LINK: Learning to create Integrated community Networks through Knowledge exchange

Dr Fiona Riordan, Dr Tanya van de Water, Dr Sheena McHugh

School of Public Health, University College Cork

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Friendly Call Cork

Comhar Chathair Chorcaí Ctr Cork City Partnership Clg EDUCATION | EMPLOYMENT | EMPOWERMENT

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List of abbreviations

FCC	Friendly Call Cork
CCP	Cork City Partnership
SICAP	Social Inclusion Community Activation Programmes
TILDA	The Irish Longitudinal Study on Ageing
HCP	Health care professionals
SIPC	Cork City Partnership Social Inclusion Programmes Co-ordinator

RAP	Rapid Assessment Procedure
SLT	Speech and Language Therapist
OT	Occupational Therapist
PHN	Public Health Nurse
DW	Development Worker

Executive summary

Why did we carry out this study?

The COVID-19 pandemic has focused more attention on befriending services to support people who may be vulnerable, cocooning, and experiencing loneliness. There are more than 60 befriending services in operation across Ireland, supporting approximately 4500 people. However, there is not a lot of research on how befriending services work or how they link in with healthcare services.

Friendly Call Cork is a voluntary befriending service which has been operating in Cork City since 2011. Friendly Call Cork addresses isolation and loneliness through a daily phone call to older people, and individuals with physical and mental disabilities.

What was the aim of the study?

We wanted to answer the following questions:

- How is the service delivered and what are the barriers and facilitators (what hinders and what helps)?
- How has the service adapted (changed) during the pandemic?
- How does the service link in with other healthcare services?
- How do people who use the service (clients) and volunteers experience the service?

What did we do?

To answer these questions, first we analysed anonymised data from the service about clients. These data included the reasons why clients were referred into Friendly Call Cork and where they were referred from, for example, health care professional, family, friends, or another agency or service.

Next, we carried out interviews with:

- 3 people involved in the coordination of Friendly Call Cork
- 10 health care professionals from different services
- 9 clients of the service
- 1 volunteer and we conducted 2 focus groups with volunteers

We also held an online workshop with coordinators, health care professionals, and volunteers. During the workshop we discussed the research findings and possible actions to address some of the challenges within the service.

What did we find?

The service played an important part in the pandemic response and began to provide more practical support to clients, for example, assisting with shopping and collecting prescriptions. We found that Friendly Call Cork provides a '*safety net*' for vulnerable people and their families by providing daily contact.

For **clients,** Friendly Call Cork was a way to replace connections that may have been lost through bereavement, ill health or cocooning due to COVID-19. It was flexible to meet their needs, providing both emotional and practical support. During the pandemic, when a lot was changing, clients appreciated that FCC was consistent and reliable.

Coordinators felt that Friendly Call Cork benefits from the strong relationships it has with other agencies and health care providers. Having a committed and accessible person to manage the service, a person who other agencies trust, was seen as an asset to the service. During the pandemic, other agencies became more aware of Friendly Call Cork, and the number of referrals into the service increased. As a result, Friendly Call Cork is facing additional resource challenges. Currently the service relies on one central coordinator and has limited funding.

For **health care professionals**, having a simple referral process and one central person to organise referrals made it easier to link in with the service. However, health care professionals also suggested that the service could be promoted more among other professional groups who may not be aware of Friendly Call Cork or the valuable supports it provides.

Volunteers found the role rewarding. Newer volunteers were able to make the calls from their homes during the pandemic which meant it was easier for them to fit volunteering into their life. Sometimes volunteers found it difficult to manage the boundaries of their relationship with clients and would like more experience or training to help them to support clients, for example with health and mental issues. Some new volunteers were uncertain where to direct clients if they needed help. Volunteers also had limited support from other volunteers partly because they were working remotely.

Actions to address challenges faced by Friendly Call Cork

Several actions to address the challenges were discussed during the workshop. Participants prioritised five actions which they felt would be feasible and have the greatest potential impact:

1. Train an additional support or back-up person to take on coordination responsibilities. For example, volunteers who have been with the service for a long term could take on more responsibility.
2. Introduce new ways to monitor and support volunteers as they work remotely.
3. Create opportunities for volunteer peer support.

4. Define the service and provide more information and education about the service for potential new referrers.
5. Introduce a formal screening process for eligible clients to manage capacity.

Introduction

Loneliness is a serious public health issue[1], associated with dementia[2,3], and depression[4], with an influence on mortality risk comparable to other well-established risk factors (e.g., smoking).[5] Findings from The Irish Longitudinal Study on Ageing (TILDA) estimates that one third of the 50+ population in Ireland experience emotional loneliness at least some of time, and that loneliness is associated with poorer quality of life.[6] Based on the size of an individual's social network and types of social connection, almost a third of those surveyed were moderately socially isolated (29.6%) or in the most isolated group (8.6%).[6]

Befriending services are increasingly seen as a popular intervention to address loneliness and social isolation. They provide support to socially isolated vulnerable individuals in the community, are valued by service users[7,8], and may improve patient-reported wellbeing and quality of life[9], and reduce loneliness.[10] As the pandemic has highlighted loneliness and social isolation[11], there has been greater demand for these types of services which can connect with and support those who may be vulnerable, cocooning[12,13] and experiencing greater loneliness due to COVID-19.[14] Though research on befriending services is growing internationally, most studies to date have focused on evaluating the effectiveness of these services[15–19], befriending for people with mental health challenges specifically[20–22] or understanding the dynamics of the befriending interaction, namely the relationship between befrienders and service users.[23–25] Few have focused on service delivery.[26,27]

There is also a dearth of research on how these services operate in Ireland. Most studies focus on effectiveness in terms of client outcomes[17,18] rather than how these services are delivered[28], and the factors which support or hinder the implementation. As such, the process by which these services reach and support many older and vulnerable adults in the community, often with chronic conditions, and how these services link in with community healthcare providers (HCPs) is less well understood. There is also limited specific evidence on telephone befriending interventions[8,19,26–28], although their value during COVID-19 has been recognised.[16,28] Integration of health and social care services around an individual's needs, is posited to improve quality of care, user satisfaction and health system efficiency.[29,30] While befriending is an intervention to address loneliness and isolation, exploring the part these types of services play in an individuals' integrated network of healthcare providers and other supports is important.

Considering the role of these services is timely given the policy context in Ireland. The HSE Social Prescribing Framework[31] was launched in 2021, signalling the national commitment to investing in non-clinical supports for health and wellbeing. The Sláintecare reform programme focuses on integrating health and social care and establishing links with the voluntary sector, development of integrated, community-based models of care for older people and those with chronic conditions, and expanding community-based care.[32] Understanding how befriending, as non-clinical social support service in Ireland, links with other providers in the community, is an important part of optimising the potential of these services as part of an integrated and cohesive network for vulnerable adults.

Overview of Friendly Call Cork

There are more than 60 befriending services in operation across Ireland[33], supporting approximately 4500 people.[34] Friendly Call Cork (FCC), which has been in operation since 2011, is a voluntary befriending service based in Cork City, addressing isolation and loneliness for older people, and individuals with physical and mental disabilities, through a daily phone call.[35] Previous work conducted with clients highlighted the perceived benefit of the service.[7] FCC also provides several other services (**Box 1**). FCC is managed by a Development Worker (DW) and Cork City Partnership Social Inclusion Programmes Co-ordinator (SIPC). Oversight is provided by the SIPC who also manages other Cork City Partnership (CCP) programmes, including the Social Inclusion Community Activation Programmes (SICAP), chairs the FCC steering committee, assists with funding applications, and fills in when the FCC DW is on leave. Members of the steering committee include community garda, a HSE Community Health Worker, public health nurse, representatives from the CCP, HSE Cork Kerry Community Healthcare, HSE Public Health Nursing, Community Garda, Cork City Council, and a local community representative.

Box 1 List of functions performed by FCC during non-COVID-19 times

- Daily phone call
- Visiting service to some clients
- Minibus to take people to hospital appointments, shopping & outings
- Social events e.g., afternoon tea
- House cleaning and maintenance where need arises
- Postage of handmade birthday and Christmas cards
- Referrals to or liaison with other services on behalf of client e.g., Meals on Wheels, Personal Alarm Systems

Project aims and objectives

Through this project we aimed to establish links between UCC School of Public Health and FCC to understand the current and changing scope of the service during COVID-19, understand how the service is implemented, and explore how to maximise its potential through integration with other community healthcare services.

Our objectives were to:

1. Understand how the service is implemented, including barriers and facilitators, how it has been adapted and scaled up during COVID-19.

2. Understand the scope of integration of FCC with health care services particularly those in the community (how referrals work, where they come from, links with health service providers, and links out from the service).
3. Determine what public health/health promotion/mental health support and advice is provided by volunteers and identify needs.
4. Understand client experiences of FCC before and during COVID-19.
5. Facilitate knowledge exchange between befriending service coordinators, volunteers, health care professionals and the research team, though a co-production workshop and launch.

Methods

Design

This mixed methods study incorporated quantitative data collection and analysis to profile FCC clients and referrals, qualitative data collection and analysis to describe the experiences of different stakeholders (service coordinators, volunteers, clients, and HCPs). These steps were followed by co-production workshop where preliminary findings were presented, and further feedback was sought from stakeholders (**Figure 1**).

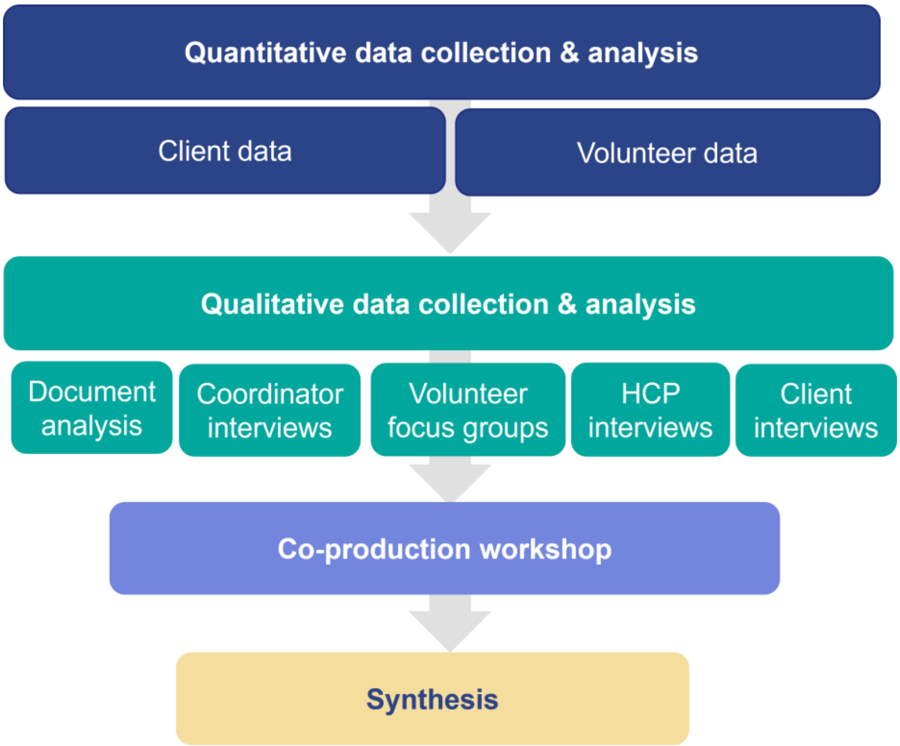

Figure 1 Overview of data collection and analysis

Data collection and analysis

Quantitative

Data collection

The FCC team extracted data in August 2021 describing the source of referrals and reason for referrals among clients in the database at that timepoint. The DW inputs these data when new referrals are received. Data included total current clients, age range, sex, length of time with service; reasons for referral and referral sources; current volunteers, age, sex, time with service, frequency, and intensity of case load.

Data analysis

We analysed referral data descriptively (frequencies and percentages) in Excel. We recoded reasons for referral and source of referrals into categories (e.g., visual, auditory, and speech impairment coded as 'sensory impairment'; occupational therapist and speech language therapist coded as 'allied health').

Qualitative

Data collection

We conducted interviews and focus groups with the three stakeholder groups described in **Table 1**. We conducted semi-structured key informant interviews with service coordinators, and the DW recommended members of the steering committee with knowledge about FCC's links with health care and implementation as sample of service coordinators. The DW acted as a gatekeeper to recruit HCPs, clients, and volunteers.

We also carried out interviews with long-standing (at least 1-year pre-COVID) and new (joined since COVID-19, since March 12th, 2020) clients, and HCPs who had and had not referred into the service, including public health nurses (PHN), and HCPs working within community mental health services, allied health, general practice, and hospital services. We purposively sampled HCP representatives from each of the main health care services which refer into FCC using referral source data. The DW contacted HCPs who had previously referred into the service and sought their permission to pass on their contact email to the research team (**Table 1**). We then followed up with a formal invitation and further study information, after which the HCPs could decide whether to take part. We identified additional HCPs who had engaged with the service through snowball sampling. We identified HCPs who had not previously referred to the service through professional networks known to the team and cold calls to HCPs identified through HSE health office directories and publicly available directories of supports and services for older adults in the city[36], community services for adults with chronic disease[37] and the Irish College of General Practitioners (ICGP). Lastly, we attempted additional recruitment via PHN contacts known to the team.

We conducted focus groups and interviews with volunteers, including a mix of longer-term volunteers (started with FCC before COVID-19), new volunteers (started with FCC after COVID-19 began), and former volunteers (had left the service). The DW initially contacted volunteers who met the criteria and sought permission to pass on their contact details to research team. We then followed up with interested participants to formally invite them to take part in an interview or focus group.

