# CARE Direct

## Evaluation Newsletter 2

### May 2002


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

CARE direct
0800 444 000
Information And Help For Older People

# Evaluation Update

*Care Direct is a new service being developed by the Department of Health in partnership with some local councils, for people aged 60 years and older and their carers and relatives. It arose from a cross-cutting review sponsored by the Treasury and Cabinet Office and led by the Department of Health, to find ways of improving information about services for older people. Care Direct is a practical response to the Government's modernising agenda to improve access to information and services, to respond to people in a holistic and integrated way, and to use IT to make these services more accessible.*

## Background

By the end of April 2002, Care Direct had been running between 5 and 7 months. Helpdesks have been successfully established and maintained in all 6 pilot local authorities in the South West of England.

The initial start-up period was one of local development, and a very busy period for local implementation managers, so the evaluation fieldwork was not started until a couple of months ago. For this reason, we can only report limited findings at this point.

Initial implementation of Care Direct has been somewhat different to the way it was described in Newsletter 1, though that is the way it may eventually become. In particular, the central Call Centre, run by NHS Direct, has had a different role to that originally envisaged. At present very few queries are being dealt with by the Call Centre. Calls are normally being routed direct to the local Helpdesks, to be dealt with by an advisor there. They are only directed to the Call Centre if they are not immediately answered by the local Helpdesk. Most frequently this applies to out-of-hours calls, late-night or weekend. The great majority of calls received by the Call Centre are not dealt with there, but passed to the relevant Helpdesk when it next opens.

## The IT Function

The IT supporting various functions of Care Direct is still being developed. In principle it performs three services:

- Providing a client data-base of information, recorded mainly during the telephone call. It is this that, in principle, allows a 'one-stop' approach which permits clients to be referred smoothly through the social care system as appropriate. It also supplies management information to local authorities and centrally.
- Routing call handlers and advisors through the call, ensuring the appropriate questions are asked and that calls are handled consistently. This may come to serve as an 'expert system' akin to that used by NHS Direct.
- Providing a computerised database of local resources for older people, 'DORIS' which eventually should become integrated nationally.

At present these functions are in the course of development. There have been a number of teething problems (see page 5), and it is anticipated that a major new version of the software will be launched in time for implementation by the second phase pilot sites open.

### Pilot Sites for Care Direct

Phase 1: Autumn 2001
- Devon
- Gloucestershire
- Somerset
- Bournemouth
- Bristol
- Plymouth

Phase 2: Autumn 2002 (South West)
- Cornwall
- Dorset
- Wiltshire
- Bath & NE Somerset
- North Somerset
- Poole
- South Gloucestershire
- Swindon
- Torbay

Phase 2: Autumn 2002 (Elsewhere)
- Bradford
- Essex
- Nottingham & Nottinghamshire (as one)
- Surrey

[§] NHS Direct findings from Munro, J.. Nicholl, J., O'Cathain, A, Knowles, E. (2000), *Evaluation of NHS Direct first wave sites*. ScHARR , University of Sheffield.

## Activity Levels

The clearest indication of activity levels is provided by analysis of answered calls to 0800 444 000. The diagram below shows the volume of calls during the first 24 weeks to the first 6 local authorities.

By March 2002, the call rate was 58 per 1000 population aged 60+ per annum. A comparison can be made with the early operations of NHS Direct. The first three pilot sites averaged a call rate of 37 per 1000 population aged 60+ per annum over the first 16 months[§].


**Call rate per 1,000 people aged 60+ per annum, in the first 24 weeks.**

This comparison is not entirely fair. A proportion of calls to Care Direct come not from older people but from relatives calling on their behalf. (At present we do not know what proportion). Furthermore, the telephony statistics alone may not be an accurate guide to the volume of activity at Care Direct pilots. Many queries are being redirected from elsewhere, particularly from social services departments. And contact via out-reach services, just getting started, will not be recorded this way.

Even so, the telephony statistics do provide some information. Seven calls out of eight have come in during normal office hours: weekend and evening calls are rare. And as the diagram shows, there was a large drop in calling during Christmas week. This is completely different from the pattern of calls to NHS Direct, where peak call rates occur in the early evening and there has been a surge at Christmas.

