Health Innovation Wessex

Independent Evaluation of the Hampshire and Isle of Wight

Alternatives to Crisis Programme

Full Report: May 2024

Part of the Health Innovation Network

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Disclaimer

This report presents the findings of an independent evaluation of the Alternatives to Crisis Programme. The findings of this independent evaluation are those of the author and the evaluation team, and do not necessarily represent the views of the Alternatives to Crisis Programme.

Acknowledgements

We would like to thank the Alternatives to Crisis Service Managers, the teams working within the services, the Commissioners and the Service Leads for their engagement and input during the period of evaluation.

We would also like to thank NHS South, Central and West Commissioning Support Unit and Hampshire Constabulary for the data provided and knowledge shared. Additionally. the NHS Digital Data Services for Commissioner Regional Office (DSCRO) team for their assistance with the data landing portal and data pseudonymisation process.

Finally, we would like to thank all the system stakeholders for taking part in our data collection activities, especially the people who use the Alternatives to Crisis services that came forward to share their experience.

Contents

Key messages

The following two slides summarize the top eight take home messages to come from this evaluation

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Key messages

- The Alternatives to Crisis services **supported over 1,154 people** between 01 April 2022 and 30 June 2023

- The Alternatives to Crisis services have been shown to **effectively support crisis de-escalation and reduce emotional distress** for the people they support

- **People using the services would recommend them** and have described them as **"a lifeline".**

- General trends suggest that contact with an A to C service could help **reduce the average monthly use of emergency services, such as 111, 999, and ED;** however, data limitations and local variation between services as well as the impact of frequent service users all require further investigation.

Key messages

- **Stakeholders from emergency response services and primary care value the Alternatives to Crisis services**

- However, more needs to be done to **raise awareness about the services**

- **Lived experience and peer support is highly valued**

- **Training and support** for peer support workers is crucial

Limitations

The data presented shows that overall, these services are having a positive effect on the people who use them and the system they support, however there are several limitations that impact these findings and therefore suggest further exploration may be necessary. The limitations are detailed in each section of the report.

Alternatives to Crisis Programme

This section addresses the following questions:

- *What is the Alternatives to Crisis Programme?*
- *Why is it being evaluated?*
- *Who are Health Innovation Wessex?*
- *Which services were included within the evaluation?*

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The Alternatives to Crisis Programme

- Hampshire and Isle of Wight Integrated Care Board (HIOW ICB) used funding provided by NHS England to invest in a range of community services, to support people aged 18+ years during a mental health crisis.
- These services are collectively referred to as the Alternatives to Crisis (A to C) Programme.
- The aim of these services is to provide timely support in a safe environment.
- Offering short-term emotional and practical help, with the intention of reducing pressure on emergency departments, 999, the ambulance service, 111, psychiatric admissions, the police, and mental health crisis teams.
- Health Innovation Wessex was appointed by HIOW ICB to carry out an independent evaluation of the A to C Programme.
- The aim of the evaluation is to understand if the A to C services are meeting the needs of the local populations and benefiting the ICB's emergency response partners by reducing pressure on these services.

Health Innovation Wessex – who we are:

Health Innovation Wessex is funded by NHS England and the Office for Life Sciences to identify best practice in healthcare and to drive the adoption and spread of innovation for a healthier Wessex.

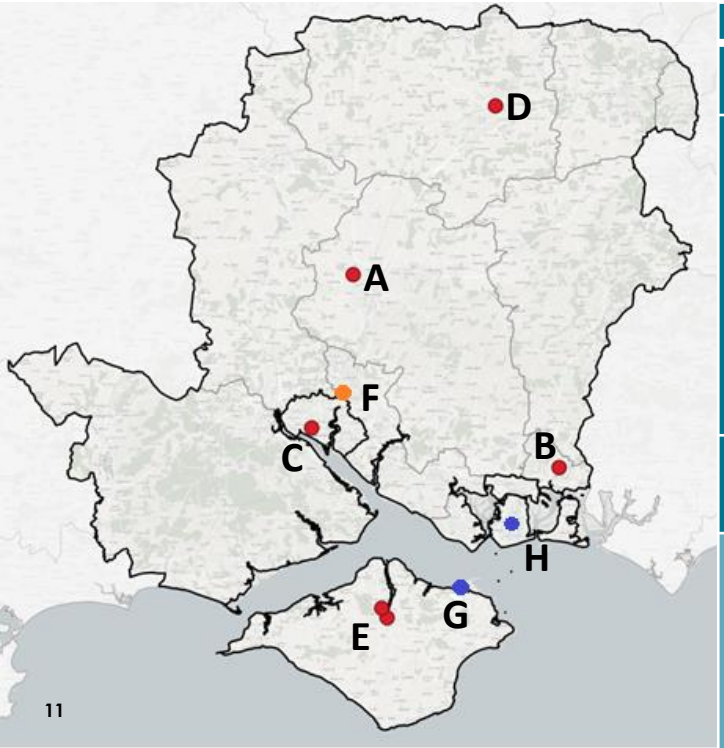
Health Innovation Wessex is part of the Health Innovation Network. The Health Innovation Network is made up of fifteen organisations and was established by NHS England in 2013.

The aim of the Network is to bring together health services, academia, research and industry to promote and support innovation to improve patient outcomes and generate economic benefits.

Health Innovation Wessex covers Hampshire and the Isle of Wight, Dorset and south Wiltshire.

Alternatives to Crisis Services

This final report focuses on seven services (●). A further three A to C services, included within the evaluation specification, were later excluded from the analysis, either due to service closures (●) or due to delayed launch (●).



Service Model	Service	Location
Crisis house– offering short stay accommodation	The Lookout	Winchester (A)
Safe Havens - 'out of hours' face to face drop -in services	Adults' Safe Haven (Havant)	Havant (B)
	The Lighthouse Shirley	Southampton (C)
	The Lighthouse Bitterne	Southampton (C)
	North and Mid Hampshire Safe Haven	Basingstoke (D)
	Newport Safe Haven	Newport(E)
Integrated Peer Support Workers	Peer Support Service - Integrated Mental Health Hub (IMHH)	Newport(E)
Excluded services	*South West Safe Haven (service launched after evaluation data collection ended)*	*Eastleigh (F)*
	Ryde Safe Haven (service closed March 2023)	*Ryde (G)*
	Harbour Crisis Support (crisis phone line – service closed January 2023)	*Portsmouth (H)*

Alternatives to Crisis Service Overview

	Service	Overview
Crisis house	**The Lookout (Winchester)**	**Launched:** July 2021 Short-term (up to 28 days), respite accommodation. Referrals via Crisis Teams. The service covers North & Mid Hampshire, South West Hampshire and Southampton, but excludes Portsmouth and Fareham areas. **Open:** 24/7, 365 days a year **Provider:** Sanctuary Housing Association
Safe Havens	**Adults' Safe Haven (Havant)**	**Launched:** January 2020 Drop in – face to face. Telephone if unable to physically attend. Open access, no referral or prior appointment required. **Open:** 6:00pm-10:00pm both face-to-face and by telephone (7 days a week 365 days per year) **Provider:** Havant and East Hampshire Mind
	The Lighthouses (Southampton)	**Lighthouse (Shirley) launched**: September 2019 **Lighthouse (Bitterne) launched:** September 2019 as a virtual service alongside Lighthouse (Shirley), while the physical site for face to face appointments in Bitterne opened in: April 2024 Open access, no referral or prior appointment required. You can access the service by texting "Lighthouse" to the Solent Mind text line number: 07789390812. The team will then respond and offer text support, telephone support, webchat or where possible, face to face. **Open:** 4.30pm - 11.30pm (face to face support ends at 11:00pm), 7 days a week, 365 days a year **Provider:** Solent Mind and Southern Health
	North & Mid Hampshire Safe Haven (Basingstoke)	**Launched:** September 2021 Drop in – face to face, virtual or over the phone. Open access, no referral or prior appointment required. **Open:** 6:00pm -10:00pm, 7 days a week, including bank holidays **Provider:** Andover Mind
	Newport Safe Haven (Newport, Isle of Wight)	**Launched:** November 2019 (under Two Saints Ltd, however service has existed since 2017) Support from staff and volunteers can be accessed by telephone, email, text or face to face during evenings, weekends and bank holidays. **Open:** Monday – Friday, 5:00pm – 10:00pm, weekends and bank holidays, 12:00 noon – 10:00pm, **Provider:** Two Saints Ltd
Integrated Peer Support Workers	**Peer Support Service - Integrated Mental Health Hub (IMHH) (Newport, Isle of Wight)**	**Launched:** September 2021 Peer support workers began taking referrals from September 2021. Their role is to support people in person and/or over the telephone, providing brief social intervention to prevent escalation into crisis, de-escalate during a crisis, or to support with recovery following a crisis. They take referrals from both mental health and physical health services; however, they receive the majority of referrals from the Single Point of Access Team, the Liaison Team and the Home Treatment Team. **Peer Support Available:** 9:00am – 5:00pm, Monday -Friday. **Provider:** IoW NHS Trust

Evaluation scoping and logic model development

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Evaluation scoping and logic model development

- A detailed scoping exercise was carried out between July and November 2021 to understand the evaluability of the programme, the setup of the services, and the data requirements.
- Appendix I outlines the evaluation data requirements and information governance process.
- Health Innovation Wessex hosted a Logic Modelling workshop for the service commissioners and other key stakeholders on 20 September 2021.

What is a logic model?

- Logic models are a framework to structure thinking and a way of telling the programme story
- They provide a way to systematically make the connections between the inputs, activities, outputs, outcomes and impacts of a programme, and help to identify where to focus evaluation activities

Evaluation scoping and logic model development

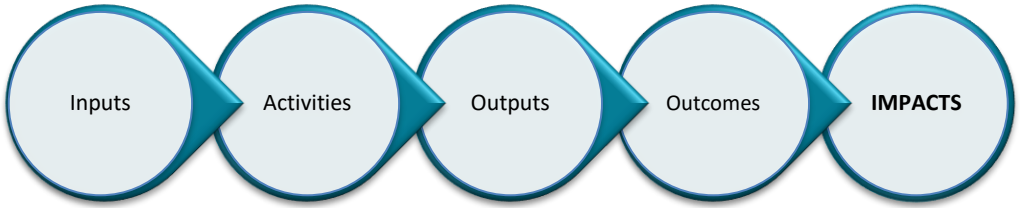
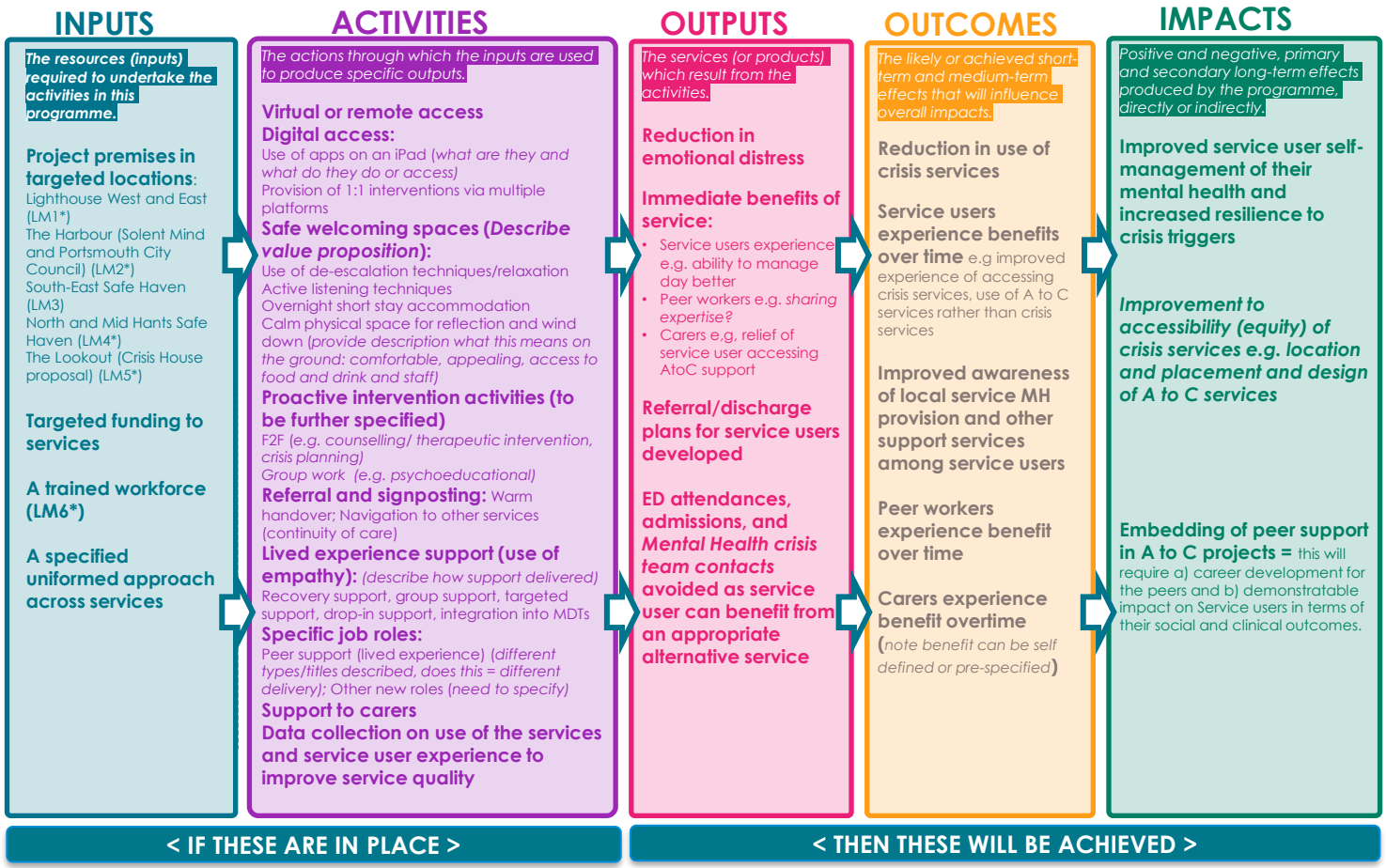


Diagram showing the key components of a logic model

- Logic models were developed for the programme and then for each of the services individually to understand how the connections between the inputs, activities, outputs, outcomes and impacts varied at a service level
- The scoping report and logic models were finalised and circulated in January 2022; please see Appendix II and Appendix III For further information
- The scoping activities informed the development of the evaluation specification and the evaluation questions, which were signed off by the HIOW ICB Crisis Care Board in May 2022.

A to C programme-level logic model



*LM1 etc. = individual project logic models, which will be provided as separate appendices to the final report

Evaluation questions

Health Innovation Wessex has evaluated the impact of the Alternatives to Crisis Programme as a whole. Direct comparison between individual services was outside the scope of this evaluation.

Further information on the sub-questions included within the evaluation specification, and a summary of the evaluability of each question following data collection is provided in Appendix IV*.

1. **What impact has the A to C Programme had on local emergency services?**

2. **What impact has the A to C Programme had on the people who use the services and their carers?**

3. **What impact have the A to C services had on addressing local inequalities?**

4. **What was the experience of peer support from the perspective of those that interact with the service, internal colleagues, people using the services, and the peer support workers themselves?**

5. **What was the cost-effectiveness of the A to C Programme, by service model, in 2022/23?****

*This appendices is for client information only; not for publication or onwards circulation.

**Question 5 was added in July 2022 following an economic feasibility analysis completed by Emma Stewart, Head of Finance at the Midlands and Lancashire Commissioning Support Unit (MLCSU), on secondment with Health Innovation Wessex. See Appendix IV evaluability review.

Evaluation approach

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Evaluation approach

The evaluation adopted a mixed methods approach combining both **quantitative** and **qualitative** techniques. Data was synthesised from multiple sources to address the evaluation questions. Methods included:

Quantitative methods:

- Creating a **Standardised Data Collection Tool**, to ensure all services across the programme are collecting the same:
  - *Service utilisation data*
  - *Service impact data – including the Adapted Subjective Units of Distress Scale**

  ** The Subjective Units of Distress Scale (SUDS) is a 10-point scale that was developed by psychiatrist Joseph Wolpe in 1969 to measure the subjective intensity of distress experienced by an individual. Health Innovation Wessex and the HIOW ICB Lived Experience Lead adapted the scale; providing a colour coded printable tool with supporting statements to reflect escalation of crisis. Each service was asked to use the scale at the beginning and end of each interaction with a person, as a measure of the service's impact on emotional distress.*

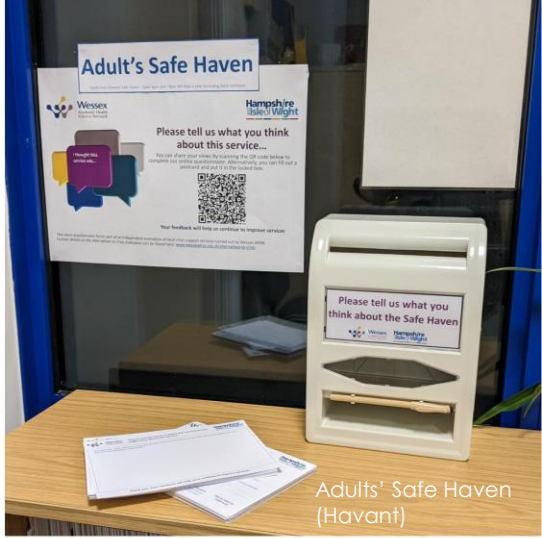
  - *Personal characteristics data to enable the evaluation to explore whether services are addressing local inequalities.*
- Using **pseudonymised NHS numbers to explore attendances at Emergency Departments and other NHS services** for the population who use A to C services
  - *NHS numbers were submitted to NHS Digital via a secure data landing platform, where the Data Services for Commissioners Regional Office (DSCRO) pseudonymised the data before sharing it with Health Innovation Wessex for analysis.*
- Exploring data held by the **Hampshire Constabulary** to understand the **impact of the A to C services on police deployments and section 136 suite detentions.**

Evaluation approach

Qualitative methods:

- **Rapid Insight Events** *held on 15 June 2022 and 19 April 2023*
- **Interviews with people who use the services**
- **Surveys**
  - *Online survey for people who use the services*
  - *Short feedback postcard for people who use the services (the images to the right show the postcards and locked ballot boxes)*
  - *Staff survey*
  - *Peer support worker survey*
  - *Emergency response partner survey (circulated to 111, 999, ambulance, police, ED, psychiatric liaison and Crisis Teams)*
  - *Primary care survey*
- **Discussion Logs** – from each conversation between the evaluation team and service teams.

North & Mid Hampshire Safe Haven



Adults' Safe Haven (Havant)

The Lighthouse Shirley

Newport Safe Haven

The Lookout

Evaluation approach - *Adapted Subjective Units of Distress Scale*

Service commissioners and service providers were invited to attend an A to C data meeting on 03 March 2022. This meeting provided the opportunity to discuss the best approach for measuring the impact of the services on emotional distress. A range of approaches were debated and ruled out. During the discussion, a Senior Crisis Practitioner working at one of the Safe Havens suggested the Subjective Units of Distress Scale (SUDS) as a measure. SUDS was developed by psychiatrist Joseph Wolpe in 1969 and uses a 10-point scale to record the answer to the question:

"On a scale of zero to ten, where zero is the best you can feel and ten is the worst, how do you feel right now?"

Further research into the scale confirmed its suitability for the evaluation:

- *It is **designed as a communication tool** which can help a person to **express the severity of their emotions**.*
- *It has a **history of being used to evaluate therapeutic effectiveness**.*
- *It has documented **reliability and validity as a measure**.*
- *It has been **successfully used to measure impact within an equivalent service setting** (Heyland et al, 2013, 'The Living Room, a Community Crisis Respite Program: Offering People in Crisis an Alternative to Emergency Departments').*
- *The questions used for SUDS have **overlap with questions already being used by one of the services** as part of their own data collection.*
- *The scale **mirrors the pain scale** which is frequently used in physical health to gauge the impact of an intervention. Using a similar tool to physical health would **align with the NHS's agenda to achieve parity of esteem***.*

**NHS England: In essence, 'parity of esteem' is best described as: 'Valuing mental health equally with physical health'.*

Evaluation approach - *Adapted Subjective Units of Distress Scale*

To support services with using SUDS Health Innovation Wessex adapted the scale, providing a colour coded printable tool with supporting statements to reflect escalation of crisis. The descriptive supporting statements were developed with the ICB Lived Experience Lead to reflect escalating levels of distress.

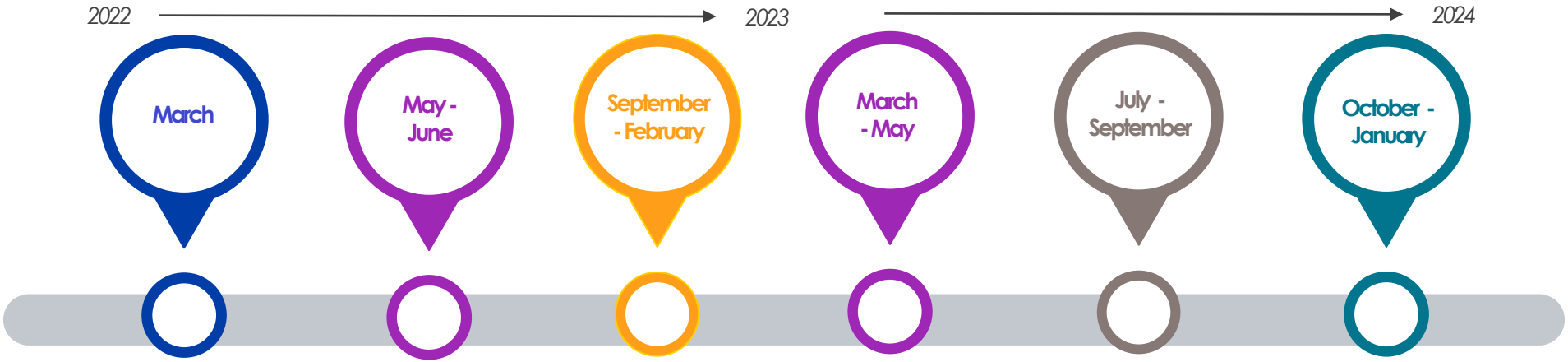
"On a scale of zero to ten, where zero is the best you can feel and ten is the worst, how do you feel right now?"

10	**Unbearable**	*The worst distress, anxiety, fear or discomfort you have ever felt.*
9	**Extreme**	*"I am finding it hard to cope"*
8	**Very distressed and uncomfortable**	*"I am so upset that I am struggling to think about anything else"*
7	**Strong feelings of distress**	*"I am so upset that I am finding it difficult to function"*
6	**Moderate - strong**	*"How I am feeling is affecting my ability to focus on other things"*
5	**Moderate**	*"I feel uncomfortable, although I can still focus on other things"*
4	**Mild - moderate**	*"I am feeling more anxious than usual, and I am worried about how I am feeling"*
3	**Mild**	*"I am feeling anxious, and it is upsetting me"*
2	**Minimal**	*"I am feeling a little anxious or upset"*
1	**Neutral**	*"I am feeling OK"*
0	**No distress or anxiety**	*"I am feeling calm and relaxed"*

Working with HIOW ICB Lived Experience Lead

- Sarah Curtis is the Lived Experience Lead (No Wrong Door Community Mental Health Transformation Programme) for HIOW ICB.
- Lived Experience Leads contribute their experiential knowledge of mental health services and recovery to inform policy, service design and delivery.
- Throughout the evaluation, Sarah has advised on wording and language and advocated for the people using services. She has also been fundamental to the design and delivery of the evaluation.
- A Joint Working Agreement (JWA) was established and signed in April 2022 to formalise Sarah's involvement within the evaluation to ensure that co-production was integrated into the evaluation design, implementation, and analysis.
- A Qualitative Working Group was also established with three evaluation experts from Health Innovation Wessex and three system experts from HIOW ICB (including Sarah). This group met regularly throughout the evaluation.

Key areas of input from HIOW ICB Lived Experience Lead



Adapted Subjective Units of Distress Scale

Codesigned the adapted SUDS scale used in the Standardised Data Collection Tool to measure impact on emotional distress

First Rapid Insight Event

Codesigned the questions for the first Rapid Insight Event

Surveys & postcards

- Advised on the length, structure and content of the tools used
- Codesigned the survey questions
- Reviewed and provided feedback on the finalised versions prior to circulation

Second Rapid Insight Event

- Codesigned the second Rapid Insight Event
- Co-hosted the event as an 'observer'
- Completed data analysis following the event
- Supported the development of the mind maps

Interviews

- Codesigned all interview materials
- Created an 'easy read' information sheet to ensure accessibility
- Supported interview recruitment
- Ran and facilitated all interviews alongside one of the Health Innovation Wessex evaluation team

Thematic analysis

Participated in meetings with Health Innovation Wessex evaluation team to identify and develop themes from across the qualitative data collected from people who use the A to C services

Challenges

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Main challenges

- The information governance process, particularly around cyber security clearance, was complicated and protracted.
- There was no established mechanism for all the services to share data for the purposes of the evaluation, therefore the majority of the services needed to have their contracts amended to allow the data to flow.
- In some instances, staff turnover within HIOW ICB and the services made relationship-building between the evaluation team and the services challenging*.
- Data collection across the services was not standardised; therefore, a Standardised Data Collection Tool had to be developed and implemented.
- Most of the services are run by voluntary sector organisations, which in some instances meant:
    - *they were unfamiliar with NHS data reporting.*
    - *their internal IT systems have issues interacting with NHS systems, which caused problems with accessing records and data submission.*
- The services operate with limited administrative support, and this restricted capacity to engage in additional data collection activities.
- Each service made extensive efforts to contact people who had used their services to participate in interviews and to complete the online surveys, but people were very reluctant to come forward, which limited data collection and prevented exploration of carers' experiences.
- Two services started their data collection later than the other services.
- There were significant issues around data provision, data submission and data quality.

** For five out of seven of the services at least one of the key contacts changed over the duration of the evaluation. Key contacts included the Lead Commissioners for each service, the Provider Lead, and / or the Service Lead. In one instance the key contact changed on three separate occasions.*

Data issues and their impacts

Issues that impacted the project timeline:

- NHS England data landing platform (DLP) registration and submission process was prohibitively time-consuming for both the services and the evaluation team.
- Additional time was required to support some services in preparing their data for the DLP submission template.
- Several services were required to resubmit their data to the DLP due to significant errors; three services had to resubmit on multiple occasions. Errors included:
  - *data pulled from the Southern Health data warehouse incorrectly due to errors in the SQL code used*
  - *invalid NHS numbers provided by the services - mistyped*
  - *missing data fields, which had previously been present during previous data quality checks.*
- The complexity of the data meant there was a significant amount of data sorting, cleaning and processing required before analysis could begin.
- Hampshire Constabulary (HC) and the South, Central and West Commissioning Support Unit (CSU) were unable to provide data in the format and timeframe originally agreed. The intention was for HC and the CSU to provide finalised outputs for July 2023 and August 2023 respectively, for inclusion in the final report. Unfortunately, this was not possible, and therefore both parties provided Health Innovation Wessex with raw data in November 2023.

Due to the issues outlined above, a costed extension to the evaluation timeframe was requested and a 'plan B' for the data cleaning, processing, and analysis had to be initiated.

Data issues and their impacts

Issues which impacted data quality, and therefore limited the data which could be included within the analysis:

- Errors made at the point of data capture e.g. incorrect time stamps recorded with times outside of service opening hours.
- Specified drop-down menus provided within the Standardised Data Collection Tool were not consistently used across the services.
- Inconsistent or non-existent reporting against some key data fields.
- The Peer Support Service on the Isle of Wight only partially reported their activity; the evaluation can only report on the data provided*.
- Limited engagement with qualitative data collection from people who use the services.