Where numbers of HCPs, volunteers and clients allowed, we purposively sampled participants from those who returned their contact information to or contacted the research team.

Table 1: Stakeholder sampling and data collection

Stakeholder Group	Sampling approach and rationale	Data Collection Method
Service coordinators	**DW** identified steering team members who are most knowledgeable about the service	Semi-structured key informant interviews
HCPs	**DW** could identify HCPs who had referred into the service. **Existing networks/relationships, cold calling, online directories, snowball sampling** was used to identify additional HCPs who had and had not referred to FCC	Semi-structured interviews
Volunteers	**DW** could identify long term, new, and former volunteers	Semi-structured focus groups and interviews
Clients	**DW** could identify long-standing and new clients	Semi-structured interviews

HCPs, Health Care Professionals; FCC, Friendly Call Cork; DW, Development Worker

Qualitative data collection took place between June and September 2021. The following topics were broadly discussed in the interviews and focus groups:

- How referrals (into and from) the service work, who refers, what works well about referrals and what could be done differently e.g., what would help HCPs to use FCC more.
- How client-volunteer interactions work, what works well and less well.
- Barriers and facilitators of service implementation, changes to the implementation of the service during COVID-19, why and how these changes happened (including barriers and facilitators).
- Client experiences of the service before and during COVID-19 and why they became involved in the service initially.

Document analysis

In addition to promotional material about FCC available on their website, the research team was given access to FCC training material, the volunteer application form, and reports. We consulted these documents for descriptive information on the service.

Rapid analysis

We used rapid qualitative analysis[38] to prepare preliminary results for the co-production workshop. We summarised each interview and focus group audio recording on a Rapid Assessment Procedure (RAP) sheet outlining the topic area. For each topic, we summarised data on: (a) how the process worked and why (b) what works well / less well or could be done differently. To ensure consistency, both the interviewer and another member of research team completed the RAP for the first four interviews, comparing discrepancies in coding.

To prepare for the workshop, we extracted data on the RAP sheets into a structured Excel Matrix. We grouped data by stakeholder cluster (a sheet each for coordinators, volunteers, HCPs, and a row for each participant) and arranged it by question (a column each for client-volunteer interaction, referrals in, referrals out, implementation as usual, implementation during COVID-19, other findings).

Co-production workshop

We held an online co-production workshop on the 11th of November 2021 with participants representing the three stakeholder groups (coordinators, HCPs, volunteers). All coordinators who were interviewed were invited by the research team. HCPs who had expressed an interest in participating in an interview or who had taken part in an interview, were invited to attend the workshop by the research team. The DW highlighted the workshop date with service volunteers and passed on details of volunteers who were interested in attending to the research team.

The aim of the workshop was to share preliminary findings and to give participants an opportunity to build on this knowledge, generate new ideas, and prioritise actions to address some of the challenges faced by the service. During the workshop, we presented the barriers and facilitators for each topic and proposed actions for discussion. At the end of the workshop, using the chat function on Microsoft Teams, we asked participants to indicate the top three actions based on impact, feasibility, and to flag whether they would like more information on a proposed action. Lastly, we asked participants to provide a phrase or word that comes to mind when they think of FCC. We used this information to generate a word cloud.

Data integration

During a final phase of analysis, findings from the workshop were:

- integrated with existing findings if they provided additional clarity or context
- used to prioritise potential actions for the service

We initially developed actions to address service challenges based on interviews and focus groups, and by consulting list of existing strategies to support implementation (Expert Recommendations for Implementing Change strategies[39]). We elaborated on these actions drawing on workshop and post-workshop feedback from participants.

Findings

Participants

Details of participants from each stakeholder group are included in **Table 2**. Of eight HCPs contacted by the DW, six took part. In total, 11 people attended the workshop: two coordinators, three volunteers, and six HCPs. Six participants rated the priority of solutions, no volunteers.

Table 2 Participants from each stakeholder group

Stakeholder group	N
Service coordinators	3
HCPs[1]	10
Referred into service	7
Had not referred into service	3
Clients	9
New	
Long-standing	
Volunteers[2]	9
New	3
Former	3
Long-standing	3

HCPs, Health Care Professionals

Findings are organised according to client and volunteer profiles, and four areas of focus: overall service implementation, referrals in and out of the service, volunteering and client perspectives. Solutions which were prioritised in the workshop, are highlighted.

Client profile

Since FCC started in 2011, 745 clients have used the service, and 198 clients joined between March 2020 and August 2021. The number of clients rose from 220 to 397 at the peak of the pandemic. In August 2021, 364 clients were using the service, ranging in age between 38 and 97 years old (average of 74.8 years), of which 62% (n=227) are

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[1] HCPs included public health nurses (n=3), nurse practitioners in other disciplines (n=3), allied HCPs (n=2), and general practice staff (n=2).

[2] One long-term volunteer who had more in-depth knowledge of the service, participated in a semi-structured interview. Two focus groups were conducted with a mix of new, long-term and former volunteers (n=8).

female. Most clients stay with the service until their circumstances change, thus calculating average length of service was not feasible based on the data available.

Volunteer profile

In August 2021, there were 70 volunteers listed with the service ranging in age between 22-80 years (average of 65 years old) of which 79% (n=55) are female. This number is in flux as people join and leave the service. As of August 2021, there were 53 volunteers. Volunteers have been with the service for 2 weeks – 10 years varying in frequency (daily vs one day a week) and intensity of case load (1–25 daily calls).

Service implementation

Perceived value and benefits of the service

Stakeholders expressed admiration for FCC describing it as "*a great innovation … a model that can be used in other countries*" (P#10, HCP), and "*a valuable lifeline [to those not linked in with mental health resources]"* (P#18, HCP) (**).** They considered the service necessary to "*prevent isolation*" (P#11, HCP) as clients "*might be living in the city with lots of people around them, but yet they mightn't see or hear a voice except for maybe a doctor, or me calling*" (P#17, HCP).

> *We really see the value in the service... we talk about the social isolation and being lonely and lonesome, but we don't always go deeper to think about what's behind that and what is the harm in being isolated, what's the harm to the person in being on their own. And what can we do to reduce that harm. And that harm very often is mental, emotional, psychological wellbeing* **(P#16, HCP)**

Stakeholders also reflected on FCC's flexibility to meet client needs and "*how it has evolved over the years*" (P#10, HCP) and continued to adapt (**Box 2**) based on client needs during the different phases of the pandemic.

Figure 2 Word cloud in relation to what defines the service as created from key words and phrases offered by workshop participants (n= 8)

Changes to service implementation during COVID-19

During COVID-19 FCC saw several changes to the services, in relation to (1) the source and format of referrals, (2) acquisition of new resources and functions (3) dropping some volunteer and client activities (4) volunteer training, rota and remote working (5) client-befriender conversation topics. These are summarised below.

Changes to the source and format of referrals

- **Referrals increased**, **with accelerated case finding** as the service became more known, partly through the Cork City Rapid Response Line and via filter down effect of ALONE national marketing strategy, but also following active promotion at the start of the pandemic. This has stopped now as the service is at capacity. With COVID-19 there is now a **tension between marketing and being unable to take on more clients**.
- During COVID-19, the HSE Community Worker would **coordinate referrals from the COVID-19 response line** and refer people to FCC for different purposes (e.g., shopping, pension, loneliness, hospital appointments).
- During the early stages of COVID-19 there were less referral forms and **more direct or verbal referrals**.
- There was **more communication about referrals** during COVID-19.
- There were **more referrals from family members** who were living abroad and referred a family member living at home in Ireland.
- According to coordinators FCC saw **more diversity in referrals**, now including more 50–60-year-olds with mental health needs. Coordinators felt people calling the council line for practical support, referred on to FCC, needed to join FCC anyway.
- Since COVID-19 people have **not been as keen to give key (emergency) contacts** on the application, but one volunteer flagged that when they understand the reason, they are willing to provide the numbers

New resources and functions added

- Friendly Call Cork (FCC) was assisted by formal **deployment of staff** from other agencies e.g., HSE Community Workers trained as callers, SICAP staff involved with calls and managing the volunteer database**.**
- **Extra funding and resources** were provided to the service. They were able to buy mobile phones to facilitate remote working and provide phone credit**.** Acorn tablets were provided via the Cork Education and Training Board to increase client digital connectivity**.**
- Some **resources were diverted**, for example, the FCC driver was deployed to assist with Meals on Wheels deliveries.
- There was greater **influx in volunteers**, attributed to people having more time, off work, and/or the greater awareness of mental health issues due to the pandemic**.**
- **New activities were added**, including more practical support (collecting shopping, prescriptions, supporting people to log on and register for the vaccine), more need for certain aspects (e.g., the bus transport service due to the limitations on public transport) setting clients up with Acorn tablets, and acting as a distribution

channel for other agencies, like the city council (e.g., care packages) to reach to older adults in the community.

Client and volunteer activities dropped

- **Certain activities were dropped**, including in-person befriending visits, and client afternoon tea socials.
- Previously the DW would have caught up with volunteers when they made calls from the office once a week. The DW met the volunteer group every 8 weeks but **meet-ups with volunteers are no longer happening** since the pandemic.

Changes to volunteer training, rota, and working

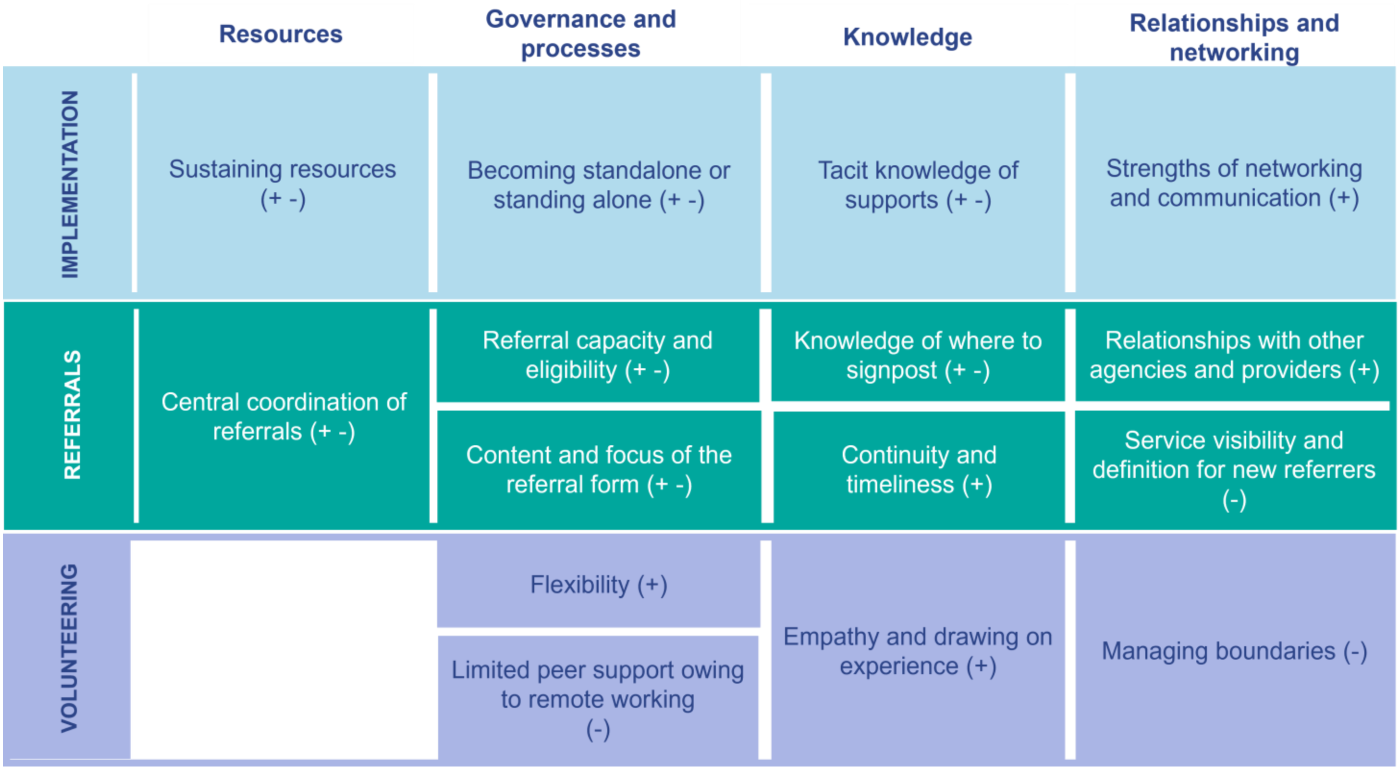
- Before the pandemic, training took place in person on four consecutive Thursday evenings. During the pandemic, **training was condensed into a single one-hour Zoom session**.
- Assignment of volunteers to clients changed. Rotating through clients was more typical before COVID-19, whereas during the pandemic volunteers are **assigned to set clients for longer periods of time**.
- Volunteers are **no longer calling from the office**, and the hours during which calls are made may vary (previously between 11am and 3pm).

New conversation topics

- Coordinators and volunteers felt **topics discussed during COVID-19 have changed**. Now it might be how to register for vaccine and supporting them to do so, computer literacy, more health promotion (exercise, diet), and signposting new services like supermarket grocery delivery or their bus for hospital visits. One volunteer felt the emphasis had shifted from a focus on necessity earlier in pandemic (e.g., meals), to digital issues "*to expand their connection with the rest of the world."* (Anna, FG#1)

Barriers and enablers

Barriers and enablers related to resources, governance and processes, knowledge, and relationships and networking (**Figure 3**). Some factors acted as both a barrier and enabler depending on the context. Full details of barriers and potential solutions for service implementation, referrals in and out of the service, and volunteering are listed in **Appendix 1**.



