CHANGE STEP AND VETERANS NHS WALES PILOT STUDY

Eleri Lloyd

Foreword

Change Step is an established and effective peer mentoring service delivered by veterans for veterans, with a significant record of success throughout Wales.

Supported by funding from Betsi Cadwaladr University Health Board, over the last 12 months Change Step has undertaken a pilot study to test and evidence the value of a new partnership approach with Veterans NHS Wales. This partnership brought Change Step Veteran Peer Mentors together with Veterans NHS Therapists throughout north Wales, and sought to demonstrate the benefits of collaboration in the delivery of an integrated approach between the third and statutory sectors. The report identifies the positive impact on the Veterans NHS Wales service, as well as other areas of health and social care.

As a third sector provider of services, CAIS is well aware of the need to deliver evidence of effectiveness, and commissioned Mantell Gwynedd to undertake a social return on investment (SROI) evaluation on the partnership and its impact on the veterans accessing support. With this in mind the £7.19 in value created for each pound spent shows the significant social gains which can be made through Change Step's collaborative approach to peer mentoring. We believe this makes the case for investment in Change Step even more compelling.

I would like to thank Betsi Cadwaladr University Health Board for funding the pilot study – and for providing us with the opportunity to showcase the collaboration between our peer mentors and Veterans NHS Wales therapists, and the impact this has on the veterans accessing the service.

I would also like to thank Mantell Gwynedd for producing a report that is not only comprehensive, but also captures the essence of the collaboration.

And finally, I would like to extend my thanks to the peer mentors, therapists, veterans and their families who agreed to share their experiences to make this report possible.

Geraint Jones

Director of Partnerships and Development, Cais Ltd

Executive Summary

This report details the Social Return on Investment (SROI) forecast analysis conducted on the Change Step / Veterans NHS Wales pilot, a new collaboration funded by Betsi Cadwaladr University Health Board that sees Change Step peer mentors working alongside and supporting Veterans NHS therapists. The results demonstrate that significant social value is created through the project's activities, with a **SROI result of £7.19:1 – meaning that for each £1 invested, £7.19 of value is created.**

The success of this pilot study lies with the peer mentors who were described by the veterans as a 'friend' but also a professional staff member that was able to support them before their therapy, during and post therapy. This balance was seen as 'unique', and as veterans themselves provided the clients with immediate trust and reassurance.

Current waiting times for therapy is 5-6 months, and during this time their symptoms and concerns could continue to deteriorate as was explained by the clients and their families. When asking them about what had changed, some referred to the positive feeling of 'not feeling forgotten'. During this period, the peer mentors provided them with support on different issues that were having an impact in their lives. This included social, financial, housing, employment, education, and mental and physical health concerns. Under the supervision of the therapists, they were also able to focus on particular areas that needed attention as well as gather a further understanding of their needs. By the time clients had reached therapy, many had already made improvements in certain areas and already some positive changes had happened in their lives which included *improved relationships with family members*, *improved mental health and also feeling less isolated and alone in their situations*.

These outcomes also created significant value for other stakeholders. Family members expressed that the peer mentors support provided them with reassurance by gaining an understanding about what their loved ones were experiencing, as well as reducing their anxiety and stress levels as support was available. Identifying that their loved ones were making small but positive steps towards recovery ensured that the whole family benefited.

This collaboration will also have an impact on the Veterans NHS Wales service, as well as other health and social care costs. As this was a short term pilot, further data is needed to continue the discussion on potential savings here, however, by involving all stakeholders which included the veterans, family members, peer mentors and the veteran therapists, there was agreement that when considering

'what could have happened' without this support, many felt that they could have deteriorated, and for many they feared that could result in a worse situation which could include the breakdown of relationships, homelessness, hospitalisation or, as many suggested, life loss.

The Social Services and Well-being (Wales) Act 2014 puts a great focus on prevention and that the needs of the individual is central to their care. This model responds positively to these requirements and looks at the needs of every client and responds accordingly. We have a duty to listen to our stakeholders and they are best placed to tell us what changes in their lives as a result of a service.

This report does not place a price on everything; instead it values those things that are important so that we can **be more accountable for our decisions**, **make better decisions**, and **create ever more social value in the lives of people**.

Acknowledgments

This report would not be possible without involving key stakeholders that can help us to understand what changes and establish the impact. This was a pilot project, so time was limited to see any big change, but for those that received support from the service, their involvement was key and we're extremely grateful to them for feeding back on their experiences and their willingness to help us understand what happens. A huge thank you to the peer mentors who are clearly passionate about their work, and in many cases, had gone over and above to help the veterans. A big thank you also to the Veteran therapists and the CAIS staff who all supported us with gathering the information together that has been contributed to this report.

Also, we'd like to show our appreciation to Nikki and Darel from Glyndŵr University who supported us with the qualitative information and the data collection.

Diolch yn fawr / Thank you

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1.1 Introduction

This forecast report will analyse the value of the peer mentor service provided through Change Step in partnership with Veterans NHS in North Wales. The impact of this service on veterans will be considered, but also the value to the peer mentors and the Health Board.

Through engaging with both individuals receiving the service, family members, peer mentors and the organisations and examining information and data was available, appropriate estimations have been made supported by secondary evidence.

The report will initially set out the background of this support service, followed by a discussion of the Social Return on Investment (SROI) framework used to evaluate the service. The SROI results will then be discussed in detail to explain the 'story of change' and value for key stakeholders.

1.2 Purpose and Scope

This is a Social Return on Investment (SROI) forecast to measure the social value of the role of the Change Step mentors working alongside the Veteran NHS therapists. This report looks specifically on the outcomes and their value for veterans who suffer from a service related mental health illness.

This report was commissioned by CAIS Ltd in order to review and ascertain the following:

- The views of the key beneficiaries involved in the project that is the veterans and their family members.
- The outcomes experienced by all material stakeholders, but most importantly the clients that received this service from the Change Step Mentors.
- To understand the difference the role of the peer mentor has in the lives of the veterans, and especially the difference this support has on the Veteran NHS therapy sessions. Is there a difference to clients that received no support from mentors?
- To give a value to the service and to answer the question does Change Step provide good value for money to the Veterans NHS programme.
- To see what changes to the service can be introduced to provide more outcomes and further value to beneficiaries.
- To recognise the value of this partnership working.

1.3 Audience

This report has been prepared for both internal and external audiences. These include:

- **Funders** –This project is funded by Betsi Cadwaladr University Health Board, Veteran Services, and the relationships between the Veterans NHS therapists and the Change Step mentors are also key to this service. The funders will need to understand what the value is for money from this partnership, and how the role of the peer mentor has had an impact on their service.
- **Internal Management** – Change Step had been a service provided by CAIS for several years. Due to funding cuts, this has now been restricted. By measuring the social value of this service and understanding what the outcomes are for veterans and their families decisions can be made based on this information to manage and plan services.
- **Policy and Decision Makers** –With the new legislation in Wales there is an increasing need to understand what is most valuable to service users, and how services prevent people from needing statutory care. Although a higher level of rigour would be needed to have an impact on policy and further data, this report will help to demonstrate the impact of services being coproduced.
- **Veterans and families** – To understand and communicate the value of the Change Step peer mentor to those who matter the most, the veterans and their families.

A summary report will also be available which can give an overview to a wider audience.

2. Background and information

2.1 CAIS and Change Step

CAIS is a registered charity (Charity Number 1039386), and a company limited by guarantee registered in England and Wales (Company Number 2751104). This voluntary sector provider supports people with personal problems such as mental health illness, addictions, employment and housing. CAIS is established on the vision that they can create;

"A world where people have access to inclusive, consistent support which is tailored to their needs; empowering and inspiring change to promote happier and healthier lifestyles, creating a better society for all."[1]

[1] http://www.cais.co.uk/mission-vision-values-aims/

Change Step was established in 2013 following the partnership established with Drug and Alcohol Charities Wales (DACW) as part of the personal service offered by CAIS Ltd. The main aim was to support veterans with mental health issues, substance misuse, and criminal justice and housing issues. This was based on the notion of having veterans supporting veterans.

'Delivered by veterans for veterans'[2]

Peer mentors were recruited who were themselves veterans and were able to offer one-to-one support for veterans and their families. As well as the moral support, there were opportunities for training and education, volunteering, community activities and much more.

The Faculty of Health and Social Care, University of Chester evaluated this service in April 2016. Over 32 months, this project had supported 848 veterans across Wales with 21 peer mentors trained to support. Alongside Change Step, they also had the Listen In programme that supported families of veterans who themselves need emotional and practical support.

After an initial one-year voluntary Change Step project, the project was established on the needs identified for veterans to be supported by fellow veterans. The data gathered in the University of Chester evaluation, underpins the success of that programme,

"It is the common experiences of the veteran clients with their veteran peer mentors which bind individuals together. Shared experiences and a shared 'veteran identity' are the foundation for this project." [3]

2.2 Veterans' NHS Wales

Each Local Health Board in Wales has an experienced Veteran Therapist who offers therapy, "to improve the mental health and wellbeing of veterans with a service related mental health problem"[4]

The second aim is to ensure a sustainable and effective way of offering services to veterans in Wales. In North Wales, there are two Veteran Therapists, one in the North West and one in the North East.

In the Call to Mind: United Kingdom report, the Veterans' NHS was recognised as an example of good practice,

"In Wales, Veterans' NHS Wales (VNHSW) is a high quality national service that is unique to Wales. Veterans with any service-related mental health problem are eligible for outpatient treatment from VNHSW." [5]

However, one of the concerns addressed in the Call to Mind report was the demand on the service and the possible impact of waiting times and the service being too stretched.

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[2] http://www.changestepwales.co.uk/

[3] Mottershead, R. Bray, B. Ellahai, B. Evaluation Report Change Step: A peer mentoring support Programme for Veterans in Wales. April 2016. P7.

[44] www.veteranswales.co.uk

[5] Call to Mind:United Kingdom. June 2017. Page 36

Between April 2015 and 31st March 2016, 163 referrals had been made to the service from across North Wales. In the year previously, (2014-15) 135 were admitted to hospital with PTSD, however, it is not noted how many of these were from a military background. [6]

In the Care & Support Needs of Military Veterans North Wales Report by Public Health Wales, some gaps in current provisions were identified. This included having Change Step mentors working closer with Veterans NHS, and also working more as the 'glue' between all services. Better partnership working was also identified in other reports to ensure the best possible service and reducing waiting times for services.

2.3 Veterans NHS and Change Step Pilot project

In response to the needs and gaps identified in current services, a partnership was created between Veterans NHS Wales and Change Step, funded by Betsi Cadwaladr University Health Board with a grant agreement of £71,921 given to CAIS Ltd to pay for two full time peer mentors and to cover all other administrative costs. This service began in April 2017 and will run for 12 months.

This service sees Change Step peer mentors working alongside Veteran NHS psychological therapists to support veterans with not only their psychological support needs but also social support and helping on matters such as housing, and signposting to other services within the community. The peer mentors will help to prepare patients for treatment, offer support during treatment and post treatment for a while to continue to ensure the benefits of the treatment. This service takes the benefits from the Change Step model and adapting it to fit around the Veterans NHS Wales service.

The Chair of Betsi Cadwaladr University Health Board, Dr Peter Higson said,

"This collaboration means that the specialist psychological therapy that Veterans NHS Wales provides will now be supplemented with individual, personal support to help ensure that the benefits of this therapy are maintained over the longer term,".[7]

Two Change Step Mentors were recruited in April 2017 with one working in the North West (Anglesey, Gwynedd and Conwy, and another in the North East (Flint, Denbighshire and Wrexham). Both mentors are veterans themselves that was identified as critical in the University of Chester evaluation on the original Change Step programme. Over the past ten months 98 veterans have been receiving support by the peer mentors, some are in therapy, others are on the waiting list and others in the process of opting in. It is forecasted that 123 veterans will receive support by the end of March 2018.

The support given to the veterans by the peer mentor will vary but can includes the following;

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[6] Atenstaedt, R. Jones, C. Care & Support Needs of Military Veterans in North Wales. Public Health Wales. November 2016.

[7] http://www.changestepwales.co.uk/wp-content/uploads/2017/07/News_Jun171.pdf

- Financial support – make sure they are in receipt of the correct benefits
- Grant application through Forces charities
- Support to education or employment
- Encouragement to take part in activities whilst working through their anxieties
- Therapy support
- Support to access service – such as medical appointments
- Housing support
- Signposting to other services
- Support for whole family with communication and explaining what it is they are going through
- Using other support for mental health and sleeping problems such as apps available
- Problem solving skills
- Legal support – with matters such as family contact
- Support with medical matters such as hearing problems or encouraging fitness programmes.
- Life skills – such as budgeting, cooking shopping etc.

When a referral is received, actions will be taken by both peer mentor and veteran therapist to assess eligibility. The veteran can then decide to opt in to the service. Some will decide not to opt in as they might not be eligible or may not feel they are ready to do this, whereas other might be eligible but will need some encouragement to return the forms. Following opting in, the peer mentor will then do a social assessment with the client, and the clinical assessment done with the veteran therapists. While they are then on the waiting list, the peer mentor is able to start supporting them with some of the key issues as mentioned above. A full table demonstrating each step of the process can be seen in Annex 1.