The median length of a call is 3 minutes, but this is low because of a significant number of calls of very brief duration, which may be misdialled or mistaken. About 10% of calls exceed 10 minutes.

As with NHS Direct, the pilot sites have experienced quite different rates of call, with the three smaller areas generally achieving higher rates (per capita over 60) than the three counties. Across the six pilots, the highest rate is around nine times greater than the lowest rate.

These differences are quite possibly in part due to the level of publicity that has been given to Care Direct, with a fairly slow start-up in many areas. Plymouth, for example, have found a direct relationship between rises in activity level and various publicity campaigns including a benefits bus, articles and advertisements in the media, leafleting, and adding a logo to Council Tax and HB/CTB claims forms. The implication would seem to be that there is plenty of potential for growth.

Another important factor affecting these differences between pilots is the arrangements made for cross-referring enquiries from other agencies. In some areas, arrangements are being put in place for some initial social services enquiries to be redirected to Care Direct in the first instance. The service is at this stage predominantly telephony based. Out-reach services are just beginning to be started.

Preliminary returns from some of the pilots indicate that around 25-40% of calls are for benefits and money advice, while most of the remainder concern social care or aids and adaptations. Housing and community health issues probably comprise no more than 10% of all calls. Around two-thirds of calls are closed after providing the caller with information, the remainder are passed or directed to other agencies.

Early feedback from the consumer call-back survey is providing an insight not only to the type of needs callers have, but also their views about the service. The great majority have been positive (see page 4), with callers happy to recommend the service to others. Among the reasons given are:

"It's instantly available. There's no answering machine. I liked the personal touch."

"Because they're not `the Council'. The personal touch."

Preparations are now well in hand for the second wave of a further 14 local authorities which will be taking part from October 2002 forwards. Care Direct will then be available throughout the South West, as well as in some other selected areas. The challenge for them will be to implement the new service, learning from and taking forward the experiences of the initial six areas.

# Care Direct in Action

*The following are real case-histories of people who were contacted as part of the customer call-back survey, or have been identified to us by pilot sites.*

Mr A, an 83 year old man, heard about Care Direct from regional television, his church magazine and the free local paper. A friend encouraged him to ring to find out if he was eligible for attendance allowance. Mr A was very pleased with the quick and courteous service offered. A letter and an attendance allowance form arrived promptly after his telephone call and he is now receiving the additional benefit. He said that he might have approached someone else if Care Direct hadn't been available but would probably have put it off.

Mrs B, caring for her 79 year old aunt, rang Care Direct looking for information about car hire and taxi services that would accommodate someone with severe mobility problems. She hadn't heard much about Care Direct before calling, just an item in the local newspaper. The helpdesk advisor was able to give her a fair amount of information immediately but also called her back with further details. More information was sent in the post. As well as responding to her immediate enquiry, the advisor had checked out the benefits that she and her aunt were receiving. The caller said that she `couldn't be happier' with the service, which had supplied more information than she had asked for, all of which had been of help. `A fantastic service that's long overdue' was her verdict.

Mrs C rang to enquire about respite care for her elderly father while she and her husband were on holiday in France. The Care Direct advisor rang back immediately with the required information, and the caller was able to arrange the respite break immediately with the advisor's help.

Mr D. rang for information on financial help for repair of his stair lift. The lift was bought about 25 years earlier through a disabled facilities grant. He had since purchased his council property therefore the council would not help with the cost of the repair (in excess of £200). The Advisor was able to inform him that he could apply for a new grant, which would pay for a new stair lift and with the caller's permission made a referral to Social Services to instigate the process. It was also identified that due to his wife's health and care needs she might be entitled to Attendance Allowance. They would qualify for Minimum Income Guarantee if both were in receipt of Attendance Allowance. This would increase their weekly income by over £100 per week. The couple also welcomed the offer of support from Age Concern for assistance with completion of the claim forms.

# Care Direct – A True Story

*Geoff Watson, Care Direct Manager Bristol, describes the trials and tribulations of getting the new service running. We are grateful to Care Direct Bristol for permission to reproduce the cover illustration showing a Bristol bus advertising Care Direct.*

Well - you've heard the official version of the Care Direct story. I'm here to give you the lowdown, viruses and all.

