Project Evaluation Report
InCARE Project

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Supporting INclusive development of community-based long-term CARE services through multi-stakeholder participatory approaches

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InCARE (Supporting Inclusive development of community-based long-term CARE services through multi-stakeholder participatory approaches) aims contribute to the design of a coordinated approach to the development of national long-term care policy and care services at local and regional level, by establishing socially innovative and participatory decision-making processes. We work with care users, care providers and policymakers in Spain, Austria, and North Macedonia to design, implement and scale-up innovative care services.

More information on the project's website: https://incare.euro.centre.org/.

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1. Introduction

The InCARE Project Evaluation Report is a culmination of implementing Work Package 6 “Monitoring & Evaluation” (WP6). The evaluation methodology for the InCARE project has been developed by applying the “Theory of Change (ToC)” approach. Therefore, the project’s evaluation design was not aimed at a post hoc evaluation of project activities and outputs but instead had been co-developed with the implementation partners of the pilot case interventions and relevant stakeholders (such as care users, policymakers, and care providers).

ToC is an approach often used to co-develop project activities with stakeholders to understand the strategic direction of a project, program, or policy, to develop relevant interventions and to monitor and evaluate programs. In this method, the goals are specified by all involved and affected parties and pathways through which the goals need to be achieved are determined together. The ToC, then, visually charts the activities and outputs that systematically need to be taken into action to reach the goals. Within the ToC process, a chain of such outcomes is developed, and even though such processes may appear quite linear, feedback loops exist in the project life cycle. In the InCARE project, the ToC method has been used to ensure that the target goals of the activities are linked to the defined project outcomes and to contribute to the (continuing) relevance of the action after the project. Overall, the evaluation’s starting point within the ToC framework was to develop the necessary indicators for achieving the broader impact goal of InCARE, namely that “older people with care needs and their informal caregivers have access to adequate and affordable care and they, together with their families, live well and with dignity at home.”

The InCARE project evaluation report presents the application of the ToC framework in the pilot interventions in the three case countries, Austria, North Macedonia, and Spain, as well as the whole project. Each pilot intervention has also been evaluated through country-specific evaluation and monitoring strategies, which are described in detail in the “Country Evaluation Reports”.[1] This report presents the methodology behind the ToC framework applied in InCARE, the evaluation criteria and guideposts used, and discusses the shaping of both the projects' and the pilot cases' evaluations and the relevant data collection throughout the project cycle. The report concludes by discussing the findings from the data gathered and the assessment of change linked to the project.

[1] Country evaluation reports of each pilot intervention are not published but are available upon request.

2. InCARE Evaluation Aims, Application of Standards, and Quality Assurance

As part of WP6 activities, the InCARE team has developed its evaluation plan at the beginning of the project cycle (February 2021). The evaluation considered both the **accountability** and **learning** outcomes of the project. The need for accountability has been considered in assessing whether the project-specific objectives have been achieved (**outcome evaluation**) and whether the project activities and action plans were designed effectively and reached the broader impact and policy relevance goals throughout the project cycle (**process evaluation**). The evaluation team, thus, assessed such outcomes and processes. The project's approach was to apply a multi-stakeholder design and a learning-oriented environment for the development of its activities and pilot interventions in which the evaluation and monitoring activities contribute to learning and practice by involving stakeholders who are expected to use evidence generated by project-related activities. To contribute to these aims, the Theory of Change (ToC) methodology was chosen.

As process monitoring and adaptability through learning within the project is essential in the ToC approach, the evaluation plans for the pilot interventions and the project have been continuously discussed and evolved with input from the stakeholders and implementation partners. Therefore, as stated in the initial evaluation plan, the evaluation methodology and data collection strategies had built-in flexibility applicable to different user groups, variables, and instruments in each country. At the same time, an overarching and comparative method has been upheld for the country case evaluation to allow for an analysis that brings together the results meaningfully.

The evaluation team adhered to professional evaluation standards for utility, feasibility, propriety, accuracy, and evaluation accountability. Overall, the InCARE evaluation considered the widely accepted Organisation for Economic Co-operation and Development (OECD DAC) evaluation criteria: relevance, coherence, efficiency, effectiveness, impact, and sustainability as the basis of its ToC approach in its multi-stakeholder workshops and the further development of its specific methodologies for the different dimensions of data collection and interim process monitoring. Table 1 presents the criteria for evaluation questions that framed the evaluation process:

Criteria	Key Evaluation Questions Addressed for InCARE
Relevance	Does the InCARE approach address developmentally important problems, and is it geared to the target groups' needs? (Target groups are care users, decision-makers, and service providers)
Coherence	To what extent is the InCARE project compatible with other projects from the public, NGO, and private sectors—at both the national and European levels?
Effectiveness	To what extent will InCARE activities attain the expected overall and specific outcomes?
Efficiency	How do InCARE outcomes relate to resources? Are the outcomes meaningful and achievable within the available resources?
Impact	What are the long-term benefits of InCARE for the target groups?
Sustainability	How sustainable are the InCARE pilots expected to be? Do the results last beyond project completion?

Source: InCARE Project Evaluation Plan.

TABLE 1: BASIS OF THE INCARE EVALUATION CRITERIA APPLIED TO THE PROJECT AND PILOT INTERVENTIONS

Finally, InCARE's evaluation strategy also followed its quality assurance goals, particularly for process evaluation, which was institutionalised at the Steering Group level. The Steering Group included one or more individuals from each partner organization and met regularly throughout the project duration. Each implementing partner was responsible for applying the monitoring and quality assurance guidelines for their activities and deliverables.

3. InCARE Evaluation Methodology: Theory of Change (ToC)

To achieve its evaluation and monitoring aims and the targeted impacts, the InCARE project adopted a ToC approach. The most crucial aspect and the key advantage of implementing ToC methodology is that it allows spelling out **the theory** that underpins the development of a program or an intervention in a way where all the aspects of **why** and **how** a specific action would work to achieve its goal (Coryn et al. 2011) are included. This is, for instance, in contrast to the linear approaches to intervention evaluation, where the programmes are evaluated based on the results only, often without focusing on the underlying assumptions that led to the choice of a specific program. Importantly, as an increasingly popular way of planning and evaluating social change today in international development and in the fields of medicine and health (Breuer et al. 2022; de Silva et al. 2014; Vogel 2012), ToC begins with **multi-stakeholder inputs,** which lead to the development and agreement on a theory which is assumed to be leading to a potential change that is sought by the interventions. This multitude of inputs enriches the intervention itself. It allows researchers or the implementing organisations to explicitly trace which aspects have been more (or less) successful based on the framework.

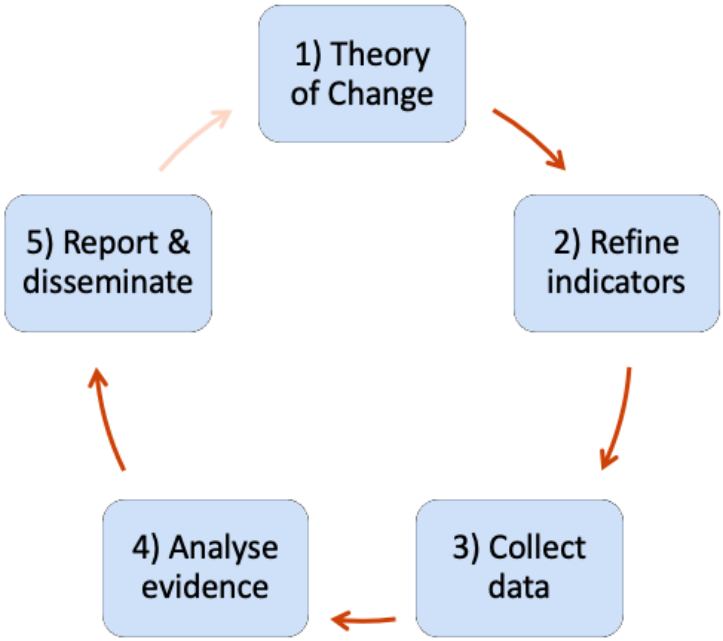
ToC is particularly lauded for having the flexibility to understand and, as one of its key proponents, to **visualise the causal pathways** through which an intervention leads to an outcome. Another defining feature of ToC is that it allows, through the visualisation via ToC maps, the description of short-, medium- and long-term outcomes that must be achieved to reach the end goal (Andersen 2004). Therefore, it is a standard in the evaluation practices and literature that ToC evaluation approaches begin with developing the ToC maps with input from the multiple stakeholders relevant to the impact that is being targeted by any program. To use the ToC approach for evaluation and to empirically assess the project as a whole and the pilots, the ToC maps were transformed into **measurable indicators**.

Application of Theory of Change in InCARE

Following the existing conventions in the applications of ToC, the design of the evaluation steps in the InCARE project is illustrated in Figure 1. The five steps started with developing ToC for each relevant project component and ended with analysing and reporting the evaluation results. In this process, learning and feedback loops have been standard functions to leave room for learning and necessary adjustments. The project's first starting point was to develop the ToC maps, which summarized the theory underlying the development of the interventions for individual case pilots and the whole project. This means that four different ToC maps were developed. Within the InCARE project, Steering Group meetings and Jour Fixes have been used to continuously get feedback from the project partners on their applications of the ToC.

ToC for each case pilot and the whole project were visualized in ToC maps, which were turned into measurable indicators. As multi-stakeholder input and flexibility are crucial elements, these indicators were discussed with the relevant parties and were iteratively designed without compromising the comparability between the country pilot indicators. In the indicator refinement stages, a critical balance

had to be struck between the ability to have an adequate number of indicators and the more practical issues of data availability, time, and cost. With the definition of the indicators, in the next step, relevant data was collected, coordinated by the WP6 leading team, and analysed by the country pilot teams and the evaluation team of the InCARE project. At the final stage, the results were written in reports and disseminated. Three country evaluation reports, one final project evaluation report (the present document), and one policy brief were produced for final written output from the evaluation and monitoring WP of the InCARE project.



Source: InCARE Project Evaluation Plan.

FIGURE 1: EVALUATION STEPS FOR THE INCARE PROJECT

Co-development of the Theory of Change for the pilots and the projects via workshops

As illustrated in Figure 1, InCARE evaluation and monitoring started with developing ToC maps. In developing ToCs, two key aspects were determined first: the **intended impact of the intervention** and the **outcomes that need to be achieved on the path to impact**. In this respect, an important step of developing a ToC was to identify the key intended impact and the series of outcomes and discuss why these outcomes are related to the primary goal. ToC maps also visualise the assumptions made by the participants and the stakeholders for the intervention to follow the logic determined by the ToC between the impact and the outcomes (Breuer et al. 2016). Next, the concrete actions and activities were also placed on the map. ToC also included a ceiling of accountability for the intervention. This described the line after which aims are so large that the project cannot achieve them alone.

For the InCARE project, the selected method for the development of the ToCs has been multi-stakeholder workshops. Overall, these workshops which conducted with the participation of approximately 100 stakeholders, including care users, care professionals, service providers, care organisations. These participatory events allowed InCARE team members and decisionmakers to

develop a shared vision for long term care in the InCARE project, both across and within countries, and to have a collective understanding for how to achieve these goals. 4 ToC maps made up the basis of the ToC method applied in this project. Considering the variation in the interventions, each ToC for case country pilot interventions was constructed separately. Figure 2 below summarises the structure of the application of ToC in InCARE project evaluation.

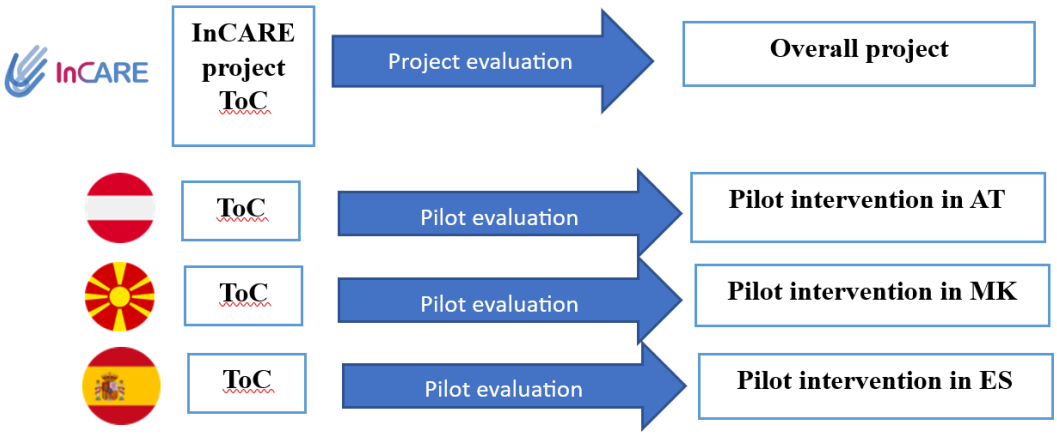


FIGURE 2: THEORY OF CHANGE STRUCTURE WITHIN THE INCARE PROJECT

The method selected for guiding the ToC development workshops has been adapted from a previous project from which the implementing expert have instructed the InCARE partners (Breuer et al.2019).[2] Sometimes, the workshop guidelines had to be adapted to the online format and to the specific needs of the InCARE. Preparation for the workshops included meetings with the facilitation team, InCARE partners with experience in Theory of Change or other experts. Following the workshop format guidelines, the evaluation team decided on the purpose and scope of the Theory of Change and the meeting agenda, discussed the evaluation of the workshops, and refined the list of participants when planning them. During the workshops, the questions addressed were as follows: the context in which the programme is to be fielded, population size, characteristics of the existing situation (including key challenges, nature of the social policy and long-term care provision system in the country), existing provisions for the long-term care users or providers, actions and aspect of priority in addressing the relevant challenges, identification of stakeholders, and determining the scope of the intervention.