3. Veterans in Wales and strategic context

The Ministry of Defence defines a veteran as anyone who has served in HM Armed forces for at least a day. The eligibility for Veterans NHS Wales supports this definition;

“Any veteran living in Wales who has served at least one day with the British Military as either a regular service member or as a reservist who has a '**service related psychological injury**'”[8]

According to the North Wales Population Needs Assessment[9] we have approximately 51,000 veterans living in North Wales (data from 2014), which represents 9% of the population. The highest

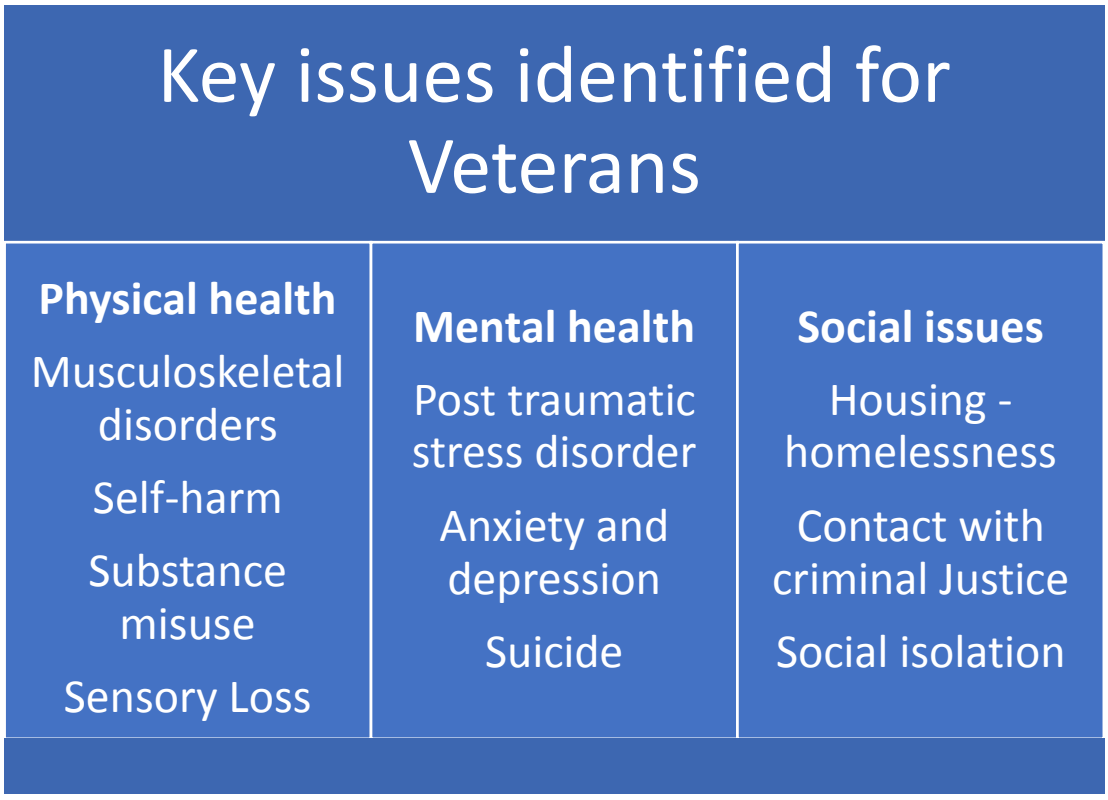
[8] http://veteranswales.co.uk/about-us/eligibility-and-access.html
[9] North Wales Population Needs Assessment. April2017

percentage is in Flint, and the smallest in Anglesey. These are based on estimates, as it is believed there are many 'hidden' service men and women that are not included in these figures, especially in local communities.

Although the majority of veterans are considered to be elderly, there is a need to identify the changes in the demographics of veterans, as is identified in the local Population Needs Assessment,

"This is important for care providers to consider, since the health needs of younger, more ethnically diverse veterans are likely to differ considerably from those in older age groups." (p.317.)
As reported in the Population Needs Assessment, many leave the service and will suffer no long-term illnesses, however, many will suffer from a physical and/or mental illnesses. Many physical, mental and social issues are reported and some of those are highlighted in figure 1;

Figure 1



Supporting the Population Needs Assessment was a report on the 'Care and Support Needs of Military Veterans in North Wales' by Public Health Wales. This report gives a clear overview of the challenges facing veterans in Wales and some are listed above. Based on the RBL Household Survey (2014),

"Difficulties are most likely to be related to relationships or isolation (particularly loneliness and bereavement), self-care, mobility (especially outside the home) and psychological problems (particularly depression), followed by finance and housing."[10]

The Population Needs assessment is prepared in response to the Social Services and Well-being (Wales) Act 2014 and supports the Well-being Assessment as part of the Well-being of Future Generations Act (Wales) 2015. The fundamental principles of the Act are:

Voice and control – putting the individual and their needs at the centre of their care, and giving them a voice in, and control over reaching the outcomes that help them achieve well-being;

Prevention and early intervention – increasing preventative services within the community to minimise the escalation of critical need;

Well-being – supporting people to achieve their own well-being and measuring the success of care and support;

Co-production – encouraging individuals to become more involved in the design and delivery of services;

Multi-agency – strong partnership working between all agencies and organisations.

In response to the different way of working, the North Wales Armed Forces Forum was established in 2012 to bring together representatives from the Betsi Cadwaladr University Health Board, Public Health Wales, North Wales Local Authorities, Armed Forces, North Wales Police, Welsh Government, Education, Employment and third sector (voluntary) organisations. This provides a good basis to share information and good practice, to ensure a strong partnership is established, to avoid duplicating service, and to avoid gaps.

Much research has been done to look at the transition period from being in the Armed Forces and back in to civilian life. Lord Ashcroft published a review in February 2014 on 'The Veterans' Transition Review' and challenged the debate of whether further support was needed to support veterans to integrate back in to society, or whether this should be dealt with elsewhere. However, he did consider what areas of support was needed which will be considered which includes training, employment, housing, and health, all of which the peer mentor could influence upon.

[10] Atenstaedt, R. Jones, C. Care & Support Needs of Military Veterans in North Wales. Public Health Wales. November 2016.

4. Methodology – Social Return on Investment (SROI)

By explicitly asking those stakeholders with the greatest experience of an activity, SROI can quantify and ultimately monetise impacts so they can be compared to the costs of producing them. This does not mean that SROI can generate an 'actual' value of changes, but by using monetisation of value from a range of sources it is able to provide an evaluation of projects that changes the way value is accounted for – one that takes into account economic, social and environmental impacts. Social Value UK (2014) states;

'SROI seeks to include the values of people that are often excluded from markets in the same terms as used in markets, that is money, in order to give people a voice in resource allocation decisions'

Based on seven principles, SROI explicitly uses the experiences of those that have, or will experience changes in their lives as the basis for evaluative or forecasted analysis respectively.

Taking a more holistic approach to impact measurement means that positive, negative, intended and unintended changes can be accounted for on a constructed Value Map – and ultimately when these are compared to the relative costs of their creation, the SROI is identified. The formula used to calculate the final SROI is highlighted below;

$$\text{SROI} = \frac{\text{Net present value of benefits}}{\text{Value of inputs}}$$

For example, a result of 4.50:1 indicates that for each £1 of value invested, £4.50 of social value is created.

However, SROI is much more than a number. SROI is a story of change, incorporating social, environmental and economic costs and benefits, requiring both quantitative and qualitative evidence.

There are two types of SROI reports, evaluative and forecast. **This report is a forecast SROI report as we are measuring results up to March 2018**. At the time of analysis, the project had been operating 10 months and as such existing data was used to support the analysis, but as there was still 2-months until completion the analysis forecast the value created for the remaining veterans on the programme. SROI does not provide a rigid method of measuring social value, rather it is based on seven principles

and these underpin how SROI should be applied. The use of principles is intended to provide consistency, yet also allow flexibility to recognise and incorporate varied experiences of different people, and these are highlighted in figure 2.

Figure 2 - Social Return on Investment Principles [11]

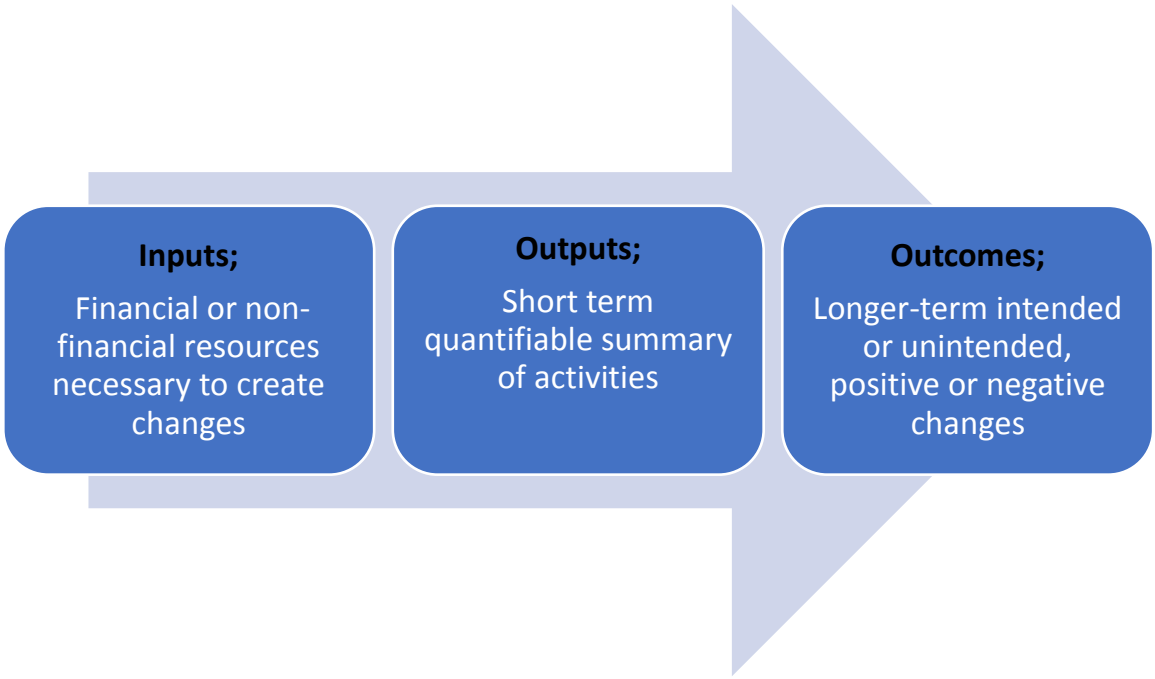
[11] www.socialvalueuk.org

These principles overarch everything that we do during the analysis, and is also a good framework for any organisation to adhere to. As well as the principles, there are six stages to conducting an SROI analysis as seen in figure 3.

Figure 3 - Social Return on Investment Stages[12]

Whilst different analyses will apply varied techniques to capture data, adherence to these principles of good practice ensures that the *how* of social impact measurement remains central. As a result, for each material stakeholder, chains of change are created on the Value Map (appendix 3) that articulates the transformation process from necessary inputs, through immediate outputs to ultimate measurable outcomes. Figure 4 highlights the fundamental elements of the chain of change, albeit a simplistic visualisation when accounting for complex changes.

[12] www.socialvalueuk.org



Inputs can be financial or non-financial resources. For example, whilst a project may require necessary finances, it will also be dependent upon the time, expertise and other intangible resources of people to ensure its success.

Outputs are often the things that are measured as a result of activities, yet importantly these do not indicate to the success or failure of activities. Take for example, a course providing advice and skills to enable people to secure employment that only measures the output of the number of attendees of each course; this does not indicate the relative success or failure of the course on the important outcome of people securing employment. Regardless of the activity, only by measuring outcomes can we be confident that an intervention is working, and this is the explicit focus of SROI.

The key distinction of SROI allows identified material outcomes to be monetised, after which accepted accounting principles are applied that progress the analysis towards understanding the impacts of activities. In accordance with the principle not to over-claim, key questions must be asked for each outcome to understand the value of a change that is a result of a particular intervention, those of; How long will the change last (duration)? How likely is it that this change could have occurred without the intervention (deadweight)? Who else contributed to their creation (attribution)? Have these activities displaced outcomes that would have occurred elsewhere (displacement)? And how does the value of the change that is as a result of the intervention reduce in future years (drop-off)?

In summary, SROI is able to articulate an understanding of holistic value created and destroyed as a result of activities. By understanding the value of outcomes we are in a stronger position to manage them as we have a greater understanding of their relative importance and can target strategy and

resources more effectively. Monetisation of outcomes is not an attempt to place a price on everything; rather it is designed to not only allow for the meaningful measurement of impacts, but also importantly for their subsequent management. This is of particular relevance for third sector organisations, as adherence to a social mission places a moral duty on decision-makers to maximise their social returns. Effectively, SROI can bridge the accountability gap that often occurs between those with decision-making powers, and those that decisions are intended to target.

5. Identifying Stakeholders

Including stakeholders is a fundamental requirement of SROI. Without the involvement of key stakeholders, there is no validity in the results – only through active engagement can we understand actual or forecasted changes in their lives.

