SOCIAL RETURN ON INVESTMENT (SROI) INTERIM REPORT ON THE ICAN CENTRES IN NORTH WALES JANUARY 2019-APRIL 2019

"Inspiration is so powerful."

ICAN
Law yn llaw at iechyd meddwl
Together for mental health

MI FEDRAF
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GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Mesur Measure
Effaith Impact
Dysgu Learning
Llesiant Well-being
SOCIAL VALUE CYMRU

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Executive Summary

This is an interim report on the ICAN Centres based in Ysbyty Gwynedd, Ysbyty Glan Clwyd and Ysbyty Maelor. The social value will be forecasted as this report analyses the initial four months of the pilot service only but will provide recommendations for the next 11 months. Any findings in this report should be read with caution and will need to be explored further and should be used for future planning.

There is a growing need for an alternative to support the growing pressures on statutory services. The legislative framework in Wales encourages sectors to co-produce services and provide more innovative solutions.

ICAN centres provide an alternative solution for patients with low level social and mental health challenges who access ED departments between the hours of 7p.m. and 2a.m at Ysbyty Gwynedd, Ysbyty Glan Clwyd and Ysbyty Maelor. The Centres will be staffed each evening by ICAN supervisors and volunteers who offer emotional support and signposting to various other community-based services.

Although limited stakeholder engagement took place due to this being a short-term pilot, clients /patients explained how the service provided them with the reassurance and ability to cope due to the crisis they faced. For the volunteers who give their time to the service, they felt a better sense of personal satisfaction from being part of a service that could offer an alternative for the clients / patients and could give the time to look beyond any medical concerns. The health professionals also agreed that the service was beneficial for the hospitals and for their roles and, with time, could be fully utilised to provide the best possible outcomes for the client / patient.

Acknowledgements

This report would not be possible without involving key stakeholders who can help us to understand what changes have taken place and establish the impact of those changes. We are extremely thankful to the volunteers and supervisors who gave their time in order to help us understand what had changed in their lives as a result, as well as helping us to understand how to build on this impact in the future. They also helped to give us a better insight into what changes took place for the clients /patients.

Although we were only able to engage with a small number of clients /patients, we are extremely grateful to them for giving their time to discuss what happened at a difficult time for them.

A huge thank you also to the health professionals who took time out from their busy schedules to engage with us and helped us to understand the impact for both clients, as well as to them and the service.

Diolch yn fawr / Thank you

1.0 Introduction

This evaluation report will analyse the value of the ICAN Centres based at Ysbyty Gwynedd, Ysbyty Glan Clwyd ac Ysbyty Maelor, provided by Betsi Cadwaladr University Health Board which has been funded initially by the Parliamentary Review Fund for four months. The impact of this service on clients /patients will be considered as well as on the volunteers and supervisors, but also the value to other statutory services, especially the Health Board.

Through engagement with individuals receiving the service, volunteers, supervisors and health professionals, and from examination of information and data available, appropriate estimations have been made, supported by secondary evidence.

This report will analyse the findings from this pilot using the Social Return on Investment (SROI) framework to complete an evaluation report up to April 2019 but will provide recommendations for the next 11 months.

1.1 Purpose and Scope

This is a Social Return on Investment (SROI) forecast to measure the social value of the ICAN project. This report looks specifically at the outcomes and their value for patients who are referred to the service after attending Emergency Department, but also the impact on volunteers, supervisors and the impact on health departments within the hospitals.

This report was prepared to review and ascertain the following.

- The views of the key beneficiaries involved in the project, that is the clients / patients referred.

- The outcomes experienced by all material stakeholders, but most importantly the clients /patients.
- To give a value to the service and to answer the question: 'does ICAN provide good value for money?'.
- 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 new model based within Emergency Departments across north Wales.

1.2 Audience

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

- **Funders** – This project was funded for the initial four months through the Parliamentary Review Fund, which included all staff costs, volunteer expenses and set-up costs. The funders will need to understand the value that is created from their investment, and how the project has had an impact on services.
- **Internal Management** – By measuring the social value of this service and understanding what the outcomes are for individuals, decisions can be made based on this information to manage and plan services.
- **Policy and Decision Makers** – With 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 co-produced.

- **Clients / Patients** – To understand and communicate the value of the service to those who matter the most: the clients / patients receiving the service.
- **Volunteers –** This service depends on volunteers giving their time to support others. They will need to understand the impact that's created, but also any results could be communicated to recruit new volunteers.
- **Supervisors –** Supervisors are employed by BCUHB and they will manage the volunteers at each site. They will need to understand the impact, but the results could also help to recruit more.

2.0 Background & Context

2.1 Key Organisation

Betsi Cadwaladr University Health Board (BCUHB) is the largest health organisation in Wales providing a full range of health services for the population of north Wales which consists of six counties (Gwynedd, Anglesey, Conwy, Denbighshire, Flint and Wrexham.) There are three main sites where the ICAN Centres are based including Ysbyty Gwynedd, Ysbyty Glan Clwyd and Ysbyty Maelor in Wrexham. The Health Boards' purpose and vision is stated on their website[1];

Our Purpose

- To improve health and deliver excellent care.

Our Vision

- We will improve the health of the population, with a particular focus upon the most vulnerable in our society.
- We will do this by developing an integrated health service which provides excellent care delivered in partnership with the public and other statutory and third sector organisations.
- We will develop our workforce so that it has the right skills and operates in a research-rich learning culture.

[1] http://www.wales.nhs.uk/sitesplus/861/page/84723 Accessed 17/04/2019

In north Wales the Together for Mental Health Strategy is a new strategy developed by BCUHB. The responsibility of implementing this strategy lies with the Local Implementation Teams (LITs) and will be divided into East, West and Central.

The ICAN Centre Coordinator is currently based within Mantell Gwynedd which is the County Voluntary Council (CVC). This was agreed by all six north Wales County Voluntary Councils as with the initial set up of the centres, it was considered that the partnerships with the CVCs was vital to ensure they were best placed to recruit volunteers. Mantell Gwynedd was also responsible for administrating the volunteer and supervisors' costs. Some importance was given to place the service as much as possible within the third sector.

2.2 Project Outline

ICAN centres provide an alternative solution for patients with low level social and mental health challenges who access ED departments between the hours of 7p.m. and 2a.m at Ysbyty Gwynedd, Ysbyty Glan Clwyd and Ysbyty Maelor. The Centres will be staffed each evening by ICAN supervisors and volunteers who offer emotional support and signposting to various other community-based services.

The service is open to anyone over the age of 18 who are experiencing some emotional distress but might not need to be treated within the Emergency Department as they need non-clinical intervention.

"This is part of an ambitious plan to improve mental health support in North Wales which has seen a number of organisations including BCUHB, North Wales Police, local authorities, Welsh Ambulance Service and mental health charities working much more closely together in order

to establish a seamless integrated urgent care system for people who experience a mental health crisis."[2]

Some initial funding was available through the Parliamentary Review Fund and allowed for a four-month pilot project.

When clients /patients attend ED departments, their situation will be assessed by the Triage team to determine what treatment is required and the degree of urgency. Triage within hospitals will determine the order of treatments to patients based on their concerns and urgency. The average waiting time across all hospitals will vary but based on statistics in Wales in February 2019[3] only 63.1% of patients at BCUHB were seen within the four-hour target at EDs, which was the lowest rate in Wales. If the Triage team identifies a patient with a low level social or mental health concern between the hours of 7p.m. and 2a.m. then they can refer to the ICAN centre. Any mental health related referrals will first need to be assessed by the psychiatric liaison practitioners, and then they can refer appropriately to ICAN.

As the service has evolved volunteers also attend the wards to offer support to patients and offering their services to the nurses.

2.3 Identifying the need and Strategic Background

The pilot was developed as a result of the work carried out by the Local Implementation Teams (LITs) who are responsible for implementing the Together for Mental Health Strategy

[2] http://www.wales.nhs.uk/sitesplus/861/page/97914 Accessed 12/04/2019
[3] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Accident-and-Emergency/performanceagainst4hourtargetallemergencycarefacilities-by-localhealthboard

in north Wales and especially to develop effective pathways to meet the needs of those in mental health crisis. An increasing need to support those in social or mental health crisis is recognised, and the Welsh Government prepared a 'Together for Mental Health Delivery Plan 2016–2019'[4] as a response to this need. A number of the actions in this plan are a response to the Social Services and Well-being (Wales) Act 2014[5] which transforms the way Social Services are delivered. This also is a response to the Well-being of Future Generations (Wales) Act 2015[6] which aims to:

- Think more about the long-term
- Work better with people and communities and each other
- Look to prevent problems and take a more joined-up approach.

Moving on from here the Together for Mental Health in North Wales strategy has provided some key changes which need to be implemented including Improving Crisis Care and have better community services available 24/7. [7] Within the first-year work programme of Improving Crisis Care, the Local Implementation Teams (LITs) will need to ensure an effective urgent care system for people in acute mental health crisis which includes;

- Working to prevent mental health crises by focusing on early intervention and promoting emotional resilience
- Developing local alternatives to admission: crisis cafes, sanctuaries, strengthened home treatment services, step-down services

[4] Welsh Government (2016). http://gov.wales/docs/dhss/publications/161010deliveryen.pdf
[5] Welsh Government (2016) http://gov.wales/topics/health/socialcare/act/?lang=en
[6] Welsh Government (2016) http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en
[7] BCU Three Year Plan 2018 / 21
http://www.wales.nhs.uk/sitesplus/documents/861/18.92b%203%20year%20plan%202018-21%20v1.0.pdf

- Reviewing and improving the routine processes of bed management and patient flow
- Working with criminal justice services to divert demand arising from the police, via section 136 arrangements, street triage or control room-based mental health staff
- Working with voluntary and third sector agencies to review their role with people at risk of severe mental health crises
- Reviewing how CMHTs work with people at periodic risk of severe mental health crises

In the BCUHB Three-year strategy it is stated,

"Mental well-being is concerned with how people feel about their lives and whether their lives are worthwhile. It is not just the absence of mental health problems – it is broader than that. It is about how much control someone feels they have; resilience and support networks; participating and being include." [8]

The ICAN Centres are not specifically here to support people with mental health concerns, but there for people who are in social or mental crisis at that time.

Behind the mental health strategy in north Wales was the acknowledgment that currently there was a 'fragmented approach' towards helping those in mental health crisis and identifying how that could have a further negative impact on individuals. The strategy therefore aims to provide a more integrated support system for people in crisis and to avoid unnecessary hospital admissions. It is recognised that in order to implement these changes there would need to be a big culture change, moving away from reliance on hospital beds.

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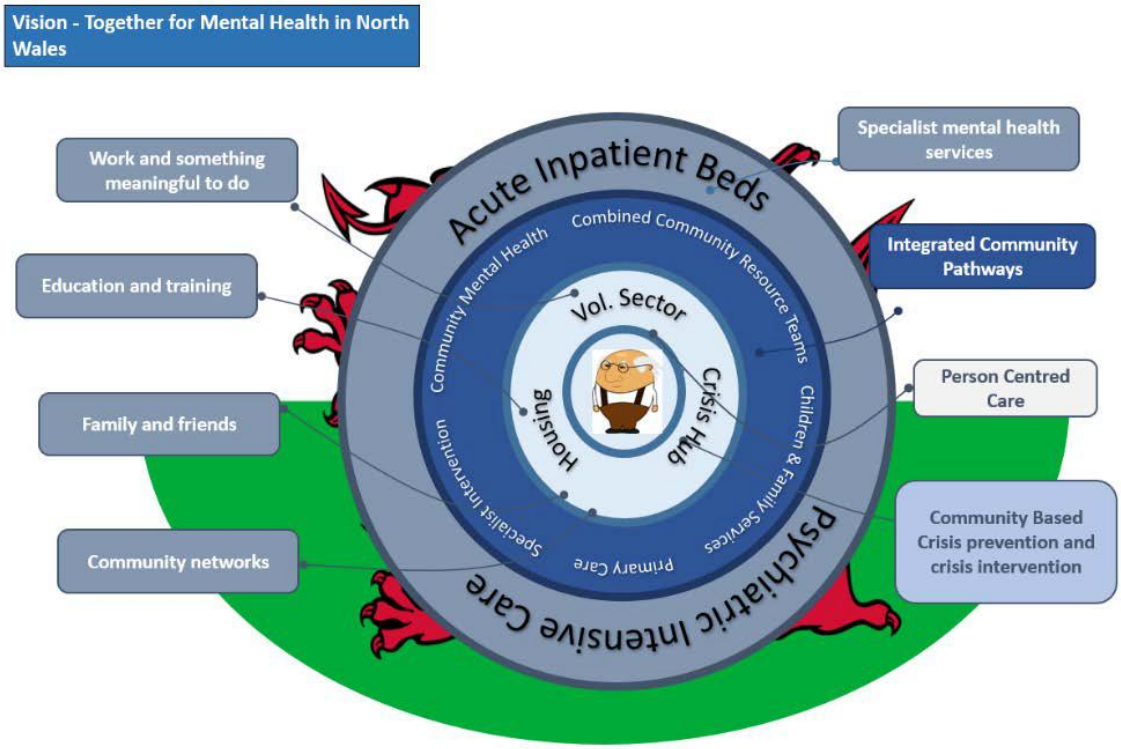
The model below identified how they propose to have a more integrated model of working in North Wales [9]

Figure 1



Every year, Betsi Cadwaladr University Health Board receives approximately 45,000 referrals to adult mental health services and responds to 8,000 unscheduled assessments in emergency departments and hospital wards. [10] In the 'Alternative Places of Safety' report published in October 2017 by BCUHB and North Wales Police, the authors considered the need for more crisis support needs within the community and considered different models currently available across the UK. One of these models was 'The Sanctuary' at MIND in

[9] The North Wales Response to "A Healthier Wales". North Wales Social care and Well-being Services Improvement Collaborative.
[10] Cook, J. O'Brien, D. Alternative Places of Safety. October 2017

Bradford. The main aim was to “support people to resolve or better manage crisis to reduce the number of people attending A & E and reduce pressure on acute beds.” The staff at the Sanctuary will work with individuals using four key elements:

- Listening with empathy
- Treating people with warmth, kindness and respect
- Ensuring people don’t feel judged or assessed
- Providing a different and calm environment

Another model was the Leeds Survivor- Led Crisis Service which is led by people who have experience of being in crisis and can offer empathy and understanding. There is no pre-determined definition here of what a ‘crisis’ is, some will not return again after the initial crisis is dealt with, others will have more intense support for a few months and there were 6% frequent users who had used the service for many years.