*The Peer Support Service based at the Integrated Mental Health Hub (IMHH) on the Isle of Wight provided attendance data for 35 people who were directly referred to the service during the evaluation data collection period. This data was reviewed with the service lead in September 2023, after data collection had ended. The service lead stated that while this data is accurate, it only reflects direct referrals to the Peer Support Service as the service was unable to capture data to reflect the role the peers play in supporting 'other' services. *Other activity outlined by the service lead which was not captured or provided to Health Innovation Wessex included:*

- *Supporting patient discharge from the Sevenacres Inpatient Unit (mental health/psychiatric inpatient unit at St Mary's Hospital in Newport)*
- *Working alongside Crisis Resolution Home Treatment Teams*
- *Supporting Psychiatric Liaison service*
- *Supporting people through Single Point of Access*
- *Facilitating a local peer support group.*

Data issues

Standardised Data Collection Tool

Key:

- *Data provided (completed for 95% or more of attendances)*
- *Data provided, some values missing (completed for 85-94% of attendances)*
- *Data provided, a lot of values missing (completed for 50-84% of attendances)*
- *Majority missing values or returned as null values (completed for fewer than 30% of attendances)*
- *Alternative data provided*
- * *Errors in some time stamps*
- ** *Inconsistencies in the data reported*
- *** *Service activity only partially represented*

		The Lighthouses *(Bitterne & Shirley)*	North and Mid Hampshire Safe Haven	Adults' Safe Haven (Havant)	Newport Safe Haven	The Lookout	Peer Support Service at IMHH
Identifier	NHS numbers provided:						***
Location Data	Lower Super Output Area (LSOA) from postcodes:						***
Service Utilisation	Attendance data:	*	*	*	*		***
	Type of support required:						
	Reason for visit:						***
Personal Characteristics	Age (Years):			**			***
	Disability:			**			
	Ethnicity:			**			***
	Religion or belief:			**			
	Gender identity:			**			***
	Sexual orientation:			**			
	Military veteran:			**			***
Impact Measure	Subjective Units of Distress:						

Key findings

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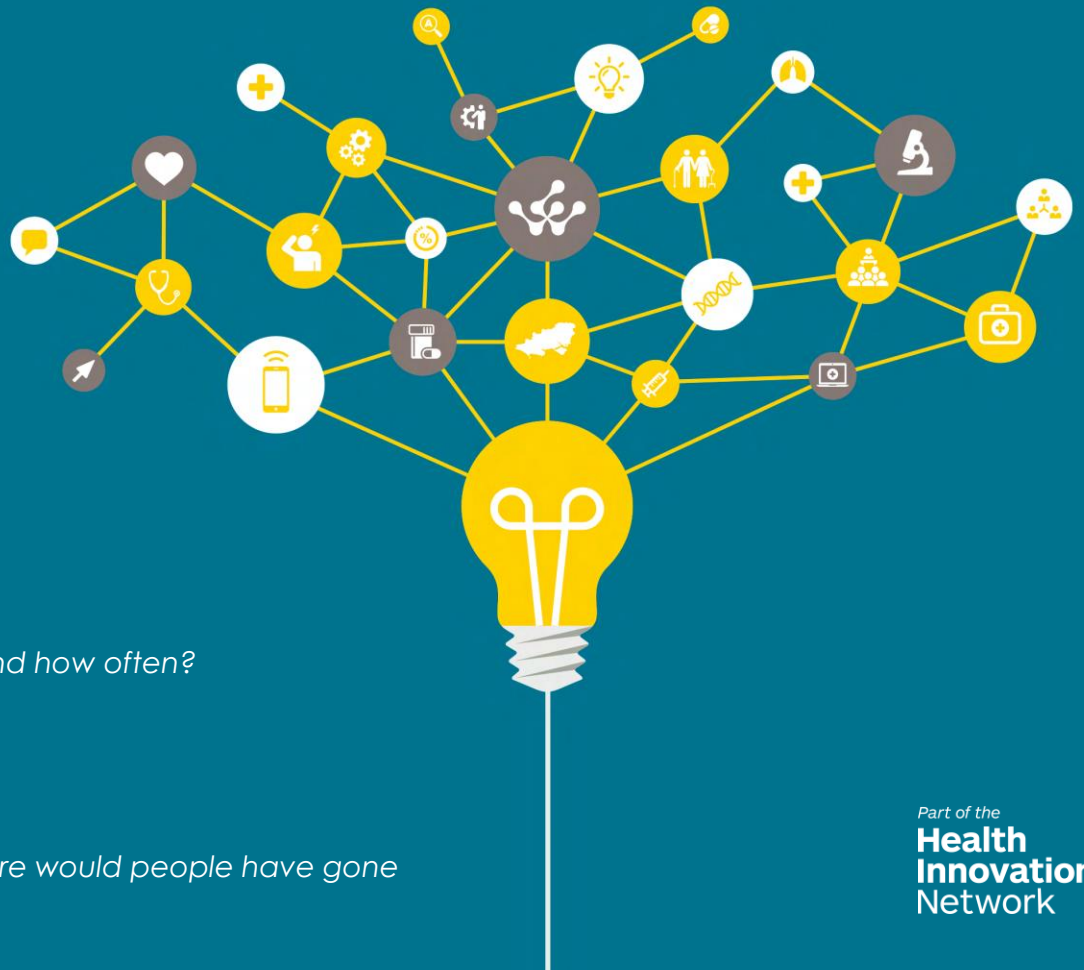

Service activity data

- *How many people are using the services and how often?*
- *How are the services being accessed?*
- *Who is using the services?*
- *What support do people require?*
- *If the services had not been available, where would people have gone for support instead?*

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Individual service profile reports

Individual service level profiles have been compiled and shared as separate standalone reports. Each report includes:

- An overview of the service
  - *Challenges experienced by the service*
  - *What has worked well for the service*
  - *How the service has changed over the course of the evaluation period*
- Service activity data for the evaluation period
- Personal characteristic data for the people using the service
- Service impact data
  - *Adapted Subjective Units of Distress Scores (SUDS)*
  - *Feedback from people using the service*
- Summary

Headline findings from the service activity data

Data on service utilisation was collected by each service via the Standardised Data Collection Tool. The data showed that between 01 April 2022 and 30 June 2023:

- The seven A to C services supported over 1,154 individuals across 10,260 contacts/attendances/admissions
- White British females aged between 25 and 44 made up the largest grouping seeking support from the A to C services
- 64% of contact made with the Safe Havens was via telephone
- 45% of contact made with the Peer Support Service on the IoW was via text or e-mail
  (a further 34% were via telephone)
- 50% of the people using the Safe Haven services only attended or contacted the service for support on one occasion.

Headline findings from the service activity data

Data on service utilisation was collected by each service via the Standardised Data Collection Tool. The data showed that between 01 April 2022 and 30 June 2023:

- 6% of the people using the Safe Haven services accounted for 60% of the service activity
  (64 people collectively contacted or attended the Safe Havens on 6,149 occasions during the data collection period)

- 61% of contacts with the Safe Haven services were from people either in crisis or looking to prevent escalation into crisis

- When asked where they would have gone for support had the service not been available:
  - *28% of respondents from the Safe Havens said they had nowhere else to go, while 24% said they would have contacted 111 and 10% said they would have gone to their local Emergency Department*
  - *46% of admissions to The Lookout said they would have been guided by the Crisis Resolution Home Treatment Team, while 17% said they would have gone to their local Emergency Department, or they would have been admitted to hospital*
  - *Several respondents from both the Safe Havens and The Lookout stated that they would have "acted on their thoughts" relating to suicide or self-harm had the services not been available to support them.*

Overview of the service activity

The following table summarises the service activity for each of the A to C services over the data collection period (01 April 2022 – 30 June 2023)

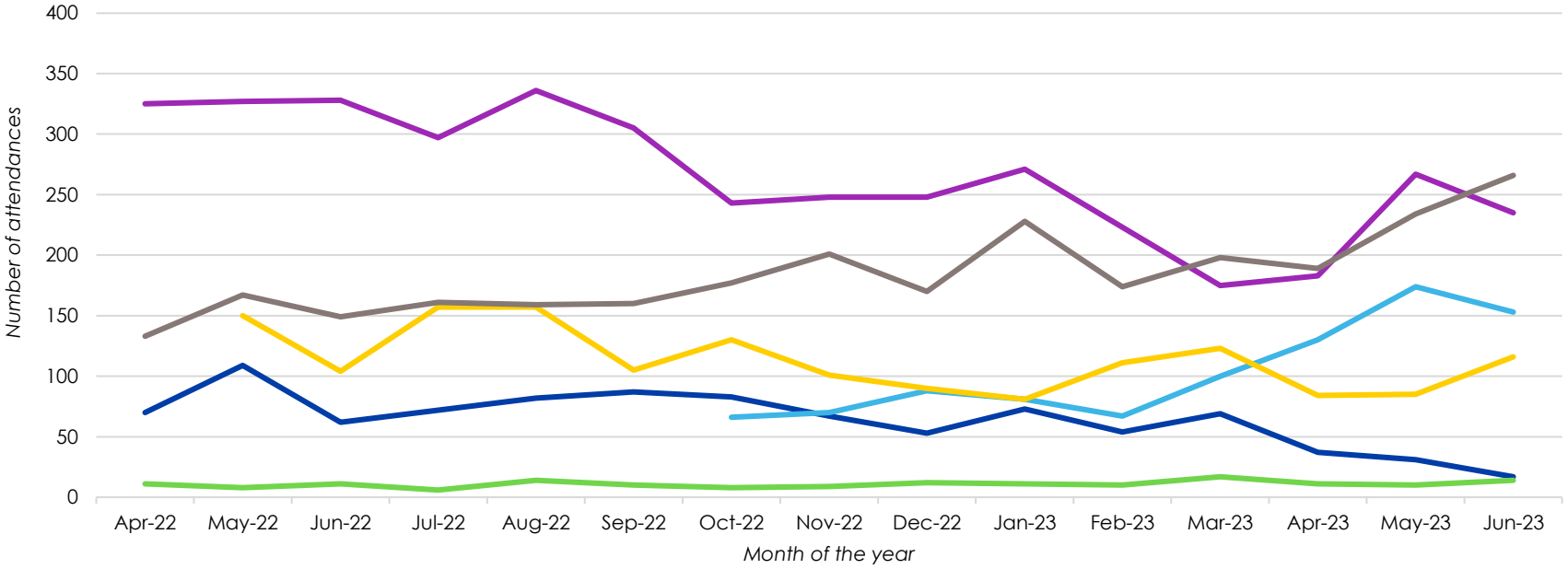
Service Model	Service	Total number of contacts / attendances / admissions between 01 April 2022 and 30 June 2023	Total number of people supported between 01 April 2022 and 30 June 2023	Average number of attendances / contacts each month	Average number of people using the service each month	Average number of attendances / contacts per shift
Crisis house– offering short stay accommodation	The Lookout (Winchester)	162	132	11	11	N/A
Safe Havens - Out of hours face-to-face drop-in services	Adults' Safe Haven (Havant)	2766	375 +*	184	49 - 54	6
	The Lighthouses (Shirley & Bitterne)	4,011	414	256	67	8
	North and Mid Hampshire Safe Haven (Basingstoke)	1491	147 +*	114	28 - 44	4
	Newport Safe Haven (Isle of Wight)	929	88 +*	103	21-27	3
Integrated Peer Support Workers	Peer Support Service - Integrated Mental Health Hub (IMHH) (Isle of Wight)	967	35	64	10	2
	ALL SERVICES:	**10,260**	**1154 +* ****	/	/	/

- 112 people stayed at The Lookout on one occasion during the data collection period.
- 21 individuals stayed at The Lookout on more than one occasion, of which eight individuals stayed on three or more occasions during the data collection period.

**'Number of people supported' is based on the number of unique NHS numbers recorded next to each attendance/contact. Three services had a proportion of anonymous attendances; therefore, it is not possible to know exactly how many people these anonymous attendances are attributed to.*

*** 37 people attended more than one service.*

Attendance/contacts by month



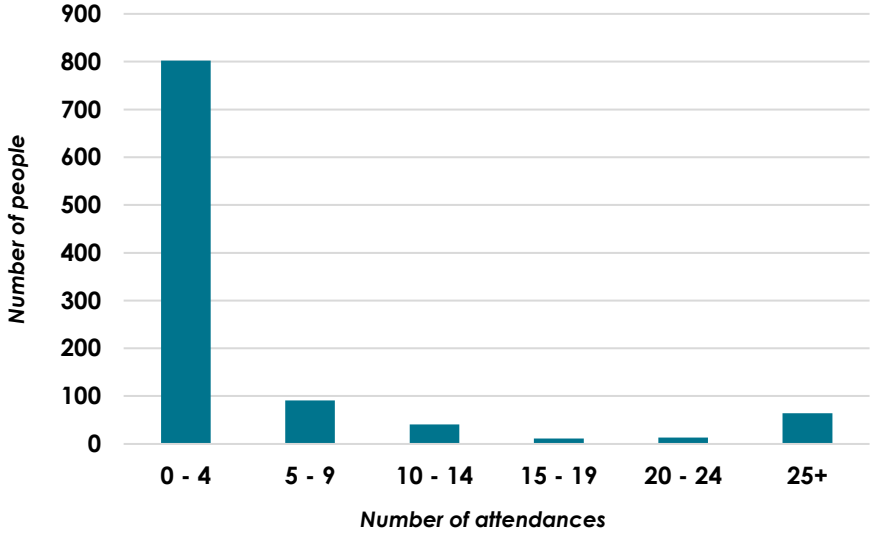
* *Newport Safe Haven joined the evaluation in October 2022*

** *North & Mid Hampshire Safe Haven commenced data collection a month later than the other services*

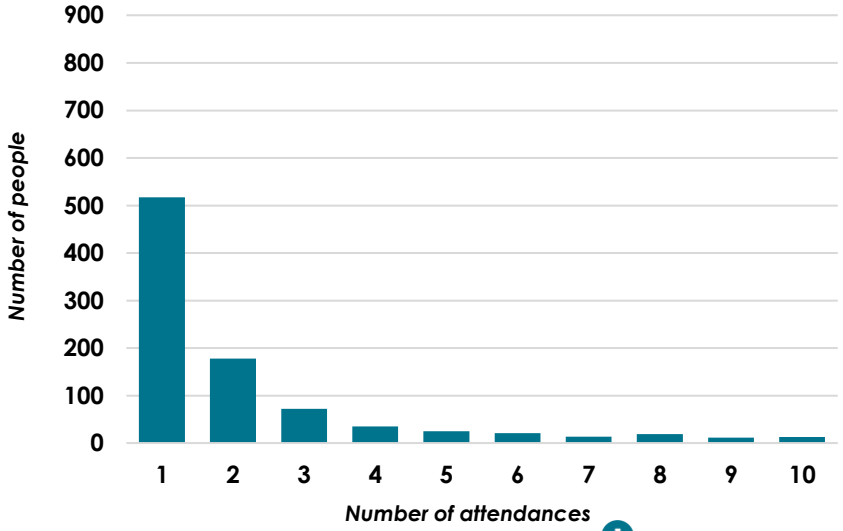
How many times do people attend the Safe Havens?

- The Safe Haven services supported more than 990 individuals between 01 April 2022 and 30 June 2023*
- 77% of people attended the Safe Havens on fewer than five occasions
- 50% of people only attended on one occasion

Distribution of Safe Haven attendances per person



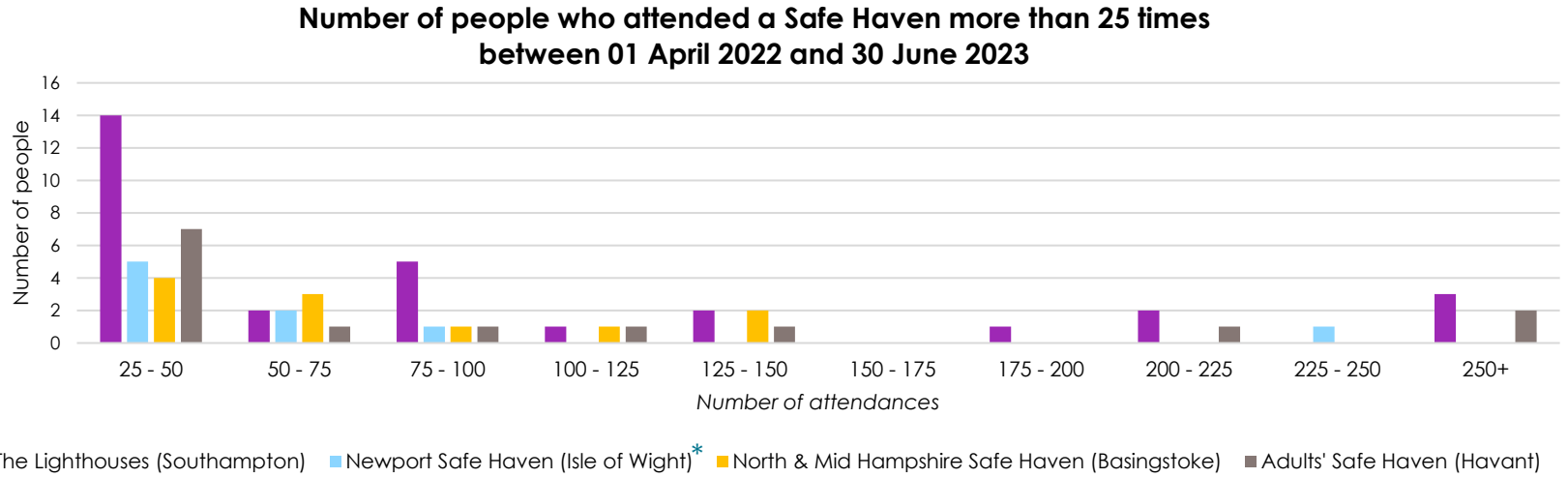
Distribution of Safe Haven attendances per person (0-10 attendances)



*This figure is based on the number of unique NHS numbers recorded next to each attendance/contact. Three services had a proportion of anonymous attendances; therefore, it is not possible to know exactly how many people these anonymous attendances are attributed to.

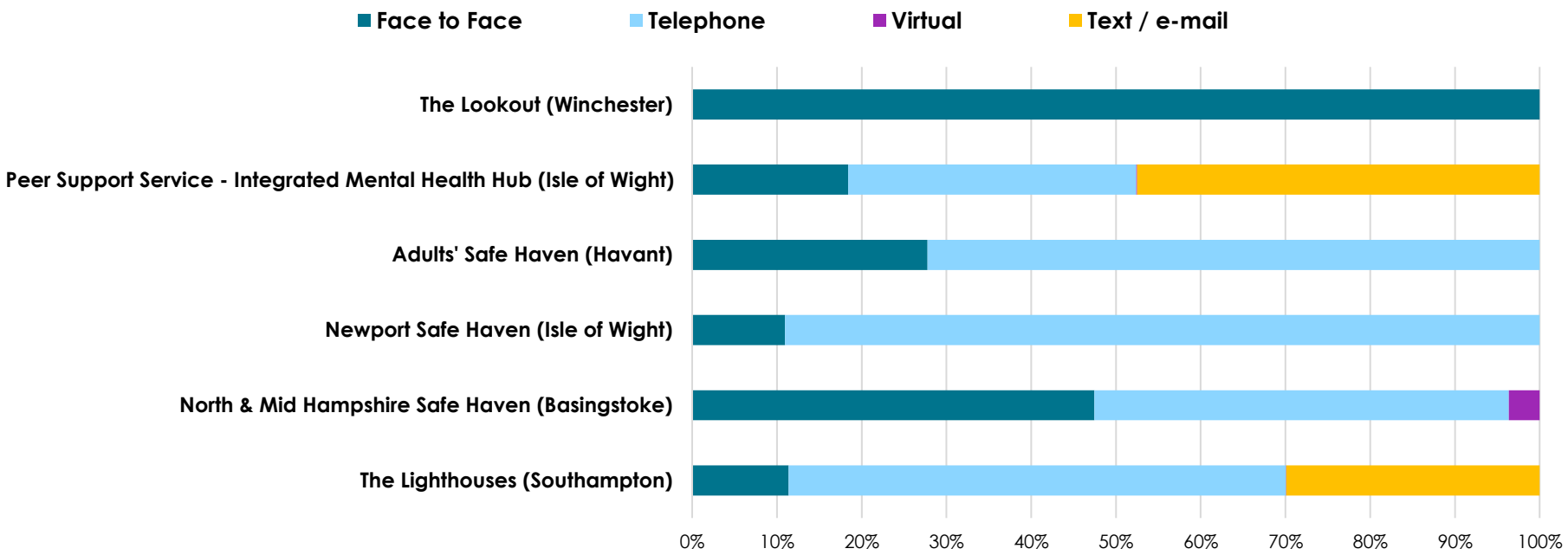
Safe Haven frequent attendees

- Between 01 April 2022 and 30 June 2023, 63 people attended or contacted the Safe Havens on more than 25 occasions
- **6% (63) of the people using the Safe Haven services account for 60% (6149) of the activity**
- All four Safe Haven settings have at least one person who contacted their service more than 100 times during the data collection period
- Adults' Safe Haven (Havant) and The Lighthouses supported individuals who contacted their services more than 400 times during the data collection period.

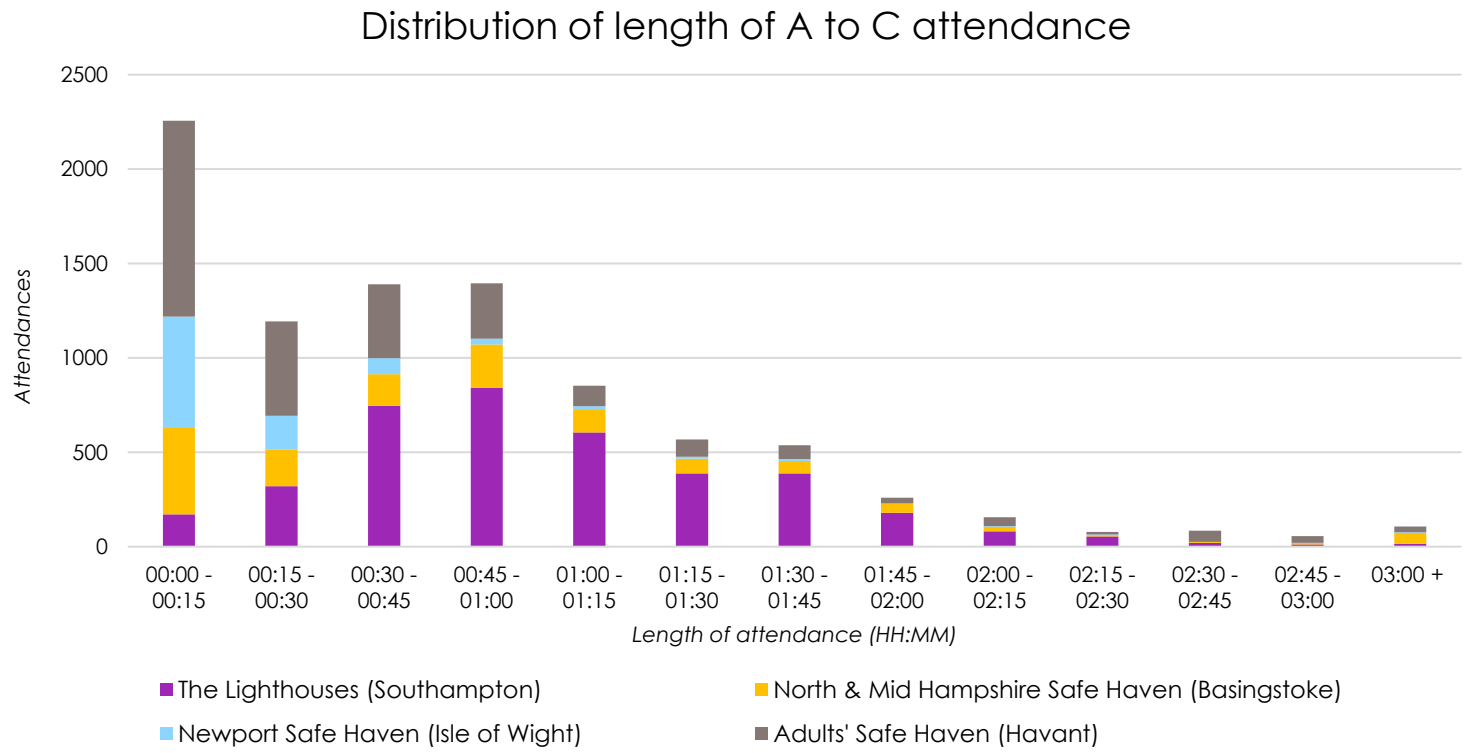


* *Newport Safe Haven joined the evaluation in October 2022; consequently, the data collection period for this service was six months shorter than that of the other services, therefore the number of high frequency attenders is likely to be underrepresented.*

How people access each of the A to C services:



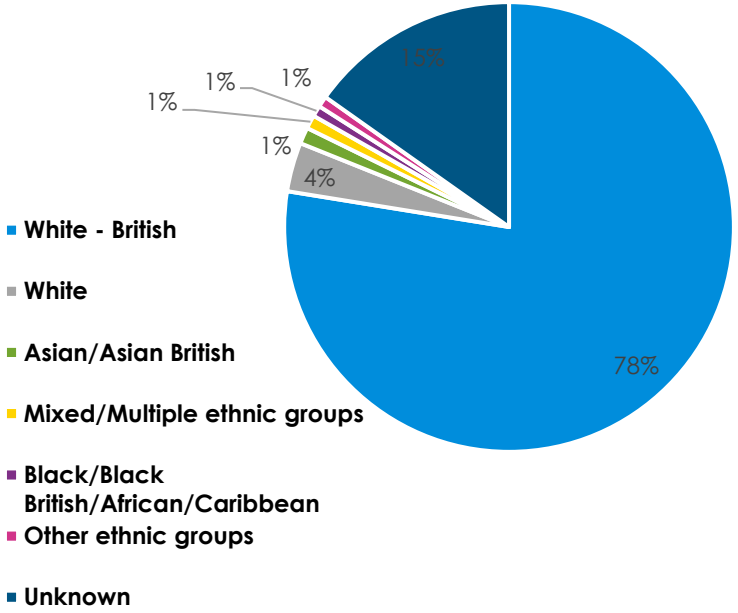
Average length of attendance/contact by Safe Haven



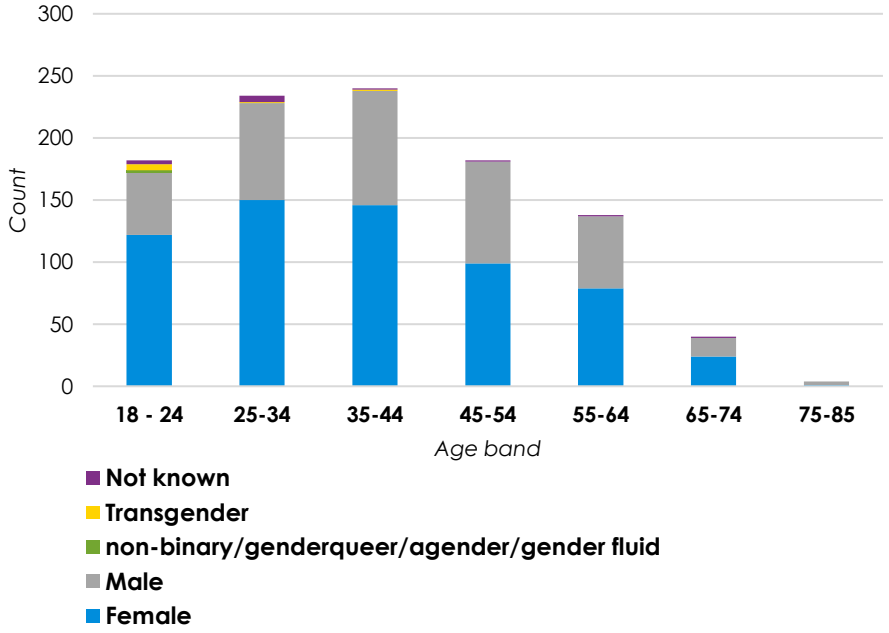
Who is attending the Safe Havens?

- **Just over 60%** of the people using the Safe Haven services during the data collection period identified as **female**
- **81%** of the people using the Safe Haven services were **white – British or white – European**.
- White - British females aged between 18 and 44 made up the largest proportion of people using the Safe Haven services during the data collection period.

Ethnicity breakdown:



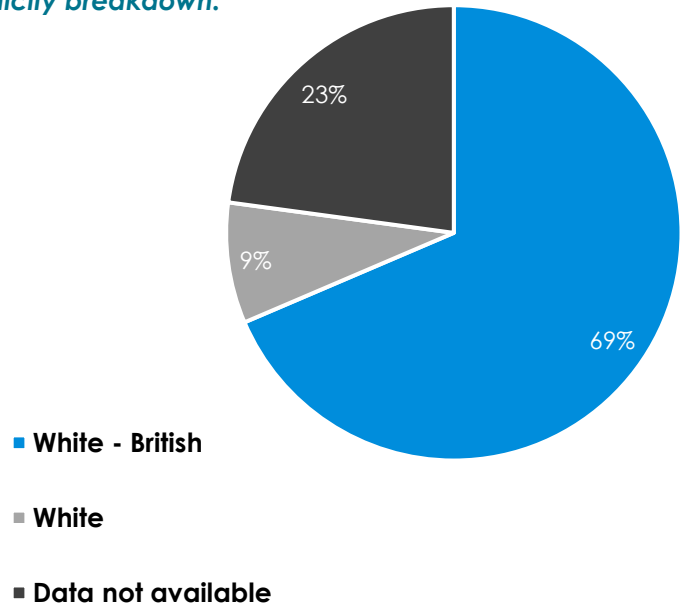
Age band by gender identity:



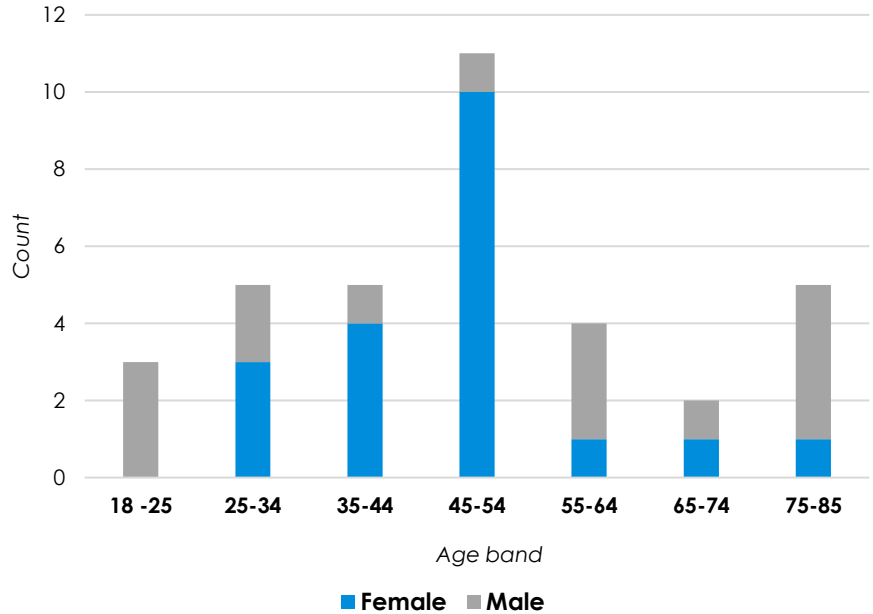
Who is using the Peer Support Service at IMHH on the Isle of Wight?