Ahead of the workshops, substantial work was required to invite stakeholders, including individual pre-workshop meetings to introduce stakeholders to the project, multiple contacts and the preparation of invitations, flyers, and summary documents for the registered participants. Personal communication with stakeholders and multiple follow-ups were essential to ensure participation.

InCARE Project Theory of Change Workshop

Within the WP6 activities, a two-day workshop was first held to develop the ToC for the whole project, which was organized on December 2, 2020 (first session) and December 9, 2020 (second session). 20 people (including facilitators) attended the first workshop session, and 21 attended the second workshop session, with 18 attending both sessions. The roles of participants are outlined in Table 2 below.

[2] See https://stride-dementia.org/ for further information.

Role in InCARE	First session (2.12.2020)	Second session (9.12.2020)
National policy partner	4	4
Implementation partner	5	4
Technical partner	10	11
Guest/other	1	2

TABLE 2: PARTICIPANTS IN THE INCARE PROJECT THEORY OF CHANGE WORKSHOP

This workshop has been designed following a participatory process model with a consensus-based project understanding, which was held with the participation of the project partners. After a brief introduction to the project for the workshop participants, the next step was to agree on impact, meaning what the project's success would look like. In this workshop, the overall impact goals of the ToC were decided to be: "*older people and their families live well and with dignity at home*" and "*older people with care needs and their informal caregivers have access to adequate and affordable care*". Therefore, older people and their families, and informal carers more broadly, were the ultimate target groups. The participants of the ToC workshop co-developed the project's ToC map, containing the project's challenges and assumptions, the **desired project outcomes** and **impact**, and which work packages are expected to influence these. All components of the project ToC, including the assumptions and the ceiling of accountability, have been jointly discussed and refined during the workshops and agreed upon by the participants.

The main challenges regarding the key impact goal were discussed during the first session. The following themes have been identified as the potential issues that may arise when implementing the project activities and outcomes. Here, we note that some of the challenges have been linked to the COVID-19 pandemic, which made online rather than in-person meetings the default option in some cases. The following potential challenges have been taken into consideration in determining the evaluation indicators to ensure that potential areas in which such issues may be the most influential. Some of the issues outlined here were revised, taking into consideration the post-covid measures which occurred within the project duration period:

1) *Internal project coordination and communication*, particularly without meeting face-to-face (for post-covid period activities).
2) *Policy processes and systems*, including engaging stakeholders across sectors, fragmented long-term care systems, financing, and changing paradigms from a rehabilitative system to a person-centred care model.
3) *Community participation and buy-in,* including building trust in the community without meeting face to face (because of COVID-19) and convincing care users to be involved in the pilot.
4) *Implementing the pilot,* particularly ensuring implementing staff are motivated and are creating and evaluating impact in a short time frame
5) *Scale up of the pilot,* which included capturing the attention of decisionmakers and potential austerity measures after the pandemic.

The primary outcome of the project ToC workshop sessions has been the ToC map, see Figure 3 below, agreed upon after the workshop. The map was refined after the workshops with reviews and feedback from the participants. The map has been turned into measurable indicators by the WP6 coordination team with feedback loops from implementation partners of the project, which is discussed in more detail in section 6.

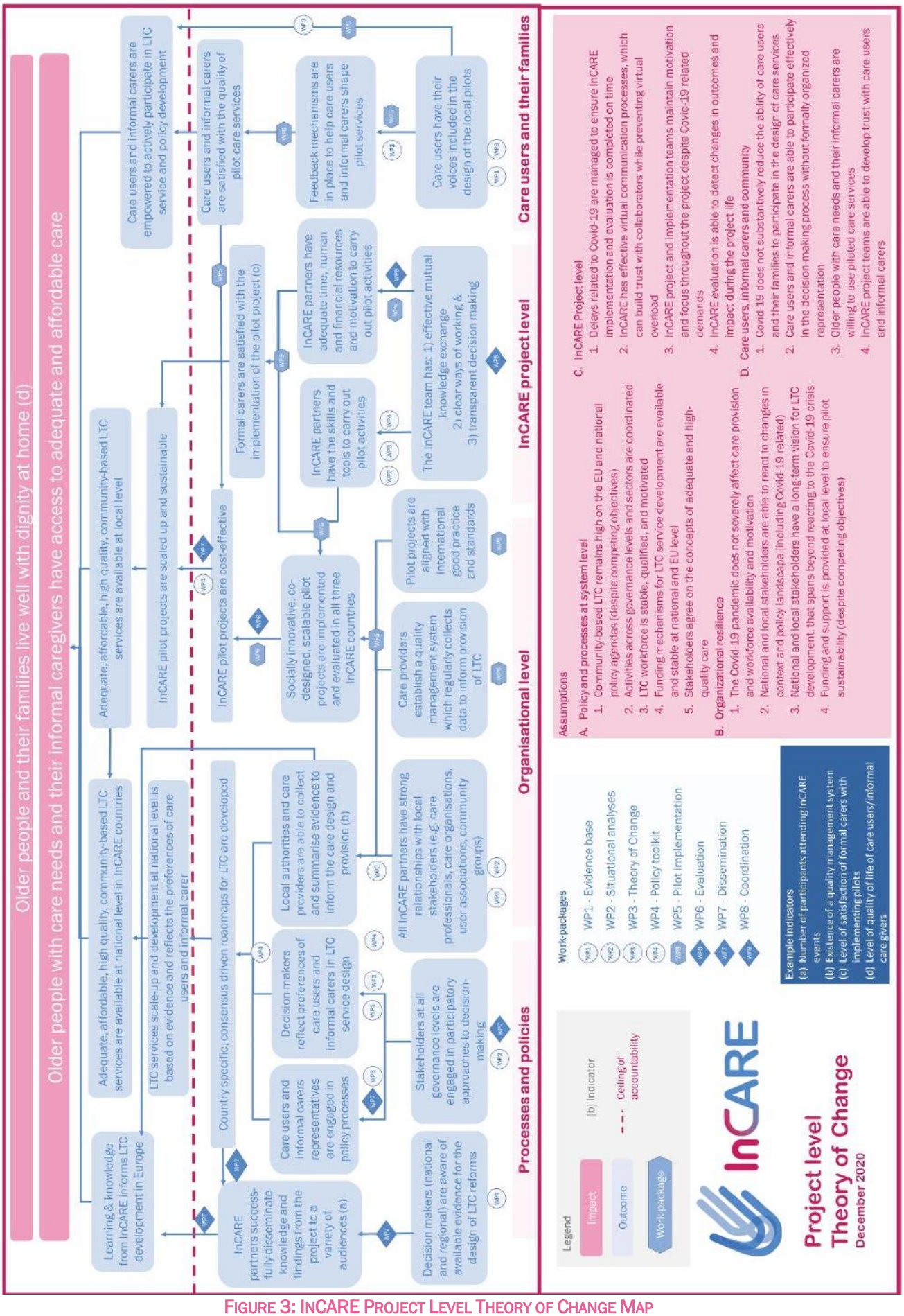


FIGURE 3: INCARE PROJECT LEVEL THEORY OF CHANGE MAP

The participants of the project ToC workshops in December 2020 have filled out feedback surveys. According to these, completed by 17 participants, all participants rated their overall impression of the workshop as excellent (41.8%) or above average (58.82%) and the technical organisation of the meeting as excellent (64.7%) or above average (35.3%). Concerning the participatory development of the ToC process, the survey showed that all participants agreed that they could share their views (41.8% strongly agreed and 58.82% agreed). Furthermore, the workshops were also considered consensus based as the participants responded that the decisions taken in the session were agreed upon jointly. The qualitative comments showed that participants particularly valued the small group work and using the ToC to understand how the work packages lead to the project's overall impact. Overall, the visualisation strategy in the ToC method has been seen as a valuable aspect of the design, and the participants have agreed that this is a beneficial strategy for the implementation of the evaluation and monitoring of the project activities.

4. Theory of Change and Evaluation Trainings for Pilot Implementation Partners

To ensure the correct application of ToC across the project, pilot implementation partners have participated in two trainings. These trainings have taken place before the national pilot workshops for developing the pilot ToCs with the national stakeholders. In this way, the project ensured that the staff had the resources, expertise, and know-how on how to apply the ToC methodology in their interventions. At the end of each training session, participants filled out feedback surveys for the WP6 team to track the learning outcomes and expected objectives to be achieved from these project activities.

The first training, “Supporting local partnerships and organising the multi-stakeholder ToC workshop” took place on 24 February 2021 and was held online. The training was facilitated and led by Erica Breuer, an expert on the application of ToC. The aim of this training was to prepare the project partners who will be implementing partners for their organisation of the country ToC workshops. The training also aimed to give the participants the necessary tools to facilitate a ToC workshop and to guide the development of a ToC map and report, which can be used to write the monitoring and evaluation plans for the pilot interventions. In the training, participants went through the steps of building a ToC for a hypothetical case intervention and applied all the relevant ToC components. This practical and hands-on training ensured the consistency of the application of the ToC across the pilots. It was part of the outcomes that needed to be achieved in the larger project ToC map, i.e., to ensure that the project staff has the necessary skills and resources.

The second training, “Pilot evaluation and monitoring within the ToC process”, was organised on 7 April 2021 and was facilitated and led by Rahel Kahlert from the European Centre. This training followed up on the topics of the previous training and was focused on providing the participants with the tools for developing their pilot evaluation plans based on the ToCs developed during the country ToC workshops for the pilots. Moreover, it also gave information on monitoring a pilot intervention, going from a ToC map to developing the indicators for the InCARE pilots, and collecting data on evaluation indicators both on outcomes and process. As an illustrative example, before the trainings, Rahel Kahlert, as part of the WP6 coordination team, provided an indicator reference sheet developed for the project ToC to guide the participants.

5. Country Theory of Change Workshops

Following the trainings, the country pilot implementation teams (with support from technical and policy partners) held their own country pilot ToC workshops and subsequently wrote their pilot evaluation plans. These workshops have taken place sometime between June 2021 and January 2022. By January 2022, all three country pilot implementation teams have finalised their pilot evaluation plans for their national cases and developed their ToCs. The methodology of the workshops used in the project ToC development has been applied in each country case. Details of the country ToCs are presented in each case´s country evaluation report (available upon request). Table 3 provides an overview of the country pilot ToC workshops held in Austria, North Macedonia, and Spain.

The Austrian team conducted two online Theory of Change workshops with local and national stakeholders involved in long-term care in Styria. The **pilot intervention of the Austrian case was to establish an integrated provider network for the delivery of community-based long-term care in Styria**. Before the workshop, the Austrian InCARE team planned to adopt an integrated provider network based on the Buurtzorg model from the Netherlands to the Styrian context and establish a local care management platform to link local authorities with care providers. However, during the workshop, it became clear that some of these functions already existed in the community. The innovation's design was then changed to better link these existing service providers rather than create a new system. The workshop also helped identify key issues that the pilot should address such as the lack of capacity-building opportunities for care providers, limited coordination between actors and agencies involved in long-term care and the importance of increasing empowerment and control of care users throughout the care process.

	Austria		North Macedonia		Spain				
Social innovation planned for the pilot	Integrated provider network for delivery of community-based long-term care in Styria		Integration of an "Emergency Button Service" within a home-care service package		Support for family caregivers of people with dementia within an integrated service approach				
Workshop sessions	1	2	1	2	1	2	3	1	2
					National			Local	
Date held	10th Jun 2021	17th Jun 2021	14th Dec 2021	24th Dec 2021	1st Dec 2021	2nd Dec 2021	27th Jan 2022	2nd Feb 2022	10th March 2022
Length (in hours)	4	4	5	4.5	7	3.25	1.5	5	5
Format	Online	Online	In person	Online	In person	In person	Online	In person	Online
Software used	Zoom Padlet Yopad Mural Powerpoint	Zoom Padlet Yopad Mural Powerpoint	n/a	Zoom Mural	n/a		Zoom Power point	Powerp oint	Zoom
Language	German		Macedonian		Spanish			Spanish	

TABLE 3: OVERVIEW OF INCARE COUNTRY PILOT TOC WORKSHOPS

The InCARE team in **North Macedonia** conducted a two-session workshop with one face-to-face and one online session to develop a Theory of Change. They established the impact goal for their pilot intervention, which was integrating **an emergency button intervention in a home care package.** Stakeholders included the Ministry of Labour and Social Policy representatives, the Ministry of Health, local decision-makers, NGO representatives, providers, and long-term care users. The ToC developed in the workshop took a broad view of the long-term care system, and some of the outcomes, particularly around policy processes, are policy changes which need to be addressed in the longer term. These included changes in legislation on the employment and working conditions of caregivers, financing, quality assurance and monitoring of long-term care services and increasing availability of employment measures to stimulate the care economy. The changes are relevant for transforming the innovation (emergency button) into a regular social care service and its financing in the frame of the social protection system. Lastly, both long-term social and healthcare providers emphasised the importance of communicating clear information to and ensuring early involvement of the users, family members and caregivers.