Setting up one of the first Care Direct projects has involved quite a few challenges and a fair share of anguish. The fun has come from creating something from a completely blank sheet of paper, and seeing it come to life. It has come from dealing with Lord Mayors, councillors, voluntary organisations, city council colleagues, the Department of Health, publicity officers, older peoples' organisations, IT people, furniture suppliers, unions, NHS-Direct, MPs, telecoms people, Benefits Agency people… and that's just in the first fortnight.

The pain has come from the battles that have had to be fought to get Care Direct on the map and taken seriously. Different people have had differing visions of what the service should look like, and a certain amount of conflict is inevitable in the change process. Some have been behind the project from the beginning, others have sniped from the sidelines.

Probably the biggest problem we have faced in Bristol has been - you guessed it - the IT. Back last summer, we were promised an all-singing (if not all-dancing) system which would provide a link with NHS-Direct, decision-support software known as 'algorithms' and a comprehensive database of resources, now known as DORIS (modesty forbids me from saying who came up with this name).

As of today, however, we are still using pieces of paper, and referrals from NHS-Direct are still coming through by fax.

One of the great things about computer systems is that there is so much scope to blame someone else when they go wrong. In this case, at least six parties were involved – BT, AXA, who designed and installed the software, the 'systems' people, the 'networks' people, the DH and, of course, the users of the system (us).

I could write pages about our painful experiences with routers, firewalls, IP addresses and the like - but, don't worry, I won't. Suffice it to say that - if you happen to be setting up your own Care Direct project - make sure you've got an IT person who really knows their stuff and is able to bang all the necessary heads together when required. And it will be.

As for the algorithms … the best thing to say is that we have kept an open mind about them. The DH is still very keen to make them work, so no doubt they will. In due course.

The other big problem has been persuading the public to call the new number. No new business would start up without spending a significant amount of money on advertising, and yet the budget we had available to publicise the service was distinctly limited. With only six pilot sites in operation, we were obviously not in the business of large-scale TV or radio campaigns. But - believe me - sending out leaflets to surgeries and libraries is not enough: when did you last pick up a leaflet at your doctor's and rush home to phone the number?

So we have put a lot of effort into local advertising - on buses, on poster sites, on council tax information sent to everyone in the city and in a whole range of publications. We've done radio interviews and shopping centre promotions. We've translated publicity into various languages. We're just about to start a door-to-door maildrop to 20,000 households. We've given away thousands of Care Direct biros and phone stickers. And we've even made a Care Direct video. But call volumes are still far too low, and this issue will need to be taken more seriously by the DH over the next few months.

It is fair to say that the relationship between the DH team and the various Care Direct sites has felt a bit strained at times. We have felt supported, bullied, encouraged, neglected and monitored in about equal measures. That's fair enough - they're paying the piper, after all - and the DH team has been under-resourced for the huge job they have had to do, but a lot of lessons have been learned by all of us in the short time we have all been working together.

Although I have focussed on the problems, I'm certain that Care Direct has an important future. I have a feeling, though, that it will end up looking rather different from the original vision.

As we keep saying every time we meet - it's a pilot. And that's what pilots are for - to identify the problems and do our best to find the answers.

# Phone Helplines in the Public Arena

*Judith Unell, Evaluation Project Manager, describes how the evaluation has been grounded in a systematic understanding of how the telephone has been used as a medium for providing information and support to the public. The following article draws on our review of the literature and visits to existing helplines.*

## What is a telephone helpline?

`Telephone helpline' is a conveniently accommodating term that gathers up many different interventions under a single banner. It can be difficult to see a common denominator but, from the evidence we have assembled, we offer the following working definition.

*A telephone helpline is a service which offers personal support and/or help with a query or problem through a dedicated telephone link which is accessed directly by the caller. It involves a one-to-one conversation between caller and helpline worker.*

Our definition excludes variants such as telephone groupwork or services which have developed in line with communications technology and depend indirectly on the telephone link, such as email and internet counselling, although we recognise that the latter in particular are likely to have a significant impact upon the shape of support services in the future[1].

