

Maximising the Impact of Technology Enable Care

1. Discovery Phase Review



Problem to Solve

Stockport Council serves a population of over 290k people, with a 5% growth in over 65s and 11% growth in over 85s predicted by 2020. This demand is also reflected in the contact we receive regarding adults social care, handling 8,973 contacts in 2017/18, including 7,609 from over 65s.

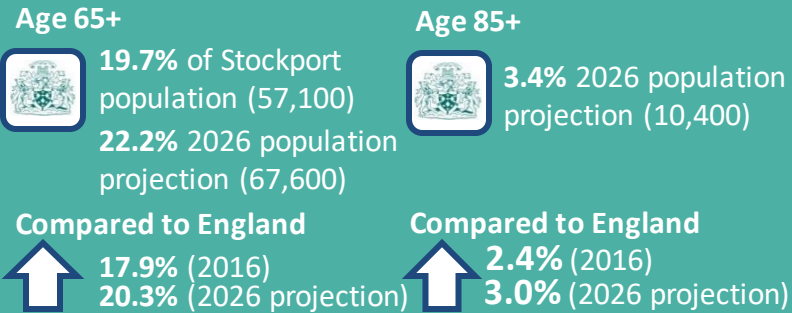
To meet the demand for health and social care services new models of care were introduced under the Stockport Together NHS Vanguard Programme focusing on early intervention and prevention.

In addition to this, the commissioned TEC (Technology enabled Care) service has been supporting 1,500 people to remain safe within their home or place of residence, and to live independent lives. However, the take-up and impact of the new models of care and Technology Enabled Care (TEC) is not as high as we would like, and the impact is lower than targeted.

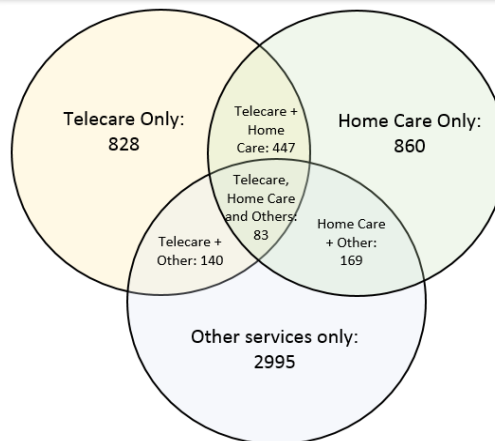
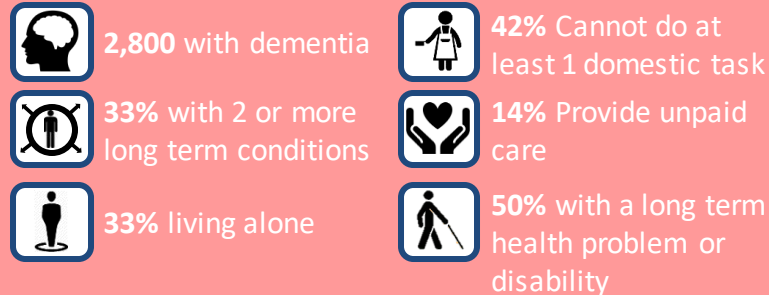
Our existing TEC solutions require installation by technical staff and demand has put pressure on the service, leading to long waiting times for installation and delays in discharge leaving people potentially at risk in the community. There is also a tendency to prescribe TEC as an additional service along with non-technical solutions, so we are not achieving significant savings.

The main objective of our discovery and implementation phase would be to provide a speedy and proportionate intervention to keep people safer at home with access to support in case of emergency and to provide reassurance to the person and their support network. The potential solution could link into the existing monitoring/response centre or contact family carers direct depending on client choice.

% of population (2016 data)



Health and wellbeing



It costs around 1% of the total annual social care expenditure to provide telecare to around 38% of the residents receiving some form of social care

Problem statement:

'Addressing the increasing pressure on **social care services** by identifying a quick, easy and effective technological solution to keep **people** safe and independent at home, avoiding the need for hospital admission or more complex social care. Increasing the impact of our **TEC service** and embedding TEC as the first line response to social care needs

Refinement and reframing:

From the beginning of the project, we were aware that this statement needed to be narrowed down to give us more focus for the limited time of the discovery phase. **Social care services:** One of our first challenges was to choose an area of adult social care. After some discussion it was decided to focus on the Councils newly formed STAT team. It is a direct point of contact for the public, and is looking for ways to solve issues without the need for a care package.

People: We chose to focus on (potential) older users of the current telecare service as this was the average user profile but would also be easier to engage with (considering ethics approval and capability) than e.g.. users with disabilities or people to be discharged from hospital.

TEC service: We decided to focus on Carecall, the Commissioned telecare service, rather than the stand alone kit service that the councils OT duty team provide due to the much larger amounts of clients and data they deal with.

Research Methodology – How we tackled the problem

The discovery phase was only the beginning of our journey, enabling us to explore our challenge in a holistic way. We followed the double diamond approach to move between diversion and conversion and will keep working this way to further refine and test ideas and move into the next phases beyond March 2019.



Using this model helped us to navigate through periods of uncertainty (eg. being faced with many insights from the user engagement period and many ideas from the solution workshop) and focus back on the initial problem.

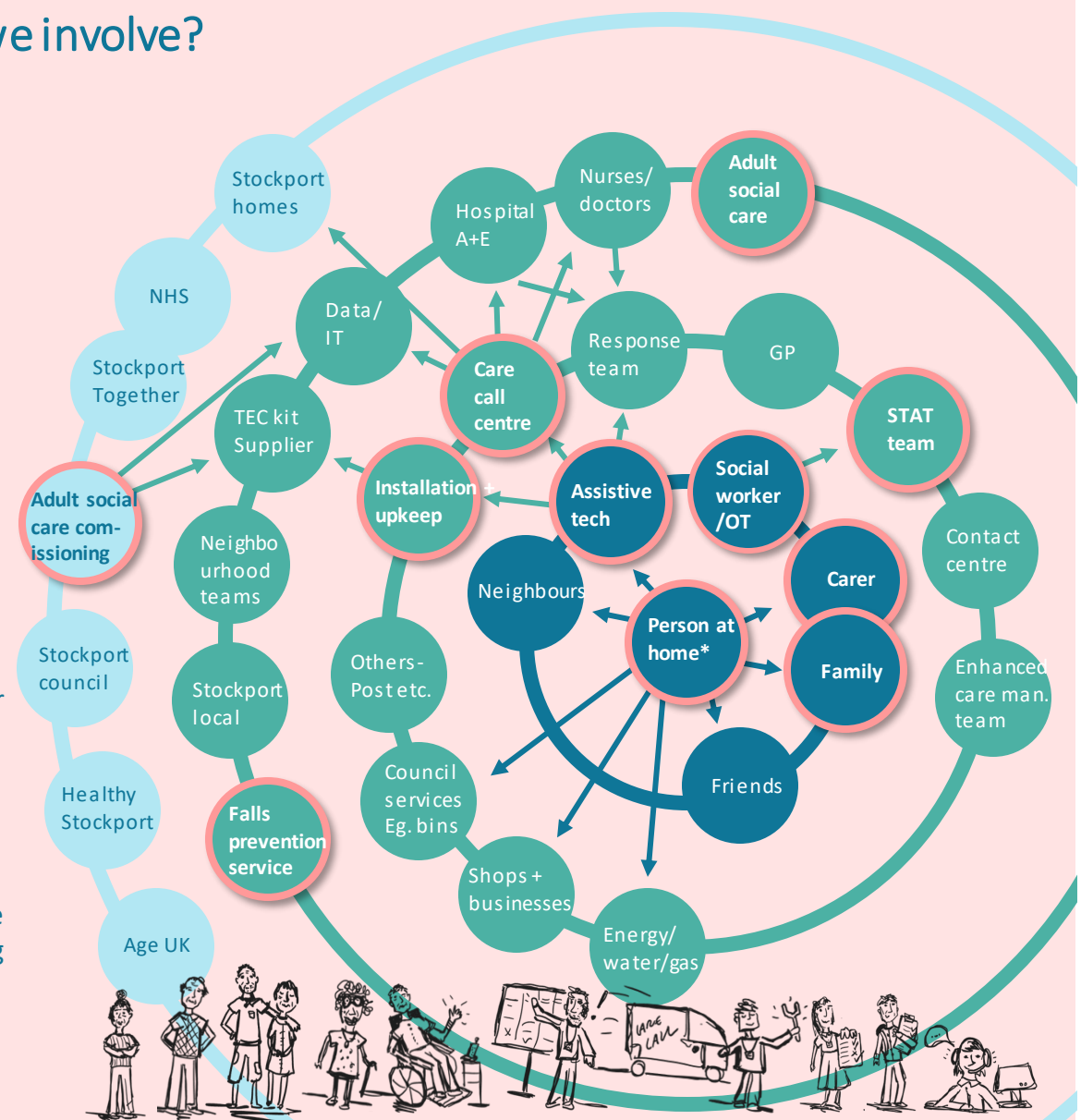
As we moved through these stages, we always reflected back on the aim of the project, but at the same time also didn't want to force it in a specific direction because we 'needed' a digital solution. We would have liked to engage with more, and a greater variety of users but the timescale did not allow for this, so we anticipate further 'mini' discoveries as the project progresses and we are able to focus on other vulnerable groups.

