Appendix II: SCOPING REPORT

Alternatives to Crisis mental health services

Hampshire and Isle of Wight

The following table has been included to assist anyone who is new to the Alternatives to Crisis Programme. Several of the services and organisations involved with this evaluation have changed name over the project's lifespan. Please see below:

Service name in Final Report	Service name used in Scoping Report
Lighthouse (Shirley)	Lighthouse West
Lighthouse (Bitterne)	Lighthouse East
Adults' Safe Haven (Havant)	Southeast Safe Haven
North and Mid Hampshire Safe Haven	North and Mid Hampshire Safe Haven
Peer Support Service based in the Integrated Mental Health Hub (IMHH)	IOW integrated hub/peer support workers
The Lookout	The Lookout
Newport Safe Haven	N/A as service joined the evaluation at a later point (October 2022)
Not included as service closed	The Harbour
Hampshire and Isle of Wight Integrated Care Board (HIOW ICB)	Hampshire and Isle of Wight Clinical Commissioning Group (HIOW CCG)
Health Innovation Wessex	Wessex Academic Health Science Network

Overview

NHS England & Improvement (NHS E&I) provided funding to develop community-based alternatives to mental health crisis across England. Hampshire and Isle of Wight (HIOW) on receipt of funding are progressing their response and Alternatives to Crisis (A to C) model to meet local needs. HIOW commissioned Wessex AHSN to undertake an evaluation of this A to C model. To ensure evaluability of this care model an initial scoping exercise has been undertaken. This exercise aimed to develop answerable evaluation questions, provide an outline of the intended evaluation approach, and specify the data required to develop a fully costed evaluation specification. It is informed by the following activities:

- **Documentary Review** - Review of the relevant commissioning documentation stored within the shared NHS Futures Folder, including service specifications, to provide context for this work and commissioning expectations.
- **Logic Model Development** – completed with service leads to understand the 'theory of change' that underpins the programme of services and their expected impacts.
- **Data Scoping Exercise** - to understand what data is currently collected (e.g., activity data, surveys) and what new data would be desirable?
- **Exploration of the aspects of 'inequalities' that this programme is aiming to address**
- **Identification of key stakeholders, or stakeholder groups,** to involve in the evaluation co-design.
- **Identification of risks associated with the evaluation**

- **Identification and review of other similar evaluations** e.g., Dorset Retreat for any learning on evaluation design.
- **High level exploration of the relevant literature.**

The scoping objectives are responded to in detail in Annex A.

A core aim of the A to C programme is to address local inequalities and ensure the programme's individual projects are meeting local needs. The principal outcome is whether these services provide sufficient support to reduce emotional distress and enable the service user to manage their emotions more effectively, signposting them to more appropriate services and diverting them away from emergency and crisis services. Logic models were developed with project leads to ascertain how the programme of services both collectively, and individually intend to meet key objectives and deliver key outcomes. A specific area of interest will be the integration of peer support workers into the workforce delivering these services. A design feature of the fully specified evaluation will involve mapping data to service location to understand how best services meet local needs and address health inequalities. The perspectives of workforce (professional and peer support), service users and those in crisis services will be key evaluation components

Two key findings of this scoping report, which require further development before undertaking a formal evaluation are:

1. For the evaluation and as a future audit tool, it is proposed that data needs to be standardised across the individual programme projects. This will ensure common metrics are collected that will enable comparative data analysis to address the outcomes and impacts specified in the logic models. A core set of metrics should be collected with local customisation of further metrics to accommodate differences between projects. This evaluation needs to establish robust data collection activities.
2. Stakeholders identified in the scope, yet to be engaged, will be invited to a proposed Rapid Insight event to gain important information on service impacts of the A to C services.

Finally, the primary outcome of "reduction to emotional distress," needs specifying to enable its proper measurement.

Background context to alternatives to crisis (A to C) services

NHS E&I as part of the remit set out in the NHS 5-year plan sought to develop comprehensive mental health services across the care pathway. This range of services includes community-based alternatives to crisis mental health services. A plurality of integrated services needs to meet a range of needs and preferences for both crisis and pre-crisis support. Core components of this remit were to increase the peer support workforce and conduct a needs analysis to ensure local needs, especially inequalities, are addressed by planned services. Such services might include crisis cafes, safe havens, and crisis support. The remit specifically states services should gather and improve on current patient satisfaction data.