- **57% (20/35)** of the people being supported by the Peer Support Service during the data collection period identified as **female**
- For **all** individuals where data on ethnicity was available their ethnicity was listed as either **white or white British**
- White - British females aged 45-54 made up the largest proportion (29%) of people using the Peer Support Service during the data collection period

Ethnicity breakdown:



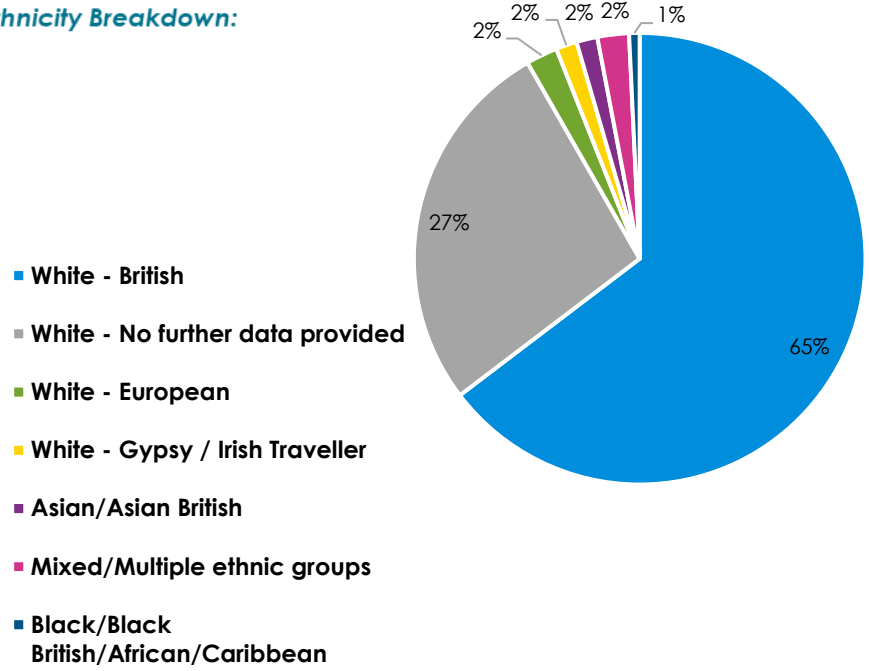
Age band by gender identity:



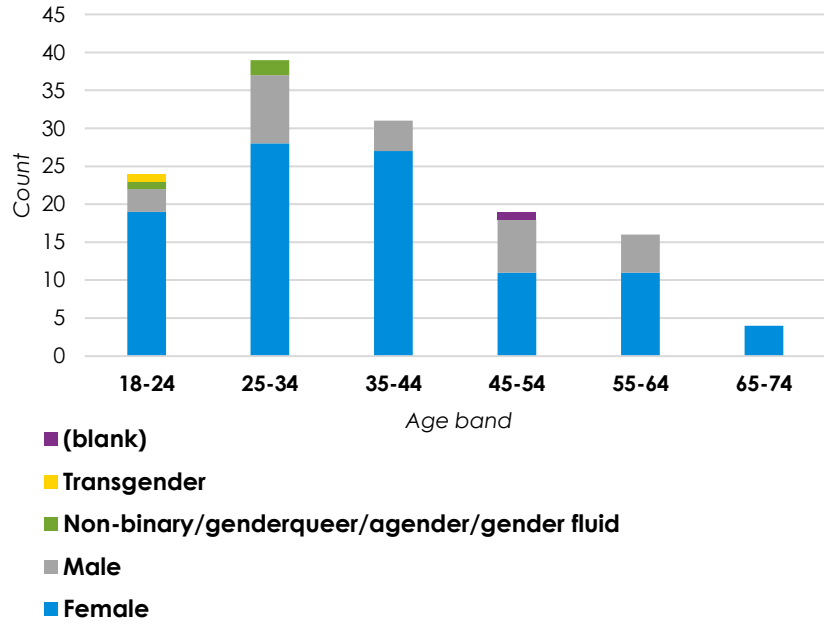
Who is staying at The Lookout?

- **75% (100/132)** of the people staying at The Lookout during the data collection period identified as **female**
- **65% (86/132)** of the people staying at The Lookout were **White – British**.
- White - British females aged 18-44 made up the largest proportion (35%) of people staying at The Lookout during the data collection period.

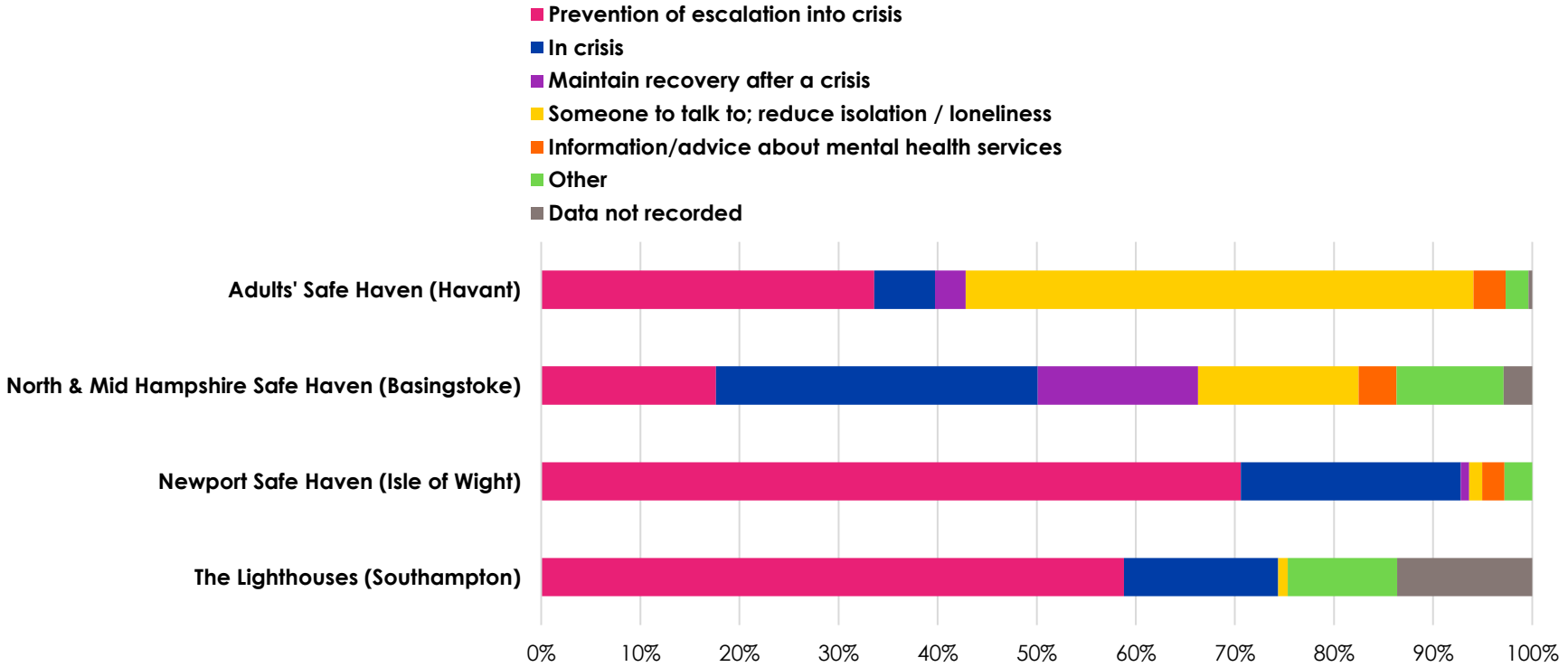
Ethnicity Breakdown:



Age band by gender identity:

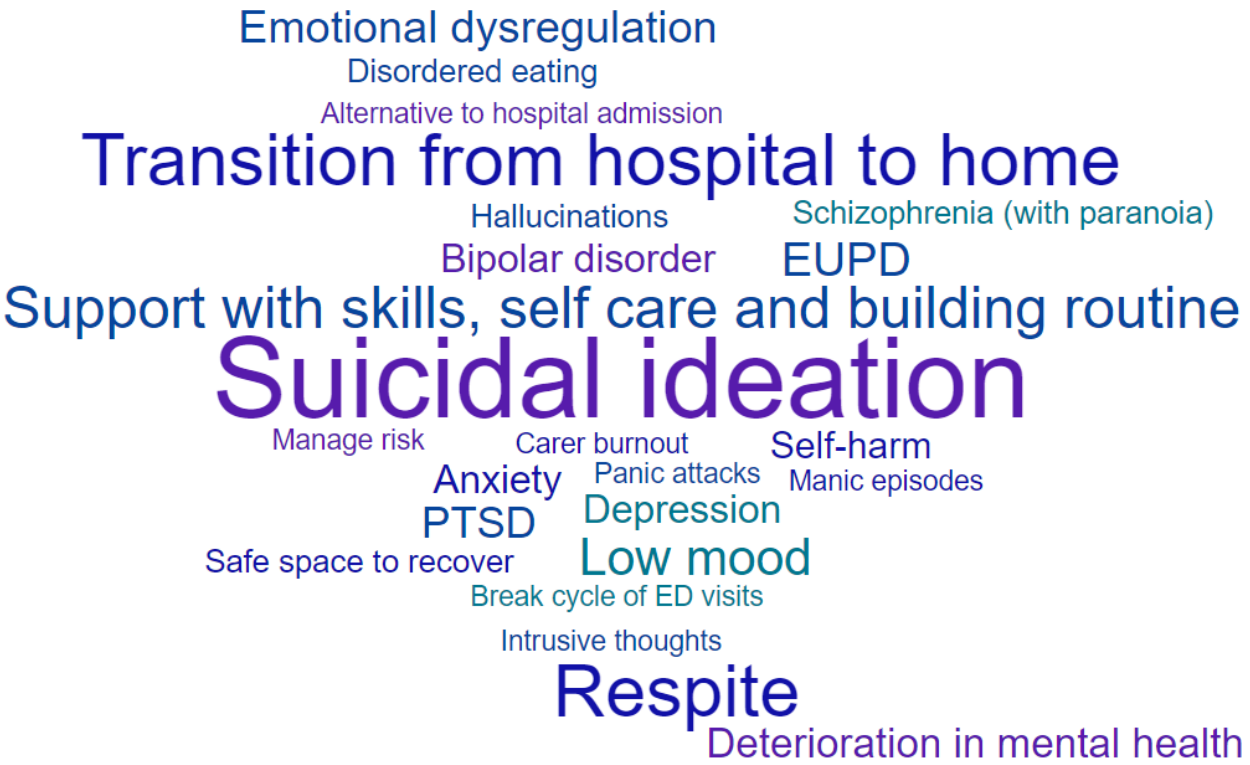


Main type of support required from the Safe Havens



The Lookout: Reasons people contacted the service

The word cloud shows the reasons people contacted The Lookout (Winchester) between 01 April 2022 and 30 June 2023. The size of the words reflects the frequency they were recorded. This data was recorded within the Standardised Data Collection Tool for each of the 162 admissions.

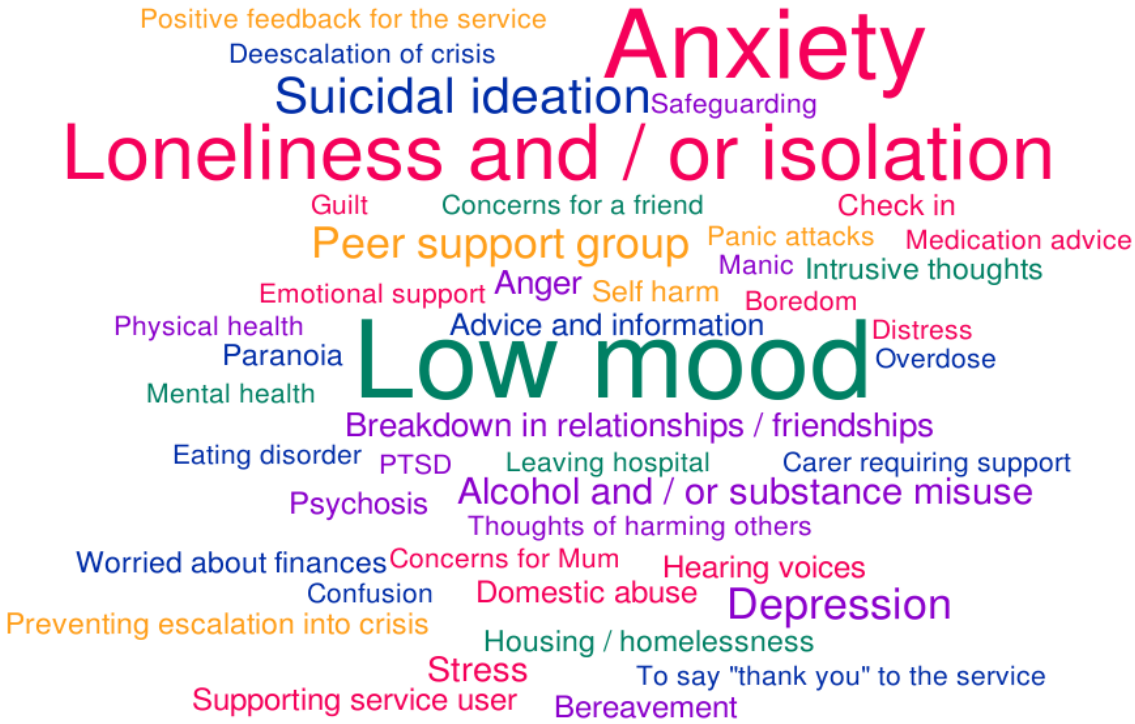


Newport Safe Haven: Reasons people contacted the service

The word cloud shows the reasons people contacted the Newport Safe Haven (Isle of Wight) between 01 October 2022 and 30 June 2023. The size of the words reflects the frequency they were recorded. This data was recorded within the Standardised Data Collection Tool for each of the 929 contacts. 67% of contact was due to low mood or anxiety.

Adults' Safe Haven (Havant): Reasons people contacted the service

The word cloud shows the reasons people contacted the Adults' Safe Haven (Havant) between 01 April 2022 and 30 June 2023. The size of the words reflects the frequency they were recorded. This data was recorded within the Standardised Data Collection Tool for each of the 2766 contacts. 47% of contact was due to low mood or anxiety.



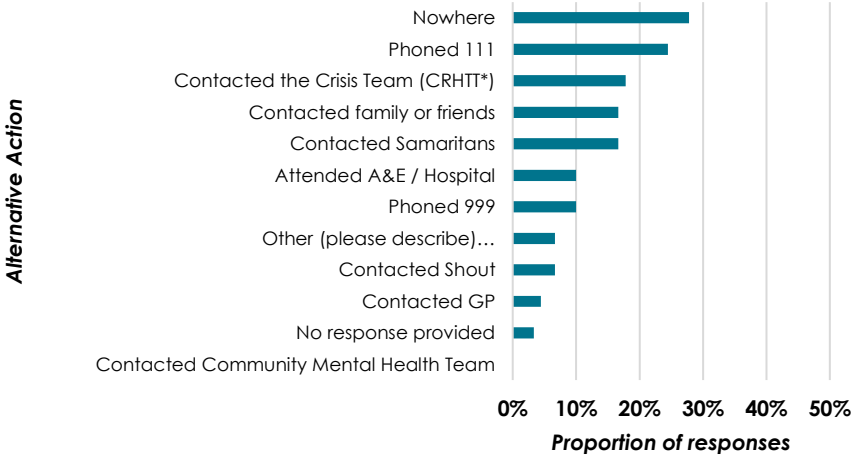
Peer Support Service at IMHH (Isle of Wight): Reasons people contacted the service

The word cloud shows the reasons people contacted the Peer Support Service (Isle of Wight) between 01 April 2022 and 30 June 2023. The size of the words reflects the frequency they were recorded. This data was recorded within the Standardised Data Collection Tool for each of the 967 contacts. 58% of contact was due to anxiety.

Alternative action - *If the service had not been available, where might you have gone for support?*

- *Safe Havens – this question was answered by all 90 respondents to the postcard and online surveys*
- *The Lookout – the service asked this question of all 162 of their admissions*
- *All respondents were able to select more than one option.*

Safe Havens

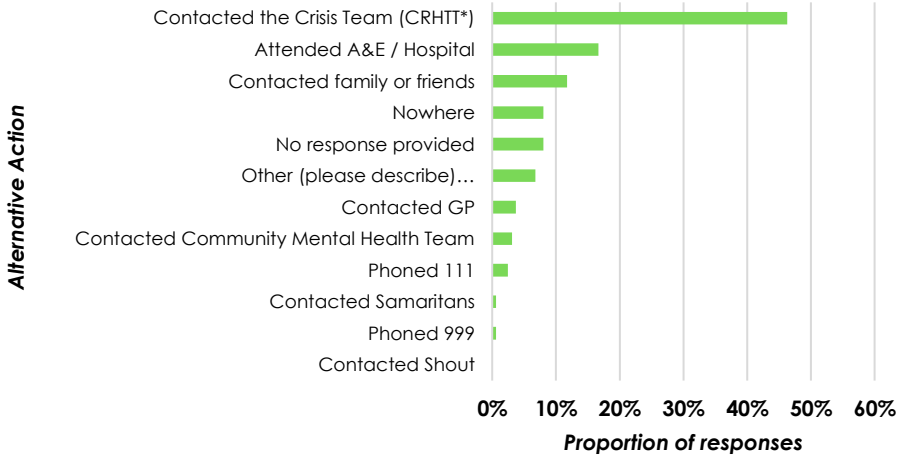


"Other, please describe" responses included:

"Dead" "Not sure" "No other service would listen" "SANE Helpline"

"I would have ended up harming myself and likely had to visit A&E for medical attention. I wouldn't call any of the above for emotional support."

The Lookout



"Other, please describe" responses included:

"Acted on thoughts" – (individuals experiencing suicidal ideation)

"Contacted Care Coordinator" "Safe Haven" "Run"

"I would have spent the night outside"

Limitations

- *Consistent recording across the data fields would have allowed more in-depth analysis*
  - *Not all services reported against the full suite of data fields set out in the Standardised Data Collection Tool*
  - *Drop down menus were not consistently used, with some services adding additional options to the lists, or opting for free text responses instead*
  - *Several Safe Havens reported that they were uncomfortable asking people "If the service had not been available, where might you have gone for support?" – therefore this question was removed from the Standardised Data Collection Tool and added to the feedback questionnaires instead, which limited the number of responses collected.*
- *Only limited personal characteristic data could be provided which has restricted the analysis*
  - *Many fields were found to be blank within people's medical records, so no data could be extracted*
  - *In some cases, where services collected the personal characteristic data themselves, different characteristics have been recorded against the same NHS numbers.*
- *The data required extensive cleaning and processing to try to overcome some of the inconsistency in the reporting at programme level; this reduced the time that could be dedicated to analysis.*

Impact of A to C services on emotional distress

- *Changes in the Adapted Subjective Units of Distress Scores*

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Innovation
Network

Adapted Subjective Units of Distress Scale

To support services with using SUDS, Health Innovation Wessex adapted the scale, providing a colour coded printable tool with supporting statements to reflect escalation of crisis. The descriptive supporting statements were developed with the ICB Lived Experience Lead to reflect escalating levels of distress.

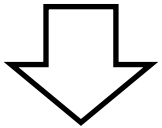
"On a scale of zero to ten, where zero is the best you can feel and ten is the worst, how do you feel right now?"

10	**Unbearable**	*The worst distress, anxiety, fear or discomfort you have ever felt.*
9	**Extreme**	*"I am finding it hard to cope"*
8	**Very distressed and uncomfortable**	*"I am so upset that I am struggling to think about anything else"*
7	**Strong feelings of distress**	*"I am so upset that I am finding it difficult to function"*
6	**Moderate - strong**	*"How I am feeling is affecting my ability to focus on other things"*
5	**Moderate**	*"I feel uncomfortable, although I can still focus on other things"*
4	**Mild - moderate**	*"I am feeling more anxious than usual, and I am worried about how I am feeling"*
3	**Mild**	*"I am feeling anxious, and it is upsetting me"*
2	**Minimal**	*"I am feeling a little anxious or upset"*
1	**Neutral**	*"I am feeling OK"*
0	**No distress or anxiety**	*"I am feeling calm and relaxed"*

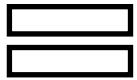
Impact of the services on reducing people's emotional distress

Subjective Units of Distress Scale

Services were asked to collect Adapted SUDs scores at the beginning and end of each interaction*. Scores were reported for 50% (4,710/9,396) of all service interactions.



- **83% (3915) of the Adapted SUDS scores showed a decrease in level of emotional distress**



- 16% (752) reported no change in their level of emotional distress

- <1% (28) of the Adapted SUDS scores showed an increase in level of emotional distress

- **Across the services the average change in Adapted SUDS score was a decrease of 2.2***

*This change in score is comparable to the findings reported in Heyland et al, 2013, where attendees at The Living Room Crisis Service in Chicago reported an average decrease of 2.13 points on the Subjective Units of Distress Scale (Heyland et al, 2013: 'The Living Room, a Community Crisis Respite Program: Offering People in Crisis an Alternative to Emergency Departments').

Overview of change in SUDS scores across all the services

Service model	Service	Number of Adapted SUDS scores collected between 01 April 2022 and 30 June 2023	Change in Adapted SUDS Score			
			% of scores that showed a **decrease** in distress	% of scores that showed **no change** in distress	% of scores that showed an **increase** in distress	Average change in score
Crisis house – offering short stay accommodation	The Lookout	**118** over 162 stays *(73%)*	**75%** *(89/118)*	**14%** *(16/118)*	**11%** *(13/118)*	**Decrease of 2.5**
Safe Havens - Out of hours face-to-face drop-in services	Adults' Safe Haven (Havant)	**2664** over 2766 attendances *(96%)*	**80%** *(2128/2664)*	**20%** *(529/2664)*	**<1%** *(7/2664)*	**Decrease of 1.7**
	The Lighthouses (Shirley & Bitterne)	**10** over 4,011 attendances (<1%)	/	/	/	/
	North and Mid Hampshire Safe Haven	**997** over 1493 attendances *(67%)*	**84%** *(834/997)*	**16%** *(157/997)*	**<1%** *(6/997)*	**Decrease of 2.7**
	Newport Safe Haven	**916** over 929 attendances *(98%)*	**94%** *(864/916)*	**5%** *(50/916)*	**<1%** *(2/916)*	**Decrease of 2.9**
Integrated Peer Support Workers	Peer Support Service - Integrated Mental Health Hub (IMHH)	**5** over 35 referrals *(14%)*	/	/	/	/
	GRAND TOTAL:	**4710** over 9396 contacts **(50%)**	**83%** *(3915/4709)*	**16%** *(752/4709)*	**<1%** *(28/4709)*	**Decrease of 2.2**

Average score on arrival vs. average score on departure, by service

Service model	Service	Average score on arrival	Average score on departure
Crisis house – offering short stay accommodation	The Lookout	6.9	4.4
Safe Havens - Out of hours face-to-face drop-in services	Adults' Safe Haven (Havant)	4.6	2.8
	The Lighthouses (Shirley & Bitterne)	/	/
	North and Mid Hampshire Safe Haven	6.9	4.2
	Newport Safe Haven	4.5	1.6
Integrated Peer Support Workers	Peer Support Service - Integrated Mental Health Hub (IMHH)	/	/

Safe Havens – emotional distress on arrival vs departure

Adapted Subjective Units of Distress Scale

"On a scale of zero to ten, where zero is the best you can feel and ten is the worst, how do you feel right now?"

Level of distress on **arrival**		Level of distress on **departure**										
		0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
0	No distress or anxiety	39										
1	Neutral	30	208		1							
2	Minimal	22	197	205			1					
3	Mild	16	233	280	48	1						
4	Mild - moderate	18	152	261	156	40						
5	Moderate	16	116	199	221	91	31	1	2			
6	Moderate - strong	5	70	132	170	159	67	36	3			
7	Strong feelings of distress	3	30	56	99	131	96	58	37	3		
8	Very distressed and uncomfortable	1	10	44	75	78	56	70	63	40		2
9	Extreme	2	12	12	17	21	30	40	52	37	30	
10	Unbearable	2	6	17	16	9	10	9	16	18	25	22

The Lookout – emotional distress on arrival vs departure

Adapted Subjective Units of Distress Scale

"On a scale of zero to ten, where zero is the best you can feel and ten is the worst, how do you feel right now?"

Level of distress on **arrival**		Level of distress on **departure**										
		0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
0	No distress or anxiety	1										
1	Neutral	2	1	1			1			1		
2	Minimal	1	4									
3	Mild				1							
4	Mild - moderate			1		1						
5	Moderate	2	1					1		1		
6	Moderate - strong		4	3	2	2	4	4		2	1	
7	Strong feelings of distress	1	3	2	1	1	8	3	1	1	1	1
8	Very distressed and uncomfortable	1	1	1	3		5	3		4	1	
9	Extreme		3	3	1	2	5	2		1	3	1
10	Unbearable		1	1			4	6	1	1	2	

Limitations

- *Adapted SUDS were intended to be self-reported, but several services assigned scores on the person's behalf using the scale provided to look for verbal cues. Therefore, SUDS scores could vary based on how the person recording it personally perceives distress (this could be influenced by factors such as job role, personal experience of distress, or training).*
- *There is a risk of subject bias when self-reporting SUDS scores, where the respondent consciously or subconsciously answers in a way that they think the person asking them wants them to respond.*
- *Adapted SUDS were not collected for every attendance - a larger sample size would have increased the analysis potential.*
- *Two services were unable to collect SUDS scores, which means this impact measure cannot be reported for these services.*

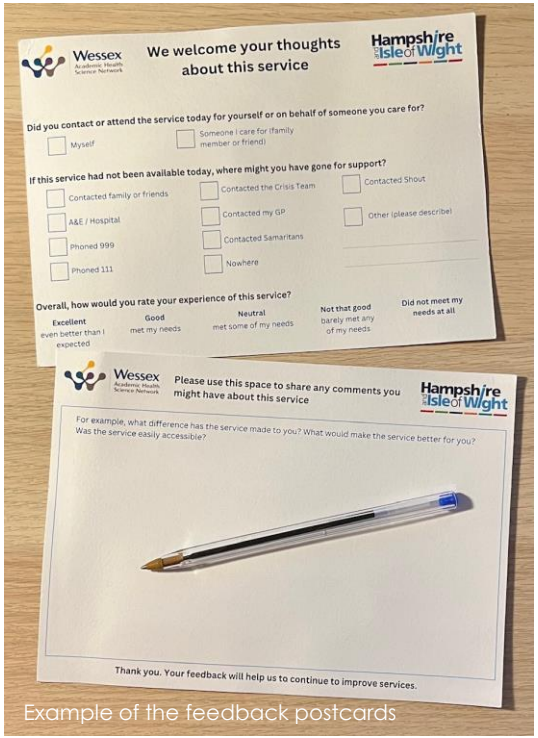
What did the people who used the A to C services say about them?

Headline findings from the feedback collected via:

- *Online questionnaires*
- *Postcards*
- *Interviews.*

Part of the Health Innovation Network

Online survey and postcards – number of responses



Example of the feedback postcards

A core set of questions were included on both the postcards and the online survey.

Both the survey and the postcard included short multiple choice style questions and free text questions, where people could provide further comments about their experience of the service.

Further information on the findings from the online survey and postcards is provided in the Individual service profile reports.

Number of responses received:

Services	Number of postcards	Number of online surveys	Total
The Lighthouses (Bitterne and Shirley)	5	23	**28**
North and Mid Hampshire Safe Haven	8	1	**9**
Adults' Safe Haven (Havant)	24	22	**46**
Newport Safe Haven	7	0	**7**
The Lookout	12	6	**18**
Peer Support Service (Isle of Wight)	N/A	9	**9**
GRAND TOTAL	**56**	**61**	**117**

Online survey and postcards – feedback from the people who use the A to C services

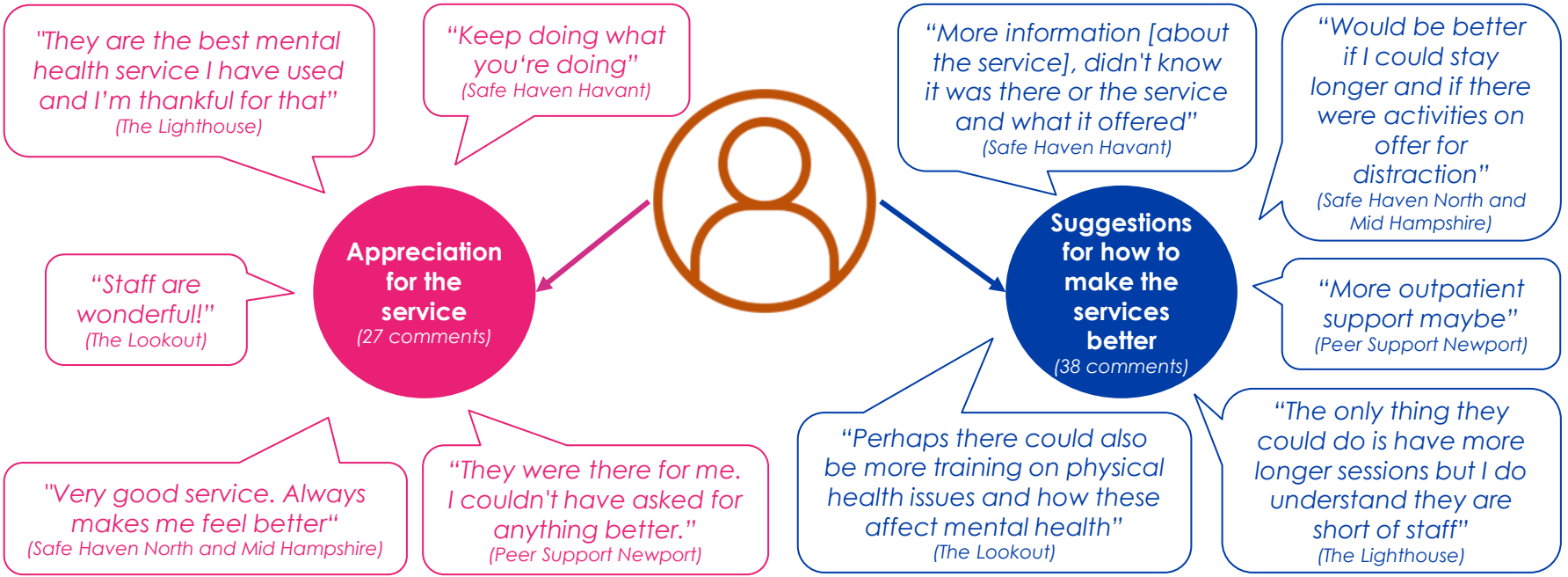
The online surveys were circulated between March 2023 and June 2023. The postcards and ballot boxes were distributed to the services in March 2023 and collected in June 2023. Across the three models of service delivery (residential (The Lookout), Safe Havens and Peer Support Service – Isle of Wight) 56 feedback postcards and 61 online surveys were completed, giving a total of 117 postcard and survey responses for the programme as a whole.