Another model was identified by Dr Baker, a Clinician in north Wales who recognised that this model would work well in North Wales. Safe Haven Crisis Café was developed after some research on why people in mental health crisis access A & E Departments. The research found that this was the result of people wanting to have a physical place to go. Since 2014, evaluation suggests that the model has helped to reduce psychiatric admissions by 33%. Research also demonstrated that before the Safe Haven opened, the number of people attending A & E on a Sunday had dropped by 279 per day.

This following analysis will consider how the ICAN centres can respond to the needs of the new legislation in Wales, the needs of local residents based on the Population Needs Assessment and if it can reduce some of the pressure on statutory services, but most importantly create a positive change in the lives of people in North Wales.

3.0 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 experienced, or will experience, changes in their lives as the basis for evaluative or forecast 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 illustrated 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.

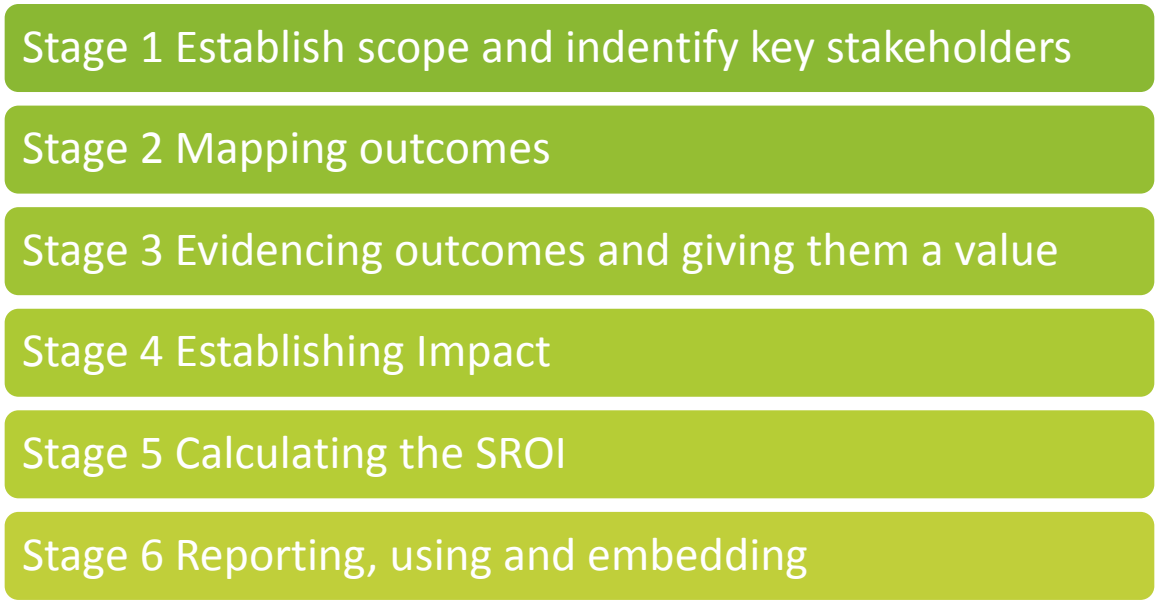
There are two types of SROI reports: evaluative and forecast. **This report is an interim forecast SROI report of the initial pilot project from January – April 2019**. **As this is a short-term pilot, the social value is forecasted based on the findings from the stakeholder engagement process and should be used with caution.** 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 allows 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]

These principles overarch everything that we do during the analysis, and also form 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.

[11] www.socialvalueuk.org

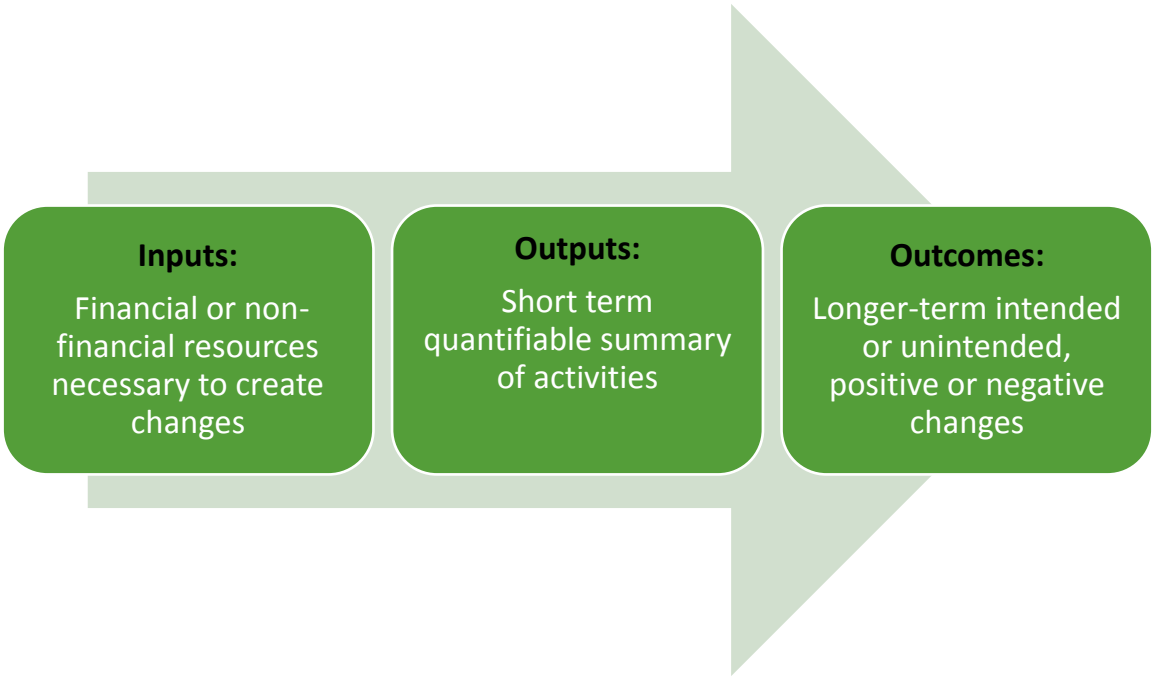
Figure 3 – Social Return on Investment Stages[12]



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

Figure 4 – Chain of Change



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 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 whom decisions are intended to target.

4.0 Stakeholder Engagement & Scope of the Analysis

Including stakeholders is the 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 forecast changes in their lives. Only then can SROI value those that matter most.

To understand what is important for an analysis, the concept of materiality is employed. 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 (see Figure 5). The former identifies if an outcome is important to stakeholders, and the latter identifies the relative value of changes. Initially, for the evaluation of the ICAN Centres, a range of stakeholders were identified as either affecting, or being affected by, the project – Table 2 highlights each stakeholder, identifying if they were considered material or not for inclusion within the SROI analysis.

Figure 5 – Materiality Principle

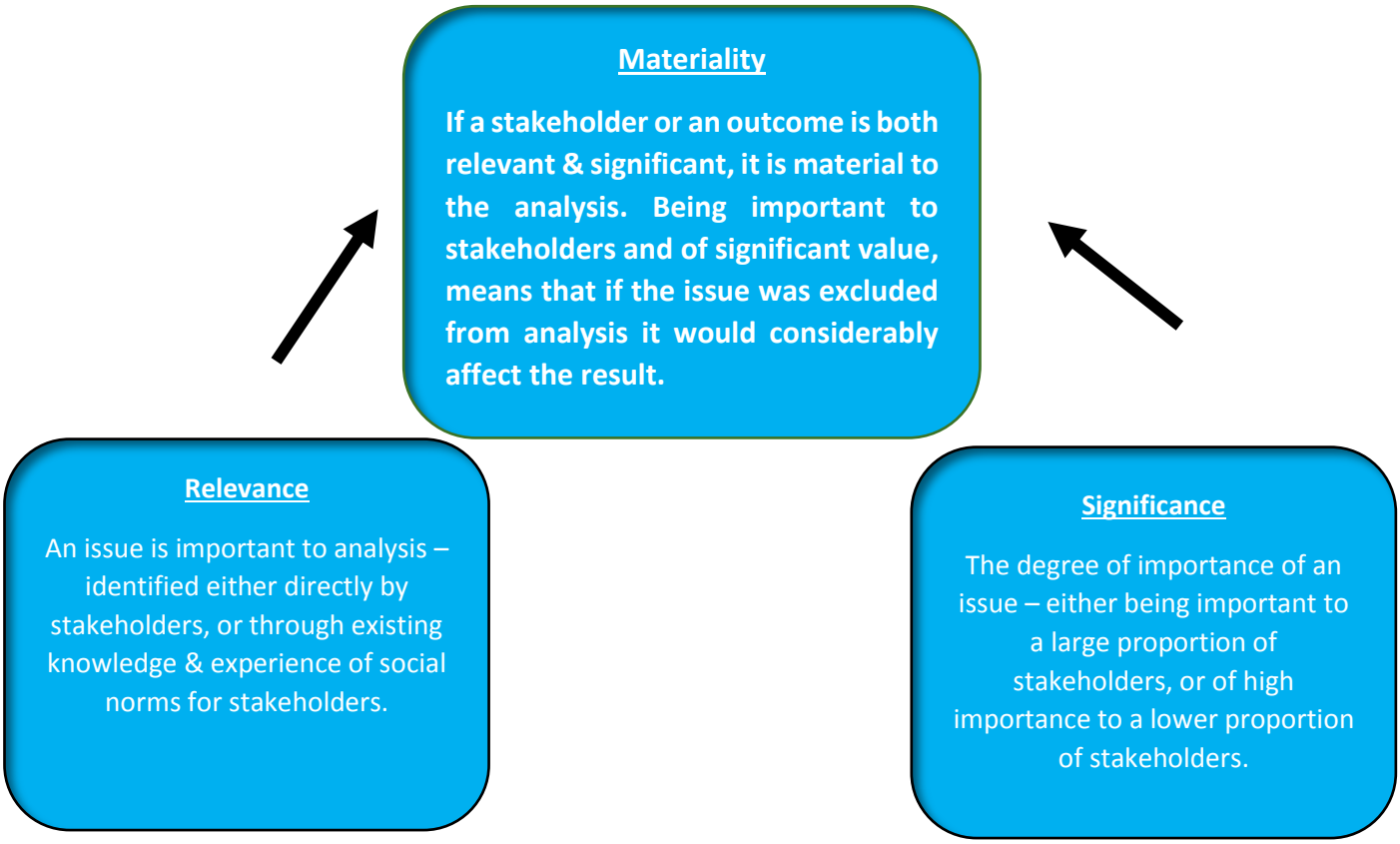


Table 1 – Stakeholder List & Materiality

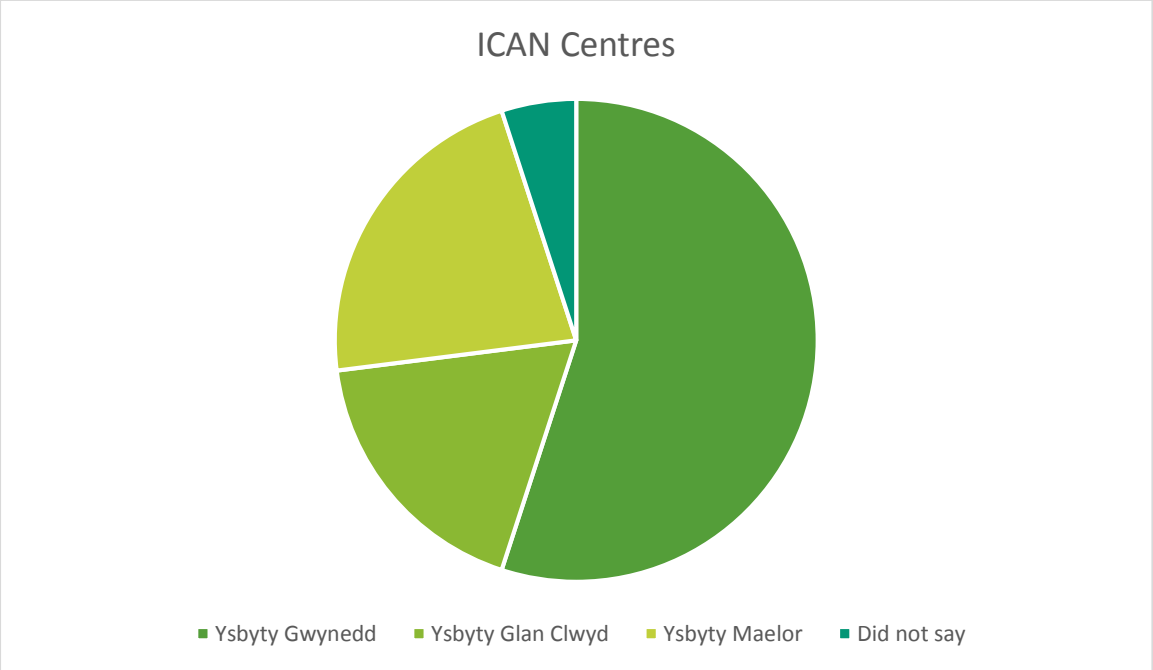
Stakeholder	Material stakeholder?	Explanation
Clients / patients	**Yes**	As key beneficiaries of the service these are the most important stakeholders and some changes experienced will be both relevant and significant. However, due to the confidentiality and nature of the service it was not possible at this time to engage directly with many of these stakeholders. However, third party data was obtained from volunteers and supervisors. Further stakeholder engagement will take place in phase 2.
Family members	**No**	Although the changes to the individuals potentially have an impact on other family members, unfortunately we were not able to engage with them for this analysis. Possibly this could be added in phase 2.
Volunteers	**Yes**	Without the volunteers, this service would not be possible. Volunteers experience changes by being involved in the service and giving their time and therefore their outcomes will also be relevant and significant.
Supervisors	**Yes**	Without the supervisors, this service would not be possible. They also experience changes by being involved in the service and giving their time and therefore their outcomes will also be relevant and significant.
Betsi Cadwaladr University Health Board – **Maelor Wrecsam** **Ysbyty Glan Clwyd** **Ysbyty Gwynedd**	**Yes**	The involvement of BCUHB is essential for the creation of any changes. Therefore, financial resources and the inputs from key members of staff must be included. Consideration will be given to different department within BCUHB such as GPs, Psychiatric Liaison teams, triage, ambulance, nurses etc. and any potential costs savings or reallocation of resources.
The County Voluntary Councils across North Wales **Mantell Gwynedd**	**No**	The involvement of Mantell Gwynedd is important as the administrator is based there as well as the financial resources being managed there. However, financial resources and the inputs from key members of staff are included under BCUHB. However, changes experienced by the organisation are not included as they are not relevant to the project.
Local Authorities – social services, CMHT	**No**	Some of the changes are likely to have an impact on the Local Authority; however, this was beyond the scope of this report.
Other Third Sector Organisations	**No**	Some of the changes are likely to have an impact on other third sector organisations, especially in terms of demand because of the signposting; however, this was beyond the scope of this report.

