SOCIAL RETURN ON INVESTMENT (SROI) EVALUATION REPORT ON THE ICAN CENTRES IN NORTH WALES JANUARY 2019-MARCH 2020

"It made a difference…it allowed us to stay and get the treatment needed whilst taking away the anxiety. We were treated like normal people."

I CAN
Law yn llaw at iechyd meddwl
Together for mental health

MI FEDRAF
Law yn llaw at iechyd meddwl
Together for mental health

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

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

Contents

Executive Summary

This report details the Social Return on Investment (SROI) evaluation analysis conducted on the ICAN centres based in Ysbyty Gwynedd, Ysbyty Glan Clwyd and Ysbyty Maelor Wrexham. The results demonstrate that significant social value is created through the project's activities, with a SROI result of £4.24:1 – meaning that for each £1 invested, £4.24 of value is created.

The report analyses the social value created over the initial 15 months of service from January 2019 until March 2020 and will provide recommendations for the service. 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 clients / 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.

Fundamental to the success of this project is the volunteers who give their time to support people in crisis. By giving their time and listening with empathy, they were able to empower clients / patients to feel they could take control of their own situation, and in many cases take positive actions towards creating change.

Many of the volunteers and supervisors had themselves needed mental health support in the past, either directly or for a friend or family member. This allowed them to have a level of understanding and empathy with the clients / patients, and also ensure the service was non-clinical and not judgmental.

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

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 client / patients.

Although we were only able to engage with a limited number of clients /patients, we are extremely grateful to them for giving their time to discuss what happened at a difficult time for them. Many of the new volunteers who had experience as clients / patients were able to share their insights which was extremely useful.

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 / patients 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 Wrexham, provided by Betsi Cadwaladr University Health Board which has been funded initially by the Parliamentary Review Fund for four months and then by the Transformation fund for Mental Health in Wales. 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 March 2020 and will provide recommendations for the future of the service.

1.1 Purpose and Scope

This is a Social Return on Investment (SROI) evaluation to measure the social value of the ICAN project. This report looks specifically at the outcomes and their value for clients / 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 and then through the Transformation fund in Wales 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. The purpose of the transformation fund is to look at new ways to provide health and social care to address the need identified, and therefore this will be considered.
- **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 ICAN created, but also any results could be communicated to recruit new volunteers.
- **Supervisors –** Supervisors are employed by BCUHB and they 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 Board's 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 06/04/2020

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 is divided into East, West and Central.

Following the initial four-month pilot there were some changes in the staffing structure. An ICAN Volunteering and Training Coordinator was employed and based within CAIS, a registered charity in Wales supporting individuals with mental health concerns. There was also an ICAN Administration support role based within Mantell Gwynedd which is the County Voluntary Council (CVC). Mantell Gwynedd was also responsible for administrating the volunteer and supervisors' costs.

2.2 Project Outline

ICAN centres provide an alternative solution for clients / patients with low level social and mental health challenges who access ED departments at Ysbyty Gwynedd, Ysbyty Glan Clwyd and Ysbyty Maelor. The Centres is staffed each evening by ICAN supervisors and volunteers who offer emotional support and signposting to various other community-based services. Originally the centres opened between 7p.m. and 2a.m. but these opening times have now been changed to fit with demand but also to ensure the safety of the staff. The following opening times now apply:

Ysbyty Gwynedd 7p.m. until 1a.m.

Ysbyty Glan Clwyd 8p.m. until 1a.m.

Ysbyty Maelor 7p.m. until 1a.m.

The service is open to anyone over the age of 18 who is experiencing some emotional distress but might not need to be treated within the Emergency Department as they require 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 and then further funding was provided through the Transformation Fund. The aim of this fund is to look at new models of Health and Social Care as part of the Healthier Wales Strategy.

In North Wales this fund has been used for the Together for Mental Health in north Wales project and the aims are to:

- Have an effective framework in each county for identifying people who are most vulnerable and take a multi-agency approach to prevent crisis occurring.
- Develop a multi-agency crisis care pathway that will provide prudent (right time, right response, right place) care and support that meets the needs of the person.
- Underpin the multi-agency approach to crisis care by training front line staff from all organisations on roles and responsibilities to improve practice and the experience for people in crisis, as well as to avoid escalation.

[2] http://www.wales.nhs.uk/sitesplus/861/page/97914 Accessed 12/04/2019

- Integral to the recovery pathway for people, the project will align with plans for developing supported housing in North Wales and key services which are currently not available.[3]

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[4] 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 where ICAN is open, then they can refer to the ICAN centre. Any mental health related referrals will first need to be assessed by the psychiatric liaison practitioners at Ysbyty Glan Clwyd, and then they can refer appropriately to ICAN. This was not the case in Gwynedd and Maelor, however, the team did work closely with psychiatric liaison.

As the service has evolved, volunteers have also attended the wards to offer support to patients and offer their services to the nurses. Another development to the service has been the nightly telephone service available for clients / patients for those who might have been frequent attenders previously or for those who were identified as needing on-going support to ensure some sustainability of any outcomes. This is a service mainly in Wrexham and Gwynedd and is not yet offered in Glan Clwyd. Clients / Patients will be offered this service

[3] https://gov.wales/sites/default/files/publications/2019-03/transformation-fund.pdf Accessed 23/04/2020
[4] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Accident-and-Emergency/performanceagainst4hourtargetallemergencycarefacilities-by-localhealthboard

and there will be a timetable to call each evening. As well as the phone service available to those who have attended the centre, some phone calls were also passed on by out of hours GP and by the Welsh Ambulance service when deemed appropriate.

Since the interim report, ICAN in the community has also been developed, with new venues being identified in different areas. This report will not evaluate the value of this service, but this development is important to understand any change for the clients / patients in the sustainability of any outcomes, and also the impact on the ED centres.

Lesley Singleton, BCUHB's Director of Partnerships, said:

"We are determined to shift the focus of care to early intervention and prevention, so people receive the right support, in the right place, at the right time.
"Once fully established, we expect that more people will receive the early support they need in the community, leading to reduced waiting times and improved outcomes for people who require the specialist support of our mental health services."[5]

2.3 Identifying the need and Strategic Background

The Healthier Wales strategy in Wales is a long term plan to look at new ways of providing health and social care in Wales to respond to the changes that has been seen in the demand over the last few years, including the increasing demand on mental health services. To develop these changes there is an aim to develop,

"'new models of seamless local health and social Care"[6]

[5] http://www.wales.nhs.uk/sitesplus/861/news/51349/local Accessed 27/04/2020
[6] https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf

There are ten design principles set out in the Transformation fund 2018-20 guidance[7]. These are:

- Prevention and early intervention – acting to enable and encourage good health and wellbeing throughout life; anticipating and predicting poor health and wellbeing.
- Safety – not only healthcare that does no harm, but enabling people to live safely within families and communities, safeguarding people from becoming at risk of abuse, neglect or other kinds of harm.
- Independence – supporting people to manage their own health and wellbeing.
- Voice – empowering people to make decisions about their own care.
- Personalised – health and care services which are tailored to individual needs.
- Seamless – services and information which are less complex and better coordinated for the individual.
- Higher value – achieving better outcomes and a better experience for people at reduced cost.
- Evidence driven – using research, knowledge and information to understand what works.
- Scalable – ensuring that good practice scales up from local to regional and national level, and out to other teams and organisations.
- Transformative – ensuring that new ways of working are affordable and sustainable, that they change and replace existing approaches.

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

[7] https://gov.wales/sites/default/files/publications/2019-03/welsh-government-transformation-fund-2018-20-guidance.pdf

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'[8] as a response to this need. Several the actions in this plan are a response to the Social Services and Well-being (Wales) Act 2014[9] which transforms the way Social Services are delivered. This also is a response to the Well-being of Future Generations (Wales) Act 2015[10] 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. [11] 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

[8] Welsh Government (2016). http://gov.wales/docs/dhss/publications/161010deliveryen.pdf
[9] Welsh Government (2016) http://gov.wales/topics/health/socialcare/act/?lang=en
[10] Welsh Government (2016) http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en
[11] 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." [12]

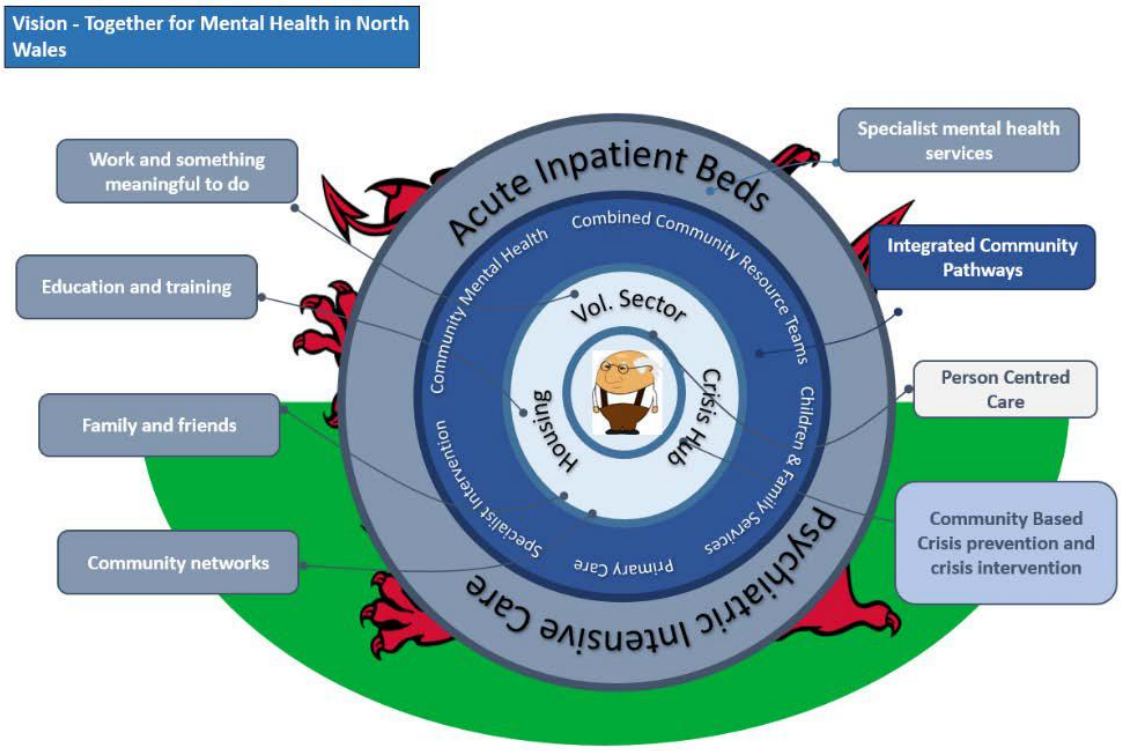
The ICAN Centres are not specifically here to support people with mental health concerns, but there for people who are in social or mental crisis at that time.

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.

[12] http://www.wales.nhs.uk/sitesplus/documents/861/18.92b%203%20year%20plan%202018-21%20v1.0.pdf

The model below identified how they propose to have a more integrated model of working in North Wales [13]

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. [14] 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 Bradford. The main aim was to "support people to resolve or better manage crisis to reduce

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

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.

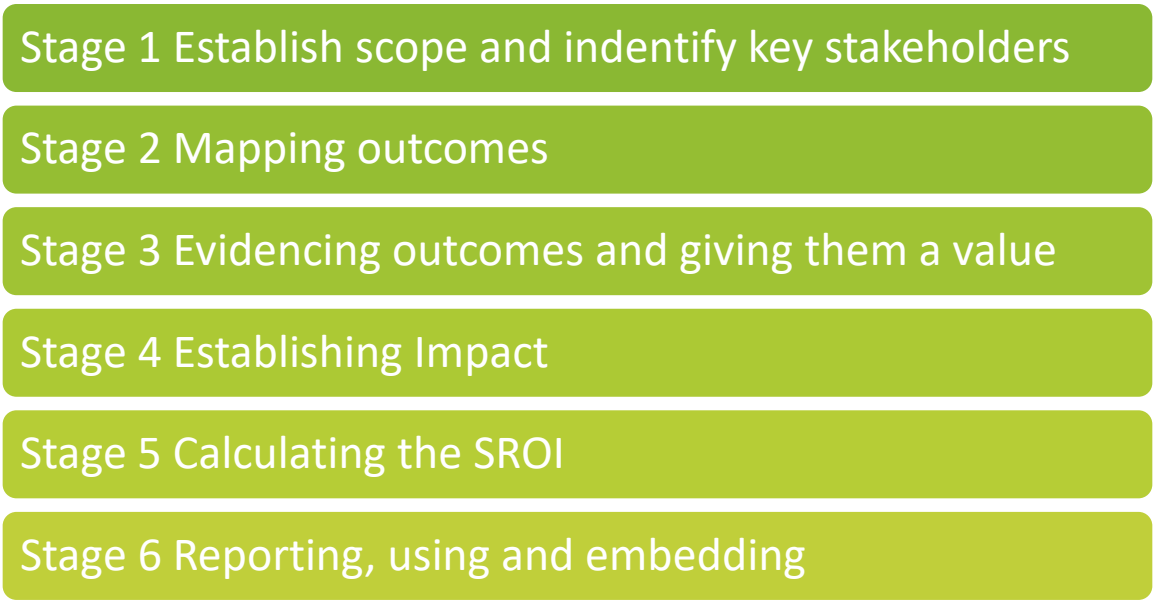
There are two types of SROI reports: evaluative and forecast. **This report is an evaluation SROI report of the ICAN Centres at the three main hospital sites in north Wales from January 2019 – March 2020.** SROI does not provide a rigid method of measuring social value, rather it is based on seven principles 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 [15]

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.

[15] www.socialvalueuk.org

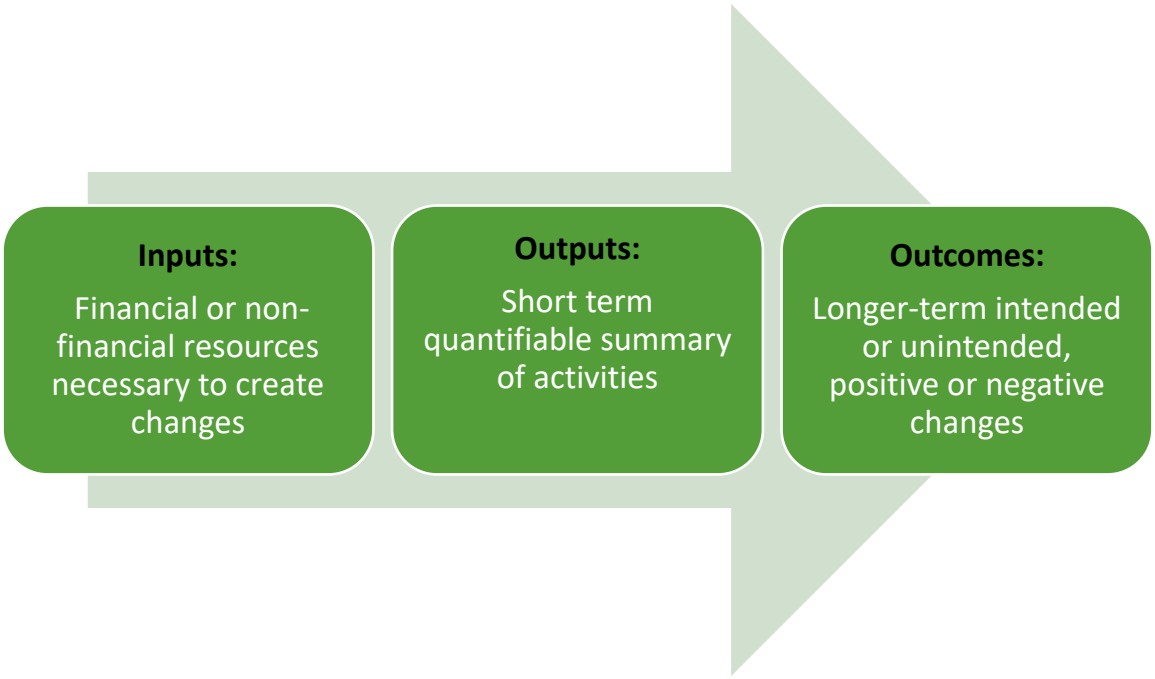
Figure 3 – Social Return on Investment Stages[16]



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.