To understand what is important for an analysis, the concept of materiality is employed. See Figure 5. This concept is also used in conventional accounting, and means that SROI focuses on the most important stakeholders, and their most important outcomes, based on the concepts of relevance and significance. The former identifies if an outcome is important to stakeholders, and the latter identifies the relative value of changes. Initially, for this forecasted SROI of the Change Step / Veteran NHS pilot report, a range of stakeholders were identified as either having an effect on, or being effected by the project – Table 1 highlights each stakeholder, identifying if they were considered material or not for inclusion within this study.

Figure 5 - Materiality[13]

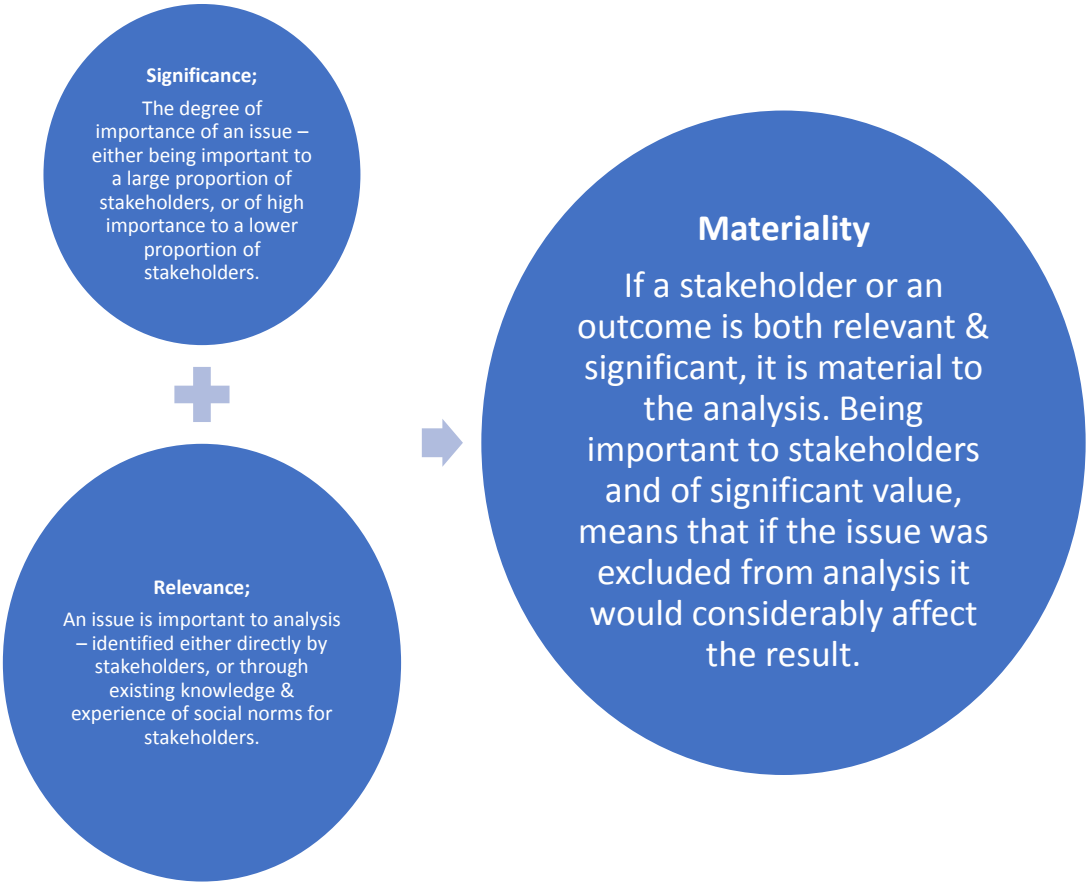


Table 1 Stakeholder list and Materiality

Stakeholder Group	Material stakeholder?	Reason for Inclusion / Exclusion
Veterans	Yes	As key beneficiaries of the service, these are the most important stakeholders and some changes experienced will be both relevant and significant.
Family members	Yes	Family members are likely to experience some positive impact and changes experienced will be both relevant and significant.
Peer mentors	No	Peer mentors are vital to this process to create positive changes in the lives of the clients. However, when we value the outcomes the changes will not be significant as there is only two. Their

[13] www.socialvalueuk.org

		inputs are crucial for any change and will be discussed in this report.
CAIS	Yes	Provides material inputs of finance, skills and other resources to ensure the strategic direction of the project, so must therefore be included.
NHS	Yes	Veterans' NHS Wales – their partnership is essential here towards the success of this pilot. The service is likely to have an impact on them and those changes will be both relevant and significant. However, other areas of the NHS are also likely to experience change. • GPs • Mental Health Department • Hospital – inpatient and outpatient service
Criminal Justice	No	Some of the changes are likely to have an impact on the Criminal Justice Department; however, this was beyond the scope of this report.
Local Authority	No	Some of the changes are likely to have an impact on the Local Authority; however, this was beyond the scope of this report.
Department of Work and Pension	No	Some of the outcomes in the long term will be maintaining in employment or going back in to employment. However, this will not be measured in this report.
Other third sector organisations	No	The peer mentors will signpost clients to other relevant services, so some attribution will be given to those organisations.

5.1 Stakeholder engagement

Principle number 1 of Social Return on Investment framework is to Involve Stakeholders as seen in figure 2. Therefore, a great deal of time is given to establish who the stakeholders are, and how best to engage with them. Stakeholders are best placed to establish the following;

- Theory of change
- Identify outcomes
- Identify how much change has happened
- What value is to be placed on the outcomes

- Deadweight, drop-off and attribution
- Verify results

Engaging with the veterans themselves and their family members was crucial to be able to achieve everything noted in the list above. However, due to the sensitivity of clients we needed to find the best way to engage to ensure they were comfortable. The support of the peer mentors was crucial for this to happen.

Initial interviews with Change Step Managers was conducted in May 2017 to understand the scope of the analysis, and to understand the purpose of the project. Conversations were also had with the new peer mentors as well as the South Wales Change Step Manager to understand the process, as well as identifying the list of potential stakeholders. As veterans themselves, it was crucial to understand what the peer mentor role meant for them and to begin to get a level of understanding about veterans supporting veterans.

All qualitative data were gathered through phone conversations with veterans who had been receiving support through the project. Some were already going through treatment, which meant they were still experiencing change, but were best placed to tell us what had already happened, and what they hope will happen by the end of their treatment. It was crucial that sufficient veterans were engaged with in order to reach saturation point, which is giving confidence that all relevant outcomes are captured. It was also important that a similar sample was taken from both the North East and North West to see if the outcomes were the same.

Although this report only focuses on the role of the third sector peer mentor, as the veterans are NHS patients, registration of the analysis was done through Betsi Cadwaladr University Health Board. All veterans who took part in the analysis were given a letter from the peer mentors explaining what the purpose of the report was and what measuring social value means. They also completed a consent form for the qualitative and quantitative data gathered by Social Value Cymru and Glyndwr University. Glyndwr University are also evaluating this new partnership, but focusing more on how the service is management and how the relationship is managed between all partners. An agreement was therefore established early on to ensure all data could be shared where appropriate to avoid duplicating and exhausting clients with research.

Although a great deal of thought was given to the questions being asked to the veterans about their experiences, in order to adhere to the SROI principles and to understand what had changed, a loosely structured approach was taken that allowed them to tell us what happened as a result of the support given by the peer mentor. The added flexibility of semi-structured probing questions, such

as asking people what they now do differently because of the change they had experienced, how long they believe the change will last, and importantly if they had any negative experiences allowed them to tell their story from their own perspective. Each interview lasted approx. 30-40 minutes. Each veteran was extremely open and was eager to speak about their experiences. They were also able to provide an insight into what had changed for them, but also what they think might have happened without the service and the possible difference it would have. Questions were also asked around impact such as who else contributed to any changes? And would they have support from somewhere else if this service wasn't available. These will be discussed later in the impact section.

The same approach was used with family members to understand if they had any outcomes from the service, but also they were able to confirm some of the outcomes for the veterans. Table 2 provides a summary of the stakeholder engagement process.

5.2 Stakeholder segments

Not all of our clients are the same, and some will have different needs and will experience different results. Consideration will therefore be given to different stakeholder segments to understand if there are difference in the results and could demonstrate a need to manage the service differently for different segment of stakeholders.

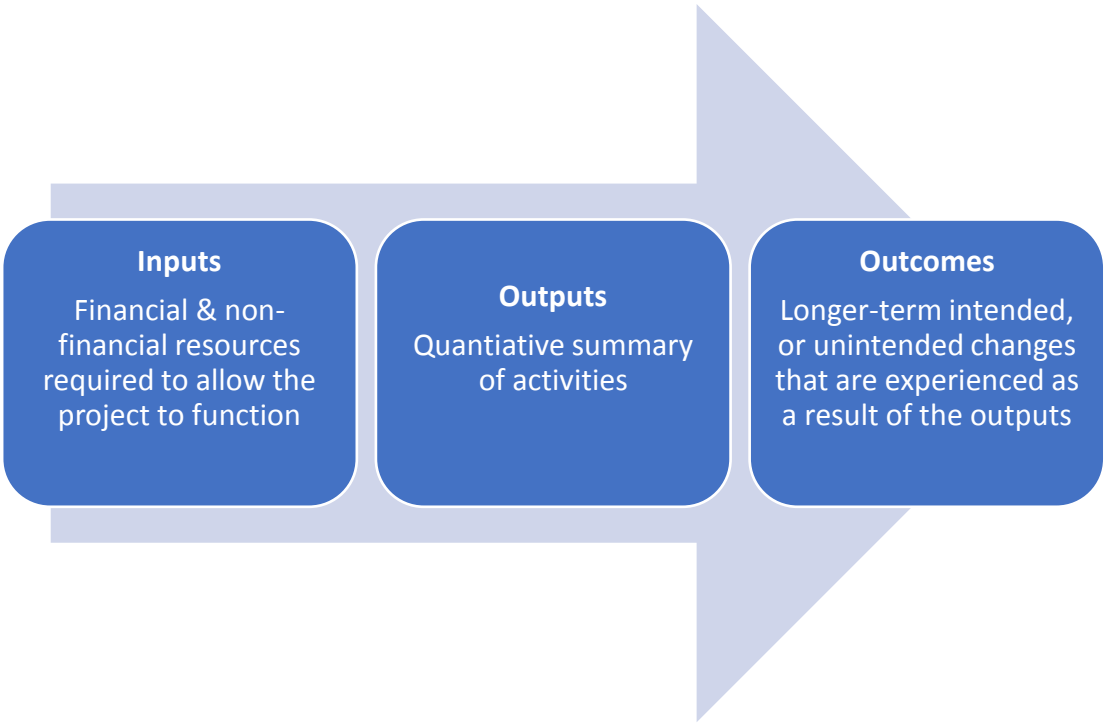
Table 2 – Engaging with stakeholders

Stakeholder group	Reason for inclusion	Number of sample	Population	Method of engagement
Veterans	As key beneficiaries of the service, these are the most important stakeholders and some changes experienced will be both relevant and significant.	7 27	123 123	**Step 1** ; Qualitative interviews over the phone **Step 2**; Analysis of the Data through Life Compass and Clinical Measures
Family Members	Family members are likely to experience some positive impact and changes experienced will be both relevant and significant.	2		**Step 1**; Qualitative interviews over the phone **Step 2**; Family survey to confirm outcomes and amount of change
Cais Ltd	Provides material inputs of finance, skills and other resources to ensure the strategic direction of the project, so must therefore be included.	1	1	Initial conversation with Director of Therapeutic Services. Interviews and further conversations with peer mentors. Conversation with other staff with the data.
Veterans NHS	Veterans' NHS Wales – their partnership is essential here towards the success of this pilot. The service is likely to have an impact on them and those changes will be both relevant and significant.	2	2	Conversation with both Veteran therapists in North Wales. Also, discussions with the Manager and other staff members in the steering group meetings.

6. Mapping Outcomes

The guiding principles ensure that *how* value is accounted for remains paramount. To ensure a consistent approach is used, chains of change are constructed for each material stakeholder explaining the cause and effect relationships that ultimately create measurable outcomes. These chains of change create the overall Value Map (attached separately as appendix 3), and these stories of change are equally as important as the final result of analysis. In fact, SROI is best thought of as a story of change with both quantitative and qualitative evidence attached to it. Figure 6 summarises the different elements for each chain of change included within the SROI analysis (before the impact of outcomes is calculated).

Figure 6 – Outline of the Chain of Change



6.1 Project inputs

This section of the report describes the necessary inputs from multiple stakeholders. Some inputs are financial, whereas others are not – yet where possible inputs are monetised.

6.1.1 CAIS Ltd

The financial input is managed by the Social Enterprise CAIS Ltd. A financial input of £71,921 was given as a grant by Betsi Cadwaladr University Health Board and this pays for the salary of the two full time peer mentors and provide the management, resources and admin support needed for this service.

The learning from the original Change Step model was also crucial to ensure that these positives could be replicated here and provide the new peer mentors with a good basis as well as any training they needed.