Police	**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.
Universities	**No**	Some of the changes are likely to have an impact on the Universities, as many students are referred as volunteers and supervisors; however, this was beyond the scope of this report.

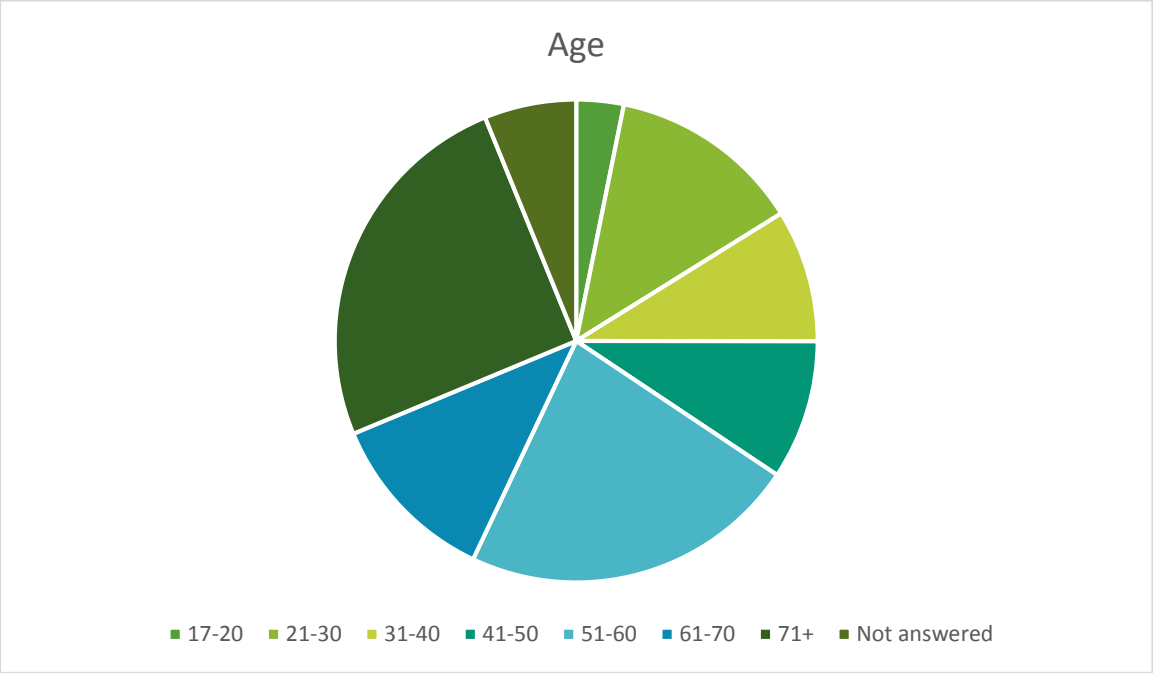
4.1 Potential Subgroups of clients / patients

It's important to recognise that not all individuals are the same. Understanding that different characteristics have an impact on the data can help us to manage and inform decision making. Consideration is therefore given to the different characteristics below, which are age, gender and which hospital did they visit. The diagrams below indicate the number of clients /patients attending all three ICAN centres and the subgroups of individuals that took part in this project.

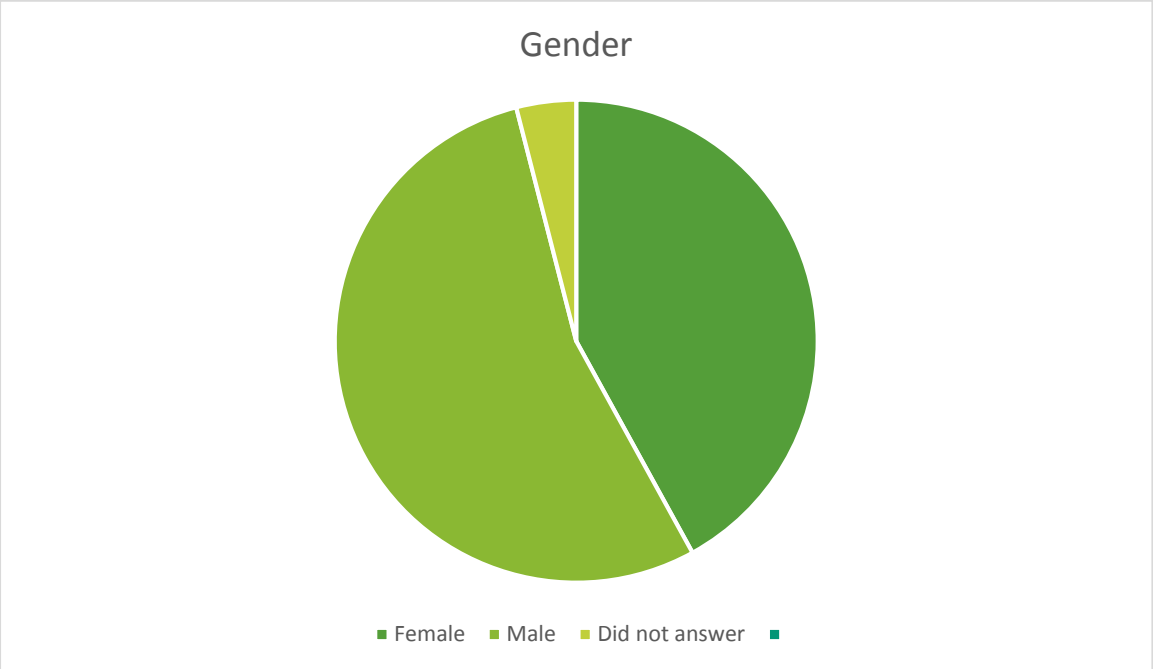
ICAN Centres



Age Data



Gender data



4.2 Potential Subgroups of volunteers

Data on characteristics of all the ICAN volunteers across the three centres is not available but based upon the results from our SurveyMonkey questionnaires and visiting the ICAN centres to carry out the qualitative part of the research with focus groups the following data was established:

- 66% of volunteers are female;
- 27% of volunteers were aged between 51-60 and further 27% were aged 41-50;
- Less than 25% were in education

The number of volunteers that received induction training for the ICAN centres at April 2019 stands at 170 across all three centres in North Wales, however when we look at the actual number of volunteers actively taking part in the ICAN centres at least one day a month, the number drops significantly to 54. The number of volunteers at Ysbyty Gwynedd and Ysbyty Maelor remain fairly consistent – it is anticipated that the proximity of the centres to University health boards creates a demand for course placement and interest in the field. On the other hand, Ysbyty Glan Clwyd has struggled to retain volunteers – it is considered that this might be as a result of the accessibility of public transport and also relative lack of connection with urban settlements.

Having identified the material stakeholders for analysis, Table 3 highlights the size of the populations, the sample size engaged with and the method of engagement.

An initial conversation was had with the ICAN Project Coordinator and Project Administrator to understand the scope and the potential list of stakeholders.

As well as monitoring the paperwork, three focus groups were held between the three ICAN centres along with SurveyMonkey online questionnaires which were completed by 18

individuals. Due to this being a four-month pilot it was challenging to arrange three focus groups, but the support in each area was positive.

Unlike quantitative methods, qualitative interviewing does not have a statistical method for identifying the relevant number of interviews that must be conducted. Rather, it is important to conduct enough until a point of saturation is reached – this is the stage at which no new information is being revealed. Due to the time and sensitivity constraints, we were reliant upon mainly internal data through the project and customer satisfaction forms. We were able to engage with 8 clients via SurveyMonkey and received a 50% feedback response.

Table 2 – Stakeholder Engagement

Stakeholder	Population size	Method of engagement
Clients / Patients	**427**	Phone interviews Survey monkey for those who gave content
Volunteers & Supervisors	**54 volunteers** **11 supervisors**	3 x focus group (Ysbyty Gwynedd, Ysbyty Glan Clwyd, Ysbyty Maelor Wrexham) Survey Monkey or paper questionnaire completed by 18 volunteers and 11 supervisors
BCUHB	**1**	Meetings with ICAN Coordinator Meetings with health professionals including Psychiatric Liaison Team Manager Consultant in Emergency Medicine Out of Hours GP

5.0 Project Inputs

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

5.1 Clients / Patients

This service is free to those that receive it, but some non-financial inputs are also necessary to ensure any changes. The individuals that access the service are in some form of crisis and therefore very likely to be feeling very low, anxious, and vulnerable. Trust therefore is important, so they are able to engage with the volunteers and supervisors and open up about their concerns. Their willingness to communicate and receive information is important for any change to happen.

As one of the health professionals said, any change will depend on them developing an understanding about where they can get support, which requires time which is something ICAN can offer. However, any change will depend on them following up on any advice given,

“Often, they are the solution to the problem.” Health professional

5.2 Volunteers and Supervisors

The volunteers give their time to ensure that this service is available and without their contribution the service would not be possible. Although their time is donated without charge, it is still reasonable for this to be monetised as it represents the opportunity cost to the volunteers. Potentially, if they were not volunteering their time, they could offer their services elsewhere and be paid. Therefore, the standard hourly living wage could be used as

a suitable approximation of value for each hour of time volunteered. The living wage for anyone over 24 years of age is £8.21. Although there are some younger volunteers, the breakdown of age wasn't available and therefore the standard is used. There can be up to 4 volunteers at each hospital site in an evening, however, often they will only be able to have two per evening and therefore that is the total used here. The input therefore is;

120 evening of ICAN @ 7 hours per evening = 840 hours of ICAN

840 Hours * 6 volunteers per evening (minimum) *£8.21 = £41,378

As well as their time, the volunteers need to have a listening ear and empathy. Many of the volunteers have experienced similar crisis in their life and therefore can offer patients that level of understanding that they are searching for.

It is important to recognise also that a lot of their own emotional energy is used as they are supporting people in crisis. Although the people who are referred should be low level or with low mood, they will also be supporting people in crisis, some in bereavement, some cases of abuse and therefore this can be challenging.

The financial input for supervisors is included below as they are employed by BCUHB. The salary of the supervisors is £70 per evening. The other non-financial input reflects that given by the volunteers; however, they also need the management skills to lead a team and to identify who is best placed for each situation.

5.3 BCUHB

The financial input is managed by Mantell Gwynedd. A financial input of £68,579 was provided for the initial 4-month pilot by the Parliamentary Review Fund. This paid for the salary of a full-time ICAN Centre coordinator, administrative support, management and resources, and

also included the start-up costs of recruiting and marketing the service. This also includes the salary of the supervisors as well as the volunteer expenses. As this report was prepared in early May, the costs for April is forecasted based on the March's expenses.

The skills of the Supervisors to work with individuals in an empathetic manner and the ability to identify the client's needs and match that with locally available options within the community and the third sector, are essential to the success of the project. The ability to establish a good partnership and work closely with the different health professionals is also incredibly important for the success of the service.

Consideration was given to include a financial input for the time required by the health professionals to refer into ICAN. However, having engaged with some health professionals, it was not considered that ICAN had required any more of their time, and as triage already need to consider each patient, it is recognised as another service that they are able to refer to rather than something that takes additional time to administer. In Glan Clwyd, all Mental Health referrals will need to go through the Psychiatric liaison team, and they can there ensure appropriate referrals are sent to ICAN. This is not the case in Bangor and Wrexham as direct referrals come from triage, and in Wrexham the ICAN team will sit in ED at times when they are less busy and will reassure some patients while they are waiting for triage.

5.4 Total monetised inputs

The total inputs for the project over the whole 4-month period have been calculated as £109,957 created by both financial and non-financial inputs from the range of stakeholders above. This information is displayed in Table 3 and is compared to the costs per individual.

Table 3 – Total Monetised Inputs for ICAN

Stakeholder	Financial input	Non-financial input	Cost per individual
Clients / Patients	N/A	Trust, willingness to take part and take action identified with the ICAN staff	N/A
BCUHB managed by Mantell Gwynedd	£68,579	Strategic management, time, expertise	
Volunteers	£41,378	Time, skills, commitment, emotional energy	
Supervisors	Salary included under BCUHB	Time, skills, commitment, management	
Totals	**£109,957**		**£257 per individual**

6.0 Outputs, Outcomes & Evidence

6.1 Outputs

The immediate outputs for the ICAN project, are the number of referrals made to the project and how many hours of support each person received from both the ICAN volunteers and supervisors. Over the 4-month period January – April 2019, 427 clients / patients have been supported by the ICAN team. The majority of clients will be referred through triage either directly or via the psychiatric liaison team. Some clients will be seen on the wards also as the ICAN Supervisors and volunteers will present themselves on wards and ask the burses if anybody would benefit from having a conversation with them. Table 4 below shows a breakdown of how individuals have arrived at ED.

