CARE Direct

Evaluation Newsletter 4

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PSSRU

at the University of Kent,
the London School of Economics
and the University of Manchester

CARE direct

0800 444 000

Information And Help For Older People

No further roll out for Care Direct but…

Dave Page, Project Manager for Care Direct within the Pension Service, describes the benefits of the experiment.

In August 2002, Alan Milburn, then Secretary of State for Health, announced the conclusion of the Care Direct project in line with emerging plans for the development of a Third Age Service led by the Department for Work and Pensions. This meant the second wave, involving a further 14 local authorities due to 'go live' in late 2002 did not go ahead. Planning work in preparation for commencement was not wasted and many authorities seized the opportunity to reconfigure services and partnerships to enhance their services to older people.

The benefits of Care Direct principles were evident at this time, as published in the PSSRU's first report. Cooperation between Ministers and officials of the Department of Health and the Department for Work and Pensions ensured full completion of the pilot period until March 2004 in the six first wave local authorities. Responsibility for Care Direct transferred to The Pension Service (South West) in April 2003. Towards the end of this period, The Pension Service (DWP) will undertake a full 'lessons learned' exercise to use the experience and learning from Care Direct to inform Third Age Service planning.

Despite commitments to Third Age being within Spending Review Year 2005, The Pension Service has continued to maintain and develop partnerships across government departments, local authorities and the independent and voluntary sector. This will ensure all views and contributions are captured to inform a future Third Age framework. Contributions from older people and their carers are of particular importance.

Although early in terms of planning, it is already accepted that Third Age will embrace a far wider concept than Care Direct, both in scope and depth. It will build on the key government objectives of e-Government/e-Local as well as addressing the modernisation agenda captured in *Better Government for Older People* and the *National Service Framework for Older People*. Joint plans and 'joined up services' at both government and local levels are challenging improvements to data sharing processes and local joint accountabilities.

The Pension Service has welcomed the transfer of Care Direct and used the opportunity to engage with the first wave LAs. Wider development will allow autonomy to transfer the service to LAs in 2004 and agree plans to link the gateway or contact centre to the newly emerging Joint Teams. These teams combine pension service and local authority staff into a single, multi-skilled visiting team providing an assessment for both benefits and possible charges for social care in a single visit. The scheme has also provided a unique partnership opportunity with local voluntary sector partners.

This service has proved extremely successful and demonstrates the potential to increase depth of service while continuing to provide a holistic gateway service available to the joint team.

These initiatives are also beginning to deliver efficiencies through shared and joint working. Care Direct, while disappearing in brand as a single service, will carry its principles and successes into new single gateway contact centres.

As a commitment to the further development of the contact centre model linked to visiting teams and driving both efficiencies and service improvement for older people, The Pension Service will support first wave sites both financially and in staffing resource in 2004 to evaluate and deliver the improved model.

Editorial

The Department of Health has commissioned the PSSRU to undertake the evaluation of the pilots of Care Direct. The evaluation is being conducted by Andrew Bebbington, Susan Downey and Judith Unell.

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Views expressed in this newsletter are not necessarily those of the Department. Comments may be sent to Andrew Bebbington at acb@ukc.ac.uk, or Judith Unell at Unells@btinternet.com. Further copies and information are available from the evaluation website at: www.pssru.ac.uk/projects/caredirect.htm.

Cover picture courtesy of Health Canada.