## Helpline types

Our research has led us to develop a new typology of telephone helplines, and what follows is an explanation and development of these ideas.

Clearly, there are different possibilities for grouping helplines in order to make sense of a bewilderingly diverse field. Perhaps the most obvious is in terms of their physical coverage –national, local or regional – although this in itself reveals little about their different spheres of activity. The Telephone Helplines Directory, which contains details of around 1000 not-for-profit helplines, classifies them primarily according to their specialist focus, whether this is a subject area (such as alcohol) or a target group (such as children and young people)[2], This system suggests a concentration of helpline development around aspects of health and disability and also reveals large numbers of helplines targeted upon highly sensitive and personal issues where confidentiality and perhaps anonymity are likely to be at a premium for the caller, notably sexuality and sexual health, sexual abuse, HIV and AIDS, and alcohol and drug misuse. Compared to many other interest groups, older people and carers would seem to be under-served. Just 19 services are listed for older people - of which 7 are local Age Concern helplines - and 31 services for carers. In comparison, there are 151 helplines for lesbians and gay men, 58 for drug use and 70 for rape and adult sexual abuse.

Presuming that the THA Directory is broadly representative of the field, this suggests that older people and carers have not been priority targets for helpline services. The reasons for this are less easy to discern. It may be, for example, that many of the information needs of older people are served by helplines in the health and disability field and that there has been less need for an age-specific service. Or perhaps the telephone medium is one that older people and carers (many of whom will also be found in the older age groups) find less congenial than other groups, and the sparse development of helplines therefore reflects their preferences. Alternatively, the pattern may have evolved from unevenness in the availability of funding. Many helplines in the drugs and alcohol fields, for example, have received their funding through special central government initiatives, whereas those for older people and carers may depend more upon traditional sources of local authority and charitable grant aid.

Whatever the underlying reasons, the existing pattern of helpline services poses some interesting questions and challenges for Care Direct as it seeks to create a seamless and accessible service for older people and carers. Its capacity to engage older people and carers as direct users will be one measure of its success.

Another way of categorising helplines is according to activity or function. This is possibly more illuminating than an analysis by user group since it begins to tell us something about what helplines actually do and what they contribute to public well-being.

[1] See, for example: Oravec J-A, *Online counselling and the Internet: Perspectives for mental health care supervision and education.* Journal of Mental Health, 2000: 9 (2): 121-135

[2] Telephone Helplines Association, Telephone Helplines Directory, 2000

## Seven Models

- *Coping with public health emergencies.*
  Usually short-term, this type of helpline is often set up by a local public health department or hospital trust in response to a high-profile and alarming event, such as a meningitis scare or a medical incident. [3]

- *Offering crisis support to individuals at risk.*
  A different type of emergency line, this provides support to individuals in crisis. It may be developed as part of a specialist support service to known individuals who are at high risk of relapse, such as problem drug users and certain people with mental health problems. There are also examples of anonymous, generic and open-access services for people in crisis, most notably that provided by the Samaritans through its teams of telephone counsellors. [4]

- *Supporting behaviour change in relation to 'problem' activities, such as smoking, drinking, gambling and risky sexual behaviour.*
  Here the intervention is focused upon a specific behavioural outcome- a cessation or reduction of the problem activity.[5]

- *Operating a health care triage system.*
  The essential function of the telephone link is to direct callers to the most appropriate level of care, including self care. NHS Direct is, of course, the best-known and most comprehensive home-grown example but it was preceded by many examples of local nurse-led triage schemes across the UK and by insurance-linked managed care schemes in the US and Canada.[6]

- *Providing after-care support following hospitalisation.*
  Telephone support has been incorporated into the after-care regimes of certain groups of hospital patients, such as cancer sufferers, for whom emotional readjustment is an important aftermath of surgery and therapy.[7]

- *Responding to the information and advice needs of specified groups of people.*
  Particularly well-developed within the voluntary sector, such helplines often complement established information and campaigning activities on behalf of people who experience a common health problem (such as diabetes), a social condition (such as homelessness) or a life-status (such as being recently bereaved). Within the public service sector, telephone helplines are more likely to be geared towards assisting people who are eligible for specific services or financial benefits.[8]