	Resources	Governance and processes	Knowledge	Relationships and networking
IMPLEMENTATION	Sustaining resources (+ -)	Becoming standalone or standing alone (+ -)	Tacit knowledge of supports (+ -)	Strengths of networking and communication (+)
REFERRALS	Central coordination of referrals (+ -)	Referral capacity and eligibility (+ -)	Knowledge of where to signpost (+ -)	Relationships with other agencies and providers (+)
		Content and focus of the referral form (+ -)	Continuity and timeliness (+)	Service visibility and definition for new referrers (-)
VOLUNTEERING		Flexibility (+)	Empathy and drawing on experience (+)	Managing boundaries (-)
		Limited peer support owing to remote working (-)		

Figure 3 Barriers and enablers to overall implementation, referrals in and out of the service, and volunteering. Each square represents a factor which was a barrier or enabler or both. Barriers are denoted by (-), enablers by (+)

Service delivery

Sustaining resources

Implementation of the service was enabled by the commitment of a key worker to coordinate the service while challenged by having just one person in this role. There was an insufficient number of volunteers to meet the influx of clients and additional activities was a barrier to service delivery, and the sustainability of the service is challenged by the nature of funding which is often ad hoc and tenuous.

Coordinators

The service has one main DW, a key resource with multiple responsibilities. These responsibilities include marketing the service, managing volunteers (recruiting and processing applications, vetting, providing training and support, coordinating, overseeing), and securing funding. In terms of working with clients, the DW orientates new clients, managing the "*huge work in organising who rings who every day*" (P#1, DW), conducts calls when volunteers are unavailable, manages incoming and outgoing referrals (including calling a new client the first week to build relationship and determine needs using application form (e.g., mobility, heating, housing, hospital visits, supports available to them), following up on missed calls to clients, and coordinating additional projects (**Box 1**). Across the stakeholder groups, individuals commented on the commitment, accessibility, and attitudes of the DW as an enabler of service delivery.

> *… I think a lot of it is [DW] personality and she's so committed to the service. I suppose the thing is the service has grown with [DW] so maybe it's probably that. She's so enmeshed in it.* **(P#2, SIPC)**

While beneficial to have one committed individual with a knowledge of all clients, the reliance on one central coordinator was also recognised as a challenge and a potentially unsustainable scenario, particularly should she have to take extended leave.

> *I think it [service] works really well. But then I think it's because we have* [DW] *She's just one of these people. I'd love to have a brain like hers. I think she possibly knows all of the 300 people. If you mention anything about anybody, she knows. She is brilliant, absolutely brilliant.* **(P#4, Community Health Worker)**

> *It's lovely but I take if something went wrong, even if* [DW] *went sick. If* [DW] *was long term sick, what happens then? You've got 370 people wanting a daily phone call. Who is going to pick it up?* **(P#2, SIPC)**

Volunteers

The low volunteer turnover was a factor which was an enabler of service delivery (see Volunteering). There was an influx of volunteers during COVID-19. In August 2021, the number of volunteers had risen to 70 compared to 27 before the pandemic. However, this was insufficient to meet the demands associated with a growing number of clients and additional activities (e.g., Acorn tablets, grocery shopping). Pre-COVID the service was already "*at breaking point"* (P#2, SIPC).

Based on available resources, coordinators were uncertain about the feasibility of reintroducing activities which had been dropped as result of the pandemic. Even prior to the pandemic, there was a need to ration certain aspects of the service, like the bus transport. Since COVID-19 they were managing a balance between assessing and meeting client needs with existing resources, while avoiding overextending the service such that they let people down. Previously volunteers would have made visits to some client homes, recognising that some people "*need to see someone*" (**P#3, Volunteer**) once a week but these visits stopped. One HCP flagged that with more resources, calls could be made more frequently to target groups e.g., those with mental health issues who might be more isolated than most, whose family might be less inclined to contact the person or might have been "*pushed away*" **(P#16, HCP)**.

> *…I just think the service that they operate is so valuable, you'd love to see it to be able to be extended to more people. That somebody could have more calls in the week if that was possible. Because some of these people are so isolated* **(P#16, HCP)**

Coordinators experienced tension between wanting resources to expand the service - to take on additional clients and reinstate other activities - and yet keep the personal touch, whereby a central person, ("*it doesn't have to be me*") would "*know all our clients… have a personal relationship with them and know all my volunteers really well* (P#1, DW). This was seen as valuable within the service and different to larger befriending services like ALONE.

> *We can't provide the additional services because we don't have the resources. We have to maintain those calls because we have just such a volume of them. I'd love to introduce the other things and so would [DW]. There just isn't scope at the moment. Something's going to break and then you're letting people down saying you're trying to arrange these and then you can't because you don't have capacity* **(P#2, SIPC)**

FCC is not the "*last line of defence*" (P#1, DW). They are not HCPs or counsellors, and are supported by additional resources, for example, they can refer to other services (see Referrals). FCC also benefits from ongoing support from other SICAP programmes, a link which particularly came to the fore during the pandemic.

Funding

The service is continually seeking funding. Funding is received through from the HSE, Education and Training Board, and others, but the fact that current levels are insufficient, and often sources can be ad hoc, and tenuous was a barrier to service implementation. As FCC sits under Cork City Partnership, they do not qualify for some grants. One issue flagged by coordinators is the difficulty of obtaining funding to keep delivering the service *as is*, often funding necessitates implementing something new. One HCP cautioned the potential implications of funding; depending on the source, with funding comes regulation, "*that can be as much of a barrier as a help*" (P#16, HCP) if it were to place bounds on the service e.g., timing of calls, what the service does and does not do.

Becoming standalone or standing alone

The delay in FCC becoming a standalone service, independent of Cork City Partnership, was a key barrier to service implementation, as it has implications for how much funding FCC can seek. There is a cap on how much funding Cork City Partnership can seek overall. While FCC benefited from being linked in with Cork City Partnership, and the additional support of staff from SICAP programmes during COVID-19, this support is tenuous and dependent on older people being the named SICAP target emerging needs group to focus on by Cork City Local Community Development Committee. Coordinators acknowledged the difficulty of now separating FCC from other SICAP programmes.

Strengths of networking and communication

The implementation of FCC benefits from the longstanding links and trusted relationships it has with several agencies and healthcare providers in the community, in part cultivated by the DW who has been in the role for several years.

Links in the community include community garda, community health workers, public health nursing (PHN), and the city council, representatives of which have sat on the FCC steering committee since it was first established. FCC also has links with other community organisations like Meals on Wheels, and the Samaritans. The DW who has been in the role for over 10 years as a single point of contact, *"the face of Friendly Call"* (P#2, SIPC), was felt to have built up a trusted relationship with different agencies. During COVID-19 the service was able to capitalise and build on this trust and years of working with these agencies who could *"see the value of the linkages"* (P#2, SIPC); closer relationships developed between SICAP and FCC and with community health workers during COVID-19.

> *I think it's better now because there's more of an awareness that we can't all be working on our own, we have to link in better with other services, and for us, that's the winner, if I can actually get something done for a client, they're actually ecstatic then.* **(P#1, DW**)

The willingness of FCC to try new things, their capacity to problem-solve to *"find a way around everything"* (P#4, Community health worker), and to go above and beyond **i**n working with other agencies to address client needs, was flagged as a strength when working with them, particularly during the pandemic response. Communication channels in place between FCC and Cork City Partnership; i.e., WhatsApp group for CCP, facilitated quick resolution of certain issues particularly during the pandemic.

> *We had one woman, she didn't have a television. And one of my colleagues had put it up on our WhatsApp work group, there's about 40 people working for the partnership. And she gave a television to give to the woman. So, one of the lads connected it up. Simple stuff.* **(P#1, DW)**

Tacit knowledge of supports

Alongside establishing trusted links with other agencies, an enabler of implementation was the tacit knowledge the DW has developed of who and where to reach out to for different services and supports. This knowledge has continued to develop particularly during COVID-19, whereby the DW felt she *"got better at finding out how to do things for people as well, and you learn who to go to for this and who to go to for that".* One suggestion from a HCP who attended the workshop was to share this knowledge of local services, flagging that it is quite difficult to know all of them.

> *There are about 5, 6 people on the steering group and she would use us all in different ways. There's usually a member of the guards on the steering group. She would use them in a different way to the way she would use me. She's very good at using our skills and where we come from.* **(P#4, Community Health Worker)**

However, linked to the challenge of relying on a central coordinator, there is a risk of losing that tacit knowledge should that person be unavailable or absent.

> *It’s tough taking some time off too. Because in my head there’s a lot of stuff too that maybe I haven’t written down, and then I write it down in different places.* **(P#1, DW)**

Referrals

Referrals into and from the service are reported separately. The source, reason, and process of referrals are described first before barriers and enablers.

Referrals into the service

Source of referrals

Data on referral sources was available for 232 clients. The main source of referrals is public health nursing (n = 66, 28%) followed by HSE community health workers (n = 51, 22%) (*Error! Reference source not found.).* Other agencies, w hich made up 10% (n = 24) of referrals comprised community garda, ALONE, local authority, advocacy services, safeguarding and protection team and seniors alert system.

> *I mean they [referrals] come from such a wide range of sources. But the last year we would have gotten a lot more through the COVID-19 community response help line and through ALONE. Because there was so much publicity nationally for ALONE last year through the pandemic and they would refer people on to us locally. So, if somebody rang them nationally, they would refer on to us locally. Family members.* **(P#2, SIPC)**

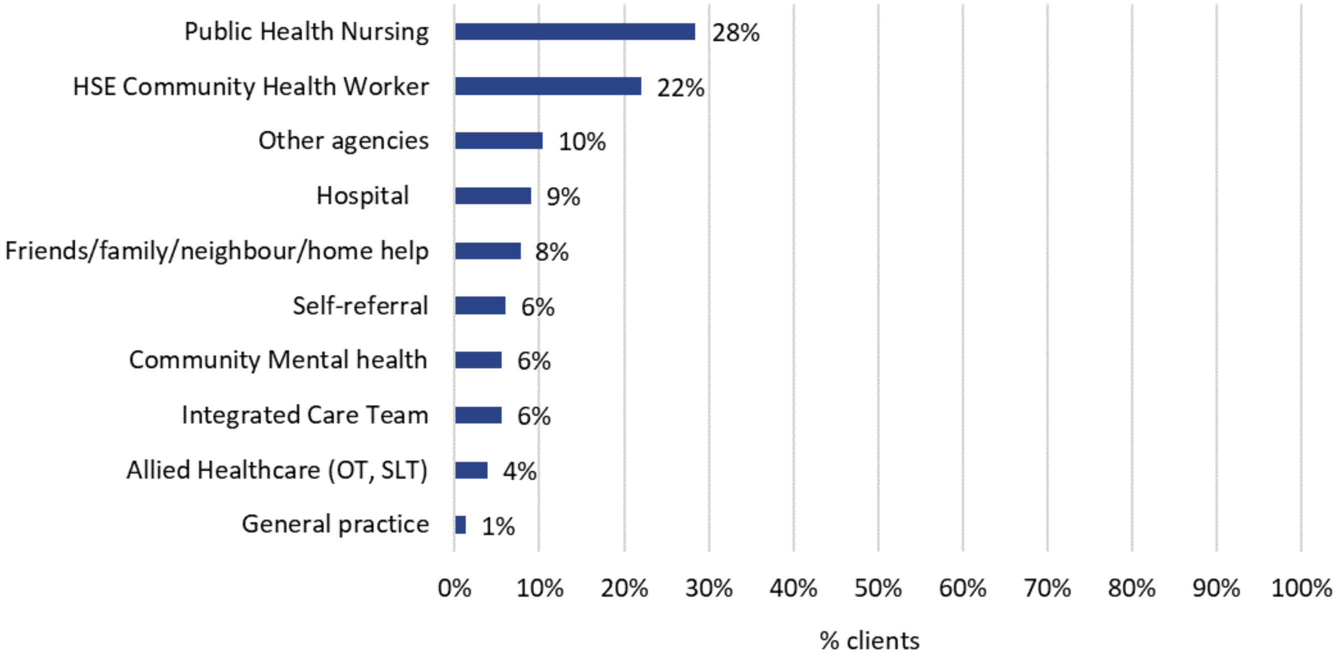


Figure 4 Sources of referrals into Friendly Call based on a subset of clients with these data available (n = 232). SLT, Speech and Language Therapist; OT, Occupational Therapist

Reasons for referral into FCC

Data on 279 clients with available data on the reason for referrals were analysed. Some clients may have been referred for more than one issue; the results only include the person's primary reason for referral. Some service users did not have a reason for referral or a recorded referral source (the list includes n = 279 clients). Main reasons for referrals were mental health (n = 63, 23%), isolation/loneliness (n = 60, 22%), or mobility/disability (n = 55, 20%), including physical disability (e.g., polio, cerebral palsy) or mobility issues due to a fall or related to stroke, amputation, osteoporosis (**Figure 5**).

These reasons were reflected in the HCP interviews who spoke of referring isolated people, or people with mental health challenges, or, in case of those with dementia where being isolated might be a "*trigger*" (P#16, HCP) for certain behaviours. Throughout, the emphasis was that these individuals do not have more acute physical or mental ailments and it may be "*somebody that doesn't want any other kind of service, cause they're quite well" (*P#7, HCP*).* HCPs who had not engaged with the service flagged they would refer people socially isolated due to COVID-19 or other circumstances, people who might not have a specific medical need but would benefit from the social contact the service provides.