Who should/can we involve?

The next step after high level project planning was to develop a plan for engaging with stakeholders in order to explore the problem and the current experience, as well as to create relationships for co-creation and feedback on the final proposed solution.

It was important to firstly understand the bigger picture around the end user (person at home) and from there identify key stakeholders that would help us understand the context (within the limited time frame we would have for discovery).

The key aim was to gather insights from diverse range of stakeholders by using different methods (qualitative and quantitative) and creating outputs that can speak for both the user and business requirements of any solution.



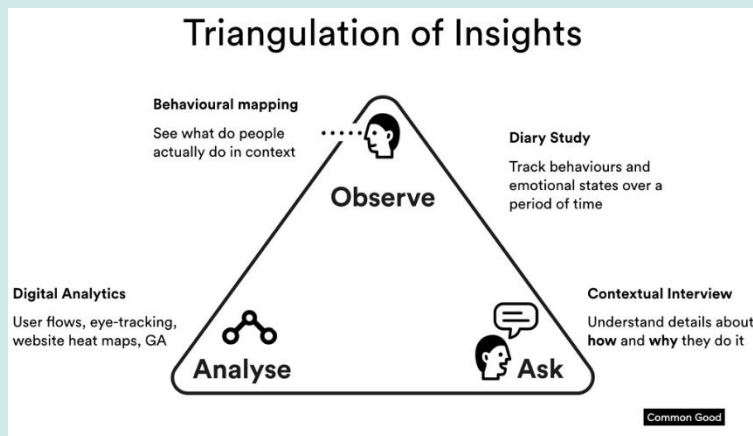
Research Methodology – User Engagement Strategy

The service designer and business analyst created a stakeholder engagement plan, validated by the project leader and manager. It draws on principles from human centred design, UX, service design and business/management to give a holistic view of the problem. The original plan can be viewed in our [online diary](#), but it evolved as we scheduled sessions and discovered insights as we went along.

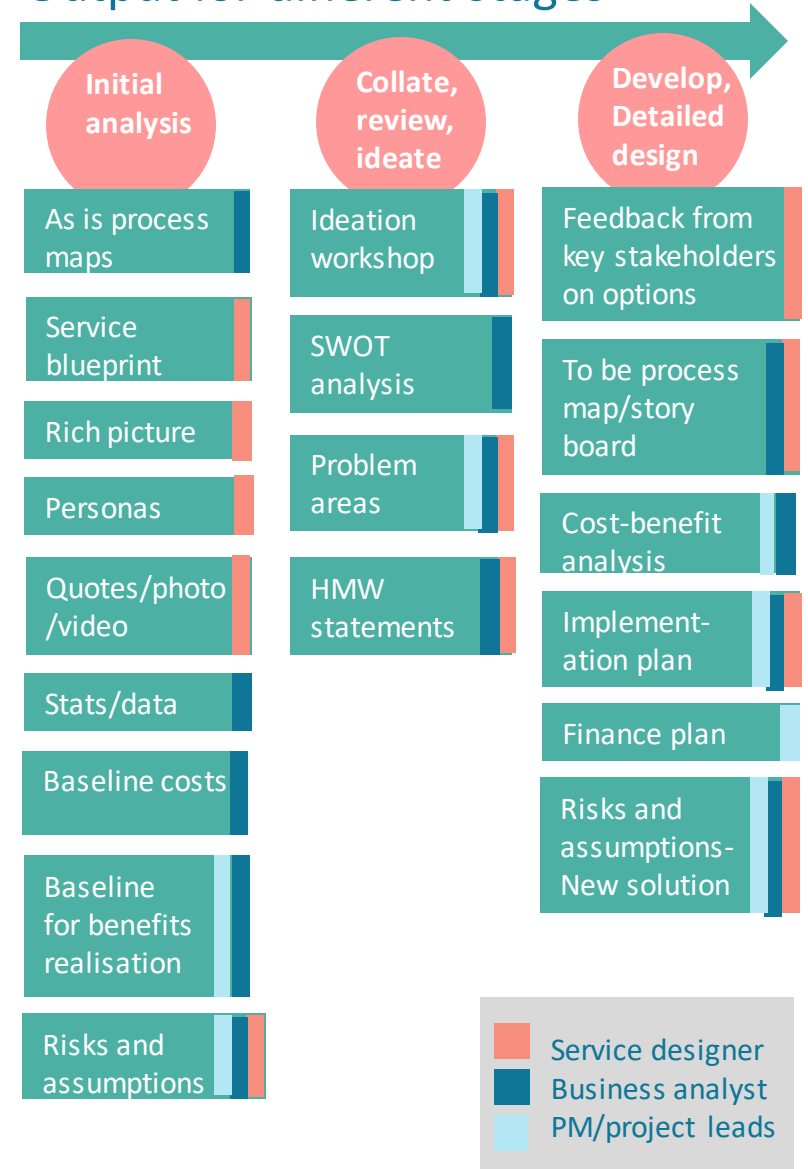
The methodology to create this plan was to establish the **key questions** we needed to answer, which stakeholder could answer them, what **activities/methods** we would use as conversation tools and what **outputs** would be produced.

We made sure to include a variety of methods of uncovering insights so that we came out with a robust foundation on which to build solutions and ideas.

- What is the current **end to end journey** from a service and user perspective- who/what is involved)? (from contact to implementation)
- Who are our **target users**? How do they live, what do they do, what do they need/want?
- Where are there **opportunities**/areas to implement change in the current process?
- What are the **costs** (not just financial) associated with the current solution/process?
- How does it link to **wider council/health objectives and initiatives**?
- How would we **measure success**?
- How are **others** tackling the issues? Can we learn from them?
- What are the **trends and barriers** around assistive technology/living?



Output for different stages



Research Findings

As we did our first desk research, talked to different stakeholders and progressed through the discovery we kept track of all our insights and key points in our research planner. This helped us to keep pain points and opportunities from each stakeholder engagement session organised and ready to be reviewed to identify our main challenges.

