Edinburgh Health and Social Care Partnership

Working together for a caring, healthier, safer Edinburgh

Proactive Outbound Calling

Assistive Technology Enabled Care 24 (ATEC24)
Edinburgh Health and Social Care partnership

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Project Lead

Introduction

- **Assistive Technology Enabled Care 24 (ATEC24)**
  - Community Alarm Service (Monitoring and Response)
  - Community Equipment Loan Service
  - The Assistive Living Team
  - Sheltered Housing
  - Business Support

- **The Assistive Living Team**
  - Prevention and early intervention remit
  - Assessment and review incl. digital technology, equipment and minor adaptations /Fallen and Un-injured Person Pathway (FUPP)
  - 3 Conversations Innovation Site

Phase 1 overview

- **Collaboration** with Care and Repair (Age Scotland)

- **Purpose** - to develop the learning from delivering outbound calling as part of Covid-19 response and provide higher quality personalised services

- **Cohort** - Citizens identified as frequent callers and no regular access to care and support services / informal carers

- **Main learnings**
  - Participant / staff satisfaction, early intervention and prevention of crisis (falls prevention/ review and assessment / responder protocols / testing and replacing faulty equipment), advice and signposting to prepare for future needs, closer connections with other teams/services, direct access to Care and Repair Services, Jontek record updating
  - Data sharing, call handler continuity and building relationships, early recruitment, and measuring outcomes

Proactive Outbound Calling model

Model developed with the aim to impact positively on citizens ability to:

- **Stay Well** – promoting the health and wellbeing and confidence of citizen and informal carer(s)
- **Stay Active** – promoting independence and safe living by exploring self management strategies and equipment, minor adaptations and technology enabled care and, including mobility / transfers and falls prevention
- **Stay Connected** – reducing loneliness and isolation, providing advice and info re digital technology and supporting citizens with connecting with family/friends and other community resources

Phase 2 overview

- **Aims/objectives**
  - Regular outbound calling to citizens who are at risk of falls, to reduce the number and frequency as well as the negative impacts of falls on the health and social care system i.e. Scottish Ambulance Service, hospital admissions following a fall
  - Working collaboratively with Falls Practitioners to integrate processes and build on the benefits of both services, supporting citizens building confidence to remain safe, active and independent

- **Target population**
  - Recurrent falls (2 or more within a 3 month period)
  - Frequent fallers / Fallen and Uninjured Person Pathway (FUPP) / Falls Practitioners

- **Key things we wanted to test and learn**
  - Participant recruitment, 3 Conversations approach, FUPP follow up outbound call, call handler continuity, review and assessment of telecare / technology, equipment and minor adaptations

Process

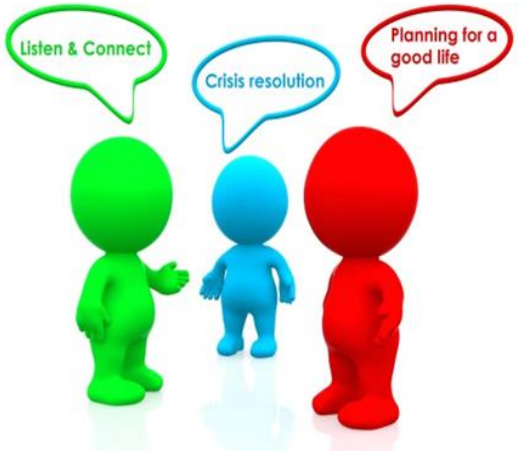
- **Screening and recruitment**
  - Falls data analysis and application of filters:
    1. Identified as experiencing actual falls
    2. Able to engage in phone conversations (cognition / hearing / communication impairment)

- **Wellbeing calling**
  - 38 participants
  - 8 weeks intervention with frequency of conversations weekly/fortnightly + 4 week follow up call
  - Call handler case load providing continuity, promoting trust and relationship building
  - 3 Conversations approach
  - Home assessment and provision of technology enabled care, equipment and minor adaptations for safety, transfers and mobility, as required
  - Data collection