> *I suppose in the old days, like public health nursing is seen as a pop in or check or surveillance. But, unfortunately it's very changed now. And just for that link, [it's good] just to have somebody to ring up and check up on them I suppose and make sure they're ok.* **(P#7, HCP)**

> *Vulnerable older adults like that that may have good family supports but the family struggle to maybe get into their parents during the day or whatever and they've that worry where they're trying to work or look after kids themselves, whereas at least if they know that their loved on is getting a phone call from Friendly Call and if there's anything kind of askew, that they'll get in contact with the family. So, it's a safety net for some people.* **(P#9, HCP)**

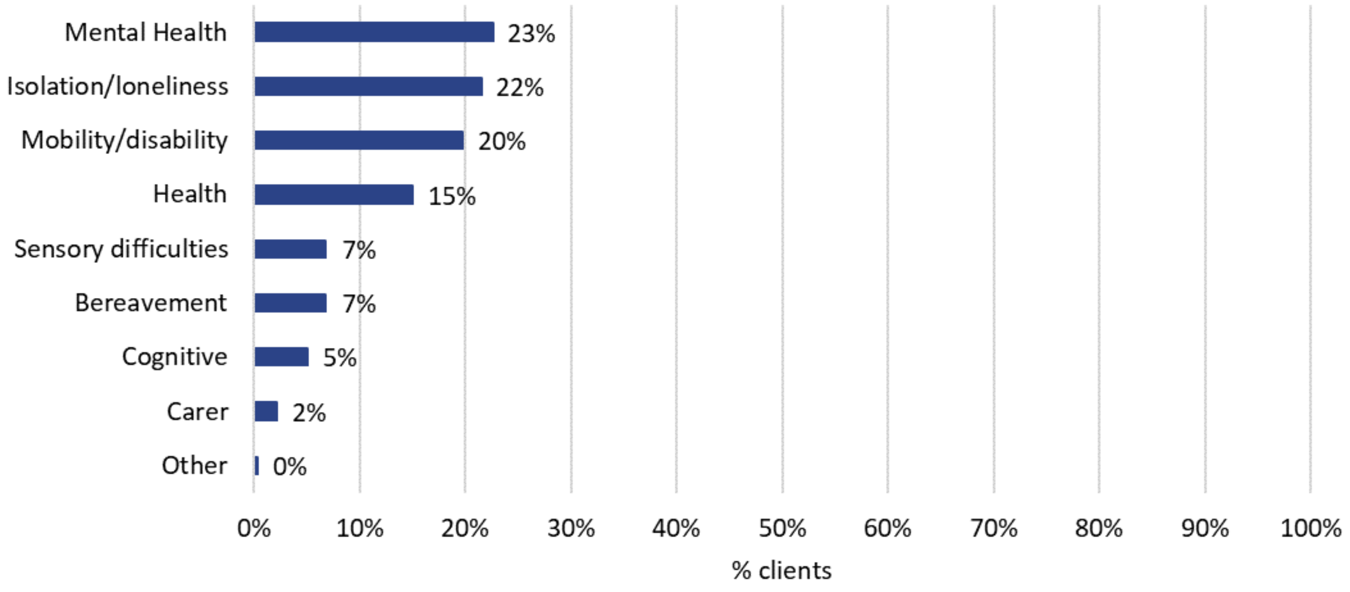


Figure 5 Primary reason for referral to Friendly Call based on subset of clients with these data available (n =279) Health issues including cardiac disease, diabetes, cancer, vertigo, Parkinson's Disease, Chronic Obstructive Pulmonary Disease, Multiple Sclerosis, dialysis, epilepsy. Cognitive issues included intellectual disability, and dementia or memory loss, 'Other' (n=1) was fear of not being found after a fall.

Triggers for a referral could be the **person expressing themselves** that they are lonely to a HCP, or the HCP **recognising loneliness** (e.g., person's interaction in chatting as part of their own sessions, as a "*signal*" (P#8, HCP) someone might benefit or be interested). The individual may be known by the HCP to go a day without talking to someone – a person like that with mental health issues might have a "*downward spiral*" (P#16, HCP) if they have limited social contact due to specific circumstances (e.g., lack of family, family overseas or occupied during the week, new mobility issue withholding them from engagement as usual e.g., walks/bowls). Getting out of bed to take a call on the landline can motivate them to get up in the morning and provides the additional benefit of "*indirect monitoring*" (P#16, HCP) the service provides. A further trigger for a referral may be identified **needs or gaps in the individual's health and social care** (e.g., financial or mobility barriers to accessing appointments, or no access to home help – particularly give the national shortage and the shift in guidance so this can be used for personal care only). One PHN spoke of using FCC as a "*gateway*" (P#9, HCP) to other supports for a woman who was resistant to other services like home help.

> *And for some of these people, it was the call that got them out of bed in the morning. A lot of these people wouldn't have mobile phones, so they'd have to get out of bed to get to a landline. So, it some sense, you're kind of triggering their day. Also, they're very often the same people whose self-care would be at a level that they wouldn't meet the criteria for home help so they would be quite isolated if they didn't have Friendly Call, if they didn't have someone to engage with at a reasonable hour, they may spend the day in bed. And that's not good for your health, mental health, you begin to ruminate, you're not taking care of yourself, you're missing a meal. So that's the downward spiral from that can be quite significant.* **(P#16, HCP)**

Some HCPs appeared to engage in an informal screening process when deciding the person to refer, recognising that someone with more complex medical needs or acute mental health needs might not be suitable. HCPs recognised that volunteers are not trained mental health professionals and it would be inappropriate to refer someone acutely unwell, or with more advanced dementia – people are only referred if they are well enough to manage the phone and can have conversation.

Process of referring into FCC

Generally, the client is aware of the referral (if made on their behalf) and consent is sought to contact the service on their behalf, so "*there is no cold calling*" (P#1, DW). The referrer generally completes the application form providing contact details for the client, key (emergency) contacts, and GP, health information (checklist identifying problems with vision, hearing, speech, mobility, mental health, vulnerability, social isolation), whether living alone and or receiving care, preferred time to call, and consent. The referrer emails or posts this form to the DW (**Figure 6**). However, the process varies slightly across and within HCP disciplines, in terms of the route referrals take, the level of information provided, and the degree of follow-up between referrers and FCC. The level of ongoing contact between FCC and referrers varies. FCC may have some ongoing and more regular contact with some HCPs, for example, the virtual integrated care team. This is not the case for other services, who do not come back to FCC unless they need something. One HCP flagged they might be contacted about a problem but do not necessarily know how the service is working out for the client.

> *If they [client] have any issues we can go back to the integrated team and say "Look you referred onto us, not doing very well" That's one of the ways it works both ways. But most of the referrals, the referral is sent from the hospital or from the guards. But I know I can go back to them as well when I know where the referral came from. But it's not normally that they come to me and say "How's she [client] getting on". Not normally, but maybe in the integrated care pathway, that is, more structured, do you know?* **(P#1, DW)**

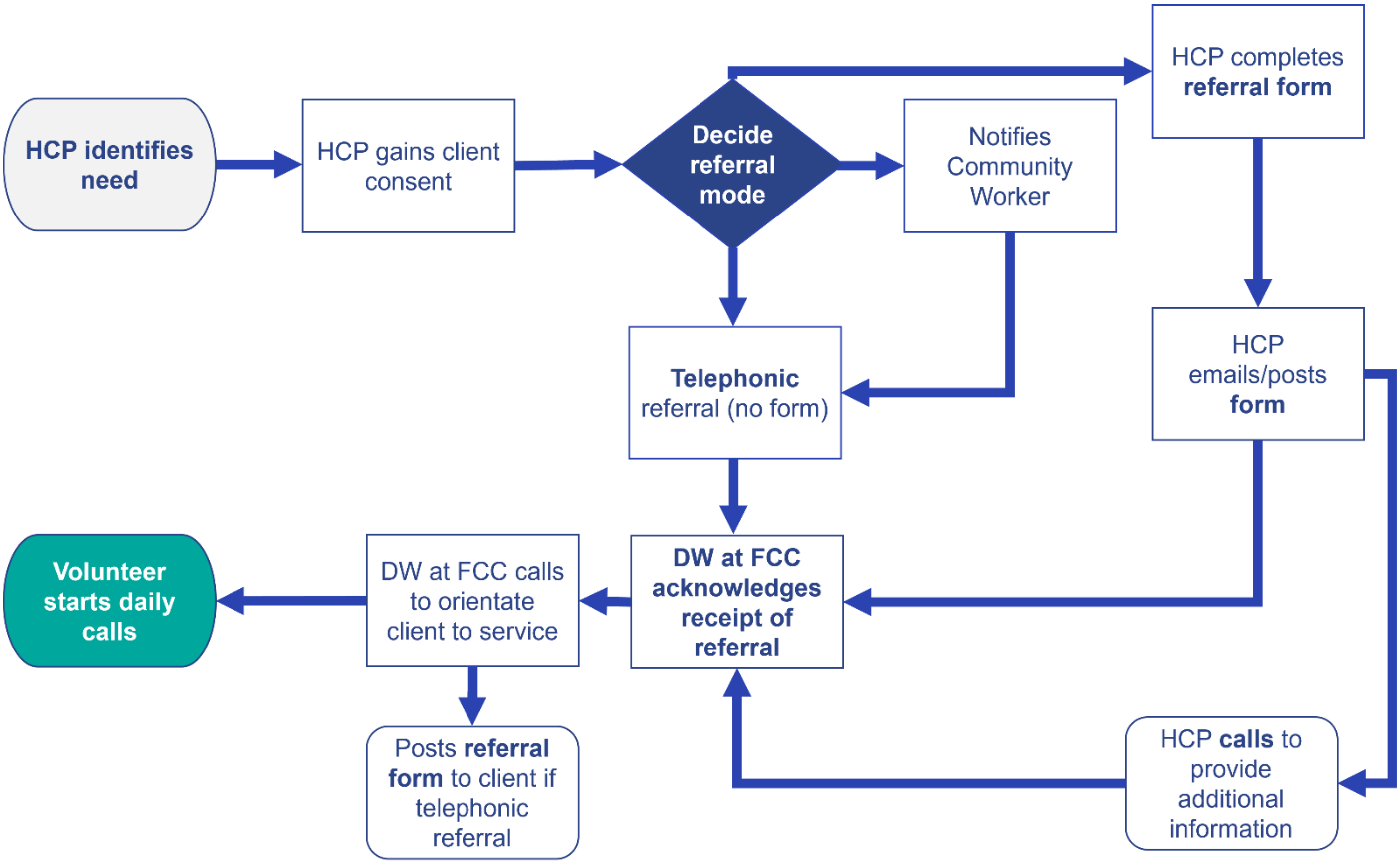


Figure 6 Process map of various routes of referral into the service (green block: service has received it). Health Care Professional (HCP), Development Worker (DW), Friendly Call Cork (FCC)

Barriers and enablers of referrals into the service

Barriers and enablers of referrals are discussed under the headings of content and focus of the referral form, service visibility to referrers, referral capacity and eligibility, service visibility and definition for new referrers, and central coordination of referrals. Barriers mapped to potential solutions are provided in **Appendix 1.**

Content and focus of the referral form

The simplicity of the application form facilitated the referral process for HCPs. However, HCPs felt there could be more space for additional contextual information, and the DW flagged that the level of information provided on the forms can be variable.

HCPs were generally happy with how the referral process worked and found the form easy to use. The form does not take too long to fill out, it is relatively easy to complete with tick boxes, and is "*concise*" (P#9, HCP) compared to referrals for other community services. HCPs suggested including more space on the form (or prompts) to facilitate more relevant background or miscellaneous information (e.g., fact client hard of hearing so tendency to not hear phone ringing, additional detail on nature of their vulnerability, or "*life story*" (P#14, HCP) details to help give to start out that first call). This type of information is sometimes filled in instead in the email body or via phone along with sending in the form. However, along with providing additional contextual information that cannot be captured on the form, HCPs also agreed an initial phone call can still be necessary and important to facilitate case discussion about a person, their circumstances, what aspects of the service might be available for them.

> *I think overall it's [the referral form] good. I do often find that I do need to write a note somewhere…miscellaneous bits of information that is important for the client. You know, some people they might have hearing difficulty, so you might have to ring three or four times. So, there are some points, these little snippets because we have access to them [the patient], we would like to put that in as well.* **(P#10, HCP)**

> *I think maybe there's scope on the form to give a little bit more information about the person, a little bit more about the person, about who they are, what their, maybe what their life story is? So that when the first call goes in, they have something to say. But then maybe equally it's better that they develop their own sort of relationship, that it's not it's not a sort of a guided phone conversation?* **(P#14, HCP)**

While referral (application) forms always include a name and contact number, they do not always contain all information, including key (emergency) contact details, or may include different levels of information provided on the client. Sometimes the referrer information is missing. This can create a challenge. For example, the lack of emergency contact details means that the community garda need to be sent to check on people who do not answer calls, and incomplete forms require more information gathering at the first call with client.

> *I like to them to fill in the form but sometimes it's not possible. So, then what happens is I get a name, address and a phone number and I follow up with clients, I've already spoken to them, and then I post the form the clients. So, it doesn't always work, the clients aren't always able to fill it in or doing have the capacity to fill it in. But mostly, most of our referrals, the application form is filled out by whoever refers.* **(P#1, DW)**

HCPs and coordinators acknowledged that date mix ups with the bus service can be an issue. To prevent "*toing and froing*" (#9, HCP) one HCP proposed creating a dedicated referral form and process for the bus transport, to communicate dates and times required for hospital appointments. During the workshop, however, the DW flagged that instigating daily calls are important for clients originally referred for transport to hospital visits; the calls act as reminder to the client and are a means to update FCC with any changes to the scheduled appointment.