6.1.2 Peer mentors

The two mentors are themselves veterans which was recognised by all clients as being a crucial element of the service. When engaging with stakeholders, the word 'understanding' was used often, and their own experience allowed this to take place. By listening to the clients and providing a friendly, non-judgmental support service, they give the clients reassurance that positive changes can happen. Their skills, experience and professionalism is crucial towards having a positive impact. Although they are often seen as a 'family friend', at times they must also be the leader and the disciplinarian and push them encouragingly to make positive changes.

Some of the work involved taking them out to crowded areas and to work through their anxiety. As veterans themselves, at times this has been challenging for them also, but by allowing the client to experience that with them they can demonstrate that they also can have positive changes.

Due to the nature of the work, at times it can be difficult to not become too emotionally involved, or to turn off the phone at 5p.m. as was discussed during an initial meeting with them. The level of understanding due to the veteran to veteran bond is important, but it can be difficult not to become too involved in situations. However, it was clear that boundaries was set by both Veterans NHS therapists and the CAIS management team, and the peer mentors did manage to have a good balance of friendliness and professionalism.

6.1.3. Veterans

This service is available for all veterans who fits the Veterans NHS eligibility criteria, that being they have a 'service related psychological injury'. Although there is no financial requirements from the clients, it's important to recognise the non-financial inputs needed to ensure any change.

Referrals can either be made by GPs, other agencies, families or self –referral. For some, an almost fatal incident occurred before they were referred as many of the veterans, family members and the peer mentors referred to an attempted suicide attempt or serious injury and feeling incredible low and unable to cope. Families also explained the feeling of helplessness when seeing their loved ones struggling and not really having an understanding as to what they were going through. One family described the event in detail before she was referred to this service, and the feeling of total despair and confusion as to where they can get support. She described leaving A & E after her husband had hurt himself, and given leaflets to read, but not knowing where to go and what to do. Therefore, for many having somebody there that helped the whole family was a huge relief and reassured them.

Many explained a lack of understanding of what they were going through. Therefore, a willingness to engage with the service is needed as well as trust. This trust seemed to be established early on with the peer mentor due to the veteran supporting veteran, with the peer mentor able to reassure them about the therapy itself and that things can change.

Most of the activities with the peer mentors involved dealing with their anxieties when they go in to crowded areas. Many described being pushed to their limit and therefore the willingness to take part in these activities and put in to practice the tools given to them by both mentor and therapist is vital to recognise any change.

Some explained the exhaustion after sessions with both peer mentor and the Veteran Therapists. They explained this as being emotionally draining and that the sessions took them to areas they prefer not to go, however, with the understanding and trust that this will help them in the long term. Therefore, perseverance is also important to recognise here. If they were to leave the service before seeing any positive change, they might well be feeling worse as they had tried to get support and it didn't work. This wasn't the case with anyone that took part in the qualitative interviews, but many did refer to times where they needed the peer mentor to encourage them to continue and to give them a gentle push to attend therapy sessions.

However, although many said that they might not have continued with therapy or would miss appointments, looking at data from 2016-17 to 2017-18 suggests that this wasn't the case. Looking at the referral numbers, 73% opted in in 2016-17 and only 70% in 2017-18. The number of people who

didn't attend appointments were higher this year also. On discussing this with key staff members, this could be as the peer mentors are dealing with some very hard to reach cases and those who are most difficult to engage with. This will not have an impact on the value created for those veterans who do go for treatment and will be measured in this report.

6.1.4 Family Members

Through the stakeholder engagement process, it was apparent that the peer mentors had an impact on the whole family. Again, no financial input is needed from family members, but their support and encouragement, as well as understanding is important and contributes towards seeing any sustainable changes.

6.1.5 Veterans NHS

This is a service that was already available and this new partnership provided some opportunities but also some changes to their usual way or working.

Their skills and expertise is vital and the relationship with the peer mentor is crucial. Through the stakeholder engagement, many clients commented on how the therapy sessions and the sessions with the peer mentor complemented each other well, and therefore it was clear that there was good communication between them.

Some time was needed from the therapists, especially at the beginning to provide guidance and supervision for the mentors, and also advise on relevant training opportunities they needed in addition to perhaps what was being offered by CAIS. Time is also needed to attend the Steering group meetings to ensure that the partnership is working.

Table 5 provides a summary of all inputs involved in this pilot, and how much this cost per client that received support.

Table 5 – Total Monetised Inputs for Veterans NHS / Cais pilot

Stakeholder	Financial input	Non-financial input	Cost per individual
Clients	N/A	Willingness to take action and	N/A

		work with the peer mentor	
Family members	N/A	Support and understanding	N/A
CAIS – manage the fund	£71,921	Strategic management, time, expertise	£585
Veterans NHS and BCUHB	Financial input included above. Consideration was given to monetise the time to make referrals in to the service. However, as the therapy would have received these referrals already it has not been included here.	Working closely with the Peer mentors and providing supervision, support and guidance.	N/A
Totals	£71,921		£585 per client

6.2 Project Outputs

As would be expected the majority of outputs are associated with the veterans receiving the support. However, the project's activities also create important outputs for other material stakeholders, and each will be discussed below.

6.2.1 Veterans

In total, 95 veterans had been given support by the peer mentors by the end of January 2018. Based on the data and a discussion with the peer mentors, the forecasted outputs until the end of March 2018 will be 123 represented by 65 in the North West and 58 in the North East. Not all the veterans receiving some form of support by the peer mentors will go on to therapy. However, some will be recognised as a

client in need of some support and an initial assessment meeting will be organised with the peer mentor. An initial assessment can take up to 2 hours and then there will be some travel time to consider also as they usually take place in the veteran's home. If they aren't suitable for the Veterans NHS therapy, then they will be signposted to the Community Mental Health service as well as other services to ensure that they receive the right care and support. There will be value created here also as they prevent matters from deteriorating and deal with the immediate concern, whether it's a financial matter, a housing matter or anything else and the peer mentor explained that this could also be up to 10 hours of support. In total 123 have received treatment by the peer mentor, which includes clients who might not opt in for therapy, which breaks down to 65 in the North West and 58 in the North East.

The amount of hours spent will vary depending on the needs of the client and the support needed whilst in therapy, but an average of 16 hours is spent with every client according to the data. However, the peer mentors explained that this could be much higher especially when considering travel time. The peer mentors explained how some clients will just need some initial signposting and support, where others will need an appointment every week for a few months and could be 50 hours + of support. As they cover a big area as well then travelling time can also be vast. This time represents everything from having an initial assessment, to meeting in the home and having a conversation, to going out to public areas to work on their anxiety. Time can also be sent signposting to other services, or making enquiries on their behalf, such as housing enquiries.

Referral issues are of course mainly to do with mental health, 91% reporting this as their main reason for referral according to the Change Step data. Referrals will mainly come through the usual Veterans NHS Wales referral process, with some also being referred directly through the peer mentors, but will still follow the same referral pathway. Many also reported social isolation as an issue, as well as drug and alcohol issues, housing issues and many with financial and benefits issues.

6.2.2. Family members

Although this service is for the veterans, family members have also been supported either directly or indirectly. There were examples of families been given information to read or having a one to one conversation with the peer mentor which helped them to understand and support their loved ones.

CAIS are not currently measuring the impact on family members and therefore actual figures on the number of family members involved were not available, however, an estimate of 25% of family members has been included here as to not over claim. As a much higher percentage of veterans are reporting a positive change in family relationships, we will look at 31 members of a family receiving a positive change as to not over –claim. There will be children and others that have also benefited and it

is recommended that the outcomes for families is monitored also moving forwards to capture the full value.

6.2.3 Peer mentors

The two peer mentors are employed full time, for the 12 month pilot project. The output of employment for each of the peer mentor represents the immediate consequence of their necessary inputs, and is that which helped to provide support for 123 veterans and their families.

6.2.4 Veterans NHS

The outputs for Veterans NHS is the number of clients that have been supported by the peer mentor alongside the therapy service.

6.3 Project Outcomes & Indicators

As highlighted, it is only by measuring outcomes that we can be sure that activities are effective for those that matter most to this pilot project. This section of the report highlights the outcomes experienced for each material stakeholder, and also examines those outcomes that represent end-points in the chains of changes for each stakeholder (and are therefore included on the Value Map). Identifying specific outcomes is essential to understand what has changed as a result of activities, yet it is not always an easy task to identify the causal links between the various stakeholders and their outcomes. Appendix 2 illustrates the overall chains of change for those involved in Veterans NHS /Change Step pilot, and highlights both those included in this discussion and those excluded from analysis.

As with other important elements of this analysis, this illustration was verified with the peer mentors, Veterans NHS therapists and CAIS management to ensure a thorough understanding of what had changed for material stakeholders.

6.3.1 CAIS Ltd and Peer Mentors

No material outcomes are included for CAIS. Although they may experience changes related to income and reputation, it is reasonable to state that these are not relevant to the project.

For the peer mentors, as veterans themselves this role offered them a job satisfaction that possibly another role couldn't. For one especially, he saw this as a continuation of his own therapy and helped him to feeling self-fulfilled in helping others in the position that he had been. However, as we only have the two peer mentors, the overall value will not be significant when compared to the others and therefore they will not be included on the value map. However, it is important that we recognise their outcomes as well as their inputs in this report.

While engaging with the peer mentors, it is clear that they get a lot of pleasure from seeing the veterans making positive changes in front of their eyes and to know that they are responsible for many of those changes. The peer mentors mentioned many case studies of where they'd improved family lives, helped clients financially, and encouraged many to go on to education or employment. There was one example where the client initially would not open his door, would not change his clothes for a week and had no motivation. That client was able to move out from a veteran's hostel and get his own home with the peer mentor's support. His relationship with his son has improved and he now attends school meetings and takes an active role in his life whilst also attending an University course. These changes clearly made the journey for the peer mentors worthwhile and gave them a feeling of self-worth and purpose.

However, there will be many clients they see that will be at crisis point and this role can be emotionally draining at times. The support network around the peer mentor is therefore vital also, and it was clear that each case can be discussed in detail with the veteran's therapists.

6.3.2 Veterans

To understand the success of any project, then we must understand the outcomes experienced by the clients, in this project those are the veterans receiving the support from the peer mentor. Outcomes are those things that change and are sustainable.

A full Chain of Change can be seen in Appendix 2, and those that are highlighted in bold are those included in the value map. To ensure we are not over claiming, it is only those final three outcomes that are given a value. However, this section will look at each stage to understand the importance of every step in the client journey, and to recognise what are the indicators for these changes. Consideration will also be given to potential negative outcomes.

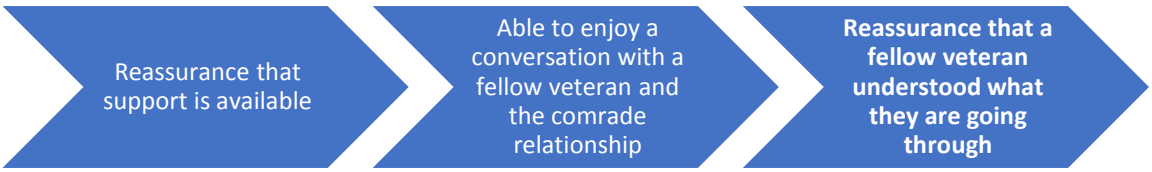
Outcome – Reassurance that help is available and they don't feel forgotten

During the qualitative interviews, many of the clients expressed how reassured they felt that there was a service who understood what they were going through, but also that they had not been forgotten. Some had experienced difficulties for a long time and whether they had not seeked support or were unsure where to go, they felt let down in some way. The peer mentors referred to some clients struggling at time to believe this service might be any different.

The current waiting list for therapy is 5-6 months. Although they will receive an initial assessment and reassurance that they will have therapy sessions, this is a long time for them to wait and many expressed how they would deteriorate during this time. Having the peer mentor there provides them with reassurance that they are important and that some positive changes can already be achieved.

One family member explained how alone they had felt in their situation, and the reassurance of having support from someone was a huge weight being lifted for both veteran and family members.

Outcome – Reassurance that they had support from a fellow veteran



As was seen in the evaluation of the Change Step programme[14], the veteran to veteran support was seen as being essential for most clients. Some expressed that they would have worked with others, but that it would have taken a longer time perhaps for them to establish trust.

“He gets where I’m coming from.” Client

Many mentioned the level of understanding that another veteran has as to what they are going through, that others, even loved ones, doesn’t have. They also saw them as non-judgmental and felt they could relax in their presence.

It was apparent in the qualitative interviews, that the peer mentor was regarded as a ‘friend’ and a fellow veteran. Having another veteran explaining to them what they were going through and providing reassurance that support was available and that positive changes could happen was seen as an important part of the service as was recognised with the original Change Step model.

“I feel like a load has been lifted.”

“He helped me to understand why I felt as I did.”

Many explained how they feel ‘at home’ when speaking about their time in the military and when having a banter about different things related to their time in the service.

The peer mentors also described how using some of the stories that only ex-military would understand the meaning of was a way to “have a laugh” and to break the ice. It was a means of getting them to trust them and to engage with them, before they were able to start addressing some of the concerns.