It was important for us to not only look inwards at what the service and our clients/residents are experiencing (and what priorities they have- see right) but also to understand the wider context and trends around telecare, technology and the ageing population.

Some key points from this were:

- Common barriers to uptake of assistive technology for older people are usability problems, lack of perceived benefits and technological ability.
- Technical (eg. appearance, functionality) and human dimensions (self-image, autonomy, knowledge) shape a users experience with technology.
- 55-75-year-old 'silver swipers' are the fastest-growing adopters of smartphones, with 77% already owning smartphones. 64% of people in this age group also own a tablet. (Deloitte 2018)
- Around 85% of 55-75 year olds use a voice assisted speaker (eg. Amazon echo) daily (Deloitte 2018)
- 33% of all Brits believe wearable technology will make their lives better and have helped drive sales of smartwatches and fitness bands to an estimated four million devices in 2017, up 18% on 2016 (Mintel, 2018)



Remain independent and keep up lifestyle (around the house and outside).

Peace of mind that I will get help quickly when something happens.

Reassurance for carer/partner/family that they are ok/have access to help.

Priorities of users/staff

Service/kit that is inclusive and tailored to individuals and their context.



Alarms received are genuine Incidents/emergencies

Complete high quality referrals according to SLA lead times

Get in early and prevent people from needing more complex care/ambulance services.



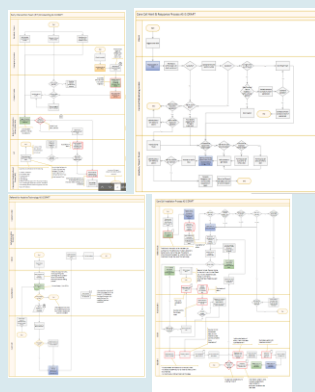


Research Findings

Process and user journey

With the stakeholders identified and the objectives refined, we met with the people who could provide an overview of the end-to-end processes to ask the key investigatory questions: What, why, who, when and how? To do this we met with: Adult Social Care Commissioners, the Carecall Concierge Manager and the Early Intervention Team Leader. The objective of these sessions was to get a view of their world and the current 'as is' process as they see it working today.

From here, we identified the pain points and areas which required further investigation. We also combined the process maps into a high level, end-to-end service blueprint to get a better understanding of the user and Staff touchpoints and experiences.* Furthermore, these sessions created a platform from which we could expand our investigations through: persona creation, user journeys and contextual interviews.



| | Belief | Context | Assessment | Referral | Self-referral | Request and | Referral/Request? | Response/Ref? |
|--------------------|--------|----------------|--------------|------------------|---------------|---------------|-------------------|---------------|
| Front stage | | | | | | | | |
| What happens? | | Telephone call | Get to staff | Lead to referral | Referral made | Referral made | Referral made | Referral made |
| What is involved? | | Telephone call | Get to staff | Lead to referral | Referral made | Referral made | Referral made | Referral made |
| Touchpoints? | | Telephone call | Get to staff | Lead to referral | Referral made | Referral made | Referral made | Referral made |
| Pain points? | | Telephone call | Get to staff | Lead to referral | Referral made | Referral made | Referral made | Referral made |
| Back stage | | | | | | | | |
| What happens? | | Telephone call | Get to staff | Lead to referral | Referral made | Referral made | Referral made | Referral made |
| What is involved? | | Telephone call | Get to staff | Lead to referral | Referral made | Referral made | Referral made | Referral made |
| Touchpoints? | | Telephone call | Get to staff | Lead to referral | Referral made | Referral made | Referral made | Referral made |
| Pain points? | | Telephone call | Get to staff | Lead to referral | Referral made | Referral made | Referral made | Referral made |
| Operational? | | Telephone call | Get to staff | Lead to referral | Referral made | Referral made | Referral made | Referral made |

Personas and needs



As someone living alone, recovering from illness, I need piece of mind that I am supported, so that I can go about my life without fear, because I need to focus on other things.



As an OT, I need to be able to stay on top of my visits and pass on high quality referrals, so that people can be helped quickly, because otherwise their situation may get worse.



As a carer of someone with dementia, I need to know what they are doing at all times, so that I can decide when I need to intervene/help, because I want them to stay independent.



As a team leader (STAT) I need to identify and pass on potential cases quickly, so that we can intervene early, because we want to avoid using more complex/costly care solutions.



As someone who is disabled, I need to be able to rely on care call to help me in certain situations, so that I can cope with living alone, because I don't have anyone else to support me.



As a call handler I need to be able to dedicate the most time to urgent alarms, so that we can help people as quickly as possible because that's what they use our service for.



As a carer, I need to be sure my wife is okay at all times so that we can continue enjoying our life-style for as long as we can, because we don't know how things will be in a few years time.



As an installer I need to know as much information as possible before I visit a client, so that I am well prepared, because otherwise installations can take a very long time.



As someone with mobility issues, I need my husband to help with everything, so that I can live my daily life, because I don't want to give up the things I enjoy doing!



As a team leader (CareCall), I want to be certain that we provide a good service, so that we can help clients appropriately, because we are often the only support they have.

* We would like to keep process maps and blueprint confidential, so please request the full documents from us if you would like to see them

Research Findings - Overview

One client said it's not a big deal, and one said she appreciated CareCalls **patience with false alarms**.

One client reported not **hearing the unit** from the bedroom was sometimes an issue.

Having kit makes people less worried and more confident. It's also crucial in helping carers feel less anxious, so they can up their own hobbies/social life. For some people their kit is a lifeline to the outside world. Appreciate simplicity of only having to press one button if help is needed.

Everyone is worried about falling and it seems it can happen anywhere, at any time. The perception from one user was that when a fall happens, one would certainly be unconscious and not able to press a button. Carers/partners sometimes don't have the strength to lift the person who has fallen. Little awareness of falls prevention services/support.

There were some comments about long waiting times but these were said to be 'understandable'. People making a decision about if they want to try it adds extra delay. **In some cases it was clear that users need telecare ASAP but due to the current process would have to wait.**

Few user aware of how CareCall works, who it can help and what it can help with. One client no clue about kit before installation and therefore very sceptical. Assumption that you don't need it if your partner/carers is there to help you. Opposing attitudes- client says "I don't need it" vs. partner/carers/family "I think it would really help".

False Alarms

The #1 reason for inbound calls from devices to the monitoring centre. Equivalent to 76 hours spent taking these calls, based on an average call time in Q1 2018

No Voice Contacts

86% of all No Voice Contacts were recorded as false alarms Jan – Jul 2018. Teams of 1 or 2 people have to physically attend to residential properties to confirm this.

Reassurance / Anxiety

The #1 'genuine' reason for inbound calls to the monitoring centre, where action can be taken

Fall Detection Accuracy

During Q1 2018, there were more than 1,983 inbound calls triggered by the automatic falls detector. Of these only 24 were genuine falls, whilst 1,465 were false alarms

Actual Falls

The 2nd highest reason for inbound calls to the monitoring centre, where action needs to be taken but arguably the highest costing, with falls expected to cost the NHS £2 billion by 2020*

Long assessment lead time

It currently takes around 8 weeks for a social carer to complete a low level assessment – which could result in telecare – following an initial referral due to demand and available resources

Long installation (lead) time

From Jan – Jul 2018, on average it took 20 days for 'routine' and 16 days for 'urgent' from receiving the referral to installation. The SLA is 5 days and 1 day respectively. Proportion of time spent on admin + paperwork during installations high.