Referral capacity and eligibility

Currently, screening clients to join the service is an informal process; FCC aims to take everyone they can and there are no boundaries on referrals, they can come from any part of the county or city. While the lack of eligibility criteria, that FCC "*never says no*" (P#4, Community Health Worker), and that "*you don't have to have a diagnosis*" (P#16, HCP) to benefit from the service, was seen as a positive, there was recognition this need to be revised. With the service at capacity '*at breaking point'* (P#2, SIPC), since the influx of referrals and additional case-finding during COVID-19 and lack of drop of clients, a wait list has reluctantly been introduced.

> *And maybe because of the big number of new people who – like I said to somebody the other day, a lot of those people should have been on Friendly Call anyway…. I suppose the healthcare professionals too, the nurses and the social workers in [city hospital], they became more aware of what I can do. So, they would have referred a lot more people to us as well. And I still think we're only at the tip of the iceberg, but we are kind of full at the moment.* **(P#1, DW)**

Service visibility and definition for new referrers

HCPs spoke of finding out about the service from colleagues, by word of mouth, seeing limited information about the service, and the need for "*bit more visibility maybe. Sometimes [it's] harder to find out about the transport aspect*" (P#9, HCP). They flagged that awareness of the service may vary between health areas/centres (for example, centres based outside city boundaries with little knowledge of community services for older adults in general, or in more rural areas where there is increased isolation) or in acute centres, or between longstanding and newly qualified HCPs. HCPs who had and had not referred into the service flagged a perception and concern often these types of service might not last – HCPs may not be aware the service is still running before sending in a referral. One GP flagged the risk of "*earnestly"* (P#15, HCP) doing too much rather than focusing on one thing; for referrers in general practice, having one number for one clear service (e.g., social support) is important particularly if there are duplicate services providing wide range of supports. This GP based in the city centre with mix of patients from different health service areas, found it challenging to identify which services are available in which locations.

> *I suppose I worked rurally for a little while recently. Again, it's a group of very socially isolated [people]. Would I have flagged? Would I have referred them to Friendly Call? I would have probably thought that it's more of a city-based service and I don't know if there is kind of a catchment area for the service. I might not have thought people rurally would have access to the service.* **(P#10, HCP)**

Central coordination of referrals

Having a central person for all referrals, a DW who is connected to all the clients and knows them well was seen as a positive. HCPs valued being able to contact the DW directly and easily, the fact that she gets back to them relatively quickly to let them know what is happening with that client, when the service will commence, and having that "*rapport*" (P#9, HCP) with her to discuss clients and "*bounce things off her*" (P#9, HCP)

> *[DW] is fierce contactable. She's very contactable, she'll always come back to me. So, I find it very easy and if it's not, if it's not something that's picked up on straight away, she picks it up. Or if there are problems arising, she'll come back and she'll give me the heads up* **(P#14, HCP)**

HCPs felt the DW was contactable and easy to communicate with, and volunteers valued being able to return to one person who will know what to do. However, as outlined in Sustaining resources, having one coordinator in central role is challenging to sustain, with some volunteers suggesting the benefits of additional contact points.

> *You know, [DW] is so busy. I called her but can't get through to her. She'd always phone me back. But I don't think I ever go through to her directly. And so, it probably is an under resourced centre.* **(Abigail, FG#2)**

Referrals from the service

Services referred to by FCC

FFC refer clients onward to a variety of services, including community workers, community garda, Meals on Wheels, mental health services, Samaritans, home help, community warden, Tús for small jobs or house maintenance, housing services, Cork City Council, St Vincent De Paul. Personal alarms systems are also arranged by FCC. When FCC does link in directly with healthcare services on behalf of clients, PHNs are the main service largely because the historical service of home visitations is no longer in place.

Reasons for referrals from the service

For volunteers, the decision about when to escalate an issue depends on the client. For example, it may be typical for some clients with mental health issues to not answer the phone. According to volunteers, referrals are usually triggered by the client directly flagging something, or them as volunteer picking up on it from conversation with clients. In terms of health services, according to the DW, they only intervene when the client is unable to resolve an issue themselves and situation does not improve. It could be for something small like a medical complaint where the client is looking for reassurance, or for a more back and forth process of arranging medical services for that client, or to arrange support e.g., referrals to counselling services for someone who made a suicidal disclosure. FCC sometimes advocated for clients when the client could not (e.g., of council follow up)

Process of referring from the service

Volunteers can direct a client to Age Action, but if they are unable, the DW will ring on behalf of the client. The protocol for volunteers, in cases where the client does not answer the phone is to follow up with the DW, who will check for their recorded contact; if they do not have one or that person does not answer then the DW contacts the community garda. The referral mode depends on the service. For example, sometimes the referral is made verbally via a HSE Community Health Worker if the DW does not know the contact (e.g., to notify a PHN, or to the Meals on Wheels organiser in the local area), but otherwise she will go directly (**Figure 7).** Informally, the DW may go back to some HCPs who originally referred a client, reaching out directly by email or phone if there is some problem with that client.

When someone is ill, coordinators and volunteers generally advise them to call their doctor or advise them how to go about accessing health service rather than arranging a referral or contacting the service on their behalf. They try not to take responsibility away from the client and encourage ownership over their health.

> *I like the client to have that responsibility, I don't want to take that from them, and I want to make them responsible for themselves too. But I will refer people to PHN because sometimes it might be too hard for people to make a call, sometimes they don't or they're not able or they're too stressed or too anxious* (**P#1, DW**)

There were some exceptions to the protocol made by long standing volunteers. For example, one volunteer calls to check on people if they are not answering the phone but live nearby. Although there is no expectation to do this, this volunteer, and another volunteer, gave examples of sometimes using their own experience and contacts to facilitate referrals (e.g., organising PHN as already had contacts from previous role, or contacting a GP surgery when the client had fall and the DW was unavailable)

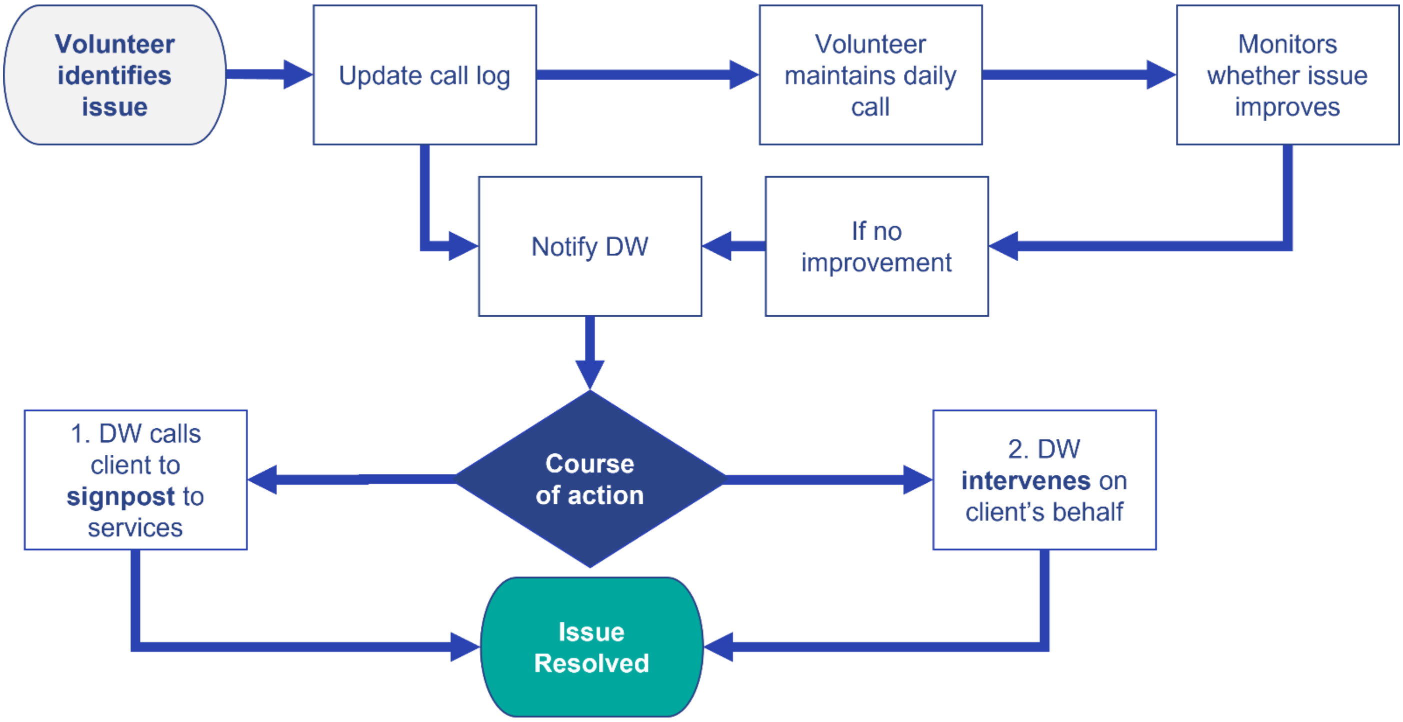


Figure 7 Process map of referrals out

DW: Friendly Call Cork Development Worker

Barriers and facilitators of referrals from the service

Barriers and enablers of referrals are discussed under the headings of relationships with other agencies and providers, knowledge of where to signpost, continuity and timeliness. Barriers mapped to potential solutions are provided in **Appendix 1.**

Relationships with other agencies and providers

Good relationships with other services and agencies established by FCC meant that anything asked for "*anything we ask for, it's done…we don't have to fight for it*" (P#3, Volunteer). There is give and take between agencies. Coordinators felt agencies tend to listen to the DW so she can get things get done for the clients. This is not the case for all agencies; some require perseverance and arranging services around clients can be resource intensive – involving "*a lot of follow up and chasing people and trying to get things done for people that really should be simple*" (P#1, DW). Certain types of referrals (e.g., arranging an ambulance) can sometimes be more complex.

> *And we also have good contacts with the council, meals on wheels and PHNs. So, people have problems I am in a good position the agencies listen to me. Housing maintenance or you know anything like that.* **(P#1, DW)**

Knowledge of where to signpost

Knowledge of the right place to point clients, among volunteers and coordinators, was important to facilitate referrals. Long standing volunteers knew to direct clients to Age Action services and would defer to the DW where there was a need to reach out on behalf of the client as "*They don't want the worry of it either, so they pass it on and then I'm trying to figure out what's the story or where that person is or there's a problem"* (P#1, DW). However, newer volunteers were not always familiar with where to signpost clients to trusted contacts for simple things like odd jobs. DW acknowledged that while the Age Action booklet is pointed out to volunteers during training, with changeable contact numbers this guide may be too static.

> ***Emily:*** *[awareness] that there are job guys. How to refer to them. And they are approved and that kind of thing. Maybe this kind of guy can do your plumbing and this one your garden and this one can cut the hedge for you. You'd have a list of people.* ***Tim:*** *referrals…. Of numbers.* ***Emily:*** *of numbers that you can refer to these people. You know, Tim can cut the hedge, he's very good. And they liked him, and he was nice, and he was courteous and respectful to you. So that would be the thing [I'd like], that I would be able to refer. The odd job man to them. That they could give them another sense of security, because I think that's one of the biggest things*. **(FG#1)**

Continuity and timeliness

The DW felt that "*because we're talking to the client every day, we know"* about any issues, and can monitor their progress, for example to be able to signpost the service initially, and to check whether the service has reached or responded to them. Judging when a missed call is significant and relies on volunteers knowing clients very well; for example, recognising that many clients do not answer because of mental health issues where they may not feel like talking. This continuity can facilitate an early warning of something different or wrong with the client and raise concerns earlier. From one HCP's perspective, this contrasts to friends or family where there is no "cross cover" – who can be on "peripheries" (P#14, HCP) and may not see the whole picture.

> *So, it's a befriending service where there's continuity, and getting to know people and sometimes it's that bit of conversation, socialisation, it means an awful lot to people who are socially isolated. And again, like what happened between myself and [DW] in the last few weeks, it's the fact that she was able to pick up on something because she'd been phoning every day and she knew what was going on. That she could say [HCP] can you get in contact here because I think this woman is in trouble.* **(P#14, HCP)**

Table 5 presents the barriers to referrals to and from the service and potential solutions.

Volunteering

Volunteers join FCC from variety of sources: newspaper/radio advertising, community employment schemes, organizational support projects. Volunteers heard about FCC through various avenues including a talk at work, exposure while at Tús, and via the Cork Volunteer Centre. Their interest was piqued as FCC represented a way to volunteer within their own time constraints, the mutual benefit of feeling appreciated and listened to in return, and there was a growing awareness brought about by the pandemic that people are isolated and lonely. Volunteers are assigned to clients, considering the client's preferred time. Some volunteers work a full or half day so the commitment can range from calling 2-15 clients per day Monday - Friday office hours. Calls are usually short because often they are made daily but can vary in content and length, which may depend on the client, their 'form' and whether they want to talk. In terms of content, sometimes calls are run of the mill conversations, sometimes philosophical.

Benefits of volunteering

Volunteers found the experience rewarding, they spoke of getting immediate positive feedback from calls and being "*buoyed*" (Abigail, FG#2) by volunteering during the pandemic, and forming "*deep, friendships with people"* (Anna, FG#1). There were benefits for them personally, for example, getting greater insight into people, improving listening skills and how they interact with other family members, learning more about technology, and continuing to have connections with people particularly during the pandemic.