A recent review by Warmsley (2020) found that a third of those attending Alternative to Crisis services were potentially diverted from emergency departments, with concomitant reductions in psychiatric admissions, police involvement and mental health crisis teams (Warmsley 2020). This review showed a reduction in levels of distress during the visit and that half of attendees, at follow up, report feeling more in control of life and its challenges. Nonetheless, the review also indicated that these services may not appeal to all relevant populations such as older people; emphasising the importance of examining whether all target populations are being reached. Findings from the review were limited because data was reliant on subjective, self-report and interpretation in relation to

outcomes and lacked control or comparison groups. This highlights the importance of considering what data is captured for the evaluation. Although a comparison with a control group is not planned, one possible consideration is to examine data before the introduction of the A to C service and after introduction to gauge impact.

Dalton Locke (2021) on reviewing models of A to C in England concluded:

"*The composition of catchment area crisis systems varies greatly across England and popularity of models seems unrelated to strength of evidence. A group of emerging crisis care models with varying functions within service systems are increasingly prevalent: they have potential to offer greater choice and flexibility in managing crises, but an evidence base regarding impact on service user experiences and outcomes is yet to be established*." (Dalton Locke et al, 2021, p.2)

On reflection, there is an important opportunity to ensure a contribution to the evidence base with this HIOW care model.

Two local evaluations, the Aldershot Safe Haven report (2017) and Dorset Retreat (date unknown) both provide out of hours services. Findings from both reports and lessons learnt are summarised at Annex A. In summary, repeated use of services by some individuals is likely, therefore repeat attendances need to be identifiable in the data with greater exploration of the service users' needs (i.e., what support are they seeking when using the service?). These services provided an effective service with future improvements noted. Impacts on emergency services and service users are key stakeholders of interest. These reports indicated benefits to both. These reports provide suggestions on data collection.

A to C Programme project descriptions

The following summarises information from the documentary review (Appendix 1), project data scoping exercise (Annex B, Objective 4) and logic model development (Appendix 2). Also, evaluations conducted on similar services mentioned above informs this scope. This report provides an initial set of evaluation questions and an outline evaluation plan for discussion.

Details of programme and individual projects are provided in the attached logic models. Summary below.

Evaluation context

The services all consistently offer out of hours support and are for people who are 18 years +. The services do not offer a 'Place of Safety' for Mental Health Act Assessments (MHA) (i.e., you cannot be sectioned under the MHA at any of these services. They also do not provide services to people who:

- need medical attention
- are incoherent because they are under the influence of alcohol or drugs
- are threatening or show physically aggressive behaviour
- are under 18

Location of services

The HIOW A to C programme plan was to place the services in key locations that would ensure local needs for such services were met and the evaluation will consider whether attendance is meeting expectations and local need. In particular, understanding accessibility for all mental health services to address specifically known inequalities is a key requirement. Annex C summarises current data collection for protected characteristics across the services. Lighthouse East, and North and Mid

Hants Safe Haven record race and ethnicity (templates in NHS Futures folder). Lookout target those that are homeless and have co-dependencies with drugs and alcohol and mental ill health. Mapping data on social deprivation with the location of services will enable exploration of whether the services are located in the right location by comparing attendance with the local population based on expected mental health rates. Interaction with other local services is covered by referral route and alternative action. It is currently possible to cross tabulate attendance rates by post code.

In addition, the evaluation needs to establish whether services are located where those who need them can access and use them. Under use of a service is a concern. Attendance data is crucial to answer this question. Southeast Haven and North and Mid Hants Safe Haven, the lookout and the Harbour Crisis support service collect referral data on new and returning service users, Lighthouse West does not, and Lighthouse East is not known. The Retreat 2 project report provides useful information on data collection of visits to services both by frequency, by individual user and peak attendance by time/day of visit to service. This data is collected by Southeast Haven currently, an all day and evening service, and North and Mid Hants Safe Haven by evening as it is an evening only service, and the same for the Harbour. See summary table 1 of data required and data collected by project