Performance Indicators

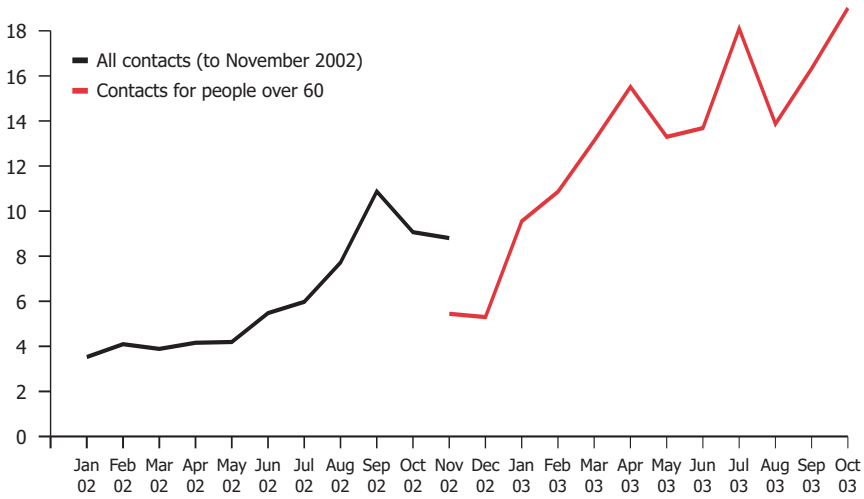
Newsletter 3 showed that while Care Direct had been experimental in its first year of operation, nevertheless the evaluation showed it seemed to be meeting provisional targets for activity levels. However, there was a great deal of variation in between the six sites and a number of problem areas in management and service delivery were identified. As a result the site budgets were reviewed for the financial year 2003/4, and a number of performance targets were set for each site. The measures were agreed between the Department of Health and the participating sites, and are summarised in the table below, though the actual targets have been subject to change. A small proportion of the budget is conditional on satisfactory progress towards these targets, and by autumn 2003 it appeared that all sites were making satisfactory progress.

Numbers of Calls

Monthly activity statistics continue to be monitored. The diagram shows the numbers of enquiries recorded at helpdesks up until the end of October 2003, which since July 2002 have been recorded on the client activity system, and earlier were being monitored by the evaluation. There is a discontinuity in November 2002 when the series moves from all calls to calls on behalf of people confirmed to be over 60. This does not represent a change in Care Direct, but during 2002 the subject's age had not been recorded for many enquiries.

Care Direct has continued to expand rapidly during 2003, with all sites well above target numbers. The general trend is still upwards. The main reasons for calling continue to be concerning aids and adaptations, social care generally, and money and finance.

Enquiry rate per annum per 100 population aged 60+



Key Performance Indicators for Care Direct, 2003/4

Standard	Measure
1. Call numbers	Number of enquiries for people over 60 relative to the population aged 60+
2. Benefits	(i) The number of people offered a benefit health check (ii) The total income generated from successful claims
3. IT/information database	(i) Volume of use of the information database (ii) Fully completed contacts on client activity system
4. Volunteers	Number of volunteer hours supporting service delivery
5. Breadth of access	Contacts other than by phone to ensure a wide range of access methods
6. Ethnicity	Number of older people from ethnic minorities contacting service, relative to population.
7. Hard to reach groups	Number of contacts from (i) rural and (ii) social inclusion target areas
8. Holistic service delivery	The range and information and advice offered to clients, measured by the total number of dispositions
9. Customer satisfaction	The number of people over 60 who are satisfied with the service
10. Unit costs	Gross annual cost and the number of contacts in a sample week

Caller Survey Follow-up

The great majority of calls to Care Direct are from people aged 60 or over, with a median age of 80. Just under one half of all enquiries are by people on their own behalf. Of the people called about, the majority live on their own. Most have a longstanding illness or disability, and one half have limited mobility. This is a relatively needy group of people. One-third are already in contact with social services, and a similar proportion receive a disability related benefit.

The original survey found callers were satisfied with both the process and the outcome of calls. Virtually everyone agreed that Care Direct was welcoming, courteous and intelligible. 94 per cent were completely or reasonably satisfied by the service, and 84 per cent thought that Care Direct had provided or would be able to provide the help needed.

However, that enquiry gave little insight into the impact of Care Direct in the longer term. To remedy this, a follow-up survey of 50 of the original subjects was undertaken, after an interval of around six months from the original call.

This enquiry focused on those callers for whom there had been a likelihood of longer-term consequences as a result of their original call. This included callers who originally mentioned that the Care Direct adviser had suggested further steps might be taken to deal with the client's query, those where the client had been expecting to undertake further action following the original call, and those where the caller had received, or was expecting to receive, new services or support as a result of contacting Care Direct. This group constituted one quarter of the original sample of 600, of whom 50 were contacted. Table 1 details the topics these callers asked about.