Perception of service/eligibility

From Jan – Jul 2018, 16% of installation bookings had not gone ahead due to problems. The leading reason for not completing an installation was "Refusal"

Research Findings: Call reasons

When a telecare device is 'triggered' it generates an inbound call to the call centre. An operator answers the call and attempts to make contact with the resident:

- Via a loud speaker on the central unit
- Or by phone
- Or records a no-voice contact and makes arrangements to send someone to the residence

Once contact is established, a reason for the call is recorded by the operator. There are a lot of different reasons to choose from a defined list. We've analysed this data to identify the most common reasons for residents to call in, the devices which trigger the call and any other supporting information

One time she fell and she was banging her walking stick against the wall for ages- husband downstairs couldn't hear her or "ignores" her- *User comment whilst shadowing OT*

"I'm always falling!" "We had to cancel our holiday because her face was that bad"- *User/partner*

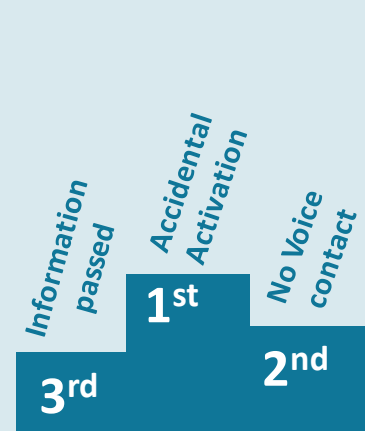
Bathroom and stairs are most tricky but could fall anywhere - can find yourself in a difficult situation and fall. *(Common point from user research)*

"I think the list of call reasons needs to be looked at as it's so big, but at the same time some reasons are missing, like something to deal with the medical reminders" – *Call handler Carecall*

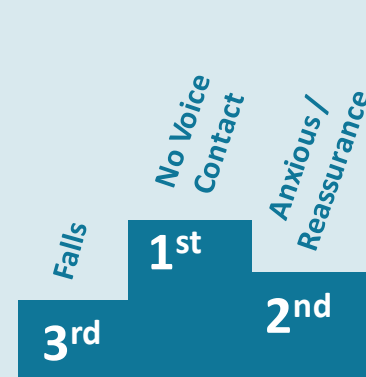
"Still worth the weight of gold having this" *(referring to automatic falls detector bracelet even though she is now in a wheelchair and false alarms happen regularly)*
 "Sometimes I've rang care call and said 'could you ring my mum and ask her to come over'" - *User*



Top 3 reasons for inbound calls – general:

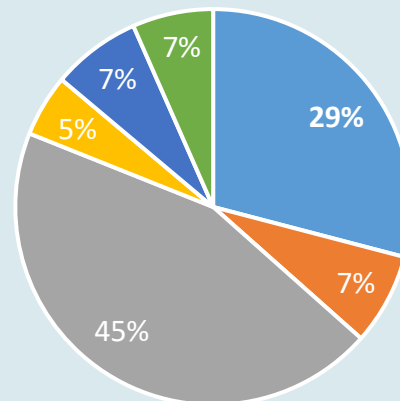


Top 3 reasons for inbound calls – where action is required:

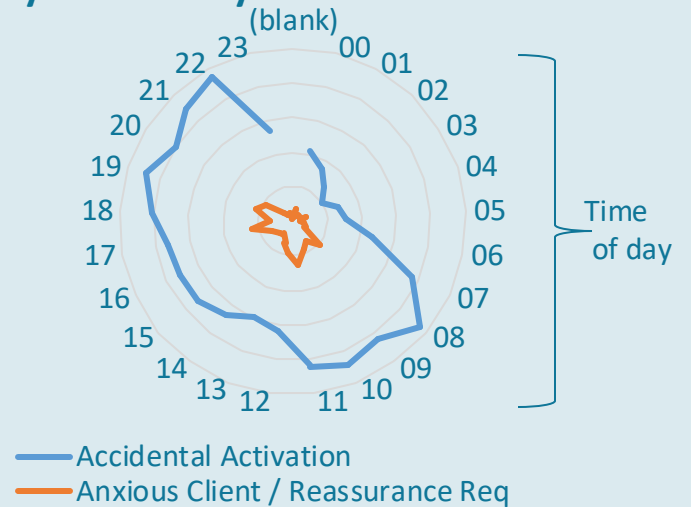


Fall by Location

- Lounge
- Kitchen
- Bed or Bedroom
- Hall
- Bathroom
- Chair



Accidental activation and reassurance calls by time of day



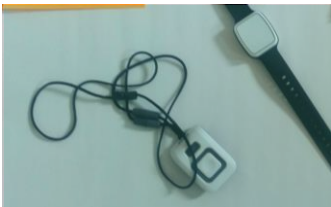
A potential pattern in peak calls for false alarms and people seeking reassurance. Could there be some overlap? Residents just want to know that there is 'someone' there.

Research Findings: The Kit

A range of different products are available within the telecare package, with the home unit and pendant being the most common 'standard' ones. The majority of the kit is reactive – it only responds when a certain event has happened, doing nothing for prevention. The products are classified as first and second generation telecare, lagging behind the third generation which would be AAL (ambient assisted living). We analysed the data from the most common devices to find further opportunities/problems...

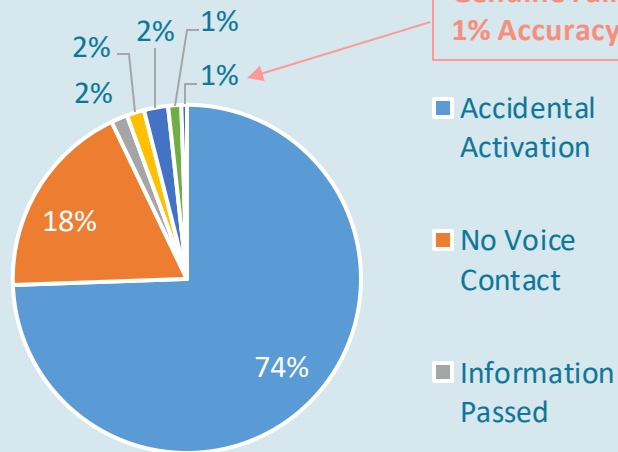


Lifeline unit and pendant – 54% of total kit spend



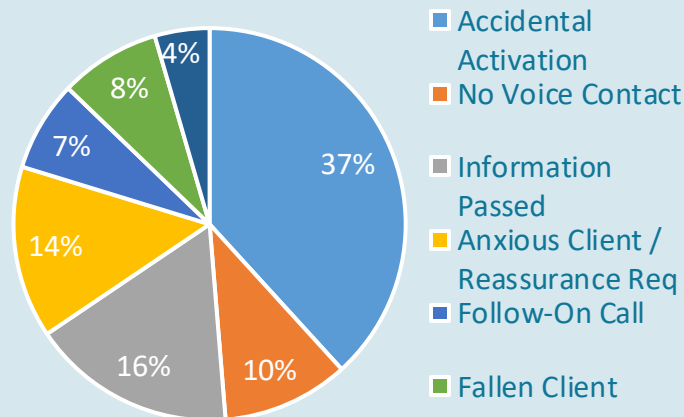
Automatic falls Detector – 16% of total kit spend

Reasons for Automatic Fall Detector Alarm



Genuine Falls – 1% Accuracy!

Reasons for manually pressing button (Manual trigger / button)



Emergency Visit data taken from Jan-Jul 18. Call Data is taken from Q1 18

"We threw ourselves on the floor but the alarm didn't happen" – User (ordered a falls detector online but it didn't work so now sceptical of Care call one they are about to receive)



"Wouldn't make any difference if I had ten things, I only press one" – User



Gps tracker is brilliant. Most tech is "absolutely useless" for people with dementia- just press the buttons as they don't know what its for. - Carer

Difficulty hearing Unit when in other room- User

Move to more preventative approach- get in earlier before cognitive decline to make telecare kit part of everyday life/habit - Carecall team leader

What we've got at the moment does it's job/..the smoke detector saves lives- Carecall installer



Research Findings: Referral process

Another problem area was the referral process itself- both in terms of lead time for assessments/installations and the quality of the referrals (lacking important details, kit rather than outcome based).