- **90%** (105/117) of respondents who had used an A to C service rated their experience **as good or excellent**

- **100%** (61/61) of respondents who had used an A to C service said they would be ***likely or extremely likely*** **to recommend the service to someone else if they needed similar support** *(This question was only included in the longer online survey, not the postcard.)*

Online survey and postcards – feedback from the people who use the A to C services

90/117 provided responses to the free text questions, which could be broken down into 261 distinct statements.
The statements were grouped into three key areas: **appreciation for the service**; **suggestions for how to make the service better** and personal examples of **how the services have helped people** *(shown on the following slide)*.



Online survey and postcards – feedback from the people who use the A to C services

How the services helped people
(196 comments)

Accessible at time of need
(21 comments)

"Access to contact mental health support when required instead of going into full crisis"
(The Lighthouse)

"Knowing they are there if you need them is comfort"
(Safe Haven Havant)

Someone to listen and understand
(78 comments)

"Was listened to and understood, no judgement from anyone"
(Safe Haven Havant)

"This is the best one, they are more approachable and understanding."
(Safe Haven Newport)

A lifeline and safe space to calm down
(61 comments)

"Reduces my urges to harm myself, it also calms down my distress and anxiety"
(The Lighthouse)

"On a few occasions it has saved my life."
(Safe Haven North and Mid Hampshire)

Support to move forward
(36 comments)

"Gave me the resources to enable me to regain my mental health stability, confidence and strength to carry on"
(Peer Support Newport)

"Helped equip me with confidence to be able to move forwards with things upon leaving and have helped me become a version of myself that I am quite proud of."
(The Lookout)

Online survey and postcards – Feedback provided by carers

Feedback postcards were completed by four carers supporting people who had accessed the Safe Haven services

"I have been offered a lifeline for myself and a way to help my son that I didn't know existed until I visited Safe Haven. I am at crisis stage myself not knowing how to support my son who has mental health issues. Safe Haven have offered me a way forward. Thank you so much"

– Carer visiting the Adults' Safe Haven (Havant)

"Friendly environment, really helpful talking with you both, we now have a plan. Thank you so much - fabulous"

– Carer visiting the Newport Safe Haven

"Very helpful - thank you!"

– Carer visiting the Adults' Safe Haven (Havant)

"It has been a lifeline"

– Carer visiting the North and Mid Hampshire Safe Haven

Interviews – feedback from the people who use the A to C services

Practical and inclusive approach

- Participant information provided in different formats - e.g. easy read version, information video.
- Interviewers were a qualitative evaluator from Health Innovation Wessex and HIOW ICB Lived Experience Lead.
- Liaised regularly with the key contacts (service managers / leads) to promote participation.
- Interview options included a video call, telephone or in-person.
- Online voucher to thank participants for their time.
- Interviews carried out with eight individuals: four from The Lookout and four from the Adults' Safe Haven (Havant).
- Full details of the interview findings can be found in Appendix V.

Interviews – feedback from the people who use the A to C services

Below are the overarching messages identified from the interviews:

Important to be seen as a person, not a medical diagnosis or a patient

- The services provide a safe, confidential space for participants to share their thoughts and emotions without the fear of their liberty being taken away.
- Participants felt they were welcomed without pre-judgement of their mental health experiences. They were treated with mutual respect and autonomy to freely access the support that they feel they need, as and when needed.
- Many of the participants found it reassuring that the A to C services are separate from the NHS and they valued the non-clinical environment. Some participants had negative associations between the NHS and being let down by overstretched services or being sectioned in an acute mental health ward.

Important to be able to talk to someone who can validate the person's experience

- This 'peer' type relationship flattens the power hierarchy often experienced in a clinical contact with healthcare professionals.
- The services are perceived as participants' preferred point of support because they can talk to someone who can relate, listen and understand, helping them to process their thoughts and emotions.
- Participants' feel accessing the services has helped reduce their need to seek support from other services such as 111, crisis team, emergency department, etc.

Interviews – feedback from the people who use the A to C services

The following quotes come directly from the interviews:

"A lot of the time it's me… just blurting stuff out and just… Having that safe place. That you're not gonna get judged and. You know, I actually find they're really helpful."

- Rose*, an interviewee from the Adults' Safe Haven (Havant)

"I did speak to one gentleman there who told me a lot of his problems, which made it easier for me to talk to him… And I realised I wasn't on my own. And that helped a lot."

- James*, an interviewee from the Adults' Safe Haven (Havant)

"I'm in a safe place [at the Lookout] and that's very important for me… [I] was absolutely terrified [in the mental health hospital]."

– Donna*, an interviewee from The Lookout in Winchester

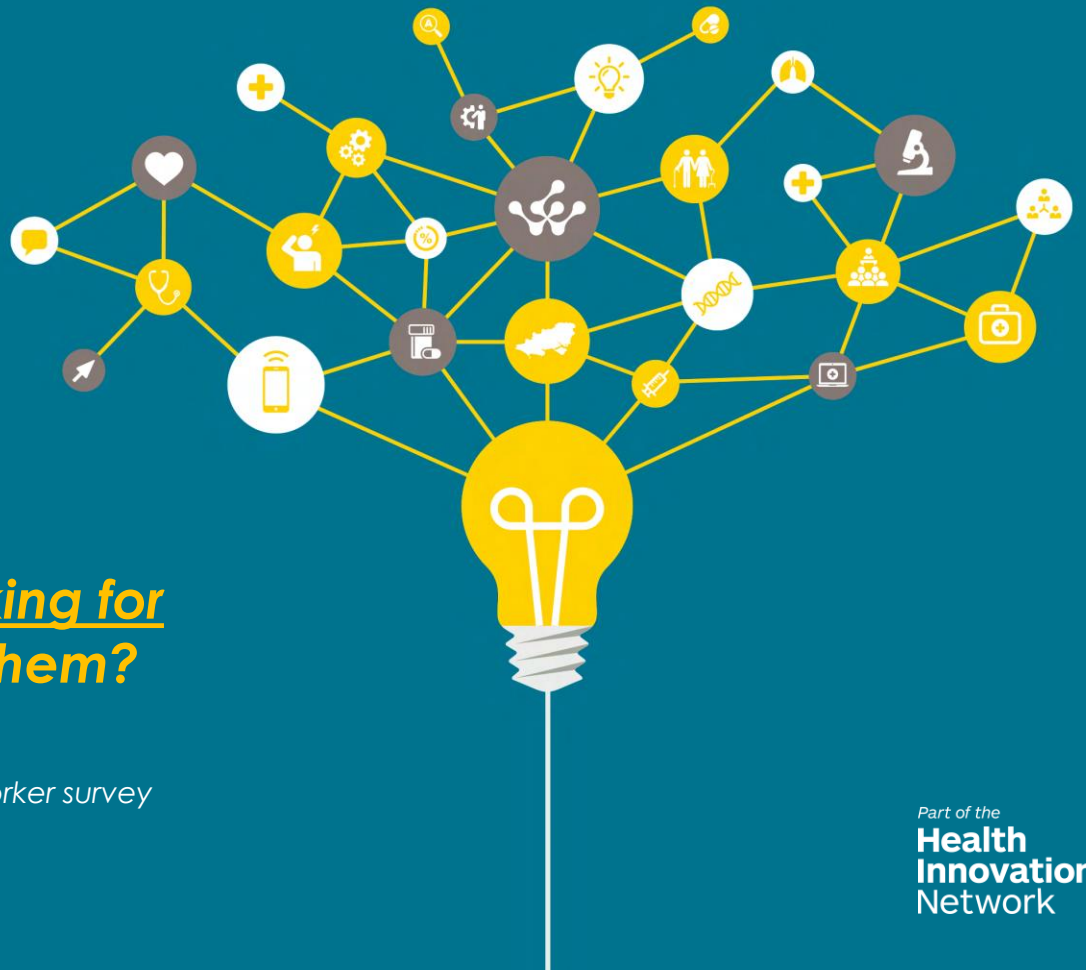
"…And then she realised [I was not in good place] she was like, no, you're coming in [to Safe Haven]. You're coming inside. She saved my life."

- Gail*, an interviewee from the Adults' Safe Haven (Havant)

**Pseudonyms used to protect participants' identities*

Limitations

- *The sample size for the questionnaire, postcard responses and interviews is relatively small compared to the overall number of individuals who used the services during the data collection period.*
- *A larger sample size would have increased the analysis potential.*
- Questionnaire and postcard responses were anonymous to encourage participation, therefore it is not possible to link the qualitative and quantitative data to identify trends in relation to characteristics of the individuals.
- *There was no means to prevent people from completing the questionnaires or postcards on more than one occasion.*
- Due to the nature of the services supporting people in crisis, the people were reluctant to participate in the qualitative data collection activities. It was also challenging for services to ask people to provide feedback following a difficult interaction.
- *The feedback may be biased towards those who were less distressed.*
- *Only four people who had stayed at The Lookout and four people who had been in contact with the Adults' Safe Haven (Havant) accepted the invitation to be interviewed. Therefore, the other services are not represented within the interview analysis.*
- *Not all services collect contact details for confidentiality reasons, therefore the service had no means to contact people to invite them to participate in the data collection.*



What do the people working for the services think about them?

- *Headline findings from the staff survey*
- *Headline findings from the Peer Support Worker survey*

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Staff and Peer Support Worker (PSW) surveys – headline findings

Staff survey:

- Staff feel supported by their organisation and believe they make a difference to those they support
- Greater clarification is needed around opportunities for career progression
- Staff working alongside PSWs value their peer support colleagues - however, comments were mixed regarding peer training, with some concerns raised around whether peers receive sufficient training, particularly peers with little or no prior formal experience

Peer support worker survey:

- PSWs value the training they receive, however more tailoring to PSW needs is required
- PSWs feel valued and supported by others within their own organisation and by partner organisations
- Greater clarification is needed around opportunities for career progression
- PSWs reported that their role has a positive impact on their own mental health
- PSWs believe they make a positive difference to those they support

Staff and peer support worker surveys

Both surveys comprised short answer multiple choice questions and long answer free text questions for further comments. The staff survey was circulated to all members of staff in 'non peer support' roles working for or with the A to C services May 2023.

- *There are 28 members of staff directly employed by the services, 17 chose to participate in the survey (61%)*

The peer support worker (PSW) survey was circulated to all members of staff specifically employed for their lived experience in peer support-based roles.

- *There are 21 members of staff employed in peer support-based roles across the services; 14 chose to participate (67%)*

Services	Number of peer support workers	Number of PSW responses	Number of staff in non-peer roles	Number of staff responses
The Lighthouses (Bitterne and Shirley)	12	8	3	0
North and Mid Hampshire Safe Haven	3	3	8	8
Adults' Safe Haven (Havant)	/	/	5	4
Newport Safe Haven	/	/	5	2
The Lookout	/	/	7	3
Peer Support Service (Isle of Wight)	6	3	/	/
GRAND TOTAL	**21**	**14**	**28**	**17**

For further information on the findings from the Staff and Peer Support Worker surveys, please see Appendix VI.

Staff survey – results

17 responses were received from members of staff directly employed by the A to C services.

Summary of key findings *(from both short answer and free text questions):*

- Staff feel supported by their organisation and believe they make a difference to those they support.
- However, greater clarification is needed around opportunities for career progression
- Improvements suggested by staff include:
  - *Better relationship with external services e.g. CMHT and emergency services*
  - *More crisis practitioners*
  - *Facilities need to support demand on service*
  - *Daytime service at weekends*
  - *Increase therapeutic interventions*
  - *Outreach service for those who cannot attend in person*
  - *Availability of services in more locations.*

17 members of staff directly employed by the A to C services said that they…

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	*Do not know*
…feel supported by their organisation	7	7	3			
…feel there is a **clear pathway for progression**	2	6	6	1	1	1
…feel they make a **difference to people experiencing a mental health crisis**	12	5				
…find working for the service **very satisfying.**	8	7	2			

Staff survey – results

Perception of peer support workers:

Members of staff employed directly by the A to C services working in 'non peer support roles' were asked the following two questions:

1. *Thinking back to when you first started working with the service: on a scale of zero to ten, please mark how comfortable you were about the idea of peer support workers delivering support to people experiencing a mental health crisis?*

2. *Now thinking about your current attitude: On a scale of zero to ten, please mark how comfortable you are about peer support workers delivering support to people experiencing a mental health crisis?*

Respondents were then given the opportunity to explain their scores.

- **60% (6/10) of the scores showed an improvement between the first and second question, with the average score rising from 6.6 to 10.** 30% (3/10) of the scores remained unchanged, while 10% (1/10) of the scores showed a decrease.

- Key points to come from the comments:

  - *Peer support workers are seen as having a valuable role to play and are valued by their colleagues*

  - *Concerns were raised around training, and whether peers receive sufficient training, both to protect their own mental health and to provide suitable support to others when working in a crisis setting, particularly peers with little or no prior formal experience*

  - *Need for clear boundary setting to protect both the peer and the person using the service.*

Peer support worker survey – results

14 responses were received from members of staff employed in peer support specific roles.

Summary of key findings *(from both short answer and free text questions):*

- PSWs value the training they receive; however, more tailoring to PSW needs is required
- PSWs feel valued and supported by others within their own organisation and by partner organisations
- Role of PSW provides opportunities for individual growth; however, as with the staff survey, greater clarification is needed around opportunities for career progression
- All respondents said they found their role very satisfying
- PSWs reported that their role has a positive impact on their own mental health
- PSWs believe they make a positive difference to those they support
- Not all respondents felt their lived experience was valued, as some people prefer professional support
- Desired improvements for PSWs include:
    - *Better support and communication from crisis and local mental health teams*
    - *More development of the job role.*

Peer support worker survey – results

14 responses were received from members of staff employed in peer support specific roles.

The 14 PSWs were asked to consider the following statements:	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	*Do not know*
Training provided by my employer **enables me to feel confident within my role**	4	7	2	1		
After completing the training for my role, **I have a clear understanding of what is expected of a peer support worker**	5	7	2			
After completing the training for my role, **I have a clear understanding of the organisation's policies and procedures**	6	7	1			
I have **opportunities for further training** within my role	6	4	3		1	
The service I work for has **realistic expectations of its peer support workers**	6	7	1			
I feel **supported by the organisation** I work for	5	6	3			
I have **effective strategies to help me 'unwind'** following a distressing interaction	5	9				
I can contact someone within my organisation for **support and to debrief after an interaction**	6	6	1	1		
I feel **valued** as a peer support worker **by my clinical colleagues** (clinicians working directly within your service)	5	7	1	1		
I feel **valued** as a peer support worker **by colleagues working in our partner organisations** (crisis teams, Emergency Departments, paramedics, etc)	3	5	4			2
I feel my **role has helped me grow as an individual**	9	5				
I feel there is a **clear pathway for progression** within my role as a peer support worker	4	3	4	2	1	
Overall, I find **being a peer support worker very satisfying**	8	6				
I feel that **the people I support value the fact I have lived experience** of mental health crisis	7	4	2	1		
I feel **I make a difference to the people I support** at the service	7	7				

Limitations

- *Questionnaires by their nature only allow a limited depth of response. Interviews by contrast allow for deeper exploration of nuanced or complex opinions. However, due to the number of services involved, the time constraints of the evaluation, and the large number of key stakeholders to speak to, questionnaires provided the most practical approach.*

- *Due to the range of different ways the services are set up (some with dedicated peer support worker, some without, some with clinicians employed by the service, some with clinical input operating alongside the service, and some without clinical input at all) designing a questionnaire to capture this variation was challenging. In some instances, people answered an incorrect set of questions, and in doing so missed the questions relevant to them (for instance, answering a series of questions on working with peer support workers, when your service does not employ dedicated peer support workers). This unfortunately meant a small number of responses had to be discounted.*

Stakeholder perspectives

- *Headline findings from the Rapid Insight Events*
- *Headline findings from the Emergency Response Partner survey*
- *Headline findings from the Primary Care survey*

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Rapid Insight Events

Rapid Insight Events (RIEs) were developed by Health Innovation Wessex, initially in response to the pandemic, to enable health care systems to gain knowledge quickly.

Key stakeholders are gathered into a tightly managed, virtual forum to share system intelligence by answering a series of open questions. This provides an opportunity for a **rapid cycle of data collection, analysis and feedback**.

Health Innovation Wessex hosted two RIEs as part of the evaluation, and to support Hampshire and Isle of Wight ICB to gain insight into the Alternatives to Crisis services. The questions for the event were developed in partnership with the ICB, under the guidance of the ICB Lived Experience Lead. For further information on the set up of these events, and for full details of the outputs, please see Appendix VII and Appendix VIII.

- Each of the seven services were asked to invite their key stakeholders to attend; including:
  - *People who use the services and their carers*
  - *Service staff (clinical and non-clinical, peer support workers, and service managers)*
  - *Local emergency service partners, e.g. police, emergency departments, ambulance services*
  - *GP services and other primary care contacts*
  - *Crisis Mental Health Teams*
  - *Representation from any groups who might benefit from the service, but struggle to access it.*
- The two events were held on **15 June 2022** and **19 April 2023**
  - ***June 2022:*** *39 stakeholders joined the session and 32 actively participated (providing responses to one or more of the questions). 158 comments were collected across the six questions.*
  - ***April 2023:*** *47 stakeholders signed up for the event, 33 attended, and 25 provided responses in the chat bar to one or more of the questions.133 comments were collected across the six questions.*

Rapid Insight Events – *key findings*

The following pulls together the key themes identified from the stakeholder responses collected during the two RIEs.

What are the strengths and benefits of the Alternatives to Crisis services?

Main themes identified across the responses:

- Providing support in a non-clinical environment to support people in crisis
- Perceived reduction in pressure on other services
- Benefit of peer support (e.g. reduced barriers, validation of person's experience)
- Improving the experience for people who use services
- Building good working relationships with partners
- Offering more choices for accessing the services
- Increased visibility

What has not worked well?

Main themes identified across the responses:

- *Workforce challenges (e.g. recruitment, some services not always fully staffed)*
- *Hard to ensure wider representation in the staffing mix*
- *Gaps in existing processes (e.g. information sharing barriers)*
- *Inconsistent engagement with partner organisations*
- *Coverage (e.g. travel time to reach services)*
- *Accessibility and service provision (e.g. limited opening hours, still not reaching some minority groups)*
- *Can be insufficient capacity to meet demand*
- *How some people use the services (e.g. can be used by some for loneliness rather than crisis, frequent attendees, difficult to find long term support for signposting on)*
- *Technology (e.g. restricting joint working)*

What could the services do better going forward?

Main themes identified across the responses:

- *Improve communication and promotion of services*
- *Identify and reach out to the groups that are harder to engage with*
- *Improve collaboration and partnerships between services*
- *Increase the breadth and accessibility of service offerings*
- *Address communication barriers for people with communication challenges (e.g. people with hearing and sight impairments, non English speakers, people with autism or learning disabilities)*
- *Extend the opening hours of the services*
- *Recruit and retain a stable, skilled, knowledgeable workforce*

What steps have been taken to raise awareness about the availability of these services? *...with emergency partners ...across the local population?*

Main themes identified across the responses:

- Public engagement
- Briefed key teams
- Embedded the services within processes
- Produced promotional materials
- Digital promotion
- Three respondents felt that they had not seen any attempts to raise awareness, suggesting more needs to be done

Are the right Alternatives to Crisis services, in the right places, and are they reaching the whole community? *...If not, why not? ...Is there anything missing from the current model?*

Main themes identified across the responses:

- Location of services patchy...
- Accessibility issues due to location and lack of suitable transport *(cost of travel prohibitive for low income households)*
- Services not reaching whole community
- Need for data and service information
- Blended services provide options

Stakeholder surveys

- *A Primary Care survey and an Emergency Response Partner survey were circulated in May 2023 to understand how these stakeholder groups perceived and interacted with the A to C services.*
  - *The emergency response partner survey was circulated to key contacts within the police, ambulance service, 111, Liaison Psychiatry, Mental Health Crisis Teams and Emergency Departments (ED) for wider distribution*
  - *The Primary Care survey was circulated in the GP Bulletin (which reaches 700+ GPs across HIOW) and via primary care mental health leads*

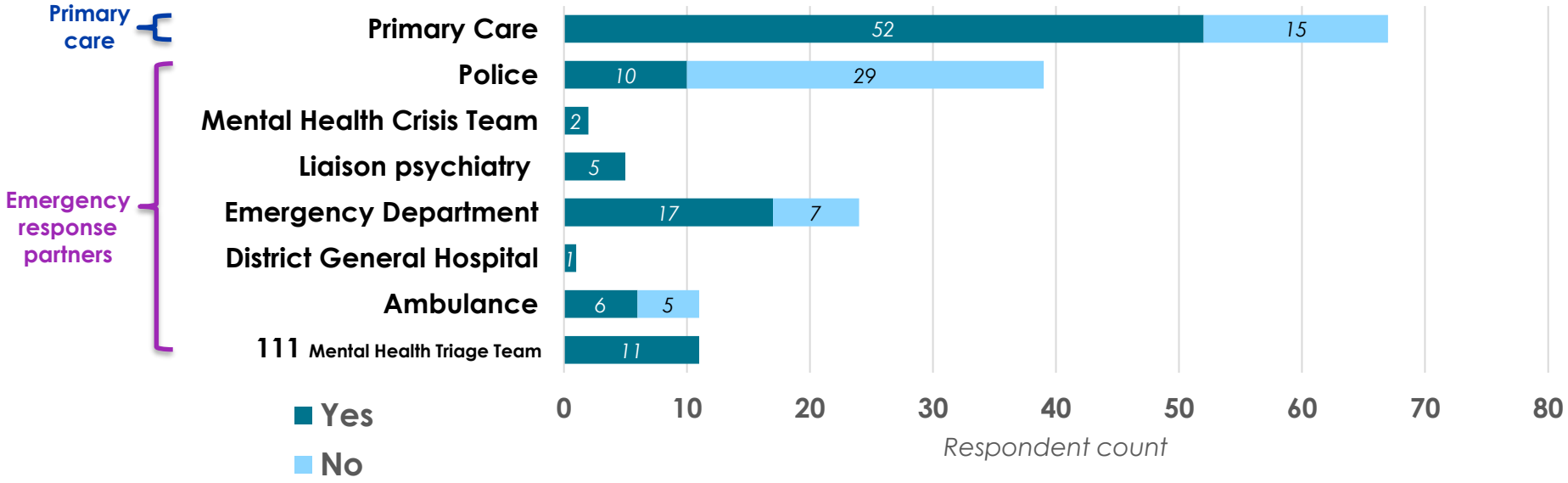
- *Both surveys were split into two sections:*
  - *Section one simply asked: '**Had you heard of any of the A to C services prior to receiving this survey?**' followed by '**What more could be done to raise awareness of the A to C services within your organisation?**'*
  - *Section two asked more detailed questions around the impact and perception of the A to C services and was only directed to those who had prior knowledge of at least one A to C service*

	Number of respondents	
	Primary care	Emergency response
Section one:	67	93
Section two:	52	51

- *Full findings from both surveys can be found in Appendix IX Primary Care Survey and Appendix X Emergency Responder Survey. Including recommendations for raising awareness of the services amongst different stakeholder groups.*

Had the respondents heard of the A to C services prior to receiving the survey?

- ***78% (52/67)****of respondents from* ***primary care*** ***had heard of at least one A to C service*** *prior to receiving the survey*
- ***55% (51/93)*** *of respondents from the* ***emergency response sector*** ***had heard of at least one A to C service*** *prior to receiving the survey*



Headline findings from the emergency response partner survey

- **88%** (45/51) of emergency response partners **agreed or strongly agreed that the A to C services play a valuable role in supporting people in mental health crisis**

- **73%** (37/51) of emergency response partners **agreed or strongly agreed that the A to C services helped to reduce pressure on their organisation**

- **84%** (38/45*) of emergency response partners **would recommend an A to C service to someone under their care experiencing a mental health crisis**

** Out of the 51 emergency response partners taking part in this section of the survey, only 45 held a job role where they directly cared for patients / people; others had managerial responsibilities, or held positions where signposting patients was outside of their responsibilities*

Emergency response partner survey

What impact, if any, do you feel the A to C services have had on your service?

- Most responses across 111, the police, the ambulance service and Liaison Psychiatry were positive regarding the impact of the A to C services on their own service.

"Having the ability to signpost to a professional face to face support service for patients experiencing mental health crisis"

- 111 Mental Health Triage Service

"Given us an alternative to hospital care, or leaving the person to their own devices"

- Hampshire Constabulary

"Helps us to avoid unnecessary conveyance"

- South Central Ambulance Service

"Good to be able to offer patients not meeting threshold for secondary mental health care an alternative if they are in crisis"

- Liaison Psychiatry

Emergency response partner survey

What impact, if any, do you feel the A to C services have had on your service?

- 6/18 respondents working within the Emergency Department were either unsure of the impact or felt unable to say without access to the relevant data. Five respondents chose to leave their answer blank. The remaining responses were mixed, as illustrated by the sample below:

"I feel if more people used or knew about them, they could reduce attendances to ED"

- Nursing Associate

"Very little when patient already in the ED, but hopefully they might think of going there instead of ED the next time"

- Consultant in Emergency Medicine

"I don't know, we are currently overwhelmed with mental health presentations"

- Consultant in Emergency Medicine

"They provide out of hospital support to reduce burden on the ED"

- Consultant in Emergency Medicine

Headline findings from the primary care survey

- **71%** (37/52) of respondents from primary care **agreed or strongly agreed that the A to C services play a valuable role in supporting people in mental health crisis**

- **63%** (33/52) of respondents from primary care **agreed or strongly agreed that having access to an A to C service had positively impacted their patient(s)**

- **71%** (37/52) of respondents from primary care **would recommend an A to C service to someone under their care experiencing a mental health crisis**

Primary care survey

What impact, if any, do you feel the A to C services have had on primary care?

- 38/52 respondents answered this question. 61% (23/38) of the comments reported a positive impact. 16% (6/38) of respondents were unsure of the impact. 21% (8/38) felt there was little or no impact. No one reported a negative impact.

"Gives us somewhere to signpost people… They receive a better response than in ED"

- GP, Basingstoke & Deane

"Very helpful to have a service that patients can access themselves in their own time if needed"

- GP, Portsmouth

"Reduces the medicalisation of mental health crisis"

- GP, Isle of Wight

"Positive impact. It has given practitioners in primary care the opportunity to signpost patients on for further support which can ease the workload within primary care and most importantly could promote safety and positive mental health"

- Wellbeing Advisor, Basingstoke & Deane

"Limited impact due to the hours the service is accessible and the staff are not clinicians"

- GP, Isle of Wight

Limitations

Rapid Insight Events:

- Each event provides a single snapshot, and therefore can only reflect experiences and learning at that point of time
- Representation across all stakeholder groups was not evenly distributed, furthermore not all attendees participated in answering the questions; this could have led to bias within the responses
- The information presented on slide 79 and in Appendices V and VI are derived from personal opinions and represents the perspectives of the individual participants.
- The findings from an RIE are not conclusive. The findings cannot be extrapolated to a broader population of users and/or applied to settings or contexts other than that described, nor can it be assumed that the findings are applicable to a similar setting or context.

Limitations

Primary care and emergency response partner surveys:

- *Surveys by their nature only allow a limited depth of response. Interviews, by contrast, allow for deeper exploration of nuanced or complex opinions. However, due to the number of services involved, the time constraints of the evaluation, and the large number of key stakeholders to speak to, questionnaires provided the most practical approach.*
- *A larger sample size across both questionnaires would increase the analysis potential.*
- *There were more representatives from primary care responding to the questionnaire from some areas than others; this has resulted in an uneven level of representation across the sample. For instance, the largest proportion of respondents, 31% (21/67), were from the Isle of Wight, whereas <1% of respondents were from Southampton (3/67).*

Have the services impacted the way people use other NHS healthcare services?