> *There's huge learning from the health side of things. The lady [I call] is [age], my dad is [age]. And now I manage my dad a lot more, would I say, patiently (group laughs). This lady has taught me that wow my dad is amazing for [age]. So, it just gave me, it's all about perspective.* **(Abigail, FG#2)**

Barriers and enablers of volunteering

Barriers and enablers of volunteering are discussed under the headings of managing boundaries, empathy and drawing on experiences, limited peer connection and support owing to remote working, and flexibility. Barriers mapped to potential solutions are provided in **Appendix 1.**

Managing boundaries

Coordinators and volunteers recognised they need to carefully manage the boundaries of their relationship with clients. Volunteers were not rotating through clients as frequently as they would have done before the pandemic. While this facilitated familiarity and continuity, some volunteers found they had become too emotionally attached to clients. They were uncertain about how far to go in terms of their relationship and how to pull back from the relationship.

Volunteers felt it was part of their role to "*bolster*" (Emily, FG#2) people on the calls, to be positive – encouraging them that they can do things, building confidence. This was something which became more important during COVID-19, when clients were more nervous and volunteers would encourage them to get out for walks, or to engage in activities in their community. However, both coordinators and volunteers recognised interactions can be "taxing" (P#1, DW) – volunteers require breaks and flexibility. They accepted the need for boundaries on the relationship and place limits on what can be done for clients within the context of the befriending relationship.

> *So that's why the volunteer side is really important to manage it and make sure that they are doing what they signed up for. In a nice way. And look [it's great] if they end up being like super friends on the phone, without ever crossing that boundary. And boundaries are really important.* (**P#1, DW**).

During the pandemic turnover on the volunteer rota decreased; volunteers no longer change as frequently to new clients, or they stay with the same clients. This means that they "*get to know them better and you get to know them longer"* (Tim, FG#1), with clients becoming "*like family*" (P#3, Volunteer). The DW spoke of the value of having volunteers who know clients well, in terms of facilitating referrals, and making suggestions during COVID-19 about what the clients want and need.

However, the static rota, meant some volunteers became too emotionally attached to clients. Some mentioned experiencing guilt and worry about clients even when on leave, and others found it difficult to separate the interactions with clients from their own life, feeling "*drained*" (Jenny, FG#2) when coming off a call. These issues were raised with the caveat that the degree of attachment might depend on different styles, the need to invest themselves to build the relationship. Volunteers also recognised that changing the rota more often would be a "*nightmare*" (Emily, FG#2) for the DW and that having people assigned for a long period is probably easier.

> ***Jenny:*** *I feel I am so involved with them. I was [away for a period] and back today and I was two hours on the phone…I'm like you Abigail, I just over share. So that's my problem really (group laughs knowingly).* ***Abigail:*** *I think if you're an empath you can't help yourself. You are trying to build a relationship and trying to make them laugh* (**FG#2)**

Some volunteers expressed uncertainty about overstepping boundaries, how much to give to their relationship with clients, and how far to go; this could include calling on clients to help with other tasks, or counselling over phone, or providing medical advice. For example, one volunteer, flagged occasionally getting into topics with little experience - she was asked for her opinion on medical topics and appointments and sometimes found herself trying to research medical issues – and recognised this was going beyond her remit.

This contrasted with other volunteers who outlined how they were careful to "*never get into any of that*" (Emily, FG#2). Some were unsure what was considered overstepping e.g., linking in with other family members, and treating the client as they treat their parents. This was particularly relevant with respect to mental health. Volunteers recognised they are not trained or expected to deal with mental health issues "*we're only volunteers*" (Birgit, FG#2), as outlined in the volunteer training and echoed by the DW who was conscious not to give volunteers too much responsibility. Nevertheless, challenging scenarios did arise, and there was variation in terms of how volunteers dealt with clients experiencing mental health crises including suicidal ideation; some went back to the DW for additional support, others dealt with the issues themselves.

> *I come off the phone drained and I have to it's very hard to separate it from me, and, especially for me one of my ladies now would be very down at times so you would have to try and get the balance right for her and for me because I don't know. I suppose [DW] is our only contact if you are available for somebody. You know, we don't have [others]. One man lives with his [relative], you know, so, she picked up the phone one day so we made contact and we said I might phone you if he is sick but like, I think I was overstepping again, you know what I mean. I find it hard. I was treating him as well as my mom and dad I suppose. I suppose that's natural, is it? I don't know* **(Jenny, FG#2)**

There was also uncertainty on the best way to 'pull back' from calls, and the right way to frame this for clients, in instances where their work/life is getting busier, and they are unable to give as much as they'd like to volunteering. A potential challenge to this is that clients may not want to be switched to other people. For example, although it did not create an issue, one long standing volunteer spoke of a client who "*took to her*" (P#3, Volunteer) and did not want to move onto another volunteer.

In the context of staying within the scope of their role, some volunteers expressed desire to have additional "*back-up numbers to fall back on*" (Jim, FG#1) and contact numbers in relation to clients (in addition to those submitted on the application forms), perhaps another contact for a person in the client's life. This point was based on a concern that they may not be able to reach the DW, though they had not experienced that issue to date. While volunteers valued being able to go back to the DW, they also recognised the challenge with the DW carrying the burden of care and weight of responsibility for all clients.

> *It's always go back to [DW] if I have any doubt about anything because she is our first point of call. You, you're going down a minefield if you start thinking about what to do or where to go if you know what I mean.* **(Jenny, FG#2)**

Empathy and drawing on experience

There is some health promotion within calls, but often this takes the forms of light, unspecified advice; go out for a walk, asking about sleep, reminding people about taking medications, advising clients on getting vaccination or encouraging them to call their GP or mention the health problem to another provider (e.g., home help). The ethos within the service, as expressed by coordinators and volunteers, is encouraging clients to take charge of their health.

> *He [client] suffers terrible from depression. Before when I was on to him, I said why don't you volunteer for something, and get you out of the house and things like that. So, he joined a voluntary association thing and was volunteering until the pandemic hit. He was getting on great*. **(P#3, Volunteer)**

However, some volunteers felt they were able to draw on their own previous experience of dealing with people in general or older people and were better able to "*clue into people*" (Emily, FG#2). For example, one long term volunteer had been a carer for elderly relatives, one with dementia, another volunteer had been a health care professional. The former explained how in managing her interactions, along with drawing on her experience from her own family, she would also draw on what she has learned from other clients, "*maybe you could try that, or might work for you too*" (P#3, Volunteer).

> *I looked after my [relative] for year. And I suppose, I know the way she used to react to things like that. I know the way she wanted people to treat her. I might be talking to someone who is in their 70's, that would be my [relative] age. I would think, what way would she want someone to speak to her. I think to myself, how would I react. If someone was to say something to me, what way would I want them to say it? I try to do it that way. I try to look back on things. Like my [relative] had dementia and if I am talking to somebody with a touch of dementia - I went to the classes for it - so I know how to get things across to them.* **(P#3, Volunteer)**

The length of a call varies depending on whether client is in 'form' to talk, and volunteers agreed on the importance of being tuned in to when a person is having a bad day, in those scenarios keeping the calls short and leaving the person in peace. Long term volunteers spoke about knowing what clients need from the calls of being able to '*tell if they are feeling that little bit out of it or that they are not feeling right' (P#3, Volunteer)*, and the length of the call required, and when they want to talk. For example, giving more time to a client who has very limited social contact during the day.

Limited peer support owing to remote working

Beyond the initial training, volunteers can go back to the DW at any stage with queries regarding the process, concerns about clients, or when they need a break. However, coordinators and volunteer recognised the challenge presented by the pandemic in terms of the support available to volunteers. Whereas previously there had been a regular check-in with volunteers during weekly visits to the office, coordinators now found the remote working made it challenging to achieve this type of monitoring and support.

Outside of support provided by coordinators, the importance of social interaction for volunteers was recognised, there were concerns about a lack of peer support for volunteers, and volunteer fatigue. These issues were echoed by volunteers who outlined the challenges of being unable to check in with other volunteers, and a desire for an opportunity to do so, to obtain feedback, to "*gauge what's the norm and is there something else I could be doing and sometimes you can do with a listening ear yourself"* (Anna, FG#1) particularly for new volunteers given the shorter training sessions.

> *if I had had the opportunity to give feedback a bit more quickly, I think I might have changed my approach and done some things a little bit differently. Because we had the one training session and that was it. Away you go. I thought I was doing it wrong.* **(Abigail, FG#2)**

Flexibility

Flexibility around when and how volunteers do the calls was an important enabler. Volunteers spoke of having the freedom to do the calls as they like, and the importance of being able to do calls when it's good time for both client and volunteer, of being in the "*right form*" and "*upbeat*" (Emily, FG#2) to call.

> *Because it's a friendly call and you were calling them under duress and fitting them in at ten past two and you only have 5 minutes or 20 minutes and you're under pressure, they would feel it. and it's not good in the long run. Also, we are kind of in our own autonomy as well. You can decide and tell [DW] look it's working very well for us at the moment and if the client changes, we can always say if you want to change the time, we can look at that again* **(Brigit, FG#1)**

The change to remote working, was felt to facilitate flexibility. Volunteers spoke of the arrangement being compatible with their own schedules and, in one case, conversational style, if they were chatty and desired to keep talking beyond the time when the FCC office would normally close. However, as volunteers began making calls from home, one concern with this was the fact that clients could be called now from an unrecognised number. This may lead to hesitancy with answering the calls when they first join the service, due to the fear of scams.

There was also some flexibility in terms of mode which was seen as a positive. One new volunteer spoke of texting as the client prefers it, which works well. Another had arranged an in-person meeting with a client and felt this helped him to better understand family dynamics and issues he had been discussing with the client.

Client perspectives

Client experiences of the service were captured through four main themes: replacing lost connections, building meaningful relationships, client-centred support, and appreciation for the service.

Replacing lost connections

Clients joined the FCC service for a variety of reasons, which could all be encapsulated as a need to replace lost connections. Connections were lost through bereavement, ill health of family members, loneliness, and social isolation because of cocooning during COVID-19. Some clients spoke in general terms about loneliness and social isolation but did not specify a reason for this, while other new clients spoke about losing social connections specifically, because of cocooning.

> *Well, I was cocooning I would be high risk, I was told to get onto the Friendly Call service, it was really the lockdown that made me get involved. I had a lot of fear and wasn't getting out or seeing anyone at all it was a lonely time* **(Client E)**

A client who had recently been discharged from mental health services in the hospital gained additional support from FCC alongside that received from professionals in the community. This was cited as their reason for initially connecting with FCC.

Building meaningful relationships

Building meaningful relationships with their befriender was a standout experience for clients. Meaningful relationships were those in which they felt cared about, could be open with the person. The relationship was two-way and went beyond "just a chat*,* I'm starting to feel part of a family" (Client A). Since joining FCC clients felt a sense of belonging and felt remembered which was important for those who were without family.

Participants distinguished between their befrienders and others in their lives, including family members. Clients described being able to share personal information with their befrienders that they would not share with their families.

> *Someone you can talk things through without imposing on your own, you don't want to bother family at times* **(Client C)**

Shared interests were beneficial to break down any conversation barriers and establish a genuine reciprocal relationship. It was critical for clients to be able to converse as well as listen to and hear about other people's lives and events.

> *We talk about everything, who I met, my experience and he will tell me about his life. We have a lot in common* **(Client D)**

> *I enjoy the conversations we talk about current events and shared interests, really interesting topics come up that I feel he (the befriender) enjoys as well. it is great to have someone call* **(Client G)**

Client-centred support

Clients felt their befrienders were not "*invasive"* (Client A) and that they were considerate of their needs. They reported that the service was not only flexible in a practical sense in terms of how often people call or what the call involves, but also responsive to their needs, be they emotional or practical. For example, they did not feel *"under pressure to talk"* (Client F) and that *"you only share what you feel comfortable with"* (Client A).

Within the theme of client centre support, there were two sub themes of emotional support and practical support. In terms of emotional support, the calls gave clients something to look forward to, to "*brighten your day"* (Client A), provided intellectual stimulation, and improved their confidence in socialising. For example, clients talked about how they were now doing things on their own that they would not have done before the befriending support. As result, they become more independent. For some, greater confidence led them to get more involved in their community.

> *Friendly Call gave me the courage to join new experiences, I asked to join a local prayer group. Without the confidence gained through my friend this wouldn't be possible* **(Client H)**

While not all clients required practical support, being linked in with the service addressed transport issues including transport to medical appointments, and issues accessing necessities like food and medical prescriptions. It should also be noted that practical support was offered pre and during COVID-19.

Appreciation for the service

All clients were asked about their experiences of FCC during COVID -19, but only longstanding clients were asked specifically about changes in experience during COVID-19. Those clients had a greater appreciation of the service during COVID-19. The clients recognised how COVID-19 had impacted the delivery of other services but felt FCC continued to deliver valued and consistent service during a difficult time.

> *Even during lockdown when everyone was under pressure, they did their best the consistency of the calls was the same every Monday-Friday* **(Client C)**

Although clients did not report any changes in delivery or quality of FCC during COVID-19, clients' overall experiences of the pandemic were of loneliness, social isolation, fear, and issues with accessing health care facilities. FCC remained consistent and reliable during a difficult time for clients.