Table 1 – Summary of data collected and data required for evaluation by project

DATA REQUIRED (WAHSN)	DATA PROVIDED (HIOW)					
	The Lookout	**The Harbour**	**Nth & Mid Hants Safe Haven**	**Lighthouse East (no data recorded)**	**Lighthouse West**	**Sth East Safe Haven**
Referrals						
Pre-diagnosis (separate category from presenting issue	√	√	√		X	√
Presenting issue (categories need to be defined)	3	X	X		2	11
Protected characteristics (See Annex C) 7/9 required (includes post code)	3 + post code	2 + post code	2 + post code		1 + post code	2 +post code
Referral route need to add whether a diversion if known. Purpose of categories not clear	Southern HFT	Solent Mind	Andover Mind Southern HFT		X	Havant & East Hants Mind Southern HFT
Onward referral/signpost (outcome of visit) (two categories currently: Intervention and alternative action	N/A	Not able to answer	Contacted crisis team only		7 categories covered	7 different categories covered
Service user feedback questionnaire (e.g. needs development – model SE Safe Haven).	√	√	√		√	√
Nature of contact where relevant: telephone call, F2F	N/A	3 categories	4 categories		4 different categories	5 categories
Degree of need to manage and reduce emotional distress – currently "Client support level" (requires clarification). This is a primary service outcome	4 categories	Unknown	X		X	5 categories
Contact time and day	Residential	Evening 7 days	Evening 7 days		Not specified	Evening 7 days
Number of contacts per week	√	√	√		√	√
Per day average	**X**	√	√		√	√
Repeated visits (added)	NK	NK	NK		NK	NK

Key assumptions derived from logic modelling and documentary review

From the documentary review, it is noted that the following were key outputs reported in the service specifications and therefore key assumptions of the services provided:

- Reduction in emotional and psychological distress for someone experiencing a mental health crisis.
- Increased support for carers.
- Reduction in the number of people attending ED in a mental health crisis, including repeat attendance.
- Reduction in the number of admissions to a mental health or acute in-patient bed due to de-escalation and management of crisis.
- Reduction in police contacts
- Reduction in the use of Section 136 by the Police
- Reduction in contact with acute MH Teams – specifically the crisis home treatment teams out of hours.
- Reduction in GP visits
- Increased access for BAME service users

Data collection templates are comprehensive for Southeast Safe Haven only. Northeast Haven and Southeast Haven produced very different surveys for obtaining the service user perspective (service satisfaction). For effective data collection both for the evaluation and as an audit tool going forward, projects will need to agree standardisation of data collection.

Define principal outcome

The main purpose of the A to C programme of projects is to intervene and prevent individuals from entering emergency services such as emergency departments or the crisis mental health team. The services provided aim to 'reduce emotional distress' and divert individuals to other forms of support and enable better management of their emotions. 'Reduction in emotional distress' requires a clear definition to properly determine its measurement. Multiple factors are relevant e.g., whether someone is under the influence of drugs or alcohol (note: if they are incoherent, they are not able to use the service but still might be under the influence). Both "Presenting issues and "Client support level" captured by projects (Evaluation Data Scoping exercise – see Annex B, objective 4) would need revisiting and to be defined more clearly. Some presenting issues are diagnostic categories (depression, OCD) or symptoms (panic attacks, stress) and most of these categories are only gathered by Southeast Haven. Further discussion will enable the project teams to consider what they need to know, for instance mental health diagnosis and presenting reason for distress may both need to be identified as they may or may not be related. Client support level would warrant definition and clarity as to how it is interpreted across projects. Equally further understanding in relation to the role of peer support workers within each service through discussion with the project leads will be required.

Engage key stakeholders

Stakeholder engagement in the evaluation should in principle include people from an organisation's senior level or area specific leads, decision makers, those likely to be impacted by the service, those that run services on a day-to-day basis, people who are recipients of services, and potentially those

known to be sceptical about the service, alongside those who are delivering similar services elsewhere. Stakeholders most pertinent to this evaluation are:

- Service users and their carers
- Healthcare providers most impacted by the service's success for example, emergency departments and mental health crisis services
- Peer support workers
- Representation from any populations identified as at risk locally based on a protected characteristic

Stakeholders for this evaluation are proposed at Annex A. Engagement of those impacted by the service need to provide input into expectations for these services.