- *Headline findings from the Emergency Response Partner survey*
- *Headline findings from the Primary Care survey*

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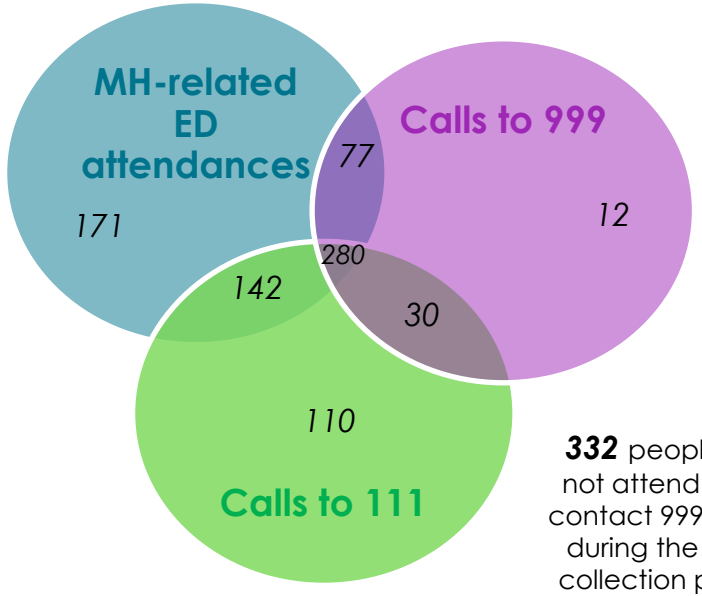
NHS healthcare service usage

- Using the Standardised Data Collection Tool the services were asked to record each person's NHS number against each contact with the service
- **NHS numbers were collected for 1,154 people** during the data collection period (01 April 2022 – 30 June 2023)
- This data was then submitted to NHS Digital for pseudonymisation
- The CSU linked the pseudo-NHS numbers to each person's activity across other NHS healthcare services between April 2018 and September 2023
- This data was then passed to Health Innovation Wessex for analysis.

Overlap in service usage: *Number of MH-related ED attendances, calls to 999, and calls to 111 associated with the 1,154 people who used A to C services between 01 April 2022 and 30 June 2023*



332 people did not attend ED or contact 999 or 111 during the data collection period

Cohorts included within the analysis

- To explore the impact of the A to C programme on individuals' NHS healthcare service usage, the usage data was examined before (baseline) and after the person first contacted an A to C service
- 910* people contacted the A to C services for the first time during the data collection period
- The analysis predominantly focused on three distinct cohorts identified within the data:

A to C cohort – 501 people

- *The activity of this cohort was examined over a three-month baseline and nine-month follow-up period. Although 910 people attended an A to C service for the first time during the evaluation data collection timeframe (01 April 2022 – 30 June 2023), only those who first attended before the end of December 2022 could be followed up for nine months, leaving a cohort of 501 individuals for inclusion within the analysis.*

Safe Haven frequent attendee cohort – 63 people

- *The Safe Haven frequent attendees are 63 individuals identified on slide 38 as having attended or contacted the Safe Haven services on more than 25 occasions during the data collection period (01 April 2022 - 30 June 2023). Their contact with the Safe Haven services accounted for 60% of the services' activity during the data collection period.*
- *Most of the frequent attendees contacted the services for the first time prior to the evaluation data collection period (i.e. before 01 April 2022) therefore their first attendance dates were manually looked up by either the service managers or the Business Information teams and provided on an individual-by-individual basis. The activity of this cohort was examined over a three-month baseline and nine-month follow-up period.*
- *The NHS healthcare service usage of this cohort was found to consistently skew the data, so they have been treated as a separate group of interest and presented accordingly.*

High frequency contact with NHS healthcare services cohort – variable size

- *This cohort varied in sized depending on the dataset and specific definition used for 'high frequency contact' by the NHS service. All 910 individuals who attended an A to C service during the data collection period were eligible for inclusion in this grouping as the timeframes for analysis were reduced to 30 days baseline and 90 days follow-up.*

** NHS numbers were collected for 1,154 people during the data collection period (01 April 2022 – 30 June 2023); however, 244 people had already attended an A to C service for the first time prior to the data collection beginning.*

Headline findings from the NHS healthcare services data

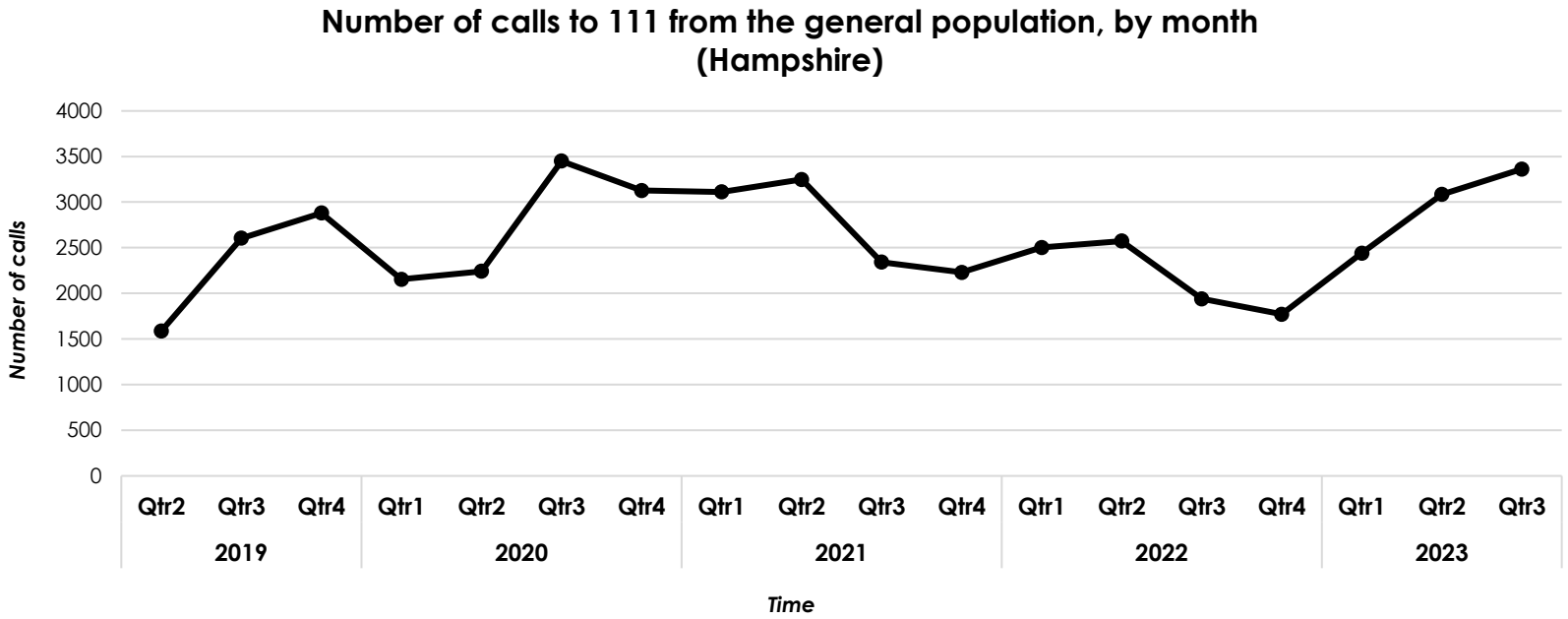
- **29%** (332/1,154) **of the people who were in contact with an A to C service** during the data collection period **did not used 999, 111 or ED for support with their mental health** between April 2018 and September 2023
- **All cohorts** showed a **decrease in their average monthly calls to 111*** following their first contact with the A to C Programme
- Overall, the **A to C cohort** and the **high frequency NHS contact cohort** both showed a **decrease in their average monthly calls to 999*** following first contact with the A to C Programme
- Overall, **A to C cohort** and the **high frequency NHS contact cohort** both showed a **decrease in their average monthly mental health-related ED attendances*** following first contact with the A to C Programme
- ***However***, the **Safe Haven frequent attendee cohort** demonstrated an **increase in their average monthly calls to 999*, while their average monthly mental health related ED attendance* remained unchanged** following first contact with the A to C Programme

Baseline average monthly attendance was calculated using three months of data prior to first contact with an A to C service, while the monthly average for the follow-up period was calculated based on nine months of follow-up data

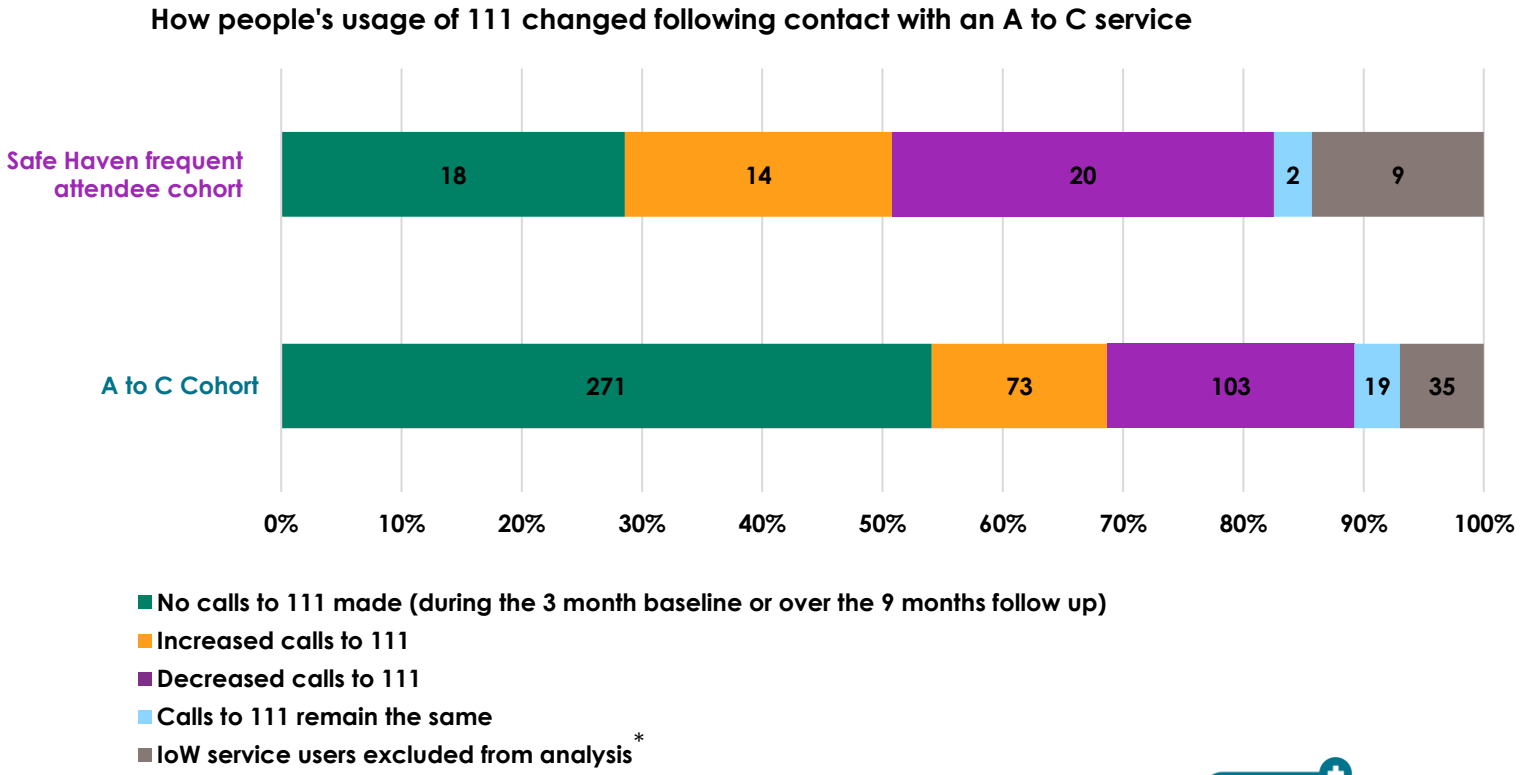
111 usage

111 usage

- Analysis of 111 usage was carried out by Health Innovation Wessex using data provided by the CSU from the South-Central Ambulance Service NHS Trust's 111 minimum data set
- There was no data provided in relation to 111 call activity on the Isle of Wight, therefore the two Island-based services had to be excluded from the 111 analysis.
- Data was provided from 01 May 2019 to 30 September 2023



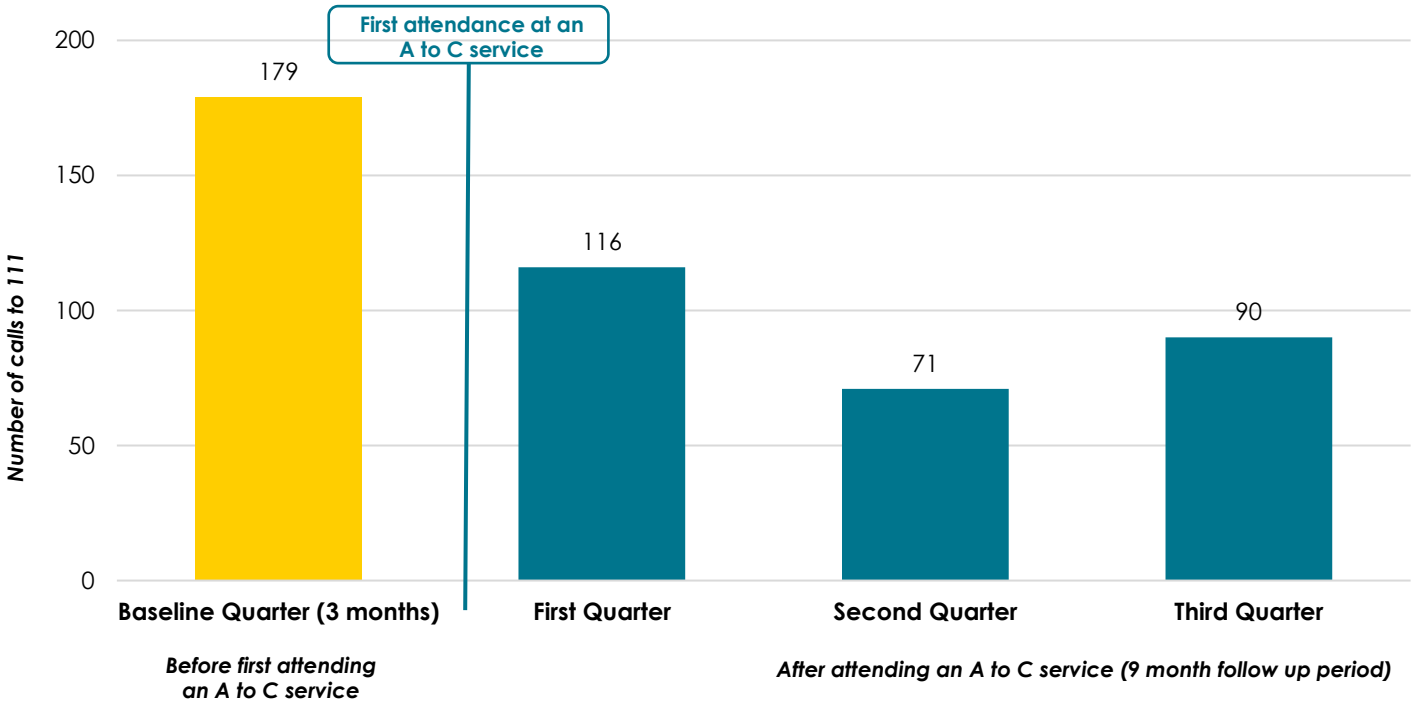
111 usage



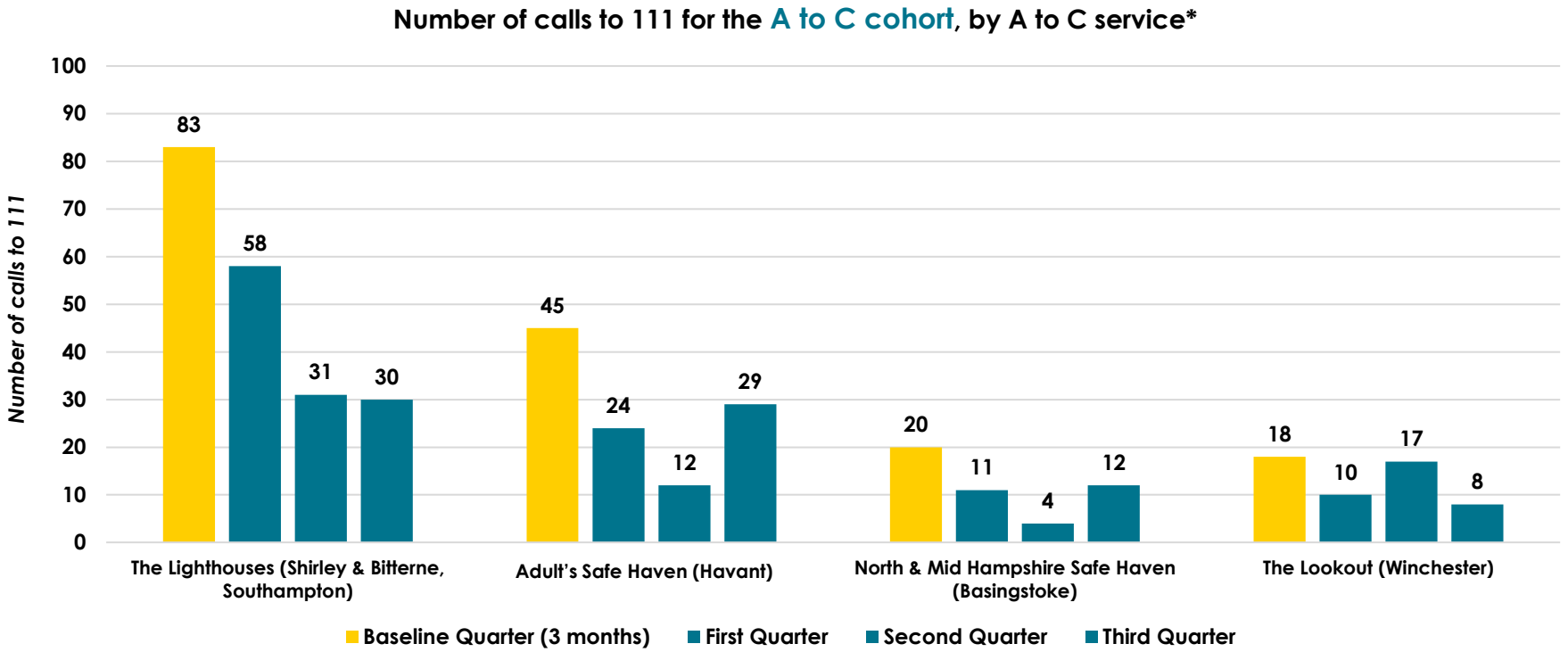
** Health innovation Wessex were not provided with 999 activity data for the Isle of Wight; therefore, Newport Safe Haven and the Peer Support Service could not be included in this part of the analysis.*

111 usage

Number of calls to 111, by quarter for the A to C cohort



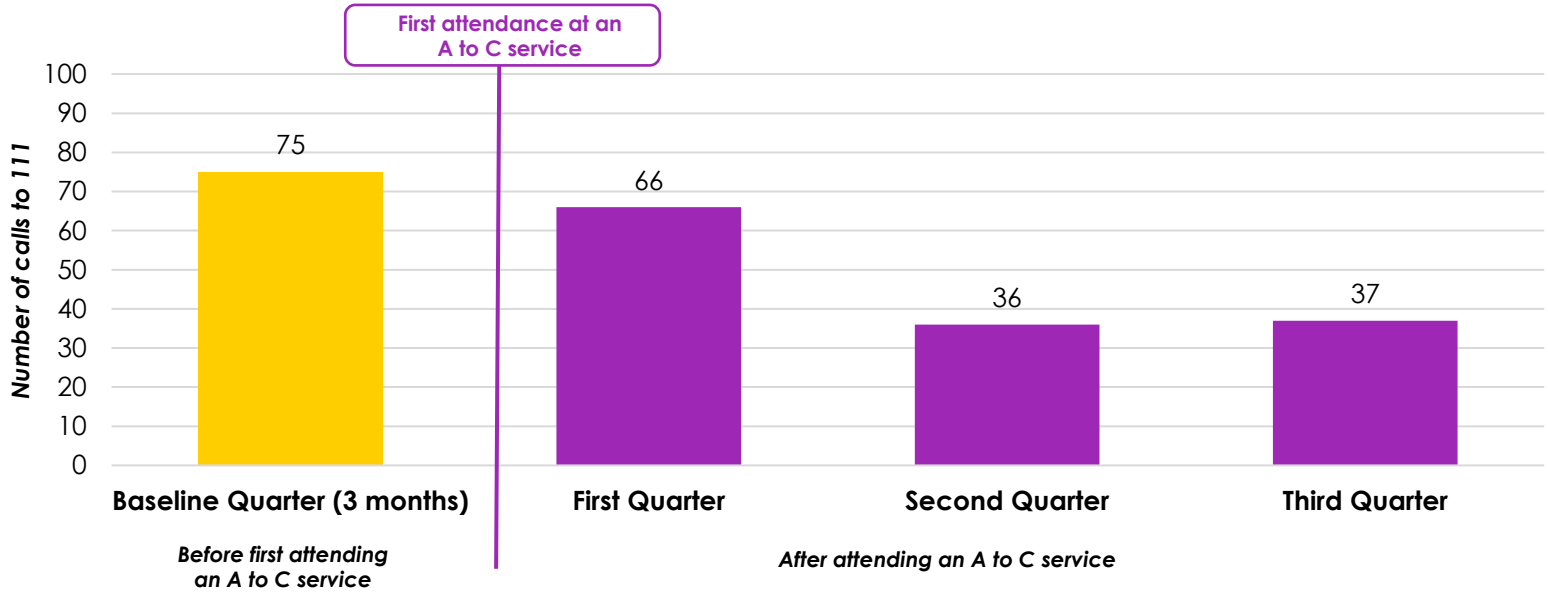
111 usage



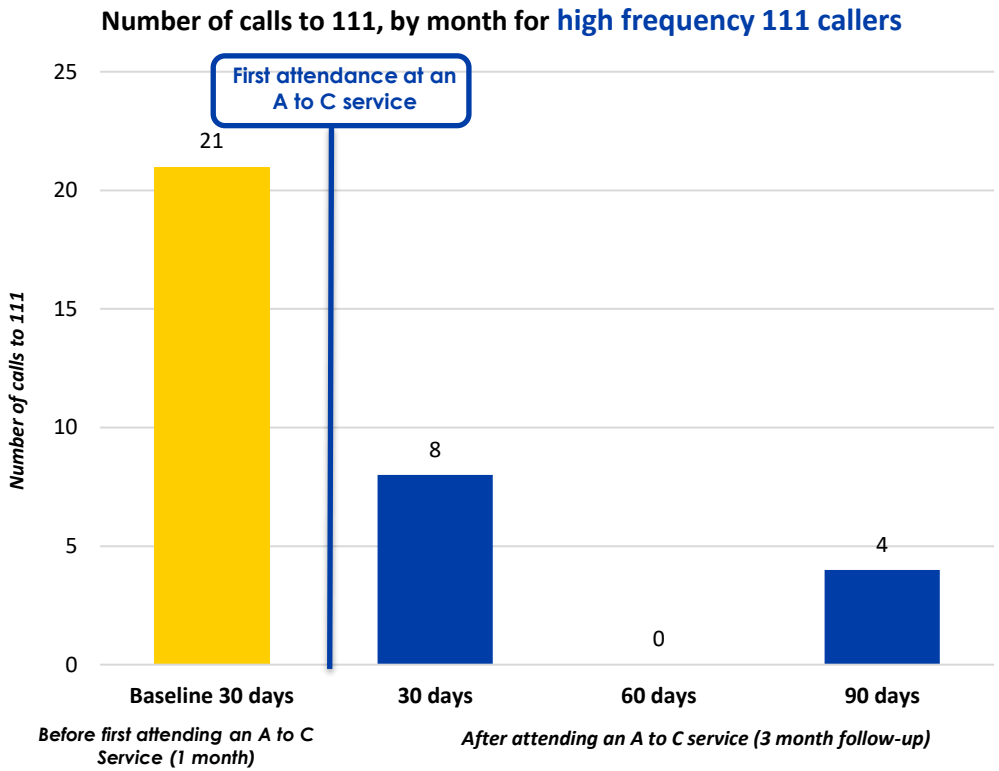
** Health innovation Wessex were not provided with 111 activity data for the Isle of Wight, therefore Newport Safe Haven and the Peer Support Service could not be included in this part of the analysis.*

111 usage

Number of calls to 111, by quarter for the
Safe Haven frequent attendee cohort



111 usage



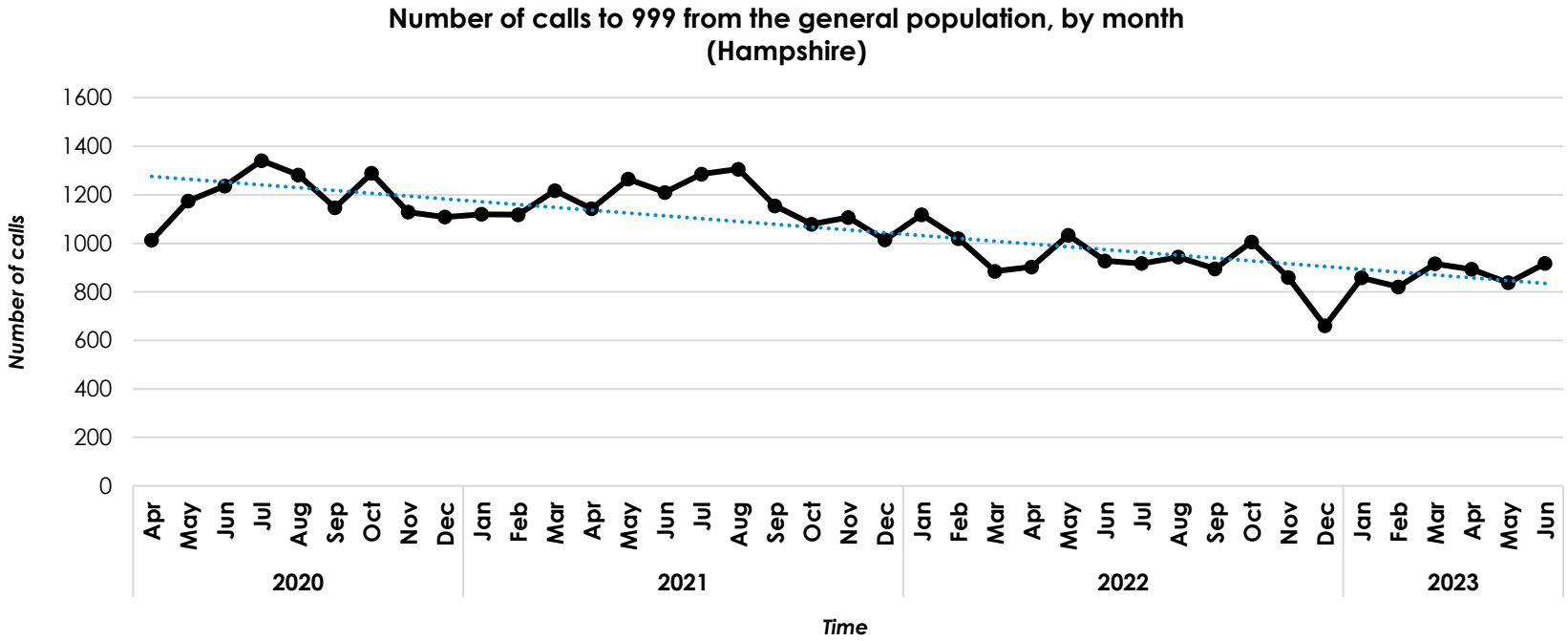
- Definitions for 'high frequency 111 caller' varied by NHS trust.
- The 111 Mental Health Triage Team defined this as someone who called 111 on eleven or more occasions in a one-month period. However, no-one from the A to C cohorts met this criteria.
- Therefore, for the purposes of the analysis, the IoW NHS Trust definition was adopted. They defined a 'high frequency 111 caller' as someone who called 111 three times or more over a 96-hour period.
- The timeframes for this analysis focused on 111 activity 30 days prior to first attending an A to C service and then over 90 days follow-up.
- This timeframe allowed exploration of the 111 usage data for 910 individuals.
- Five people were identified as meeting the IoW NHS Trust criteria for 'high frequency 111 caller'.