The **Spanish** InCARE team conducted a Theory of Change workshop on long-term care in Spain, with two face-to-face sessions followed by an online consolidation session. This workshop involved decisionmakers, long-term care providers, care users, and their informal caregivers. The intervention in the Spanish case was focused on **developing support for family caregivers of people with dementia within an integrated service approach**. The workshop defined the underlying short-, medium and long-term outcomes, activities and strategies that could enable change in national long-term care policy over the next decade to achieve the following impact agreed with stakeholders: "*All people in need of long-term care can develop their life project in the community and improve their quality of life, with quality care and quality jobs. Family and professional carers can continue to develop their life project*"'. After the face-to-face sessions, the organising team synthesized the inputs from the workshop in an iterative way to develop the Theory of Change map. This map was subsequently presented in the online consolidation and feedback session and validated by the participants. To ensure the engagement of local stakeholders and operationalize the pilot study further, an additional two-session ToC workshop with sixteen stakeholders (representatives of the provincial government, care organizations, family caregivers and health services) in the implementation area, Gipuzkoa, San Sebastian, was carried out. Through this, understanding the local context and ensuring that an implementable and sustainable social innovation was developed were achieved.

6. From Theory to Measurement: Development of Evaluation Indicators and Data Collection

As the next step of the ToC methodology, the developed ToC maps, including the determined outcomes, activities, and end impact goals, were translated into measurable evaluation and monitoring indicators. The evaluation team of the InCARE project, leading the WP6, has prepared the indicators for the project ToC monitoring and evaluation. After the relevant trainings and national ToC workshops, each country's pilot implementation team has also prepared their pilot evaluation indicators with guidance and feedback from the expert evaluation team of the project. Throughout the process, the evaluation team monitored and coordinated the translation of the country-level ToCs into selected indicators. Given that each pilot had specific activities unique to the intervention, many of the pilot-specific indicators differed between teams. However, to have a comparative and integrated approach within the project, the method applied in the development of the indicators was the same as instructed in the training with the pilot implementation partners. Specific indicators for each pilot evaluation, how they were

developed, and their detailed results are available in the three country evaluation reports (available upon request). In this report, we detail the method of indicator development applied in the InCARE project evaluation, which is also mirrored in these pilot project evaluations. Importantly, project evaluation indicators generated a shared approach in measuring specific dimensions of the activities conducted by the pilot implementation teams.

Indicator Selection and Refinement

An indicator is an empirically observed and recorded measure (quantitatively or qualitatively) to assess whether an expected ToC outcome has been reached (Meyer 2004). The InCARE project's ToC and the specific outcomes were developed in the ToC workshop in December 2020. Based on those outcomes, the evaluation team developed and suggested one or more indicators per each of the desired results and prepared the first draft of the evaluation indicators, which was shared with the project partners in February 2021. The indicators were then deliberated on and refined with several feedback loops, and the last changes to the project evaluation indicators were made and finalized in January 2023. Pilot evaluation indicators for each specific country case were finalized earlier as of the submission of the pilot evaluation plans. Practically, indicator reference sheets were prepared using Excel sheets to facilitate data collection.

The indicators were developed using a checklist to ensure that they theoretically corresponded to the outcome that was intended to be measured, methodologically possible to be measured validly and reliably, feasible to collect data on with the resources available in the project, and useful for the multi-stakeholder participative goals of the project. In addition to these questions, the evaluation team has also considered that the indicators developed fit the conventional SMART criteria to determine suitability (specific, measurable, achievable, relevant, and time-bound). Each indicator was defined and described in an indicator reference sheet. This includes choosing thresholds, i.e., the minimum for the outcome to be successfully achieved, the responsibility of collection, and the time frame.

Description of the InCARE Theory of Change Evaluation Indicators

Figure 3 presents the project´s overall ToC map, demonstrating key elements of the framework. Working from the ToC map and the relevant impact goals and outcomes, the InCARE evaluation team developed the indicators for measuring the project's evaluation and monitoring of targeted change. The team has determined four levels of measurement indicators: process and policies (see Table 4), organisational level (see Table 5), InCARE project level (see Table 6), and the level of care users and families (see Table 7). For each theme, the indicators were built from the specific sentences included in the project level ToC, which described outcomes to be achieved by the project with medium to short-term time horizons within the project duration as well as some impact goals above the ceiling of accountability.

Table 4 presents the 17 indicators that were selected to measure and evaluate the "process and policy" level of the project. In this theme, the long-term outcomes to be achieved are related to the goals, such as learning and knowledge from the InCARE project informing long-term care developments in Europe and that there are scaling up and improvement developments on the long-term care services available at the national level. Importantly, these indicators are targeted to ensure that one of the project's goals, i.e., pilot activities that reflect the preferences of care users and providers, is met. Therefore, the common ground selected for this theme as part of the ToC is to evaluate whether InCARE project activities sufficiently engage relevant stakeholders and inform them and the broader public. In this section, we also assessed whether the pilot project implemented has potential scaling-up plans.

Indicator No.	Indicator Name	Measurement target	Source of data	Target measure	Data type
PP.1	Attendance - 1	Number of decision-makers participating in InCARE national events	Participant list	50 per pilot	Numerical
PP.2	Attendance - 2	Number of decision-makers participating in InCARE national workshops	Participant list		
PP.3	Attendance - 3	Number of decision-makers participating in national InCARE trainings of long-term care (LTC) evidence	Participant list		
PP.4	Knowledge transfer- quant	Number of decision-makers stating that the national event/workshop/training has contributed to their knowledge in a relevant manner	Feedback surveys, Event reports	50 per pilot	Numerical
PP.5	Knowledge transfer - qual	Decision-makers stating that the national event/workshop/training has contributed to their knowledge in a relevant manner	Qualitative reporting	N.A.	Self-reporting Open-ended
PP.6	Awareness	Number of decision-makers stating that they are aware of LTC evidence in pilot countries	Feedback surveys, Event reports	50 per pilot	Numerical/ Self-reporting
PP.7	Participation - experts	Number of experts/researchers engaged in participatory process of pilot countries	Pilot logs/ documents	10 per pilot	Numerical
PP.8	Participation - decisionmakers	Number of decisionmakers engaged in participatory process of pilot countries	Pilot logs/ documents	10 per pilot	Numerical
PP.9	Participation - carers	Number of care professionals engaged in participatory process of pilot countries	Pilot logs/ documents	10 per pilot	Numerical
PP.10	Participation - users and informal carers	Number of care users and informal carers engaged actively in policy process of pilot countries	Pilot logs/documents	10 per pilot	Numerical
PP.11	Event attendance - InCARE	Number of participants attending InCARE events	Eurocarers tracking and reporting	125 (25 for 3 pilot ToC workshops + 50 for final conference)	Numerical
PP.12	Event attendance - non-InCARE	Number of participants attending non-InCARE events	Eurocarers tracking and reporting	75 total	Numerical
PP.13	Dissemination - Emails	Number of individual emails containing	Eurocarers tracking and reporting	2000 total	Numerical (checks in

		information on InCARE disseminated			6-month intervals)
PP.14	Dissemination - social media	Number of views of social media posts related to InCARE	Eurocarers tracking and reporting	5000 total	Numerical (checks each year)
PP.15	Dissemination - Website	Number of visits to the project website	Eurocarers tracking and reporting	5000 total	Numerical
PP.16	Dissemination - Downloads	Number of downloads on the project website	Eurocarers tracking and reporting	500 total	Numerical
PP.17	Scaling-up - plans	Each pilot country plans a national scale-up.	Pilot evaluation plans/ documents	Yes	Nominal

TABLE 4: PROJECT EVALUATION INDICATORS FOR THE "PROCESS AND POLICY" LEVEL

The second theme of the InCARE ToC´s evaluation indicators is the "organisational" level. In this theme, our focus is on the quality of the stakeholder engagement that has been achieved in the project and pilot implementation stages. Likewise, as an organisational aspect, we also aimed to assess whether the pilot projects are sustainable, scaled up, cost-effective, aligned with international standards, innovative, and generally co-designed as intended. Table 5 presents the 8 indicators selected to measure this theme in evaluation.

Indicator No.	Indicator Name	Measurement target	Source of data	Target measure	Data type
O.1	Quality of stakeholder engagement - 1	There are good relationships with care organisations	Pilot and project documentation, Self-reporting	Yes	Nominal Qualitative
O.2	Quality of stakeholder engagement - 2	There are good relationships with user associations	Pilot and project documentation, Self-reporting	Yes	Nominal Qualitative
O.3	Quality of stakeholder engagement - 3	There are good relationships with professionals in the field	Pilot and project documentation, Self-reporting	Yes	Nominal Qualitative
O.4	Scaling-up - implementation	InCARE pilot projects are scaled-up	Documentation, Self-reporting, Pilot evaluation reports	Yes	Nominal Qualitative
O.5	Sustainability	InCARE pilot projects are sustainable	Documentation, Self-reporting, Pilot evaluation reports	Yes	Nominal Qualitative
O.6	Co-design	InCARE pilot projects are co-designed	Documentation, Self-reporting, Pilot evaluation reports	Yes	Nominal Qualitative
O.7	Social innovation	InCARE pilot projects are socially innovative	Documentation, Self-reporting, Pilot evaluation reports	Yes	Nominal Qualitative

0.8	Scalability	InCARE pilot projects are scalable	Documentation, Self-reporting, Pilot evaluation reports	Yes	Nominal Qualitative

TABLE 5: PROJECT EVALUATION INDICATORS FOR THE "ORGANISATIONAL" LEVEL

The third level assessed in the project theory of change is related to the project resources and working principles. Here, some of the aspects which have been identified were the resources in terms of time, skills, finances, and tools, on the one hand, and the existence of an effective and clear working relationship within the project at both project and pilot case levels. Another dimension of this theme is that the carers perceive the project´s pilot implementations as satisfactory. Table 6 presents the details for each of the 6 indicators selected to evaluate this level.

Indicator No.	Indicator Name	Measurement target	Source of data	Target measure	Data type
IP.1	Working - effectiveness	Existence of effective, mutual knowledge exchange in the project	Self-reporting/self-evaluation, Feedback surveys	Yes	Nominal Qualitative
IP.2	Working-clarity	Existence of clear ways of working on the project	Self- reporting /self-evaluation, Feedback surveys	Yes	Nominal Qualitative
IP.3	Working - transparency	Existence of transparent decision-making in the project	Self- reporting /self-evaluation, Feedback surveys	Yes	Nominal Qualitative
IP.4	Partner resources	InCARE partners have adequate time, human and financial resources, and motivation to carry out the pilot	Self- reporting /self-evaluation, Documentation	Yes	Nominal Qualitative
IP.5	Partner skills	InCARE partners have the skills and tools to carry out the pilot	Self- reporting /self-evaluation, Documentation	Yes	Nominal Qualitative
IP.6	Carer satisfaction	Formal carers are satisfied with the implementation of the pilot project	Self- reporting /self-evaluation, Pilot project reports	80% satisfied	Nominal Qualitative

TABLE 6: PROJECT EVALUATION INDICATORS FOR THE "INCARE PROJECT TEAM" LEVEL

Finally, the last level considered in the project ToC is more directly related to the pilot implementation and its results. These are the outcomes and impacts related to care users and their families. Here, the ultimate effect that is aimed at is that older people and their families live well with dignity at home and, overall, the activities which are undertaken as part of the pilots have all this end impact in mind even when their specific interventions take different starting points. The specifics of each case country´s activities, objectives, and outcomes are described along with their theory of change in the country evaluation reports. Here, as presented in Table 7, linked to some of the pilot relevant indicators, the aim is to capture whether care users and carers are empowered as a result of the pilot activities and whether they are satisfied with the quality and co-design aspects of the pilots.

Indicator no.	Indicator name	Measurement target	Source of data	Target measure	Data type
CF.1	User input	Care users have their voices included in the design of local pilots	Pilot project evaluations and surveys, Self-reporting by pilot partners	Yes	Nominal/Ordinal (based on data availability)
CF.2	Feedback loops	Feedback mechanisms are in place to help care users shape pilot services	Pilot project evaluations, Self-reporting by pilot partners	Yes	Nominal/Ordinal (based on data availability)
CF.3	User satisfaction	Care users are satisfied with the quality of the pilot care services	Pilot project evaluations and surveys, Self-reporting by pilot partners	Yes (80% satisfied)	Nominal/Ordinal (based on data availability)
CF.4	User empowerment	Care users and their families are empowered to actively participate in LTC development	Pilot project evaluations and surveys, Self-reporting by pilot partners	Yes	Nominal/Ordinal (based on data availability)
CF.5	Target outcome	Older people and their families live well and with dignity at home	Pilot project evaluations and surveys, Self-reporting by pilot partners	Yes (Above average)	Nominal/Ordinal (based on data availability)

TABLE 7: PROJECT EVALUATION INDICATORS FOR THE "CARE USERS AND THEIR FAMILIES" LEVEL

Data Collection

Data for measuring the indicators were obtained from several sources, including those from the country-level evaluation indicators as indicated in the tables above. The primary data sources which were used for the project indicators are:

- Documents from desk review include reports, information from the dissemination and coordination work packages, meeting minutes, training materials, and documentation of the InCARE activities and events.
- Analyses and results from other work packages (e.g., situational analysis).
- (Online) Feedback surveys: a tailored survey was conducted for each meeting, training, or workshop to collect participant feedback.
- Stakeholder interviews and electronic exchanges: informal and formal ways of communication with partners and stakeholders.
- Observations (e.g., during events, pilot implementations process etc.).
- Baseline and follow-up (survey) data from care users and care givers (wherever available).