Table 1: Nature of help and advice sought from Care Direct

Information/referral for mobility aids/house adaptations	24
Information/forms for benefits and financial queries	18
Information on carers and home help	7
Information on respite care/day centres	5
Information on other services (e.g. mobile hairdresser/alarm systems)	4
Volunteer to help complete benefits forms	4
Follow up query for client with other agencies	4
Information on free transport	2
Information on Meals on Wheels service	2

The total is 70, as some callers asked about more than one subject.

Seventy-four per cent of clients reported at the follow-up that the help and advice they were given was sufficient to deal with their problem/query. This was rather less than the 92 per cent of this group who shortly after the call had thought that Care Direct had or would be able to provide the help needed. Table 2 summarises callers' responses at the follow-up.

Table 2: Responses of callers regarding Care Direct's help and advice

Query resolved	28
Contacts given by CD resulted in poor service/ no resources, misinformed by CD, CD contact unsatisfactory (no follow up), CD info did not answer query	12
Query ongoing	5
Client followed up independently	4
Client not eligible for benefits	4
Query/assistance resolved by other agencies	3
Help took too long/arrived too late	2

Total 58, as some callers made more than one observation.

The majority of callers had their queries resolved and were happy with the service from Care Direct. A caller in Somerset talked about being 'overwhelmed' by the support he had received and was hoping to publish an article to that effect in the local newspaper in the near future. Another caller, also from Somerset, described the service as 'a delight' with 'lovely, helpful people'. A client in Gloucester described the service as 'wonderful' and had been impressed by the 'kindness and efficiency' of the advisers. A caller from Bournemouth stated 'I don't know what I would have done without Care Direct — I felt helpless', and in Bristol a client said the help offered as a result of contacting Care Direct 'saved my life'. The service offered by Care Direct can make an enormous difference to individual caller's lives. For example an elderly housebound caller in Devon now has a weekly social outing to a club that is 'the highlight of my week'. One caller did feel the service should be more widely publicised, and many callers had been given the free Care Direct phone number from Social Services, rather than from other publicity sources.

One quarter of callers recalled Care Direct offering help with something in addition to their original enquiry. Mostly this concerned benefits advice. One caller from Devon reported being unaware of his benefit entitlement and that receiving the additional financial support had 'transformed life' and 'completely turned things around for us'.

Of the 12 people who had a less than satisfactory response

from Care Direct, eight callers reported poor quality of service from the list of contacts they had been given. For example, one caller stated that the home help cleaner 'spent more time talking than cleaning' and had eventually bought mobility aids independently as the waiting list was too long. Another had contacted volunteer 'home sitters' to sit with an elderly relative, but despite giving them a range of dates no one was available and the client had since found the caring too much and the relative had to be moved to another family member's house for ongoing care. Yet another had found the contacts suggested by Care Direct were unable to help and was left trying to find other sources independently. These also proved unsuccessful and the client had eventually to move accommodation as a result. In one case the caller had been told an assessment for house adaptations would take place, but then had not received any further correspondence or communication. In another instance, a social worker arrived at a client's house to do an assessment for respite care. The social worker fell asleep whilst the client was outlining the difficulties, and on awakening the social worker proceeded to describe his own problems!

A number of these problems derived from the quality of service offered by other agencies to which Care Direct had referred. Whilst Care Direct cannot be responsible for these, an association is made in the caller's mind. A follow up to all callers is impractical given the nature of Care Direct, nevertheless the implication would seem to be to encourage callers like these to make contact again and provide feedback on the service they have received, be it excellent or unsatisfactory.

Some callers reported problems completing benefits forms. This was something where volunteer help had been envisaged, but few callers reported receiving help from volunteers with filling in benefit forms.

The five queries that were ongoing tended to be where clients were still waiting for mobility aids or house adaptations. This could reflect more complex queries, for example built-in showers, and long waiting lists for the occupational therapy service, which is overstretched in some areas.