[16] 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 1 highlights each stakeholder, identifying if they were considered material or not for inclusion within the SROI analysis.

Figure 5 – Materiality Principle

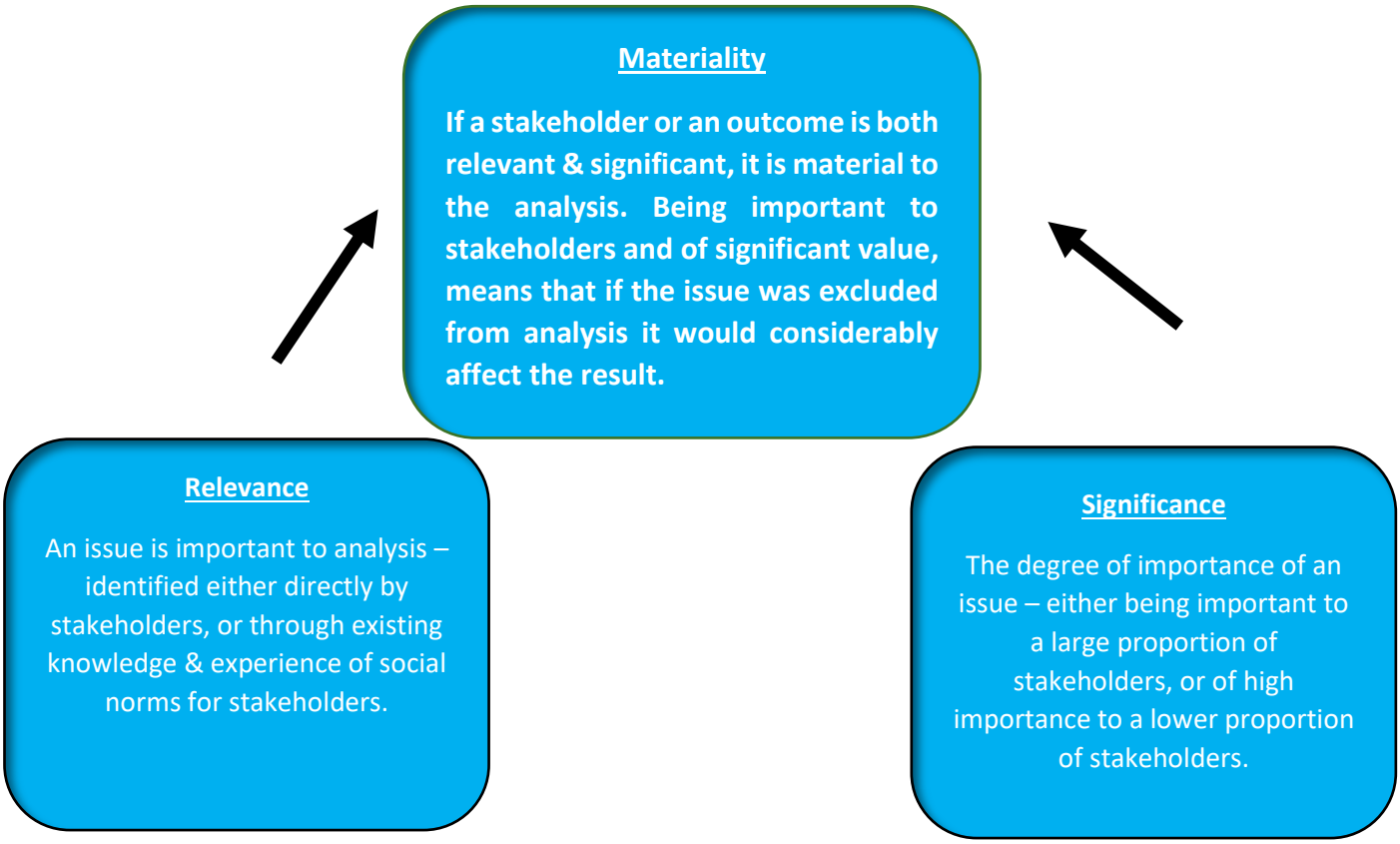


Table 1 – Stakeholder List & Materiality

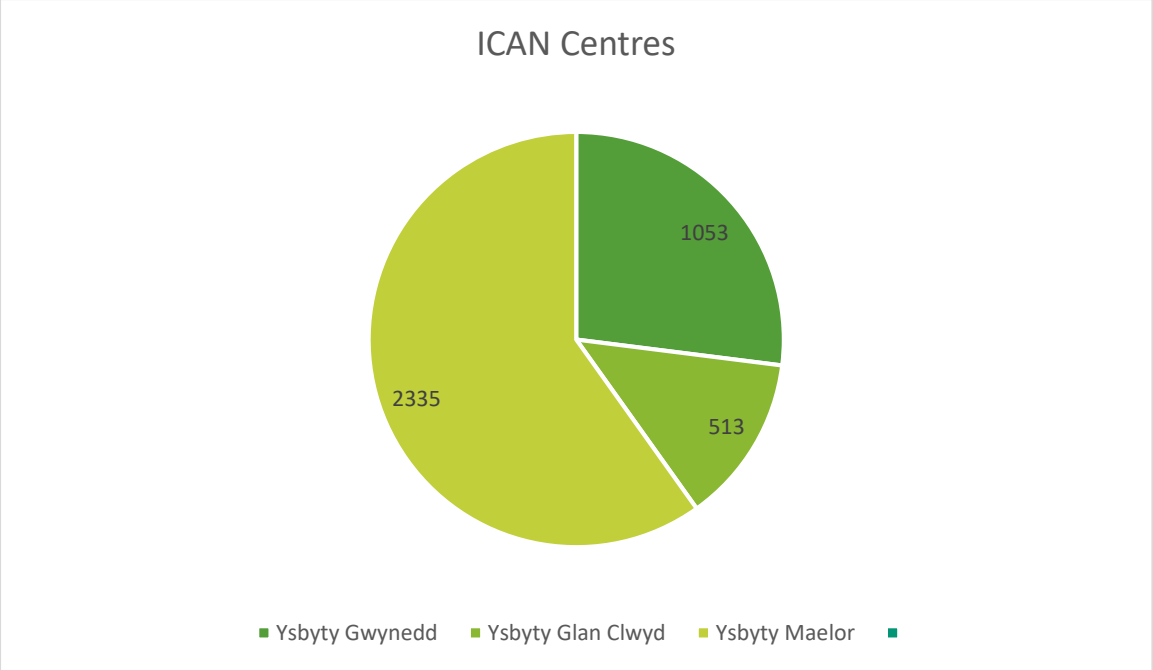
Stakeholder	Material stakeholder?	Explanation
Clients / patients	**Yes**	As key beneficiaries of the service these are the most important stakeholders and some changes experienced will be both relevant and significant. However, due to the confidentiality and nature of the service stakeholder engagement with a big sample of this group was not possible. However, a limited amount of data was obtained as well as third party data was obtained from volunteers and supervisors.
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 a large enough sample for this analysis. Some feedback from family member was obtained which supported the evidence of any change for clients / patients.
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 – **Ysbyty Maelor, Wrexham** **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

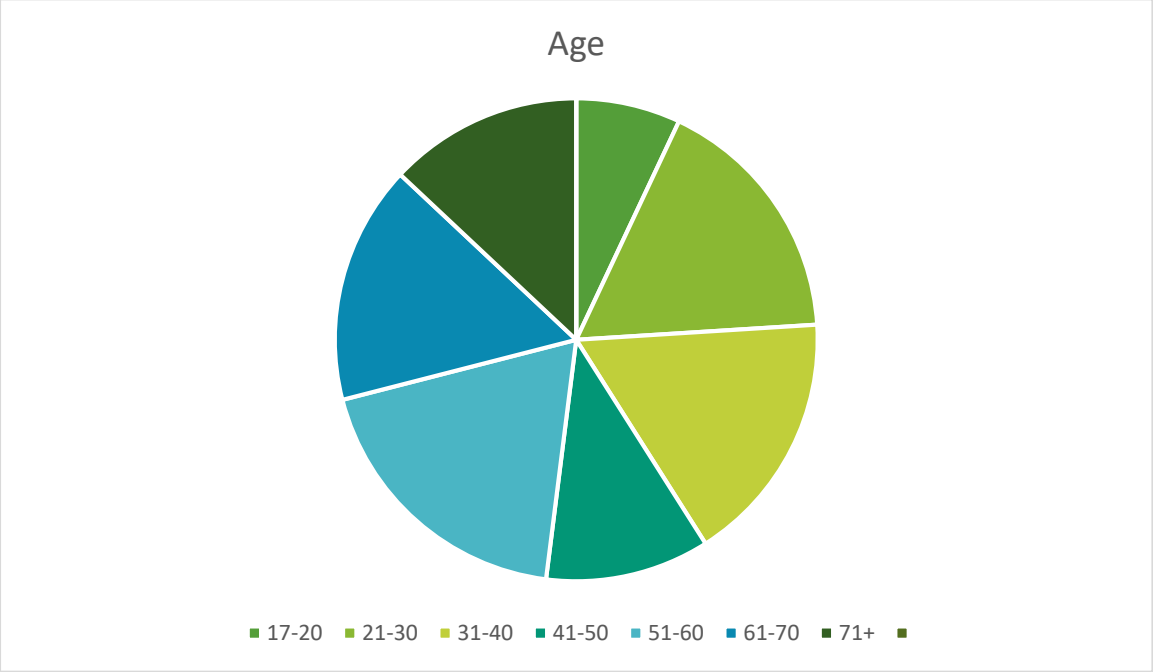
It is important to recognise that not all individuals are the same. Understanding that different characteristics have an impact on the data can help us to manage and inform decision making. Consideration is therefore given to the different characteristics below, which are age, gender and which hospital 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

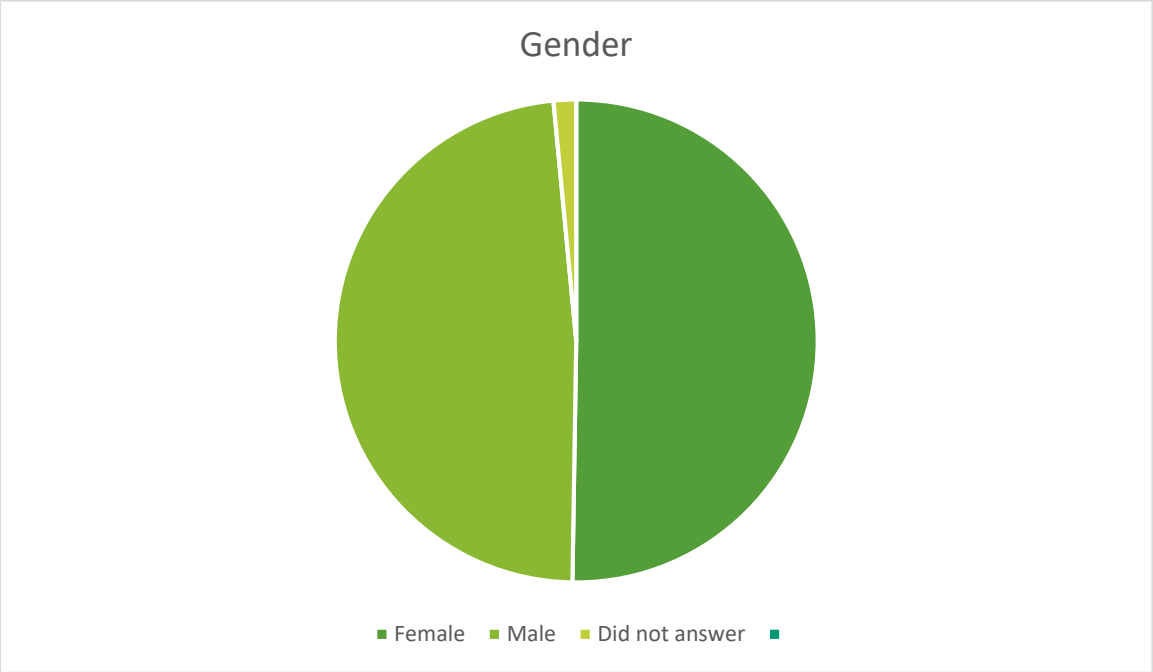


The above data from January 2019 until March 2020 was available, however, detailed data was only available until July 2019 as will be further discussed in this report. The breakdown of age and gender is therefore is based on this data.

Age Data



Gender data



4.2 Potential Subgroups of volunteers

In March 2020 there were 32 supervisors, 73 volunteers and 35 shadow volunteers. To avoid over-claiming, only the number of volunteers will be included in the analysis and in the value map, but feedback from shadow volunteers will also be contributed. During the 15 months some supervisors and volunteers had left, and new ones recruited. There is a turnaround of students especially as they need to get some experience during their term time and will then move away when their course is completed. Based on the data available on current supervisors and volunteers some of the characteristics of the volunteers are:

- 83% of volunteers are female
- 23% of volunteers are aged between 18-30, 20% between 31-40, 30% between 41-50, 26% are 51+ and over
- 33% were in employment
- 76% wanted to be involved to help others
- 63% wanted to gain more skills for employment
- 43% got involved for personal development

The number of volunteers that received induction training for the ICAN centres at March 2020 was 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 to 73 and 35 are now shadow volunteers awaiting all the checks to be completed. The number of volunteers at Ysbyty Gwynedd and Ysbyty Maelor remain 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 2 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 in February 2019 and then again in February 2020. As well as this a SurveyMonkey online questionnaires which was completed by volunteers and supervisors again in both February 2019 and March 2020.

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.

Table 2 – Stakeholder Engagement

Stakeholder	Population size	Method of engagement
Clients / Patients	**3,903**	Phone interviews Interviews with volunteers who were previous client / patients Online survey Initial feedback forms
Volunteers & Supervisors	**73 volunteers plus 35 shadow volunteers** **32 supervisors**	3 x focus group (Ysbyty Gwynedd, Ysbyty Glan Clwyd, Ysbyty Maelor Wrexham) in February 2019 and in February 2020 Survey Monkey or paper questionnaire completed by 30 volunteers and 19 supervisors
BCUHB	**1**	Meetings with ICAN Coordinator Meetings with health professionals including Psychiatric Liaison Team Managers, Consultant in Emergency Medicine,

		Out of Hours GP, Triage teams. Attendance in Clinical Governance meeting. WEDFAN meetings. Attended three ICAN steering group meetings

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 is therefore 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

A new service that needs to be considered in this evaluation is the phone service available to some clients / patients. It is important to recognise that the clients / patients time is crucial here, as well as trust. Through limited engagement with clients / patients, and extensive engagement with volunteers it was indicated how many had very low trust levels in services, and therefore to develop a relationship through weekly or nightly conversations would take a while to establish. It is also important to recognise, as already mentioned above, that for

any change to happen, they would need to follow through with some of the actions suggested to them.

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. Their costs are paid for and is included in the funding available and specified below. 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 higher rate allows us to adhere with the principle of not over-claiming. There can be up to 4 volunteers at each hospital site in an evening, however, often they will only be able to have two or three per evening with Glan Clwyd especially struggling to have volunteers per evening and therefore that is the total used here. The input therefore is:

438 evening of ICAN @ average 6 hours per evening = 23,652 hours of ICAN

23,652 Hours * 9 volunteers per evening (minimum) *£8.21 = £194,182

There is a pathway that volunteers must follow to become active volunteers which include DBS checks, induction and mandatory training modules. This is all additional time that is not included above but should be considered.

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. Compared to the interim report, what was apparent this time was that some of the earlier client / patients of the ICAN centres had now become volunteers themselves. Although many explained that they volunteered in order to give something back to the service or felt this helped them with their own recovery, their bravery needs to be recognised by going back to where they themselves went through crisis.

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. On page 39, there is a breakdown of some of the reasons for attending ED on that evening. From this varied list it is apparent that cases can vary and can be very complicated with several reasons for the problems escalating. This highlights again the emotional energy that will need to be given by volunteers and supervisors.

The financial input for supervisors is included below as they are employed by BCUHB. The payment for the supervisors is £70 per evening, £35 per half shift and £10 for any extra hours for administration. 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 Betsi Cadwaladr University Health Board. A payroll service was provided by Mantell Gwynedd to administer payments to the supervisors and volunteer costs. 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.