The creation of a dashboard for data collection for each individual country pilot team facilitated the data collection of the project indicators. The team members entered their data for the project evaluation into the dashboard throughout the project life cycle. The dashboards were then put together and analysed together by the evaluation team of the InCARE project.

Analysis of Data

As it was indicated in the evaluation plan of the project, which forms the basis of the evaluation and monitoring activities of InCARE, pre-intervention data for baseline measures for some of the indicators are missing. Therefore, the analysis could not provide this form of causal analysis for all pilots. Likewise, comparison groups were also unfeasible to construct in some pilot interventions. Therefore, we used a theory-based evaluation approach via process tracing to measure outcomes to carry out contribution analysis (Befani and Mayne, 2014; Mayne 2001). Such an approach provides an evidence-based analysis to interpret the data collected for determining whether the InCARE project has plausibly and reasonably contributed to specific outcomes and why while considering other influencing factors.

The project **outcome evaluation** used a theory-driven approach, based on the results of the ToC workshops, to understand and make it explicit as to how and why the project led to a specific set of outcomes by using the data collected, which directly matches the indicators defined through the theory of change maps. It tested each step of the project ToC and determined actual changes due to the intervention by triangulating baseline and follow-up data, including qualitative data from stakeholders and users. The evaluation also determined the reasonable change to be expected by using the process tracing method (Beach and Pedersen 2019). In this respect, the data was analysed by examining and revisiting the ToC behind the InCARE project. Then, each indicator´s results were discussed based on the available data collected and by highlighting where there was a limitation to assessing a particular item. Finally, we reported the extent to which the expected outcomes and determined goals were achieved.

In addition to the indicators that focus on more outcome-orientated goals, the process evaluation indicators discussed above were also used to track the level and quality of cooperation among project partners. Participant lists and evaluation forms were used for all joint learning sessions, multi-stakeholder meetings, local information events and the final conference. Assessments of the actions´ effectiveness in establishing transnational learning communities were based on feedback solicited and obtained from all project partners and collaborators throughout the action implementation period and the frequency and depth of their interactions (including all exchanges that have not been organised as part of the action).

7. Brief Descriptions of the InCARE Pilots

Before presenting the findings from the project ToC evaluation indicators, in this section, the report provides an overview of each pilot intervention to provide context for the evaluation´s basis. Full details of the pilot interventions are available for all three cases in the short reports on the pilot projects, which are made publicly available on the InCARE project website. The pilot-specific evaluation reports with reference to their specific ToC maps are available upon request from the author.[3]

Austrian Pilot Intervention

The Austrian case pilot intervention was designed to address the challenges faced by long-term care services in Austria, which has become an imminent policy challenge recognized by all relevant stakeholders. It was implemented by the project partner Chance B. The Austrian case tackles the issue of providing more information, creating connectedness between stakeholders, and wider information availability for informal and family carers to ensure that carers and users have the support they need.

[3] Corresponding author for requests: kayran@euro.centre.org

To achieve these goals, the Austrian implementation team have engaged in several different actions and activities described here in brief.

For the Austrian pilot, five overarching themes were defined for more than 20 activities, impulses, and interventions, further refined during the action (see Table 8). These five themes are also the link between the planned project activities and outcomes from the project proposal. Local stakeholders adjusted the design of such activities during the national ToC workshop. To made such adjustments and revisions on the actions, the Chance B InCARE team had several online coaching sessions with colleagues from Vilans in the design of the intervention.

Theme A	Training modules for women [and men] caregivers
Theme B	Give impulses for more clarity on available services on the local and regional levels
Theme C	Outreach – reaching more persons who need information but who would not approach counselling services
Theme D	The setting of professional mobile care service gets more flexible and more demand-oriented
Theme E	Networking, cooperation, and transfer of knowledge

TABLE 8: OVERARCHING THEMES OF THE AUSTRIAN PILOT INTERVENTION ACTIONS

Austrian pilot intervention activities exhibited varying degrees of complexity. For instance, while some have been difficult to achieve, others have unfolded in a manner that exceeded the expected target goals. The spirit of consequent knowledge transfer, the open-source principle, and the motivation to reach a scaling of our InCARE results is likely one of the most critical impacts that InCARE has had in these last three years in the region. This is intrinsically connected to the large horizon that the EaSI call set up which was the ambition of the implementation team. "Social Innovation in LTC" is a big promise and, simultaneously, a door opener for very diverse groups of people to share their ideas, visions, and hopes for the future.

Within Theme A (see Table 9), the Austrian interventions included organising training modules for care providers to reach our previously defined outcomes. The first round of trainings occurred in the spring/summer of 2022, when COVID-19 prevention measures were still strongly regulating daily work, especially in the long-term care sector. Therefore, in terms of training content, the team focused on urgent topics related to self-care and resilience and how the “Caring Communities” approach can help networking and inter-professional relationships. For the second round of trainings – modules III and IV – in the spring and summer of 2023, the team decided to use the "train-the-trainer" approach to empower professionals in supporting and counselling informal carers. The content of this training was developed in-house to scale it (in case it would be successful in the test phase). The resonance was positive, and significant steps have already been taken for further upscaling as of at the end of the project.

#	Action	Specification	Participants	Period	Comments
1	Training module I	Resilience and self-care	19 participants	Spring/Summer 2022	Developed in coordination with Styria Vitalis
2	Training module II	*Caring Communities* approach	19 participants	Spring/Summer 2022	Developed in coordination with Styria Vitalis

3	Training module III	Support and counselling of informal carers, part I	20 participants	spring 2023	Developed by the InCARE team
4	Training module IV	Support and counselling of informal carers, part II	11 participants	Summer 2023	Developed by the InCARE team

TABLE 9: TRAINING MODULES FOR WOMEN (AND MEN) CARE PROVIDERS IN THE AUSTRIAN PILOT (THEME A)

Within theme B activities (see Table 10), it was decided not to develop databases or to contact all services individually but to create spaces where several people involved in the field could meet, both online and in person. In the feedback surveys conducted for the online meetings to provide such impulses, many participants noted that exchanging opinions with relevant stakeholders with diverse backgrounds was a very positive experience. In cooperation with the city of Gleisdorf, the Austrian implementation team brought together different care professionals for one afternoon in 2022 and 2023, presenting their services to visitors.

#	Action	Specification	Participants	Period	Comments
5	Stakeholder Workshop I	Strengthening mobile care	17 participants: diverse group, including users, informal carers, and decision-makers	Spring 2022	Detailed report separately available (in German)
6	Stakeholder Workshop II	Support of informal carers	14 participants: diverse group, including users, informal carers, and decision-makers	Autumn 2022	Detailed report separately available (in German)
7	Info-Messe II	Open Day on Care provision: regional service providers present their services	Cooperation with the City of Gleisdorf and the regional service providers (approximately 25 professionals)	Spring 2023	See also the dissemination monitoring report
8	Structured overview	Supply gaps and waiting lists	Several attempts at more clarity concerning data availability	06/22-06/23	See also the implementation report (in German)

TABLE 10: LIST OF IMPULSES AT THE LOCAL AND REGIONAL LEVELS IN THE AUSTRIAN PILOT (THEME B)

As part of theme C activities (see Table 11), the afternoon with information on services in 2022 (Info-Messe I) was intended as an outreach activity to reach more persons who need information but who would otherwise not approach counselling services. The Austrian implementation team tried to bring the services to the public in a wide public venue; Forum Kloster in Gleisdorf, a space for events where many different cultural and social activities take place. Though not many people from the public participated, the media covered the event, and the actions of the team had a positive resonance with service providers and the City of Gleisdorf. The team made several small but significant changes for the second run, which the team considers to be one of the reasons for the better resonance in 2023. However, the Austrian pilot team also took this as a starting point for launching a series of dementia café meetings ("Café Miteinander") as an alternative way of reaching out to the public. This initiative also has had a great resonance with the public.

#	Action	Specification	Participants	Period	Comments
9	Info-Messe I	“Open Day" on service provision: Regional service providers present their services	Cooperation with the City of Gleisdorf and regional service providers; approx. 12 professionals	Spring 2022	See also the dissemination monitoring report
10	Gesundheits-tage Ilztal	“Open Day”: Regional Health service providers present their services	Local initiative, an invitation to participate with the InCARE priorities	Autumn 2022	See also the implementation report (in German)
11	Café Miteinander	Twice monthly since March 23, 2023	10 participants on average	03/23-10/23	Detailed report separately available from 10/23 (in German)

TABLE 11: PUBLIC OUTREACH ACTIVITIES FOR INFORMATION IMPLEMENTED IN THE AUSTRIAN PILOT (THEME C)

One of the most influential and lasting - but at the same time, most difficult – steps of the Austrian pilot was to introduce project results into the daily and routine operations, as was the goal of the activities of theme D (see Table 12). In the setup of the InCARE project, the national implementation team emphasised a well-functioning relationship between the project team and the routine operations of the service-providing unit for elderly persons in need of support of Chance B. This is also the project section where the Chane B team worked relatively long on seemingly small and simple tasks, like introducing an easy-to-read version of the terms and conditions for mobile care support.

#	Action	Specification	Period	Comments
12	Counselling setting in mobile care	Testing of different counselling settings, presentation of conclusions to stakeholders in charge	Spring 22 – Spring 23	Detailed documentation is separately available (in German)
13	Easy Read Version of terms and conditions	Easy Read version developed for mobile care support	Winter 22 – Summer 23	Document available (in German)
14	Meeting with 4 regional mobile care operational controllers	Knowledge transfer on scalable results of the project to other service providers	Winter 22, Spring 23	Detailed report separately available (in German)
15	Bullet-points "Changes needed in the Mobile Care sector"	Drafted in working group, addressing stakeholders in politics and administration	Winter 2022	Document available (in German)
16	Study visit to Caritas Vienna	Focus on implementation of "Buurtzorg" principles	Autumn 2023	Preparation completed

TABLE 12: ACTIVITIES IMPLEMENTED FOR IMPROVING PROFESSIONAL MOBILE CARE SERVICES IN AUSTRIA (THEME D)

Networking was one of the few areas where COVID-19 prevention measures and their impact positively affected the project implementation (see Table 13 for activities). Both during the pandemic prevention

phases and in the aftermath, online networking meetings became commonplace in the field of work. The Austrian implementation team had some working time resources in the project budget but no significant travel budget resources for networking events. Thus, the working time resources would not have covered the time needed to reach every in-person networking event – which was the norm pre-COVID. In retrospect, these manifold networking activities were crucial for the success of many impulses that the implementation team developed in the project. A combination of getting to know each other through online events and meeting at some point in person is a fertile ground for alliances and cooperation.

#	Action	Specification	Period	Comments
17	Initiating networking events	Online and face-to-face	2021-2023	Online events: national level; face-to-face: local/regional level
18	Participating in networking events	Numerous events, both online and face-to-face	2021-2023	See dissemination monitoring
19	Study visit to Vilans, Netherlands	Study visit on integrated community-based care in the Netherlands	Winter 2022	2 team members participated
20	Webinar on Community Nursing in the NL, provided by Vilans	Follow-up on study visit, focus on Community Nursing	Spring 2023	Detailed documentation is separately available

TABLE 13: NETWORKING, COOPERATION, AND KNOWLEDGE TRANSFER ACTIVITIES IN THE AUSTRIAN PILOT (THEME E)

In addition to the activities described above, the Austrian pilot implementation team has also engaged in some other noteworthy activities which are listed in Table 14 below.

#	Action	Specification	Period	Comments
21	Community Nursing pilot project	Informing the local communities about the project call, providing a summary of application requirements	Summer 2021	2 applications by local initiatives, one successful
22	Participation in the national Caring Communities workshop	Invitation as an expert in the field for defining an "ideal prototype" of Caring Communities	Spring 2023	National level, online, documentation available (in German)
23	Lange Nacht der Pflege	Invitation to radio program as InCARE project manager/ expert in the field	Spring 2023	The recording is available and can be downloaded
24	CIRAC Conference	Successful submission of abstract on InCARE findings	Autumn 2023	20-22 of September 2023, Graz
25	Follow-up to Training Modules III and IV	Various follow-up activities: two follow-up trainings, development of a 2-days-training course, publication of training materials	Summer/ Autumn 2023	Scaling is being implemented

TABLE 14: FURTHER NOTEWORTHY ACTIVITIES (NOT LISTED IN THE THEMES A-E)

North Macedonian Pilot Intervention

The intervention in the North Macedonia was implemented by the Red Cross North Macedonia (RCNM). The focus of the pilot intervention was to establish a system where older people with care needs have a quick and easy access to emergency care and, thus, to relieve the care users´ families from continuous oversight. Likewise, the pilot tests a way in which pressure on health and social systems and the need for residential homes for the care of older people can be reduced. The pilot's goals also included the importance of setting clear information for and ensuring early involvement of the users, family members and caregivers in the provision of home-based care services. For the North Macedonian pilot, five overarching themes were defined (see Table 15), and below, brief descriptions of the pilot activities which took place in the field are presented.