** The definition of a 'high frequency 111 caller' was based on guidance received from system experts including representatives from ED at St Mary's Hospital (IoW), Portsmouth Hospitals University NHS FT, University Hospital Southampton NHS FT and the 111 MH Triage Team.*

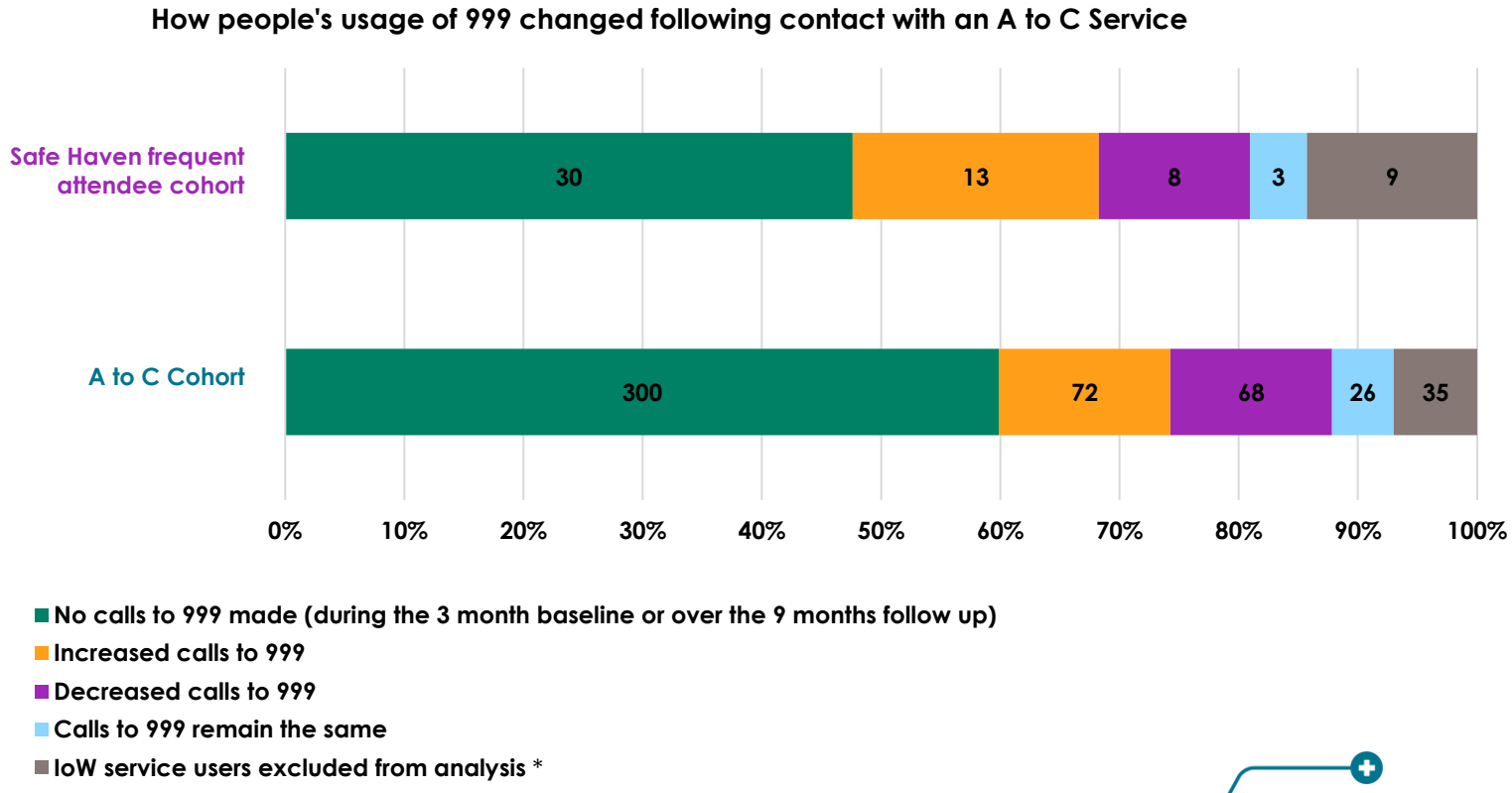
999 usage

999 calls

- Analysis of 999 usage was carried out by Health Innovation Wessex using data provided by the CSU from the South Central Ambulance Service 999 dataset.
- There was no data provided in relation to 999 call activity on the Isle of Wight, therefore the two Island-based services had to be excluded from the 999 analysis.
- Data was provided from 01 April 2020 to 30 September 2023.



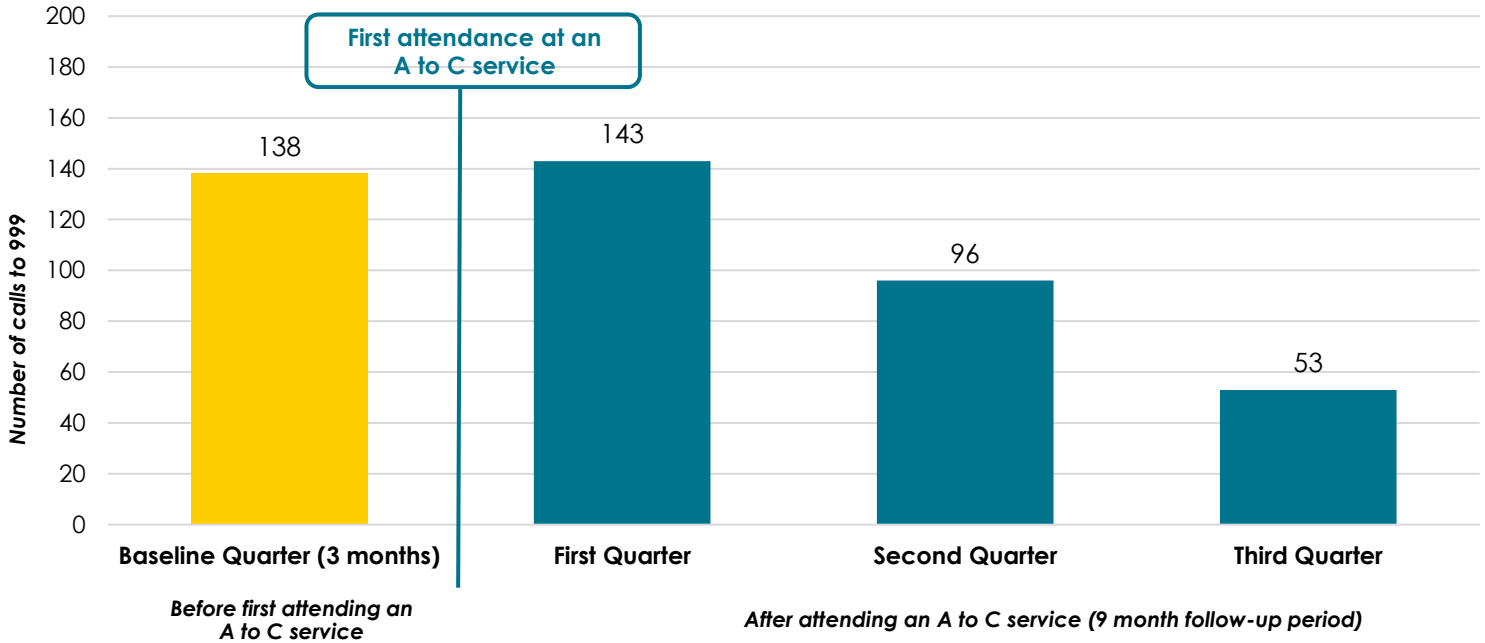
999 usage



** Health innovation Wessex were not provided with 999 activity data for the Isle of Wight; therefore, Newport Safe Haven and the Peer Support Service could not be included in this part of the analysis.*

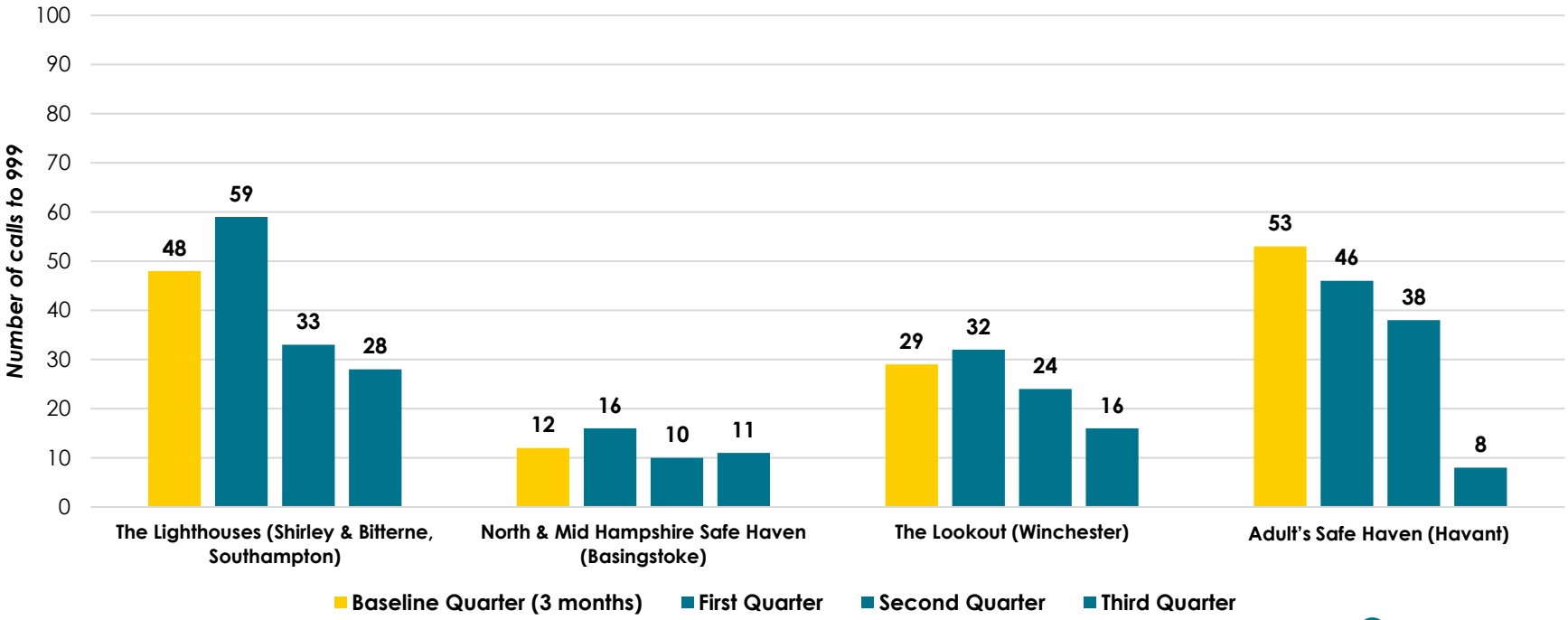
999 usage

Number of calls to 999, by quarter for the A to C cohort



999 usage

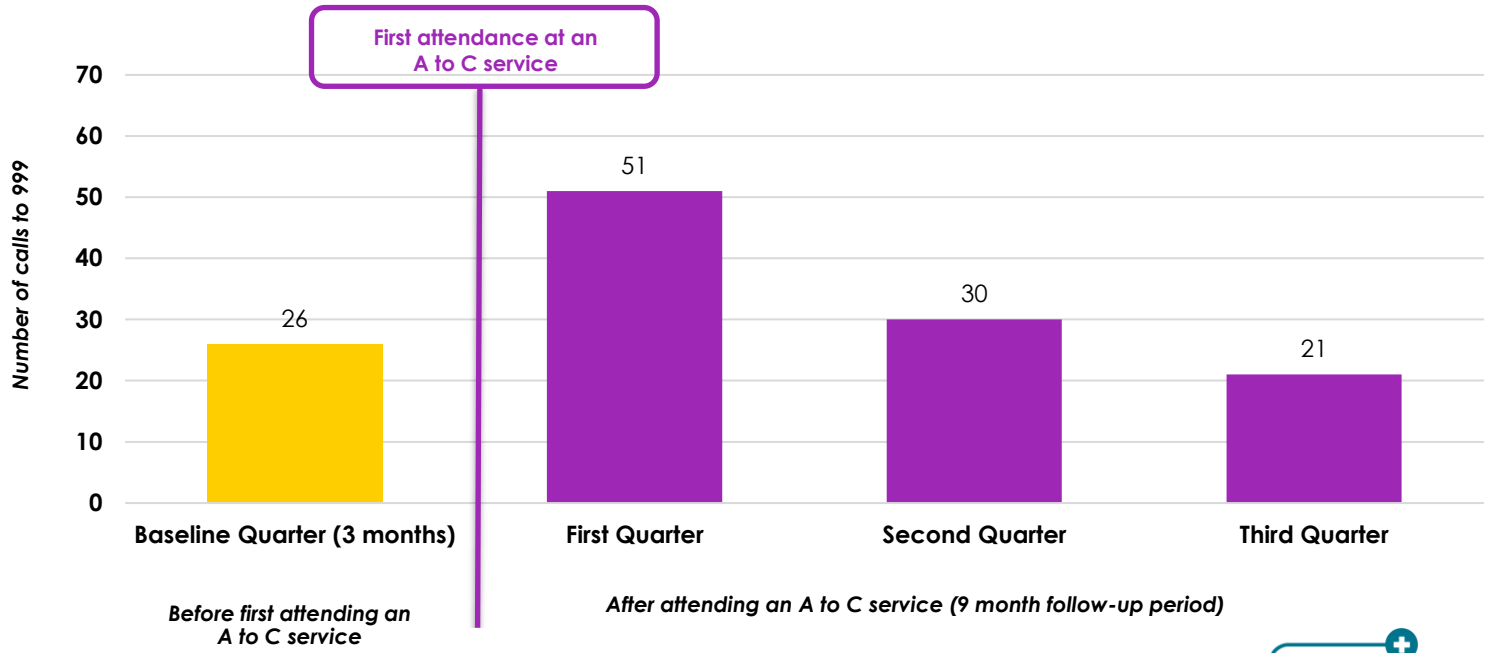
Number of calls to 999 for the A to C cohort, by A to C service



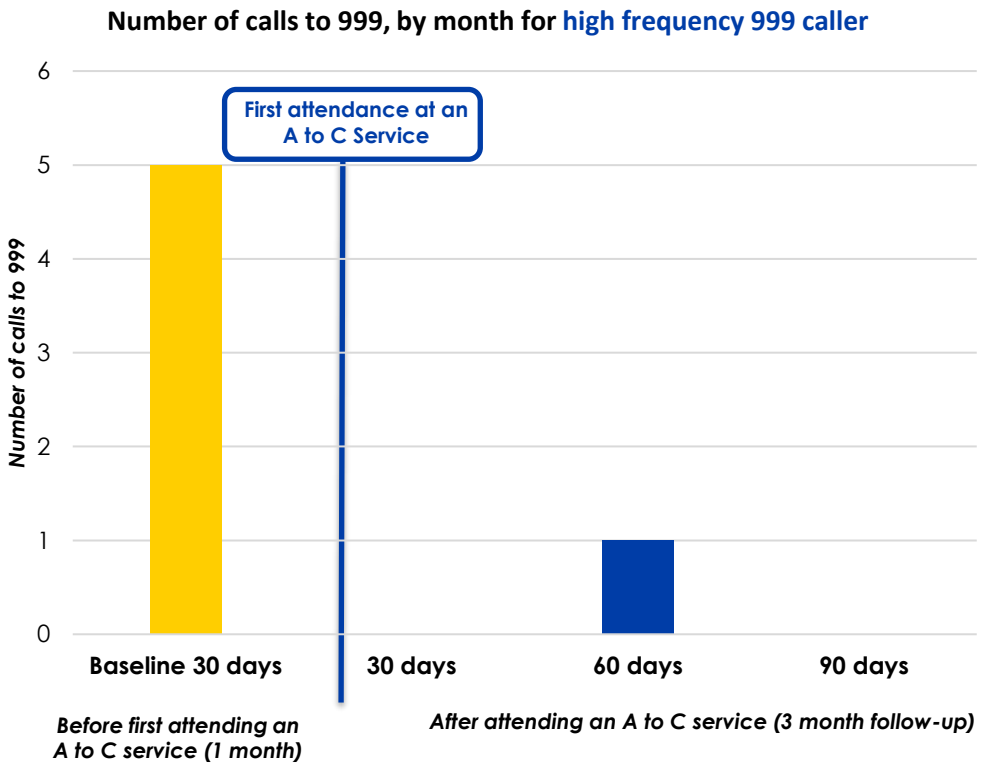
** Health Innovation Wessex was not provided with 999 activity data for the Isle of Wight, therefore Newport Safe Haven and the Peer Support Service could not be included in this part of the analysis.*

999 usage

Number of calls to 999, by quarter for the
Safe Haven frequent attendee cohort



999 usage



- Definitions for 'high frequency 999 caller' varied by trust.
- For the purposes of the analysis, a 'high frequency 999 caller' was defined as someone who called 999 five times or more within a month.
- The timeframes for this analysis focused on 999 activity 30 days prior to first attending an A to C service, and then over 90 days follow-up.
- This timeframe allowed exploration of the 999 usage data for 910 individuals.
- Only one person was identified as meeting the criteria for 'high frequency 999 caller'.

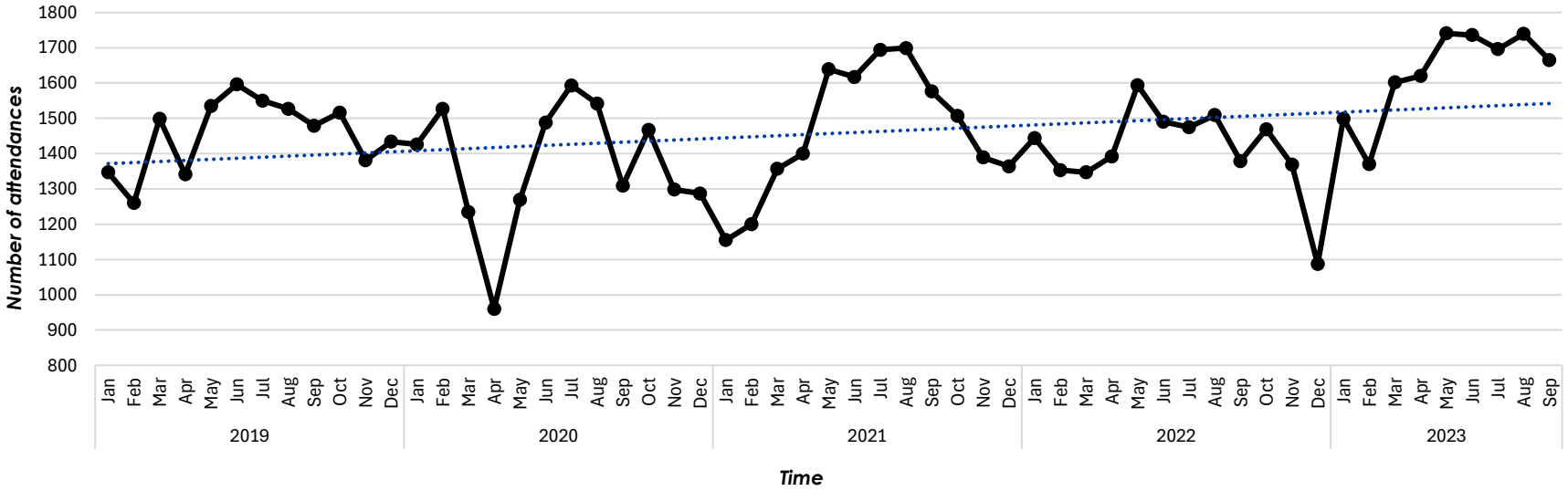
** The definition of a 'high frequency 999 caller' was based on guidance received from system experts including representatives from ED at St Mary's Hospital (IoW), Portsmouth Hospitals University NHS FT, University Hospital Southampton NHS FT and the 111 MH Triage Team.*

Mental health-related ED attendance

Mental health-related ED attendances

- Analysis of mental health-related ED attendances was carried out by Health Innovation Wessex using data provided by the CSU from the Emergency Care Data Set
- Data was provided from 01 April 2018 to 30 September 2023
- Attendances were identified as 'mental health-related' based on: Chief Complaint, Diagnosis Code and Comorbidity fields

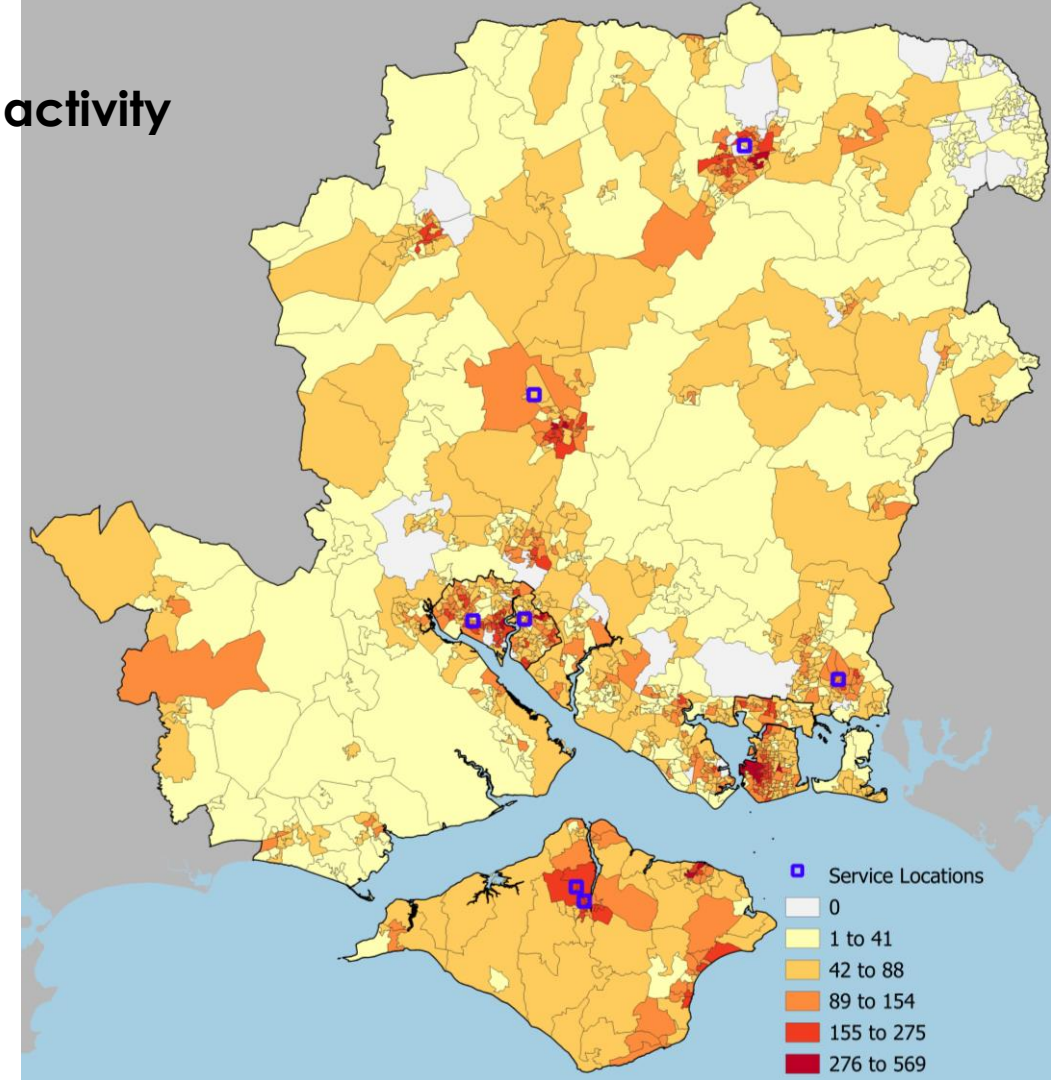
Number of mental health-related ED attendances for the general population (Hampshire & IoW), by month



Mental health-related ED activity

Choropleth map showing mental health-related Emergency Department activity across Hampshire and the Isle of Wight (April 2018 – September 2023)

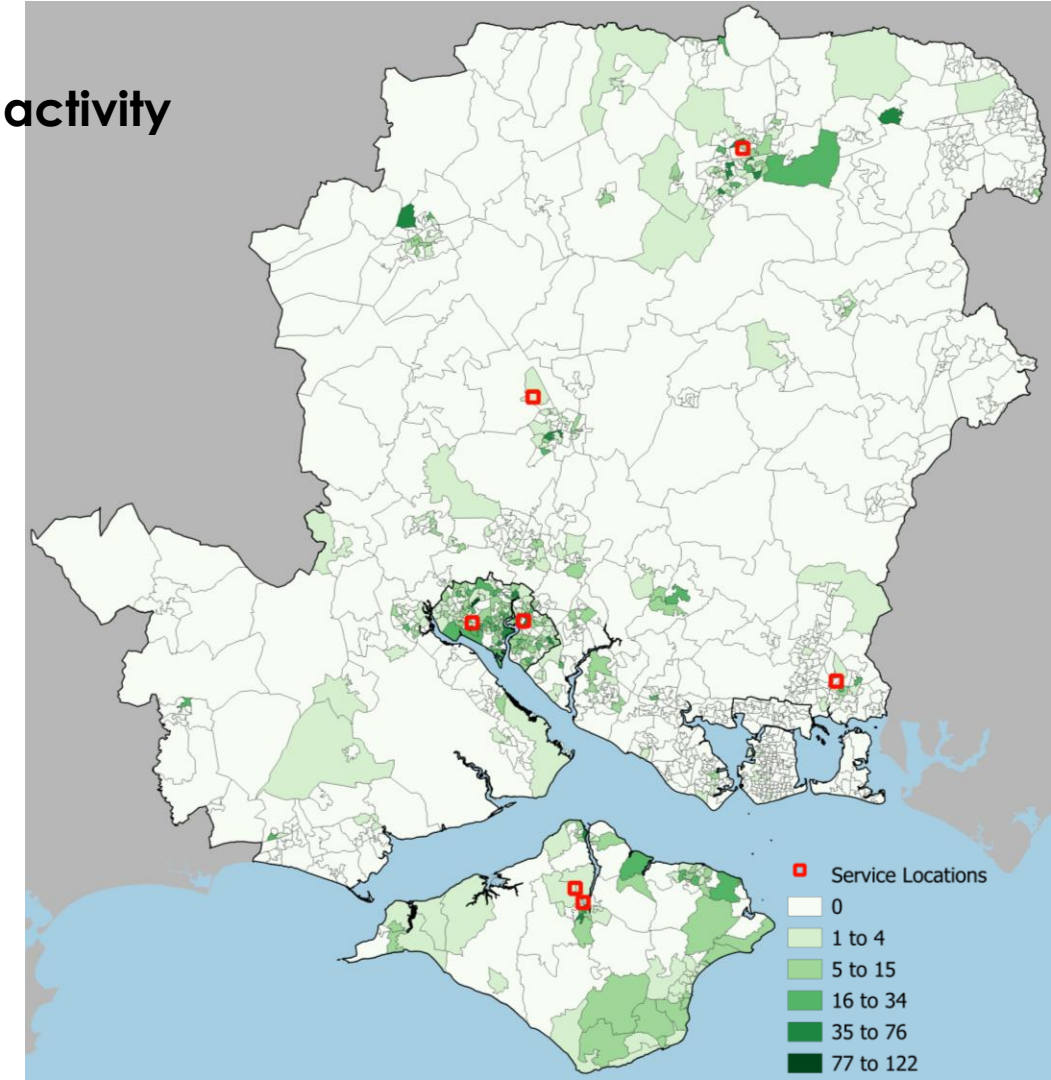
For each ED attendance provided by the CSU they also shared the Lower Super Output Area associated with the patient's place of residence. This map provides an indication of the areas across Hampshire and the Isle of Wight that are associated with the most mental health related ED attendances.



Mental health-related ED activity

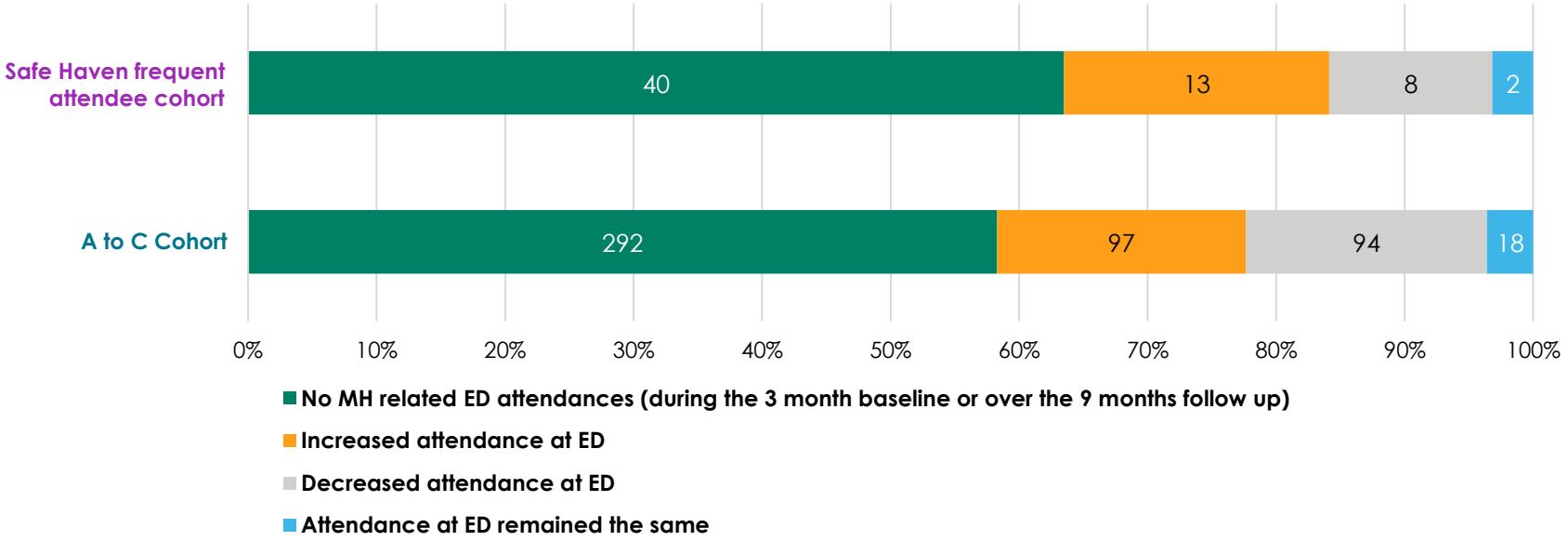
Choropleth map showing mental health-related Emergency Department activity between April 2018 – September 2023 across Hampshire and the Isle of Wight for people who were in contact with the Alternatives to Crisis services between April 2022 and June 2023.