Measure impact on addressing inequalities

NHS organisations as public bodies are obliged to work within the equality law. The Equality Act 2010 seeks to protect from discrimination, harassment, and victimisation those with one or more protected characteristics. These nine specified characteristics are: Age; Disability; Race including ethnicity and national identity; Sex; Gender re-assignment; Marriage and civil partnership; Pregnancy and maternity; Religion or belief, including lack of belief; Sexual orientation. The Act provides further information on the role of public bodies. Dr Bola Owolabi, Director – Health Inequalities at NHS England and NHS Improvement points to two key aspects in which to ensure inequalities are addressed: a. collect relevant data; and b. speak to those you seek to protect about what they need to access and use health services (Dr Bola Owolabi[1]). Annex C draws out key questions and metrics across these nine protected characteristics alongside current data collection by the alternatives to crisis projects (scoping data file, Futures Platform folder). Routine datasets can provide demographics by ward in Hampshire and IOW. This data can be presented in a visual map and gives a baseline for data subsequently collected by the different services based on their location. Further information drawn from service users and a proposed stakeholder engagement exercise will need to ensure information and data is gathered to inform future delivery of alternatives to crisis services which includes addressing local health inequalities.

There are specific local priorities for each service – see Annex C for further information.

Measure impact on workforce

Peer support workers are an important part of this evaluation. The literature is mixed and therefore a qualitative approach might help identify the key areas for follow up work or recommendations. The literature can provide questions and recommendations for exploration. Key points for consideration in this evaluation are:

- What impact peer support workers on clinical outcomes, e.g., reduction in emotional distress (White et al, 2020, Lyons et al, 2021),
- Whether they have greater impact than professionals and how professionals, themselves view peer support workers (Pitt et al, 2013)
- How well supported peer support workers feel in their roles and what training or support they might require (Jacobson et al, 2012).

Workforce recruitment was noted as a particular issue in some projects in the documentary review.

[1] Drawn from a recent presentation by Dr Bola Owolabi to the Wessex AHSN.

Measure impact on service users (and carers)

Service user and carer satisfaction are key requirements and there is an expectation that there should be development in this area. An initial review of the current data collected by the services (conducted via the data scoping exercise) indicates that all projects collect Service user feedback referred to as client). However, the two examples in the futures folder reveal very different approaches to gathering impact on service users. Going forward it would be beneficial to have an agreed standard across all projects. In addition, there is value in a more in-depth investigation into repeat/high intensity users as indicated in the Aldershot and Dorset reports.

Summary of key considerations

- Data metrics and measurement are important to establish the success and benefits of these services, collectively and individually. This requires:
    - Standardisation of data collected across services using common templates.
    - Agree definitions and categories for data collection to ensure a common standard across projects e.g., presenting issues (e.g., stimulus for distress) and client level support.
    - Agree outcome definitions e.g., reduction in emotional distress needs qualifying and clarity of expectation across projects and subsequent measurement.
    - Agreement of what is valuable to collect for the evaluation and future audits to develop a common data collection tool.
    - Agreement and standardisation of patient satisfaction starting with the Southeast Safe Haven template as a starting point.
    - Explore with our data analysts data mapping approaches and routine demographic by wards to compare with data collected in the evaluation.
    - Explore with our analysts whether cost analysis by utility of service, costs of service provision in A to C compared other emergency services and cost impact of prevention/diversion of service users from these emergency service is possible.