Theme A Carry out 4 trainings, consisting of theoretical and practical aspects, for caregivers for total of 60 participants about home-based care service
Theme B Staff trainings, knowledge transfer and dissemination
Theme C Exchange visit to EU country where Emergency Button is successfully implemented more than 15 years
Theme D Integration of a technology-aided emergency alarm system with the home-care service package for 50 older adults in Skopje
Theme E Networking, cooperation, and promotion of Emergency Button service

TABLE 15: OVERARCHING THEMES OF THE NORTH MACEDONIAN PILOT INTERVENTION ACTIONS

Within the first theme, trainings were held in the training centre of the RCNM, and the practice sessions were in the nursing home Idila Terzieva; see Table 16 below for an overview of activities in this theme. Four certified educators (social worker, special educator, doctor, nurse) were engaged during the whole process of trainings. 52 out of 60 participants of the trainings successfully passed the final exam and received a state-recognised certificate (10 ECTS credits). After the trainings, all certified participants were offered practical training in home settings. More than 60 clients received home-based care delivered by certified caregivers. After the practice, 20% of the candidates were engaged as professional caregivers for a service provider of home-based care.

#	Action	Specification	Participants	Period	Comments
1	Training I	Training for Caregivers for older people and people with disabilities	15 participants	05.04.2022-29.06. 2022	14 candidates received state-recognised certificates/cooperation with certified educators
2	Training II	Training for Caregivers for older people and people with disabilities	15 participants	31.10.2022-31.01.2023	14 candidates received state-recognised certificates/cooperation with certified educators
3	Training III	Training for Caregivers for older people and people with disabilities	15 participants	15.02.2023-15.05.2023	12 candidates received state-recognised certificates/cooperation with certified educators
4	Training IV	Training for Caregivers for older people and people with disabilities	15 participants	04.04.2323-03.07.2023	12 candidates received state-recognised certificates/cooperation with certified educators

TABLE 16: LIST OF THEORETICAL AND PRACTICAL TRAININGS FOR CAREGIVERS IN THE NORTH MACEDONIAN PILOT (THEME A)

After the Emergency Button (EB) software was set up, the RCNM staff and an external consultant with extensive experience from the Ministry of Health prepared the Standard Operative Procedures for this service provision in January 2022. The SOPs of the EB service was presented to the Governing board of the RCNM for its adoption and afterwards presented to the staff members, volunteers, caregivers, and stakeholders—Table 17 below lists the activities that were implemented in the North Macedonian pilot to achieve these goals.

#	Action	Specification	Participants	Period	Comments
1	SOP Training	Introduction to the Standard Operative Procedures (SOPs) to staff and stakeholders	37 participants	15.04.2022	2 trainings were held by RCNM staff
2	Advanced First Aid Training	Transfer knowledge to staff members and First Responders	9 participants	18.03.2023	Medical consultants were engaged
3	Workshop for Diabetes Melitus	Transfer knowledge to staff members and First Responders	13 participants	19.03.2023-	Medical consultants were engaged
4	Workshop for dementia, depression, and panic attacks	Transfer knowledge to staff members and First Responders	15 participants	15.04.2023	Medical consultants were engaged
5	Training for primary and secondary assessment of injuries	Transfer knowledge to staff members and First Responders	12 participants	20.04.2023	Medical consultants were engaged
6	Training for control of bleeding	Transfer knowledge to staff members and First Responders	12 participants	20.05.2023	Medical consultants were engaged

TABLE 17: LIST OF STAFF TRAININGS, KNOWLEDGE TRANSFER, AND DISSEMINATION IN THE NORTH MACEDONIAN PILOT (THEME B)

As part of the activities within theme C, a study visit to the Red Cross Styria in Graz was carried out for 4 participants from the Emergency Button Service of RCNM. During the visit, the team of the Red Cross of North Macedonia (RCNM) and the Red Cross of Skopje had the opportunity to get to know the services available from the Red Cross Graz in detail. The focus of the visit was on services for the elderly, such as home-based care and the Emergency Button. During the visit, the team had the opportunity to visit the largest call centre responsible for the Emergency Button service in Austria. The visit included insights into call protocols, emergency intervention procedures, and a presentation about the vehicle fleet and its specialised equipment for the special transport services. The visit also involved a practical demonstration of a defibrillator-assisted resuscitation simulation. Additionally, the team received a demonstration of the mobile application designed for first-aid responders and the software solutions utilised for the emergency service button. During the visit itself, experiences were exchanged on common challenges that the teams in both countries are facing. Potential common points for further cooperation were found, especially regarding the application of first aid in emergency situations.

To develop the emergency button service, a database with potential clients has been created to integrate a technology-aided emergency alarm system with the home-care service package for 50 older

adults in Skopje (theme D). Most potential clients in the database were already existing beneficiaries of home help services. Others had heard about the service and wanted to use it. Starting from May 2022, 108 needs assessments were conducted with a social worker and a psychologist or medical nurse in home settings. 95% of potential clients were interested in the service.

In August 2022, the team started the installation of monitoring devices at clients' residences. Four devices for testing were installed at client's homes. During the testing phase, adaptations of the software were necessary, and the beginning of the pilot phase was delayed to the end of September 2022. Covid restrictions had also made it impossible to conduct all home assessments on time.

By the end of August 2023, 57 (13 male, 44 female) clients had been part of the pilot phase and devices were installed in their home. After the installation of the devices among the users, the method of using the device and the conditions in which they can press the button on the bracelet were explained to them. The total number of emergency button calls was 744 (65% female, 35% male), most of which were pressed due to medical consultation needs, first instalment checks alarms, wrong alarms, or the need for psycho-social support. These types of calls are registered as calls from users with minor health conditions. In 20 cases, emergency medical interventions by the First Responders were required. After providing first aid and measuring vital parameters, two people needed the help of the Emergency Medical Service.

Lastly, the North Macedonia implementation team has also taken part in activities for networking, cooperation, and the promotion of Emergency Button (EB) service (theme E). The promotion of the EB started with an interview on a national TV station. The EB Manager introduced the service to the wider public. Furthermore, the introduction was published in an online newspaper article. The EB service was further promoted at an online event for the promotion of Social Entrepreneurship, "Let's talk SE".[4]

An abstract for participation at the International Conference for Integrated Care (ICIC 2022) in Denmark was prepared and sent for approval. The topic was the Emergency Button Service in Skopje, and it covered "Population health and care needs and local context" as one pillar of the integrated care model of ICIC 2022.

The service was also presented at the “First Fair for Social Entrepreneurship” in North Macedonia. Visitors of the fair had the opportunity to get more information on the service and how to apply. A promotional video and a photo session were created for the service by a professional marketing agency. An article in a newspaper was published as an explanation for the new innovative service. The start of the pilot was announced in the live broadcast morning show at TV Sitel in April 2022, with an estimated 320.000 viewers.[5] During August 2022, a draft flyer for the service was prepared. It was handed out during the International Day of Older People (1 October 2022). In February 2023, the Red Cross opened a Facebook page to promote the Emergency Button and Transport service. The team has produced two videos explaining the services and published many posts. Until the end of February 2023, the page had already 120 likes and 2400 visitors.

Spanish Pilot Intervention

The Spanish pilot is an innovation on the existing mental health intervention program (SENDIAN) for caregivers of people with dementia in Gipuzkoa, Spain. The program provides psychological support groups, individual therapy, and other resources to help carers cope with the challenges of caring for a loved one with dementia. It is open to all caregivers of people with dementia in Gipuzkoa, regardless of

[4] See at the SEtalks #6 – Innovation in Social Entrepreneurship? (hyperlinked).
[5] See at https://play.mrt.com.mk/play/52153 (starts at minute 38:33).

whether they are currently receiving support from the SENDIAN program.[6] The main objective specified in the Spanish pilot through the ToC map was: "**Family caregivers receive the care they need at all times**". To achieve this main outcome, the different intervention activities and the intermediary outcomes are listed in Table 18. Below we list some of the key activities of these outcomes to provide context into the Spanish pilot with respect to the evaluation.

	Outcomes
1	Clear criteria for prescribing the SENDIAN programme are established.
2	Consistent and sustainable training on Person Centred Care (PCC) and Case Management is available.
3	Professionals are aware of existing resources. Information on support networks is available.
4	Caregivers can receive training.
5	Family members are trained and sensitised in Person-Centred Care (PCC).
6	Professionals are trained and sensitised in Person-Centred Care (PCC).
7	Social agents (social workers, psychologists, volunteers) are aware of the needs of all users, by means of PCC instruments.
8	Social agents perform case management and prescribe
9	There is coordination between programmes.
10	Individuals receive preventive intervention.
11	Individuals receive reactive intervention.
12	Family caregivers receive the care they need at any given moment.

TABLE 18: OUTCOMES SPECIFIED IN THE SPANISH PILOT AS INTERVENTION ACTIVITIES

#1 Clear criteria for prescribing the SENDIAN programme are established.

One of the challenges of the existing program for carers of people with dementia in Gipuzkoa is the lack of awareness. There is little knowledge of the SENDIAN program among carers of a dependent person, but also among social workers in the municipalities. This is related to the fact that there is no unified criterion known by the different people to access the programme. Therefore, it is a programme that may be underused or providing services to people who may require another more specialised resource. The action developed by the Spanish pilot was focused on generating a consensus document in which criteria and further use procedures were established for participating in SENDIAN. The deputy of Gipuzkoa and Matia were contributing to the document. Matia, as a SENDIAN provider, has updated the webpage.[7] A document has been generated by consensus with the description of SENDIAN in which the profiles and the prescription process are included. The next steps in terms of upscaling beyond the project will be to update the content on the different informative websites and incorporate the service request in the *Gizartenet* so that the social workers can request it in a homogeneous and structured manner.

#2 Consistent and sustainable training on Person Centred Care (PCC) and Case Management is available.

Several trainings and materials have been developed to support case management, first in Matia and, as deemed appropriate, in the municipalities. The trainings have covered the following topics: 1. Person-centred care, 2. Case management, 3. Loneliness, 4. Bereavement, 5. Advanced directives, 6.

[6] Established in 2008, the SENDIAN program initially offered comprehensive support, including training, mutual support groups, psychosocial support, short term residential care and day care. However, the program now primarily focuses on support groups and individual therapy. Over the years, participation in the SENDIAN has grown from 136 to 160 individuals across different regions of Gipuzkoa. The caregivers who are currently enrolled in SENDIAN program, were invited to participate in the InCARE pilot project, with 129 accepting the invitation. While the pilot intervention is limited to 10 individual therapy sessions, caregivers can continue attending support groups for as long as they need to.

[7] See https://www.matiainstituto.net/es/proyectos-de-investigacion/proyectos/SENDIAN-programa

Emotional management, and 7. Management of behavioural problems. The training courses have been developed by experts in the field. These training courses will be available on the Matia Eskola platform, publicly available, and can be used for case management in the municipalities independently of the SENDIAN program. This means that the actions and material developed by the pilot can be used beyond the scope of the sample of respondents selected within the SENDIAN program and beyond the InCARE project duration.

Documents to support training in resources on Person-Centred Care (PCC) and Case Management were already developed during the pilot. This document provides 18 resources of PCC which can be used for developing adequate care depending on the context and professional groups involved. Additionally, outside of the project activities and contributing to upscaling, a psychological support short training video/podcast in three parts was developed to respond to the needs of the caregivers extracted from the project to be uploaded to the training platform of Matia (Matia Eskola).

#3 Professionals are aware of existing resources. Information on support networks is available.

One of the main challenges facing service coordination in Spain is that social workers, as gatekeepers of service provision, often work within the service portfolio of the administration without knowledge and use of community-based services. Lack of knowledge of these services by primary care social workers and lack of time to update this information are barriers for social workers to act as case managers, integrating care from different actors and contexts. To provide support on community resources, local community resource maps were developed so that SENDIAN psychologists have this information and can better orientate carers. This also helps social workers to refer or to provide information to community services and local voluntary action, going beyond the exclusive administration of portfolio services.

A common procedure has been followed for the elaboration of these local community resource maps, which is described step by step below:

1. Proposal of the elaboration of the map to the Social Services professionals of the municipalities contacted: the need for the creation of such a tool is explained in the meetings carried out in the Social Services of the different localities where the people of the experimental group are located.

2. Some Social Services centres provided us with guides already published by the Town Councils, which contain information on the services offered by the public portfolio.

3. A template was created to record the information: resources are categorised into three types (public resources, private resources and community or associative resources). It also includes information on the type of service, the description of the resource itself, the address and contact details.

4. The information provided by Social Services is integrated into the documents, and information on other private and community services in the area is added.