- *Offering a listening ear and/or counselling.*
  While listening and counselling skills are essential elements in the repertoire of helpline staff, most services would nonetheless draw a line between using these skills as part of an information and advice-giving role and entering into a more open-ended relationship through which the caller's underlying personal needs are addressed. The latter is the territory of listening ear and counselling service, which are differentiated primarily in terms of the training of their workers. A listening ear service such as Nightline, staffed by student volunteers on university campuses, will offer callers an empathetic reception, whatever the nature of their problem, as well as practical information and signposting to further sources of help[9]; while a service such as CANDID, for the care and support of younger people with dementia, uses specially trained nurse counsellors who will engage with the caller in a fuller exploration of problems and possible solutions.[10]

As a generic service for people over 60 and their carers, Care Direct would seem to fit within the second-last category, although it might be required to take on other functions, such as crisis support.

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[3] Stark C, Christie P., Marr AC. *Run an emergency helpline*. British Medical Journal, 1994; 309: 44-45

[4] Samaritans website at www.samaritans.org.uk

[5] For example: Owen L. *Impact of a telephone helpline for smokers who called during a mass campaign.* Tobacco Control, 2000; 9: 148-154

[6] *For example*, Richards D, Tawfik J, *Introducing nurse telephone triage into primary care.* Nursing Standard, 2000; 15 (10): 42-45, and Berliner H. *America on the line*. Health Service Journal, 29 January 1998: 28-29

[7] For example: Broadstock M. Borland R, *Using information for emotion-focused coping: Cancer patients' use of a helpline*. British Journal of Health Psychology 1998; 3:319-332

[8] For example: Bunt K, Adams L and Vivian D. *Evaluation of the Pension Power for You Helpline*, DSS Research Report No.121, Leeds: CDS, 2000

[9] Nightline website at www.nightline.niss.ac.uk

[10] Harvey R., Roques P, Fox N, Rossor M, C. *Candid – Counselling and Diagnosis in Dementia: A national telemedicine service supporting the care of younger people with dementia.* International Journal of Geriatric Psychiatry,1998; 13: 381-388

# Care Direct Somerset

*Somerset have launched their own regular newsletter in support of Care Direct. This note describes some recent developments, and an illustrative case (Mr D) is given on page 4.*

With the 6 months anniversary on 31 March 2002, Somerset estimate that over 8000 calls had been taken. And Within the next 12 months the number of calls received each week are forecast to quadruple.

From 1 May 2002 Somerset Care Direct Advisors will act as first point of contact for public access to Adult Primary Care Teams in Social Services at Taunton and Wellington, taking all new callers to these teams. Following a trial period of 6 months it is then expected to be rolled out to the Adult Primary Care Teams in rest of the County. Callers need only ring the usual Social Services telephone numbers. By providing this service callers will be able to access the full range of Care Direct services should they so wish.

From 1 October 2002 Care Direct Somerset are planning to provide a messaging service for the Somerset Social Services Emergency Duty Team. Calls to the EDT will be answered by Care Direct, rather than an answer phone message, if the EDT workers on duty are busy.

A new outreach programme is being set up. Trained Advisors will be manning stands and providing face to face service at local supermarkets, libraries and other information points on a regular basis across the County, hopefully to include local events like the Royal Bath & West Show and Taunton Flower Show. An open invitation to receive a talk about Care Direct has gone to local support groups and social clubs that may benefit from the service.

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CARE direct

**Information and Help for Older People**

- **Money and Benefits**
- **Care and Support**
- **Your Home**
- **Your Health**

Currently being piloted in Bournemouth, Bristol, Devon, Gloucestershire, Plymouth, and Somerset.

**How to get in touch:**

1. **Call 0800 444 000 FREEPHONE**
2. **In person**
3. **On the internet, www.caredirect.gov.uk**

## 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, Sarah Lawrence and Judith Unell.

The newsletter is published biannually by the Personal Social Services Research Unit at the University of Kent, Canterbury, England CT2 7NP. Telephone 01227 823862. Please contact the PSSRU if you wish to be added or removed from the mailing list.

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.ukc.ac.uk/pssru/caredirect