From May 2019 the service was funded through the Transformation Fund as part of the Healthier Wales strategy by Welsh Government. Total costs managed by BCUHB during this time was £270,107 which includes the initial 4 months spending above. This includes the costs of the Volunteer administration, which was located within Mantell Gwynedd, costs of supervisors, and volunteer expenses. In addition to this, there is an ICAN Volunteering and Training Coordinator which is employed within CAIS and has been located since October 2019. The cost here is £25,600 which includes salary, travel costs, expenses and management fees.

The skills of the Supervisors to work with individuals in an empathetic manner and the ability to identify the clients / patients 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 go through the Psychiatric liaison team, and they then 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 15-month period have been calculated as £489,889 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. The cost per individual is now half what was noted in the interim report at £125 per individual supported. Although more investment has been during this period in staff and supervisors, the centre has supported more clients / patients per month and therefore cost per individual supported has halved.

Table 3 – Total Monetised Inputs for ICAN

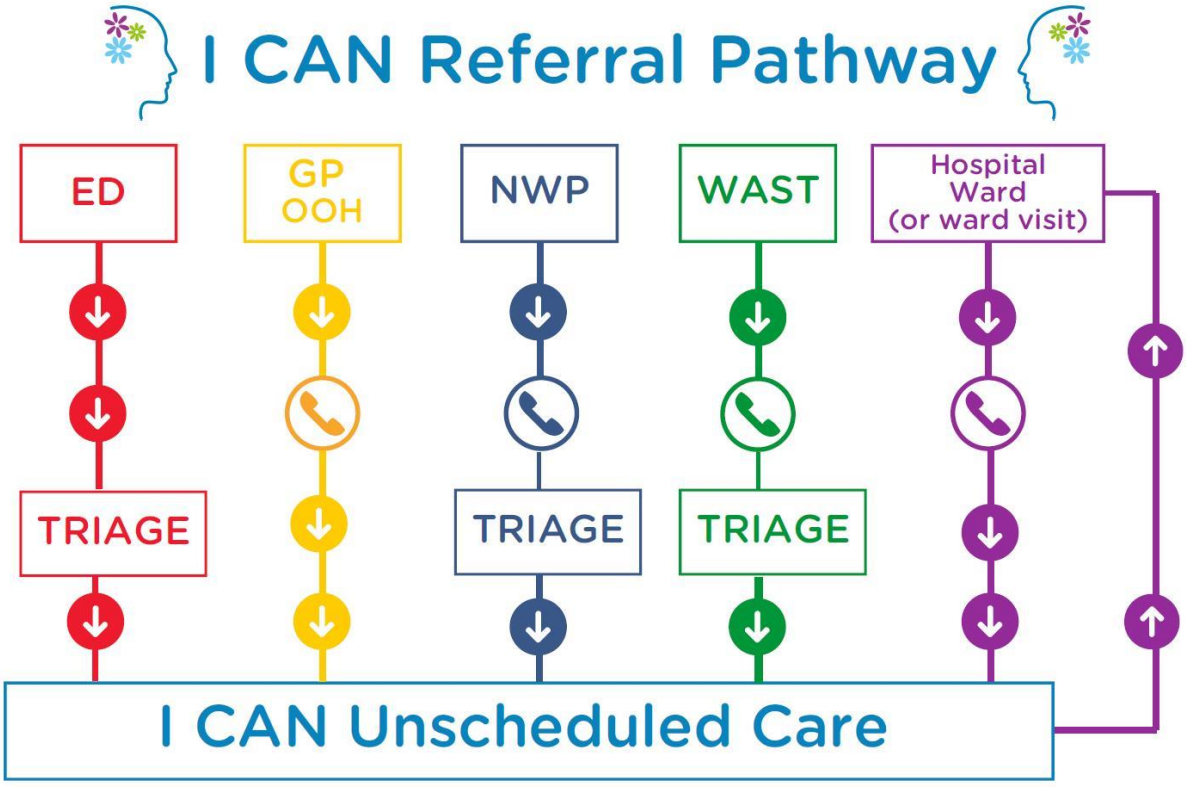
Stakeholder	Financial input	Non-financial input	Cost per individual
Clients / Patients	N/A	Trust, willingness to take part and take action identified with the ICAN staff	N/A
BCUHB managed by Mantell Gwynedd and CAIS	£295,707	Strategic management, time, expertise	
Volunteers	£194,182	Time, skills, commitment, emotional energy	
Supervisors	Salary included under BCUHB	Time, skills, commitment, management	
Totals	**£489,889**		**£125.51 per individual**

6.0 Outputs, Outcomes & Evidence

6.1 Outputs

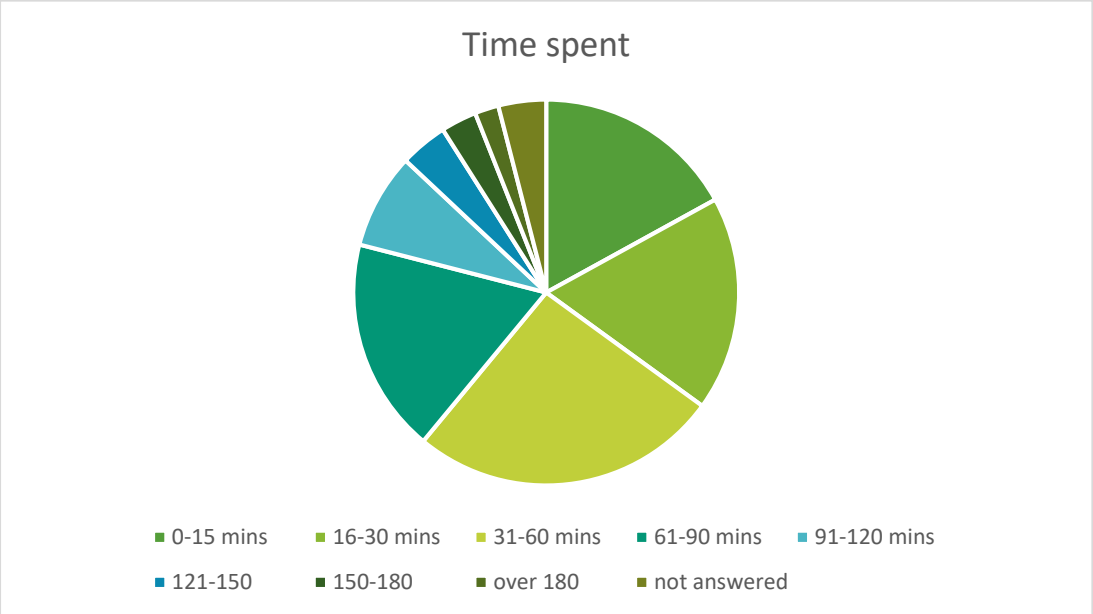
The immediate outputs for the ICAN project, are the number of referrals made to the project and how many hours of support each person received from both the ICAN volunteers and supervisors. Over the 15-month period January 2019 – March 2020, 3,903 clients / patients have been supported by the ICAN team. The majority of client / patients will be referred directly through triage but as seen in figure 6 below, some client / patients will be seen on the wards also as the ICAN Supervisors and volunteers will present themselves on wards and ask the nurses if anybody would benefit from having a conversation with them.

Figure 6



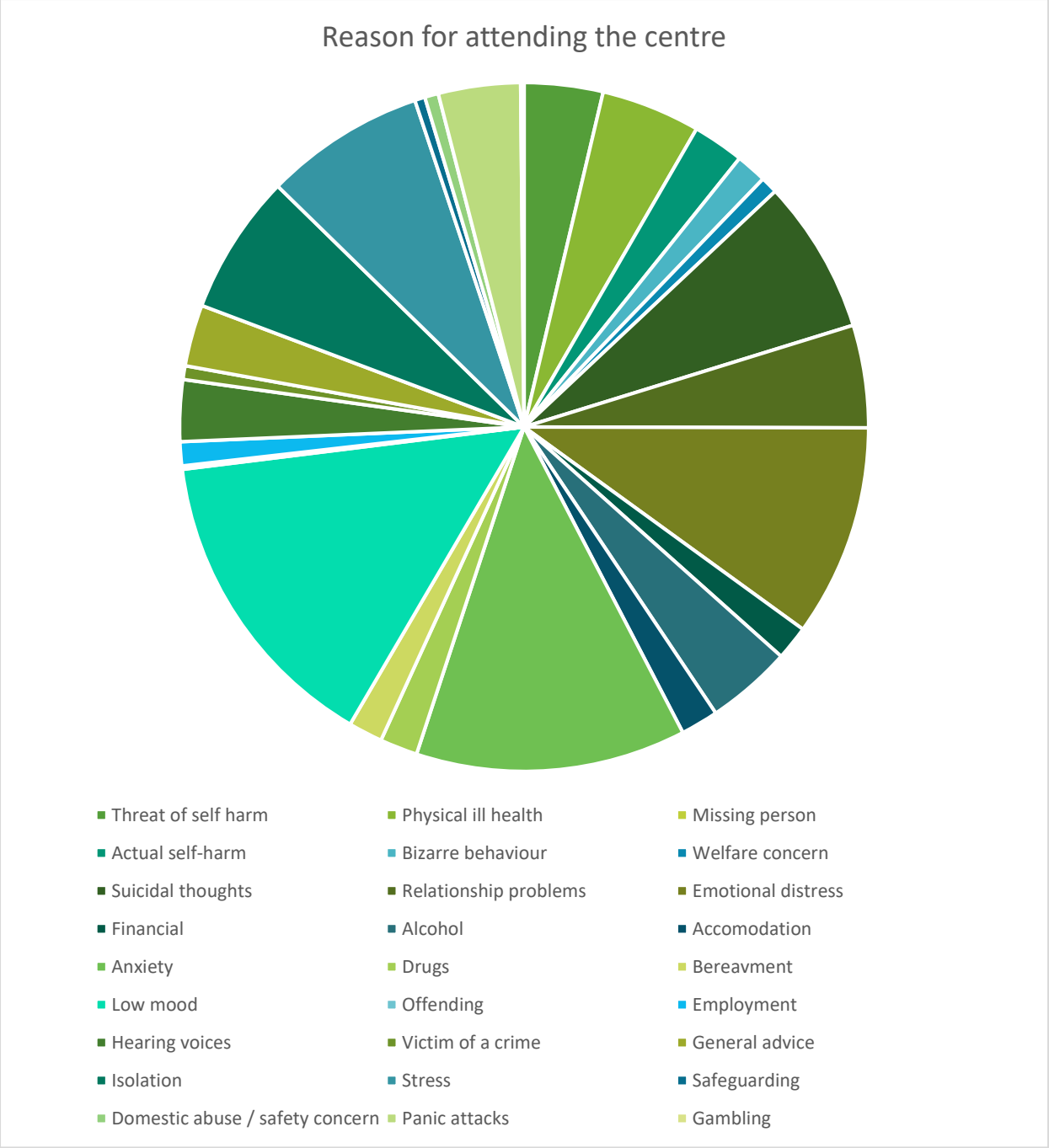
The chart below demonstrates how much time on average clients / patients will spend at the ICAN centre. The majority of clients / patients will spend 31-60 minutes with the ICAN team on a single visit, with 2% spending over 180 minutes an evening with the team. The number of time spent can be seen in 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. The difference here with ICAN was explained by both the ICAN teams and health professionals as being non-clinical, non-judgmental and much more relaxed. The staff will talk and listen usually over a cup of tea and come up with a joint action plan where appropriate. There were cases where the team had helped clients / patients to fill out forms and write applications. There were also cases where the ICAN had arranged suitable accommodation for the client / patient.

Time spent in ICAN centre



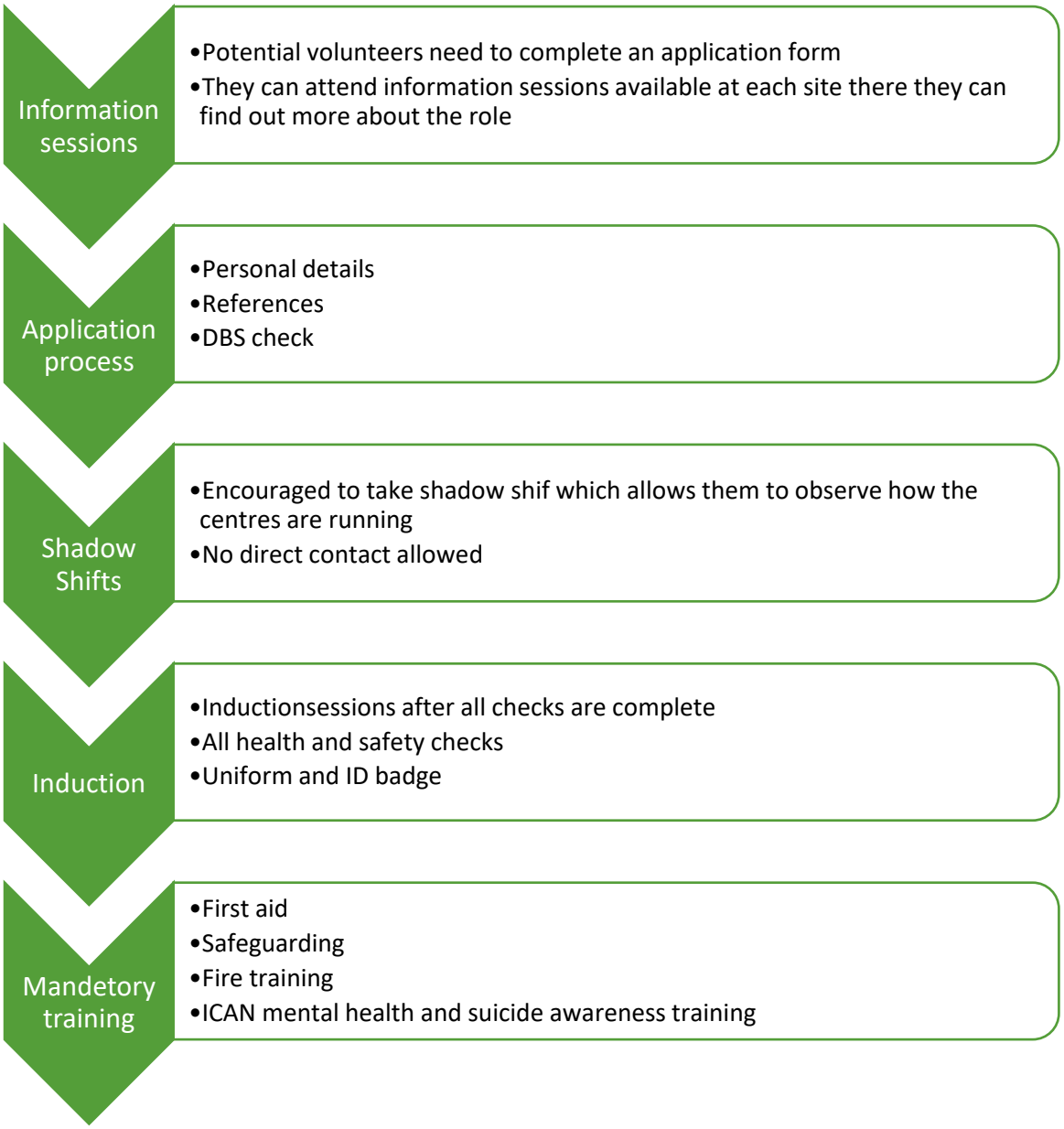
Detailed data was only available from January 2019 until July 2019 at the time of writing this report. There were some inconsistencies in how the data was recorded also, with the April and June data being recorded slightly differently. In these months, there was further information available on why people had attended ED and ICAN which could be useful to consider.

Reason for attending the centre – April 2019 is considered below. There was more than one reason for attending for many. The variety of reasons shows the variances in the needs of the clients / patients, and the cross section of skills needed. 7% had suicidal thoughts, and 2% had actually self-harmed.


Reason for attending the centre
Threat of self harm
Physical ill health
Missing person
Actual self-harm
Bizarre behaviour
Welfare concern
Suicidal thoughts
Relationship problems
Emotional distress
Financial
Alcohol
Accomodation
Anxiety
Drugs
Bereavment
Low mood
Offending
Employment
Hearing voices
Victim of a crime
General advice
Isolation
Stress
Safeguarding
Domestic abuse / safety concern
Panic attacks
Gambling

At the time of writing the report there were 73 active volunteers, volunteering on average 1 evening per week, and 32 supervisors were employed. The number of supervisors had increased by almost 2/3 since April 2020. There were also 35 shadow volunteers across north Wales who were awaiting all checks before they became active volunteers.