5. The information collected is checked with the Social Services professionals, and the documents are provided to the SENDIAN programme professionals.

As a result, **five resource maps have been drawn up**, specifically in the **municipalities of Zumaia, Eibar, Elgoibar, Azpeitia and Azkoitia**. These were the towns where the first meetings were held to present the project. The professionals showed interest in the creation of this tool and provided us with the guides published by the town council. The documents were provided to the psychologists in the experimental group of the Spanish intervention and to the social services municipalities in which people of the experimental group live or attend SENDIAN groups. Likewise, beyond the InCARE project, maps of other municipalities that are also interested in contrasting the services that they have and those that we find are being developed, so they have provided us with information about their resource guides. Some

small towns are not interested in creating a map of resources because they know most of the existing resources due to the size of the municipality, but they have shown interest in us providing them with information about some resources from surrounding towns or from companies.

#4 Caregivers can receive training.

Caregivers have difficulties attending SENDIAN support groups and other local training (provided by associations, health services, etc.) that could be of interest to them, because they are burdened with the daily care tasks. During the pilot, local voluntary organisations were contacted, and ways of support were explored with the administration so that carers could attend the groups and leave their family member in the care of other carers, volunteers or in a health and social care setting. This proved to be a difficult task as carers did not trust leaving their person in the care of an unknown person. Caregiving is a very personal task that, in some cases, requires a deep knowledge of the person only available to the closest relative or a professional worker. Additionally, the professional worker was considered too expensive to be covered by the administration. This service is provided in some cases by the administration when the training is mandatory by law (as in the mandatory training for receiving the Economic Benefit for Caring at Home-PECEF). Therefore, to achieve this in a community context, it is necessary to establish a prior relationship. This makes it difficult to carry out this action with many cases. It should be noted that in all the municipalities, few resources have been found specifically aimed at people with dementia.

#5 Family members are trained and made aware of Person-Centred Care (PCC).

Caregivers of a person with dementia faced with the need to provide care but they have scarce information about dementia, caring for a person, what a neurodegenerative disease process is, how it evolves and how to cope with it. As the work in SENDIAN is performed in groups, the Spanish implementation team aimed to know what the needs are related to care that people had. To this end, a needs assessment was performed in the SENDIAN groups during three days in each group of the experimental group. In this enquiry, 91 participants provided interests and needs that were registered and discussed to create formative oriented trainings (see below for the distribution of trainings across different localities).

Locality	Trainings
Donostia –3 groups	Group 1: 10 October; 24 October and 7 November Group 2: 10 October; 24 October; 7 November Group 3: 26 October; 2 November; 9 November
Zarautz	October 26, November 9, and 23 November
Rentería	11 October, 25 October y 8 November
Orio	10 October y 14 November
Zumaia	26 October, 16 November y 30 November
Elgoibar	19 October, 9 November y 23 November
Azpeitia	17 October, 7 November y 21 November
Eibar	17 October, 7 November y 21 November

TABLE 19: LIST OF TRAININGS HELD AS PART OF THE SPANISH PILOT

Introduction for each topic was given to the participants, and the InCARE team developed and then adapted formative sessions for the groups. Family members of the experimental group (EG) have been trained on person-centred care, promoting reflection on the care they provide, and the care people receive from the different services. This PCC framework has been informed by the different training topics generated through the needs assessment.

#6 Professionals are trained and made aware of Person-Centred Care (PCC).

There are different professional profiles that provide care in a fragmented way to meet the needs of people in need of care: social workers, auxiliary nurses, home care services, personal assistants, primary and specialised medicine, etc. These professionals do not usually work under the PCC approach. Person-centred care, if developed by caregivers or service providers, could support integration by focusing on the needs of the person and not on the characteristics of the process.

Three SENDIAN psychologists of the experimental group of the Spanish intervention have been trained through the specialised trainings generated through the activities that were developed to achieve outcome #2 (see Table 18) on PCC: Person-centred care, Case management, Loneliness, Bereavement, Advanced directives, Emotional management, Management of behavioural problems to provide the training adapted to people's needs and to foster activities of coordination with the other professionals.

14 municipalities were contacted to establish collaboration. They have been offered to work in PCC through accompaniment and training. No professional agreed to receive specific training on PCC. They understood collaboration as a joint work on specific topics rather than receiving training, which requires time and resources from the different administrations. Several participants stated that they also work through case management methodology and person-centred care, which the Spanish pilot implementation team understands this as a common resistance to change and a misunderstanding of PCC and case management methodologies. In these cases, strategies were developed to adapt the training content to the needs perceived by the social workers to develop their work with the carers.

#7 The social partners (social workers, psychologists, volunteers) are aware of the needs of all users, through the instruments of PCC.

It was hypothesised that creating spaces for joint reflection were useful ways of fostering communication and collaboration between caregivers which could improve the situation of caregivers in a preventive way or provide solutions to current problems. A two-level approach was developed, at group and individual level. First is identifying current situations in the groups to describe adequately the target population. Next, at subject level, the approach was identifying current care needs acquired by the psychologists in groups and individual therapy sessions. This information was one of the keys of the collaboration between SENDIAN psychologists and social workers.

In feedback meetings, the psychologists elaborated together with the SENDIAN support groups on the needs of the carers. Through these meetings, the topics described above in outcome 6 emerged, on which courses and training materials (training of trainers) must be developed to transfer solutions and information to carers. In addition, the knowledge gained from the psychological practices with the carers and the feedback questionnaires were used to convey real needs and possible solutions to the social workers, who are responsible for the provision of services.

22 meetings were held with the social services of 14 municipalities, in which the people attending the experimental group live. Contact was first established through an introductory email prepared jointly with the Deputy and sent to the experimental group municipalities. Afterwards an appointment was organised and held to introduce the project and SENDIAN (in case the municipality was not aware of the service). The municipalities showed different levels of interest and in some cases several additional coordination meetings were held. More than 38 social workers participated in the meetings and one representative of the Deputy Service for Dependency and Disability Care attended to start a coordination process between the Deputy and the Municipality.

As a result, in the most motivated municipalities, a coordination procedure was started, and psychologists and social workers held meetings or calls for coordinating services to improve the services coverage for the needs of people attending SENDIAN. One of the results of this action is that in 4 municipalities, an official coordination action between Deputy and Social Services with the participation of Matia has started, where meetings will be held at different intervals to coordinate

services regarding SENDIAN participants. As a product, Matia has had 14 case-studies presented in working reports in which the team described how the municipality works, what are their coordination interests, barriers, and potential actions to be carried out in the coordination activities to improve the quality of life of the participants.

	Meetings	Social Workers	Deputy
Azkoitia	3	2	1
Azpeitia	1	4	-
Deba	1	1	-
Donostia	1	8	2
Eibar	1	6	-
Elgoibar	2	-	-
Getaria	1	1	-
Mutriku	2	3	-
Orio	1	1	-
Renteria	2	1	1
Soraluze	1	1	-
Zarautz	3	3	1
Zestoa	1	2	-
Zumaia	2	5	-
	22	38	5

TABLE 20: NUMBER OF MEETINGS HELD WITH THE MUNICIPALITIES IN THE SPANISH PILOT

#8 Social workers manage cases and prescribe resources and services. & #9 There is coordination between different programmes and services.

Linked with the previous results, the activities which took place to achieve outcomes 8 and 9 are described together here as case management is one of the key aspects for coordinating programmes. As mentioned above, social workers tend to work with the services portfolio and are often not aware of the community and market resources, since they have no relation with health services. The InCARE pilot team observed that there are barriers (motivation, time, resources, etc.) to develop case management.

The psychologists, through direct coordination with some social workers, have facilitated access to resources and services, both portfolio and community, based on the holistic knowledge of the people in SENDIAN. A total of 104 coordination actions have been developed for the support of 75 people. For instance, some of the actions and activities developed to enhance coordination between the social services of municipalities, SENDIAN service providers, and the Provincial Deputy are as follows:

1. Coordination with SS of the municipalities: the coordination has been promoted by the psychologists of SENDIAN and involves the following agents:

    - Azkoitia social services
    - Social services of Azpeitia with general practitioner, PECEF, Gureak and Eguneko Arreta zerbitzua.
    - Zumaia social services and Zumaia day centre.
    - Social Services and Day Centre in Elgoibar
    - Zumaia Day Centre

2. Coordination between SENDIAN and different agents:

- Azpeitia day centre
- Geriatrics of the Matia Foundation
- Zumaia Community Care Committee

3. Coordination with the Provincial Deputy

- Establishment of procedural meetings with the municipalities: Errenteria, Zumaia, Zarautz and Azkoitia.
- Request for establishing a new SENDIAN group.

4. Information meetings for people and agents: in the cultural centre of Elgoibar, Orio, Azkoitia, to the social services of Zumaia.

As a result, several coordination actions have been performed, mainly starting with psychologists' proactivity. A coordination link has been established between psychologists and social workers based on the needs of the caregivers and the person in their care and working documents have been developed on case management from the social point of view and been circulated among professionals.

Further details of the extent to which the Spanish pilot intervention has been able to achieve its impact goal of having family carers receive the care they need at any given moment and potential limitations faced by the implementation team are described in detail in the country evaluation report (available upon request).

8. Results from the Project Evaluation Indicators

Findings from Process and Policies Indicators

The process and policies level indicators aimed to assess the change and effectiveness of the activities by the project team concentrating on the outcomes that are related to the involvement of a diverse and large pool of stakeholders and actors. Moreover, they capture the level of awareness and satisfaction from such actors when it comes to participatory and co-productive dimensions of the InCARE activities, especially the outputs, events, and other dissemination efforts. Concerning the ToC workshops, Table 21 below demonstrates the number and types of participants which were present in the pilot team activities.

Several indicators (PP.1-PP.3, PP.8) in this theme targeted the **participation of decision makers and related political representative stakeholders** in the InCARE national events, InCARE workshops (such as the ToC workshops and trainings) as well as the dissemination of the evidence on LTC. Concerning all three cases and in the final conference of the InCARE workshop 8 decisionmakers were present. The pilot team members´ reporting showed that these efforts of engagement with the decisionmakers were in great part achieved by the country teams even though it is noted in the country reports of each pilot that difficulties had to be overcome to achieve such participation.

For instance, in the Spanish case 10 decisionmakers participated in the Spanish ToC workshop in Soria on December 2021 and further 7 decisionmakers participated in the ToC consolidation session on 27 January 2022. The Spanish team have also held a policy information event to present their future scenarios results with the participation of at least 4 decisionmakers. In addition, the Spanish pilot

implementation team, along with the policy partner IMSERSO, have organised an event to present the national policy roadmap for the design of long-term care policies in Spain and of different future scenarios on the 20 September 2023 with the participation of 5 decisionmakers at different levels of governance.The Spanish pilot team (Matia) and the national policy partner (IMSERSO) have continously worked together, via monthly meetings, in involving and having feedback loops with some decisionmakers. Despite such established and routine links with the decision-makers, the Spanish pilot team also noted that the changes aimed at in the intervention at the level of coordination of the provision of care in the community had to be in great part achieved without the direct support of the health systems of Gipuzkoa (the intervention field), despite their presence in the Theory of Change workshop.

	Austria		North Macedonia		Spain				
					National workshop			Local workshop	
Workshop sessions	1	2	1	2	1	2	3	1	2
Date held	10 Jun 2021	17 Jun 2021	14 Dec 2021	24 Dec 2021	1 Dec 2021	2 Dec 2021	27 Jan 2022	2 Feb 2022	10 Mar 2022
Format	Online	Online	In person	Online	In person	In person	Online	In person	Online
Stakeholders present in workshop (total)	**22**	**18**	**24**	**15**	**32**		**22**	**16**	**12**
Decision makers	6	5	9	5	10		7	2	2
Care users	1	1	2	1	2		1	-	-
Informal carers	2	1	0	0	2		-	3	1
Healthcare professionals or providers of counselling/advice	3	1	2	2	2		2	3	1
Long term care service providers	3	4	10	6	10		6	3	4
Other	2	1	1	1	6		6	5	4
Facilitators/ project team	5	5	5	5	7		-	2	2

TABLE 21: DISTRIBUTION OF STAKEHOLDER CHARACTERISTICS IN THE PILOT TOC WORKSHOPS

From the Austrian case, the ToC workshops involved about 22 stakeholders, out of which 12 were decisionmakers at the political level and/or in the LTC domain. Among other events, the Austrian team held a policy faciliatation group on 30 June 2022 with 3 decisionmakers, focusing on the policy-making level. Furthermore, the Austrian pilot team have also made efforts in holding stakeholder workshops, such as on 12 April 2022 and 19 October 2022, which hosted about 15 and 17 decisionmakers, respectively. The Austrian pilot team also had 8 meetings (about 1-1,5 hours each) with the regional administration in the region of Styria (with 5 different persons). Moreover, some of the core pilot intervention activity events were directly in engagement with the decision makers and policy makers such as the Info-Messe Gleisdorf (12th May 2022 with the presence of the mayor of Gleisdorf and 2 city counselors), Info-Messe Ilztal (29th Oct 2022 with the presence of the mayor of Ilztal and 1 city counselor), and a second Info-Messe Gleisdorf (11th of May 2023 with the presence of the mayor of Gleisdorf and 1 city counselor).