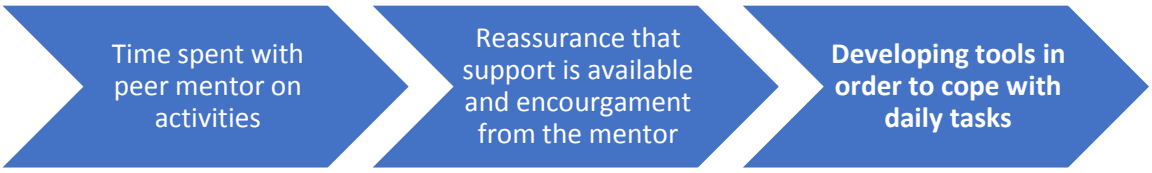
Outcome – Developing tools to help them cope

[14] Mottershead, R. Bray, B. Ellahai, B. Evaluation Report Change Step: A peer mentoring support Programme for Veterans in Wales. April 2016.

After the initial assessment, the peer mentors could already start to give them some practical and emotional support before the therapy could begin. There were cases where the therapists had worked with the peer mentor to provide the client with some support for sleep hygiene and insomnia. By the time the therapy had started, then there were already some improvements in this area with an improvement of 8 points in his measures between July and November 2017.

The peer mentors also spent time re-introducing them to social interactions and dealing with going in to situations in crowded areas. One of the veterans had explained how he continued with his studies through the peer mentors support. He explained that he was suffering from hypersensitivity and anxiety attacks and struggled to be anywhere with crowds including supermarkets. The peer mentor saw him weekly and helped him with gradual exposure to crowds, taking him through the process and reassuring him that he could make changes. He felt that without this, he would have had to give up his studies.

There was a focus on them supporting them in the first steps and giving them the tools to do this themselves. There were examples of veterans saying that they pushed them to their limits, for example with parking close to the shop entrance or taking them at times where usually they wouldn't go out. Although difficult, they expressed that they felt that the trust was there in the peer mentor to take them through these steps.

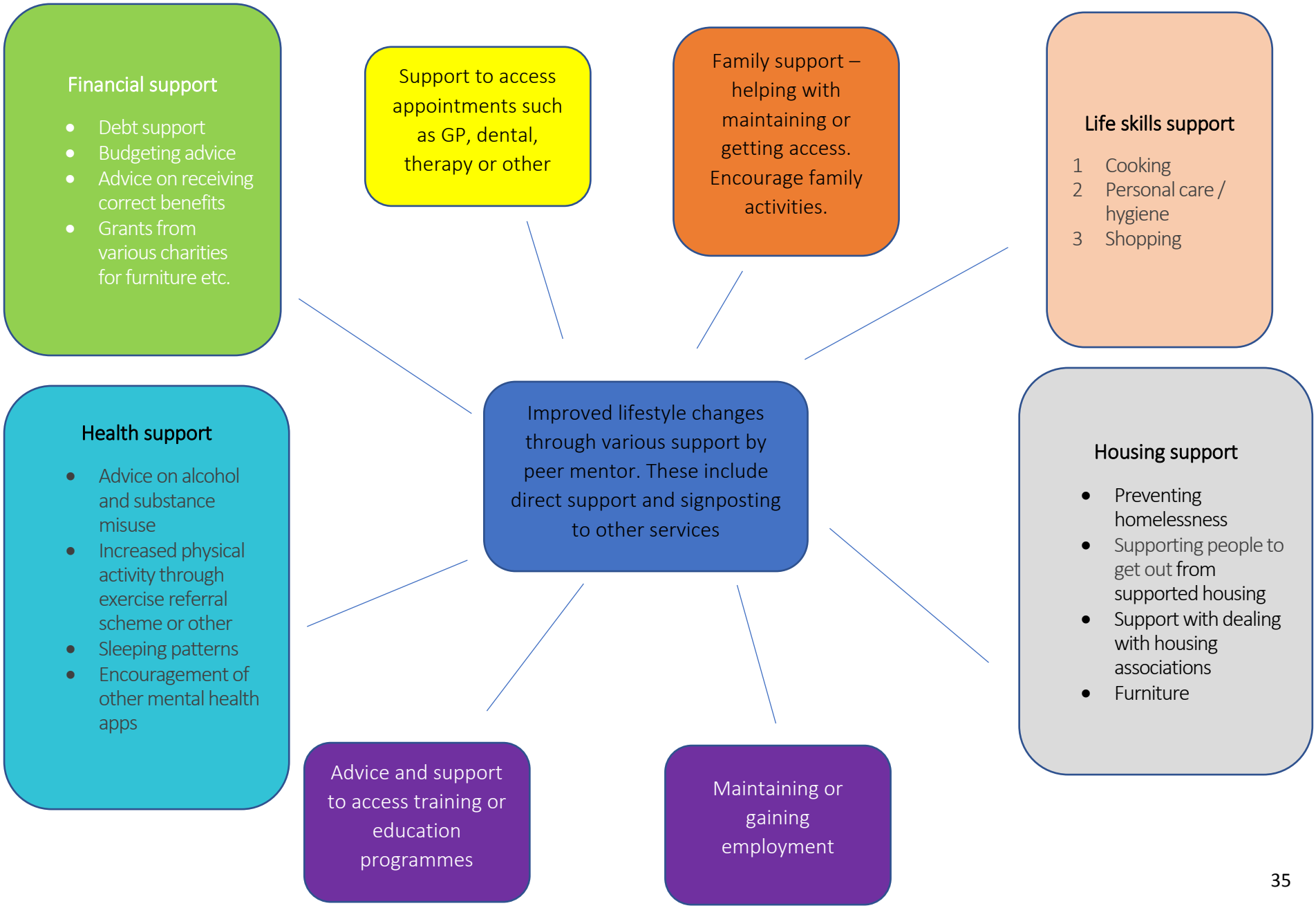


Outcome – Improved lifestyle changes

This outcome is included in the Chain of Change, however, this can be broken down to different areas of the support offered by the peer mentor. Although Education and employment and physical health is included below, they are part of the lifestyle changes included here.

Housing for example was stressed by the peer mentor to be a big area where they had offered support. Both peer mentor would work closely with the staff of supported veteran hostels and would occasionally visit to see if any support was needed. There were cases where the peer mentor had supported the veteran to leave here and get their own home which led to improved family contact and increased independence. There were also examples where they had prevented homelessness for some veterans.

These different areas of support, either directly or by signposting, should be broken down, and therefore the diagram demonstrates what are the lifestyle changes in the Chain of Change in appendix 2. These are all important intermediate outcomes, which leads to our final three outcomes in our value map.


Financial support
Debt support
Budgeting advice
Advice on receiving correct benefits
Grants from various charities for furniture etc.
Support to access appointments such as GP, dental, therapy or other
Family support – helping with maintaining or getting access. Encourage family activities.
Life skills support
1 Cooking
2 Personal care / hygiene
3 Shopping
Health support
Advice on alcohol and substance misuse
Increased physical activity through exercise referral scheme or other
Sleeping patterns
Encouragement of other mental health apps
Improved lifestyle changes through various support by peer mentor. These include direct support and signposting to other services
Housing support
Preventing homelessness
Supporting people to get out from supported housing
Support with dealing with housing associations
Furniture
Advice and support to access training or education programmes
Maintaining or gaining employment

Outcome – Education and employment

There were case studies in the project of veterans either being able to start or maintain their training or employment options. Some explained the challenges of dealing with their illness and still trying to attend work or college. Many explained that they don't believe they would have been able to carry on if it wasn't for the support they had received. Others discussed how they were starting to consider looking for employment or following a training programme with the aim of going back to work.

It is recommended that moving forwards, CAIS should look to monitor employment and education more closely, and could measure any change in income that would give a true account of the social value.

Outcome – Improved physical health

As they were starting to experience positive changes through the service, many explained how they are more able to take care of their physical health. Some mentioned improved personal hygiene, going to the gym and general better self-care. Looking at the referral issues on the CAIS data and the result of the Life Compass, only a small percentage needed support with substance abuse. From the sample of 27 distance travelled result from the Life Compass, 74% didn't have a problem and rated themselves as a 10. For the 15% that did have positive change here, the average movement was 35% but one reported an 80% improvement in this which is significant. For these clients, things could have deteriorated here while waiting for support and there were cases of clients going to A&E as a result of overdosing, and others recovering from liver transplants.

***The following outcomes will all be included in the Value Map.**

Outcome – Improved family relationships

For the majority of clients, they appreciated the support that the service had offered the whole family. For some this was direct contact or conversation with the peer mentor, or for others it was an acknowledgment of the changes or reassurance through information that was given to them to explain what their loved ones was going through.

"He's been the best thing for us." Family member.

One of the clients had moved out from supported housing for veterans, and now lives in his own home. He saw the peer mentor as 'being key in that'. He felt that by the peer mentor driving his application forward, he had benefited from these changes. This meant his son was now able to come and visit and stay with him more often which he saw as the most valuable change.

Other veterans explained how communication was now much better between them as there was a greater understanding by all about what was happening. One veteran explained how he and his partner were now doing things together for the first time in years after being encouraged by the peer mentor.

It was apparent that some family members also contacted the peer mentors when they felt they needed support or their loved ones needed support, for example if something had happened during that week. This demonstrated how they all saw him as a 'friend' and somebody to turn to.

This was seen as a key outcome by many veterans and therefore this outcome is included on the value map. When asked what could have happened without this support, many veterans and family members expressed that the relationship would have broken down as they would not be able to cope. This was also supported by the peer mentors account of what could have happened.

From the sample of data, 75% of clients reported a positive change here, with a distance travelled of 32%. This is a higher movement that for the mental health scale and could be explained by the fact that many were still waiting for therapy, or going through therapy, but the benefits of understanding what they were going through allowed them to communicate better. It demonstrates the positive changes that can happen before reaching therapy. However, as this is a small sample, we will only include 70% of positive change for all outcomes in the value map to ensure that we don't over-claim.

Outcome – Improved psychological / mental health

The main reason for being referred to this service is because of a psychological illness that is a result of their time in the military. This is therefore the key outcome expected by funders, staff and the veterans themselves. The majority of the clients suffers from severe anxiety when being in social and crowded areas, hypersensitivity, post traumatic stress disorder, stress, depression or other. It should be noted, that the work with the Veterans NHS therapist is crucial here, and therefore a fair amount of this will be

attributed to them later in the report. An understanding is needed of the impact of the peer mentor on these changes, and on establishing positive changes much earlier.

There are differences in the support given in the North West and North East. In the North East, the therapist is doing a reduced amount of exposure work, (that is going with them to public spaces to try and work through their anxiety) and work with the peer mentor to advise on what areas to focus on within his capacity as a mentor. In the North West, the therapist still does the exposure work, but the peer mentor will be able to offer additional sessions which might result in change happening sooner. However, it was noted that more time will be needed to be confident in these results.

Some of the indicators that was noted here when speaking about this change, is that many will now go to crowded areas where they wouldn't in the past. Some mentioned doing their own shopping, going in to City Centre's, going to concerts and going to nightclubs. The majority were still in therapy and therefore still recognised they needed further support on their anxiety, but some of these changes were seen as something positive and actions that they didn't think they could have done a few months ago.

"Kevin helped to prove you can come out the other side".

"I wouldn't be where I am now if it wasn't for the peer mentor."

One of the difficult questions that was asked, is what they thought could have happened if this service and support wasn't available. Some made it clear, that they would have deteriorated and in their opinion might have contemplated suicide either again or for the first time. Research shows, that for many, unfortunately this is the reality as is referred to in the North Wales Population Needs Assessment,

"Ex-service personnel may be at increased risk of self-harm and young male veterans (those under 24 years), particularly those with shorter lengths of service, are at an increased risk of suicide. They may be particularly reluctant to seek help (and some may not even identify themselves as veterans). It is vital that the North Wales Suicide Prevention Group prioritises veterans in its work."[15]

Having spoken to the veterans, peer mentors and therapists also, the use of other services during this time could be increased as will be demonstrated and explained below as outcomes for the Health Service.

There were 89% reporting a positive change here with a distance travelled here of 18%. This distance travelled might represent that many were still having treatment and either waiting for therapy or in the

[15] North Wales Population Needs Assessment. April2017. Page 320.

middle of therapy. Having a review a few months post therapy is advised to have a true understanding of the amount of change. Again, as we only have results for a few of the clients, we will only include 70% of positive change in the value map.

Outcome – Reduced loneliness and isolation

Due to their anxiety and not having an understanding themselves of what they are going through, then many expressed feeling isolated from others, within their own families and within the community. Some expressed seeing themselves different to others due to their experiences;

“I gave up everything as a civilian and became a veteran.” Client

Many of the veterans expressed not having many friends and felt that some independence was lost due to not being able to go out due to their anxiety. Many felt they couldn’t communicate what they’re going through to others that hadn’t been in the military and therefore didn’t have that level of understanding.

As was mentioned above, some had now started to engage more with their families and others. Some had also started to become more involved in civilian society through training and employment, going shopping, going to the gym and attending concerts or nightclubs. Although many were still in this process and going through therapy, they felt confident that having dealt with their anxieties, they will be able to go out more on their own and depend less on others.

A percentage of 93% had reported a change here, with a distance travelled of 30%. Many of the clients felt they had more control over going out and had more independence. However, the majority felt less alone in their situation by having the peer mentor to engage with and understanding that other also experienced the same symptoms and that help was available.