Over time, a pathway to become a volunteer has been developed as seen in the diagram below. In appendix 4 is a copy of the volunteer role description, volunteer agreement and volunteer policy.



A theory of change for the individual can be seen for client / patients on page 54 and for the volunteers on page 61 which shows the story of what can happen to individuals, and Table 4 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.

Case study – Patient feeling suicidal

A young man arrived at ED with hostel staff having attempted suicide. He had been hearing voices in his head and was feeling extremely low and also felt very alone.
ED having discussed with the Psychiatric liaison team didn't view him as high risk of suicide that evening but needed some emotional support, and therefore was triaged to ICAN.
He stayed with the ICAN team for two hours and was able to spend time discussing his concerns and sharing more about his feelings. He felt much calmer and relieved having been able to open up about his feelings and then returned to the hostel without needing to be seen by the health professionals.

Case study – Change in medication

A young man had his medication changed which resulted in him being anxious and feeling that he couldn't cope. His girlfriend was concerned for his safety and therefore brought him to the ED department.

He was triaged and referred to ICAN where they were able to speak with him for 30 minutes. They then referred him to Psychiatric Liaison team here an appointment was made by them for him to see his psychiatrist and review his medication.

They felt that having some time in ICAN had helped both of them to feel more relaxed and reassured, but also that they had options and organisations that could support them.

Table 4 – Stakeholder Outcomes

Stakeholder	Outputs	Outcomes	Included / Excluded
Client / patient	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 client / patients, volunteers and health professionals, all intermediate outcomes lead to the client / patients 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
		Reduced isolation	Excluded – At the time of sitting in the waiting room in the middle of their crisis, things can escalate and deteriorate, and they can feel alone. However, with the development of the phone service, there was further relevance of this outcome. For those who are offered the service and get phone calls each evening, it helps them to feel supported, develop more trust but also leads to empowerment.
		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	73 number of volunteers on average volunteers 6-7 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	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 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	Excluded - This was relevant to most stakeholders; however, this is an intermediate outcome that leads to the well-defined outcomes
Supervisors	32 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 – reallocation of resources	Reduced demand of out of Hours GP time	Included – Although this is subjective and quantifying the actual amount of time that has been reallocated due to ICAN is complex, 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. Reasonable judgments are included in the value map.
		Reduced demand on Psychiatric Liaison Practitioners time	Included – Although this is subjective and quantifying the actual amount of time that has been reallocated due to ICAN is complex, 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. Reasonable judgments are included in the value map.
		Reduced demand on nurses' time	Included – Although this is subjective and quantifying the actual amount of time that has been reallocated due to ICAN is complex, 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. Reasonable judgments are included in the value map.
		Reduced demand for hospitalisation?	Excluded – There were many cases of where the client / patients faced very complex needs and early intervention could have prevented hospital admissions in the longer run. However, it is not included in the value map as more data is needed to support this.
		Reduced ambulance call outs	Excluded – There were cases where ambulance had call and diverted them to ICAN due to the waiting time. These resulted in no ambulance needing to attend the scene in some cases. However, it is not included in the value map but can be used as evidence of change.

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 7 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 4 lists all the outcomes and considers which are included and excluded based on the materiality test.

6.2.1 Clients / Patients

For the interim report, there was limited amount of both qualitative and quantitative data available for the clients / patients. It is still worth noting that engaging with many client / patients directly was difficult due to the confidentiality and the nature of the service. In April 2019, ICAN did introduce a client / patient 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. However, some feedback was also available through volunteers who were previous clients / patients or had family members who had been attending ED in the past with mental health problems or in a time of crisis. All this data along with secondary research was used to make reasonable judgment as to what had changed as a result.

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.

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 / patients 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 / patients 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

“Brilliant team! Made me feel listened to.” 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 / patients to a service that could give them the time they needed.

For those that did take part in the client / patient survey, all client / patient s said they felt reassured at the time, and that knowing the service was there provided them with some reassurance, and there was an average 50% change in the outcome, with 50% reporting quite a lot or a lot of change.

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 rising 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 having the highest number of attendances.[17] Medical staff cannot possibly have the time to listen and need to deal with the immediate concerns.

"Extremely understanding, supportive and very very helpful" Client / patient

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[18]

[17] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Accident-and-Emergency/accidentemergencyattendances-by-age-sex-site
[18] http://www.mindinbradford.org.uk/the-sanctuary Accessed 18/04/2019

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.

Intermediate Outcome 3 – Better able to develop trust in services

Referrals come into ICAN from triage when it is considered appropriate, but ICAN volunteers / supervisors will also visit 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 patients 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 / patient

During the focus group with volunteers and supervisors, the importance of being non-clinical was expressed. Many clients / patients had bad experience of services previously and therefore having a safe space and time to spend describing what they are going through is important. One case study was discussed of a family attending ED and how both the client / patient and parents were really at point of despair.

“They said we gave them hope in humanity again.” Volunteer

Many of the health professionals also echoed how important it was that they received this non-medical support, as health professionals can de-power individuals by the very nature of

the service. Many are not ill but do need support, and this service they felt can help client / patient to cope and empower them.

100% of clients / patients in the completed feedback forms had said that the ICAN centres were very good when asked about how welcoming the ICAN teams were.

“Excellent communication for advice and support, superb individuals for guidance and people to talk to” Client / patient

In the survey, all client / patient s explained that the service had helped to create some change in this outcome, with an average change of 53% for the clients / patients.

Intermediate outcome 4 – Better able to work through crisis

Again, as discussed above, having the time to discuss what was happening was 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 / patients developed a better understanding of what was happening to them and once their crisis had become manageable or had 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 to which he was signposted will hopefully allow him to manage what was happening in the future.

One of the clients / patients who took part in this analysis explained how her partner who was dealing with bad anxiety and often drank a lot to deal with that. They had been at ED for many hours before they were referred to ICAN and his anxiety levels was increasing. They spent two hours with ICAN before they could see a specialist, and she felt this really helped to avoid further deterioration. He was also on the waiting list at CAIS already, but the ICAN team was able to get his application fast-tracked due to the severity. Since then she felt there has been some change in his drinking habits as he is now receiving support, but also having that engagement helped her to better understand what was happening and what she could do in future.

"It made a difference…it allowed us to stay and get the treatment…taking away the anxiety. It got us out of the waiting room. We were treated like normal people" Family member

In the client / patient surveys, they were asked about the amount of change in being able to better cope in a crisis. 75% said there was quite a lot or a lot of change here, with an average distance travelled of 39%.

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.

One client / patient who took part in the analysis explained how she was previously addicted to drugs had had problems with her mental health and had tried to take her own life on many occasions. She had been at the ED on many occasions previously. When referred to the ICAN centre she was glad of having somebody to listen. She had also taken up the offer for the follow up phone service and felt that having these calls was something she could forward to.

Having information and actions that she could take was important, and as many health professionals mentioned during the engagement process, getting clients / patients to understand they need to take some understanding that they have the power to make these changes. Overtime she feels that her confidence had improved, and at the time of engaging with us she was starting the process of becoming a volunteer and felt that a few months previously she wouldn't have been able to engage with us or think about volunteering which was an indication of change.

"It's the difference between life and death." Client / patient

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 / patient 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.”

Another health professional said that she felt that this was the most important outcome created by ICAN, and that having options and somebody to listen to was really important. From the phone service also, this helped with reducing their loneliness and isolation.

“I now find it difficult to imagine providing care without ICAN.” Health professional

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 / patients 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 / patient who was supported in the centre to write an application form. The successful job application resulted in him becoming employed which truly life is 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

In the client / patient survey, there was an average amount of change in feeling more empowered of 56%. 75% of clients / patients said they had quite a lot or a lot of change here.

Possible negative impacts for clients / patients

Considering the possible negative outcomes is important to allow ICAN Centres to manage these in the future. All clients / patients who took part were given an opportunity to say about any negative changes, or what could be better. Negative changes for clients / patients were also discussed with volunteers, supervisors and health professionals.

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.

The phone service has developed since the last interim report, and some of the phone calls that were made by GPs or WAST previously was now being done by ICAN. These are calls were clients / patients needed somebody to talk to, needed reassurance and also routine was important to avoid deterioration. However, this dependency that was on the statutory service could be transferred to ICAN if no actions were taken. There were cases of where some clients /patients had been using the service for a while but had then either gone back to employment, or started volunteering, some with ICAN.

Inappropriate referrals?

Care must be taken to ensure the ICAN team are used appropriately and for the right reasons. There were cases in the first few months 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.

This seemed to have been better developed over time, with a better understanding between hospital staff and ICAN as to what service they can provide and what is most appropriate. The health professionals said that the system works well, and said that at the beginning they felt that there were some cases that could have been better dealt with when referring back in to the system, but felt that now it worked well.

In the data available, there was one case of a 14-year-old child being supported. It is clear that this service is for those 18 plus, and therefore this service is not appropriate to support children and could create more harm.

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

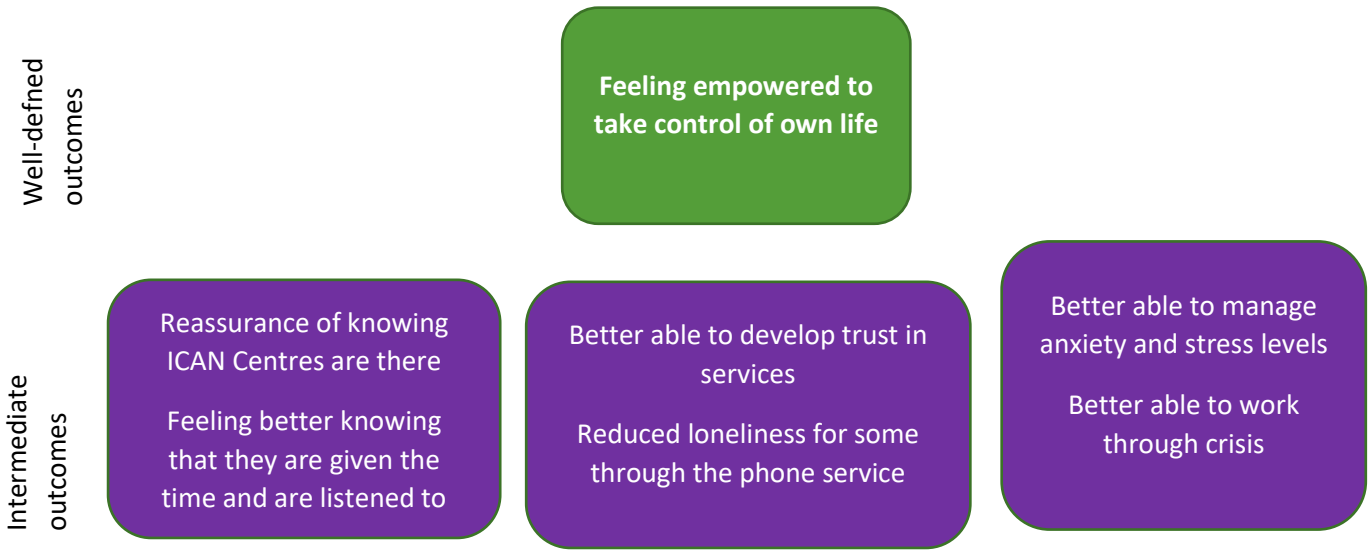
place. Having contact numbers of ICAN in the community could be a solution here as they are not able to contact the ICAN centres without being triaged.

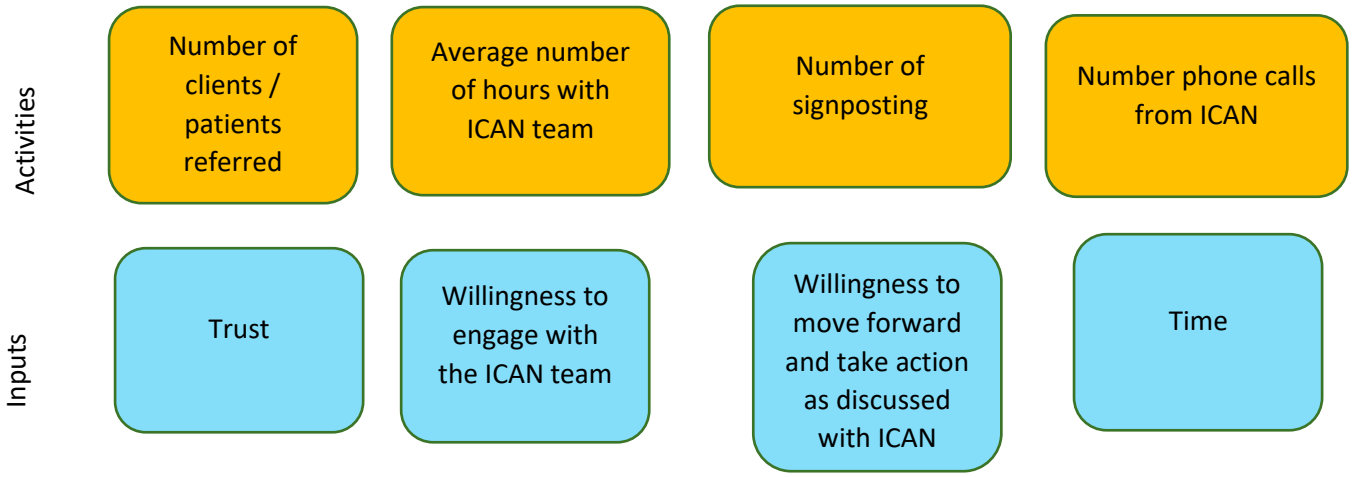
There were also examples of volunteers being concerned about whether or not they had given the right advice and it was recognised that there is a fine line between helping or escalating a problem. However, these cases were rare, but further training and processes will help to avoid this in the future. There is a good system where all supervisors assess each case but also ensure that no one is left alone and could provide support if needed. In Maelor, they had a system of allowing the supervisor to know if they needed support but without alarming the client / patient.

Many volunteers and supervisors have been through similar crisis themselves either directly or indirectly. Although this was seen as an advantage overall due to the empathy and level of understanding that they could better offer, some concerns were also raised about their own safety and risk. This was raised by some ICAN staff and health professionals. Great care must be taken to manage their own recovery.

Figure 7

Theory of Change Clients / Patients





To contribute to the outcomes recognised through the qualitative and quantitative stages, it is worth noting the outcomes being recorded by ICAN as primary and secondary outcomes. There were some inconsistences in the data, that being in the results but also in how they are recorded. Data was not available after July 2019, apart from the number of referrals, and therefore this initial 7-month data is analysed. Data was recorded differently in April and June 2019 also. The April and June data did provide some additional data which were useful such as a description of the referral, and reasons as to why they had attended ED.

Looking at the data, no pattern is apparent and that might be due to the inconsistency in how data is recorded in terms of system and how paperwork is completed. Looking at the complete 15-month data would allow better consideration for patterns. For example, see below in June 2019 there were 159 recorded for Listening talking but only 3 in July 2019. Listening talking refers to clients / patients who were offered support by having a listening ear and talking through their concerns. The data below suggests that different volunteers and supervisors' records outcomes very differently.

Table 6 – Primary outcomes reported by ICAN team

Primary outcome	Jan	Feb	March	April	May	June	July
Divert ED Physical Health	2	3	1	6	4	9	2
Divert Ed Physical Health, Safeguarding, Listening & Talking & Advice/signposting	1	2			4		1
Divert Ed Physical Health, Safeguarding, Advice/signposting & referred to Police	1	5			12		6
Divert Ed Physical Health & Safeguarding	1	2	1		1		2
Safeguarding, Listening & Taking & Advice/signposting	2	3	1	4	1	5	1
Did not require any input	1	1	9		1		6
Did not require any input & Listening & Talking	4	1	6		4		1
Did not require any input, Listening & Talking, Advice/signposting	1	4			1		81
Divert Liaison	1	1	1	18	6	18	45
Divert Liaison, Listening & Talking & Advice/signposting	3	2	5		7		1
Listening Talking	9	1	45	7	95	159	3
Listening & Talking, Advice /Signposting	28	32	33		52		3
Listening & Talking, referred to social services, Advice/signposting	1	43			1		1
Referral to Social Services	1	1	1	2	2		2
Advice/signposting	4	15	3	62	1	72	2
Referred to NHS services, Listening & Talking, MHS assessment, Advice/signposting	1	1			1		
Referred to NHS services, Listening & Talking & Advice/signposting	2	1			1		
Not answered	4	2			1		

6.2.2 Volunteers and Supervisors

There were different reasons why people decided to volunteer or work 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 working within health and social care setting. Some were students at Bangor University or Glyndwr University and needed some practical experience. Figure 8 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 initial focus group in February 2019, 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. During the 2020 focus groups it was apparent at all three sites that the teams had further developed and that the skills and expertise had become clearer. Many new volunteers had also come on board and for those who were new they did express how they felt welcomed to the teams.