In the North Macedonian case, as the signing of a Memoranda of Understanding was also a built in as an outcome goal of the pilot ToC, the team has held multiple meetings with the decisionmakers. These took place particularly at the local level and involved the municipalities, especially the city of Skopje as

well as the Ministry of Labour and Social Protection. In the ToC workshop, the North Macedonia team have also particpatorily worked with 24 stakeholders out of which 9 were decisionmakers.

Another dimension of the participatory stakeholder activity monitoring was captured by the indicators which focused on the **engagement of formal and informal care providers and care users** in pilot countries and experts on LTC (PP.7, PP.9, PP.10). Regarding the participation of experts in the design and activities of the InCARE activities, about 1-2 scientific experts were present in each of the national ToC workshops. All teams had informal and formal care givers in the pilot ToC workshop development as stakeholders. Informal carers were also beneficiaries of InCARE pilot activities. For instance, a key pilot activitiy of the Spanish team was trainings and support for informal care givers which involved activities implemented with 76 care givers in the intervention group.

In the Austrian case, there were also multiple activities undertaken to ensure the participatory dimension. To illustrate, in addition to their participation in the ToC workshops, care professionals and informal carers were also actively present in the national events such as the stakeholder workshops (11 November 2021, 12 April 2022, 19 October 2022), where a total of 14 care professionals and a total of 6 care users and informal carers were present. In the Austrian pilot a high level of engagement existed with care professionals due to the design of the pilot. In this respect, the Austrian team also held 4 trainings on various different topics (resilience, self-care and caring communities) with the participation of about 19-20 participants. The North Macedonian pilot team also had a component of care-giver trainings to about 60 participants.

Beyond the number of participants, we also collected data wherever feasible on the extent to which **knowledge transfer and awareness** have been achieved between the project teams and stakeholders (PP.4-PP.6). For each country pilot ToC workshop, the national pilot team and the project evaluation team monitored the feedback surveys and participated in all three countries reported above average satisfaction with their role and opportunities for contribution and discussion (see Table 21 above). Based on the reporting from the country evaluation reports of the national pilot teams, the external stakeholders, invitted to the ToC workshops, have reported high level of satisfaction with the participatory and knowledge transfer outcomes of the events. Importantly, they have replied that the workshops have raised their awareness on the issues and the activities of the project.

Outreach and dissemination of the InCARE outputs and activities have been monitored consistently by Eurocarers as one of the partners of the InCARE project. For indicators that focus on overall attendance numbers of InCARE events and dissemination efforts (PP.11-PP.16), the data presented here comes from the reporting of Eurocarers, which culminates from the reporting of the partners. These indicators aim to capture and assess whether the project met some of the outcomes defined in the project ToC such as stakeholders´ continuous engagement and awareness of the project activities as well as that the InCARE project developed strong relationships with the stakeholders. As tracked and collected data by Eurocarers shows in Table 22 (with reference to the target numbers shown in 4), the project activities in this field have gone above and beyond meeting the targets expected.

The InCARE website was launched on 19 April 2021 and, as shown in Table 22, received a remarkably high number of visits and interests. Furthermore, Eurocarers have also managed to achieve these targets via newsletters and continuous posting and updates on social media with links on services.

Lastly, within the InCARE project, scalability is understood as the generation of evidence through the pilot studies which can be then used in other external contexts which could be different from the pilot context in terms of location, groups, or scope. Scalability of the pilots is one of the targeted outcomes of the project, thus, each pilot project´s evaluation plan ensure that activities and measures are foreseen. Related to the indicator PP.17, the evaluation team confirms that the national pilot evaluation plans have all a priori included the topic of scalability.

	As of the end of Year 2	As of the end of Year 3
Number of participants attending InCARE events (PP.11) *	73	104
Number of participants attending non-InCARE events (PP.12)	776	1948
Number of individual emails containing information on InCARE disseminated (PP.13)	4023	7336
Number of views of social media post related to InCARE (PP.14)	48132	57082
Number of visits on the project website (PP.15)	7197	11850
Number of downloads on the project website (PP.16)	438	871

*The number reported here is only considering the ToC workshops and the final conference.

TABLE 22: ATTENDANCE AND DISSEMINATION MONITORING RESULTS

Findings for the Organisational Level Indicators

The organisational level concentrates on three broad areas; (1) the quality of the engagement of the stakeholders with the pilot teams, (2) the characteristics of the pilot intervention activities with respect to sustainability, co-design, and social innovation, and lastly, (3) the scalability of the pilots and the relevant actions to be taken.

Starting with the relationships with care organisations, all three countries have reported some extent of engagement. Related also to the nature of its pilot intervention, the Austrian implementation team has had both a large volume and the strongest links with the care organisations. For instance, in their ToC workshop, the Austrian team had 3 different care organisations represented as well as in their stakeholder workshops. The effort in establishing good relationships is also evidenced by the participation of 10 different care organisations in the Info-Messe event on 12 May 2022 and 8 different care organisations on 11 May 2023. Likewise, overall, about a total of 25 care professionals have been participating in the networking, information and/or knowledge sharing events of the Austrian pilot.

Turning to Spain, the team reported good relationships with care organisations, with the Gipuzkoa region deputy and absent to good relationships with the social workers in the field depending on the municipality. The Spanish team notes this as one of the challenges in the implementation of the pilot. In addition to the lack of labour resources to carry out coordination work between social services centres, there has been a lack of confidence on the part of social workers in long-term care at home (possibly because it is not an area they can manage directly. Another reason may be that the home care service in Spain is currently insufficient for home care. Furthermore, there are difficulties in coordination with other services, lack of confidence in private and community services, high turnover of staff in Social Services, varying perspectives on resource guides and barriers related to the conception of and processes of learning about case management methodology. Despite these difficulties, several actions have been achieved in line with the project objectives: contact and collaboration meetings with Social Services centres, the development and provision of explanatory documents on case management methodology, the creation of resource maps in different municipalities, and the establishment of case coordination and monitoring meetings in 4 municipalities.

The North Macedonian pilot team has organised and held practical trainings for 60 care givers delivered by certified educators. The trainings were held in the trainings centre of the RCNM, and the practical sessions of the trainings were held in an elderly nursing home, Idila Terzieva. Furthermore, agreements with trainers for home care trainings from the Nega Centre, Austrian Red Cross, social workers from City of Skopje, and the municipalities of Kisela Voda and Gjorce were made which are illustrative

examples of the presence and the good relations with care organisation established by the national team.

The INCARE project understands scalability through the generation of evidence of success in a pilot study, which can be exported to other contexts, groups, or broaden its scope and impact. To this end, the project established links with national partners. Concerning scalability indicators (O-4, O-8), we assess whether the pilots are scalable and whether any actions of scaling have already taken place. In this respect, based on pilot country evaluation reports, all pilot teams have taken steps for scalability and have implemented scalable activities in the field. Starting with the Austrian intervention, the regional pilot had an impact on the local and the national level and succeeded in disseminating the findings of the project implementation phase on a larger scale. This is done not just through decisionmaker engagements but also with the wider public and care professionals. Thus, the pilot team and the project became visible as an active network of partners, promoting mobile care in the regional context. Furthermore, all activity reports and results of the regional pilot are made public open access (such as the webinars held with Vilans and documentation about community nursing etc.). This further increases the likelihood of scaling up of the pilot actions. The team has also self-reported, based on their consultations and experience from the trainings, that they will likely achieve the scaling of the train-the-trainer module, both in continuing the training module and publishing the material developed. As expected, the full scope of the scaling is difficult to assess at this point at the end of the project without the long-term perspective.

In the case of the Spanish pilot, this collaboration was considered, on the one hand, as the piloting of social innovation solutions and the transfer of knowledge to the public administration and, on the other hand, from the administration as the facilitation of the social innovation actions implemented in the pilot and to enhance their scalability. The Spanish team note that the disparity between the short-term planning of a pilot project and strategic system change do not facilitate possible synergies between pilot and administration. Thus, the pilot was developed in a direct working relationship in a more local environment in Gipuzkoa rather than at the national level, generating knowledge about the processes, materials, and effects of a social innovation programme. The pilot has allowed to increase the number of programme beneficiaries, creating new groups in municipalities where this service did not exist, raising awareness on the programme on social workers and municipalities, and creating new procedures. However, the geographical scaling up to other autonomous communities has not taken place, due to the very focus on the local process, but it seems a promising process based on the effectiveness indicators. To be able to scale up to other groups and contexts, it would be advisable to study cost-effectiveness and sustainability indicators in a broader economic scenario than the actual expenditure incurred in social services, including health services, cost-opportunity, and possible benefits in terms of economic well-being. Generating information in a systematic way will provide administrations with information for decision-making. Networking and trust in participatory processes would be key for the systematic upscaling of social innovation.

Particularly of note for the Austrian case is the wide outreach activities conducted to ensure the wide-spread knowledge about the activities not just at the regional but also at the national level. This, in the medium-term, has the potential to ensure the geographical upscaling of some of the activities at the national level. Moreover, the Austrian pilot team reported that the second round – modules III and IV of the trainings empower a group of professionals in supporting and counselling informal carers is currently being prepared for further upscaling.

The sustainability (O.5) of the three pilots is ensured by the policy roadmaps which were developed by each national team and presented at targeted events for decisionmakers in the last two months of the project. Both the Spanish and North Macedonian pilot teams´ reporting on sustainability highlight the need for such outreach, promotion, and decisionmaker engagement also for the pilots to have the necessary financial backing after the end of the InCARE project.

The codesign of the pilots (O.6) has been achieved by the development of ToC workshops which were engaging stakeholders on national and local levels. The ToC maps and the design of the interventions

were validated with feedback directly after the workshops and with the feedback loops which were established through the co-production with stakeholders continuously (see also discussion of indicator CF.2 below). Relatedly, the innovative nature and social impact of the interventions (O.7) were ensured through the participatory elements of the design of activities. Furthermore, each pilot and case country built on the InCARE project´s situational analysis of the long-term care sector which identified the most important challenges and the state of play in the cases through desk research.

Findings from the InCARE Project Level Indicators

At the InCARE project level, the targeted outcomes were to follow whether the partners´ resources, skills, and time were sufficient and that the exchanges and work practices within the project were transparent, efficient, and clear in a way that allowed the project aims to be achieved. To ensure consistent and ongoing communication between the project implementation, policy, technical, and research partners (IP.1, IP.2, IP.3). The InCARE project established online *Jour fixe* events, bringing together all partners, which were held on the fourth Wednesday of the month (almost every month), starting from 22 March 2022 (in 2022: 27 April, 25 May, 22 June, 27 July, 24 August, 28 September, 25 October, 23 November; in 2023: 25 Jan, 21 Feb, 5 April, 26 April, 28 June, 22 August, 25 October). Through such regular communication, the project team defined mutual targets and agreed on any steps which needed to be taken, and all partners participating in the meetings got an update on the ongoing activities of others. Likewise, the partners have also met in interim and final steering group meetings. The feedback surveys which were administered at the end of these meetings asked the participants regarding their satisfaction with the opportunity to discuss and the transparency of the working norms in the project all showed that partners were consistently satisfied with the teamwork and the knowledge exchanges within the project. The pilot team members have also stated the existence of regular and sufficient communication with the lead partner.

Another important outcome determined was to ensure that the partners, in particular the pilot implementation teams, have adequate time, human, and financial resources (IP.4) and skills (IP.5). In this respect, considering the primary role of the application of theory of change methodology in the project, training on how to design and implement such an approach was delivered to all team members. As discussed in the section above, two trainings (24 February and 7 April) were held in 2021 with the project partners to ensure that, at the InCARE project level, teams have the skills and tools to carry out the activities. The aim was also to ensure that the team has clear ways of working as well as that the ToC methodology is aligned with international standards. For these two trainings that were organised to ensure that the project team has consolidated knowledge, resources, and know-how to correctly implement their activities in line with the project ToC methodology, the participants evaluated the trainings positively with participants rating the first training mainly excellent (66.67%) or above average (33.33%) and the second training mostly excellent (60%) and above average as well (33.33%).

With respect to achieving its goals in preparing the project partners for the InCARE activities, the first training on preparing for facilitating a pilot level ToC workshop and developing country ToC maps, participants have reported that the workshop on 24 February 2021 had achieved its goals (60.33% of the respondents strongly agree or agree). Likewise, most of the participants in the second training on 7 April 2021 strongly agree (33.33%) or agree (53.33%) that the training achieved its objectives of preparing them for developing measurement indicators for pilot evaluations and writing pilot evaluation plans. Table 23 below presents the summary of the participants in each training and results from the feedback surveys on some important aspects. For both trainings, the participants have been happy with the participatory aspect of the workshops in being able to share their input and receiving input from others.