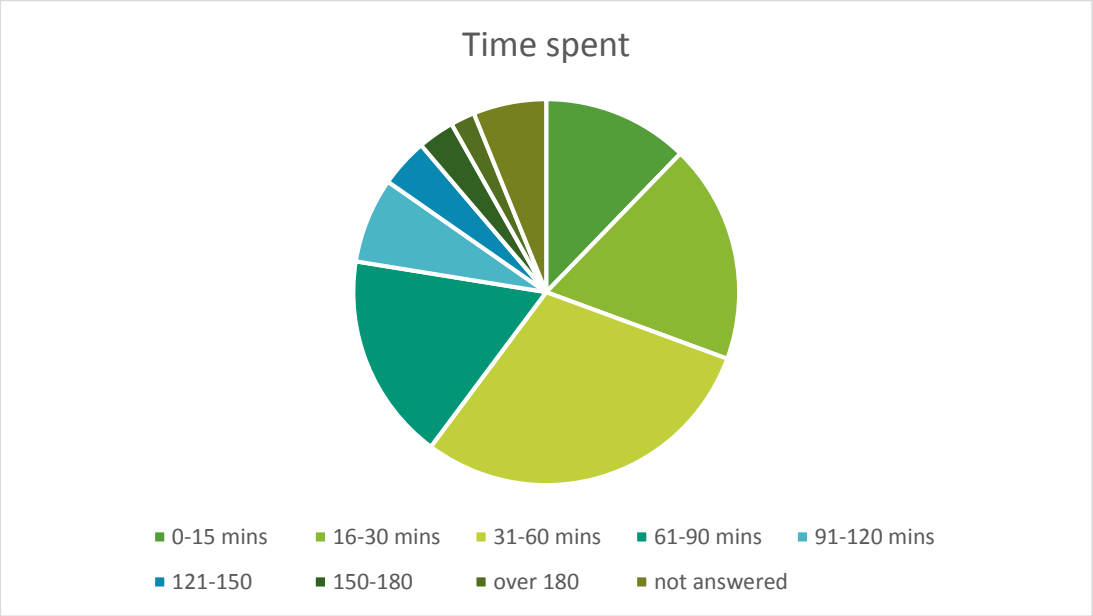
The majority of clients /patients will spend 31-60 minutes with the ICAN team on a single visit, with 2% spending over 180 minutes an evening with the team. The number of time spent can be seen in the diagram below. During this time, the team will engage with the individual, talk with them and reassure them and will support with some action points and signposting. There were cases where the team had helped clients to fill out forms and write applications. There were also cases where the ICAN had arranged suitable accommodation for the client.

For the volunteers, there are 170 volunteers who have completed the induction training. At the time of writing the report there were 54 active volunteers, volunteering on average 1 evening per week, and 11 supervisors were employed.

A theory of change for the individual can be seen for clients on page 44 and for the volunteers on page 50 which shows the story of what can happen to individuals, and Table 5 below summarises all the stakeholders, their outputs and looks at all possible outcomes considered

after engagement with all stakeholders. Consideration is given to what will be included and excluded and can then be seen in the Chain of Change.

Time spent in ICAN centre



Case study

An elderly lady was referred to ICAN by the Psychiatric Liaison Team in Wrexham. The case was referred to the Bangor ICAN Team for telephone support.

The lady had recently lost her daughter to cancer and was quite anxious and experiencing sleep difficulties. The supervisor was able to refer the case to one of the most appropriate volunteers with experience of working with bereavement. The volunteer contacted the lady and gave her advice on sleeping and also provided her with tools for reducing anxiety. The volunteer also reassured the client that the confusion she was feeling may be due to the witnessing her daughter's traumatic death whilst undergoing cancer treatment. The volunteer also suggested signposting to bereavement counselling, however the lady had already tried this and said that this only brought back painful memories. She found talking it through helpful and also the one to one support, practical advice and an insight into the grieving process At the end of the call the lady said that she was happy to try out the suggested techniques and that she felt much calmer having received support from ICAN.

This case study demonstrates how practical and emotional support helped the lady to gain a deeper understanding of what was happening to her as a result of the loss of her daughter which then led to a reduction in anxiety. This also shows a close working relationship between the hospital sites and how expert volunteer roles are developing. The ICAN Team were able to identify issues and signpost top the relevant volunteer

Table 5 – Stakeholder Outcomes

Stakeholder	Outputs	Outcomes	Included / Excluded
Individuals	Referral made by triage to the ICAN Centre and spend on average 60 minutes with the volunteers	Reassurance of knowing the ICAN Centres are there	Excluded - This was relevant to most stakeholders; however, this is an intermediate outcome that leads to the well-defined outcomes
		Feeling better knowing that they are being listened to	Excluded - This was relevant to most stakeholders; however, this is an intermediate outcome that leads to the well-defined outcomes
		Empowerment	Included – Having engaged with the clients, volunteers and health professionals, all intermediate outcomes lead to the clients feeling more empowered as they are able to get more knowledge about what to do if faced with another crisis.
		Better able to work through the initial crisis	Excluded - This was relevant to most stakeholders; however, this is an intermediate outcome that leads to the well-defined outcomes
		Develop trust in other services	Excluded - This was relevant to many stakeholders; however, this is an intermediate outcome that leads to the well-defined outcomes
		Manage stress and anxiety better	Excluded - This was relevant to most stakeholders; however, this is an intermediate outcome that leads to the well-defined outcomes
Volunteers	54 number of volunteers on average volunteers 7 hours a week	Increased confidence to communicate with those in crisis	Excluded - This was relevant to most stakeholders; however, this is an intermediate outcome that leads to the well-defined outcomes
		Improved skill set for employment	Included - This was relevant to many stakeholders during the qualitative stages where this was their main aim to volunteer, and the quantitative data demonstrated a lot of change
		Better sense of personal satisfaction from being able to help others	Excluded - This was relevant to most stakeholders; however, this is an intermediate outcome that leads to the well-defined outcomes
		Better sense of own purpose	Excluded - This was relevant to most stakeholders; however, this is an intermediate outcome that leads to the well-defined outcomes
		Increased social interaction	Excluded - This was relevant to most stakeholders; however, this is an intermediate outcome that leads to the well-defined outcomes
		More able to manage own recovery and maintain mental well-being	Included – For many volunteers, they had experienced crisis in their own life, and felt that volunteering for ICAN was an opportunity for them to help others, but also helped maintain their own mental well-being by providing a routine and purpose.

		Reduced stress / anxiety / depression	Excluded – Some volunteers explained how volunteering had helped reduced their own stress and anxiety levels. However, for some this wasn't applicable. For those that it was applicable – this led into the outcome of maintained own mental well-being
		Reduced loneliness and isolation by volunteering and being part of a team	Included - This was relevant to all stakeholders during the qualitative stages, and the quantitative data demonstrated a lot of change
Supervisors	11 supervisors working on average 2 shift per week	Improved skill set for employment	Included - This was relevant to all stakeholders during the qualitative stages, and the quantitative data demonstrated a lot of change
		Better sense of personal satisfaction from being able to help others	Included - This was relevant to all stakeholders during the qualitative stages, and the quantitative data demonstrated a lot of change
NHS	Reduced demand on services	Reduced demand of out of Hours GP time	Included – Although it is early to have any data on any impact here, based on engaging with stakeholders, it is reasonable to identify material changes. Based on some cases, resources could be reallocated elsewhere when ICAN was able to offer support. In cases also this meant less pressure on the staff having reassurance that more support was available. Any judgments based in the value map will need to be re-examined in March 2020.
		Reduced demand on Psychiatric Liaison Practitioners time	Included – Although it is early to have any data on any impact here, based on engaging with stakeholders, it is reasonable to identify material changes. Based on some cases, resources could be reallocated elsewhere when ICAN was able to offer support. In cases also this meant less pressure on the staff having reassurance that more support was available. Any judgments based in the value map will need to be re-examined in March 2020.
		Reduced demand on nurses' time	Included – Although it is early to have any data on any impact here, based on engaging with stakeholders, it is reasonable to identify material changes. Based on some cases, resources could be reallocated elsewhere when ICAN was able to offer support. In cases also this meant less pressure on the staff having reassurance that more support was available. Any judgments based in the value map will need to be re-examined in March 2020.
		Reduced demand for hospitalisation?	Excluded – Although it is plausible based on the results of the stakeholder engagement that it will have an impact on ED visits over time, it is not included in this value map but will be considered at a later stage.

6.2 Outcomes and 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 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 in appendix 2). 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. Figure 6 illustrates the theory of change for the clients / patients for those involved in the ICAN Centres, and highlights both those included in this discussion and those excluded from analysis. Table 5 lists all the outcomes and considers which are included and excluded based on the materiality test.

6.2.1 Clients / Patients

It's worth noting, that due to the confidentiality of the ICAN service as well as this being a short-term pilot, engaging with many clients directly wasn't possible at the beginning. In April 2019, ICAN did introduce a client feedback survey which asked questions around satisfaction, but also ask for consent to contact them afterwards to discuss any impact. A small sample was therefore contacted with some taking part in the qualitative stages as well as completing a survey monkey to confirm any changes. Further work needs to be done following this analysis to provide indicators to measure the impact on clients and also engage more with patients to understand the impact.

Great care must therefore be taken not to over-claim. The outcomes shown is gathered from engaging with a small sample of clients patients and supported through volunteers, supervisors,

health professionals and from secondary research. This interim report should stimulate conversation, and by March 2020 further data should be made available to look at the impact.

Intermediate outcome 1 – Reassurance of knowing ICAN Centres are there

It takes time for all stakeholders to develop knowledge and understanding of a new service. During the qualitative interviews, some 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.

Clients present themselves to ED when faced with crisis and having ICAN volunteers and supervisors there to take time to talk through what was happening provided them with reassurance.

“Extremely helpful, understanding, and very very supportive.” client /patient

Having engaged with all stakeholders, many felt that knowing that ICAN existed and was there when needed provided reassurance. Many of the health professionals expressed how any further support for mental health and people in crisis was a positive step, and it provided them with reassurance that they could refer clients to a service that could give them the time they needed.

Intermediate outcome 2 – Feeling better knowing that they are being listened to

One common theme that came out of the stakeholder engagement process was “time” and “listening”. Statutory services are very stretched with demand raising all the time and waiting times at an all-time high. Looking at the attendances in ED over the last 12 months, there is an average of 4,000 – 5,000 attendances per month at all sites, with Maelor Wrexham with the

highest number of attendances.[13] Medical staff cannot possibly have the time to listen and need to deal with the immediate concerns.

One of the volunteers commented on how a service was needed that looked at the patients as human beings,

"Look at them as a human, not as something medical." Volunteer

This was backed up by one of the health professionals who explained how they can only put a "band aid" over the issue, but ICAN can provide the time needed to understand what really was going on.

A similar model to ICAN but based in the community can be seen in Bradford. Mid Bradford run a service called 'The Sanctuary' and there are four key elements to their support;

- Listening with empathy
- Treating visitors with warmth, kindness and respect
- Ensuring visitors do not feel judged or assessed
- Providing a calm and non-clinical environment[14]

ICAN is based on the same elements and as seen in Bradford, having the time to work through their crisis and signposting them to further support which allows them to have a better opportunity to manage their own health in the future and preventing problems from escalating.

[13] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Accident-and-Emergency/accidentemergencyattendances-by-age-sex-site

[14] http://www.mindinbradford.org.uk/the-sanctuary Accessed 18/04/2019

Intermediate Outcome 3 – Better able to develop trust in services

Referrals will come into ICAN from triage when it is considered appropriate, but ICAN also will go around the hospital wards offering their services. This is where it was identified that they are in some cases assisting the nurses as they were able to spend time reassuring patients and talking to them, something the nurses might have had to do previously. There were cases of where patient and family members where anxious about their treatments or anxious as they were waiting to be seen by a professional, and the ICAN volunteers were able to empathise and reassure them that they were safe, and that support was available.

"Very warming and trustworthy." Client

Intermediate outcome 4 – Better able to work through crisis

Again, as discussed above, having the time to discuss what was happening was seen as the ultimate positive ingredient that ICAN brought. As many of the health professionals discussed, they would like to give more time to the patients, but due to the pressures of working in ED environment, they can only look at the medical issues.

As the ICAN team could listen and empathise, clients developed a better understanding of what was happening to them and once their crisis had become manageable or passed, many went home without needing to see any of the health professionals. In one case, an elderly gentleman had taken an overdose of paracetamol and was in distress. The ICAN team signposted him to various services that could support with the issues that was causing him distress in his home. As well as this, he was also given information about support that could help with underlying concerns such as support with his hearing as well as coping techniques. His distress levels were

considerably lowered after spending time with the ICAN team, and some of the services he was signposted to will hopefully allow him to manage what was happening in the future.

Intermediate outcome 5 – Manage stress and anxiety better over time

Many of the referrals who came to ICAN had low level mental health concerns and therefore the psychiatric liaison team could refer to ICAN. Similar to the previous intermediate outcome, the ICAN team could empathise with how they were feeling and, in many cases, could draw on their own experiences and provide reassurance. There were many cases of where the supervisors and volunteers offered them some practical advice as well as signposting to other services that could help such as Mindfulness Centre. They also referred them to some self-help support such as apps and videos available that provided guidance and advice.

Outcome – Feeling empowered to deal with the crisis and take steps

A big part of the service is being able to listen and empathise with the client, and then advice and signpost appropriately. These include services such as Citizens' Advice, Shelter, Housing associations, Stepping Stones, CAIS and many more. By having the time to understand what the ingredients of the crisis are, then supervisors and staff can ensure that they can look at services to address the right issue, and not just looking at the medical concerns.

This was backed up by one of the health professionals that took part in the analysis, that said of the case studies she had witnessed, individuals were empowered to realise that "they are the solution to the problem."

One case was discussed of a woman had come into ED from a refuge and was very distressed. She was threatening suicide, but the medical staff felt this was low level risk. She was referred to ICAN while she waited, and they sat with her and they were able to talk with her. As she

wasn't seen as a patient it was empowering as she had options of what she could perhaps do to change the situation.

"Inspiration is so powerful," volunteer

There were case studies where clients were given advice and helped to manage their crisis but who then went on to make big changes in their lives. There was one client who was supported in the centre to write an application form. The successful job application resulted in him becoming employed which is truly life changing. Another client /patient felt so inspired that evening that when he is better, he would like to volunteer with the ICAN team and help others in crisis.

"When you're down, this is a lifesaver, brilliant people." Client /patient

Possible negative impacts

Considering the possible negative outcomes is important to allow ICAN Centres to manage these in the future. Although there isn't enough data available yet to identify any negative results, we can consider these based on the qualitative work.

Dependency

Some of the individuals were dependant on statutory services such as the GP in the past, and some were recognised as frequent attenders which is anyone who is presented to ED at least 4 times in the last month. It is recognised that many attended ED due to non-medical reasons and for some this was due to needing to communicate and have time with others. Ensuring individuals do not become dependent on the ICAN Centres is important. This is managed currently by ensuring that individuals are aware of the short-term contact with them, but that

this leads to a long-term plan by integrating them into current services available within the community.

Further work needs to be done to identify if those who were frequent attenders have reduced the number of ED visits, they make because of the time given by ICAN. There is one case of an individual was attending very often but had reduced the visits significantly due to ICAN.

Inappropriate referrals?