We found that too many referrals were classified as urgent and that the targets 5 days for routine and 24 hours for urgent referrals are not being met.

The complete journey from initial contact, referral, assessment and installation takes place across multiple different systems and teams. This made it difficult to track and provide a reliable extract for analysis. Instead, we've used anecdotal evidence to provide an approximate lead time, based on feedback from residents and staff.

"I think probably as time goes on I need carecall because my husband wouldn't have a clue what to do if I passed out" – *Caring for husband with dementia*



Referrals end up being 'shopping lists' - sometimes it's not common sense to put in telecare kit. – Occupational Therapy Duty team handy person

Currently not using the Carecall referral form at home visits (take notes and log information after). Some details/questions get missed and overlooked. – *STAT team Occupational Therapist*

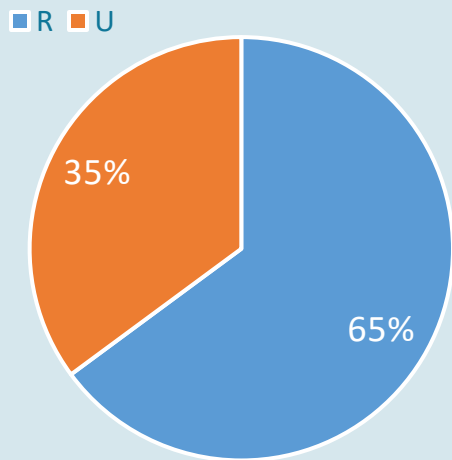


Took long to get going (9 weeks from assessment to care call installation). Understand we are not an emergency but it is still a long wait. - *User*

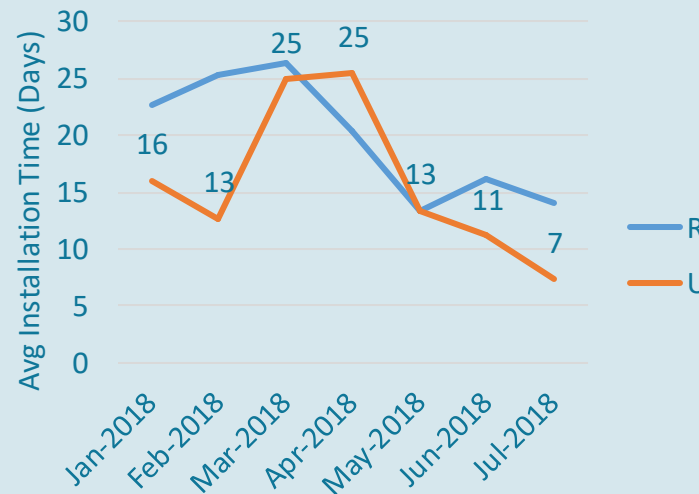


" If the information they give us is right , we could get more done" – *Carecall installer*

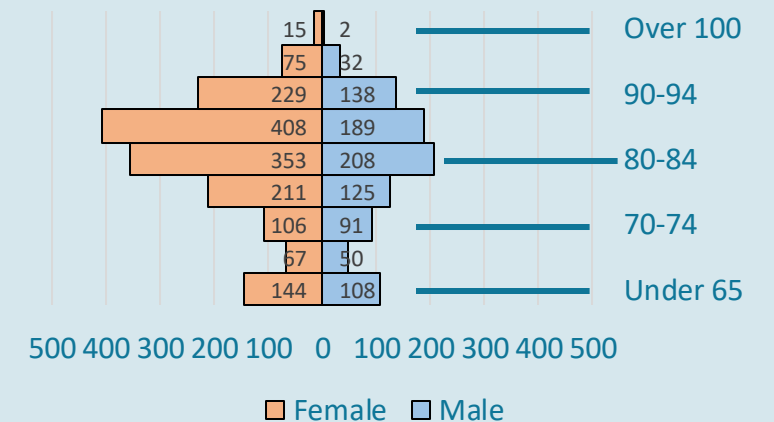
Routine / Urgent Referral Proportional Split



Average installation time, by month and urgency



Clients starting with Telecare (recorded on CareFirst) - April 2016 to August 2018 inclusive

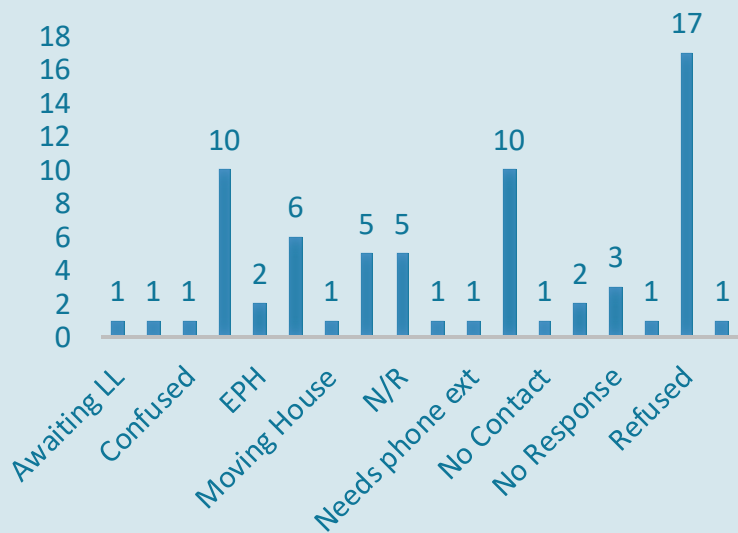


Research Findings: Perception of service/tech

One other area of concern/opportunity was the attitude toward assistive technology and the Carecall service. We discovered that few people knew what telecare is (even those expecting an installation the next day) and if they were eligible or not. They made assumptions that if, for example, they live with a partner they would not be allowed to receive the service. This is likely to cause some delays and confusion later on in the process where they would either decide against the free trial because they don't know what Carecall does, or refuse an install (figures below) because they are not prepared.

We realised that there is a common negative/sceptical attitude towards the technology, but once people have tried (and been helped by) the service this changes...

Reasons for failed installations – Jan-Jul 2018



"I'm on carecall so that does away with the worries about falling, but they also remind me to take my medication every four hours, so that's a good thing" – User with Parkinson's



"He hates it. Let's say he's too proud so he hates all these systems... I thought it was quite a good idea" - Carer



"It doesn't matter whether I'm in the house or not...I can't have a collar and lead on him, so he's got his care call, the neighbour knows I've gone, and he's got a key"-Carer