Prioritised actions

Several potential actions to address challenges were generated through discussion with service coordinators, health care professionals and volunteers. These actions were elaborated on during and after the workshop and prioritised based on input from participants. More detail on each action and how they map to barriers is provided in **Appendix 1.** Eleven (**Table 3**) were considered feasible, five of which were considered to have the greatest potential impact:

1. Training an additional support or back-up person, which could be achieved by formalising an existing system whereby volunteers who have been with the service for a long term take on more responsibility.
2. Introducing new protocols for monitoring and supporting volunteers remotely.
3. Creating opportunities for volunteer peer support.
4. Defining the service, providing more information and education about the service for potential new (HCP) referrers.
5. Introducing a formal screening process to manage capacity.

Table 3: Prioritised actions to address service challenges

Potential action	Feasible	Impact
1. Train an additional support/back up person	**x**	**x**
2. Implement a formal needs assessment to introduce a tiered approach to calls	x	
3. Implement a timed approach to calls	x	
4. New protocols for monitoring & supporting volunteers remotely	**x**	**x**
5. Enhance remote training and ongoing training	x	
6. Create opportunities for volunteer peer support	**x**	**x**
7. Define the service, and provide more information and education about the service for HCPs who have not referred	**x**	**x**
8. Consider an online referral form	x	
9. Implement a formal screening process	**x**	**x**
10. Raise awareness of places to signpost clients among new volunteers Age Action booklet part of the start-up pack	x	
11. Link with other befriending services across the country/county e.g., ALONE Befriending Network Ireland	x	

Training an additional support worker

Having a single coordinator with multiple responsibilities including recruitment, managing referrals, onboarding clients and volunteers, and making calls among other tasks, was considered a key challenge, particularly with the greater demand on FCC during COVID-19. FCC volunteers with the service for a long time previously took on more responsibility, for example, filling in for the DW on calls or manning the main contact phone when she is unavailable. However, now this role is typically fulfilled by a Cork City Partnership staff member or an individual on a work placement scheme. Formalising the system with long term volunteers was proposed as one way that additional support or back-up could be provided. For example, if the service continues to expand, one suggestion from the workshop was to have a designated person coordinate referrals for each area or catchment, with senior volunteers taking on these roles. However, this would potentially require more training and monitoring. Guidance from ALONE suggests establishing task subgroups (e.g., social events subgroup) with a designated volunteer Chairperson, supporting volunteer leadership by having volunteer representatives on the management committee, and engaging in a formal Training Needs Assessment with volunteers to identify areas where training is required.[40]

Peer support and protocols to monitor and support volunteers remotely

One proposed action was to create opportunities for volunteer peer support. Suggestions included a 'buddy' system, introducing a WhatsApp group for sub-groups of volunteers or the group they trained with, and reinstating elements that happened pre-COVID-19, including shadowing of more experienced volunteers, and volunteer social events. Volunteers who participated in the focus groups, appreciated the opportunity to connect with other volunteers, even online, suggesting that meetings via Zoom may be a viable option. However, it would be important to be aware of volunteers who may not have the technology, capacity, or knowledge/skills to participate in online meetings. In these instances, providing additional training or, in the absence of in-person meetings, facilitating one-to-one peer support via phone, may be an option. In terms of implementing peer support, ALONE advocates for a volunteer buddy system or a more formal volunteer mentoring structure if the buddy system proves unfeasible with growing number of volunteers. The latter establishes a structure whereby more experienced volunteers undertake mentoring, supporting, and managing a number of newer volunteers.[40] These senior volunteers could take the lead with organising online meetings, monitoring, and checking in with volunteers remotely.

A further support when volunteers have faced difficult issues or experiences, could be provided via psychological debriefing. This is an approach to manage stress or provide closure on an event, involving distinct phases: assuring confidentiality, re-enactment phase, emotional reaction or feeling phases, symptom phase (where the participants discuss any outcomes of the event), teaching phase (where the participant is educated on stress and adaptive responses) and summary or re-entry phase.[41] Debriefing has been used positively among mental health professionals, and also been utilised as part of volunteer support structures within crisis helplines[41,42], critical incident management[43], dementia care[44] and hospital volunteer programmes.[45] Creating a space in which a volunteer could discuss difficult issues or experiences, along with weekly debrief Zoom meetings, were adaptations made by an Australian befriending programmes in the context of COVID-19.[26] ALONE provides guidance on establishing volunteer meetings to support shared learning and networking.[40] In the context of FCC, it may be beneficial for volunteers to talk through, with other volunteers or service coordinators, their experience of providing more intensive emotional support to a client. Additional support could take the form of counselling; these supports are offered to volunteers with ALONE and may be helpful, for example, should a volunteer experience death of a client with whom they were close.

While the return to in-person engagement was possible at the time of this report, it remains important to have clear protocols in place to remotely monitor volunteers and provide support, should the need for remote working arise again. Volunteering remotely and engaging in online training and peer support meetings may be more feasible for some individuals. Having these options, or hybrid approaches in place, may enhance the accessibility of the service and attract more volunteers or a different cohort of volunteers to the service.

Service definition

One prioritised action was to define the service, and to provide more information and education about the service for potential new (HCP) referrers. This aligns with a report on befriending in the UK which highlighted the lack of clarity about what befriending should and can offer, and that 'befriending' is a general term applied to multiple different models.[46] An evaluation of befriending services in New Zealand suggested reliance on self-referrals may lead to gaps in accessing older people - they might not be aware of the service or be deterred from reaching out due to the stigma attached to admitting loneliness or social isolation.[47] Indeed, only 6% of referrals to FCC were self-referrals. This further emphasises the importance of supporting referrals from friends/family and HCPs, for example, GPs with whom people may disclose issues of being isolated and requiring support. Important aspects to highlight about FCC, as suggested by HCPs in this study, included the following:

(1) The fact FCC is delivered via phone as not all services are and therefore this could be considered a distinct advantage.
(2) That the service is still in operation, given some HCPs may expect that many voluntary services have been dropped over the past few years.
(3) What the service can do (for example that it can link in with other healthcare services) but importantly what it *cannot* do, what is out of scope, as this will help HCP referrers to decide whether FCC is the most appropriate referral for their patient.
(4) Eligibility and referral boundaries (who is accepted and from where) and the screening process, essentially who is accepted and who is not.
(5) how to refer, emphasising simplicity and providing a single number or contact point to avoid confusion.

(6) Clinical governance, namely if a client is referred by a HCP, where responsibility lies should the client fall ill and what happens next.

Raising awareness of the FCC could be achieved through the development of a targeted communications plan, including flyers in health service waiting rooms, regularly flagging FCC at community health area meetings, linking in with key contacts at health centres, and reaching out to social prescribers who have links with general practice. However, given the challenges with resourcing and that more awareness may drive more referrals, increased communication about the service needs to be contingent on an appropriate expansion in resources.

Formal screening process for clients

Introducing a formal screening process was suggested as an action to manage service capacity. This would involve putting eligibility criteria in place and setting clear boundaries around the service in terms of location and scope. FCC to date has endeavoured to accept all referrals and has a broad remit to help as many clients as is feasible. As mentioned, a wait list has reluctantly been introduced in response to the demand created by COVID-19. Any process or protocol to assess who needs the service and who does not, and the next steps to take if someone is deemed ineligible, would ideally be co-developed with stakeholders (i.e., coordinators, referrers, volunteers, and clients where appropriate) to determine what would be acceptable and feasible. Managing the intensity of the service provided, introducing a step-down service (e.g., daily calls for a set period followed by twice weekly for a further period), or tiered service (e.g., some clients on daily versus weekly calls) may partly address some issues with capacity. Open dialogue with the client is key to determine how best to arrange the call frequency. Fakoya *et al.* (2021) in their evaluation of case studies of befriending services in Northern Ireland, cited how it is important for befriending services to have explicit service goals which are tailored to the needs of service users. This may include actively integrating some clients into community life and helping them to establish social networks outside of befriending, while linking others to longer term interventions.[24]

Discussion

Summary

The aim of this study was to understand how the FCC service is implemented, including barriers and facilitators, and explore how the service links in with community healthcare services. To achieve this aim, we analysed data on the profile of clients and volunteers with the service, conducted interviews and focus groups with service coordinators, volunteers, HCPs, and clients, and held a co-production workshop with stakeholders to share knowledge, reflect on the interim findings and prioritise actions for the service. The findings indicate the central role of FCC, not only in providing daily contact and social support to isolated and vulnerable individuals, but also through advocating for clients and linking them to other services in the community including health and mental health services (e.g., public health nursing, bus to appointments), other practical and social supports (e.g., maintenance, housing, Meals on Wheels).

Established in 2011, the implementation of FCC is strengthened by the continuity of staff, including a central, committed coordinator, along with the long-standing links and trusting relationships the service has built with other agencies and health care providers. The service is described by HCPs who refer into it as a "*lifeline*" and "*safety net"* for vulnerable people and their families. For HCPs, the simplicity of the referral process and a "*contactable*" central coordinator were facilitating factors. Volunteers were "buoyed" by the role, drawing on their own empathy and experience to engage with clients during calls. They were facilitated to undertake their role by the flexibility afforded through remote volunteering with the service. Clients who joined before and during COVID-19 were able to replace lost connections through engaging with the service. The relationships they built were meaningful, two-way friendships, bringing a sense of belonging. They felt the service was flexible to meet their practical and emotional needs and appreciated the consistency of the service during COVID-19.

Some of the findings have broader relevance and highlight important considerations for other voluntary organisations who offer a similar service. First, there is **value in having a central coordinator** who is committed, knowledgeable, familiar with service users, and who has established trusted relationships with other agencies and organisations. Second, it is **challenging to sustain that type of service model**, when coupled with tenuous funding sources and the difficulty of building a volunteer base to meeting growing service demands. Third, given the demands which valued voluntary services like Friendly Call face, **defining the service and eligibility criteria is increasingly important**, as is achieving a balance between raising awareness of the service and managing capacity. Fourth, while it was clear how volunteers found their role rewarding it is important to **be aware of the potential difficulties, volunteers may face in terms of managing boundaries**.

Changes to the service during COVID-19

During COVID-19 the service shifted to a remote model (with volunteers working from home) and showcased its ability to pivot and become a central part of the pandemic response.[48] It also scaled up, providing a greater level of practical support to clients (e.g., collecting prescriptions, shopping, additional bus transport given restricted access to public transport), along with adapting and providing new resources (e.g., distribution of food hampers, play packs, Personal Protective Equipment) and new services (e.g., Acorn tablets). The pandemic also saw the service engage more with other agencies, becoming more visible, and it experienced an influx of both volunteers and clients as referrals increased.

Challenges

Challenges faced by the service include (i) capacity to take on new clients, (ii) reliance on one central coordinator to manage the service and (iii) ensuring sustainability given the lack of multi-annual funding, the influx of referrals into the service, and the continued increase in demand following COVID-19 as clients who joined the service during COVID-19 have tended to stay on with the service. **Specific challenges in terms of the referral process** include (i) the occasionally limited information provided on referral forms, (ii) the potential lack of visibility of the service for HCPs who have not referred but may use the service, (iii) uncertainty among newer volunteers about where to signpost clients and (iv) the need for supplemental contact points should there be an issue with their client. Lastly, some **volunteers found it challenging** (i) to manage the boundaries of their relationship with clients, sometimes lacking relevant experience or training to draw on when engaging or advising clients, and (ii) limited peer support owing to remote working.

Comparison with other studies of befriending services

Studies which have explored the delivery of befriending services[26,27,46], have cited similar challenges and strengths to those identified in the current study. These include: limited resources, including volunteers[46,47] and time to meet the demands of the service[27,46] or to manage and develop the referral process[27]; challenges securing sustainable funding[46,47,49] or a lack of control over funding[27]; lack of a formalised structure for publicising the service[27], and; the importance of operational flexibility to meet changing client needs.[39,40] In contrast to FCC, the 'Call in Time Programme' based in the UK, flagged challenges with volunteer retention[27], desire for more local control, and the need to generate trust with other agencies.[27] A recent study of a befriending organisation in Australia examined how the service adapted during the pandemic, citing challenges with shifting to remote work and staff redeployment.[26]

As with the current study, previous research has also cited the benefits experienced by volunteers, highlighting their role in encouraging clients to engage with different activities and make new connections.[8,17] Volunteers within the Australian befriending service reported a desire to return to the role after a few weeks of initial absence at the beginning of the pandemic, citing their own loneliness and need for engagement as motivation.[26]

The current study highlighted the importance of training and peer support for volunteers. A systematic review of befriending interventions, highlighted that little has been reported in the existing evidence about the training and support provided to volunteers.[16] However, a recent evaluation of in-person befriending services in Northern Ireland[24] involving interviews with befrienders, service users and their family members/next of kin, reported when befrienders had relevant experience (i.e., similar health condition or personal experience) they were better able to empathise with service users. Where the befriender lacked this experience, training was cited as helpful to equip them to engage with service users. In contrast, volunteers who took part in focus groups as part of a study in the Republic of Ireland conducted by Lawlor and colleagues, did not flag the need for additional training, citing the role as 'intuitive'.[17]

In line with our findings, a study focused on befriending for carers of people with dementia, reported that the befriending role can be emotionally demanding.[25] A workshop on befriending services conducted as part of the UK Campaign to End Loneliness, identified a lack of clarity about what is appropriate for befriending to offer and difficulties determining the boundaries between volunteer and client as one of the main challenges facing befriending services.[46] This was echoed in an evaluation of befriending services in New Zealand which reported volunteers experiencing 'blurred' boundaries.[47] Holton and colleagues also highlighted how volunteers go beyond their usual role (e.g., buying shopping for their client) and cited the importance of managing boundaries within the relationship and supporting volunteers should they transgress those boundaries.[50] FCC volunteers who took part in the current study, highlighted how they sometimes delivered general 'light' health promotion advice to clients. In their interview study conducted with clients of ALONE during COVID-19, Holton and colleagues reported how the topic of vaccinations, as seen in the current study, was raised by service users, with the authors questioning whether promoting vaccine uptake could be mediated through befriending services.[51]

Strengths and limitations

This research is strengthened by the inclusion of multiple perspectives, a diverse set of HCPs working in different disciplines, and different data collection phases (interviews/focus groups followed by co-production workshop) which allowed participants to build on interim findings from the research. One limitation is that the workshop was less interactive than intended, in part due to the online format and technical difficulties experienced by participants. To provide additional opportunities for member checking and feedback, the research team contacted workshop participants via email after the event to seek their comments and clarify their priorities. A further limitation is that not all participants engaged in rating the proposed actions. Given the challenges of engaging online, and that most topics to be discussed related to operational aspects of the service, along with the potentially sensitive nature of some issues (for example, volunteer boundaries), the decision was made not to include clients in the workshop. However, client perspectives were sought via interviews and a subset of clients were invited to read the lay summary for this report and provide feedback. Those who provided feedback considered the lay summary clear.