For each ED attendance provided by the CSU they also shared the Lower Super Output Area associated with the patient's place of residence. This map provides an indication of the areas across Hampshire and the Isle of Wight that are associated with the most mental health related ED attendances for people who have been in contact with the Alternatives to Crisis Services.



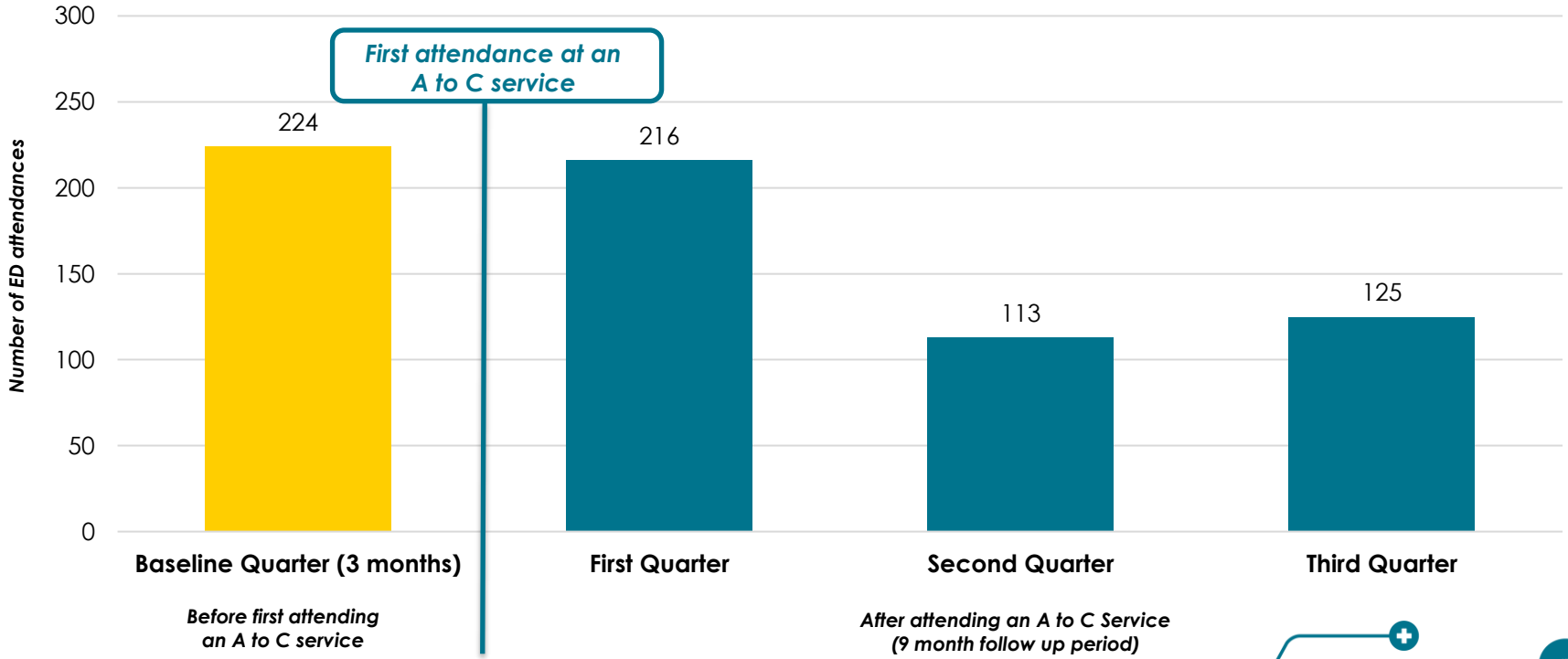
Mental health-related ED attendances

How people's mental health-related ED attendance changed following contact with an A to C service



Mental health-related ED attendances

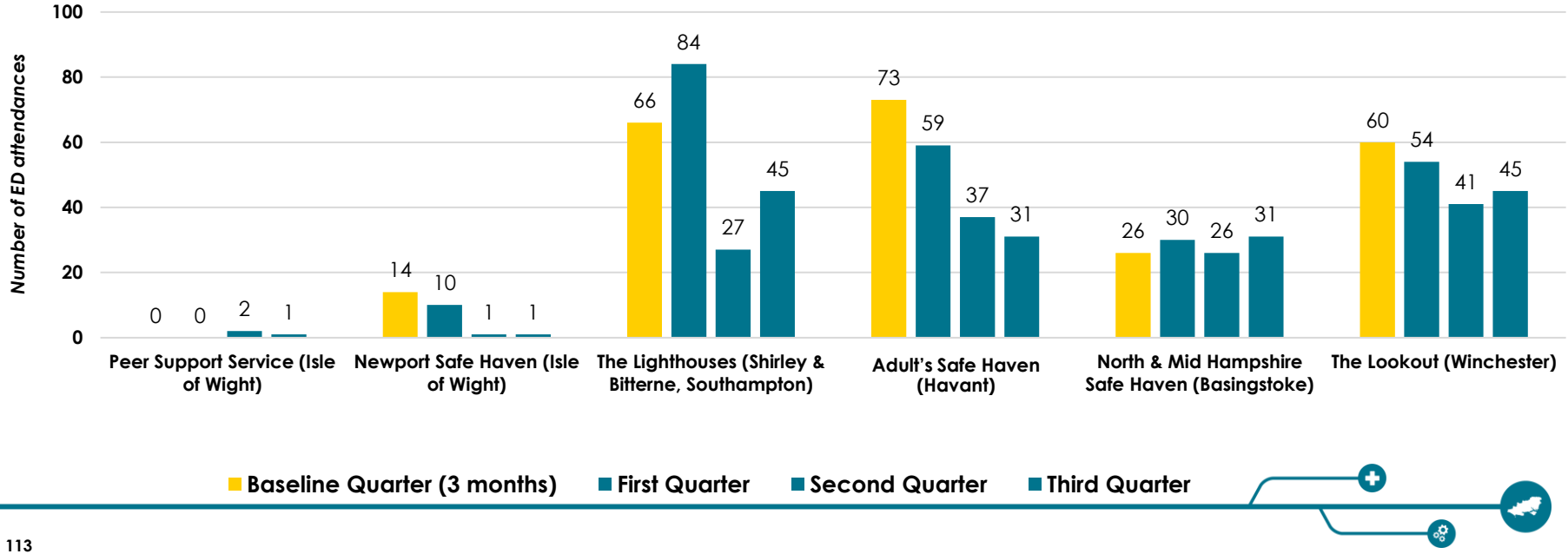
Number of mental health-related ED attendances, by quarter for the A to C cohort



Mental health-related ED attendances

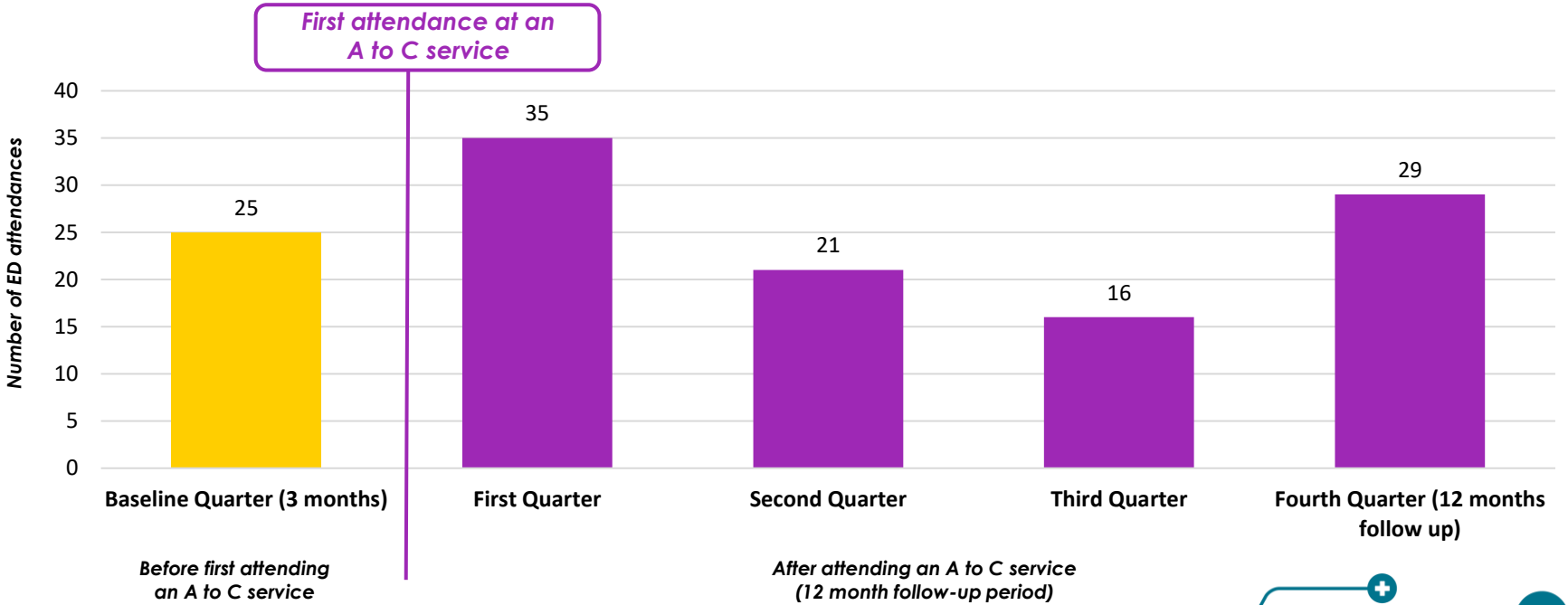
- Average monthly ED attendances decreased for all services, when comparing the three months prior to first attendance at an A to C service (baseline quarter) to the 9 month follow up period (first, second and third quarter), except for the Peer Support Service and North & Mid Hampshire Safe Haven, which both showed a slight increase in average monthly attendances.

Number of mental health-related ED attendances for the A to C cohort, by A to C service



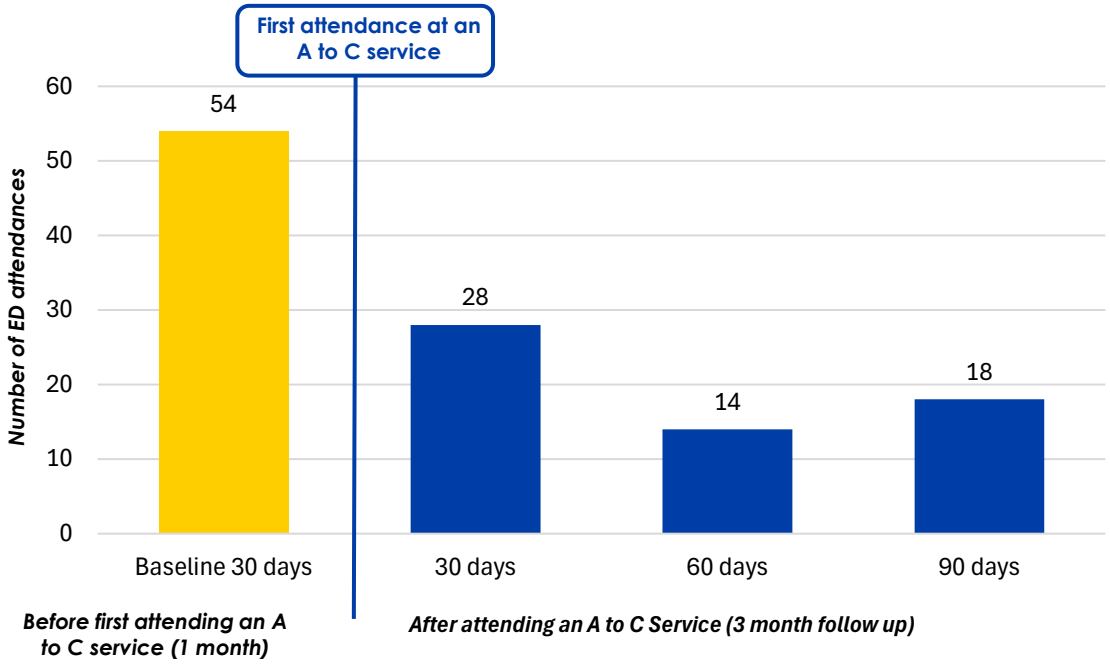
Mental health-related ED attendances

Number of mental health-related ED attendances, by quarter for the Safe Haven frequent attendee cohort



Mental health-related ED attendances

Number of mental health-related ED attendances, by month for high frequency attendees at ED



- Definitions for a 'high frequency attendee at ED' varied by Trust.
- For the purposes of the analysis, a 'high frequency attendee at ED' was defined as someone who attended ED for their mental health 4 times or more in the last 30 days prior to first attending an A to C service*.
- The time frames for this analysis focused on ED activity 30 days prior to first attending an A to C services and then over 90 days follow up.
- This time frame allowed exploration of the ED attendance data for 910 individuals.
- 11 people were identified as meeting the criteria for 'high frequency attendee at ED'.

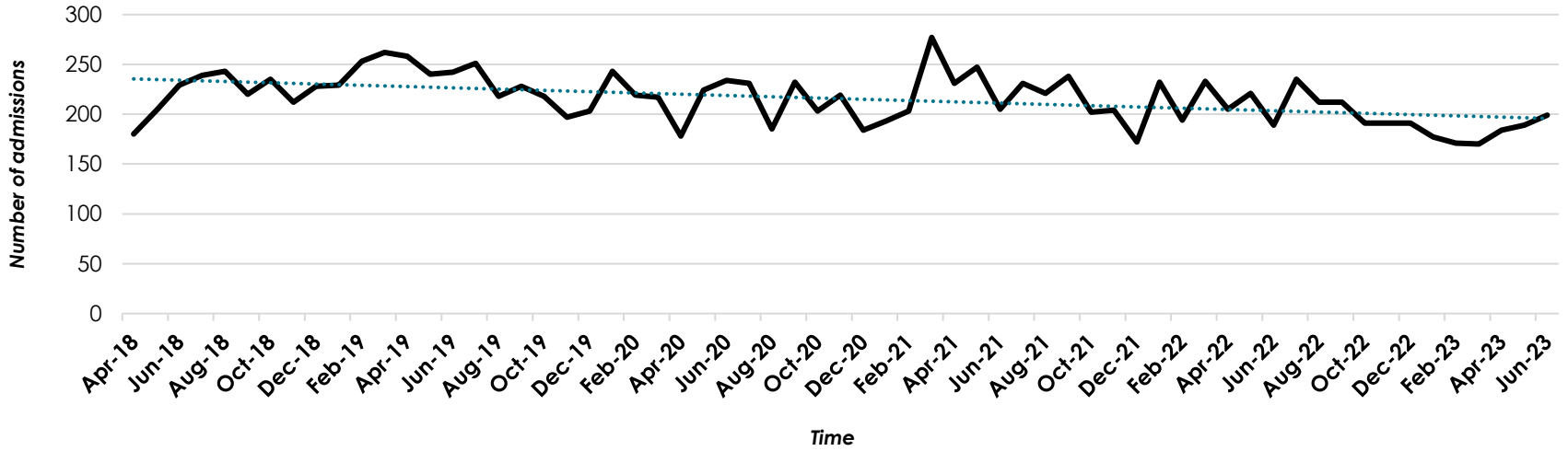
** The definition of a 'high frequency attendee at ED' was based on guidance received from system experts including representatives from ED at St Mary's Hospital (IoW), Portsmouth Hospitals University NHS FT, University Hospital Southampton NHS FT and the 111 MH Triage Team.*

Acute admissions

Mental health-related ED attendances

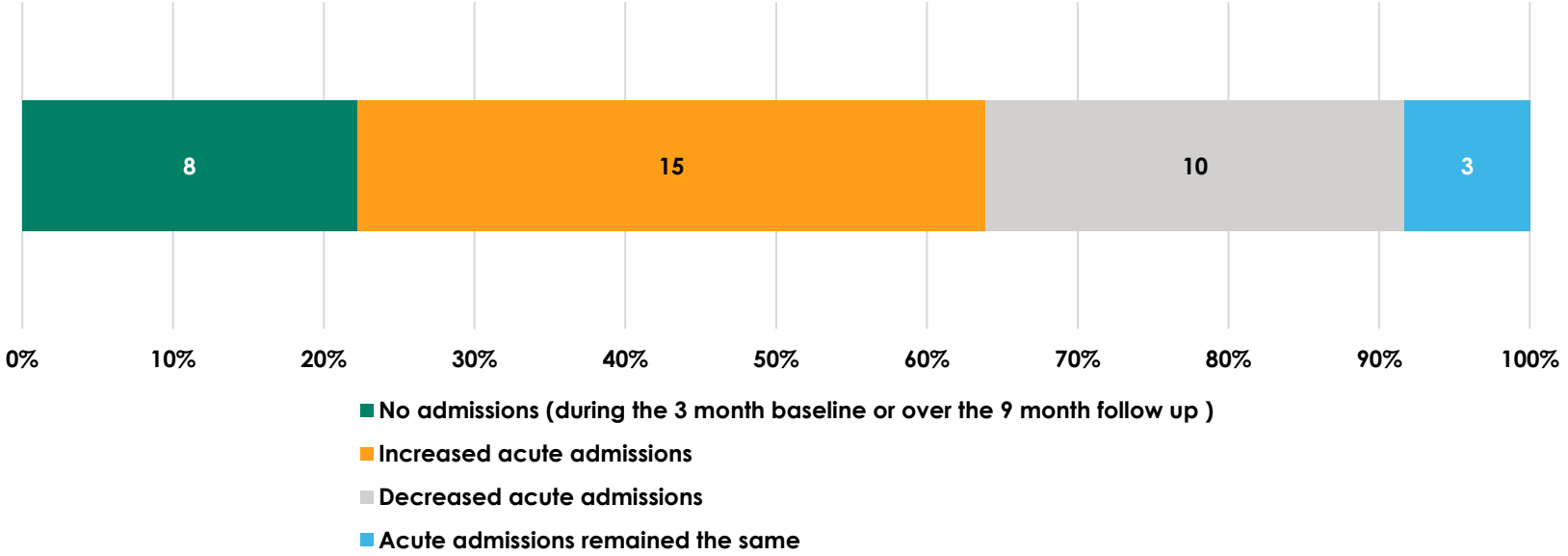
- Analysis of mental health-related acute admissions was carried out by Health Innovation Wessex using data provided by the CSU from the Mental Health Services Data Set
- Data was provided from 01 April 2018 to 30 September 2023
- Admissions acuity was determined by the CSU data analysts using a combination of the admission method (e.g. via the Crisis Resolution Home Treatment Team), the priority type, and the 'Clinical Care Intent' description, i.e. short stay, long stay, intensive care.

Number of acute mental health-related admissions for the general population (Hampshire & IoW), by month

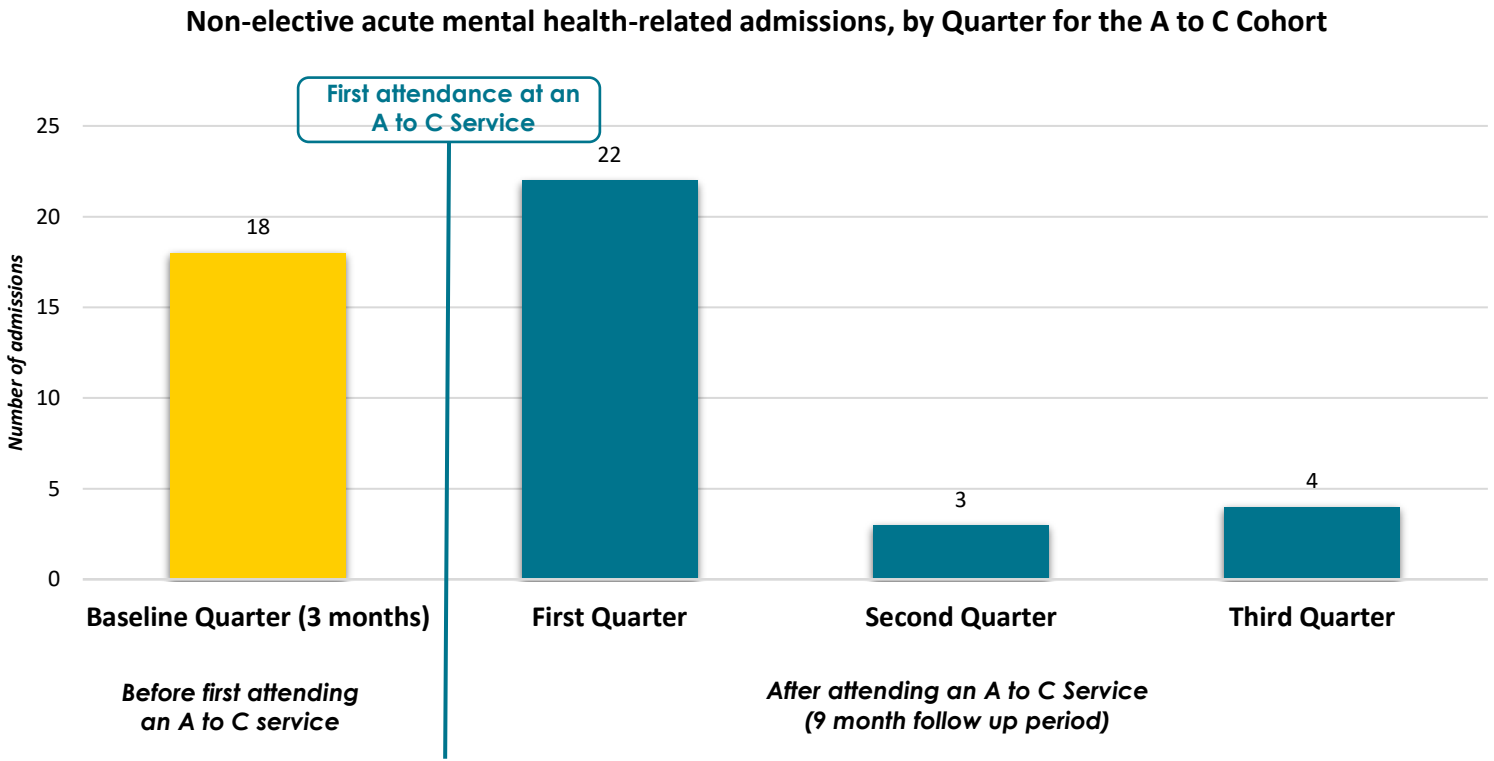


Mental health-related acute admissions

How people within the A to C Cohort's mental health-related acute admissions changed following contact with an A to C service



Admissions to acute mental health beds



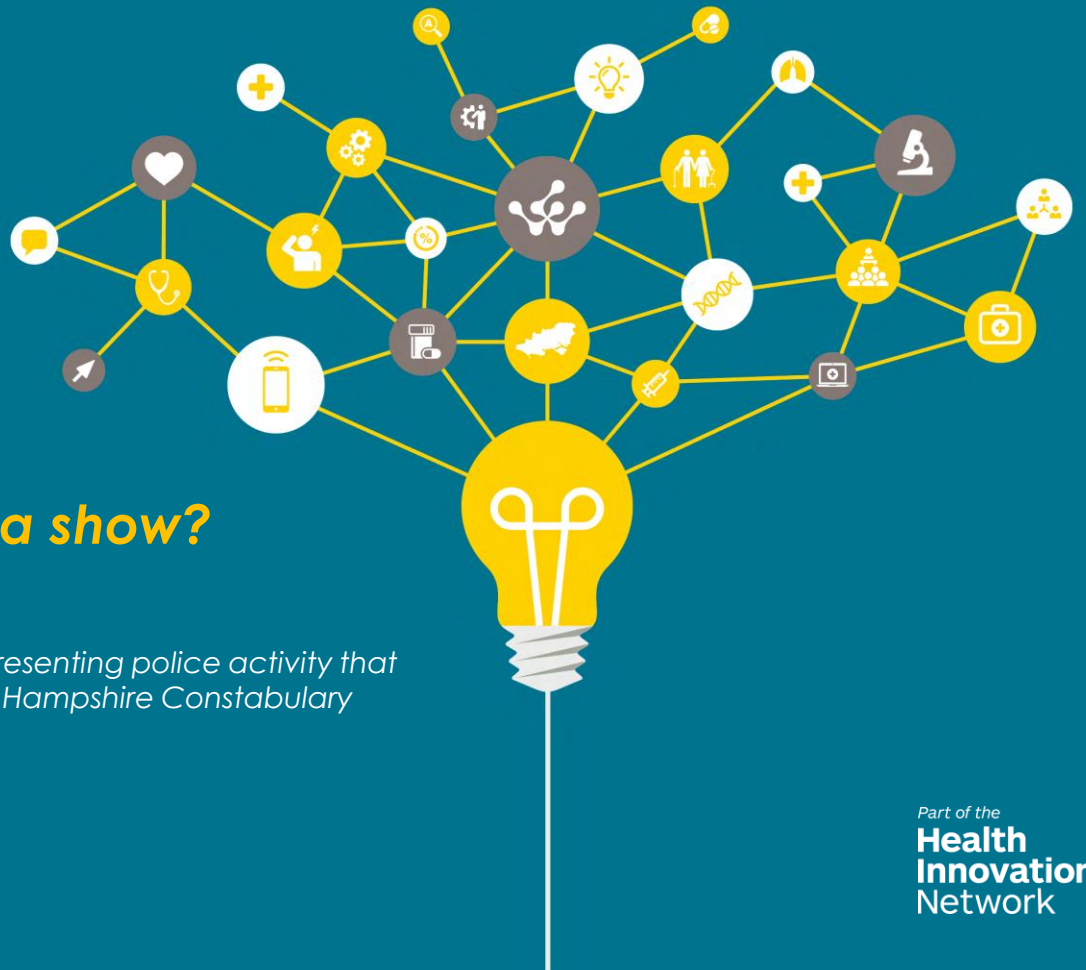
Limitations for the quantitative analysis

Limitations

- *Analysis for the A to C cohort was limited to people who had contacted an A to C service for the first time between 01 April 2022 and 21 December 2022, as nine months of follow-up data was required for inclusion.*
- *Without a control group, reductions in NHS healthcare service utilisation cannot definitively be attributed to the A to C services; an appropriate control group would allow comparative analysis to understand what would happen to activity if the A to C services had not been available.*
- *There was no data provided in relation to 999 and 111 activity for the Isle of Wight. The CSU extracted data from the South Central Ambulance Service (SCAS) datasets, which does not cover the Island, as 111 and 999 activity for the Isle of Wight goes through the Isle of Wight Ambulance Service (IWAS), not SCAS.*
- *Follow-up time was set to nine months for the A to C and Safe Haven frequent attendee cohorts, and to three months for the NHS high frequency contact cohort, in order to ensure the maximum number of people could be included within the analysis. However, a longer follow-up period across all cohorts would allow a greater exploration of long-term impact.*

Limitations – specific to the admissions data

- *Trends seen within the acute admissions data are heavily dependent on clinical need and system capacity. Whereas use of 999, 111 or ED attendance are impacted by the personal choice of the individual.*
- *Without data on survival, suicide rates cannot be accounted for within the analysis. The admissions data which focuses on small numbers of acutely unwell individuals has the potential to be particularly vulnerable to the impact of this. Lower admissions or presentations to other services may be due to the denominator being reduced.*
- *It was not possible to present admissions data analysis for the* **Safe Haven frequent attendee** and **high frequency contact** *cohorts due to small number suppression. Furthermore, the impact of individual level variability and therefore chance becomes too great when examining such small numbers.*



What does the police data show?