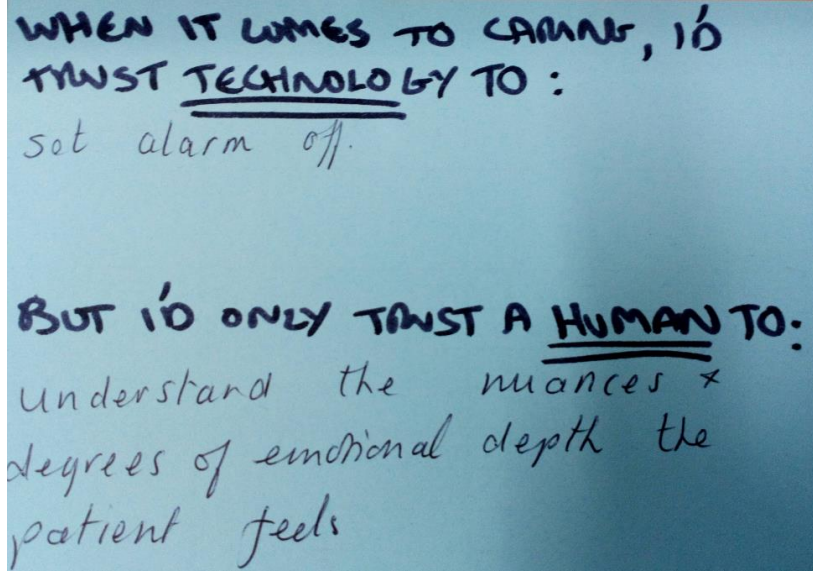
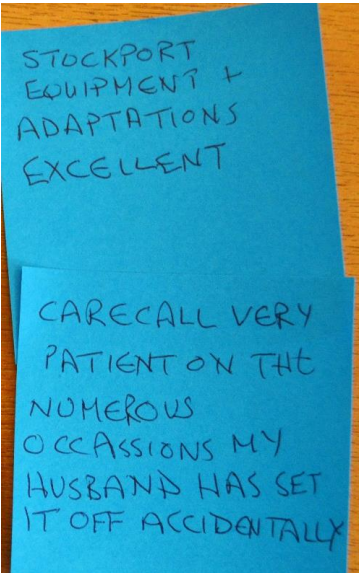


"I like to exercise but I don't want to leave him too long." – Carers health being impacted...

"If we can do the normal things then let's just keep going that way- it's much better" – User

"This disembodied voice says 'do not worry'...oh my god....I realised it's care call" – Carer talking about care call alert after power cut

"I do (need care call) but you're always here. He can do as much as they can" - User talking to partner

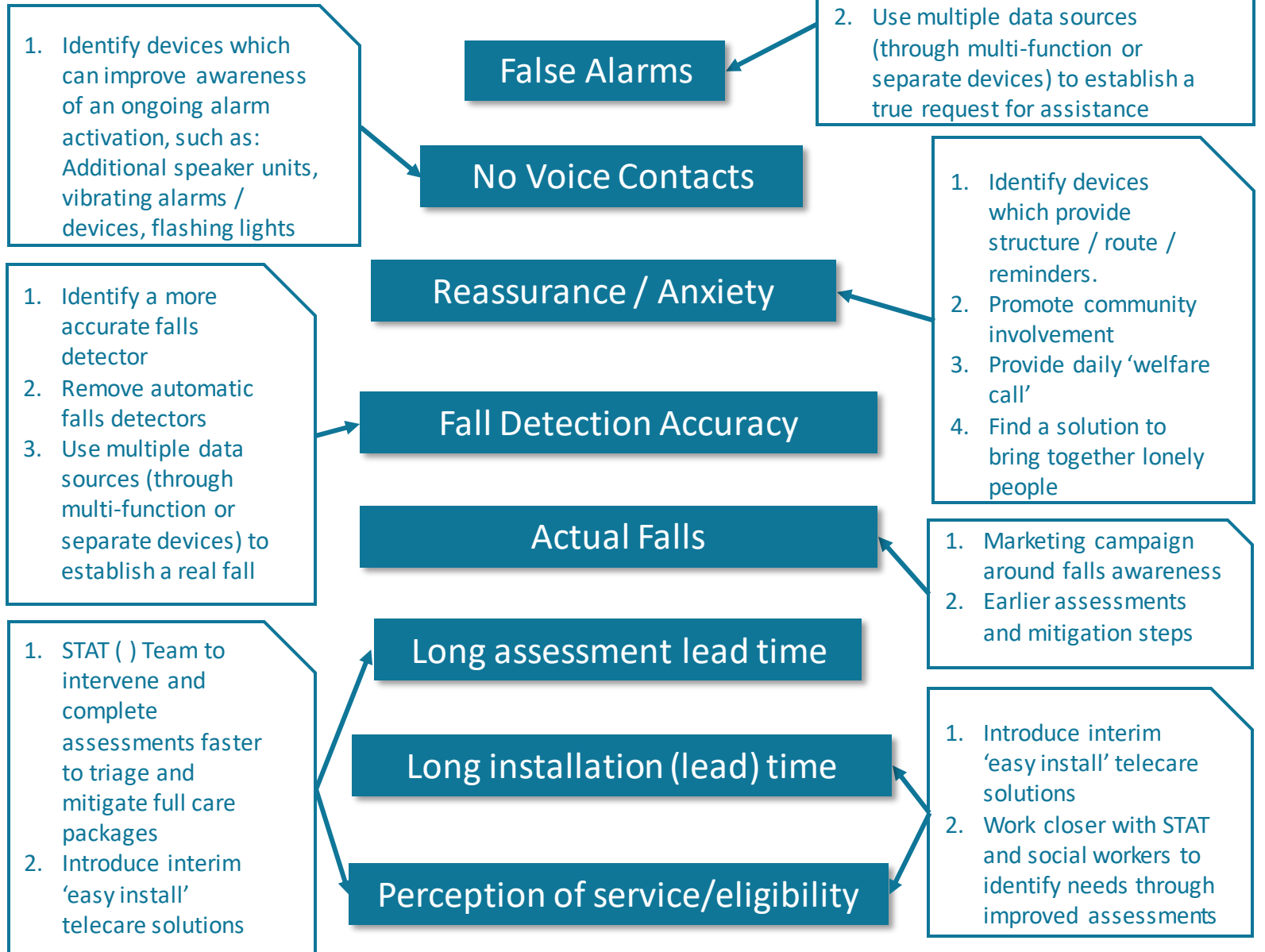


Validating Initial Ideas – The solution workshop (Ideation & Discussion)

After the stakeholder engagement sessions it was time to pull all our findings together and plan the solutions workshop. We used our research planner to identify our key problem areas, making sure that we consider both Service/staff and user perspectives.

The aim of the workshop was to present attendees (a variety of people from internal and external services and roles, some with 'fresh eyes' on the project) with the current situation, help them to empathise with key stakeholders, encourage them to come up with ideas to tackle key challenges, and then evaluate the most promising ideas to get 3 or 4 options to explore further (which we had to do after the workshop as there were too many to evaluate in the time we had).

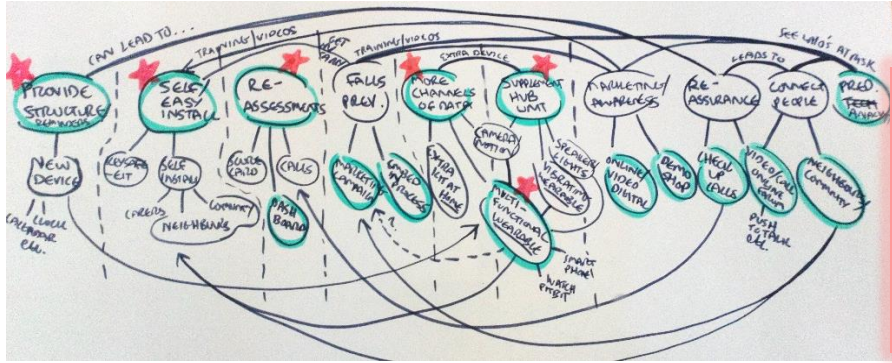
After the workshop we asked some participants how they found the workshop, and which idea they thought was most promising...(Click image below to play video)