	Training on ToC development and ToC workshops 24.02.2021	Training on indicator development and writing evaluation plans 7.04.2021
Participants: Role in InCARE		
National policy partner	3	4
Implementation partner	5	4
Technical partner	4	6
Guest/other	0	1
Total	12	15
Share of participants who strongly agree or agree that they could share their views	100%	93.33%
Share of participants who strongly agree or agree that the contributions of the participants were valuable	100%	93.33%
Share of participants who are completely satisfied or satisfied with the support they received for their InCARE work	83.34%	86.67%
Share of participants who are completely satisfied or satisfied with their understanding on how prepare and organise a ToC workshop	75%	-
Share of participants who are completely satisfied or satisfied with their understanding on how to develop indicators	-	93.33%

TABLE 23: PARTICIPANTS AND FEEDBACK IN THE INCARE TOC AND EVALUATION TRAININGS

In addition to the trainings on ToC and indicator development and evaluation, InCARE project also included actions which aimed at further ensuring that all partners had the necessary skill and resources for the activities that need to be achieved. Relatedly, three other trainings were held. On 3 February 2021, a training was held to support the national partners on conducting their situational analysis for the pilot countries. Held by experts in research on the topic of LTC, namely Stefania Ilinca and Adalina Comas, project partners were informed and trained on the skills that they would need to carry out project activities. Next, two trainings were also held in summer 2021, on providing the partners of the project an overview of the available knowledge and state of the art on the challenges and opportunities for social innovation in LTC and the financing and organisation of integrated care in Europe,

Furthermore, the Spanish pilot team reported that the resources and motivation of the team were adequate but that time resources were seen as the challenging aspect. The team noted that especially to achieve mature results for establishing relationships with different stakeholders and having shared objectives in relation to the wellbeing of the participants required a significant amount of time. A similar issue was also raised by the Austrian team linked with the COVID-19 related delays and preparations that needed to be made for their intervention activities. Likewise, the North Macedonia implementation team reported sufficient human and financial resources but that the technical development of their intervention tool required more time than anticipated.

Regarding skills required, all teams reported adequate skills to carry out the pilot (as evident also from their personal expertise available publicly on the InCARE project website). In the Spanish and North Macedonian interventions, wherever speciality skills were needed to carry out the tasks, training needs have been identified and were addressed such as in the case of psychologists in the Spanish case and on the use and implementation of the technical aspects of the emergency button in the case of North Macedonia.

Lastly, formal carers who were involved during the project lifetime have also reported high satisfaction with the implementation of the pilots (IP.6). In the case of Austria, the four training modules administered have all received very positive and high satisfaction evidenced by the results of the

feedback surveys. The training module for carers on 15 March 2022 (11 out of 11 satisfied) on resilience and self-care, on 22 March 2022 (10 out of 10 satisfied) on the Caring Communities Approach had feedback received in which all participants filling out the survey reporting full satisfaction. The latter two modules on support and counselling for informal carers held on 9 June 2022 (7 out of 8 satisfied, 1 partially satisfied) and 14 June 2022 (2 out 9 satisfied, 4 partially satisfied) also had all participants either mostly fully or partly satisfied with the intervention activities.

In the Spanish pilot, involvement of the carers and their direct level of satisfaction could be measured related to the formative trainings delivered. In these trainings five different topics were developed and psychologists were also trained to deliver the material to the home carers. As a result of the survey administered at the end of the trainings, the carers participating in the trainings showed high satisfaction (an average result of 9.2 out of 10) with the intervention.

Finally, in the North Macedonian pilot, carers were trained over a period of three months and received theoretical and practical training. Among the carers taking part in these trainings, 52 out of the 60 initially enrolled have completed the trainings. The trainers collected the results from the satisfaction questionnaires after each training. In general, carers gave positive feedback for upgrading their knowledge and skills. According to these surveys, 100 % of the participants gave the highest rating to the following group of questions of the satisfaction survey: the caregiver training was interesting, well organised, and useful; the questions asked to the trainers were adequately answered by them; the theoretical and practical parts were connected, and the trainings provided informative data that could be useful in practice They mentioned that such trainings are much needed.

Findings from the Care Users and their Families Level Indicators

The last level of the project ToC indicators focuses on the outcomes of the pilot interventions and concentrate on whether the care users and their families (who could be informal and home carers themselves) have had chances to have their voices heard during the design of the local pilots (CF.1) and throughout the implementation via feedback loops (CF.2) As mentioned, such stakeholders were routinely involved in the project activities and events, as evidenced in the key national ToC workshops which formed the basis of the defined goals and activities of the pilots. More specifically in North Macedonia, in the design phase of the standard operating procedures (SOPs) of the emergency button, staff members from the Red Cross branch, social workers, doctors and legal associates were included. Once finalised and adopted as official, the SOPs of the emergency button service were disseminated to the staff members, volunteers, and caregivers of the EB and home care service. 60 care users have been consistently involved in the project via trainings and had chances to give their feedback.

In the case of the Austrian pilot, in addition to the participation of the care users and their families in the project activities, the pilot implementation team had routine e-mail correspondence with the care user representative as well as having in person meetings three times in July 2021, October 2021, and March 2022 to receive input. Likewise in the Spanish pilot, the participants in the intervention group have been giving routine feedback to the implementation team throughout the pilot activities.

Next, other outcomes which were described in the project ToC were the satisfaction of care users with the quality of the interventions (CF.3) within the pilot and that care users and their families are empowered to have their voices heard in the long-term care services sector in their countries (CF.4) with the goal of improving the well-being of care users and their families (CF.5). Regarding user and their families´ empowerment, as discussed particularly in the first theme of the project indicators, all pilot teams have consistently and routinely taken feedback into account throughout the project. Quantitative assessments of the various effects (such as indicators of quality of life, well-being, burden, depression, and social support) were feasible to measure in the case of the Spanish pilot, where quasi-

experimental impact evaluation was built in the pilot. The research design applied by the Spanish pilot team to evaluate the impact of InCARE intervention on the two groups of SENDIAN participants was to provide the experimental group with the additional coordination aspect of the programme which is linked to the InCARE pilot intervention. The control group, on the other hand, only continued to receive the existing SENDIAN support programme. In this case, when compared with the control group of informal carers, those who have received the pilot intervention reported statistically significant levels of burden decrease and better quality of life indicators. For instance, when compared to the SENDIAN participants in the control group, those in the experimental group (with the InCARE intervention accompaniment) have reported 9.4% decrease in loneliness, 12.7% decrease in burden, 7% decrease in depression indicators, 6.8 % increase in the quality-of-life composite indicators, and 9.8% increase in well-being. The data collected for comparison of groups were administered by the Spanish pilot team, whose results in greater detail are available in the short report of the Spanish pilot project and in the country evaluation report (available upon request).

While such a quasi-experimental evaluation was not available for the other two pilots to directly assess the improvement on the lives of target groups, which can be linked to the pilot intervention, feedback survey, discussions with participants in the project activities which come from user and family target groups inform our measurement on these indicators. For instance, in the North Macedonian pilot, we are also able to assess, through the surveys administered with those who have received the emergency button service that out of the 57 participants surveyed, 53 expressed positive experiences, while one had a negative experience and four had no experience to report. 52 participants found the alarm device easy to use, and 47 reported feeling more secure when wearing it. Additionally, 38 participants noted that the Emergency Button team responded quickly to alarms, while 18 participants indicated that they had not yet the opportunity to use the alarm.

Lastly, in the case of the Austrian pilot, the evaluation team planned to use the EuroQol assessment tool to measure the impact of pilot interventions on client's quality of life change. Yet, reconsidering the validity and reliability of such an approach, due to the inability to attribute any change or no change to the pilot activities, the project team decided to rely on qualitative data to measure this indicator. Qualitative assessment of networking impacts indicated improvements in case management through well-established networking and collaboration. Moreover, the "Café Miteinander" for persons with dementia and their relatives is a new leisure time opportunity for this target group. It was developed as an impulse for the region within the project framework and will continue after the project implementation phase ends. Likewise, the Austrian pilot team gave impulses for better networking in counselling, both with the Open Day on Care provision and with the training modules, especially in training modules 3 and 4, and impulses for a better general setup of counselling in mobile care.

9. Discussion of Assessment of Change

In this section, we provide a discussion based on the presentation of our assessment of the indicators of change for the InCARE project in four defined themes which were (1) process and policies level, (2) organisational level, internal project coordination and management level, and the care users and their families level. Based on the ToC map of the project, our assessment and findings presented above focused on the outcomes defined within the ceiling of accountability. Six medium term outcomes (see Figure 3) fall beyond the life cycle of InCARE and cannot be assessed in the current time frame. However, wherever relevant we refer to the extent to which the outcomes we concentrated on gives way to advance towards the achievement of these outcomes in the future. In this way, here, we provide an assessment of the InCARE project theory of change with link to the results of the project activities.

The project implementation and policy partner teams have jointly ensured that the decision-makers at the national, regional, and local levels have been made aware of the InCARE activities. This is clearly shown in the relevant indicator results, demonstrated through the dissemination activities, public outreach efforts, as well as the communication strategy implemented by the project. InCARE partners have engaged in participatory processes in the decision-making and in the development of the pilot interventions. This has made it possible for the relevant actors to be aware of the intervention actions and facilitated knowledge transfer. InCARE partners have also made a strong effort in inviting, regularly updating, and communicating with the end users of long-term care, informal and formal care givers as well as care giver organisations representing these interests. With such efforts, the InCARE project as a whole and its national pilots have made considerable way in achieving that LTC services at the national level are developed and improved reflective of the preferences of care users and carers themselves. Thus, the activities in the project can be traced into achieving the outcomes of engagement as defined *a priori.*

All three country pilots have achieved the development of the roadmaps for long-term care. Both InCARE research findings and the country specific stakeholders have been decisive in the design of the recommendations. Local authorities have been engaged and all relevant stakeholders have found space in coming together during InCARE project activities, with project partners facilitating the empowerment and giving a voice to all stakeholders.

It is notable, however, that for all three national teams some administrative challenges were encountered during the dissemination of activities and results as well as in engagement with stakeholders. To address such issues, pilot teams have worked closely with the local and regional administrations and stakeholders. It is important to underline that the scaling ambitions of the pilots at the national or EU levels rely heavily on the extent to which robust lines of communication are established prior, during, and after the pilot implementations. It has been highlighted by the partners that coordination between different levels of actors, collaboration with the administration and the care providers and care users have represented the most important challenges that needed to be addressed within the 'processes and policies' theme outcomes. Therefore, while the theory in the theme of 'processes and policy' has been developed and followed through successfully in the project, the validation of success in achieving the goals of 'adequate, affordable, high-quality community-based LTC at the national levels' and the 're-orientations of the discourses at the EU-level' depends on factors external to the project activities themselves.

In the chain of process of the project ToC map, one of the outcomes to be achieved is to ensure that pilot projects are scalable and sustainable. These two aspects of the project interventions are beyond the ceiling of accountability since it is unfeasible to argue that the pilots will have a broader, long-term impact. However, it can be assumed that some achievements of the pilots will be taken up by national or local stakeholders, and that the funding and resources of defined activities will not be stopped. Likewise, for informing EU-level and EU-wide changes and improvements of LTC which can be traced to the InCARE project, long-term monitoring would be required.

As the presentation of the indicators for the organisational level above showed, pilot projects have aligned themselves also in existing public projects and/or have used resources from previous and existing resources (such as the SENDIAN project in Spain). Likewise, the North Macedonian intervention utilised existing evidence and practice as a basis for the application of the emergency button. The project promoters had established relationships within the network of care organisations This ensured that the engagement and active participation of formal and informal carers as well as of care organisations were present in the design and the implementation of the pilots. Given the evidence of the data collected and presented here, pilot projects' organisational elements did indeed follow the process steps as defined in the theory of change. The pilots were thus developed in scalable ways which helps decision-makers to take up such evidence and consider these outcomes in the future design of services.

Among the more technical and participatory components as well as outcome-oriented processes defined in the project theory, the theme 'evaluating and monitoring the project team´s resources, skills, and effective working relationships' is also of key importance. To ensure that internationally accepted pilot designs of high standard are generated and that all project activities are completed as planned, the internal communication channels have been strong within the project. Likewise, the collection of evaluation data as well as the interim and ongoing checks on the team's working relationship demonstrated that there has consistently been effective mutual exchange, clear ways of working, and transparent decision-making throughout the project. The cost effectiveness and adequacy of the financial resources of the project are also reported by the pilot teams and are evidenced, wherever relevant, in the financial reporting of the project. The team has kept in close and routine contact despite the difficulties and hurdles which needed to be addressed through virtual communication strategies. These mechanisms kept motivation and focus on the project high.

Lastly, concerning the level of care users and their families, one of the expected outcomes (beyond the ceiling of responsibility) of the chain of process in the theory is that care users and carers are empowered to participate in the decision making and policy making processes. This is to ensure that the decisions made, and systems developed in the long-term would more directly cover their needs and preferences. Along the process chain, our evaluation results showed that the project team has effectively and actively included the voices of care users and carers in the design of the pilots. Moreover, feedback loops have been in place to shape the pilots as they went along. Despite the successful steps undertaken within the project's accountability level, the execution of planned activities revealed a nuanced landscape influenced by numerous stakeholders and multifaceted factors. While the intended outcomes of the project were achieved, it is impossible to assess whether the empowerment of the involved users and carers will lead them to actively participate in the future development of long-term care services and policy. The interactions between various actors and the broader societal context will continue to play a crucial role in shaping the trajectory of change beyond the timeframe of the InCARE project.

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