3 Conversations approach

Principles and core values

- Strength based and person-centred approach
  - Listening to “what matters” most to people and their families, focussing on assets and strengths
  - Connecting people with local resources and opportunities that will support them to get on with their lives and engage with their communities
  - Sticking with people in a crisis and, when the time is right, helping them make longer term plans
- Recognize and respect that people are the experts in their own lives and work with them and others to help build a better future
- No hand-offs, no referrals, no triage, no waiting lists
- Promotes collaborative working
- Peer support is the backbone of 3C – huddles, reflective practice, Making It Happen
- Co-design with innovation sites and support for initial 13 weeks / ongoing
- Roll out across EHSCP in partnership with Partners4Change



Learning

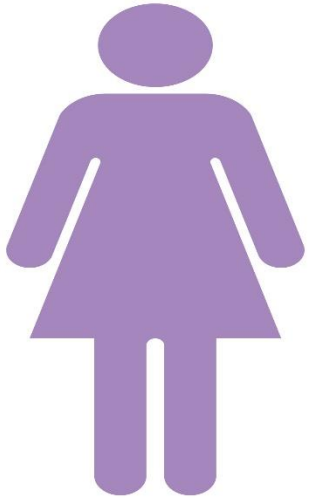
- Screening phase
- Clearly defined and mutual team understanding of proactive calling remit and role essential before recruitment takes place
- Proactive calling for citizens referred via the FUPP pathway to be further explored
- Identify potential gaps and overlaps with Falls Practitioner intervention, promoting collaborative working and integrating processes.
- Call handling function transfer to another LA as part of internal service developments.
- The 3 Conversations approach supported us developing wellbeing conversations developing staff skills and confidence around active and intuitive listening, and exploration without a “referral” for meaningful conversations
- Emotional support for team (planned /unplanned) working from home
- Conversation themes varied greatly i.e. citizens at a stage of life changing events - acceptance of living with chronic pain, moving house to increase quality of life. Also emotional support including isolation / loneliness and long term condition management, carers support (spouse) and falls prevention.

Outcomes

- Provide support and reassurance, i.e. emotional, loneliness and bereavement
- Connecting to community services via advice, info and sign posting (i.e. befriender and friendship calling, financial advice, carer's support)
- Falls prevention advice and assessment of home environment and provision of equipment and minor adaptations for safe transfers and mobility as well as digital technology
- Referrals directly to social work and medical teams
- Rockwood CFS self assessment identified improvement in perceived ability from start to end of intervention
  - 50% feeling less able prior to project start / 3% at end of intervention
  - 0% feeling more able prior to project start / 10% during intervention
- Overall reduction in alarm activations and responder visits
  - Comparison of alarm activations between 2 periods (pre-project and end of project)
    *Control group 1 % increase / Intervention group 43% reduction

*Activation reasons identified were not solely linked to falls, but also includes accidental alarms requiring call handler screening, information and re-assurance, test calls, technical faults etc

A Story of Difference



Mrs X suffers from a number of long term conditions affecting mobility, transfers and continence. History of falls, low mood and isolation. Lives on her own in a 2 story property and has a CAS alarm.

The issues

- Husband moved to long term care due to advanced dementia and associated aggressive behaviour. Mrs X was his main carer
- Strong family support with daughter now main informal carer
- Coming to terms with husband no longer living at home – bereavement / guilt

What the worker did

- Wellbeing conversations initially with daughter supporting her in her role as informal carer, with Mrs X engaging at a later stage. Emotional support / encouragement coping with current situation
- Identified gardening as an area she enjoys

What's different

- Home assessment with provision of equipment and minor adaptations facilitating safe transfers and stair mobility, reducing risk of falls
- Motivation and confidence to take up gardening tasks and go out socially
- Advice and signposting for benefits check incl. carer's allowance
- Cancellation of referral for Social Work as no longer required