Across all three sites, they were all very proud of the service and clearly felt that they were making a difference within the sites and changing lives. For those who had been involved from the beginning they felt a sense of ownership and felt very protective of the service.

“An amazing facility, the difference it makes.” Supervisor

“We are very proud of it.” Supervisor.

90% of volunteers said they had experienced a positive change here with an average distance travelled of 56% on average.

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

Based on those who took part in the analysis, approximately 33% of the volunteers are in education, 13% are unemployed and 33% are employed either full or 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.

The nature of the cases was very varied, and they all explained how you never know what might unfold, and therefore this provides them with a variety of experiences. Through each other also, and with training they develop a bank of knowledge of how best to deal with different situations and where to refer client / patients.

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. 70% of volunteers said that they had experienced quite a lot of change in the outcome of ‘developing new skills for employment’ with an average change of 48%.

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.

There were some volunteers who had themselves received support from ICAN previously. They felt that being involved with support them with their own recovery,

"It heals me to heal others." Shadow volunteer

In the volunteer questionnaire, 53% of volunteers said they had experienced some change here. For many though this was not applicable which shows the cross section of volunteers.

In the survey, they were asked to say in their own words why they wanted to get involved. Some of the comment were:

"help people like myself who struggle with mental health disorders."

"To pass on my experience of mental illness to help sufferers to manage the illness and find peace."

"Job satisfaction from helping other by using my past experiences."

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 had not 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

In February 2019, 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.

Since the interim report, there have been changes in the training provided, with a training coordinator and more courses being offered. There is mandatory training that all supervisors and volunteers should attend which includes:

- First Aid training
- Safeguarding
- Fire training
- ICAN Mental health and suicidal awareness training

As well as this, there is other in-house training offered such as bereavement training, autism awareness, dementia awareness and much more.

However, there were still a few who felt that more training could be provided when discussed during the stakeholder engagement. Included in this, many felt a lack of clear guidance and leadership and needed a better introduction to the systems and better communication,

"Better leadership and all round rules for everyone, especially those who are shadow shifts. Sometimes it's not clear what volunteers or shadows should be doing" Volunteer

Space

At all three sites, space was considered an issue during the interim report analysis. In Gwynedd they were close to the ED department but felt the room itself was not 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.

11% of clients / patients in the feedback forms had said that the location was poor or just so so.

Figure 8 - 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, 80% said they had experienced change in the outcome of improved skills for employment, with an average distance travelled of 57%.

Similar to that of the volunteer's results, 90% 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

All outcomes for BCUHB relate to the potential for cost reallocation related to avoided demand on services.

Consideration was given in the interim report to any impact of this service on health services, and ultimately the main incentive for establishing this service was to look at reducing the pressure and demand on Emergency Departments. In the interim report in April 2019 there was no data available to look at any impact on ED attendance numbers and waiting times, however, consideration could now be given to identify any impact on these numbers.

Table 7 shows the ED numbers in 2018-2019 compared to 2019-20. Although ICAN was established in January 2019, it was early to consider any impact on data. Data from March 2020 was not available at the time of writing this report. Red boxes indicate where ED attendances had increased from 2018-19 and green boxes indicates where there has been a

decrease in attendance. By analysing the data, it can be identified that having the service hadn't had an impact on those attending ED numbers and in general the trend has been an increase in attendance which is in line with the trend across Wales. For example, considering the ED attendance numbers in Hywel Dda Health Board there has been a slight increase in these numbers also as is the case in BCUHB, with 11,905 attendances in February 2019 and 11,341 in February 2020.

To receive support through the ICAN centres, patients must be triaged in the usual way, and therefore it is reasonable to say that the centres wouldn't have an impact on these numbers. There were examples where frequent attenders no longer attended ED as often if at all and therefore there were success stories, but the trend of increase had been continued as demand by others replaced those that might have reduced demand.

During the qualitative engagement, one of the changes that were discussed was the impact on waiting times, and referrals to patients being 'off the clock'. This meant that if they were referred through triage to the ICAN centres, they would be 'off the clock' which could have an impact on the waiting time stats. This did not mean that patients were 'off the system' as they would still need to be signed off by a health professional before being discharged but could see an improvement on the patient experience in terms of waiting times. Table 8 considers the % of patients who spend less that the target time within the ED department, against the 4 hour target. The data did not demonstrate any real impact here, and in most cases the number of % spending less that the target time had decreased. Comparing to Hywel Dda health board who do not have ICAN services a similar trend was also apparent there.

The ICAN phone service had become available in Maelor and Gwynedd since October 2019, and again there were good case studies where frequent attenders had not been attending ED

as often. There were also case studies of where WAST had referred callers to ICAN which had resulted in people not requiring ambulance and attending ED services.

With the development of ICAN in the community, it is possible that over the next 12 months that this is where impact on ED numbers can be identified and therefore further analysis of these numbers should be made.

Although there is no evidence yet as to the impact on ED numbers and waiting times, were consideration can be given is to cost reallocation when looking at the change in demand on services within ED.

Table 7 – Number of attendees at ED department across all three hospital sites

	April 2018	May 2018	June 2018	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018	January 2019	February 2019	March 2019
Ysbyty Gwynedd	4,237	4,670	4,334	4,865	4,802	4,323	4,333	3,905	4,074	3,975	3,841	4,200
Ysbyty Glan Clwyd	4,808	5,216	5,083	5,279	5,149	4,571	4,861	4,564	4,791	4,599	4,222	4,801
Ysbyty Maelor	5,158	5,645	5,550	5,628	5,189	5,031	5,396	5,125	5,075	5,459	4,909	5,308
	April 2019	May 2019	June 2019	July 2019	August 2019	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020
Ysbyty Gwynedd	4,474	4,704	4,431	4,792	4,935	4,495	4,467	4,133	4,264	4,008	3,844	
Ysbyty Glan Clwyd	4,938	5,153	4,975	5,317	5,292	4,798	4,922	4,745	4,998	4,689	4,321	
Ysbyty Maelor	5,207	5,447	5,227	5,687	5,374	5,147	5,197	5,034	5,243	5,049	4,870	

Table 8 Percentage of patients who spend less than the target time in ED departments -4 hour target

	April 2018	May 2018	June 2018	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018	January 2019	February 2019	March 2019
Ysbyty Gwynedd	70.9	78.2	74.7	70.6	70.9	70.9	71.6	75.4	73.0	70.5	70.8	70.7
Ysbyty Glan Clwyd	60.8	65.0	62.3	54.5	52.9	56.0	58.5	60.4	54.7	54.7	63.2	58.5
Ysbyty Maelor	62.3	64.8	57.2	54.0	49.7	50.9	54.1	55.9	50.6	49.3	57.1	56.5

	April 2019	May 2019	June 2019	July 2019	August 2019	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020
Ysbyty Gwynedd	69.6	69.1	70.9	70.9	72.1	70.6	71.1	69.6	54.0	57.0	55.2	
Ysbyty Glan Clwyd	55.7	59.6	59.6	59.9	58.7	59.8	57.3	57.5	52.4	53.5	56.7	
Ysbyty Maelor	50.3	53.7	50.7	56.3	51.7	51.1	54.6	62.5	46.6	46.1	40.9	

Reduced demand on services

The purpose of this report is to capture what has occurred 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. Continuous data collection should take place to ensure greater confidence in any results. 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.

Any data relating to cost reallocation is subjective data and based on engagement with health professionals and case studies where they were able to say that they were able to reallocate some of their services who might need more urgent support or who might require more medical care other than emotional support.

Reduced demand on out of hours GP

There is no real objective data that demonstrates reduced demand of their time. Having engaged with all stakeholders, some case studies were provided of where ICAN was able to offer support

and communicate with client / patient whereas previously the GP would have needed to do this. In this previous twelve months also, and since the introduction of the phone service, there were many examples of the ICAN team now calling clients / patients each evening where previously GPs were making these calls.

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."

During some stakeholder engagement in February 2020, one GP explained how at the beginning of the service she did invest some time in the service to ensure that systems were in place and that other staff members were aware of ICAN. She now refers to the service and how often she does will vary. The phone service especially she felt was beneficial and many and has helped with reallocating some resources where previously they would need to make some of these phone calls. She explained how difficult it is to quantify this but stressed how having the service call some frequent attenders has really helped them with their time. As well as time, she also stressed how it helps them with saving some of this emotional energy that was often referred to. Quite often they are faced with a situation where ideally they know they would want to spend more time with a client / patient to get to the route course of the

problem, but due to demand aren't always able to do so, which leaves them with a nagging feeling where they feel they hadn't been able to give the level of support that they wish they could.

For the purpose of the report and the value map – 438 hours saved across North Wales is given, which corresponds to an hour per evening, but across all sites to avoid over-claiming.

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. 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 client / patient 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 but it was apparent that they work very close with the ICAN team.

During the qualitative engagement with health professionals, there was an agreement by psychiatric liaison representatives that any support they can get for mental health is seen as an advantage. There were many examples of how the ICAN team had prevented problems from escalating, but also examples of patients being discharged without having to engage with the psychiatric liaison team, which again allows them to reallocate their time elsewhere.

In the data available between January and July 2019 recorded at the ICAN centres as seen in table 6, there were 72 cases recorded under 'divert liaison', meaning the primary outcome was recorded as avoiding being seen by Psychiatric liaison teams.

Apart from reallocating their time what was also made apparent was that it helped to reduce some of the emotional energy of the health professionals. Patients who attend ED are often in some form of crisis, and those triaged to ICAN are usually facing some form of emotional energy were there might not be any medical treatment as such, and although the patients are vulnerable and need support, it can mean a lot of time and emotional energy for those who need to offer support. By having ICAN there, the psychiatric liaison team representatives felt this reduced some of that pressure on them.

"The more we have ICAN there the better." Psychiatric Liaison

Again, they explained how difficult it was to quantify any real change here. The demand for services has not decreased as we've seen above, but there were many examples of how they were able to reallocate their time to other patients due to having ICAN support. There were also examples of patients being discharged without needing to be seen by psychiatric liaison where in the past they would have.

Only 20% of all clients / patients is included as having a positive change in the value map. 50% of those clients / patients can be considered as possible diversion cases that would have been needed to be addressed by psychiatric liaison and therefore 390 cases are inputted as a potential saving in the value map.

Reduced demand on nurses' time at the wards

ICAN have also been working on the wards during their shift since very early on in the project. 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.

During this time we also spoke to some ED nurses and matron. They explained how glad they were to now have another alternative service then can offer patients which filled a gap for them. One Matron explained clearly her need for the service,

"We want them to stay." ED Matron

It was apparent again, more than creating saving to BCUHB, the real impact here is allowing staff to reallocate some of their services, but also how the service does support with some of their emotional energy. Many of the client / patients presented to ED and ICAN, if not all are in crisis, and may not need medical support, but do need time, somebody to listen and emotional support. This can take a lot out of the staff and taking some of this pressure away allows them to redistribute some of that energy elsewhere.

The majority of the ICAN work is for those triaged through ED departments, but during the focus group it was apparent that they have a good relationship with the wards and will help when appropriate. There less time is included here.

In the data recorded in table 6 above, which is data recorded by the ICAN centres, 59 cases was recorded as being diverted from needed ED physical health assessment. All health related figures in the value map has been taken as a minimum, and careful judgments used to not over –claim.

Reduced number of ambulance calls and police time

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.

During the stakeholder engagement, there were some examples of WAST phone calls being transferred to the ICAN team. There was one example of a father who was having an anxiety attack and was a frequent attender with ambulance and ED. The ICAN team managed to speak with him and helped him to feel more reassured and reduce anxiety levels and he was able to stay at home.

It was also apparent that the ICAN team was well know with the police. Some would contact the ICAN team to explain of a patient that might need their support. Although all patients need to be triaged, some were fast-tracked to allow the police officers to leave rather than sitting in the ED department with patients.

Some of the costs of these services are considered below, but these potential savings are not included in the value map as no direct stakeholder engagement was possible with WAST or the Police as it was beyond the scope of this analysis.

Actions taken following recommendations in interim report and what could be better?

- **Data collection and stakeholder engagement –** In order to measure and manage social value, we need to engage with stakeholders, and we need indicators of change. At the very basic we need outputs, but measuring outcomes is where impact can be understood managed. Since July 2019 no data was available on the project / service due to staffing problems, and this complete data was still not available in April 2020. There were also inconsistencies with how data was recorded during the 7 months, with April and June being recorded in a different way which made it difficult to analyse. The number of clients / patients had been available since the end of March 2020, but other data was still being inputted by volunteers such as time spent in the centers, route of referral, and any actions / outcomes. There is a high risk that if no data was available that the project was not being managed in terms of capacity etc. Although local supervisors were able to report if there were any problems, management were not able to see what was happening and therefore any actions that could have been made to improve impact were lost.

  To understand the social impact of any activities, the first principle is to involve stakeholders. Were possible this has happened for this analysis, but engagement with client / patient is understandably complicated due to the fact that client / patients are in crisis at the time, and may not want to be contacted afterwards as it may remind them

of a difficult time. There were consent forms available for those who felt they would be happy to interact afterwards, however, these forms were also not used, or if used were not made available. Some supervisors felt these were not appropriate to share at the time, which is understandable. However, to understand the impact of any services, some qualitative and quantitative data is needed and therefore it will be recommended that better systems are in place in future.

Better ways of recording data was identified by the volunteers as something that could be improved. Some said they needed a better way of strong data and simpler way. Storing data was also a concern, with some data being stolen on one occasion which is a significant concern.

- **ICAN in the community –** In the previous report, it was recommended that there was a bit more focus on developing ICAN in the community. Many of the stakeholders at the time felt that having a service within the community would be beneficial for individuals with mental health concerns, but having the service within the community would also reduce pressure on ED departments as currently clients / patients would still need to be triaged.

  The community hubs have now been set up in some areas such as Holyhead, Pwllheli, Llandudno and Wrexham. It is still early days for these community hubs and therefore there is no evidence yet to see if these have had any impact on reducing pressure on ED. These hubs are in many cases are further developments or branding of services that were already available within the community, for example Felin fach in Pwllheli where some drop-in sessions were already available. Having a consistent ICAN brand could be beneficial to develop a clear pathway. However, many of these services are still only available during Mon- Friday 9-5, and therefore it is unclear currently how this is different

to services already available. Further recommendations on this will be discussed later. The development of community hubs was echoed by volunteers,

"…I think it should be expanded in the community in places such as GPs and community centres. Would benefit people before they feel they are in final way. As it happens in A&E" Volunteer

- **Time –** in the last report, some stakeholders, especially health professionals felt they could do with having ICAN available earlier, or even during the day. The opening hours has not changed much. The ICAN in the community can address the problems now during the day, however, there is still lack of provision in some areas such as Caernarfon and Bangor. Many of the volunteers and supervisors have other work or are students and therefore considering their availability as well as safety in terms of travel is important.
- **Pathway –** a clear route of referral was also noted in the first report. All client / patient s still need to be triaged and at all sites this was clear. All centers also worked within the wards and a relationship had developed within the hospitals with staff. One health professional mentioned that she now considered ICAN as one of the many other services she might need to refer to such as x-ray or surgery.

  Previously there was some confusion regarding police referrals and whether they could contact ICAN directly, but it was made clear that all patients need to be triaged in the same way. However, in a case where a police officer might need to be present, if they are a suitable ICAN client / patient, then they might fast track this so that the police officer could be relieved. A clear pathway has been developed as is seen in Figure 6 above.
- **Training –** it was agreed by all stakeholders during the analysis for the interim report that more training was needed for supervisors and volunteers when starting their role and as

continuous development. The project had started very quickly, and many felt that they needed more training before being faced with some situations.

There had been a change with training, and it was clear that apart from the induction training, there is a package of different courses available such as mental health first aid, dealing with debt, dementia awareness and much more. Some of the courses are also accredited which was seen as beneficial and especially beneficial for those who were looking to develop their careers in the mental health sector.