Care must be taken to ensure the ICAN team are used appropriately and for the right reasons. There were cases of where the ICAN team had be asked to support patients who could wonder off as nurses were changing beds for example. Although the volunteers are happy to help at quiet times, it should not be seen as a babysitting service.

Fine line between helping and creating more harm

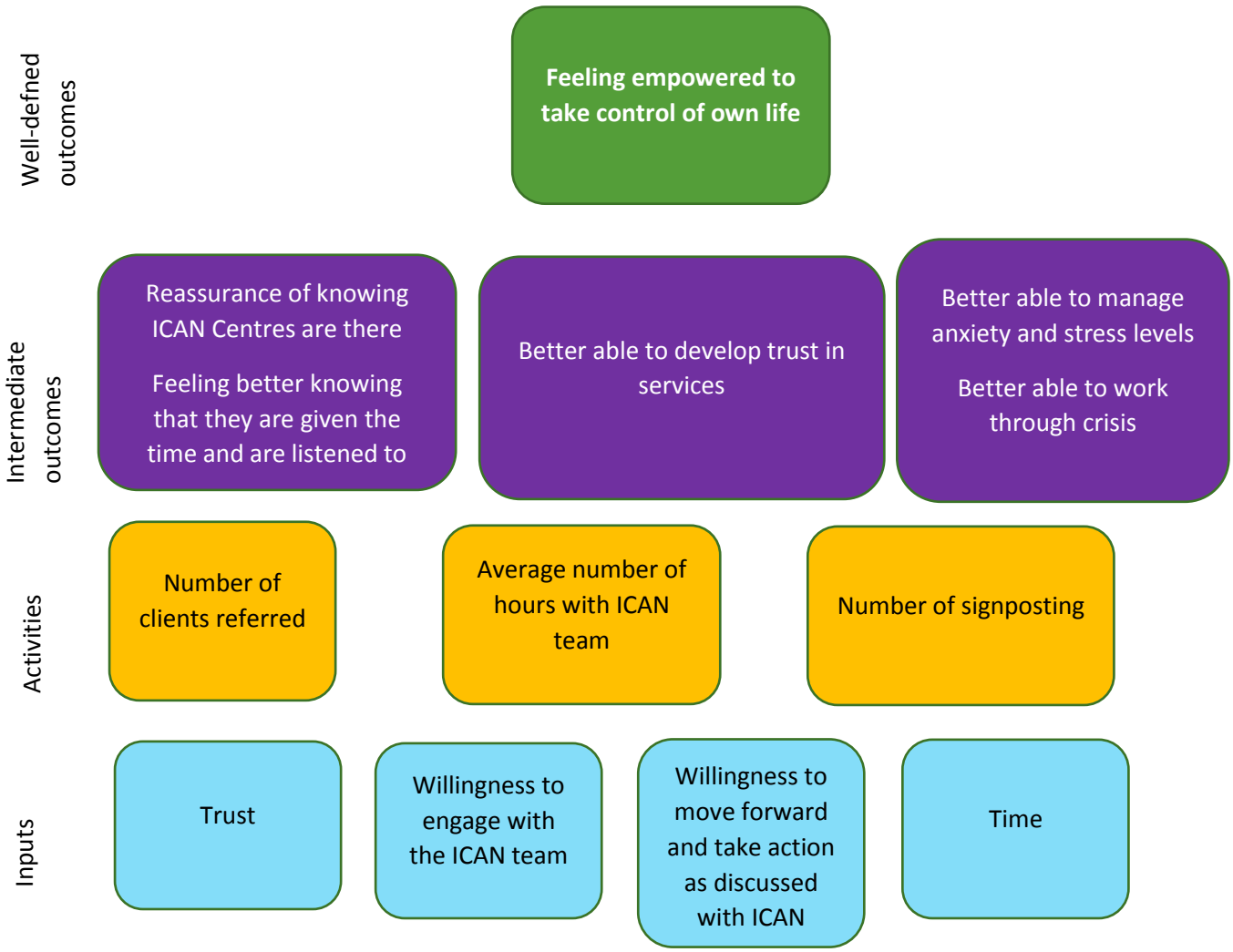
As with many projects or services, this will not work for everybody. However, by raising somebody's expectations and that expectation leading to no change, there is a possibility of somebody feeling worse due to having tried something and not being successful. This can lead to increased feelings of loneliness due to raising expectation, but then creating disappointment when this is not realised. One of the benefits of the service is the bank of knowledge they have as a team about services within the community and therefore able to signpost appropriately. However, consideration should be given as to what happens afterwards if that support isn't in place, can they get back in touch?

There were examples also of where volunteers were concerned if they had given the right advice in the situation and it was recognised by volunteers that there is a fine line between helping or making a problem escalate. However, these cases were rare, but further training and processes

will help to avoid this. There was a good system as to where all supervisors would assess each case but also ensure that no one was left alone and could support if needed. In Maelor, they had a system of allowing the supervisor to know if they needed support but without alarming the client.

Figure 6

Theory of Change Clients /Patients



To contribute to the outcomes recognised through the qualitative and quantitative stages, it's worth noting the outcomes being recorded by ICAN as primary and secondary outcomes. Breakdown of the outcomes from January – March are included below.

Table 6 – Primary outcomes reported by ICAN team

Primary outcome	Jan	Feb	March
Divert ED Physical Health	2	3	1
Divert Ed Physical Health, Safeguarding, Listening & Talking & Advice/signposting	1	2	
Divert Ed Physical Health, Safeguarding, Advice/signposting & referred to Police	1	5	
Divert Ed Physical Health & Safeguarding	1	2	1
Safeguarding, Listening & Taking & Advice/signposting	2	3	1
Did not require any input	1	1	9
Did not require any input & Listening & Talking	4	1	6
Did not require any input, Listening & Talking, Advice/signposting	1	4	
Divert Liaison	1	1	1
Divert Liaison, Listening & Talking & Advice/signposting	3	2	5
Listening Talking	9	1	45
Listening & Talking, Advice /Signposting	28	32	33
Listening & Talking, referred to social services, Advice/signposting	1	43	
Referral to Social Services	1	1	1
Advice/signposting	4	15	3
Referred to NHS services, Listening & Talking, MHS assessment, Advice/signposting	1	1	
Referred to NHS services, Listening & Talking & Advice/signposting	2	1	
Not answered	4	2	

6.2.2 Volunteers

There were different reasons why people decided to volunteer with ICAN. Some had experienced difficulties in their own lives and could empathise with people who were in crisis and needed support. Others were interested in developing their skills and interest in working within health and social care. Some were students at Bangor University or Glyndwr University and needed some practical experience. There are two segments / groups of volunteers therefore than we can consider different outcomes and different results depending on their reasons for taking part, which the data demonstrates. However, here the different outcomes are discussed. Figure 7 demonstrates the theory of change for volunteers.

Outcome 1 – Better sense of personal satisfaction being able to volunteer and being part of a team

During the conversations held with the volunteers, they explained about how good it felt to be part of a team and how they had developed friendships through the programme.

"It's a privilege to work with some of these volunteers."

During the focus group, it was apparent that there was a close relationship between the volunteers and the supervisors and that many felt part of something special. For those who were unemployed or in education, they were able to be part of a team and had opportunities to socialise with others.

100% of volunteers said they had experienced a positive change here with an average distance travelled of 27% on average.

Outcome 2 – Improved skills and experience to work in the sector

Based on those who took part in the analysis, approximately 30% of the volunteers are in education, 23% are unemployed and 15% are employed part time. Some needed practical

experience of working in the sector for their course, and others needed to improve their skills in order to follow a career path in health and social care.

Some of the volunteers who were students explained how they are taught the theory in the classroom, but in order to understand the true nature of this work, ICAN allows them to have real life experience of this field. 55% of volunteers said that they had experienced quite a lot of change in the outcome of 'developing new skills for employment' and 44% had experienced a lot of change in improving their social skills.

Outcome 3 – Maintain own recovery in some cases and or maintain own mental well-being

Many of the volunteers had struggled with mental health difficulties themselves in the past as well as other crisis such as financial or housing crisis. One volunteer explained how in the past she came to the ED department with high anxiety levels and had to wait a long time in a room where she felt she was being judged. She explained that when she learned about ICAN, she could see this was a service that could have helped her by providing a non-clinical, empathetic ear that would have helped avoid further deterioration as she waited for support. Being able to now volunteer with ICAN helps her to feel a sense of satisfaction that she is helping others that are going through what she went through.

In the volunteer questionnaire, 50% of volunteers said there was some change in this outcome with 22% saying they had experienced a lot or quite a lot of change in this outcome.

As discussed, there are various reasons why people give their time to the service, as well as various different backgrounds. During the qualitative interviews, many explained how volunteering gives them a purpose and a routine. Some were retired but still felt they needed to use their skills and wanted challenges, others explained how they were also isolated at time and therefore felt more positive that they were able to contribute to the community.

“If I can help one person then I’ll be happy.”

Negative changes or what could be better

All volunteers were asked during the focus groups as well in the questionnaires about anything negative that might happen as result of volunteering or what they felt could be better.

Emotional energy

Some volunteers hadn’t stayed for very long, and some of the supervisors and volunteers suggested that perhaps this was because of a lack of understanding about what the role might mean or that they found it too much for them emotionally. One volunteer explained how she was faced with a difficult task one evening and found herself questioning whether she had given the right advice. Some of the health professionals also explained how ICAN had at times taken cases away from professionals which saved some of their emotional energy so they can use that elsewhere. However, it is important to consider that some cases can have a negative impact on volunteers and supervisors and therefore appropriate support needs to be available. However, it was apparent that supervisors and management were very supportive and the whole ‘team’ did take care of each other.

Training

When asked during the focus groups and in the questionnaires, what could be better, a high percentage all said they felt they could do with more training at the beginning and on-going. As well as training, they felt they needed more time to shadow supervisors before being given cases themselves. As well as this some felt concerned as to the lack of background checks on some volunteers to deal with very vulnerable people, as well as a lack of processes and clear pathways for referral.

"I feel the project works well but I do think that there needs to be more checks done on volunteers and supervisors. Background, what sort of mental health issues they have that sort of thing. It's shocking how many are working and don't have CRB (DBS) checks and there needs to be more training. There is a lack of (DBS)communication and the way the paperwork and stuff are stored is a bit shocking."

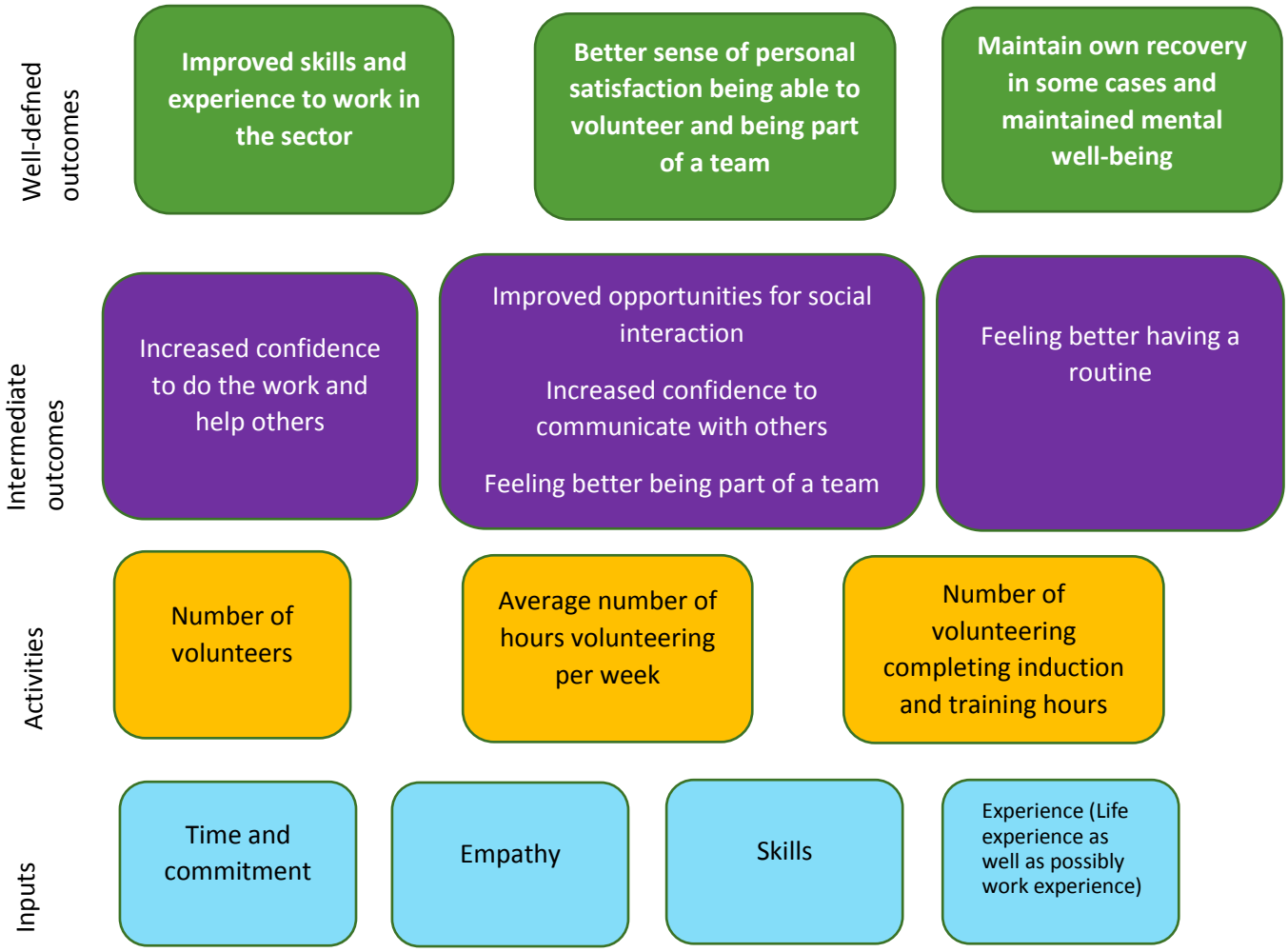
Some also expressed how they need role specifications that allowed them better understanding of what was required from them.

Space

At all three sites, space was considered an issue. In Gwynedd they were close to the ED department but felt the room itself wasn't appropriate as porters were coming past and no area for any confidentiality. In Glan Clwyd and Maelor, they were far from ED and therefore the supervisors needed to collect patients and walk with them some distance before they could start supporting. However, some did note the advantage of having the time to reflect and assess who best to deal with the situation.

