**MSC story collection template**

Name and contact details:

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Consent to share:

Your story will be anonymised. Do you give consent for other people to hear your story and learn from it? Yes with exceptions (please specify)

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| Need to make sure service users can’t be identified from the stories told and that the support provided to volunteers is included. |

A bit of background information:

In a few words, please tell us a bit about yourself and your role in co-production (e.g. a person from a community organisation, a social care service users or carer, a local authority social worker, a commissioner, a volunteer etc)

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| Work on the mental health transformation programme.  Set up ICAN unscheduled care service in 3 DGH’s. The service provides a chance for people to talk along with tea and cake. Referrals include people with panic attacks and low tier emotional needs. Often they needed support with issues such as grief, debt, relationships and didn't know how to access third sector support. Without ICAN they would likely be at the back of the queue in the Emergency Department and may not need the treatments available there.  The services opened up between December 2019 and February 2020. Until March open 7 nights a week, 365 days a year from 7pm to 2am including Christmas. Had over 4,000 interventions. When transformation funding started they were recruited.  Learned from the ethos of the ICAN unscheduled care service and began to develop:   * Primary Care ICAN: volunteers based in surgeries. The GP can refer straight away for someone to have a longer chat with the volunteer, tea and cake. The volunteer can put the person in touch with local community support. * ICAN community hub * ICAN Plus – step up/step down. Step up would provide up to 72 hours intense support for people who don’t need admission to hospital but are still in crisis. Step down would provide support for people ready to be discharge from hospital but who need additional time, for example to organise housing or other support. Also looking at developing a suicide safe have as part of this model, although this would be separate place to the step up/step down element.   The ICAN community hub is the element that is advertised rather than the support at unscheduled care and GPs as the aim is to take pressure off these services. It’s not a progression model i.e. there isn’t a pathway from one type of ICAN to another, people access the one that’s most appropriate at the time.  The first community hubs and primary care ICAN had just started when Covid struck. |

Initial reflection:

Please close your eyes and run a ‘search programme’ in your mind over the last 12 months, with the following question in mind:

**‘What good or bad changes have come about as a result of people's response to the coronavirus crisis?’**

This can include all sorts of changes, for example:

* A change in the life of someone you work with
* A change in your self – your attitude, the way you feel about yourself, or what you do
* A change in the way your organisation works
* A change in the way other people work or relate to you
* Something else

The important thing is to identify something that has ***changed***

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| List of changes:  The ICAN volunteers were taken out of GP surgeries and unscheduled care. The service had to be redesigned in three weeks. It was clear there would be demand for mental health support due to Covid-19. The new service would be referral only (due to capacity) and the acuity had to be appropriate to the support the volunteers could provide. Volunteers would be providing support over the phone alone at home, so the support they could provide and the support available for the volunteers had to change too. Had to recruit and train new volunteers, as many of unscheduled care ICAN volunteers weren’t available to provide support on the phone.  We have now had 700 referrals across North Wales and each area has 12 to 15 volunteers. There is a turnover of volunteers, for example, as some have to go back to work, but there are new ones coming in and it’s a huge bonus that interest has carried on. The referrals come to a central address, coordinators check what they need and link them with an appropriate volunteer or sign on. We have worked with partner organisations from the local communities, and the third sector have been able to quickly adapt their services which has been a positive.  A lot of the referrals come from Community Mental Health Teams and GP. GP referrals include people who are isolated because they’re shielding. The vast majority of referrals have been appropriate to what the volunteers can offer. People’s ratings from before and after the support shows that it does help to improve their mood.  Support is provided to people of all ages – the oldest client is 91. A lot of historical issues like abuse are being raised and the situation seems to be bringing back issues with OCD, bulimia or self-harming. There are people who are afraid to go out and domestic abuse referrals. Generally the referrals from GPs are similar to those before the crisis. The referrals are different to those from unscheduled care as the acuity of those was higher, so are not appropriate for this new type of support. Very few of the referrals received to this service have been inappropriate for the new support though.  There is a lot of support available for the volunteers. Tuesday afternoons have been set aside for training. Support is available for any escalation and after every call if needed, but a minimum of a supervision every 2 weeks. There is also a once a month Zoom supervision for volunteers to speak to each other.  Currently looking at building on what we’ve learned but don’t know yet how it’s going to look. The community hub is planning to reopen 2 days a week in August. |

Of the changes you have listed above, please can you tell us which of the changes listed is the ***most significant*** one to you and ***why***?

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| The most significant change is not being able to do face to face support. There are lots of challenges when supporting people with emotional issues and face to face can read people and you miss that on the phone. So in unscheduled care if someone's traumatised you could sit with them and make a cup of tea and not need to say anything for 10 minutes. So it’s a very different way of working, but not necessarily negative. It’s also shown adaptability of volunteers to change and some of the unscheduled care volunteers are now coming back as they’ve missed being part of the service. |

Regarding the most significant change you have described above, what was it like before, what is it like now and what do you think brought about the change?

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Please give your story a snappy title that will catch people’s eyes

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| North Wales says ICAN to people struggling during COVID |