Altogether 38 callers reported having received some new service as a result of contacting Care Direct. Seventeen received some form of financial benefit, most commonly attendance allowance, while 16 received mobility aids or adaptations. Eleven callers got more than one form of help or advice. For example one client received Attendance Allowance, Carer's Allowance, mobility aids and home carers as a result of contacting Bournemouth Care Direct.

Over half this group believed that they probably would not have sought help had it not been for Care Direct. Two-thirds felt that overall, Care Direct had made a significant difference to their lives, most commonly in terms of improving mobility, independence, or safety, arranging extra money, or giving carers more time. Four callers had subsequently re-contacted Care Direct about another concern.

Developing Outreach Services

What is outreach?

Care Direct outreach means moving out of the helpdesk to meet older people and their carers, and to deliver the Care Direct service, or at least to begin the process of delivery, face-to-face. Outreach differs from publicity and promotion, though in practice these are linked in raising the profile of Care Direct and all are viable means of creating awareness for the service and developing contacts. Successful outreach depends on the service being known; promotion develops this awareness and stimulates contacts.

Outreach is partly about connecting with hard-to-reach people, but also about improving the accessibility of the service and reaching as many older people and their carers as possible. Outreach also offers a choice about how to access the service for people who may prefer not to make their first contact through the free telephone number.

Models of outreach

The Care Direct sites have mostly developed their own approaches to outreach by trial and error, in response to local circumstances. There has been little detailed reference to outreach strategies developed by other organisations, and it is likely that in part this is due to a lack of outreach initiatives on which to base a methodology. Indeed, outreach is generally viewed as a relatively new form of service delivery. However, a number of sites have also researched existing surgeries and voluntary schemes in their local area to avoid replicating services. There has been some productive sharing of models of good practice between Care Direct sites.

There is now an impressive diversity of outreach activities across the sites, falling broadly into five types:

Involvement in one-off events

High profile local events, such as a County Show, a Navy Day

or a road show organised by a local organisation provides Care Direct with a ready-made opportunity to advertise its presence to the public at large and to connect with large numbers of people from its target groups. Similar in nature to the one-off events are presentations to local groups, and visits to supermarkets, cinemas and other commercial venues, where the main function is to promote the service but where referrals may also result. This type of activity is mainly about promotion, and is unlikely to lend itself to the delivery of the full Care Direct service through private one-to-one advice giving. Advisers are often reliant on personal knowledge, as they do not have access to the computerised information database.

Regular surgeries in community locations

Libraries, GP surgeries, day care centres, churches and neighbourhood projects are providing a base for Care Direct advisers to set up a desk, usually for a few hours on one day of the week. Once again, there is a strong promotional element in these activities, but there is generally opportunity for an in-depth discussion with individuals.

Linking into local networks of services

This type of outreach activity is more precisely targeted at the Care Direct user groups than those described above. For example, certain sites have chosen to contact sheltered housing networks across their patch with an offer to give a presentation to residents and also to offer advice to individuals where appropriate.

Home visits

The two smallest Care Direct areas, Plymouth and Bournemouth, have developed this most, and have been able to offer home visits by their DWP staff, though the latter in particular are aiming at providing a more holistic outreach service. For the larger sites, it has been more difficult to contemplate organising a home visiting service due to the distances involved and the time commitment for staff. Some sites reported little or no demand for home visits since starting Care Direct. However, home visits have taken place on an ad hoc basis in some instances, and this has proved valuable for individual service users. There is potential in some sites for working in partnership with the Financial Assessments and Benefits teams. In both Devon and Somerset it is envisaged that such collaboration may help people access a range of advice.

Hospital discharge projects

Two sites have created support projects in hospitals and rehabilitation/convalescent facilities to assist older people in making the transition from hospital to home, in partnership with local voluntary bodies offering practical support. One is described on page 7.

Beyond this, there are a few outreach activities that do not readily fit any of these patterns. Care Direct sites have generally tried to engage with the media for promotional activities, and in one interesting case this has led to a radio advice programme using Care Direct to mutual advantage.