Lack of resources was also considered a disadvantage such as storage, IT resources and display boards. If ICAN is really to be incorporated they need the right space and resources, but particularly the right space.

Figure 7 - Theory of Change Volunteers



6.2.3 Supervisors

During the focus groups and in the survey results, the outcomes experienced by those who are supervisors were similar to those who are volunteers. Consideration was given as to include these in the value map having considered the materiality test, that is are they relevant and significant changes. As the supervisors are being employed and paid for each shift, then consideration will also need to be given to the deadweight and attribution – that is could they experience the same change doing another role.

The theory of change for the supervisors is the same as for the volunteers. The difference is that many of the supervisors are more experienced in the line of work, however, many still noted a big change in improving their skills for employment. In the survey results, 88% said they had experienced change in the outcome of improved skills for employment, with an average distance travelled of 67%.

Similar to that of the volunteers results, 100% of the supervisors who answered the survey said they had experienced change in the outcomes of 'better personal satisfaction of from being able to help others', and as many said in the focus groups, this had provided them with a purpose and enjoyment that other roles couldn't fulfil.

The two outcomes above are therefore included in the map for the supervisors.

6.2.4 BCUHB

Reduced demand on services

All outcomes for BCUHB relate to the potential for cost reallocation related to avoided demand on services. The main objective of the service is to reduce the pressure on statutory services by supporting those who present themselves to ED who may not require immediate medical support but are facing a crisis at that time. The material outcomes for the individuals will therefore have an impact on services, and evidence from this analysis and from other previous studies was used to make conservative estimates.

The purpose of this interim report is to capture what has occurred already based on engaging with stakeholders, but any data presented in the value map is based on judgment and secondary research but should be used for discussion. Further data collection should take place between May 2019 and March 2020 to ensure greater confidence in any results. I should be

noted again that this interim report covers just a four-month period. Any reduction in demand does not imply that any health professionals now have more free time during their shift or that any actual cash savings have been identified but refers more to the reallocation of services and reduces waiting times for some patients.

A theme that emerges through this analysis is time. The individuals' needs time to engage with people due to their emotional needs. Feeling isolated and lonely for various reasons, many engaged with services as they need to communicate with someone and need reassurance from others. However, due to increased pressure on services, time is something that is limited for the health professionals on duty; they are therefore unable to give them the time to carefully identify the core of the individuals' issues. By having more time to engage, ICAN is able to gain an understanding of their needs and to find suitable solutions which hopefully reduces demand on the health professionals.

Reduced demand on out of hours GP

It is too early to have any real objective data to see if there is a reduce in demand on their time. Having engaged with all stakeholders, some case studies were provided of where ICAN was able to offer support and communicate with clients whereas previously the GP would have needed to do this. For example, there was one case study of where the GPs would need to spend time on the phone most evenings with a patient who had high anxiety levels. The ICAN team was able to take over the calls with this patient at the time and following this the out of hours GPs hadn't heard from the patient in some time, although they were unsure as to the reasons at the moment. This is one example of how the ICAN team can reduce the time spent by the GP who can reallocate their resources elsewhere. As the health professional explained, this is not just about the time saved, but also the amount of emotional energy that each call like that will take,

"I think it's meeting a gap which hasn't been met previously and it can reduce the demand on services."

For the purpose of the interim report and the value map – 120 hours saved across North Wales is given, which corresponds to an hour per evening, but across all sites.

Reduced demand on Psychiatric Liaison team

Psychiatric Liaison teams provide mental health assessments for inpatients and also patients who present themselves to the ED department. In some hospitals, members of the ICAN team will now walk around wards with the practitioners. In Glan Clwyd there are usually two practitioners on duty each evening and any mental health admissions would need to be assessed by them. If the practitioners identify someone as low mood, then they will refer to ICAN to sit with them, so they are not sitting in the waiting area and symptoms deteriorating. There were some cases where the clients went straight home after seeing ICAN as they had worked through the crisis.

In Bangor and Wrexham, referrals will come straight from triage and therefore patients are not first assessed by the psychiatric liaison team.

Reduced demand on nurses' time at the wards

ICAN have also started to work on the wards during their shift. Here they are able to provide support for any patient in distress as well as offer assistance to the nurses when needed. There were case studies of where ICAN had spent a lot of time with emotionally distressed patients as well as reassuring patients and family members. Previously, a nurse would have had to spend some time doing this, but in some cases perhaps the patient would have had to be left in distress, perhaps causing some deterioration.

Reduced number of people attending ED in crisis

Currently, the data doesn't identify any reduction in the number of people presenting themselves to ED based on comparing this year's data to 2018. However, further work can be done to identify if there is any impact on some of the patients identified as frequent attenders as well as differences in waiting times. Looking at other similar services such as 'The Sanctuary' in Bradford, they have identified outcomes such as reduced number of people attending A&E when in crisis and reduction in the amount of people wanting to be seen with mental health emergencies. There was also a reduction in the amount of police cells being used as places of safety. However, as this is a community-based service, those in crisis will be going to the Sanctuary instead of ED, whereas with ICAN they will still need to be identified by triage. The difference therefore might be seen more in the longer-term results as well as reducing waiting times and therefore further analysis needs to happen here. Over time, other indicators can also be considered such as ambulance waiting times.

What could be better?

It is recognised that each hospital site will have some variances in the way that they work and in how the ICAN teams are embedded into the hospital operation. However, a clearer pathway would be beneficial as there are variances across each site. In Wrexham, the ICAN team will sit in ED and will offer support to clients whilst waiting to be discussed by triage. In Wrexham also, patients who have been seen before can call the hospital and be transferred to the ICAN team to discuss their concerns, something that wasn't seen in Ysbyty Gwynedd and Glan Clwyd.

Since the project was set up, they are now working on all the wards also and this needs to be recorded. Having a clearer pathway and routine would allow Supervisors and Volunteers to visit different sites if needed and adopt the same ways of working.

7.0 Valuing Outcomes

The difference between using SROI and other frameworks is that it places a monetary value on outcomes. By using monetisation, it allows us to not only to give the story of what's changed in people's lives, but also allows us to put a value on those changes so we can compare costs and outcomes. This isn't about putting a price on everything, but it allows us to demonstrate what impact the service has on other stakeholders, and the possible savings an intervention can create. It also goes beyond measuring and allows organisations to manage their activities to ensure the best possible impact is created for those that matter to them the most: the individuals.

7.1 Impacts of ICAN Centres

SROI analyses use accepted accounting principles to calculate the overall impact of activities. Taking into account any deadweight, attribution, displacement and drop-off factors means that SROI analyses will avoid over-claiming value that is not a result of the activities. The boxes below outline each of the impact factors.

Deadweight

This asks what is the likelihood that an outcome could have occurred without an activity taking place. So, for example, if it is believed that there was a 10% chance that someone could have found work without a training programme, the value of that outcome is reduced by 10%.

Attribution

Considers what proportion of an outcome is created by other organisations/individuals, so this can therefore not be legitimately claimed by the SROI analysis. For example, if external agencies also support someone receiving training, those organisations are responsible for creating some of the value, not just the training organisation.

Displacement

This asks if an outcome displaced similar outcomes elsewhere. This is not always a necessary impact measure yet must be considered. For example, if a project reduces criminal activity in one area which results in increases in other locations, there is a need to consider the displaced outcomes.

Drop-off

Outcomes projected for more than one year must consider the drop-off rate. This is the rate at which the value attributable to the focus of the SROI analysis reduces. For example, an individual who gains employment training may, in the first year of employment, attribute all of the value to the training organisation, but as they progress in their career less value belongs to the initial initiative owing to their new experiences.

7.1 Stakeholder 1 – Clients / Patients

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 that these do not represent the value that the particular stakeholder with experience of the change would attribute to it. Due to the time constraints i.e four months, and the confidentiality of the service, clients were not able to prioritise outcomes for this interim report. This is why only one outcome is included in the value map that of 'feeling empowered.'

The valuations for the outcomes identified to the individuals were taken from HACT'S Social Value Calculator (version 4)[15] that identifies a range of well-being valuations. However, the data from the survey monkey questionnaire provided a distance travelled on how much change had been experienced, therefore a proportion of the wellbeing valuations were used accordingly.

Value was placed only on the one well-defined outcome for clients which was 'feeling empowered to deal with the crisis and take steps', and the well-being valuation from HACT social value calculator -Feel in Control of life (health) was used which has a value of £15,894 per individual. Following the principle of not over-claiming, we only took the amount of value that represents the amount of change. For those with a positive change, there was a

[15] Community investment and homelessness values from the Social Value Bank, HACT and Simetrica (www.hact.org.uk / www.simetrica.co.uk). Source: www.socialvaluebank.org. License: Creative Commons Attribution-NonCommercial-NoDerivatives license(http://creativecommons.org/licenses/by-ncnd/4.0/deed.en_GB)

distance travelled of 62%, and therefore that percentage of the value was used in the value map, which gave a value of £9,854. However, also as we were only able to engage with a very small sample, consideration was only given to 25% of the patients that's been supported by ICAN.

Consideration was given to the recommendations provided in the guide published by HACT[16] on how the values should be applied. Each outcome is related to a specific question from larger national survey dataset, and where possible the relevant question should be applied. For the outcome of 'feeling in control of life', the related question is 'I feel that what happens to me is out of my control' with a choice of often, sometime, not often or never. For this analysis, the main reason for the referral was concerns with mental health, and therefore the scale expanded on this question to understand how much change had happened.

The guide recommends that users follow the following key principles;

- Report the actual number of people that the activity works with
- Do not overclaim
- Clearly explain any judgments or assumptions.

This corresponds with the social value principles and therefore great care was taken to incorporate these at every stage, but especially when applying the financial values. As demonstrated above, only the appropriate amount of value was taken based on the percentage of change (62%).

[16] Trotter, L. Vibe, J. Leach, M. Fujiwara, D. (2014) Measuring the Social Impact of Community Investment: A Guide to using the Wellbeing Valuation Approach. HACT.

Consideration was also given to presenting the results based on different segments. As the data was limited for this interim report, further analysis will be done during the next 11 months to identify more insights based on characteristics.

7.2 Volunteers and supervisors

Where possible, this analysis has applied the first SROI principle to involve stakeholders as much as possible. During the qualitative interviews with volunteers and supervisors, following an understanding of the changes and the outcomes gained, clients were asked to rank and rate their outcomes. This was also asked in the quantitative surveys. 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.

The valuations for the outcomes identified to the volunteers and supervisors were taken from HACT'S Social Value Calculator (version 4). However, the survey provided to the volunteers through Survey Monkey provided a distance travelled on how much change was experienced.

The possible outcomes were first identified through the focus groups. They were then asked to choose for each change one of the following;

- Doesn't apply to me
- A little change
- Some change

- Quite a lot of change
- A lot of change

The results can be seen in the value map in appendix 2. This identified the average movement which could then be applied to assess the equivalent value. For the three material outcomes for volunteers identified, 100% of the volunteers engaged with had experienced some form of change, however, as previously stated we only took a percentage of that change.

As well as asking them to say how much change had happened, we needed to gain an understanding of how important those changes were. The outcome of 'Better personal satisfaction through volunteering and being part of a team' was experienced by all volunteers who took part with an average distance travelled of 27%. This was also weighted higher than the other outcomes. For this outcome and the well-being valuation from HACT social value calculator -Regular volunteering was used which has a value of £3,249 per individual.

This value is our anchor value, and from here the weighting of the outcomes was then used to value all three outcomes as can be seen in this table.

Volunteers

Outcome	Weighting	Value
Better sense of personal satisfaction by volunteering	6	£877
Improved skills for employment	5	£730
Maintain own recovery in some cases and / or maintain own mental well-being	4	£584

Supervisors

Outcome	Weighting	Value
Improved skills for employment	8	£1,188
Better sense of personal satisfaction by volunteering	7	£1,039

For the supervisors, they placed a higher value on some of the outcomes as can be seen in the table. However, a lesser value was used looking at HACT for regular attendance at voluntary organisation. Although they are based within BCUHB, the service is identified as third sector support. This was valued at £1,773 per individual but only taking the distance travelled of 67% per individual as seen in the table.

7.3 Health costs

To put a value on the reduced potential demand on the NHS, the published Unit Costs Health and Social Care 2018, by PSSRU[17] was used.

Considering the purpose of establishing ICAN, the aim to offer a more integrated seamless support for patient who are presented to ED with mental health issues, but also to provide support for health care professionals who are working against a growing demand. Although it is only over time that data will be able to demonstrate any real impact on services, by engaging with all stakeholder's consideration can be given as to the impact on these. What was apparent is that the ICAN team was a welcomed contribution to the hospitals and that staff at the hospital saw them as a valuable service that allowed more time to be given to the patients to understand more of the route problems, that weren't medicalised.

When patients are presented to ED, they will be assessed by triage in order to understand and prioritise patients as is needed and decide the order of treatment. All mental health assessments will be considered by the Psychiatric Liaison teams. Appropriate referrals can then be made to ICAN. As well as this the ICAN team will present themselves at the wards and offer

[17]Curtis, L.& Burns, A. (2018) Unit Costs of Health and Social Care 2018. PSSRU.

assistant to the nurses where needed if the patients would benefit from engaging with the supervisors and volunteers.

Again, there is lack of data yet to be certain of any impact. Any assumptions made here are made for discussion based on case studies. It is also worth noting that any suggested savings does not mean that we are seeing actual cash saving or that health professionals are now quitter, it means that their resources can be allocated elsewhere where perhaps the need are greater.

For the purpose of this report, the following health costs were considered;

Health service	Cost
Out of hours GP time	£108 per hour
Psychiatric Liaison Practitioner	£109 per hour
Nurses time	£28 per hour
Cost of ED visit	£134 per visit
Ambulance – see, treat and refer	£184 per call

This is a forecast report and 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.