Negative outcomes- creating dependency?

Clients were all asked about any potential negative changes or whether they felt things could have been done differently. All clients explained that their experience had only been positive and the benefits of this service from the perspective of the stakeholder, is having the peer mentor in their lives who is non-judgmental, friendly and almost becomes part of the family. However, this should be managed closely as some service users can become dependent on the support and the changes therefore would not be sustainable post service. It is worth repeating, that the peer mentors were described as both friendly and professional. However, there were a couple of examples of clients expressing they would like to see them more often, and that when faced with challenges that they wanted to discuss it with their mentor. Again, although this should be celebrated for the positives, it just needs to be closely managed. In the recommendations later on, suggestions are given with moving forwards.

Clients experiencing no change

The peer mentors could think of around 5-10% of cases where they believed no change had happened. However, to be cautious and as this is a pilot and as we only have a sample of the Life Compass results, we will look at only 70% making positive changes here. Client experiencing no change could be for a variety of reasons such as they aren't ready to engage, or that it wasn't the right service for them. It was also thought that for those who are in employment, then having an understanding employer was crucial. There was one case study where a client had changed roles and the employer was extremely supportive in terms of allowing him the time to meet with the peer mentor and the therapists, but also offering care when they return from appointments. However, for many this wouldn't be the case and therefore it does restrict them from having the support if it has an impact on their employment.

Consideration should be given that for clients with no change, which could result in negative changes of them feeling worse than previously. When we seek support but experience no change, this can result in feeling worse and therefore expectations should be managed also. There weren't any case studies like this here, but for those who are referred but no change is available, some follow up could be possible to understand the reasons, and could help to manage these in future.

6.3.3 Outcomes for family members

As well as the support given to the veterans, the families were also supported by the peer mentors, either directly by involving them in conversations, or indirectly, by giving them reassurance that their loved ones are getting the right care and support.

Some family members explained the feeling of helplessness but also a lack of understanding as to what they were going through, and feeling lost as to what they can do to support them. When asked what

could have happened, many explained that they think the relationship would have broken down, or were worried about what could have happened to their loved ones. The financial, housing and health concern also would impact on the whole family.

The main outcome here is the **reduced anxiety and stress** for the family members. Any positive changes also in the veterans will create a positive change for loved ones as well.

6.3.4 Outcomes for Veterans NHS and Betsi Cadwaladr University Health Board

Through the steering group meetings and conversations with Veteran Therapists and staff, it was apparent that there is a good working relationship between the Veteran Therapists and the peer mentors. The veterans were clearly seeing the results of this also with comments such as;

“The perfect blend of both” client.

The veterans saw the benefits of both, but saw the peer mentor as being their support network through therapy also, as well as addressing other issues that might not be addressed in therapy itself.

One of the Veteran Therapist commented on the positive result of having the peer mentor working alongside them. Some improvements could be seen in areas such as mental health and functioning, to other more specific areas such as sleeping patterns before the veteran starts therapy. As they work closely with them before therapy also, it provides the therapist with a clearer picture of the needs whist in therapy.

Dr. Neil J. Kitchiner, Consultant Clinical Lead & Honorary Research Lead for Veterans' Mental Health at Veterans NHS Wales spoke encouragingly about this relationship,

“The Peer Mentor have proven to be an asset to the service in BCU. They have been successful in reaching out to veterans who have not returned the opt-in information and worked with them and encouraged them to come for an out-patient psychological therapy assessment.”

He also sees the important role of the peer mentor support either directly or signposting carefully as veterans wait for therapy.

For the Veterans NHS Wales therefore, the outcome has been a better model of working that provides a better service for the veterans in their care. Also, due to the support from the peer mentor, this has potentially reduced the time that they need to spend on some areas of the therapy which means they are able to have less sessions per client. However, this seems to be very different in the North East and the North West. In the North East, the peer mentor has been supporting the therapist with some exposure work as well as some pre-treatment work on targeted areas, such as sleeping. Therefore, moving forwards the therapists believes this will have a positive impact on therapy sessions and

reducing waiting lists. This impact is only beginning to be recognised as initially it did take time to supervise the peer mentors and to establish a new way of working. In the North West, the therapist still does the same amount of exposure work as previously and doesn't see that this will have an impact on her time and on the waiting lists, but more that the benefits belongs to the clients from a more social economic perspective. It is recommended therefore that this continues to be monitored closely, however, based on engaging with all stakeholders, a reduction of some sessions per client is included in the value map (North East).

What needs to be considered is the possible impact on clients without the peer mentors support. The therapy itself would still be available, but as referred to above, the peer mentor can prevent matters from deteriorating during that time, and therefore potential costs saving to the NHS could be considered on GP appointments, A& E visits, mental health community team and others. In the Population Needs Assessment, it is recognised that GP followed by A&E is the most common health service used. Also, 135 hospital admissions in 2014-15 was as a result of PTSD, however, currently it is unknown how many are ex-military.[16] This was a benefit that was agreed by all stakeholders.

Based on our stakeholder engagement and secondary research, a conservative estimate is given for potential costs savings to the Health Board as a result of the peer mentor support while in treatment. The costs and the value will be discussed later in this report.

Other state agencies outcomes

As was demonstrated in our stakeholder mapping above, the positive changes in the veterans lives and their families is likely to have an impact on other services also, but was beyond the scope of this report. Potential savings for Social Services, other Heath care departments, and the Criminal Justice system should also be monitored moving forwards to understand the impact of this service.

7. Valuing Outcomes

The ability of SROI to monetise outcomes is that which affords it distinction from many other impact frameworks – and by doing so we are able to prioritise outcomes and compare the benefits and costs of an intervention in a consistent language. This section of the report outlines the various means employed to value material changes for included stakeholders.

7.1 Veterans

There are a range of approaches to monetise outcomes including using financial proxies – that is using a market-based alternative as an approximation of a stakeholder's value. However, some would argue

[16] North Wales Population Needs Assessment. April2017

that these do not represent the value that the particular stakeholder with experience of the change would attribute to it. Therefore, where possible, this analysis has applied the first SROI principle to involve stakeholders as much as possible. During the qualitative interviews, following an understanding of the changes and the outcomes gained, clients were asked to rate and rank their outcomes. Therefore, they were asked to put their outcomes in order of importance, and then to rate their importance out of 10. This is where we stopped with their involvement in valuing their outcomes and when it comes to placing a monetary value of their outcomes it was decided to use other techniques other than the value game. The value game identifies their material outcomes, and asks them to prioritise, and subsequently value them against a list of goods or services available on the market to purchase. As many of the clients were still in treatment and had faced difficulties financially, it was decided that at this time, this technique wouldn't be appropriate.

From the sample of veterans that took part in the qualitative interviews, they all prioritised their outcomes differently. 50% stated that the most important change was the reduced anxiety and stress, which led to all the other positive outcomes in their opinion. However, 37.5% felt that the most important change was improved family relationships. Some had regained their relationship with loved ones, or had seen a big difference in their relationships with others. Moving forwards, it is recommended to build in the rating and ranking of outcomes in to the normal monitoring paperwork. This allows us to understand if there are different stakeholder segments here, and require different support. As was noted above, the main aim of the service is to improve their mental health. However, for some a greater value will be placed on improving relationships or reducing their isolation and this understanding can help to inform decisions and make small changes to increase the value for clients.

The valuations for the outcomes identified to the individuals were taken from HACT'S Social Value Calculator (version 3)[17] that identifies a range of well-being valuations. However, the data from the Life Compass baseline and review provided a distance travelled on how much change had been experienced, therefore a proportion of the wellbeing valuations were used accordingly.
For the outcome of *improved psychological / mental health* the well-being valuation HACT Code HEA1602-Relief from depression and anxiety (adult) was used which has a value of £36,766 per individual. For those with a positive change, there was a distance travelled of 18%, and therefore that percentage of the value was used in the value map.

[17] HACT well-being valuations. Available at http://www.hact.org.uk/value-calculator

The valuation for *Reduced Isolation / Loneliness* was taken from the outcome 'Talks to neighbours regularly' as a well-being valuation with a value of £4,511. There were other valuations on Global Value Exchange[18] that was much higher than this, such as the wellbeing valuation for Loneliness (change in) for older people values at £15,666 (http://www.globalvaluexchange.org/valuations/8279e41d9e5e0bd8499f2cd8). Although talking to neighbours might not truly reflect this outcome, it does represent reduced isolation. Following the principle of not over-claiming, the lower value from HACT is used.

For the outcome of *Improved family relationships*, consideration was given to use the value of £600 which is a financial proxy based on family counselling sessions. However, as many of the clients demonstrated that this was of higher value than other outcomes, it was felt that this figure undervalued the change. Therefore, again a well-being valuation from HACT was used which was HACT code HEA1607, Can rely on family members with a value of £6,784.

Due to this being a short-term pilot, using already existing well-being valuations allowed us to establish the Social Return on Investment for this project. However, in the longer term, it is suggested that the value game should be used with individuals to ensure that stakeholders are involved at each stage and to ensure that stakeholders are involved at each stage (Principle1).

7.2 Family members

The same valuation is used for family members as to the veterans for reduced anxiety and stress. Although this service isn't there to support family members, it is apparent that families feel supported also. Seeing the positive change in their loved ones means that they also feel less stress and anxiety as to how they can support them. As this needs to be monitored more closely, only 25% of family members is included in the value map, with a distance travelled of 25% also provided from the surveys.

7. 3 Health and Social Care costs

It has been indicated, that as a result of the changes created for the veterans, there are subsequent outcomes for other agencies. To put a value on the reduced potential demand on the NHS, the published Unit Costs Health and Social Care 2017, by PSSRU[19] was used.

Having engaged with the veterans, family members, peer mentors and the therapists it is plausible to report that less time per client can be spent in therapy because of this new partnership. However, as was discussed above, this wasn't the case in the North West due to a different way of working to the

[18] Global Value Exchange www.globalvaluexchange.org

[19] Curtis, L. Burns, A. (2017) Unit Costs of Health and Social Care 2017. PSSRU.

North East. This reduction therefore will only be included for those clients. Although, it is only at the later stages of this pilot that these can start to be visible, the positive changes seen in the clients before therapy, as well as the increased amount of exposure work done with the peer mentor means that less therapy sessions can be used in the long run. Looking at the Health and Social Care costs, an hour of therapy costs £53. [20] There are 58 clients that have received support in the North East and 70% of clients reported a positive change in their mental health when in treatment with the peer mentor, therefore this percentage is also used here with 2 therapy sessions less per client included.

As was discussed above also, other potential savings could also be included, but especially looking at GP visits, A&E visits and hospitalisation.

An **average GP appointment** costs £38[21]. In the Population Needs assessment, it was reported that is the most common used health service for veterans. The reason for this will vary from needing medication, to isolation or other concerns. Having support from the peer mentors will not eliminate the need to visit the GP in every case, but having support from the peer mentor will reduce the demand as they are able to deal with the root cause of many concerns such as stress due to financial or housing matters, social isolation, or barriers to other services. Again, only looking at the 70% that has reported an improvement in mental health scores, a reduction of 1 GP appointment per month is taken which means a reduction of 1033 appointment per year.

Another common health service used is A&E. This could be for drug and alcohol abuse, self-harming, or in some cases suicide attempts. An A&E attendance costs £138[22] and there is the possibility that some clients would need to access A&E if their health were to deteriorate, or if an incident happened, as had happened in the past for some clients. Again so as to not over-claim, we will only look at a small sample here and will look at 5% of clients.

Due to the severe needs of some of the veterans, it is highly possible that many could have deteriorated without the support of the peer mentors. Some had referred to being **hospitalised** previously, and the peer mentors discussed case studies where intervention was seen as crucial. Based on the peer mentors experience, if hospitalised, many will need to stay in hospital for 4-6 weeks. This is backed up by the Europe figures for hospital stays with the UK average for a mental health disorder being at 37.7 days average stay.[23] As to not over claim, out of 123 clients being supported, a value is included in the

[20] Curtis, Lesley A. and Burns, Amanda (2017) Unit Costs of Health and Social Care 2017.page 154-55.
[21] Curtis, Lesley A. and Burns, Amanda (2017) Unit Costs of Health and Social Care 2017.page 162
[22] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf
[23] http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Average_length_of_stay_for_hospital_in-patients,_by_disease_injury,_2015_(days)_HLTH17.png

value map for 2 clients needing to be hospitalised for 4 weeks @ a costs of £443 per day[24] for low secure bed. A medium secure bed would be £545 but again we will take the lowest amount here to adhere to the principle of not over claiming.

These figures can be used for discussion, but further monitoring is needed on these moving forwards to understand the impact. However, based on the input of all stakeholders and secondary research, then the impact of having symptoms deteriorate on the clients as well as health and social care agencies must be considered.