A specific role was also developed for a Volunteer and Training coordinator to ensure all training needs are met. A clear pathway to become a volunteer has been developed as seen in the diagram on page 39 and also in appendix 4. There were many courses that were mandatory for volunteers with access to other training.

However, some volunteer expressed that more training was needed. Recently under the new pathway programme, it does note a vast amount of training available, as well as very recently on-line training which support those who work during the day. It seemed that these were recent development and still perhaps not fully implemented everywhere.

Space - In the previous report, space and location of the ED centers was considered a problem at each site. The only place where this had been resolved was at Ysbyty Maelor. Here they now have a designated lockable space for data to be safely stored. However, it is still a considerable distance from the ED centre. In Glan Clwyd and Gwynedd, they still do not have their own designated space and although they felt they had been accepted as a service within the hospitals, the lack of their own space makes volunteers and supervisors feel unappreciated. This impacts on morale. They also feel for the client / patient as it does not make the service look professional. They do not have the required privacy when discussing matters with the client / patient.

When asked in the survey, some volunteers and supervisors said:

"Our centre needs its own area with a more welcoming environment." Volunteer

- **Management –** It was apparent that the project / service had been developed in a short period of time and therefore there was a lack of clear process at the beginning. Many of the supervisors and volunteers had been recruited with no clear role / job description in place.

  It also become apparent that many had not had their DBS checks and were active volunteers. As all the client / patient are vulnerable there is a risk identified here, not only to the patients but also to the volunteer in protecting themselves. No individual can now be an active volunteer without an approved DBS check.

  Supervisors are not employees of BCU but are self-employed and are paid per evening that they work. There was a lack of understanding or guidance perhaps to the supervisors at the beginning in that they needed to register with HMRC as being self-employed for tax purposes as many were already employed elsewhere also so income should be declared. There was also a lack of transparency as to insurance. As self-employed, it was unclear should there be any claim, where the responsibility would lie – with BCUHB or with the supervisor. Many of the supervisors did not have liability insurance.

  As seen above, a clear pathway has recently been developed to address many of these key issues so further implementation of these actions is recommended.

- **Communication** – some of the volunteers / supervisors felt that communication at times was poor. They felt there could be a better line of communication regarding what was happening across north Wales and also better communication surrounding any new processes, training etc.

“Perhaps more team building experiences to help the team get to know each other and to help us gain more experience together outside of the work environment” Supervisor

“Better organized start up for new volunteers.” Shadow volunteer

“Better rota system.”

With regard to better rotas, many commented on how some evenings they would be too many there, and other evenings would be low on numbers.

Along with basic communication, some felt there should be better appraisals for volunteers and supervisors. Some supervisors felt they could do with having formal appraisals as they feel there is no feedback at all on their work which caused some anxiety in some cases. They are dealing with vulnerable people and a vast variety of needs and situations. Although they are not counsellors, they are offering a listening ear to people at a point of crisis, and it is surely a requirement that there should be some way of reflecting and learning from each situation, but at the same time avoiding the loss of formality that could be seen as an advantage of the service. Volunteers also could have some feedback through the supervisors.

Better leadership and line of communication was something many commented on. Some of the volunteers also commented that there were too many supervisors and many trying to “be in charge” which made it difficult. Currently there are 2 supervisors and 4 volunteers on duty, it could be beneficial to have a lead supervisor at all three sites. There clearly needs to be some discussion regarding the employment of the supervisor roles and whether or not employment would be best placed within the Health Board.

Case study – volunteer

Volunteer A is a carer and has personal experience of family members diagnosed with mental health conditions. On many occasions in the past she had visited ED with her family member when they were suffering from panic attacks or suicidal thoughts.

She decided to volunteer as she understood how much the service and support was needed. She'd experienced waiting for several hours in the waiting room as her family member deteriorated. She found this would have a detrimental impact on his health but also on hers.

She views ICAN centres as a calm space and safe environment for patients and that it helps the emotional and physical well-being of client / patient s / patients.

Being involved has helped her to feel a sense of purpose and that she is helping to create a positive change for those going through crisis, as she had been herself on many occasions. She feels the ICAN is a service that offers support with no judgment and where client / patient s / patients can relax and not feel embarrassed.

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 – Client / Patient

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. Therefore, where possible, this analysis has applied the first SROI principle to involve stakeholders as much as possible. During the qualitative interviews and in the surveys, following an understanding of the changes and the outcomes gained, client / patient were asked to rank and rate their outcomes. Therefore, they were asked to put their outcomes in order of importance, and then to rate their importance out of 10. This is where we stopped with their involvement in valuing their outcomes and when it comes to placing a monetary value of their outcomes it was decided to use other techniques other than the value game. The value game identifies their material outcomes, and asks them to prioritise, and subsequently value them against a list of goods or services available on the market to purchase. As the number of client / patient to engage with was limited, there was not enough of a representative sample to play the game, therefore this technique wouldn't be appropriate.

The valuations for the outcomes identified to the individuals were taken from HACT'S Social Value Calculator (version 4)[19] that identifies a range of well-being valuations. However, the

[19] 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)

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 client / patient 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 distance travelled of 56%, and therefore that percentage of the value was used in the value map, which gave a value of £8,901. However, also as we were only able to engage with a very small sample, consideration was only given to 20% of the patients that's been supported by ICAN.

Consideration was given to the recommendations provided in the guide published by HACT[20] 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.

[20] 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.

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 (56%).

Consideration was also given to presenting the results based on different segments. As limited data was available, all clients / patients are grouped together. Further analysis could help to better manage social value in the future if further contact with client / patient s would be possible. Consideration was also considered to include negative values as it is possible for those that changes did not happen, that they might feel worse as a result. However, these were not included here and by only including 20% with positive change, reasonable steps were taken to avoid over-claiming.

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, client / patient 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' 90% had experienced change here

with an average distance travelled of 56%. 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	8	£1,819
Improved skills for employment	7	£1,519
Maintain own recovery in some cases and / or maintain own mental well-being	6.5	£1,477

Supervisors

Outcome	Weighting	Value
Better sense of personal satisfaction by volunteering	8.5	£1,073
Improved skills for employment	8	£1,010

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 57% 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 2019, by PSSRU[21] was used.

Considering the purpose of establishing ICAN, the aim to offer a more integrated seamless support for patients 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 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

[21]Curtis, L.& Burns, A. (2019) Unit Costs of Health and Social Care 2019. PSSRU.

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	£203 per client / patient contact
Nurses time	£28 per hour
Cost of ED visit	£135 per visit
Ambulance – see, treat and refer	£196 per call

This is an evaluation report based on qualitative and quantitative data report and these figures can be used for discussion, but further monitoring is needed on these moving forward 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 / patients 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**
Clients / patients: 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 56% of this value based on the distance travelled, therefore £8,901.	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 56%. 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 20% of client / patient s were reported as experiencing change here and therefore 781 clients / patients.
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 56% of this value based on the distance travelled, therefore £1,819**.**	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 56%. 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, 90% had experienced change here, so 64 volunteers. Only the volunteers were included here, and not the shadow volunteers to avoid over-claiming.
Supervisors: Improved skills for employment	Used HACT well-being valuation for Regular attendance at voluntary organisation valued at £1,773 for unknown area. Took 57% of this value based on the distance travelled, therefore £1,010**.**	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 57%. 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, 80% had experienced change here, so 25 supervisors.

NHS: Reduced potential demand on service – psychiatric liaison	£203 per client / patient contact from PSSRU Health and Social Care Costs 2019.	Considered one case diverted per evening of ICAN across all sites therefore 390 cases * £203	

8.0 Establishing Impact

In order to assess the overall value of the outcomes of ICAN Centres we need to establish how much specifically is 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 was not available. There is always a possibility that the individuals would have received the same outcomes through another activity or by having support elsewhere.

The health professionals within the triage teams and 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.

To have a consistent approach, the different levels of deadweight and attribution will be considered using the rates below;

Low = 30%

Medium = 60%

High = 90%

The deadweight rates have been decided using three steps as follow;

1) During the qualitative interviews, the volunteers, supervisors, health professionals, management team and the limited amount of client / patient s were all asked what they thought could have happened without the support and were they aware of other support that could have offered similar results. They were also asked in a survey, asking *'Thinking about the things that have changed as a result of ICAN, could you estimate the chance that these things could have happened anyway?'*

   For the outcomes for client / patient s / patients, for those that took part in a survey a few months after their visit, 50% said that there was no chance that things could have improved for them without ICAN, and 50% said there was a little chance that things could have changed anyway. This was also echoed by the volunteers and supervisors,

especially those who had either been client / patient s, or had family members who had accessed ED in the past with mental health concerns.

"Good to know there is someone to turn to. It means a lot." Client / patient

Health professionals were also asked about what could have happened, and for them they now had another service that they could refer to when appropriate, and the need for more support for mental health was echoed.

However, clients / patients are attending the ED and ICAN at a time of crisis, and the outcome here looks at how they can be empowered to take actions to create actions themselves. The services that they are referred to or advised to contact afterwards already exist within communities and therefore this must also be considered when deciding on an appropriate deadweight percentage.

For the outcomes for **volunteers and supervisors**, they were also asked during interviews if they knew of any other roles that could offer them the same amount of change. In the surveys, the volunteers and supervisors said there was a low-medium chance they could have experienced the same changes elsewhere, with an average of 37%. Many commented during the qualitative interviews that they had struggled to get volunteering roles that gave the same amount of experience that they needed to further develop their skills and career with mental health.

2) Following this, consideration was given to what other services are available and could these organisations and services have offered the same amount of change. For mental health support during the day time, there are many organisations that can offer support such as Abbey Road Centre in Gwynedd, Aberconwy Mind in Llandudno or KIM Inspire or Advance Brighter Futures in Wrexham area. However, those presented to the ICAN centers are looking for support during the evenings and therefore options for

what is available during those hours need to be considered. Apart from ED, all other services would be over the phone which includes:

- Samaritans-
- CALL- Community Advice and Listening Line
- Combat Stress for veterans
- Dan who offer support with drug and alcohol problems.

All these services are available by phone 24 hours a day. ICAN also now offer a phone service but only for those who have accessed the service previously and where the need was identified. The difference between this service and the ones listed below is that this call can be arranged before and for some clients / patients this helped them to know that somebody would call.

For the volunteers, consideration was given as to other volunteering roles that might give them the same amount of satisfaction, and better sense of purpose as this role did. For those who were volunteering to improve their skills, many said they had struggled to find opportunities elsewhere, especially opportunities that allowed them to continue with other responsibilities during the day time such as family commitments, education or employment.

For those that were volunteering for more personal reasons, many had either directly or indirectly been in a similar situation to the clients / patients previously, and therefore for them this opportunity helped them to make a contribution in a place where they truly understood makes a difference at a time of crisis.

However, it is possible that some of the organisations such as those listed above, would also help them to experience some of these changes.

3) The last step was looking at some secondary research to look at the need for such services in the area. As was demonstrated earlier in the report, the pressure on ED departments is increasing, and the need for more support for mental health services and alternative services in this area lies at the heart of the Healthier Wales strategy. In the Welsh Health Survey, 13% of people in Wales report having a mental health illness, however, in north Wales this figure was lower than the Welsh average. In the 2017 North Wales Population Needs Assessment it was discussed that considering the Welsh Health Survey, the number of adults with common mental health problems is likely to increase by 2035, with other risk factors also considered a risk of unemployment or other life event.

   These stats help us to have a baseline in north Wales, however, many will attend ED because of a crisis, and therefore may not be known to have any previous mental health concerns and therefore would not appear on any stats.

   It's worth noting that at the time of writing this report that Britain was in lockdown due to the Covid-19 pandemic emergency. This will have a huge impact on the population but also on identifying any longer term impact on the work that has been carried out by the ICAN centers, and all the mental health programs and activities under the Together for Mental Health strategy.

   In normal situations it should be possible to identify the longer term impact of the healthier Wales strategy and the Together for Mental Health strategy in North Wales by considering and identifying if there are any changes in the number of people presenting with mental health concerns, the demand on statutory services, and suicide rates. However, as a result of this emergency, and baseline previously is likely to be irrelevant due to the impact COVID-19 will have on the population.

Table 8 – Deadweight Value

Outcome	Deadweight	Justification
Clients / patients – Feeling empowered to work through crisis and take action	60%	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. The clients / patients themselves said there was a low- medium chance that things could have changed without ICAN, and as many were in crisis at the time, understanding what could have happened otherwise is difficult. To avoid over-claiming a medium rate is used here.
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.

For the clients / patients, many were at ED on their own, others were there with family members or friends. In the scenarios where there were family members, there were case studies of how they had also benefited of the support as they were also facing their own crisis as they were unsure as to what to do to support their loved ones. Some of the volunteers themselves explained how they had struggled in the past as loved ones needed support. During the stakeholder engagement process, many were asked about support by others. The majority were receiving some support by other organisations, however, at the time of crisis felt that no

help was available. Many explained how the evenings especially can be challenging and therefore felt that attending ED was the only option for them.

Many were alone and isolated, and the phone calls especially was helpful for some individuals in maintaining and positive changes.

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, the average percentage for the volunteers was 74% and supervisors was 70% meaning that a 70% of the changes were because of ICAN, and therefore a low attribution rate. In the 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 others such as the support from the University for those in education, and others may be employed in a health and social care setting.

In terms of the clients / patients 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 / patients 'felt empowered' by the service. This was also confirmed in the client / patient 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 over-claim.

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 and duration

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.

The service is being evaluated for the initial 15 months. The value map will only include per annual value, and therefore consideration was given as to include one year or two years of value.

It is worth noting, that any value created would only be when the service was available for many. For the clients / patients hopefully the changes would be sustainable if some of the actions were implemented afterwards. There in order not to over-claim, over one year of value is included, and therefore no drop-off rate needs to be included.

Risk of over-claiming

Adhering to the principle of not over-claiming throughout, great care was taken to not over-claim at each stage of the analysis. Many assumptions have been made, but judgements based on stakeholder engagement and secondary information.

- A good representative sample was taken for the qualitative and quantitative data collection from the volunteers and supervisors. However, it was difficult to engage with volunteers who left the service early therefore in the quantitative data the amount of client / patient that did not engage were not included.
- Engaging with clients / patients as was understood at the beginning would be difficult due to the nature of the service. However, a small sample did engage with this analysis and some insights were also possible through volunteers and supervisors who had either been clients / patients or had experience of attending ED themselves or with family members. Although all clients / patients who did take part in the analysis had identified positive change, only 20% of all clients / patients were used in this analysis to avoid over-claiming.
- There was representative from all different subgroups selected for the qualitative stages. It is recognized that there is risk that the volunteers were not representative of the group, however, having spoken to veterans and supervisors at all three sites and some health professionals informed assumptions were made.

- Great care was taken to understand the right levels of deadweight and attribution. As well as engaging with stakeholder, some research was made on other services available as well as local trends.
- All clients / patients who engaged with the analysis felt that the service provided life changing outcomes. However, only one year of value was taken after project to reduce the risk of over claiming.
- Many of the clients / patients, volunteers and supervisors discussed how the service had ‘saved lives’ and that the risk of suicide was very high. Due to the severity of the situation, the well-being valuation from HACT was used, but only the appropriate amount of change was taken from the value.

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 locally 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	£1,945,395	89%
Volunteers	£125,695	6%
Supervisors	£27,094	2%
BCUHB	£64,976	3%

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	£2,030

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	£2,075,787
Investment value	£489,889
Net present value (present value minus investment)	£1,585,898
Social Return on Investment	**£4.24:1**

The result of £4.24:1 evaluation that for each £1 of value invested in the ICAN centres, a total of £4.24 of value will be created.

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 £1.36 and up to £8.21 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 £4.24.

Verification

- All clients / patients, volunteers and supervisors who took part were asked to confirm their well-defined outcomes at the end of every interview / focus group but were also asked about outcomes of others where relevant.
- Materiality – Looking at the % of change, only 2% of the value belonged to the supervisors and 3% to BCUHB. For BCU, including this was important as it was the main objective of setting up the service. Taking away the supervisors value would not have a bug impact on results, and as many had also experienced life changing outcomes, including this was considered important, but taking careful steps not to over-claim.