Table 7 – Examples of Outcome Valuations

Outcome	**Identified value-** all monetary values represented as per person per year'	**Value of average distance travelled**	**Quantity of stakeholders experiencing outcome**
Feeling empowered to work through crisis and take actions	Used HACT Feeling in Control of Life, talking to neighbours regularly valued at £15,894 for unknown area. Took 62% of this value based on the distance travelled, therefore £9,854.	Taking the lowest point for our questionnaire scale – asking individuals to rate against measures (not applicable / no change =0%, little change = 25%, some change = 50%, quite a lot of change = 75%, a lot of change = 100%). The average movement was equals 62%. Although based on small sample size the results were in line with the tone of interview comments – this was cited as an extremely significant change.	Based on the principle of not over claiming, only 25% of clients were reported as experiencing change here and therefore 107 clients.
Volunteers: Better personal satisfaction by volunteering and being part of a team	Used HACT well-being valuation for Regular Volunteering valued at £3,249 for unknown area. Took 27% of this value based on the distance travelled, therefore £877**.**	Taking the lowest point for our questionnaire scale – asking individuals to rate against measures (not applicable / no change =0%, little change = 25%, some change = 50%, quite a lot of change = 75%, a lot of change = 100%). The average movement was equals 27%. Although based on small sample size the results were in line with the tone of interview comments – this was cited as an extremely significant change	From the data from the second review, 100% had experienced change here, so 54 volunteers.
Supervisors: Improved skills for employment	Used HACT well-being valuation for Regular attendance at voluntary organisation valued at £1,773 for unknown area. Took 67% of this value based on the distance travelled, therefore £1,188**.**	Taking the lowest point for our questionnaire scale – asking individuals to rate against measures (not applicable / no change =0%, little change = 25%, some change = 50%, quite a lot of change = 75%, a lot of change = 100%). The average movement was equals 67%. Although based on small sample size the results were in line with the tone of interview comments – this was cited as an extremely significant change	From the data from the second review, 88% had experienced change here, so 9 supervisors.

NHS: Reduced potential demand on service – psychiatric liaison	£109 per hour from PSSRU Health and Social Care Costs 2018.	Considered one hour per evening of ICAN across all sites therefore 120 hours * £109	

8.0 Establishing Impact

In order to assess the overall value of the outcomes of ICAN Centres 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.

8.1 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.

The Psychiatric Liaison Team within the BCUHB will refer individuals to the ICAN project as required. Consideration is given to other crisis support available within the community including The Samaritans service which is based at Parc Menai in Bangor which offers face to face support, however the take-up rate is very low. Other sources of immediate support include helplines and NHS 24/7 offering mainly telephone support. There is a possibility that individuals could have been signposted to these services elsewhere.

One client /patient expressed how he had been referred to different places in the past but didn't feel it offered a long-term solution like this project did.

Through the interviews with individuals and other stakeholders, and the results of the second review, a reasonable estimate is given in Table 8 below.

Table 8 – Deadweight Value

Outcome	Deadweight	Justification
Clients – Feeling empowered to work through crisis and take action	30%	The services that the individuals are now, or will be, engaging with are already available within the community, so some deadweight percentage must be considered. However, barriers that had restricted them in the past meant it wasn't possible for them to use those services, so this project helped to break down those barriers to ensure positive change was created.
Volunteers – all outcomes in value map	30%	There is a chance that this outcome could have happened anyway through another activity or another organisation, so a 30% deadweight is given.
Supervisors – all outcomes in value map	30%	It is possible that other organisations could have given the same advice, that would have had a similar impact, or family and friends could have helped. However, barriers that had restricted them in the past meant it wasn't possible, so this project helped to break down those barriers to ensure positive change was created.

8.2 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.

Volunteers were asked specifically about how much of the changes were down to this project:

Question 14. How much of those things that have changed in your life since joining the scheme are down to ICAN, what is the likelihood that you would have experienced the same changes by volunteering elsewhere? (other people and organisations may have helped you)

The answers to this question in the questionnaire seemed to vary. However, in ICAN centre focus groups at all three sites it was identified that volunteers felt that the volunteering opportunity that was provided gave them personal satisfaction and in some cases for students an opportunity that they would struggle to get elsewhere.

This pilot project has a very short contact time with the individual, who then leave feeling better or are signposted for further support.

An attribution of 30% is given to all three values for volunteers and supervisors:

- Better sense of personal satisfaction by volunteering;
- Improved skills for employment;
- Maintain own recovery in some cases and or maintain own mental well-being.

Acknowledgment is given to the contribution of other such as the support from the University for those volunteers in education, and also for some, they are employed in a health and social care organisation.

In terms of the clients that visit ED departments, we have limited data around the value of the service to them but many volunteers that were interviewed in either focus groups or by online questionnaires mentioned that clients 'felt empowered' by the service. This was also confirmed in the client survey:

'*I feel more empowered now as I am more informed about my options or where I can get support.'*

A value of 30% was given for this project for clients /patients – again to acknowledge the contribution of other organisations and to not overclaim.

8.3 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 Health Board and provides a link to all other services, and therefore does not displace anything.

8.4 Drop-off

The aim of the project is to support clients /patients who present themselves to ED when in crisis. It should allow individuals to be able to manage better in the long-term and to ensure that they engage with services within the community as an alternative to medicine.

As this is a pilot and as engaging with clients /patients for a long time after their visit is difficult, the value map will only consider one year of value, and therefore no drop off rate is included.

9.0 SROI Results

This section of the report presents the overall results of the SROI analysis of the ICAN service provided by BCUHB. 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 ICAN Centres makes through the dedication of staff and volunteers to create a positive change in the lives of those admitted to ED in crisis, and also how that has an impact on demand in services.

By giving clients /patients the time to explain what is the cause of their crisis, and to reduce possible restrictions they have experienced in the past to access local based services, the ICAN team can ensure appropriate signposting is provided to allow them to make better informed decisions and allow them to better understand what it is they are experiencing. This led to some positive changes instantly, but we forecast that this will continue to improve over time for some.

Table 9 displays the present value created for each of the included stakeholders who experienced material changes. The present value calculations take account of the 3.5% discount rate as suggested by the Treasury's Green Book.

Table 9 - Total Present Value Created by Stakeholder

Stakeholder	Value created as a result of ICAN Centres per person per year	Proportion of total value created
Clients / patients	£516,660	89%
Volunteers	£41,560	7%
Supervisors	£10,838	2%
BCUHB	£13,582	2%

The results in Table 10 indicate a positive return for individuals who were referred to the ICAN and experienced positive outcomes. This is based on current data but also forecasting results based on secondary research.

Table 10 - Present Value Created per Individual Involved

Stakeholder	Average value for each individual involved
Clients / Patients	£1,305

The overall results in Table 11 highlight the total value created, the total present value (discounted at 3.5%), the net present value, and ultimately the SROI ratio.

Table 11 – SROI Headline Results

Total value created	**£**
Total present value	£557,529
Investment value	£109,957
Net present value (present value minus investment)	£447,572
Social Return on Investment	**£5.07:1**

The result of £5.07:1 forecast that for each £1 of value invested in the ICAN centres, a total of £5.07 of value will be created. Caution should be taken with this result as this is a forecast based on engaging with stakeholders during the four-month interim period.

10.0 Sensitivity Analysis

The results demonstrate highly significant value created by the ICAN Centres provided by Betsi Cadwaladr University Health Board and are 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 a 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 12.

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 clients /patients. This could be because of the relatively high value given to this outcome. Again, the sensitivity test uses a relatively large change, and needs to be carefully manage this issue in the future.

As seen in section 8, different steps were taken to support the assumptions for the deadweight and attribution percentages. From the sensitivity analysis table on the following page, the social value evaluation can be estimated to be between £2.37 and up to £9.07 for every £1 invested if we consider 50% of the clients /patients having positive change. The assumptions used in the value map estimate the social value is £5.07.

Table 12– Sensitivity Analysis Summary

Stakeholder	Outcomes	Sensitivity testing	SROI Ratio	Difference	Variance
Clients / patients	Feeling empowered to deal with the crisis and take action	Change number of clients from 25% to 20%	£4.14	-£0.93	18.3%
		Increase deadweight from 30% to 60%	£3.12	-£1.95	38.4%
		Change financial proxy to £4,000	£2.37	-£2.70	53.2%
		Change duration from 1 years to 2 year	£9.77 £5.15 when drop off of 50% added	+£4.70	92%
Volunteers	Better sense of personal satisfaction by volunteering	Change % of clients experiencing change to 50%	£4.97	-£0.10	1.9%
		Change attribution from 30% to 60%	£4.98	-£0.09	1.7%

	Maintain own recovery in some cases and or maintain own mental well-being	Change financial proxy to £250	£5.03	-£0.04	0.7%
Supervisors	Improved skills for employment	Change deadweight from 30% to 60%	£5.05	-£0.02	0.3%
		Change financial proxy to £500	£5.04	-£0.03	0.5%
		Change attribution from 30% to 90%	£5.03	-£0.04	0.7%
BCUHB	Reduced number of hours for GP's out of hours	Change number of hours from 120 to 60	£5.04	-£0.03	0.5%

11.0 Conclusion

This report has demonstrated that the ICAN Centres pilot will create over £557,000 of value, and for each £1 invested, £5.07 of value was created;

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

By having ICAN supervisors and volunteers based within ED departments in Ysbyty Gwynedd, Ysbyty Glan Clwyd and Ysbyty Maelor it provides an integrated service for those presented to ED facing mental health crisis. Already within four months, the service is being utilised like any other hospital service and patients being referred to the ICAN team when appropriate.

The clients /patients expressed their reassurance of working with a service that was unique

with empathetic volunteers who understand what they were going through, and who empowered them to create changes in their lives through appropriate signposting.

Key finding includes;

• For every £1 invested, £5.07 of social value will be created it is forecast.

• Based on a small sample and some case studies, clients had experienced quite a lot of change in feeling more empowered to manage their crisis and take actions.

• 100% of clients /patients that completed survey said they felt they were better able to cope with what they were going through at the time because of ICAN

• 100% of volunteers have a better sense of personal satisfaction in being able to help others, and many had also seen positive changes in their own skills for employment and their own mental well-being.

• The model of having volunteers based within ED who are able to spend time and listen to patients and ensure their needs are central to all planning and adheres to the needs identified within the new legislative framework in Wales.

12.0 Recommendations

ICAN is a new service in north Wales and this is an interim report to evaluate the first four months pilot and to provide recommendations for the next 11 months. Much has happened over four months and the programme has been successful in recruiting a lot of interest by those who wish to volunteer.

The recommendations we give to ICAN are as follows.

1) **Data collection** – in order to realise how much change and impact the ICAN service is having on all stakeholders we need data to understand if there is any change, but also how much change, and whether there are differences in the needs of different individuals. It is therefore recommended that any continuation of this scheme, needs to **invest the time and finances into ensuring suitable systems and processes are in place to measure social value**, and also to extend this to include other important stakeholders. When such data is collected over a period of time, the potential to use the resultant information to inform decision making is possible. Ultimately, this means that value is not just being measured, but it is being managed to improve the impacts of the project.

   Alongside this report, Social Value Cymru will work with the ICAN administrative Officer to ensure the right data collection is in place to gather data from clients / patients where appropriate as well as the volunteers and supervisors. We will also work closely with BCUHB in order to ensure that data is being collected to identify the impact on their services to understand any change in demand.

2) **Stakeholder engagement** – Connected to the previous recommendation, continuous stakeholder engagement is essential to ensure we are collecting the right data, but also to allow stakeholders to influence any change. They are best placed to confirm any changes, and therefore in order to confirm the theory of change further volunteer focus groups and interviews with clients / patients will need to take place. Initially, contacting the clients wasn't possible but as there are now consent forms given, for those who wish to provide feedback, they can now be contacted. Consideration will be given to ensuring a representative sample is involved so we get any insights if there are any differences in the need of the clients or volunteers based on characteristics. For example, we already have some insights that there are differences in the results for volunteers who are taking part due to wanting to further their careers compared to those who are volunteering as they have experienced similar difficulties in their own lives and wish to help others. Further understanding of these insights can help us to manage services better.
3) There have been comments by stakeholders about how ICAN could possibly be based within the community. The service has only been in place for four months, but there was agreement by all stakeholders that there was a need for ICAN and that it was making a difference in ED departments as well as on the wards. However, as all clients / patients still need to go through triage, then it can be considered that the service could have a bigger impact on ED visits and waiting times if based in the community? Considering the 'Sanctuary' [18]in Bradford, having the space within the community had

[18] Cook, J. O'Brien, D. Alternative Places of Safety. October 2017

seen reduced number of police cells as places of safety and also reduced number of people attending A& E in crisis.

Over the next few months, further data can be collected to understand the impact on demand on services within the hospital. As discussed, there is agreement that ICAN is a welcomed service within the hospital sites based on our stakeholder engagement. According to the ICAN manager, it is already being accepted as part of the service, almost in the same way as someone would be referred for an x-ray, they can be referred to ICAN. Consideration can be given in the future perhaps as to how the service can develop further and have centres outside the site where clients can self-refer or where the Police can refer people without taking them to ED.

4) The service is currently available from 7p.m. until 2a.m. However, it is understood at the time of writing this that most volunteers now finish at 12a.m. as between 1-2a.m. tends to be quieter which creates greater flexibility for the volunteers. Many of the stakeholders, including health professionals, expressed a need for the ICAN to be available for a longer period of time, which is an indication of how well the service is received and the need for the service. They felt a gap between 5p.m. and 7p.m. especially as many of the other services available such as the Community Mental Health Teams are not available after 5p.m. Longer hours would of course mean greater costs for BCU in employing supervisors and volunteers. Many of the volunteers also work, however earlier shift may open up the possibility of new volunteers. Again, further data is needed over the next 12 months to understand more about the impact and the need, but consideration can be given to extending the time where ICAN is available if that will provide a greater change on reducing demand on statutory services.

5) **Route of referral** – Initially, it was our understanding that all referrals came through triage, and that any mental health assessment would first be assessed by psychiatric liaison. However, it was apparent that referrals could now come directly through the wards and at one site people could be transferred directly to ICAN by telephone also through the hospital switchboard. Clearer understanding about referral routes needs to be in place.

6) **Training** – The majority of volunteers, supervisors and health professionals that took part in this analysis agreed that more training was needed. Many felt that the induction wasn't sufficient and that they needed more time to shadow other supervisors or volunteers before being left to support others. Although the teams seemed to be well established with supervisors able to identify which skills to utilise well in different scenarios, consideration can be given to formalise this process. Some expressed concerns that there wasn't enough check on volunteers beforehand, with some expressing concerns about some of the volunteers own needs.

   However, at the time of writing this it is understood that more training courses are now being offered to ICAN through BCU such as Dementia training, first aid and others. Changes is also been put in place as to how volunteers are given supervision as well as a more formal process with safeguarding issues. Supervisors and volunteers need to have DBS checks to ensure the safety of clients / patients, but also to protect members of the ICAN team.