Conclusion

This study found that FCC is valued in the community by clients, volunteers, and HCPs, and is strengthened by having a central committed coordinator, along with long-standing links and trusted relationships with other agencies and health care providers. FCC became a key part of the local pandemic response, adapting rapidly to meet client needs, providing a '*lifeline*' and '*safety net'* for vulnerable people and their families. However, the service faces key challenges in terms of funding and resources, limiting its capacity to take on new clients. National policy, specifically the National Planning Framework[52] and National Positive Ageing Framework[53], supports the development of age-friendly communities, where older people are supported to live connected lives ageing with confidence, security and dignity in their own homes and communities. Services like FCC can contribute to this goal. However, only through appropriately developed and responsive services for older people will long-term gains be made in respect of their health and wellbeing. Under key societal challenges such as the global pandemic, there is greater focus not only on loneliness and social isolation, but on finding ways to reach and support vulnerable and older people in the community and connect them to the services and supports around them. In this context, it is important focus on how befriending services, like FCC, are implemented, the challenges they face, and what supports and adaptations they require to ensure their delivery is sustained and optimised into the future.

Appendix 1: Details on barriers and proposed solutions

Details on each barrier and mapped solutions considered feasible or impactful are outlined in the tables below in relation to service implementation (Table 4), referrals in and out of the service (**Table 5**) and volunteering (**Table 6**).

Table 4 **Summary of barriers to implementation and potential solutions bolded if they were considered feasible or to have the most potential impact**

Barriers	Potential solutions
Resources	
• Insufficient funding, ad-hoc and tenuous. • At capacity, due to influx of clients and additional activities/new aspects of service. Experiencing tension between expanding the service and keeping the personal touch. • Reliance on one person. • Insufficient volunteers to cope with demand	➢ Access secure, sufficient and/or additional funding for the service on a multi-annual basis. ➢ **Train an additional support/back up person - formalize the system with senior volunteers.**[F I I I I] ➢ Recruit a support worker post ➢ Have regional areas covered by the service, with a designated coordinator for each area. Senior volunteer in charge in certain catchment area with caveat that this could potentially increase need for monitoring and mentoring and will be mean 'letting go', not knowing every client anymore. ➢ Implement a screening process. ➢ **Implement a formal needs assessment to introduce a tiered approach to calls (daily vs weekly etc. calls).**[F] ➢ **Implement a timed approach to calls: daily for 6 months, then twice weekly for 6 months etc.**[F] balanced against client-led discussion about how often they want or need calls.* ➢ Encourage more clients to become volunteers themselves, getting high functioning older adult volunteers to support the frailer and lonely older adult recognising that a client becoming a volunteer is not always suitable for various personal and emotional reasons.[F]
Knowledge	➢ **Write down or record tacit (local) knowledge.**[F F F I]

• Risk of losing tacit knowledge should the DW not be available or absent	
Policies	
• Delayed shift for FCC to become standalone service which would make it eligible for more funding. • Tenuous support from other CCP programmes.	➢ Become an independent charity or merge with another similar charity/organisation or be mainstreamed by a statutory agency ➢ Formalise support from SICAP.^{D} ➢ Clarify services to be dropped, services to be reinstated, new services.

F – Feasible; I = impact; D – more details needed; each symbol represents a vote from one person. Some solutions were not voted as a priority.

*This is with the caveat that a process to assess who need the service and who does not, may not be acceptable and feasible to clients and other stakeholders. The decision about call frequency is currently often client-led (clients might say they do not need to be called that often whereas others may need two calls a day). There is a need for open dialogue with the client to figure out how best to arrange the call frequency.

Table 5 Summary of challenges to referrals and potential solutions bolded if considered feasible or to have the most potential impact

Barriers	Potential solutions
Referrals in	
• One coordinator in central role is challenging.	➢ **Train an additional support/back up person.** ^{FIIII} ➢ DW to be freed up to maintain service with less direct client contact, making daily calls etc.
• Visibility of the service may be lower in certain sectors/areas/among certain professional groups.	➢ **Develop a communications plan to raising more awareness about the service and engage in more targeted advertisement. Suggestions included:** - Putting flyers in waiting rooms which might prompt self-referrals or referrals via family members.

	- Linking in with health area meetings every 1-2 months via assistant directors in community to flag the service. - Linking in with social prescribers and putting information in GP practices. - engage in a regular flagging system (3-5 months) for the different health centres, Including identifying a key person in the health centres to update new staff on the service. Identify a key person in GP practices. ➢ **Defining the service, and providing more information and education* about the service for HCPs who have not referred** [I F F], including on relevant advertising materials & website: - Noting that it is on the phone as lots of other public services are not e.g., diabetes support groups. - Clarifying it is still in operation. - Clarifying what it can *and* cannot do. - How to refer, the form (must be simple for GP), and a single number or contact point. - Explaining that it links in with other healthcare services. - Clarifying eligibility & screening process – who is accepted and who is not. - Clarifying clinical governance, where responsibility lies if a referred client falls ill - Clarifying referral boundaries.
• Forms do not always have key information.	➢ Address information gaps, consider enhanced form with more space on form (or prompts) to facilitate inclusion of relevant background or miscellaneous information, balance changes against maintaining simplicity of current form.** ➢ **Consider an online referral form.**[F]

	➢ Transport only form bearing in mind the call element of referrals is beneficial also ➢ Directory of PHN numbers may be useful for DW.
• Service at ‘breaking point’ and capacity for referrals reached.	➢ **Formal screening process.**[F F I] ➢ Putting boundaries on the service, in terms of location and function. ➢ Triaging new referrals.
Referrals out	
➢ Arranging services around clients can be resource intensive.	➢ Processes to streamline referrals.
➢ Volunteers were not always aware of where they could point clients.	➢ **Raise awareness of places to signpost clients among new volunteers (resource directory)** for example, making the Age Action booklet part of the start-up pack.[F F F F F] ➢ **Link with other befriending services across the country/county e.g., ALONE’s Befriending Network Ireland.**[F F F] ➢ “Decision tree” to empower the volunteers.[D D D]

*Needs to be balanced against current capacity challenges. There may be scope for more targeted communication, but FCC are cautious about advertising the service given the capacity is not there. While recognising that there is unmet need because GPs are not referring to the service, there is limited scope currently look at increasing GP referrals.

**Application form: adding more context about the client on the referral form, while it may be useful, might be difficult because people may not want to write down sensitive information

Table 6 Summary of volunteer barriers and potential solutions bolded if considered feasible or to have the most potential impact

Barriers	Potential solutions
Peer connection and support	
• Difficulties monitoring and supporting volunteers remotely. Used to meet as volunteers every 8 weeks, but not happening since pandemic. • Peer connection and support lost by virtue of volunteers working from home. If there is no return to the office, greater need to overcome this loss of support.	➢ **New protocols for monitoring & supporting volunteers remotely.**[I F F] Zoom wellbeing sessions are being organised but there is recognition that these do not offer the same type of connection and support. ➢ **Enhance remote training and ongoing training.**[F F]
Managing boundaries	
• Uncertainty about overstepping boundaries, how far to go.	➢ Additional guidance on role, boundaries, and service parameters, whether calls can happen after hours. There is already guidance on this as part of training, and clients and volunteers are matched based on client needs and volunteer ability/experience ➢ Have access to counselling supports/structured debriefing available.[D D] ➢ **Create opportunities for volunteer peer support and more opportunities to talk to other volunteers** [F F F I I I] for (a) giving and receiving advice, sharing experiences and feedback on the service to determine what is the norm, is there something else they could be doing; might lead them to change their approach, and (b) support “Sometimes you need a listening ear yourself” – would be nice to have option to meet for example with the group you were inducted with. This could achieved via: - ‘Buddy’ system - Reinstate volunteer socials

Table 6 Summary of volunteer barriers and potential solutions bolded if considered feasible or to have the most potential impact

Barriers	Potential solutions
	- Shadow a more experienced volunteer which is something which happened usually pre-COVID-19 - Introduce a WhatsApp group for volunteer subgroups / training groups
• Volunteers becoming emotionally ‘too attached’ to clients, and unsure how to ‘pull back’	➢ Enhance existing protocols to avoid becoming ‘too attached’. Currently there are protocols to match clients and volunteers based on emotional/mental health needs is already happening (e.g., there may be a lot of out-of-hours calls from certain clients and specific volunteers may be more or less able for that). Certain procedures in place to support this e.g., mobile phone to switch off helps with this. DW checks in with volunteers to see whether they want to move on from clients. ➢ Encourage rotation of clients (3-4 weeks the most) to avoid volunteers getting too involved as it becomes harder the longer you are calling them to pull away. ➢ **Call algorithm to automate the rota may lessen the burden of this.**[F D D D] ➢ Introduce standard procedure or advice on stepping back.
• Concerns about reach.	➢ More back-up and support options. Additional secondary contact points (e.g., Meals on Wheels delivery person). Another contact point through which volunteers can arrange referrals.
Empathy and drawing on experience	
• Lacking relevant experience or training to draw on for the calls.	➢ **More advice on how to counsel people or a ‘helpline’; psychological first aid training to address a distressed client without boundary violations and refer adequately.**[D I]

F – Feasible; I = impact; D – more details needed

Appendix 2: Additional information on proposed actions

Workshop participants specified they would like more information on some proposed actions, including a 'decision tree' to empower volunteers, the use of a call algorithm to automate the rota, counselling supports, structured debriefing and psychological first aid for volunteers,

Decision tree

Algorithmic decision support tools (e.g., decision trees) are often used in clinical settings to overcome uncertainty and complexity[54] and facilitate triage[55,56]. They can be presented as clinical algorithms or diagnostic flow charts[57] taking the form of 'if-then' statements or decisions. For example, decision trees have been used in many social and health care settings to aid referrals including in the areas of child welfare[58] and supporting vulnerable adults[59] including falls interventions.[60] In the most basic form, drawing on this approach, a flow chart could be created to support FCC volunteers to make decisions about what to do next for their client. For example, both the nature of the issue (i.e., is the client looking for information about a specific service *or* seeking referral to a service) and category (e.g., related to healthcare, mental health, maintenance, utilities, finance, legal) could be distinguished. Issues which require escalation, those which necessitate return to the DW (non-urgent vs. emergency action) as opposed to another senior volunteer (for advice) could be distinguished. The content and structure of the flow chart could be informed by common queries and issues and added to as both the DW and volunteers acquire new contacts and learn about new agencies and avenues. Much of this decision-making and information is already captured as part of volunteer training. While long standing volunteers are aware of support and more well-equipped to signpost, the flow chart could provide a useful reference point for newly orientated volunteers. In a more sophisticated form, the flow chart could take the form of an online tool with automated prompts.

Call algorithm

With a service at a capacity, the automation of repetitive tasks can release existing resources to focus on other tasks. Automating the volunteer rota has the potential to reduce administrative burden. Inputs into the system for each week would include volunteer availability and who is due to change rota or has requested a change, and clients who need calls and the number and time calls which are required. Automated scheduling has been used in the healthcare field, including nurse rostering[61], for example a bespoke system, ROTA, introduced to a hospital to automate nursing rotas, was shown to substantially reduce the time spent scheduling.[62] While a bespoke system may better address the specific elements unique to FCC (i.e., mix of daily and less frequent calls, unstandardized call (shift) length) a number of free[63–65] and paid software are available[66–70], including those specifically focused on management of volunteer rotas.[63,64,67–70] Some have been reviewed or endorsed by existing volunteer organisations in the UK[71] and Ireland.[72]

Training and support

More specific proposed actions to support volunteers included training in psychological first aid (PFA) which is defined as a ‘humane, supportive response to a fellow human being who is suffering and who may need support’.[73] Although initially focused on disaster and emergency management and response, there is more focus on PFA training for volunteers in the wake of COVID-19.[74,75] PFA has been delivered in a range of settings including by individuals without professional mental health training[76] and includes being supportive but non-intrusive, engaging in active listening while not putting an individual under pressure to speak if they are uncomfortable doing so.[76] PFA training could potentially better equip volunteers with the skills to recognise signs of emotional distress and act accordingly. However, making PFA a standard part of training may place undue pressure on volunteers in the role, particularly given the ethos that FCC is not a counselling service and is not designed to replace the different counselling supports and helplines that are available nationally (e.g., Senior helpline, Samaritan). In line with the action to implement a tiered approach to calls, volunteers who have an interest and capacity in providing more intense support to clients could be offered additional training. These individuals could also, if willing and able, serve as back-up supports for other volunteers, potentially as part of the mentoring structure.

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