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 client / patients from 20% to 15%	£3.28	-£0.96	22.6%
		Increase deadweight from 60% to 90%	£1.36	-£2.88	67.9%
		Change financial proxy to £4,000	£2.12	-£2.12	50%
		Change duration from 1 years to 2 year	£8.21 £4.30 when drop off of 50% added	+£3.97 +£0.06	93.6% 1.4%
Volunteers	Better sense of personal satisfaction by volunteering	Change % of volunteers experiencing change to 50%	£4.19	-£0.05	1.1%
		Change attribution from 30% to 60%	£4.19	-£0.05	1.1%

	Maintain own recovery in some cases and or maintain own mental well-being	Change financial proxy to £900	£4.18	-£0.06	1.4%
Supervisors	Improved skills for employment	Change deadweight from 30% to 60%	£4.23	-£0.01	0.2%
		Change financial proxy to £500	£4.22	-£0.02	0.4%
		Change attribution from 30% to 90%	£4.22	-£0.02	0.4%
BCUHB	Reduced number of hours for GP's out of hours	Change number of hours from 438 to 200	£4.21	-£0.03	0.7%

Limitations

As demonstrated above, great care was taken to adhere to the principle of not over-claiming. However, it is also important to recognise that there are some limitations.

- The first principle of social value is to Involve Stakeholders. To understand any changes in the lives of people who matter, we need to engage with those who experience the changes. Due to the nature of the service, it was understood that engagement with clients / patients would be limited. Although some engagement was possible, great care had to be taken to not over-claim and use judgments based on engagement with other stakeholders and based on secondary research.
- Focus groups were held at all three sites in February 2019 and in February March 2020. There was a good representative sample in Ysbyty Gwynedd and Ysbyty Maelor in the focus groups, and also a good sample of surveys. However, there was a small sample at the Glan Clwyd focus groups, and no surveys returned in March 2020.
- Data – up to July 2019, monthly data was available on the number of clients / patients, time spent, source of referral, and actions / outcomes recorded of the service. Client / patient feedback was also collected up until then. Due to some staffing issues within the data department of the Health Board, only limited amount of data was available in April 2020- that being only the number of attendees. The other data was still being processed by volunteers but was not available in time to produce this report.
- COVID-19 – at the time of writing this report, normal service had terminated due to the pandemic emergency. Although all qualitative had been completed, further verification with health professionals would have been preferred to confirm some results. However, data on ED and waiting times was available.

  Although this emergency does not directly impact the result of this report, one of the recommendations with this report, but in measuring the long term impact of all projects under the Together for Mental Health programme, would to look at how these projects have impacted on trends such as the numbers attending ED, reallocation of resources, the number of people with mental health problems, and feedback from those who matter the most on how services are more streamlined. However, it is highly

likely that this huge change changes affecting the lives of everyone in the UK will mean another layer of challenges, and therefore any baseline that was therefore before this emergency will not be relevant.

11.0 Conclusion

This report has demonstrated that the ICAN Centres pilot will create over £1,585,000 of value, and for each £1 invested, £4.24 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 Wrexham it provides an integrated service for those presenting to ED and facing a mental health crisis. Already, within fifteen months, the service is being utilised like any other hospital service and patients are 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 understood 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, £4.24 of social value was created.
- The cost per individual supported by this service is £125. This is for a service which supports individuals in crisis who attend the three main hospital sites across north Wales. When considering how problems could escalate, this does provide value for money.
- Based on a small sample and some case studies, client / patients had experienced quite a lot of change in feeling more empowered to manage their crisis and take actions.
- 100% of client / 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

- 90% 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 a service based within ED who are able to spend time and listen to clients / patients and ensure their needs are central to all planning and adheres to the needs identified within the new legislative framework in Wales.
- The service was set up quickly without taking care to ensure a clear pathway was in place to recruit volunteers and supervisors, and to ensure the safety of both client / patient and volunteers and supervisors. A pathway is now created and steps must be taken to ensure this is being managed.

12.0 Recommendations

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 results 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.

   Some of the volunteers and supervisors expressed concerns about recording data and asking for feedback which is understandable due to the nature of the service, however, there needs to be an understanding that data would need to be recorded with the aim to better manage social value. Having the volunteers and supervisors more confident in how to record, but also why the data is needed can help with this process.
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 client / patients will need to take place. Initially, contacting the client / patients was not 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 client / patients 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) **Leadership and management –** Looking at the 'what could be better' section in this report, investment needs to be given in ensuring the right leadership and management of the project. All stakeholders agreed that there is a need for such service within ED departments, but also within communities to support any sustainability of change. One of the concerns was how quickly the service had developed without a clear pathway, and some concerns were raised about safety and safeguarding. Some recommendations are given below based on feedback with stakeholders:

    - **Appraisals** - Many of the supervisors and volunteers felt that a better system for feedback and appraisals of their work was needed, both to ensure the safety of client / patients, but also to improve their own personal development and give them reassurance in the service they are providing. Although supervisors are self-employed, as with other professions when offering support for vulnerable people, there surely needs to be accountability and clear leadership. This might be a main supervisor based at each site supervising each supervisor, and then supervisors appraising volunteers every quarter. This would also help to solve another issue that was raised which is **communication**. Having a clear structure would help to ensure that volunteers have a clear line of communication, and appraisals would help to allow them to identify any training needs.
    - **Training** - A clear pathway for the ICAN volunteers and supervisors is now available as seen in appendix 4 and many steps have been taken to improve the pathway for both client / patients, and for recruitment of volunteers and supervisors since the interim report. This includes having a clear training path, steps to safeguard, as well as ensuring staff and volunteers receive feedback and supervision. This provides a solution for many of the concerns raised by volunteers and supervisors, and therefore great care must be taken to ensure all these steps are implemented.

- **ICAN Steering group** – A steering group was set up to manage the development of the ICAN centres. These meetings was not well attended and with many meetings cancelled. Minutes and agendas were not shared beforehand on a regular basis and therefore actions were not always acted upon. This group could help to ensure a greater support network for the service and a solid management structure moving forwards.

4) **Location** – Location was still an issue at Gwynedd and Glan Clwyd hospitals. In Gwynedd they were close to the ED department but felt the room itself was not appropriate as porters were coming past and no area for any confidentiality. In Glan Clwyd, 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.

5) ICAN in the community

Considering the 'Sanctuary' [22]in Bradford, having the space within the community had seen reduced number of police cells as places of safety and also reduced number of people attending A& E in crisis. As was clear in this report, currently there is no evidence of ICAN having any impact on the number of people attending ED department or a difference in waiting times. In time, looking at the impact of both ICAN in the community and ICAN within ED departments together will give a better indication of any sustainable change to the outcome experienced by clients / patients, but also to the demand on statutory services.

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

13.0 Appendices

Appendix 1 – Client / patient Survey

CAN client / patient survey

ICAN Client / patient 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

	Doesn't apply to me	A little change	Some Change	Quite a lot of change	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
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

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+

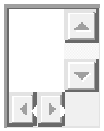
Question Title

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
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

	Doesn't apply to me	A little change	Some Change	Quite a lot of change	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
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	I feel a better sense of personal satisfaction from being	I feel a better sense of personal satisfaction from being	I feel a better sense of personal satisfaction from being	I feel a better sense of personal satisfaction from being	I feel a better sense of personal satisfaction from being	I feel a better sense of personal satisfaction from being	I feel a better sense of personal satisfaction from being	I feel a better sense of personal satisfaction from being	I feel a better sense of personal satisfaction from being	I feel a better sense of personal satisfaction from being	I feel a better sense of personal satisfaction from being able

	1	2	3	4	5	6	7	8	9	10	Not applicable
able to support others	able to support others 1	able to support others 2	able to support others 3	able to support others 4	able to support others 5	able to support others 6	able to support others 7	able to support others 8	able to support others 9	able to support others 10	to support others 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

	1	2	3	4	5	6	7	8	9	10	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 **10**

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

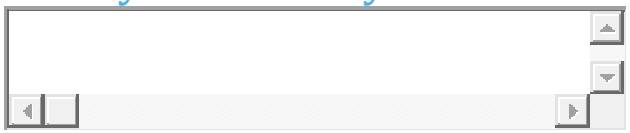
15. Is there anything that you would like to see being done differently or/and what could be better?

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.



Appendix 4 - Pathway

PATHWAY FOR THE ICAN VOLUNTEER/SUPERVISORY PROGRAMME

ICAN is a new service that provides a listening and talking facility, with signposting to people in crisis or in need of emotional support. ICAN is part of the transformation project supported by the Welsh Government. This programme is run primarily by volunteers, with support from supervisors. The Unscheduled Care Services are run at Wrexham Maelor Hospital, Ysbyty Glan Clwyd and Ysbyty Gwynedd in the evenings until late.

This service operates on the Person-Centred Theory, finding out what is important to the client / patient ; accepting what the client / patient says without judgment or reservation; helping them to reflect on the issue at hand; and then to signposting them to appropriate services. ICAN cannot resolve an individual's issues but strives to offer unlimited time for the client / patient to express how they feel and how they understand their particular situation. This is accomplished by listening and accepting the client / patient without reservation, creating a moment of stability in a moment of crisis, so that they can make the best decisions for themselves to move forward.

Working with people in crisis can be very rewarding. However, it is imperative that you, as an ICAN volunteer, are in good mental health, have a clear understanding that the client / patient 's issues are their own issues and not yours, and to work with healthy safeguarding measures in place. This document will go into further detail of how the service operates with the safeguarding structure in place to ensure the health and well-being of all involved. It is, therefore, important that each volunteer has a clear understanding of what is and, moreover, what is not permissible to do in the role of an ICAN volunteer. All volunteers and supervisors should be of good moral and social standing.

HOW TO BECOME A VOLUNTEER

Application process:

All new volunteers must fill out and complete an ICAN application form (Appendix A). This form can be found online at https://bcuhb.nhs.wales/i-can/i-can-volunteering or at one of the information sessions held on a regular basis at each of the three hospital sites: Ysbyty Gwynedd - 1st and 3rd Monday of each month at 7 pm, meeting at the main reception; Wrexham Maelor Hospital - 1st and 3rd Wednesdays of each month at 6pm, meeting at the main reception revolving doors; and Ysbyty Glan Clwyd -1st and 3rd Thursdays at 8 pm, meeting at the main reception.

Information session:
Information sessions are held either in the hospital or at volunteering recruitment events. Here, you will receive general information on ICAN working methods with client / patient s, the role of the volunteer, ICAN's ethos, how different departments of the hospital are used as pathways and how referrals and signposting are offered. Please complete the attached application form and bring it with you to one of the sessions below, along with your official government-issued identification documents (see ID information below).

Where information sessions are held on a regular basis
Ysbyty Gwynedd - 1st and 3rd Monday of the month from 7 pm (meet at the main door)
Wrexham Maelor – 1st and 3rd Wednesday of the month from 6 pm (meet at main revolving door)
Ysbyty Glan Clwyd – 1st and 3rd Thursday of the month from 8 pm (main reception)

Local CVS
ICAN is also supported by the local CVS. Advertisements for volunteers and news may also be found at these locations. If they do not have an application form onsite you can find one online at https://bcuhb.nhs.wales/i-can/i-can-volunteering

Application:

The application form gathers general information about you. Furthermore, you need to supply the names, emails and contact numbers for two (2) referees who have known you for more than six (6) months. These could be your employer, mentor and/or teacher/professor. At the end of the application, you must sign and date the GDPR (General Data Protection Regulation) agreement and the permission section, allowing us to carry out a DBS check. Please bring to the information session at the hospital two (2) pieces of official government-issued identification (Driver's License, passport, birth certificate, marriage certificate) and one form of postal identification with your current address on it (not more than 3 months old, such as bank statements, Council Tax, gas or electric bill).

DBS check:

The DBS check will be carried out at ICAN's expense. When this is completed, you will receive an email from Vibrant Nation (the company contracted to carry out the DBS checks for all ICAN supervisors and volunteers). **You will need to action that email by filling out all sections and click the "Submit" button.** After they have received your submission, and all information is correct, your complete file will be sent off to be processed. This can take several weeks. However, most seem to

come back in around a week. Once your DBS and references have come back clear, you must then come to an induction session (DBS Policy Appendix xxx.)

Shadow shifts:

During the application process, you are encouraged to do “shadow shifts”, by putting yourself on the rota, to observe how ICAN operates. It will give you a true sense of how ICAN works. You can listen in to client / patient phone calls and sit in the debriefs, if appropriate; join in conversations with other volunteers and supervisors; take an initial tour of the A&E Unit, ward sweeps and hand out flyers explaining to all hospital staff about the ICAN service. Please note, due to safeguarding issues, you may not have direct contact with client / patient s during this period. As shadow shifts run at different times at each location, please get details from a supervisor at your location. You can do as many shadow shifts as you want, but we require that you do a minimum of nine (9) hours, which is three (3) shadow shifts. It is recommended that you attend all booked training sessions during this time in your area.

Induction:

Induction sessions will take place after all checks are completed. This will be held in the hospital. Your volunteer file will be created, and you are free to place yourself on the rota as a volunteer. This session will detail the rules and guidelines of ICAN, fire safety, roles of supervisors and volunteers, signature of confidentiality forms, and you will receive an ICAN polo shirt and ID badge form filled out ready for processing. Please refer to Appendix xxx for a full list of documents needing to be signed and kept in your personal file.

Role of the volunteer:

Volunteers are expected to:

- Ensure the safety of all client / patient s by careful supervision, preparation of the space during the sessions, using safe methods at all times
- Consider the well-being and safety of client / patient s before and during the service
- Treat all client / patient s equally and ensure they feel valued and respected
- Non-discrimination on the grounds of religious beliefs, race, gender or social class as stated in the ICAN Equal Opportunity Policy (Appendix xxx)
- Always use correct and appropriate language
- Always be positive, encouraging and supportive to each other and client / patients
- Report accidents or incidents on the appropriate forms and follow all necessary procedures
- Always follow proper safeguarding procedures
- Dress appropriately - the blue ICAN t-shirt and identification badges **must always be worn during shifts**

- Always maintain confidentiality around client / patient s
- Respect and listen to the opinions of client / patient s
- Take time to explain the service and what we can do to help
- Explain care pathways and referrals when necessary
- Develop a positive working relationship with other volunteers and supervisors
- Encourage and support other volunteers
- Be trustworthy and dependable
- Not to discuss any client / patient s, issues or events with anyone external to the ICAN Team
- Not to arrive on shift under the influence of alcohol or drugs
- Work within the parameters of the service and adhere to the Centre's work patterns
- Honour shifts booked on the rota, whenever possible, and allow at least 24 hours' notice if you cannot attend a shift
- Attend training and information sessions
- Complete all relevant paperwork expeditiously
- Submit volunteer cost information sheets with receipts to your Shift Supervisor at the appropriate time
- Keep fobs and identification badges safe – If lost or stolen, report it immediately to your supervisor so that it can be cancelled and replaced
- Mobile phone use - Personal use of mobile phones should be kept to a minimum during shifts
- Keep working area clean and tidy

Volunteers have a right to:

- Access training and information to help develop skills appropriate for their role
- Support to escalate issues or report neglect/abuse
- Regular supervision and support from the Supervisors
- Fair and equitable treatment by other professionals
- Not to be left in a vulnerable position during the ICAN Centre shifts

Confidentiality:

All information concerning ICAN client / patient s is confidential. What is heard/learned in ICAN about client / patient s must stay in ICAN. There are only two (2) exceptions: confidentiality must be broken when a client / patient states they intend to either (1) hurt themselves or (2) others. This must then be reported to a Supervisor who will inform the appropriate bodies for further intervention. Detailed pathways are covered at the mandatory BCUHB Safeguarding Training. ICAN information sheets must not hold personal identifying details of an individual. Names, addresses or date of birth will NOT be recorded, with the exception of client / patient s who receive pre-arranged emotional support calls, where only their first name, phone number and a brief history are maintained while the support calls are being made. This information is held in one book, kept in the ICAN office and must

be locked and secured when not in use. The client / patient ’s information is then destroyed once the calls have finished.

All discussions about client / patient s must be carried out in a respectful manner and must be to the benefit of the client / patient . These discussions should also only be held within the ICAN environment or if an outsider is invited into the conversation. It must be clear that the information you share is relevant ONLY to the situation at hand. If, for example, someone you know comes into the ICAN unit, that fact alone must be kept confidential. You cannot share that information with anyone, including your family, friends or other agencies. Breach of this will result in disciplinary action.

Mandatory training:

As an ICAN volunteer, volunteers are required to attend and complete four (4) mandatory training sessions. These are: Safeguarding, First Aid Training, Fire Safety and ICAN Mental Health and Suicide Awareness Training. These must be completed within the first three months of volunteering.