[24] Curtis, Lesley A. and Burns, Amanda (2017) Unit Costs of Health and Social Care 2017. Page 43

Table 6 – Examples of Outcome Valuations

Outcome	**Identified value**	**Value of average distance travelled**	**Quantity of stakeholders experiencing outcome**
Veteran; Improved mental health	Used HACT Code HEA 1602, Relief from depression and anxiety valued at £36,766 for unknown area. Took 18% of this value based on the distance travelled, therefore £6,618 per client.	The Life Compass has a scale of 0-10 and therefore each movement represents 10%. The average movement was 1.8 and therefore a distance travelled of 18% was used. Although this was a small sample, it was in line with the comments about positive change, but also represents that they are still in treatment and therefore it would be expected that this would increase over time.	From the data in second review, 70% had experienced change here, so 86 individuals.
Veteran; Improved family relationship	Used HACT Code HEA 1607, Can rely on family at £6,784 for unknown area. Took 32% of this value based on the distance travelled, therefore £2,171.	The Life Compass has a scale of 0-10 and therefore each movement represents 10%. The average movement was 3.2 and therefore a distance travelled of 32% was used. Although this was a small sample, it was in line with the comments about positive change, but also represents that they are still in treatment and therefore it would be expected that this would increase over time.	From the data in second review, 70% had experienced change here, so 86 individuals.
Family member; Reduced anxiety	Used HACT Code HEA 1602, Relief from depression and anxiety valued at £36,766 for unknown area. Took 25% of this value based on the distance travelled, therefore £9,192 per client.	Taking the lowest point for our questionnaire scale asking individuals to rate against measures (very poor =0%, poor= 25%, ok = 50%, good = 75%, very good = 100%) The average movement was 1 point – which equals 20% Although based on low sample size the results were in line with tone of interview comments – this was cited as an extremely significant change.	
NHS; Reduced potential demand on service	£38 per GP appointment from PSSRU Health and Social Care Costs 2017.	Looking at the clients with positive change, we looked at reducing GP appointment by one appointment per month. Further monitoring will be needed here to get the distance travelled and to get a baseline.	Considered 70% of individuals that had positive change and reducing appointments by 12 appointments each per year.

8. Establishing Impact

In order to assess the overall value of the outcomes of Veterans NHS / Change Step pilot we need to establish how much is specifically a result of the project. SROI applies accepted accounting principles to discount the value accordingly, by asking; What would have happened anyway (deadweight)? What is the contribution of others (attribution)? Have the activities displaced value from elsewhere (displacement)? If an outcome is projected to last more than 1 year, what is the rate at which value created by a project reduces over future years (drop-off)? Applying these four measures creates an understanding of the total net value of the outcomes and helps to abide by the principle not to over-claim.

Deadweight

Deadweight allows us to consider what would happen if the service wasn't available. There is always a possibility that the individuals would have received the same outcomes through another activity or by having support elsewhere.

During the qualitative interviews, all clients were asked if they were aware of other such services available that could offer similar results. Based on these answers as well as some research and conversations with those working in this area, a reasonable judgement was made and can be seen in table 7.

There was a strong feeling that the service was unique in that it was non-judgmental and there was a high level of understanding. This was an understanding by the peer mentors of what they were going through, but also they gave the clients a better understanding themselves as many expressed the frustration of not realising why they felt as they did,

"Having Kevin is the biggest support you could get." Family member.

"What Kevin did worked for me. I wouldn't be standing here now". Client.

Some of the other services mentioned was Combat Stress and also the SAFA helpline. Some more practical support was also offered by the Royal legion and Help for Heroes. There is a chance that some of these changes could have happened anyway, and the therapy by Veterans NHS would also have happened so a fair amount of deadweight percentage must be given.

Following the principle number one of SROI, all clients and family members were asked how much change did they think could have happened anyway. Based on their own experiences, a high percentage was given to the service, however, for many they recognise that change might have happened over

time but that it happened much quicker due to the support from the peer mentors. This time is valuable for them as it's time where they are able to have with families, and also it could mean less time and pressure on statutory services. Considering all of this and the views of professionals, a reasonable estimate of deadweight is given in table 7.

Table 7 – Deadweight figures for the veterans outcomes

Outcome	Deadweight	Justification
Improved psychological / mental health	50%	Having a peer mentor who is a veteran as well provided them with a good baseline and they had a high level of trust. Much of the work done was around dealing with anxiety in public spaces. The Veteran therapist would have also dealt with this over time, however, the clients felt that the majority of change was because of the high level of support from peer mentors. Also, the peer mentors dealt with many of the issues that caused stress for the veterans such as financial troubles, housing concerns and others.
Improved family relationships	40%	During the qualitative research, it was made apparent that the peer mentors offered support for the whole family, either directly or indirectly. This was quite unique according to the families but there is a change so a 40% deadweight is given as they might have been supported elsewhere. This is a smaller percentage, as the Veterans NHS Wales would not have offered as much support for families previously.
Reduced loneliness / isolation	50%	Much of the work involved dealing with anxieties going to public places, but also around communication with family and friends. Again as with Improved psychological health, this might have improved over time with the therapy itself so a 50% deadweight is given to avoid over-claiming.

For family members, the same percentage of 50% is given for the outcomes of reduced anxiety and stress. Although this service isn't for families, the positive changes in the veterans will have an impact on family members also. There were examples of the peer mentors providing family members with support and guidance. However, there is the possibility that the family members would have support elsewhere, so as to not over-claim a high percentage is given here.

The outcomes for Veterans NHS and Betsi Cadwaladr University Health Board, a deadweight of 50% is given for all outcomes, which reflects the 50% given for the veterans outcomes of improved mental health. Many of these outcomes reflects the work being done during the time clients are waiting for therapy, which previously would not have happened. However, we must consider that others could

have supported during this time also such as family and friends, other veterans charities or third sector organisations, and therefore a fair amount of deadweight is considered.

Attribution

Attribution allows us to recognise the contribution of others towards achieving these outcomes. There is always a possibility that others will contribute towards any changes in people's lives such as family members or other organisations. Attribution allows us to see how much of the change happens because of the support by this project.

With this particular pilot, consideration is needed as to how much should be attributed to the therapy itself and how much to the peer mentors. As many of the clients are still either going through therapy or awaiting therapy then some professional judgment is needed as well as the input from stakeholders.

Clients were asked specifically how much of the change recognised did they believe should be attributed to the peer mentors support. For many, they believed their support was vital towards identifying any of the positive changes.

"If it hadn't been for Kevin, I think he would be a lot worse." Wife

"He's been key in this." Client

Some of the clients mentioned needing some encouragement before going to therapy and having the support afterwards. Some expressed that they wanted to carry on as they didn't want to let others down also, including the peer mentors. However, considering the 2016-17 data, this did not seem to be the case, as there more absences in 2017-18 which doesn't reflect the feedback given by clients.

On average, the clients gave an 80% attribution to the peer mentors, and therefore that is the percentage that will be used here for the outcome of *Improved psychological / mental health.* As this is a pilot, going forwards this is something that can be monitored more closely by asking this through the review paperwork, but also comparing data to previous years without the peer mentors support.

For the outcome of *improved family relationship* and *reduced loneliness*, a smaller percentage is attributed here. Consideration should be given to the support that all the families felt they received, which in the past wouldn't have been as apparent. This impression of a 'family friend' and the feedback from family members made it apparent that it was more personal than other services they had previously received. A percentage of 40% is given to the outcome of improved family relationship and a 50% to reduced loneliness which might be still seen as a bit high, but following the principle of not over –claiming, and that this is a pilot we will take the higher percentage.

A percentage of 40% is given for the family member's outcome of reduced anxiety and stress. Although the veteran therapists will not work directly with them, the positive outcomes for the veterans should be reflected here.

All outcomes for the Veterans NHS and BCUHB are given a smaller attribution percent. Some of the value should be attributed to others such as family, friends and other services who have also contributed towards the positive changes. The peer mentor signposts to many different services such as Citizens Advice, SAFA, training providers and many others and therefore some of the value should be given away to them. However, this percentage is lower to the others because this partnership with the peer mentors, allows the veterans to experience positive changes that would have been less likely before therapy previously.

Displacement

We need to consider if the outcomes displace other outcomes elsewhere. For example, if we deal with criminal activity in one street, have we just moved the problem elsewhere. This model is currently new to the area and provides a link to all other services, and therefore does not displace any.

Duration & Drop-off

Clients were all asked about duration and whether they were hopeful that the positive changes would last. As many clients were still going through therapy then they expressed their hopes for the future. Some change was already identified and they hoped the tools they were getting from both therapy and the peer mentor support would be lasting. Some also had gone back to work or education, and some were planning that in the near future.

Further data is needed to understand how long the changes will last, so to avoid over-claiming only 1 year of value after leaving service will be counted in this report. Therefore, there is no need for a drop-off rate here as we are only claiming for the first year.

9. Calculating SROI Results

This section of the report presents the overall results of the SROI analysis of the Veterans NHS Wales / Change Step partnership pilot. Underpinning these results are the seven SROI principles which have carefully been applied to each area of this analysis. The results demonstrate the positive contribution that the peer mentor supporting the Veteran NHS therapists in North Wales through the dedication of staff to create a positive change in the lives of those with social, emotional and practical needs.

By giving veterans support before therapy, during and after on health matters but mainly on social issues such as housing and legal cases, financial and debt advice, family support and other to increase the value and support their path to recovery and to become part of civilian society again. This lead to positive changes in their lives in the short time that we did this analysis, but forecasting that this will continue to improve over time.

Table 8 displays the present value created for each of the included stakeholders who experience material changes. The present value calculations take account of the 3.5% discount rate as suggested by the Treasury's Green Book.

Table 8 – Total Present Value Created by Stakeholder

Stakeholder	Value created as a result of this project	Proportion of total value created
Veterans	£306,792	58%
Family members	£170,960	33%
NHS	£45,460	9%

Table 9 – Present Value Created per Individual Involved

Stakeholder	Average value for each individual involved
Individuals	£4,254

The above results in table 9 indicate a positive return for individuals who received support from the peer mentors and experienced positive outcomes. This is based on current data but also forecasting results based on secondary research. The overall results in table 10 highlight the total value created, the total present value (discounted at 3.5%), the net present value, and ultimately the SROI ratio.

Table 10 – SROI Headline Results

Total value created	£
Total present value	£517,317
Investment value	£71,922
Net present value (present value minus investment)	£445,396
Social Return on Investment	£7.19:1

The result of £7.19:1 indicates that for each £1 of value invested in the Change Step peer mentors supporting Veterans NHS Wales, a total of £7.19 of value is created

10. Sensitivity analysis

The results demonstrate highly significant value created by the Change Step and Veterans NHS pilot, and is based on application of the principles of the SROI framework. Although there are inherent assumptions within this analysis, consistent application of the principle not to over-claim leads to the potential under-valuing of some material outcomes based on issues such as duration of impact.

Conducting sensitivity analysis is designed to assess any assumptions that were included in the analysis. Testing one variable at a time such as quantity, duration, deadweight or drop-off allows for any issues that have a significant impact on the result to be identified. If any issue is deemed to have a material impact, this assumption should be both carefully considered and managed going forward. To test the assumptions within this analysis, a range of issues were altered substantially to appreciate their impact. A summary of the results is presented in table 11.

Table 11 – Sensitivity Analysis Summary

Variable	Current assumption	Revised assumption	Revised SROI	Proportion of change
Veterans; Improved mental health	Quantity; 86	Quantity; 43	6.36	11.5%
	Deadweight; 50%	Deadweight; 70%	6.57	8.6%
	Attribution; 80%	Attribution; 90%	6.41	10.8%
	Value; £6,618	Value; £3,300	6.34	11.8%
Veterans ; Improved family relationships	Quantity; 86	Quantity; 43	6.27	**12.8%**
	Deadweight; 40%	Deadweight; 70%	6.27	**12.8%**
	Attribution; 40%	Attribution; 80%	5.97	**16.9%**
	Value; £2,171	Value; £1,000	6.20	**13.7%**
NHS; Reduced demand on service (less GP appointments)	Quantity; 1033	Quantity; 500	7.00	2.6%
	Attribution; 30%	Attribution; 60%	7.03	2.2%

Although some of the sensitivity tests indicate changes to the result, owing to the scale of the amendments made and the verification of assumptions and data with stakeholders, the results still indicate that if a single variable were significantly altered, the overall results remain highly positive. The most significant impact of the sensitivity analysis is based on the change to the outcome for individuals on improved family relationships. This could be because of the relatively high value given to this outcome compared to the outcome of reduced loneliness. Again, the sensitivity test uses a relatively large change, and although there is a great deal of confidence in the figure employed, it nevertheless indicates the importance for CAIS to carefully manage this issue in the future.

11. Conclusion

This report has demonstrated that the Change Step peer mentors in partnership with Veterans NHS Wales will create over £517,000 of value and for each £1 invested, £7.19 of value is created;

What that means in practical terms is that people's lives have been positively changed.

Taking the good practice from the original Change Step model and combining it with the Veterans NHS Wales service was a collaboration that allowed clients to benefit from a person centred support model looking at all support needs beyond their clinical requirements.

By having the peer mentor, who are themselves veterans, it provided that immediate reassurance and bond in most cases. The clients expressed their reassurance of working with a service that was unique with a peer mentor that understands what they were going through, were as in many cases they didn't understand themselves. This not only provided them with reassurance, but their family members also.

