **Partners involved**

Midlothian HSCP, Inverclyde HSCP, Linstone Housing Association
(i) Gore (2017): Happier futures: (scot.nhs.uk)

Process throughout Phase 1

Our Process:

Established the Programme Board

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Identified and Engaged in Training (Good Conversations)
5 half days across the programme – investment for Midlothian HSCP

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Developed engagement and expectation paperwork
(Intensive support from Midlothian HSCP)

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Decided on a caseload Management System and call rotation
(Each beneficiary receives same call handler, call at same time each week)

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Established what metrics we could measure in our existing systems and developed a MS Forms data capture form for all other required information.

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Undertook a staff baseline survey with staff

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Developed baseline customer survey

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Initiated calling customers

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On every second call, with beneficiaries, we took a baseline assessment with them (baseline customer information)

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Weekly team meetings implemented to support and encourage sharing best practice on top of monthly feedback from project manager

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Routine and regular called scheduled and implemented each week. Reviewing some of the progress measurements across the calls.

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Final beneficiary survey to compare from baseline information taken on second last/last call/

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Final staff survey undertake to compare against initial baseline.

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Headline Stats Phase 1

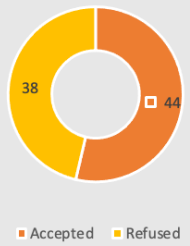
Headline Stats

1) 44 Beneficiaries took up the service from 86
2) 613 Calls (AVG 24 mins) (245 hours)
3) 5-10 mins follow up time
4) 11/44 (24%) Beneficiaries referred to Primary Care
5) 10/44 (22%) Beneficiaries referred to non-HSCP/statutory services
6) Wellbeing wheel data proved to fluctuate, more value found in the summary of conversations
7) 100% of Beneficiaries felt the service was beneficial
8) 88% of Beneficiaries would like to see this service continue with the remaining 12% wanting this or a similar service.

Dashboard: Overall

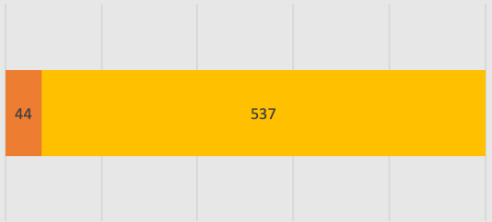
Recruitment

Service offered to 82 people



People Engaged

Number of Beneficaries / Number of Calls

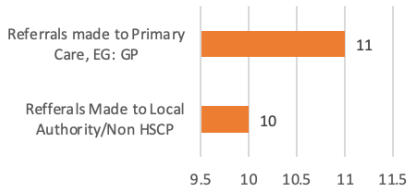


Avg Length of Call

24 Minutes ranging from 142 minutes to 11 minutes

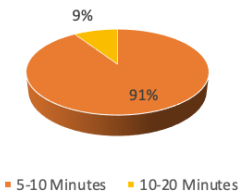
Referral Areas

Volume and Routes of Referral



Call Handler Stats

Admin Time after Call



Beneficiary Stats

AVG Impact on Alarms – No change
Total. Changes to Tech – No change to Tech
Referrals sought – a total of 12 beneficiaries referred to either primary care or local authority/non HSCP, 3 individuals referred via both routes.
Satisfaction – Customers satisfied at start of project, but value of calls decreased over time as restrictions lifted and "normality" resumed.

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Proud Of…

1) Overall commitment and support - From beneficiaries, staff and members of the programme board.

2) Approach and management of test of change – call handlers managed case loads, calling the same beneficiary consistently to allow a mutual trust and understanding to develop.

3) Training – All call handlers underwent Good conversation training which allowed everyone to open up their approaches in conversations and inclusion, really helping to steer the calls to be meaningful whilst exploring the what is needed for continuous improvement within each individuals journey.

4) The value/impact received by beneficiaries as evidenced in the qualitative data

5) Calls delivered as planned and implementation broadly as expected

6) Organisational reputation for our approach and others desire to learn from us

Challenges

1) The wellness wheel (Connect, Wales) hasn't given us the results we would have expected and we believe this is because the TOC was too short. Many of the baseline indicators had very positive starting positions.

2) 45 minute calls were good for the initial call, each week however a dynamic service of shorter duration (and potentially less frequently) proved just as valuable once the human connection was established.

3) Data capture, MS forms and Jontek use for phase 1 data capture however this was a manual task. Scope to work with platform provider moving forward for proactive telecare modules would certainly be beneficial to explore.

4) Resource management – Planning staffing and consistency whilst ensuring contingencies (core service)

5) Dependencies developed through test of change, both from a customer and staff perspective

Phase 2 – The Purpose

Aim

By September 2022, we will test the impact on both individual and responder services by introducing proactive telecare services for customers who have had a fall and referred to TEC, and also customers who have just been discharged from hospital.

Specifically, we will test if the introduction of a proactive telecare service can maintain or improve a customer's ability to live at home and if this supports the customer in maintaining or preventing further increases on levels of social care services .

Bield and Renfrewshire HSCP will use the Test Of Change (TOC) on current and new customers affected by falls and hospital discharges.

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Our Process

Headline Stats to date:

1) 137 screening referrals carried out. Principle reasons = 38 beneficiaries new to TEC/falls and 99 beneficiaries after hospital discharge

2) 107 beneficiaries eligible for proactive telecare with 43 (40.19%) accepting POC intervention, 23 (21.5%) declining the service, 12 (11.21%) who were not eligible and 29 (27.1%)beneficiaries were non contactable after 3 attempts.

3) 31 baseline customer experience surveys completed

4) 23 beneficiaries completed the POC with end of intervention and follow up call forms completed.

5) Maximum call duration 74 minutes – higher at start of POC

6) Average call duration 18 minutes 24 seconds – call times lessen once relations have been built.