Targeting the hard-to-reach

Sites have often given priority in the planning of their promotional and outreach activities to areas where there are high concentrations of older people and where there is significant social deprivation. Bristol have had a particular concern to reach ethnic minorities. In response to the Performance Indicators agreed between the Department of Health and the Care Direct sites, the targeting of wards with high indices of social deprivation is under way in all sites, although planning outreach activities in these nominated areas is still at an early stage in most.

Rural communities can face particular challenges in ensuring consistency of access and service outcomes. The first stage of the evaluation revealed low uptake in rural areas. Active experimentation is being undertaken by Gloucestershire and Devon Care Direct with the Rurality Project. This is assessing the access needs of older people and their preferred methods of contacting and communicating with the Care Direct service. The findings and recommendations from this research will help inform future outreach strategy in remote communities.

Challenges in delivering outreach

Conducting outreach is time-intensive, particularly in the shire counties, where there may be enormous distances to be covered in travelling to venues. This has forced areas to reconsider the cost-effectiveness of different approaches. Three sites have given up surgeries in public places where they waited to be approached by potential clients. This resulted in low user uptake for considerable cost, so outreach strategy has become more focused and proactive, typically with advisers visiting day centres, users' forums, outpatients' wards and special events.

There is always pressure to judge effectiveness in terms of the volume of demand created. But the longer-term impact of outreach may be difficult to judge as contact may be made some time after the event, while a regular Care Direct presence in the community maintains the service's profile among service users and professionals. Ultimately though, there has to be a viable relationship between the level of input made and the value to service users.

Outreach: Examples

Plymouth Hospital Discharge Scheme

Care Direct Plymouth have joined forces with Care & Repair to pilot the Hospital Discharge Scheme for a year.

The scheme is designed to provide assistance to patients leaving hospital who need initial help with settling back home after their stay. This comes in the form of a Care & Repair support worker who can provide company for the person in their own home on the day of discharge, collect any shopping and provisions, collect pets from their temporary care and ensure the home is safe and free of hazards.

They can also arrange for a handyperson to undertake any minor electrical work, such as replacing plugs, bulbs, fuses etc., move a bed and take care of minor adaptations such as fitting a grab rail and basic plumbing needs. Care Direct advisors can provide a benefits check to ensure the clients maximise their claims and assist with form completion.

Referrals are made primarily by occupational therapists and hospital social workers, who would normally have to make these arrangements for the patients. Details of the patient are given to one of our outreach advisors and they visit the patient on site to explain the scheme. A consent form is completed to allow the support worker access to the patient's home and arrangements are made using a referral form sent to Care & Repair. It is then the responsibility of the support worker to make contact directly with the patient and arrange for assistance.

The obvious advantages of Care Direct being the initial contact point is that there are often a variety of other issues with which the patient needs help and advice. The Outreach Advisor is able to deal with these and build a relationship for the future.

One success story happened from a visit by Mark Fagin to a patient at the Peirson Re-ablement Centre. A 93 year old lady was being discharged after a period of rehabilitation at the centre. She had no friends or relatives to help her at home and was in quite a confused state. When the Occupational Therapist did a home visit with her prior to discharge she had caught her hair on fire while trying to light her ancient gas fire. Care & Repair sent their support worker along to welcome her home and get her some shopping. Whilet there the Support Worker was able to complete a home check and make arrangements for replacement gas fires to be installed by their own personnel. They also arranged for their handyperson to repair some concrete and rendering, and for Homesafe, an organisation that provides security locks free of charge to vulnerable clients, to visit.

The potential for this scheme is huge, one of the main benefits being timely discharge from hospital/re-ablement care, thus assisting with the issue of bed-blocking which loses the NHS a great deal of funds.

Radio Devon and Care Direct

A letter describing an innovative example of outreach from Devon.

'I thought I should let you know what a superb service we have had from the Care Direct team here in Devon.