Validating initial ideas – Scoring and grouping

We had a some great feedback and suggestions. From the initial ideas, we were able to group into ‘themes’ and apply pre-defined solution criteria to establish a nominal score for comparison. Our criteria for a suitable solution included: Time to deliver, Risk, Scalability, Budget and User value/Business value. As well as identifying high-scoring ideas, we also looked for any ideas which may have scored low on their own but could achieve a high score once combined with other ideas. With a score to determine the ‘best’ ideas we targeted these for further investigation and viability.



| Theme | Solution Description | Time to Deliver | Risk (RAG) | Scalable | In Budget | Digital | Solves multiple problems | Meets problem statement | Meets Age well priorities | User value | Business / staff value | Total Score | Comments |
|-------------------------------|--|-----------------|------------|----------|-----------|---------|--------------------------|-------------------------|---------------------------|------------|------------------------|-------------|---|
| Speed up process | Self install / Easy install / Fast Track for staff, carers and residents | 1-2 Months | Amber | Y | Y | Y | Y | Y | Y | H | M | 22 | EIT/SW to take over some installs or even the client themselves? Change in process and roles. Key safe issue. |
| Process | More regular re-assessments, inc score cards | 1-2 Months | Green | Y | Y | N | Y | Y | Y | H | M | 22 | Not feasible? What if it happens automatically from updated records? |
| NVC | Replacement Hub Unit or supplementary kit to aid communication (lights, wristbands, etc) | 3-4 Months | Green | N | Y | Y | Y | Y | Y | H | H | 22 | Quite specific to Stockport kit |
| Kit - Falls, NVC's, etc | Multi-functional wearable devices | 5+ Months | Green | Y | Y | Y | Y | Y | Y | H | M | 21 | More information required. Can all link to PNC. Can smart watches? Eg. GPS tracker on a diff terminal but with pnc8 will be interoperable (peripherals don't have sim card, GPS does) |
| Falls | Marketing / Awareness campaign for falls prevention for residents and carers | 1-2 Months | Green | Y | Y | N | N | Y | Y | M | M | 20 | Highlight the support available |
| Falls | Embedding falls assessments within existing care pathways and processes | 1-2 Months | Amber | N | Y | N | Y | Y | Y | H | M | 20 | Be more proactive and make sure people referred earlier/more often |
| Reassurance / Anxiety | Introduces devices which provide structure / reminders to daily lives | 1-2 Months | Green | Y | Y | Y | N | Y | Y | L | L | 19 | Can simple solutions - good for reassurance and those living with dementia? |
| Process | Online / Digital Marketing & Training | 1-2 Months | Green | Y | Y | Y | Y | N | N | L | M | 19 | Marketed at residents and their carers - help to prep for care call and what devices do |
| Reassurance / Anxiety | Daily / Proactive telephone check up's from CareCall / Volunteers / Other Groups. | 1-2 Months | Green | Y | Y | N | N | Y | N | M | M | 19 | No capacity- depends who's doing it (volunteers, automatic)... |
| NVC and Reassurance / Anxiety | Community involvement to act as 'first responders' and strengthen community network with neighbours to promote social engagement | 5+ Months | Green | Y | Y | N | Y | Y | Y | M | M | 19 | Tried light idea a while ago- worked well but concerns about proper response/visibility of alarm out of the house security concerns |
| NVC and Falls | Combine multiple sources of data from different devices to introduce preventative measures and reduce NVC's | 5+ Months | Red | Y | Y | Y | Y | Y | Y | M | H | 19 | More information required. |
| Process | Predictive Analytics to inform marketing, proactive referrals and future initiatives | 5+ Months | Green | Y | Y | Y | N | Y | Y | L | M | 18 | Eg. age in certain areas, isolation |
| Process | Demonstration Shop / House marketing campaign | 5+ Months | Amber | Y | N | N | Y | Y | Y | M | M | 17 | Doing it anyway? |
| Reassurance / Anxiety | Video Calling / Online forums / link up people | 5+ Months | Amber | Y | N | Y | N | Y | N | M | M | 16 | push to talk? On existing units? Need a reasonable amount of people to take part- can be an issue |
| Process | Dashboard view of inbound data, kit available, history, etc. | 5+ Months | Amber | Y | Y | Y | N | N | N | L | H | 16 | Can PNC do this? |
| Reassurance / Anxiety | AI / Alexa / Virtual Assistants / Chatbots | | | | | | | | | | | 0 | Other people are doing it. Nothing new. A lot of older people don't |
| Process | Electronic referrals | | | | | | | | | | | 0 | Very local to Stockport |
| Process | Professional / Staff training | | | | | | | | | | | 0 | Very local to Stockport |



Validating initial ideas – Refinement

Taking the high scoring suggestions and ideas we looked to refine even further based on a number of factors. This included looking at the overall environment in which we are operating, the implementation timescales provided by the LGA and viability of implementation into the real world.

Telecare

We have evidence to support the view that monitored telecare solutions keep residents in their own home longer, mitigates emergency / secondary care intervention and can be more cost effective than traditional social care packages.

With this in mind and concentrating on solution scalability – both for other Stockport service sand other LA’s – we took the decision to build on the telecare foundation, when identifying appropriate solutions as much of the infrastructure already exists to support deployment.

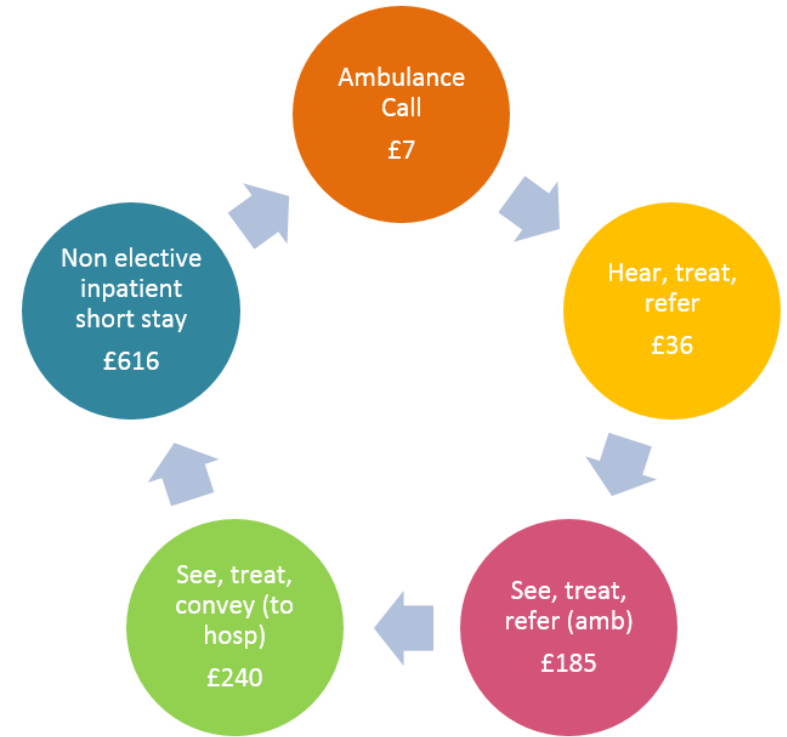
Systems

The telecare provider (Carecall) use a system called PNC to manage the service users. This is very popular system, also used by many other LA’s across the country. The provider of PNC is currently running a programme to upgrade their customers to the latest version of PNC, which will provide additional functionality. A key feature of this new version is the ability to receive digital information (rather than analogue) which is a pre-requisite to many advanced monitoring solutions and peripheral devices. Until this is implemented, we are restricted to analogue inputs. However, the upgrade is planned for December 2018 and we have made provisions to work around this to get the best possible solution, whilst future proofing our ideas.

In addition, the current system used by the social care service at Stockport Council is also part way through a large scale replacement, with all Requests for Change (RfC) on hold. Therefore, any ideas involving the systems in use and any enhancements have been carefully considered to take these ongoing projects into account.