Safeguarding:

This training is offered through the BCUHB training programme. It is offered a minimum of once a month at each of the hospital locations. Information of the dates and times of the training sessions is available from the supervisors. Once the training is completed, the volunteer must bring in their certificate to be registered in their personal training file.

First Aid Training:

This is the responsibility of the volunteer to acquire. There are many different locations and groups which offer this training. Once training has been completed, the volunteer must bring in their certificate to be registered in their personal training file.

Fire Training:

This training is offered at each location three (3) times a year. It is run by the hospital Fire Marshal. Once the training is completed, volunteers must bring in their certificate to be registered in their personal training file.

ICAN Mental Health and Suicide Awareness Training

This training is offered once every two (2) months at each of the locations. Details of the dates and times are available from the supervisors. Once the training is completed, volunteers must bring in the certificate to be registered in their personal training file. Volunteers must always wear the ICAN Mental Health Trained badge with their identification badge.

Other training:

In-house training:

Once every two (2) months, ICAN offer additional recommended training. These are, but not limited to: ACES’s training, Self-Harm Awareness, Suicide Prevention,

Autism Awareness, Dementia Friendly, Hate Crime Awareness, LGBT+, Bereavement Training, Homelessness Issues and many others. A schedule of those sessions are available from your supervisors.

BCHUB required training:

Besides the four (4) mandatory training modules for ICAN, there are other training modules necessary to work on the BCUHB sites. As an ICAN volunteer, volunteers' names and email addresses will be added to the on-line training centre and you will be given a username and password to access the site. These can be done online and or in-house as a group. These modules are:

- Adults at Risk
- Children and Young People at Risk
- Violence Against Women, Domestic Abuse and Sexual Violence
- Dementia Awareness
- Equality & Diversity
- Environment, Waste and Energy
- Fire Safety
- Health & Safety
- Infection Prevention
- Information Governance
- Mental Capacity Act
- Resuscitation
- Sensory Loss
- Violence & Aggression Module A

All these modules must be completed in the first six (6) months of volunteering.

Supervision:

Supervision is part of the daily ICAN routine. After each session with a client / patient , the volunteer will be debriefed and supported by a supervisor. If further support is needed, additional support is available from the Volunteer and Training Coordinator and other outside sources. It is of the greatest importance to ICAN that the mental, emotional and physical safeguarding of volunteers and supervisors is paramount. ICAN volunteers do not do lone work. They are never put into vulnerable situations. Each volunteer has the right to refuse to work with any client / patient without question.

Bronze, Silver and Gold volunteer status:

All Volunteers will enter the service as a Bronze level and progress to Silver and, then Gold. Their advancement will be discussed at the monthly Supervisors meeting. This is an agenda item set at every meeting. Minutes of these meetings are kept at the ICAN Administration HQ located at Bryn Tirion, Bryn y Neuadd site, Llanfairfechan.

Rota/Scheduling:

Each location runs at slightly different times. Each use a WhatsApp group for scheduling shifts. Once you are a volunteer, you will be added to this group. We ask that all volunteers do a minimum of two (2) shifts a month. This is to keep you up to date with any changes and feeling comfortable in your environment. When you want to be put on a shift, simply message on the Rota Group what day you would like to work and that night's supervisor will add you to the rota, taking a picture of the rota and posting it. The last picture on that chat is always the most up-to-date rota. If you need to cancel a shift, we please ask to give as much notice as possible. Each shift has four (4) volunteers and two (2) supervisors. Check the rota for needed spaces. The volunteer shifts may run at different times than the supervisors. Volunteers can do half (1/2) shifts, if there is space available. If a shift is low on volunteers, it is on the Rota Chat that a call out for any available support will be posted.

Expenses:

Volunteers can claim back their travel expenses. They are reimbursed 0.45 pence for each mile, up to 15 miles each way. If bringing the bus, this too can be reimbursed but please note that a receipt for each journey needs to be presented. At the induction

session, each volunteer will be given a personal bank detail form to complete. All Volunteers travelling by taxi will need to discuss this at the induction meeting in terms of compensation. Payments are made by the end of first full week of each month.

Communication:

Most ICAN communication is done in WhatsApp or Messenger. New volunteers will be invited to these groups once they have completed the induction session. To remain part of these groups, volunteers must do a minimum of two (2) shifts a month. If stopping volunteering for a time, volunteers will be temporarily removed from the groups and re-added upon their return to shifts. It is important to note that these groups are for general chat and sharing of social information, such as new services in the local community, news and group discussions. It is not to discuss client / patient s at all. Names and situations pertaining to client / patient s will be a breach of confidentiality and may result in disciplinary action. There should be no swearing and chat should be friendly, supportive and kept professional at all times. We kindly ask that all messages stop at midnight and not to restart before 9 am, so as not to disturb Volunteers/Supervisors and their partners while not at ICAN who could be sleeping. In case of an emergency, please private message the contact Supervisor. Bullying of any description will not be tolerated and will be cause for disciplinary action.

Grievance:

ICAN uses the format and structure of the BCUHB grievance policies.

Insurance:

All ICAN volunteers and supervisors are covered under the BCUHB indemnity insurance (Appendix C) while on shift and on premises. Please note that this means any contact with client / patient s must take place during the opening times and location of ICAN. Volunteers should not take client / patient s to their home after a session. If a volunteer were to take a client / patient home in their car, the volunteer is not covered by the insurance. This action is not part of the ICAN duty as a volunteer/supervisor. A copy of the BCUHB Insurance Certificate is located at each of the ICAN Centres at the DGHs and a copy is also attached in Appendix xxx.

Discipline:

In order to effectively run a service with client / patient s who are in crisis, it is fundamental that strict guidelines are adhered to, in order to maintain high levels of safeguarding. Therefore, all instances that go outside of the stated protocols, regulations and rules will be handled by the Volunteer and Training Coordinator.

In the event of an infraction being reported, a one-on-one meeting will be scheduled to discuss the issues within seven (7) days of the report. Depending on the issue and infraction, one of three (3) outcomes could transpire.

Three levels of disciplinary action are:

- No infraction of protocol found – no action taken
- Minor infraction found and understanding that same will not happen again – a record of the incident will be recorded in the volunteer file
- Major infraction found – immediate termination of volunteer

ICAN protocols

ICAN is a confidential service which works face to face with people in crisis. It is of the highest importance that safeguarding measures are always in place. Therefore, no one-on-one working. All client / patient s must have two (2) ICAN people with them: A Volunteer and a Supervisor. It is the role of the Volunteer to have direct contact with the client / patient and the session to be monitored by a Supervisor.

It is strongly recommended that Volunteers do not share their personal information. There may be occasions that the volunteer may want to share a personal life experience with a client / patient . This is only appropriate when that will benefit the client / patient . The ICAN team is there to listen, get to the core of what matters to the client / patient , help them to see alternatives to the situation they are experiencing and then to signpost them to appropriate services, events and groups.

There is never a situation that a Volunteer should give out their personal phone number or see client / patient s outside of ICAN hours or in public. Breach of this may result in disciplinary action. ICAN Volunteers/Supervisors must not enter any form of non-professional relationship with client / patient s, even former client / patient s. This includes visiting them at home, meeting in town for a coffee or calling them to see how they are doing. Any social activities with client / patient s must be approved by the Volunteer and Training Coordinator.

Physical contact with a client / patient must always be appropriate to the situation. A hug at the end of a session may be appropriate if it is initiated by the client / patient . Kissing and any form of sexual contact is never appropriate and will result in disciplinary action.

Building good friendships and contacts within the Volunteer/Supervisor group is encouraged. However, any romantic relationships that develop between ICAN Volunteers/Supervisors must be announced to the Lead Supervisor.

ICAN is in the hospital to support A&E, Out of Hours and all hospital staff. It is imperative that we support those services with professional and friendly attitude, always greeting with a smile and time to chat.

Respect of the building and environment is essential. The ICAN team will always leave the space it uses clean and proper for the next shift. Report anything that is low in stock or is broken to the supervisor.

At the start and end of each shift volunteers are required to sign in and out. The volunteers must stay in the ICAN centre or inform a supervisor if they leave the area i.e. go to the shop or go outside to smoking area, etc.

Smoking must only be done in designated areas and, if wearing an ICAN polo shirt and badge, they must be covered up.

When a referral comes in a Supervisor will go to collect the client / patient and bring them to the ICAN Centre; present that client / patient to the volunteer and then go to another part of the room where they can observe the interaction with minimal interference. The Supervisor will always be there for support if required. The client / patient is always offered a cup of tea/coffee or hot chocolate, biscuits and/or a sandwich. A referral form will be completed for each client / patient by the Volunteer. When the session is finished, the supervisor will then take the client / patient back to the referring agent, then come back and debrief the volunteer. Depending on the situation, the Volunteer may accompany them back.

ICAN cannot, and will not, accept client / patient s who are under the influence of drugs/alcohol, who are in psychosis, who are violent or aggressive or under the age of 18. If a client / patient deteriorates and/or becomes aggressive or violent, they will be returned to A&E with assistance of the hospital security team. If a client / patient uses threatening terms or behaviours, the session will be terminated immediately, and the client / patient returned to A&E.

When leaving for the night, the ICAN team all leave together and ensure that each get to their vehicle. If you are doing a short or half shift, you will be accompanied out of the building and to your car.

ICAN pathways:

All client / patient s coming into the ICAN Unscheduled Care Team must be referred from a clinical source. These sources are A&E Triage, Psych Liaison, GP Out of Hours and Ward visits. Other bodies may refer, such as North Wales Police, Ambulance Service or 999 Call Centre. Client / patient s through these sources must pass through the A&E triage before coming into the ICAN Centre. Please see the attached ICAN referral pathway document in Appendix xxx

Client / patient scale or code:

ICAN operates with the traffic light (“Green Amber Red”) code system. The clinical referral will supply this code for each client / patient . Green is low-level mental health issue – often a situational issue that has them concerned, i.e. relationship or financial issue. Amber is a higher level mental health issue, often with a client / patient who has

a mental health diagnosis or currently having strong emotional issues. Red is severe mental health issue – often thoughts of suicide - self-harm or actual self-harm. All three codes can come through ICAN if deemed appropriate by the referral agent.

Phone etiquette:

A strict phone etiquette is essential when working with client / patient s on the phone. Refrain from swearing, even if the client / patient swears. The balance is to be real, yet professional. The conversations are often about very heavy and potentially upsetting events of a person's life. Phone calls are conducted on a speakerphone so that the supervisor can also listen in. Many of the emotional support calls are just chats about daily life of the client / patient , and this is offering them that moment of stability every day. For many, it is the highlight of their day as they may be self-isolating. New Volunteer, you will have the opportunity to listen in on phone calls before making your own calls. There is also training available several times a year through C.A.L.L. to enhance your telephone support techniques and skills.

ICAN's Responsibility to the Volunteer:

- ICAN will offer the mandatory and recommended training to all Volunteers
- Offer daily supervision after each session and shift
- Adhere to all polices set out in this document
- Reimburse travel expenses
- Provide a record of hours volunteered
- Give certificates and badges of Bronze, Silver and Gold levels
- Offer insurance while working
- Provide ICAN polo shirts
- Provide BCHUB identification badge
- Offer a clean and safe place to work
- Offer a secure place to keep your belongings
- Keep your personal details and data safe
- Ensure your safe return to your vehicle at the end of shift

Responsibility of the Volunteer to ICAN

- Turn up to shifts as scheduled
- Inform ICAN via the rota chat as soon as possible any changes in schedule
- Always behave and act in a professional manner
- Treat all other ICAN and hospital staff with respect
- Treat all client / patient s with respect and dignity
- Keep all information confidential
- Attend all mandatory trainings
- Wear appropriate clothing
- Always wear your ICAN polo shirt and identification badge while working

Role of the supervisor at the Unscheduled Care Location

Procedures

- Be at ICAN office fifteen (15) minutes before shift starts
- Sign in and ensure all volunteers sign in
- Support the volunteers to set up the centre appropriately
- Ensure centre phones are working
- Adapt site to ensure client / patient s' comfort and safety
- Ensure that everyone on the team knows all fire exits and emergency contact numbers (2222 Medical and 3333 Fire)
- Ensure there is enough coffee, milk and sugar etc for the shift
- Get a supply of sandwiches for client / patient s
- Check diary for any updates from the previous night's shift and discuss and inform team
- Arrange which Volunteer will make pre-arranged phone calls
- Do a walking tour of A&E triage, minors and GP Out of Hours
- Arrange walking tour of wards for the evening (3 times a week)
- Speak to all referral agencies face to face or on the telephone to discuss client / patient and explain how they will be returned to them for discharge and debrief of each client / patient
- Discuss client / patient with triage/streaming team and Psych Liaison to confirm suitability
- Escalate any concerns around a client / patient to referral agency or BCHUB staff at A&E/Psych Liaison
- Ensure all Volunteers and fellow Supervisors are supported whilst with a client / patient
- Speak to each Volunteer or Supervisor following every interaction with a client / patient
- Conduct an end-of-session debrief with the team and escalate any concerns to lead Supervisor or Volunteer and Training Coordinator
- Oversee the closure of the service at end of shift
- Ensure all the team have signed out at the end of each shift
- Ensure that the ICAN area is clean and tidy at the end of each shift
- Ensure that all client / patient referral forms and log in sheet have been completed and are in numerical order
- Ensure that all the team leave together and that everyone is securely in their car or transport

Paperwork

- Support Volunteer or other Supervisors to ask client / patient s to complete the feedback form if appropriate
- Complete all incident forms as required
- Update the service diary
- Complete the logbook nightly

- Ensure that all information and files are securely locked away
- Support lead supervisor with relevant/required information
- Encourage all team members to gather and share information on local and relevant services and update the information file regularly

ICAN's Responsibility to the supervisor:

- ICAN will offer the mandatory and recommended training to all Supervisors
- Offer daily supervision after each session and shift
- Adhere to all polices set out in this document
- Provide a record of hours worked
- Offer insurance while working
- Provide ICAN polo shirts
- Provide BCHUB identification badge
- Offer a clean and safe place to work
- Offer a secure place to keep your belongings
- Keep personal details and data safe
- Ensure the safe return to vehicle at the end of shift

Responsibility of the supervisor to ICAN

- Turn up to shifts as scheduled
- Inform ICAN via the rota chat as soon as possible any changes in schedule
- Always behave and act in a professional manner
- Support all Volunteers with safeguarding and debriefing after each client / patient
- Escalate any issues to the Volunteer and Training Coordinator
- Treat all other ICAN and hospital staff with respect
- Treat all client / patient s with respect and dignity
- Keep all information confidential
- Attend all mandatory trainings
- Wear appropriate clothing
- Always wear your ICAN polo shirt and identification badge while working

Wages

All Supervisors will receive a set amount for each shift worked. The shift is not set in hours, the minimum shift is six (6) hours but may go to seven (7) hours or beyond given the situation. The Supervisor must complete an ICAN invoice each month. This is checked against the sing-in/sign-out sheet and approved by the administrative supervisor for each site or the Volunteer and Training Coordinator. Payments are made by the end of the first full week of each month. Supervisors are not under contract but are self-employed. Gaining a supervisory position within ICAN gives right to schedule yourself on the rota as a Supervisor and receive the session payment. There may be only (2) Supervisors' maximum per shift. Each Supervisor must report all earnings to the tax authority – HMRC. Supervisors are not entitled to holiday pay, sick leave or bank holidays. Supervisors are asked to do two (2) full shifts a week

maximum, exceptionally more if covering for sickness or holidays of other Supervisors. There are no additional benefits for this post apart from the paid session rate for each shift. As this role is not under contract, there is no notice to be given if an individual's services are no longer required as a supervisor.

Recruitment of supervisors

When a supervisory role becomes available, all Volunteers who feel they are ready to apply for this position are encouraged to do so. Gold level volunteers will be strongly considered for filling these roles as a priority. It is mandatory that every applicant have a minimum of 50 hours of volunteer service within ICAN. Applications will be made available when a position opens. All new Supervisors will go through a training process via shadowing several other Supervisors. This shadowing period will last a minimum of 10 full shifts and will be considered as a trial period. All Supervisors are self-employed. This role does not have a contract and all earnings must be reported to the tax authorities – HMRS.

The mandatory and BCUHB online training are the same for Supervisors as for Volunteers. All training must be completed before a supervisory role can be started.