'I produce the lunchtime phone-in here on BBC Radio Devon, and we have a reputation for sorting out muddles and puzzles, putting people in touch with services of use to them. Our audience tends to the more mature end of the age range, so there is a very close fit between Care Direct's potential clients and our listeners. Care Direct Devon has made a huge difference to our ability to deliver information about benefits and services. It's the answer to a phone-in producer's prayers, really, and I've never come across anything like it before. I've struggled mightily in the past to find benefits experts who know their stuff but are also confident enough to broadcast live on radio AND have the off-air backup to follow through. The team is professional, responsive and seems keen to take on just about anything we throw at it! They also let us know if there is anything coming up we need to let people know about.

'The real test for us, though, is what we hear back from our listeners. On every occasion when Care Direct Devon has run an on-air clinic, the appearance has been followed a little later by calls from delighted listeners who have subsequently called the helpline for themselves, telling us how they got on. Some of those testimonies are very moving. Care Direct has also taken on a handful of individual one-off calls generated by the programme from time to time, and again is of good report.

'I'm such a fan I've been urging relatives and friends to get in touch (I know the helpline number off by heart) and they speak well of Care Direct as well. The feeling seems to be that even if they can't get a certain benefit or service, at least they know they've tried. The audience is at the heart of everything we do here at BBC Radio Devon, and I get the impression that the clients are at the heart of everything Care Direct Devon does.'

Jacquie Wain, Producer, 'Devon's Call', BBC Radio Devon

Mystery Shopping Care Direct

One of the new evaluation activities this year has been a 'mystery shopping' of Care Direct to check the quality of advice that is being given.

Mystery shopping involves actors telephoning the service with prepared scripts, as if they were real clients. The advice they are given is recorded and then checked by expert assessors.

This approach has been used for NHS Direct (*Health Which?* August 2000, pp.13–17). Our customer feedback survey, though an important element in the measure of performance, could give only limited insight into whether Care Direct was offering good advice.

The work has been undertaken in two phases: a pilot of 20 calls in early 2003, followed by a further 60 in the autumn. The calls have been undertaken by Taylor Nelson Sofran, responsible for NHS Direct mystery shopping. Considerable care and discretion is essential to ensure the calls are realistic yet do not compromise participants. All participating agencies were aware they were taking place, but not of course which precise calls.

So far only the pilot is complete. It used four scenarios designed around typical problems brought to Care Direct:

- An elderly man living alone in a rented flat facing difficulties keeping it warm;
- A daughter asking what might be available to help her mother to continue bathing herself independently;
- A carer wondering if she was entitled to any benefits now she had stopped work to look after her mother;
- A live-in carer needing extra help to support her in looking after her mother who has Altzheimer's.

Responses given by Care Direct were compared with those given by other local specialist advice agencies such as Age Concern and CAB, approached in the same way. Each scenario was presented to three of the Care Direct helpdesks and two advice agencies.

The assessment framework was developed following consultation with the National Association of Citizen's Advice Bureaux, and loosely based on the Quality of Advice Assessments used for their own quality assurance. There were five key questions. Had the advisor correctly established the problem? Had relevant options been offered to the client? Is the information and advice given appropriate to the caller's circumstances? Has the advisor identified relevant sources of help and provided the caller with information about them? Is the information accurate, up to date, and understood by the caller?

Each of these was scored out of five by experts in each field, recruited for this purpose.

Using this scoring system the pilot assessment made three observations. First, there was considerable variation in the depth and quality of advice. Call times varied enormously. Although the length of call was not always an indicator of a good quality response, the highest scores were earned where ample time was devoted to the call. Second, three of the scenarios generally scored well, but responses to the housing scenario were less good. These calls were very short, all under three minutes, and the assessor gained the impression that advisors could hardly wait to signpost the caller to another service. Third, on balance there were no clear differences in this small sample between Care Direct and the comparator agencies in the quality of the responses given.

CARE direct

Information and Help for Older People

- **Care and Support**
- **Your Home**
- **Money and Benefits**
- **Keeping Well**

Care Direct will cease to be a national initiative after March 2004. However Care Direct is planned to continue in some pilot authorities and the others will have a successor service available. The pilot authorities are Bournemouth, Bristol, Devon, Gloucestershire, Plymouth, and Somerset.

Call 0800 444 000 to get in touch. The national number will still be available for a while after March 2004.

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