Infrastructure-

Some of the suggested solutions relied on the resident having a reliable, wireless internet connection in their homes. For most of us, this is a given but from the anecdotal evidence supplied by staff and residents themselves, this is often not the case for the generations currently requiring assistance. Although we imagine this to change in the future.



We know that costs associated with emergency services are high. Between Jun 17 - May 18 there were 3,196 Code 1 attendances to homes by responders. With the telecare service in place, only 8.66% events required an ambulance on average.

Without the monitoring and responder service, the number of residents requiring an ambulance would have been significantly higher, as would the resulting costs of care. This further justifies the focus on the current telecare service.



Validating initial ideas – Real World Feasibility

1. Steering group- staff experts

With the proposed solutions scored and refined, we took our findings and justifications to the Steering Group (SG). The SG is primarily made up of the key stakeholders and experts in their areas, so the team pitched the potential solutions to them for review.

It was essential that the proposed solutions were constructively challenged to identify problems, risks or areas of improvement as early as possible. In order to facilitate this, we created a paper based walk through of the implementation and day-to-day operations to physically step through each task.

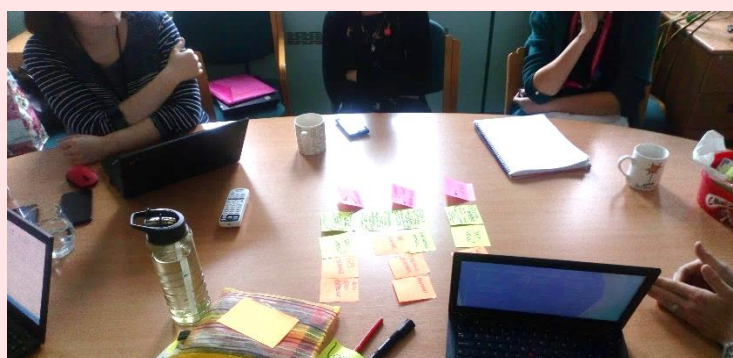
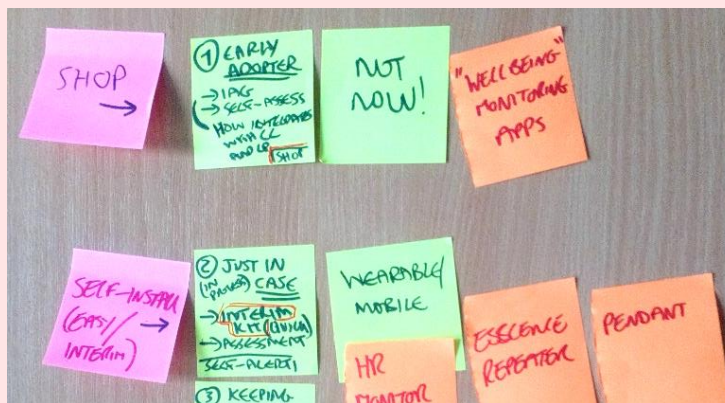
From this intense and detailed session, we were able to walk away with solutions which we are confident can be implemented and deliver the outlined benefits.

2. Frontline staff and workshop participants

We also received some feedback from other staff and people external to the council by sending out a summary presentation of our solution and asking them to fill in a feedback form (see results to the right).

3. End users

We initially planned to also contact end users and carers to present the proposal to them, but could not fit this in due to the time pressure. We felt that it would have been quite complex to get meaningful feedback for a process/product people had never experienced before and so will ensure users are engaged during implementation.



What's good about the proposed solution?

Meets the need of our population, it is achievable and it really beneficial to get something in place as soon as request comes in because that is when people have decided they need it, more informed assessment of benefit of kit and how it meet the person's needs

What's not good about the proposed solution?

Some things that need to be done to prevent channelling of residents into over-stretched social care services are not being done soon/fast enough/yet and so services will still be under pressure which may affect these pilots.

Is it innovative?

3.4 out of 5
It's part system redesign and part new technology
It's not cutting edge (and maybe we don't need that) but moves delivery models forward.

Is it scalable?

4.2 out of 5
A model can be extremely scalable across local authorities and if successful there is no doubt that others would be interested.

Is it future proof?

3.8 out of 5
Doesn't consider the use of other technologies and how the resident could support themselves

Is it valuable?

3.9 out of 5
Appears relatively low cost but doesn't go far enough in offering a 'market' to residents - seeing them as customers with autonomy.



Learning from Discovery Phase

Adult Social Care/Project manager

The discovery allowed us to

- Undertake a valuable analysis of Stockport's TEC offer in the context of reducing the need for higher level care
- Consider NVC & false alarms, issues all telecare monitoring centres deal with on a daily basis & challenge what might previously have been considered part of normal business. 'We didn't recognise the extent of the problem and didn't know there was something we could do about it until we started this Discovery'
- Learn new ways of combining thorough data analysis and stakeholder feedback to provide fresh insights into old problems
- Start to share our learning and challenges with other local authorities through the peer learning calls

(Click image below to play video)



Business analyst

We identified a few problems when it came to collecting data for analysis, as follows:

- Multiple systems in use, managed by different teams made it difficult to consolidate information for direct comparison and modelling
- The quality and content of the data was sometimes lacking. Often assumptions had been made that data was being collected regularly but in reality, it wasn't. Either because systems used didn't have mandatory fields or because the 'systems' in use were just spreadsheets
- Lack of discrete data in some instances
- Historic data only available up to certain point depending on when teams / processes / system introduced.

For future projects it would be pragmatic to get data gate keepers on board up front and prepare them for the information which may be required.



Service designer

- Tight deadline made it difficult to engage with as many/wide variety of users that we would have liked to (with GDPR and consent delaying us). With insights from user engagement coming later on in the process, the direction was possibly slightly skewed in the favour of service data/staff insights.
- Visiting carers groups was possibly not the best approach as they did not want to give up much of their valuable free time for us
- The project team learned a lot about how embracing uncertainty is a key aspect of discoveries and how one shouldn't 'solutionise' too early/have faith in the process.
- Being flexible and adaptable when it comes to research methods and outcomes is crucial as you have to adapt to the insights as you discover them, and decide what was missing or worth investigating further
- The collaboration between business analysis and service design worked very well, giving a broad perspective on the problem and enabling us to
- converge quantitative and qualitative data into meaningful insights.
- At times we were confronted with too many feasible ideas and it was difficult to objectively choose the most promising ones. Ideally we would have tested a few different option with quick and dirty prototypes.

FALLS DETECTOR

KNOWS WHEN
SOMEONE HAS
FALLEN

WHERE DOES IT LIVE?

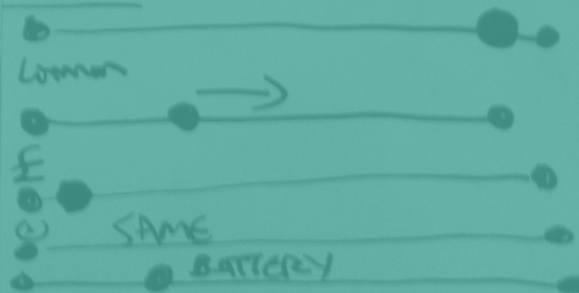


- PENDANT
- WRIST

REQUIREMENTS/
WHO:

- BATTERY
- CARE CALL

IMAGINE



USED FOR:

- DETECT FALLS
- SAME RESPONSE AS PENDANT
- BLACKOUTS

• ALOT OF
FALSE (SIGNAL)
ALARMS

POSITIVES
→ LESS STIGMA
→ ...



STOCKPORT
METROPOLITAN BOROUGH COUNCIL