   The lack of training initially perhaps reflected in that there were many volunteers who didn't go on to volunteer either after indication or after their first shift. Some felt it wasn't what they expected or hadn't realise perhaps how emotional or heavy some of the cases might be and were not prepared for that.

Some of the volunteers and supervisors expressed how having a listening ear, empathy and life experience was what made a good volunteer and that no training could prepare someone to volunteering with ICAN. Personal characteristics would definitely be important, but it was agreed that all that some formal training was needed to ensure the right systems was in place.

7) **Homelessness** – According to the administrator, 10% of all clients who visit ICAN are homeless, although it is not being formally identified on the current client forms. There is an opportunity here perhaps to gather further understanding of this over the next few months, and to create partnerships with homeless charities. There were case studies of where ICAN had helped clients into temporary accommodation, a case study that was also mentioned by one of the health professionals.
8) **Space** -At all three sites, space was considered an issue. In Gwynedd they were close to the ED department but felt the room itself wasn't appropriate as porters were coming past and no area for any confidentiality. In Glan Clwyd and Maelor, they were far from ED and therefore the supervisors needed to collect patients and walk with them some distance before they could start supporting. However, some did note the advantage of having the time to reflect and assess who best to deal with the situation. Lack of resources was also considered a disadvantage such as storage, IT resources and display boards. If ICAN is really to be incorporated they need the right space and resources, but particularly the right space.
9) **Marketing** – It takes time internally and externally to ensure a new service takes its natural place and that people become aware of the service. Many of the health professionals commended the staff and supervisors about introducing themselves and explaining what their purpose was and reminding them they are there to offer support.

Some have commented on how marketing can be better externally so people are aware that the service is there, but as all clients would need to go through triage then there is a risk of people presenting themselves directly to ICAN if this were to be done.

13.0 Appendices

Appendix 1 – Clients /patient Survey

CAN client survey

ICAN Client Questionnaire

Question Title

1. Which centre did you visit?

- Ysbyty Gwynedd Hospital
- Ysbyty Glan Clwyd Hospital
- Ysbyty Maelor Hospital

Question Title

2. Gender

- Male
- Female
- Other
- Do not want to say

Question Title

3. Age

- 18 - 30
- 31 - 40
- 41 - 50
- 51 - 60
- 61 - 70
- 71 - 80
- 80+

Question Title

4. What is your current status?

- Full time employment
- Part time employment
- Unemployed
- Retired
- In education

Question Title

5. What changed for you as a result of the support you received from ICAN?

	Doesn't apply to me	A little change	Some Change	Quite a lot of change	A lot of change
I feel reassured that ICAN is there to support	I feel reassured that ICAN is there to support Doesn't apply to me	I feel reassured that ICAN is there to support A little change	I feel reassured that ICAN is there to support Some Change	I feel reassured that ICAN is there to support Quite a lot of change	I feel reassured that ICAN is there to support A lot of change
I felt better having somebody giving me the time and listening to me	I felt better having somebody giving me the time and listening to me Doesn't apply to me	I felt better having somebody giving me the time and listening to me A little change	I felt better having somebody giving me the time and listening to me Some Change	I felt better having somebody giving me the time and listening to me Quite a lot of change	I felt better having somebody giving me the time and listening to me A lot of change
I feel I have more trust and understanding in other services	I feel I have more trust and understanding in other services Doesn't apply to me	I feel I have more trust and understanding in other services A little change	I feel I have more trust and understanding in other services Some Change	I feel I have more trust and understanding in other services Quite a lot of change	I feel I have more trust and understanding in other services A lot of change
I felt I was better able to cope with what I was going through at the time	I felt I was better able to cope with what I was going through at the time Doesn't apply to me	I felt I was better able to cope with what I was going through at the time A little change	I felt I was better able to cope with what I was going through at the time Some Change	I felt I was better able to cope with what I was going through at the time Quite a lot of change	I felt I was better able to cope with what I was going through at the time A lot of change
I feel more empowered now as I am more informed about my options or where I can get support	I feel more empowered now as I am more informed about my options or where I can get support Doesn't apply to me	I feel more empowered now as I am more informed about my options or where I can get support A little change	I feel more empowered now as I am more informed about my options or where I can get support Some Change	I feel more empowered now as I am more informed about my options or where I can get support Quite a lot of change	I feel more empowered now as I am more informed about my options or where I can get support A lot of change
I feel less stressed/anxious/depressed	I feel less stressed/anxious/depressed Doesn't apply to me	I feel less stressed/anxious/depressed A little change	I feel less stressed/anxious/depressed Some Change	I feel less stressed/anxious/depressed Quite a lot of change	I feel less stressed/anxious/depressed A lot of change

	Doesn't apply to me	A little change	Some Change	Quite a lot of change	A lot of change
I feel less isolated	I feel less isolated Doesn't apply to me	I feel less isolated A little change	I feel less isolated Some Change	I feel less isolated Quite a lot of change	I feel less isolated A lot of change

Other (please specify)

Question Title

6. Is there anything that you would like to see being done differently or/and what could be better?

Question Title

7. If you have any other comments about the scheme, please feel free to include below.

Done

Appendix 3 – Volunteer and supervisor survey

CAN

iCan Volunteer Questionnaire

Question Title

1. What site do you volunteer at?

- Ysbyty Gwynedd Hospital
- Ysbyty Glan Clwyd Hospital
- Ysbyty Maelor Hospital

Question Title

2. Please state if you are a volunteer or a supervisor with ICAN?

- Volunteer
- Supervisor

Question Title

3. How many evenings a week do you volunteer or supervise with ICAN?

Question Title

4. Gender

- Male
- Female
- Other
- Do not want to say

Question Title

5. Age

- 18 - 30
- 31 - 40
- 41 - 50
- 51 - 60
- 61 - 70
- 71 - 80
- 80+

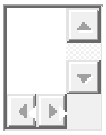
Question Title

6. What is your current status?

- Full time employment
- Part time employment
- Unemployed
- Retired
- In education
- If you answered , 'in education' is the volunteering a requirment for your studies?

Question Title

*7. How did you hear about the ICAN project?



Question Title

8. What were the main reasons for becoming involved with the ICAN? (select as many options as appropriate)

- [ ] Wanted to gain more experience and skills in this area of work
- [ ] No other opportunities available
- [ ] To meet new people
- [ ] Personal development
- [ ] Wanted to help others
- [ ] Other (please specify)

Question Title

9. What were you hoping to get from volunteering or working with with the ICAN project?

Question Title

10. Before joining the ICAN scheme, were you, or are you still a regular volunteer with another scheme?

- ○ Yes
- ○ No

Question Title

11. What has changed for you because of volunteering or working with ICAN? Please tick the box that best describes your experience.

	Doesn't apply to me	A little change	Some Change	Quite a lot of change	A lot of change
I have developed new social skills	○ I have developed new social skills Doesn't apply to me	○ I have developed new social skills A little change	○ I have developed new social skills Some Change	○ I have developed new social skills Quite a lot of change	○ I have developed new social skills A lot of change

	Doesn't apply to me	A little change	Some Change	Quite a lot of change	A lot of change
I have developed new skills for employment	I have developed new skills for employment Doesn't apply to me	I have developed new skills for employment A little change	I have developed new skills for employment Some Change	I have developed new skills for employment Quite a lot of change	I have developed new skills for employment A lot of change
I feel I have a better sense of purpose	I feel I have a better sense of purpose Doesn't apply to me	I feel I have a better sense of purpose A little change	I feel I have a better sense of purpose Some Change	I feel I have a better sense of purpose Quite a lot of change	I feel I have a better sense of purpose A lot of change
I feel a better sense of personal satisfaction from being able to support others	I feel a better sense of personal satisfaction from being able to support others Doesn't apply to me	I feel a better sense of personal satisfaction from being able to support others A little change	I feel a better sense of personal satisfaction from being able to support others Some Change	I feel a better sense of personal satisfaction from being able to support others Quite a lot of change	I feel a better sense of personal satisfaction from being able to support others A lot of change
I have more confidence to work in this field	I have more confidence to work in this field Doesn't apply to me	I have more confidence to work in this field A little change	I have more confidence to work in this field Some Change	I have more confidence to work in this field Quite a lot of change	I have more confidence to work in this field A lot of change
I feel less stressed/anxious/depressed	I feel less stressed/anxious/depressed Doesn't apply to me	I feel less stressed/anxious/depressed A little change	I feel less stressed/anxious/depressed Some Change	I feel less stressed/anxious/depressed Quite a lot of change	I feel less stressed/anxious/depressed A lot of change
I have made new friends / I socialise more with people	I have made new friends / I socialise more with people Doesn't apply to me	I have made new friends / I socialise more with people A little change	I have made new friends / I socialise more with people Some Change	I have made new friends / I socialise more with people Quite a lot of change	I have made new friends / I socialise more with people A lot of change
I feel less isolated	I feel less isolated Doesn't apply to me	I feel less isolated A little change	I feel less isolated Some Change	I feel less isolated Quite a lot of change	I feel less isolated A lot of change

	Doesn't apply to me	A little change	Some Change	Quite a lot of change	A lot of change
I feel this helps with my own recovery	I feel this helps with my own recovery Doesn't apply to me	I feel this helps with my own recovery A little change	I feel this helps with my own recovery Some Change	I feel this helps with my own recovery Quite a lot of change	I feel this helps with my own recovery A lot of change

Question Title

12. Choosing from the list of changes listed below on a scale of 1-10, where 10 is very important to you, can you say how important these change are to you, if applicable?

	1	2	3	4	5	6	7	8	9	10	Not applicable
I have developed new social skills	I have developed new social skills 1	I have developed new social skills 2	I have developed new social skills 3	I have developed new social skills 4	I have developed new social skills 5	I have developed new social skills 6	I have developed new social skills 7	I have developed new social skills 8	I have developed new social skills 9	I have developed new social skills 10	I have developed new social skills Not applicable
I have developed new skills for employment	I have developed new skills for employment 1	I have developed new skills for employment 2	I have developed new skills for employment 3	I have developed new skills for employment 4	I have developed new skills for employment 5	I have developed new skills for employment 6	I have developed new skills for employment 7	I have developed new skills for employment 8	I have developed new skills for employment 9	I have developed new skills for employment 10	I have developed new skills for employment Not applicable
I feel I have a better sense of purpose	I feel I have a better sense of purpose 1	I feel I have a better sense of purpose 2	I feel I have a better sense of purpose 3	I feel I have a better sense of purpose 4	I feel I have a better sense of purpose 5	I feel I have a better sense of purpose 6	I feel I have a better sense of purpose 7	I feel I have a better sense of purpose 8	I feel I have a better sense of purpose 9	I feel I have a better sense of purpose 10	I feel I have a better sense of purpose Not applicable
I feel a better sense of personal satisfaction from being able to support others	I feel a better sense of personal satisfaction from being able to support others 1	I feel a better sense of personal satisfaction from being able to support others 2	I feel a better sense of personal satisfaction from being able to support others 3	I feel a better sense of personal satisfaction from being able to support others 4	I feel a better sense of personal satisfaction from being able to support others 5	I feel a better sense of personal satisfaction from being able to support others 6	I feel a better sense of personal satisfaction from being able to support others 7	I feel a better sense of personal satisfaction from being able to support others 8	I feel a better sense of personal satisfaction from being able to support others 9	I feel a better sense of personal satisfaction from being able to support others 10	I feel a better sense of personal satisfaction from being able to support others Not applicable

	1	2	3	4	5	6	7	8	9	10	Not applicable
I have more confidence to work in this field	I have more confidence to work in this field 1	I have more confidence to work in this field 2	I have more confidence to work in this field 3	I have more confidence to work in this field 4	I have more confidence to work in this field 5	I have more confidence to work in this field 6	I have more confidence to work in this field 7	I have more confidence to work in this field 8	I have more confidence to work in this field 9	I have more confidence to work in this field 10	I have more confidence to work in this field Not applicable
I feel less stressed / anxious / depressed	I feel less stressed / anxious / depressed 1	I feel less stressed / anxious / depressed 2	I feel less stressed / anxious / depressed 3	I feel less stressed / anxious / depressed 4	I feel less stressed / anxious / depressed 5	I feel less stressed / anxious / depressed 6	I feel less stressed / anxious / depressed 7	I feel less stressed / anxious / depressed 8	I feel less stressed / anxious / depressed 9	I feel less stressed / anxious / depressed 10	I feel less stressed / anxious / depressed Not applicable
I have made new friends / I socialise more with people	I have made new friends / I socialise more with people 1	I have made new friends / I socialise more with people 2	I have made new friends / I socialise more with people 3	I have made new friends / I socialise more with people 4	I have made new friends / I socialise more with people 5	I have made new friends / I socialise more with people 6	I have made new friends / I socialise more with people 7	I have made new friends / I socialise more with people 8	I have made new friends / I socialise more with people 9	I have made new friends / I socialise more with people 10	I have made new friends / I socialise more with people Not applicable
I feel less isolated	I feel less isolated 1	I feel less isolated 2	I feel less isolated 3	I feel less isolated 4	I feel less isolated 5	I feel less isolated 6	I feel less isolated 7	I feel less isolated 8	I feel less isolated 9	I feel less isolated 10	I feel less isolated Not applicable
I feel this is part of my own recovery	I feel this is part of my own recovery 1	I feel this is part of my own recovery 2	I feel this is part of my own recovery 3	I feel this is part of my own recovery 4	I feel this is part of my own recovery 5	I feel this is part of my own recovery 6	I feel this is part of my own recovery 7	I feel this is part of my own recovery 8	I feel this is part of my own recovery 9	I feel this is part of my own recovery 10	I feel this is part of my own recovery Not applicable

Question Title

13. Thinking again about the changes you have experienced as a result of volunteering or working with ICAN, what do you think is the likelihood that you could have experienced the same changes volunteering somewhere else? (1=Extremely low likelihood; 10=Extremely high likelihood)

0

Question Title

14. How much of those things that have changed in your life since joining the scheme are down to ICAN (other people and organisations may also have helped you)?

- All
- A lot
- Quite a lot
- A little
- None

Question Title

15. Is there anything that you would like to see being done differently or/and what could be better?

Question Title

16. Can you please say in your own words how you believe the ICAN project benefits the patient?

Question Title

17. If you have any other comments about the scheme, please feel free to include below.