- *This section presents a choropleth map representing police activity that was flagged as a mental health-related by Hampshire Constabulary*

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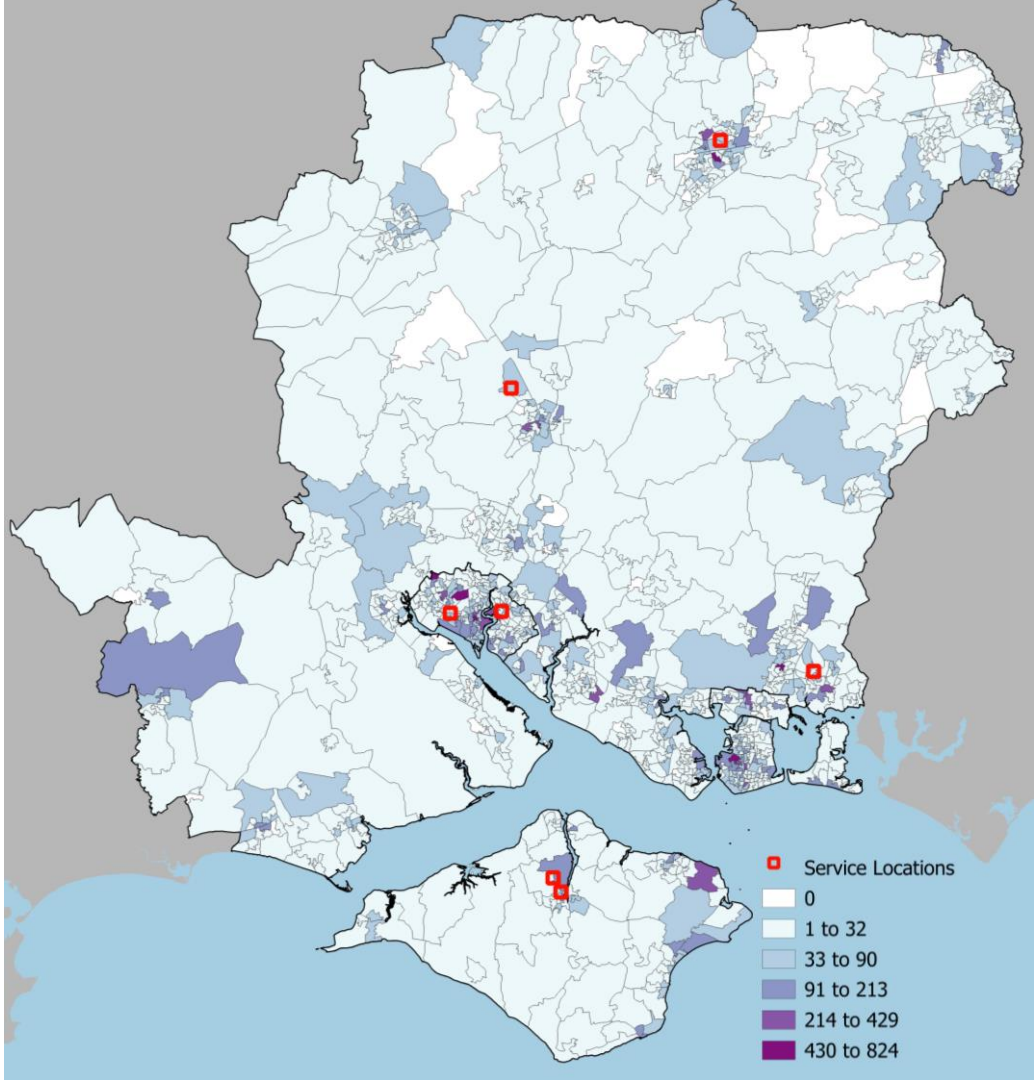
Police activity data

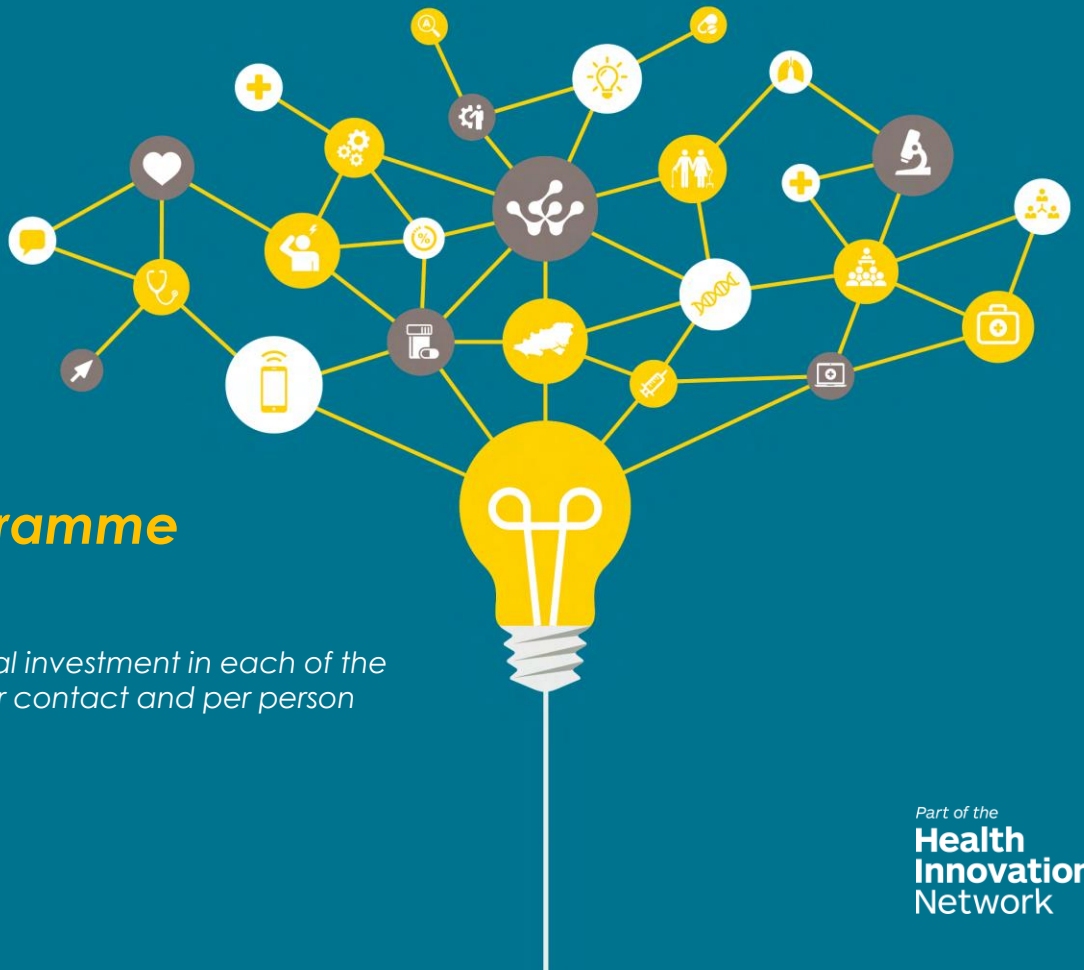
The choropleth map shows police activity reported across Hampshire and the Isle of Wight from 2020 to 2023

- *This data was provided by Hampshire Constabulary*
- *The data includes:*
  - *Mental health-related deployments*
  - *Section 136 activity*
  - *Section 135 activity*



Limitations

- *The initial intention was to compare police activity before and after the introduction of the A to C services. However, Hampshire Constabulary changed the way they collected data on mental health-related incidents in 2020, which has restricted analysis as several services opened prior to this date, so a programme level before and after analysis was not possible.*



Alternatives to Crisis Programme costings

This section provides an overview of the annual investment in each of the A to C services, along with indicative costs per contact and per person supported

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Alternatives to Crisis Programme investment

Service	Place	Funding 19/20	Funding 2020/21	Funding 21/22	Funding 22/23	Funding 23/24	Funding Type
Adults' Safe Haven (Havant)	**South East Hampshire**	£ 219,000*	£ 296,498	£ 345,000	£ 345,000	£ 375,000	• Service Development Funding (SDF)** - Community / Crisis • Hampshire and Isle of Wight Integrated Care Board (South East baseline spending) • Southern Health Foundation Trust funding (£120,000 per annum)
The Lookout (Winchester)	**Mid and North Hampshire**	~~£ 267,787~~***	£ 400,721	~~£ 132,934~~***	*£400,721****	£ 400,721	SDF - Community / Crisis
North & Mid Hampshire Safe Haven (Basingstoke)	**Mid and North Hampshire**			£ 176,301	£ 272,908	£ 281,650	SDF - Crisis Alternatives
The Lighthouse (Shirley)	**Southampton**	Approx £500k	Approx £500k	Approx £500k	Approx £500k	Approx £500k	Place Based Funding
The Lighthouse (Bitterne)	**Southampton**			£ 255,871	£ 255,871	£ 255,871	SDF - Crisis Alternatives
The Lighthouse - Top Up	**Southampton**				£ 62,000	£ 62,000	Adult Crisis / Liaison Flexible Funding
Newport Safe Haven (Newport, Isle of Wight)	**Isle of Wight**				£ 145,000	£ 145,000	Place-based funding (3yr+2 contract)
Peer Support Service - Integrated Mental Health Hub (IMHH) (Newport, Isle of Wight)	**Isle of Wight**			£ 166,853	£ 140,453	£ 140,453	SDF - Crisis Alternatives

** Adults' Safe Haven (Havant) launched in quarter 4 of 2019/20, costs for that year include initial one off set up costs*
***Service Development Funding (SDF) supporting the delivery of the NHS Long Term Plan commitments.*
****Annual running cost for The Lookout is £400,721. Funding for 2022/2023 was rolled forward from 2019/2020 & 2021/2022.*

Alternatives to Crisis Programme costings

- approximate cost per contact and per person

Alternatives to Crisis service	Annual running cost for financial year 2022 / 2023 (April 2022 – March 2023)	Descriptor	Number of contacts / people supported in April 2022 - March 2023	Cost per contact/person
The Lookout (Winchester)	**£400,721**	*number of contacts*	122	£3,285*
		number of people	100	£4,007*
Peer Support Service - (IMHH) (Isle of Wight)	**£140,453**	*number of contacts*	880	£160
		number of people	35	£4,013
The Lighthouses (Shirley & Bitterne)	**£817,871**	*number of contacts*	3186	£257
		number of people	378	£2,164
Newport Safe Haven (Isle of Wight)	**£145,000**	*number of contacts*	438	£331
		number of people	66	£2,197
North and Mid Hampshire Safe Haven (Basingstoke)	**£272,908**	*number of contacts*	1117	£244
		number of people	118	£2,313
Adults' Safe Haven (Havant)	**£345,000**	*number of contacts*	2043	£169
		number of people	346	£997

** N.B: the average length of stay at The Lookout during the evaluation period was 13.4 days.*

NHS healthcare service costings for comparison

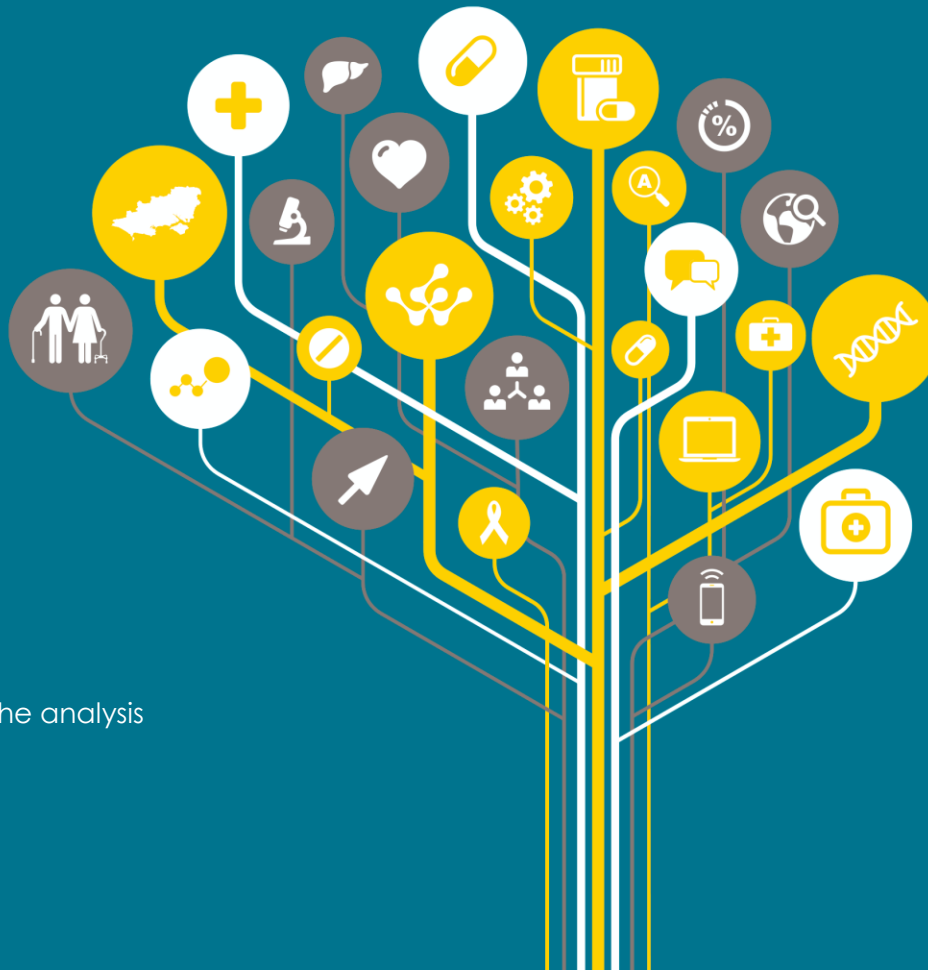
Descriptor	Value	Data source
Cost per bed day in an acute mental health bed for 2022/23	£684.40	Figure quoted by the Deputy Director of Finance, Southern Health NHS Foundation Trust
Average length of stay (LoS) (excluding leave) in an acute setting for 2022/23	38 days	Figure quoted by the Deputy Director of Finance, Southern Health NHS Foundation Trust
Average cost of an acute admission	£26,007.20	Occupied bed day cost x average LoS
Average cost of an ED attendance	£197	From the 2023 national tariff for ED, based on the median value

Limitations

- *The costings presented are for illustrative purposes only.*
- *There are too many confounding variables and unknowns within the data to provide a reliable economic analysis. For instance, the intention had been to share a case study focusing on The Lookout, however the analysts working on the project have advised that:*
  - *Direct comparison with acute admissions data will be unreliable as admissions are heavily dependent on clinical need and system capacity.*
  - *Without data on survival, suicide rates cannot be accounted for within the analysis. The admissions data which focuses on small numbers of acutely unwell individuals has the potential to be particularly vulnerable to the impact of this. Lower admissions or presentations to other services may be due to the denominator being reduced.*
  - *Due to the small numbers of people involved the impact of individual level variability and therefore chance becomes too great.*
- *Health Innovation Wessex recommend that this is an area for further investigation by a health economist.*

Conclusion

This section outlines the key messages from the analysis



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Conclusion

The findings from this evaluation indicate a positive direction of travel for the Safe Haven services and The Lookout. Insufficient data was provided for the peer support service on the Isle of Wight to reliably evaluate it. Feedback collected through questionnaires from emergency response partners and primary care colleagues indicates that the services are valued by stakeholders across the system. However, more needs to be done to raise awareness about the services.

The individual service profiles show there is local variation between the services in terms of how they are staffed and in some instances the level of need of the people they support. The findings from North and Mid Hampshire Safe Haven indicate that more system input may be needed to support people with emotionally unstable personality disorder in the north and mid Hampshire area, for example. All the Safe Havens flagged the issue of frequently returning attendees and raised the question of how best to support these individuals moving forward. Adults' Safe Haven (Havant) have adapted by setting up a regular peer support group to run alongside their service.

Not all the services have dedicated Peer Support Workers (PSWs), but those that do have shown them to be a valuable part of the workforce. Feedback from the people using the services highlighted the appreciation for being able to speak to someone who 'really understood' what they were going through.

Conclusion

Staff working alongside or managing the PSWs also provided positive feedback regarding their peer colleagues. However, the importance of good training and support for peers was also emphasised. Without suitable training for peers, it can be hard to manage boundaries, and this can place increased pressure on those managing and supporting them.

Four out of seven services were able to provide Adapted Subjective Units of Distress Scores for their attendances, which indicated that they are effectively able to support crisis de-escalation, as shown by the average 2.2 decrease in score. Furthermore, the feedback from people using the A to C services was positive, with several people crediting the services as saving their lives.

The general trends suggest that contact with an A to C service could help reduce the average monthly use of emergency services, such as 111, 999, and ED; however, data limitations and local variation between services, as well as the impact of frequent service users, all warrant further investigation.

Appendices

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Appendices

- **Appendix I:** Data Requirements and Information Governance Process
- **Appendix II:** Scoping report
- **Appendix III:** Alternatives to Crisis Programme logic model and individual project logic models
- **Appendix IV*:** Alternatives to Crisis Programme evaluation 'evaluability review' **This appendices is for client information only; not for publication or onwards circulation.*
- **Appendix V:** People who used the A to C services – Findings from the interviews
- **Appendix VI:** Staff and Peer Support Worker surveys
- **Appendix VII:** Findings from the Rapid Insight Event – June 2022
- **Appendix VIII:** Findings from the Rapid Insight Event – April 2023
- **Appendix IX:** Primary Care survey
- **Appendix X:** Emergency Responder survey

Appendix I:
Data requirements and information governance process

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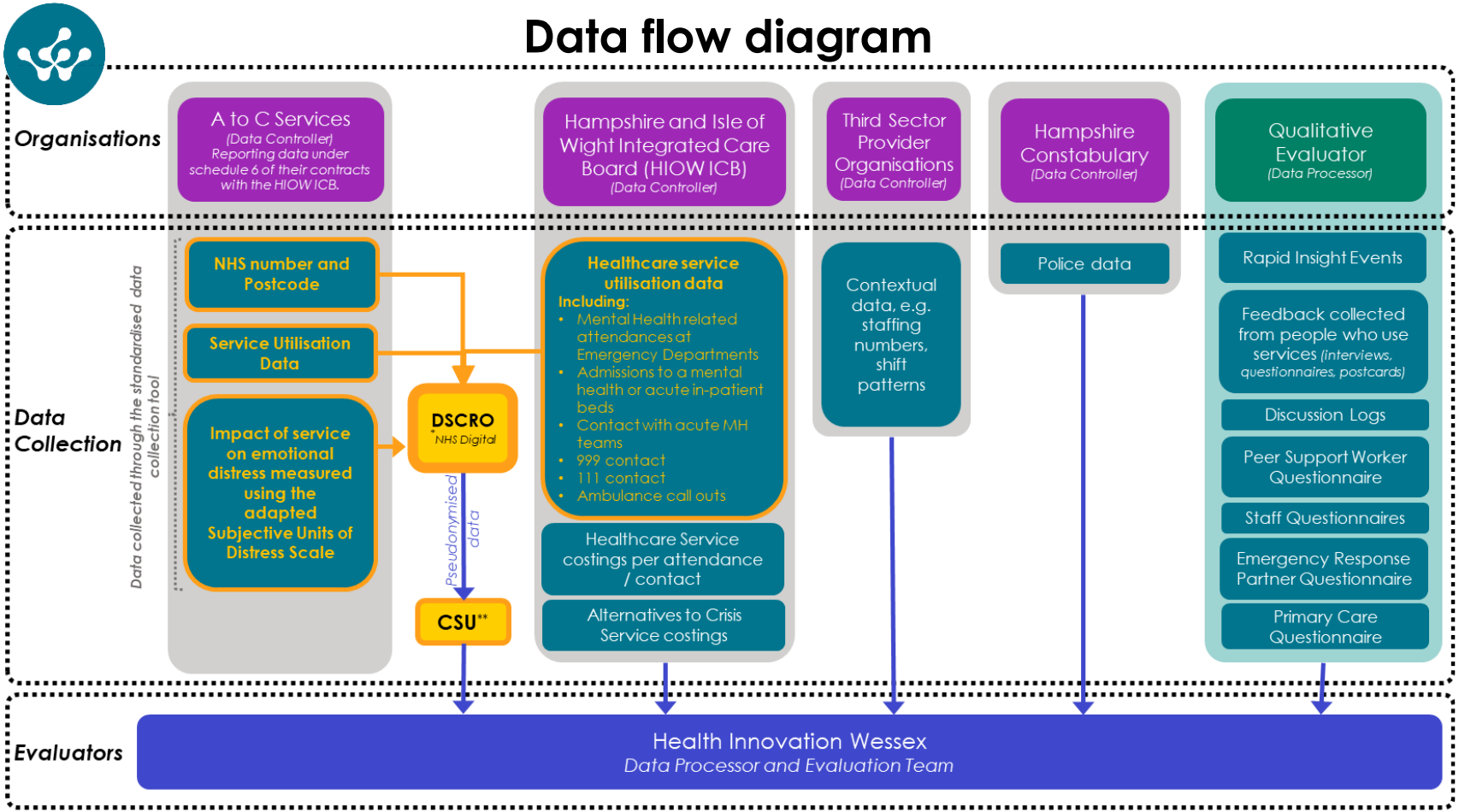
Data requirements

	Question	Data Source

1.	**What impact has the A to C Programme had on local emergency and mental health crisis services?**	• **Local flow data from the A to C services** (collected through the Standardised Data Collection Tool)
		• **Healthcare utilisation data provided by South, Central and West Commissioning Support Unit:**
		  • Secondary Uses Service (SUS) data
		  • Mental Health Services Data Set (MHSDS) data
		  • Community Services Data
		• **Hampshire Constabulary Data**

2.	**What impact has the A to C Programme had on the people who use the services and their carers?**	• **Local flow data from the A to C services containing Subjective Units of Distress Scores to measure impact on emotional distress** (collected through the Standardised Data Collection Tool) • **Voluntary Sector Data** – demonstrating uptake of other support services • **Qualitative data collection**
3.	**What impact have the A to C services had on addressing local inequalities?**	• **Local flow data from the A to C services containing personal characteristics data** (either collected directly by each service or pulled from medical records to populate the Standardised Data Collection Tool and then submitted to NHS Digital under schedule 6 of the service contracts) • **Local population data** – Office for National Statistics
4.	**What is the experience of peer support from the perspective of those that interact with the service, internal colleagues, people using the services, and the peer support workers themselves?**	• **Qualitative data collection** • **Local flow data from the A to C services** (collected through the Standardised Data Collection Tool and submitted to NHS Digital under schedule 6 of the service contracts)
5.	**What is the cost-effectiveness of the A to C Programme by service model in 2022/23?**	• **Local flow data from the A to C services** (collected through the Standardised Data Collection Tool and submitted to NHS Digital under schedule 6 of the service contracts) • **Number of avoided Emergency Department (ED) attendances / Crisis Team contacts**

Data flow diagram



*DSCRO: Data Services for Commissioners Regional Office

**CSU: Commissioning Support Units are NHS organisations that provide Integrated Care Boards with external support, specialist skills and knowledge to support them in their role as commissioners.

Information governance

Information governance (IG) advisors for the evaluation:

- **Adam Tuckett (Information Governance Consultancy Lead, Transformation Directorate – NHS SCW Commissioning Support Unit)**
- **Wendy Lee (DSCRO and IG Lead, Data Management and Architecture, NHS Digital DSCRO South, Central Southern and South West in co-operation with NHS SCW CSU)**

IG process:

- IG requirements identified to allow person level data to flow from the A to C services to NHS Digital's Data Services for Commissioners Regional Office (DSCRO) for pseudonymisation; and then from NHS Digital to the Commissioning Support Unit (CSU)* for analysis.
- Relevant documentation drafted (DPA) (March 2022 – September 2022). This included: Data Protection Impact Assessment (DPIA), Data Sharing Agreement (DSA) and Data Processing Agreement
- Documentation reviewed by the IG Advisory Panel (14 September 2022)
- DPIA, DPA and DSA finalised and circulated to IG leads / Data Protection Officers (16 November 2022)

**CSU: Commissioning Support Units are NHS organisations that provide Integrated Care Boards with external support, specialist skills and knowledge to support them in their role as commissioners.*

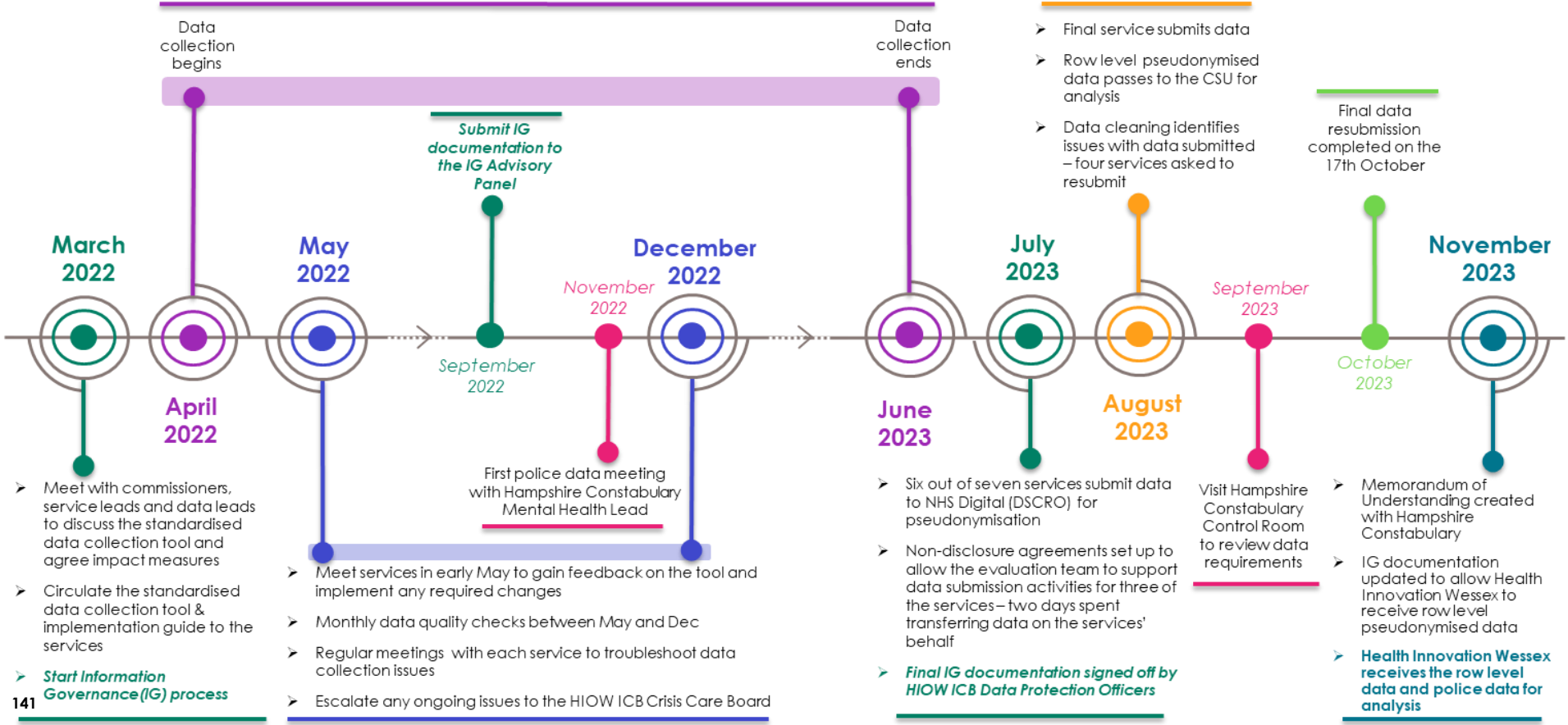
Information governance

IG process continued…

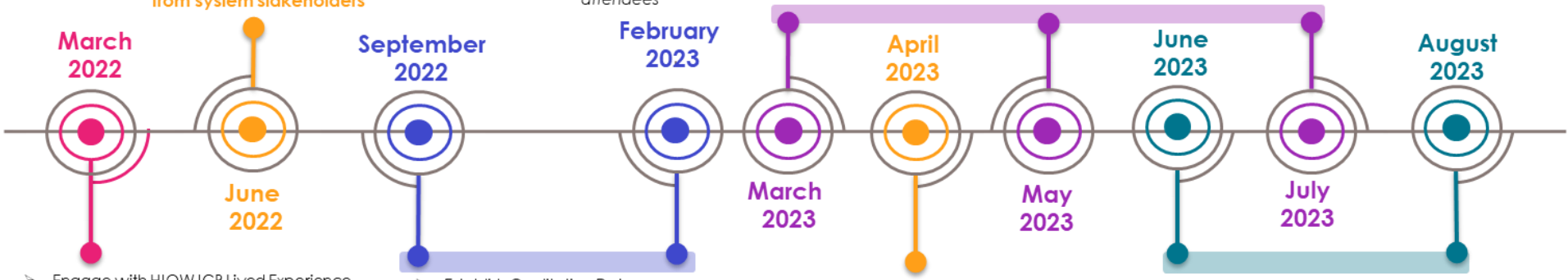
- Cyber security approval granted for Health Innovation Wessex's cloud-based server and data sharing agreement signed by NHS Digital's Data Access Request Service (April 2023)
- Amendments to schedule 6 of the service contracts finalised to allow data to flow from the services to NHS Digital (June 2023)
- DPIA, DPA and DSA signed off by IG leads / Data Protection Officers (final DPA signed July 2023)

- Amendments made to North & Mid Hampshire data sharing agreement to allow NHS Digital to use names, dates of birth, gender and area of residence to look up NHS numbers on the service's behalf (July 2023)
- Non-disclosure agreements created to allow Katherine Gale, Health Innovation Wessex and Saskia Sheehan, HIOW ICB to manually assist three of the services with their data submission
- Memorandum of Understanding between Health Innovation Wessex and Hampshire Constabulary created to allow the sharing of anonymised incident level police data (November 2023)
- DPA & DPIA updated to allow Health Innovation Wessex to receive row-level pseudonymised data (November 2023).

Quantitative data collection activity timeline



Qualitative data collection activity timeline



March 2022

- Engage with HIOW ICB Lived Experience Lead and set up Joint Working agreement
- Begin reviewing existing service feedback questionnaires
- Meet with commissioners, service leads and data leads to discuss approaches to collecting feedback from people who use services
- Begin planning for the first rapid Insight Event

June 2022

First Rapid Insight Event held to collect feedback from system stakeholders

September 2022

- Establish Qualitative Data Collection Working Group
- Codesign online questionnaires and postcard questionnaire.
- Review questions and format with system experts and people who use services

February 2023

Qualitative data collection from people who use the services begins:

- *Visit each 'in person' A to C service to deliver the postcard questionnaires, a lockable ballot box, a set of pens, and a promotional poster*
- *Online questionnaire to collect feedback from people who use services goes live – services asked to circulate link to old and new attendees*

March 2023

Second Rapid Insight Event held to collect feedback from system stakeholders

- Online questionnaire to collect feedback from people who use services promoted on HIOW ICB Social Media Platforms and added to the HIOW ICB Involve Platform
- Develop plan for interviews with people who use services

April 2023

Data collection from Primary Care and Emergency Partners begins:

- *Questionnaires go live – links to questionnaires circulated to relevant HIOW ICB contacts*
- *Primary Care questionnaire included in GP Bulletin*

May 2023

- Finalise interview schedules and supporting materials for people who use the services
- To ensure inclusivity and accessibility supporting materials include:
  - *An easy read information sheet*
  - *Information video inviting people to participate*
  - *Love2Shop vouchers to thank interview participants for their time*
- Interview recruitment begins

June 2023

- **Staff and Peer Support Worker questionnaires circulated to services** at the start of July
- **All online questionnaires close: end of July**
- *Ballot boxes and completed postcard questionnaires collected*

July 2023

Interviews take place

Health Innovation Wessex

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