The peer mentors were described as the perfect balance of both a friend but a professional staff member also. It was apparent that there was a good working relationship between them and the therapists, which is something that was witnessed by clients who had finished therapy or was going through therapy. By having the peer mentors to work closely with the therapists, they could provide more focused support and allowed the clients to reclaim their life much quicker.

This support is offered from referral, while on the waiting list, during therapy and post therapy. For many, this support was crucial in ensuring that symptoms did not deteriorate while waiting for therapy, but in some cases, improving in some areas before therapy sessions started. This provides potential costs savings for the Health Board which are demonstrated in this report.

This social value forecast report demonstrates the impact created for clients, family members and the National Health Service. It is not surprising that the majority of the value belongs to the clients with 58% of the value. This value allows the ripple effect of preventing the need for use of further statutory services in many cases. As this is a pilot study and only a small sample was available, the principle of over-claiming was used and extreme caution. These figures allows us to discuss how much more impact can be created when expanding on this model.

The Social Service and Well-being (Wales) Act 2014 puts a great focus on prevention and that the needs of the individual is central to their care. This model responds positively to these requirements and looks at the needs of every client and responds accordingly. We have a duty to listen to our stakeholders and they are best placed to tell us what changes in their lives as a result of a service. The last words should be theirs,

"What he did worked for me. I might not be here now."

"Having the peer mentor is the biggest support you can get."

“If it wasn’t for you, I would have binned it off(therapy), I did before.”

“They bridge the gap, but it’s a very big bridge to cross.”

12. Recommendations

a. Financing Change Step peer mentors

This report has demonstrated that the peer mentors add significant value to the Veterans NHS Wales service. It is therefore not surprising that the **first recommendation is that this service is funded to continue to create positive changes in the lives of the veterans in North Wales who are in need of support.**

In a time where budgets are stretched across all sectors, it is important to recognise the significant value that the third sector can create. As well as creating significant value for the veterans and their family members, this service also creates potential savings for statutory services. Some of the savings to Veterans NHS Wales as well as other NHS services are included here. However, moving forwards it is possible to consider other savings such as to the Housing sector, other health services, Local Authorities and the Criminal Justice system.

The Social Services and Well-being (Wales) Act 2014, provides a great focus on preventative services and also the need for services to be coproduced. This is a great example of how Betsi Cadwaladr University Health Board and the Social Enterprise, CAIS has brought together two services to increase the value for the clients and create long term sustainable changes. Having the peer mentors there to ensure that the veterans do not deteriorate while they are on the waiting list, helps to support the client to start creating positive life changes and reduces the risk of reaching crisis point and needing services such as A& E or hospitalisation or other. Current waiting times for therapy is around 5-6 months, during that time the veterans, family members and peer mentors explained how things could have quickly deteriorated. Some referred to feeling forgotten in the past, and therefore the peer mentors can offer support and positive changes during this time. As one family member said “they help to bridge the gap, but it is a very big bridge.”

b. Managing dependency

As with any service that offers one to one support, there is the risk of creating dependency. During the qualitative interviews, some clients did hint at needing to see the peer mentor more often, or expressed that should any issues arise during the week that then they need to consult their options with the peer mentor. It is important to work with the client to ensure the positive changes introduced are sustainable.

However, the peer mentors are very aware of this risk and expressed how there is always a focus on helping first, then doing it with them, then encouragement to do something on their own. This

allows them to help them with the first steps, but then provides them with the confidence that this is something they can do themselves. The very nature of veterans supporting veterans allows them to believe that these positive changes is possible.

c. Measuring and managing social value

As this was a 12 month pilot and that it took a few months to build up a new way of working and to ensure the peer mentors had all the relevant training, the qualitative interviews to map the outcomes wasn't possible until December 2017. Some of the outcomes were already measured here using the Life Compass as well as the Clinical measures already being used by Veterans NHS. There are other areas that should be monitored to understand the value of this service such as changes in the use of services such as GP visits, A&E visits, use of Criminal Justice system and others. Any change in income could also be measured as there were many case studies of the peer mentors supporting with benefit application, as well as veterans returning to work.

It is recommended that outcomes continues to be monitored on a regular basis to understand any changes, but also that other areas of services are also monitored. Unfortunately, the data wasn't updated on a regular basis and this needs to be managed moving forwards. Some support to the peer mentors could be beneficial here by providing administrative support or having a monthly data update so it becomes part of the normal routine. As demonstrated in this report, they offer many hours support per client and cover a larger geographical area, and therefore this could be a way to manage both requirements. By having a regular update on the amount of change, decisions can be made moving forwards. Some suggestions on data collection are given in appendix 5. Fundamentally if we do not measure social impacts, we are unable to manage them. It is therefore important that careful **systems are established to measure and manage outcomes as identified by those involved** (building on existing options where possible). Additionally, and particularly as this is a forecast report and relies on anticipated outcomes for some veterans, it is also important that follow-up monitoring is included to better understand the longer-term impacts of early-intervention.

It is also recommended that outcomes for families are monitored on a regular basis. Although this service is for the veterans, as was demonstrated the families also experience positive changes in their lives, and therefore capturing this is important as part of the story of change.

Another element of the measuring that should be considered, is the different segments of clients and possible different outcomes. In this report, all veterans were grouped together as time was restricted, however, monitoring should consider is there a difference in outcomes based on characteristics such as age, location, housing situation and nature of the military service or any other characteristics. This

will allow management to consider if there are any changes that could assist particular groups. This information is already being captured by Cais and therefore by having a bigger sample, analysis can be made by looking at the difference on location, age, gender, referral route as a starting point.

d. The impact on Veterans NHS Wales

As was discussed in this report, there was a different response to the type of support that the peer mentor would offer the therapists in the North West and the North East. In the North East, it was believed that the work with the peer mentor could in time reduce the amount of therapy sessions, and therefore could contribute towards reducing the waiting lists. Further discussions are recommended on the best way to move forwards here, and further monitoring is needed to see if there will be an impact on therapy sessions and waiting lists in the North East. However, from the sample taken, the outcomes across North Wales were consistent for the veterans that will help to ensure the benefits of therapy are maintained over the longer-term. Every therapist will have a preferred way of working and clients are benefitting from this partnership working in both scenarios here, the difference is the value created to the statutory service.

There is agreement that this will have a positive impact on preventing the use of other health and social care services and therefore again, it is recommended that a baseline is included in the paperwork on the use of services in order to have a clearer understanding on the changes.

In this report, judgements have been made based on listening to the stakeholders' voice but will care not to over-claim. By looking at small percentages of clients here and the potential savings, it opens up a discussion about the preventative work done by the peer mentors, and how increasing this support can create further costs savings towards statutory health and social care costs.

Appendices

Appendix 1 – Stages from Referral to Discharge and the intervention by the PM.

	Referral	Actions by PM or VT
	Opt in returned	Social and clinical assessment dates booked by admin
	No Opt in returned Did not attend assessment	Contact from PM Contact from PM

	Social Assessment with PM	PM • Completion of psychometric measures (not trauma) • Completion of MDS (not mental health) • Social and welfare signposting e g RBL, SAAFA, DWP etc
	Clinical Assessment with VT	VT • Prescription of suitable mental health app relating to diagnosis • Identification of PM waiting list support activities
	Waiting list	PM • social support and engagement • guided self-help using apps,
	Treatment	VT • formulation driven evidence based out patient psychological therapy PM • Delivering treatment support elements including: • behavioural activation • exposure tasks • sleep interventions • between session task support • problem solving skills • guided self-help using apps • other skills development as identified by VT • Pre / post sessions social support
	Discharge	PM • Time limited post discharge support • Signposting to other support agencies

Appendix 4 – Family members survey

Quick questionnaire about the support either you or your family member/s has received from the Veteran NHS / Change Step peer mentors.

Through the conversations we have had with some of you, you have told us about the things that changed for you by having the peer mentors in your life. Based on these conversations we have a few questions that we would really appreciate your answers to.

If you are willing to take part please tick the box below and sign.

I agree to participate in this data collection process and understand the commitment in terms of time required to complete this process. ☐
Signature _____
All of your answers will remain confidential and anonymous – thank you

Holiadur sydyn am eich profiadau yn dilyn derbyn cefnogaeth eich hunain neu aelod o'r teulu yn derbyn cefnogaeth gan fentoriaid Veterans NHS / Change Step.

Drwy ein sgyrsiau rydym wedi ei gael gyda rhai ohonoch, rydych wedi dweud wrthym yr hyn sydd wedi newid i chi drwy gael y mentoriaid yn eich bywyd. Ar sail y trafodaethau hyn, mae gennym ychydig o gwestiynau y buaswn yn ddiolchgar pe bae chi yn eu hateb.

Rwyf yn cytuno i fod yn rhan o'r proses casglu data yma ac yn deall yr amser ynghlwm i lenwi'r holiadur. ☐

Llofnod _____-

Bydd eich atebion yn hollol gyfrinachol a dienw - diolch

SOCIAL VALUE CYMRU

Thinking about what changed for you by receiving peer mentor support, it would be really helpful if you could select the options that are true for you;

WHAT HAS CHANGED FOR YOU BECAUSE OF THE PEER MENTOR SUPPORT?	Doesn't apply to me	A little change	Some change	Quite a lot of change	A lot of change
I feel reassured and less alone in my situation					
I was more aware of other services available to me					
I feel better knowing I have someone to support us?					
I feel less stressed/anxious/depressed					
I have made new friends / I socialise more with other people					
Our family relationship is now better					
Other (please state)					
Other (please state)					

In your own words, can you tell us what has changed for you, if anything, as a result of the support your family has received from the service?

Thinking about the things that have changed for you as a result of the peer mentors, could you estimate the chance that these things could have happened anyway?

No chance at all that things could have changed without the Peer Mentor	A little chance that things could have changed anyway	Some chance that things could have changed anyway	Quite a lot of chance that things could have changed anyway	A lot of chance that things could have changed anyway

SOCIAL VALUE CYMRU

Other people & organisations in your life may have also helped to create the changes you have identified such as your family or other organisations / charities – so using the boxes below could you shade in the percentage of the change that is a result of the peer mentors?

10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Thank you so much for completing this

Appendix 5 – Life Compass

Appendix 6 – Clinical measures

_
ID: _ _ _ _- _ - _

Insomnia Severity Index

For each question, please *CIRCLE* the number that best describes your answer.
Please rate the *CURRENT (i.e. LAST 2 WEEKS) SEVERITY* of your insomnia problem(s).

Insomnia problem
None Mild Moderate Severe Very severe

1. Difficulty falling asleep
0 1 2 3 4
2. Difficulty staying asleep
0 1 2 3 4
3. Problem waking up too early
0 1 2 3 4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?
Very Satisfied
Satisfied Moderately Satisfied
Dissatisfied Very Dissatisfied
0 1 2 3 4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?
Not at all Noticeable

SOCIAL VALUE CYMRU

A Little Somewhat Much Very Much Noticeable
0 1 2 3 4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all
Worried
A Little Somewhat Much Very Much Worried
0 1 2 3 4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all
Interfering
A Little Somewhat Much Very Much Interfering
0 1 2 3 4

_

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

Print out your completed Insomnia Severity Index, along with the Guidelines for Scoring/Interpretation, to show to your health care provider.

Used with permission from Charles M. Morin, Ph.D., Université Laval

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The PTSD Checklist for *DSM-5* with Criterion A

Version date: 14 August 2013

Reference: Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for DSM-5 (PCL-5) – Extended Criterion A* [Measurement instrument]. Available from http://www.ptsd.va.gov/

URL: http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

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SOCIAL VALUE CYMRU

PCL-5 with Criterion A

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.

First, please answer a few questions about your worst event, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so):

How long ago did it happen? _____ (please estimate if you are not sure)

Did it involve actual or threatened death, serious injury, or sexual violence?
Yes

No
_____ Yes _____

How did you experience it?
It happened to me directly

I witnessed it

I learned about it happening to a close family member or close friend

I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

Other, please describe

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?
Accident or violence

SOCIAL VALUE CYMRU

Not applicable (the event did not involve the death of a close family member or close friend)
____ Yes ____ ____ ____ ____ ____ ____
_____
_____ ____ ____ Natural causes ____

 PCL-5 with Criterion A (14 August 2013) National Center for PTSD

Second, below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. **In the past month, how much were you bothered by:**	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4

12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Health Questionnaire

English version for the UK

(validated for Ireland)

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

I have no problems in walking about ❑

I have some problems in walking about ❑

I am confined to bed ❑

Self-Care

I have no problems with self-care ❑

I have some problems washing or dressing myself ❑

I am unable to wash or dress myself ❑

Usual Activities (*e.g. work, study, housework, family or leisure activities)*

I have no problems with performing my usual activities ❑

I have some problems with performing my usual activities ❑

I am unable to perform my usual activities ❑

Pain/Discomfort

I have no pain or discomfort ❑

I have moderate pain or discomfort ❑

I have extreme pain or discomfort ❑

Anxiety/Depression

I am not anxious or depressed ❑

I am moderately anxious or depressed ❑

I am extremely anxious or depressed

❑

SOCIAL VALUE CYMRU

9 0
8 0
7 0
6 0
5 0
4 0
3 0
2 0
1 0
100
Worst
imaginable
health state
0
Best
imaginable
health state

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Your own
health state
today