7) 8 Referrals made, including MS society, Adult Services Referral Team (ASERT – Mobility support, change to care service/equipment) District Nurse/Health Services and ROAR (voluntary befriender service/day centre)

Proud Of

1) Approach and implementation of proactive telecare covering 7 days per week.

2) Overall commitment and support - From beneficiaries and staff

3) Approach and management of test of change – call handlers managed case loads, calling the same beneficiary consistently to allow a mutual trust and understanding to develop.

4) The value received by beneficiaries as evidenced in the qualitative data

5) Case study development from Proactive call handling team

6) Reactive team understanding proactive telecare and proactively identifying potential beneficiaries.

7) Insights around those previously not exposed to telecare

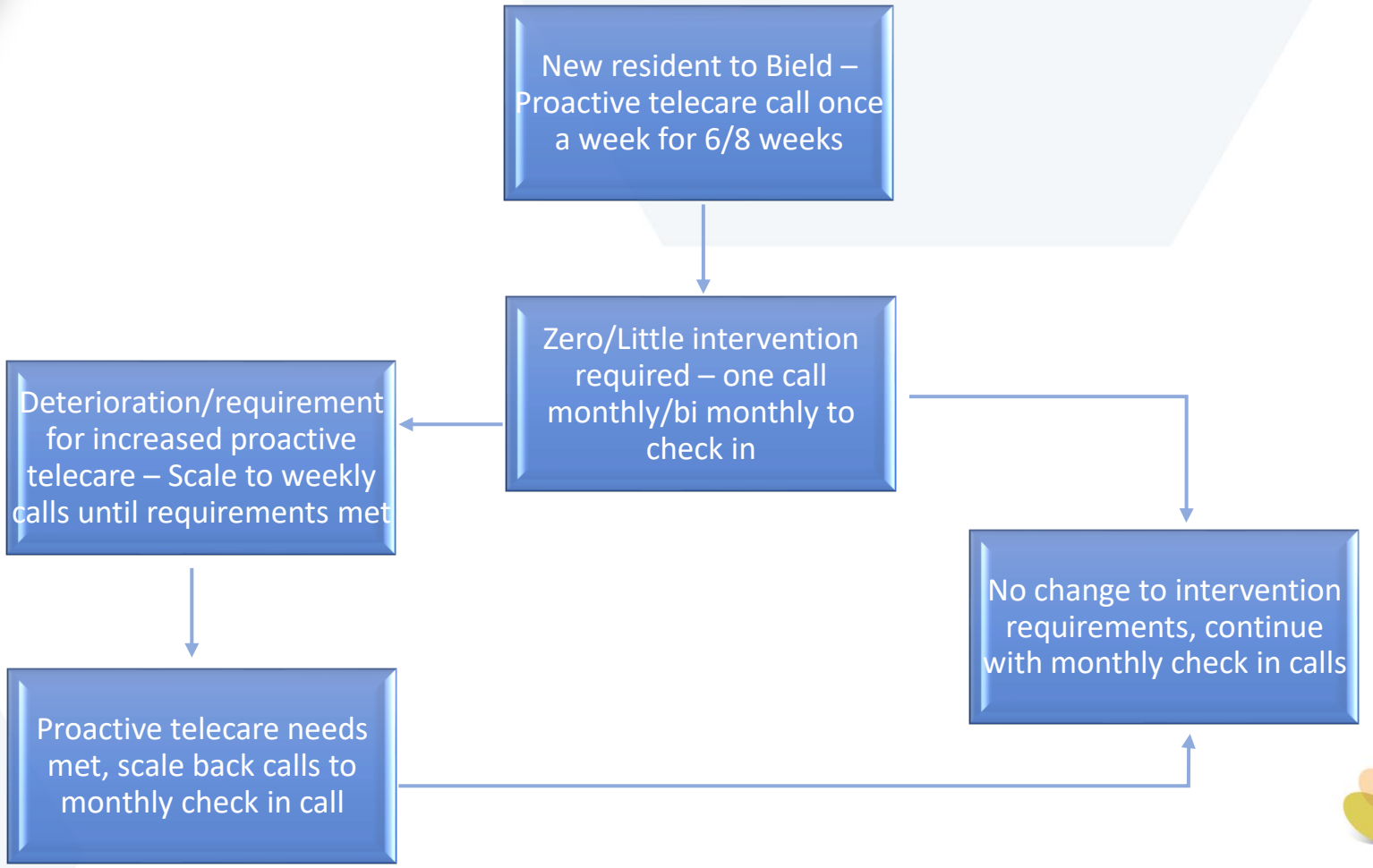
Personal Story

Mrs X, 77, was housebound for just under 5 years due to deterioration of both physical and mental health. Mrs X was a frequent faller resulting in multiple family and funded responder services called out each week, on average based on 3 months 4 visits per week.

Mrs X agreed to the proactive telecare service and with good conversations, focusing on what makes a good day, Mrs X was supported to contact ASERT who arranged a OT visit and was referred a walker with a seat. Mrs X built confidence by taking small trips out her home, to the end of the path and back however built on this.

Fast forward 8 weeks, Mrs X has had 0 falls in a recent 3 week period resulting in no requirement for responder visits. Improving both mental and physical health. Mrs X now has confidence to venture on longer walks, sitting with the walkers seat when needed. Mrs X has recently also joined David Llyod gym to undertake swimming as a hobby with support and also signed up to a personal trainer to support strengthen her legs. Mrs X has also, to top it off, joined a social day club ran by ROAR after a successful referral which will connect Mrs X to citizens in her community, building relationships.
Mrs X benefited from proactive telecare by focusing on the possible and what's available to support and empower her live the life she wants to live.

What's next? The possibilities



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