- Stakeholder engagement has been limited at this stage to project leads and needs broadening to ensure the evaluation is viable. This particularly refers to those most impacted/benefiting the services delivered e.g., service users and emergency service staff etc. Therefore, wider stakeholder engagement of the police, emergency department and mental crisis teams needs to occur, and a Wessex AHSN Rapid Insight event is proposed before the evaluation commences. This stakeholder engagement will ensure stakeholder viewpoints and knowledge are captured in the most sensitive and time conscious way. Wessex are well rehearsed in running such events. These events are highly structured and managed. They can accommodate large numbers of people and are virtual. Feedback derived will further inform the evaluation and provides a co-design opportunity. The event should also include community representation e.g., people from different ethnic or racial backgrounds.
- Investigating the high intensity use of these services by individual service users.
- There might be value in having a follow up survey that considers status of service user 6 weeks from attendance.
- Comparative studies strengthen attribution in evaluations. It is not possible to have a control group unless we compare to another region, which is not possible or necessarily truly comparable. Dalton-Locke and colleagues (2021) mapped crisis resolution services for England and found wide variability in community crisis service models and system

configurations. Pragmatically, an option is to retrospectively examine data before the introduction of the A to C service compared to after introduction.

- Mapping data on social deprivation with the location of services will enable exploration of whether the services are located in the right location by comparing attendance with the local population based on expected mental health rates.

Initial evaluation questions and design for review

Below provides a set of proposed evaluation questions considered in scope.

Proposed questions

1. Does the HIOW model of Alternatives to Crisis programme reduce the use of local emergency and mental health crisis services?
    a. What are the benefits to the emergency services of the Alternatives to Crisis service?
    b. What benefits/disbenefits are experienced by key emergency care stakeholders of the A to C programme?
    c. What differences, if any, do individual projects by type of service model e.g., telephone (Harbour), residential (Lookout), evening and weekend (Safe Haven) and the use of peers (IH on IOW) make to the overall HIOW A to C model.
    d. What is missing in the service model, e.g., geographical location or type of service
    e. How well do the current services work together to provide a cohesive service?
2. What benefits do service users experience from attendance at the Alternatives to Crisis services?
    a. What impact has attendance had on their ability to:
        i. Attend other suitable local services rather than emergency services
        ii. Reduce their emotional distress and better manage their emotional state
    b. Why do high intensity users need these services and is their use appropriate?
3. What are the impacts of the Alternatives to Crisis services on carers of service users using these services?
4. Has peer support become embedded in the Alternatives to crisis care model?
    a. What are the benefits to the project workforce, services users, and the peer support workers themselves?
    b. What are the training and support needs for peer support workers?
5. Are these Alternatives to Crisis services accessible to all members of the local population?
    a. Are the individual projects located in the correct locations for maximum service usage?
    b. Are key target categories of service users covered by the assigned local service e.g., homeless, Afro-Caribbean ethnic group.

It is not in scope to conduct an full economic cost analysis of the A to C service model, however, we will explore options for a cost benefit analysis. It is also not in scope to conduct a deep dive into each individual project.

Evaluation design

Seven individual projects comprise the A to C model of care for HIOW. Six projects deliver frontline community services. The seventh project evaluates use of peer support workers, who support the integrated hub approach on the IOW. Each project stands alone but is also part of a programme of care in HIOW. The evaluation design will need to consider both whether the mix of projects is right

and covers the remit for the A to C model, and whether any project is struggling with implementation, and what improvements/developments etc. are required going forward.

A mixed methods process and summative evaluation will involve routine datasets (service use), project specific data collection (referral/attendance) using a standardised data audit tool agreed by projects. Patient views on services will be routinely gathered as well as a purposive stratified sample of service users and carers interviewed. Rapid insight events can continue over the life of the project to gain key stakeholder and project staff input.

This might fit a realistic evaluation approach of what works for who under what circumstances and in what context to evaluate the programme theory that this model of care will reduce emotional distress and encourage the service user to manage better their emotions and divert them to use more appropriate services.

Next steps and decisions

- Report review by Sonya McClean and her team to consider the following:
    - Current status of the service during the Covid-19 pandemic and a review of the current timelines.
    - Discussion with project leads on developing a standardised approach to data collection and review of current data collection issues for both the evaluation but also ongoing audit of the services. This requires a meeting in the near future.
    - Review logic models and evaluation questions.
    - Run stakeholder Rapid Insight event in the near future
    - Agree evaluation planning and accessibility of staff, service users and peer support workers to support evaluation objectives to answer the questions.

References

Aldershot Safe Haven report (2017), Safe Haven Service Evaluation Interim Report, April 2017, Wessex Academic Health Science Network.

Dalton-Locke, C., Johnson, S., Harju-Seppänen, J. et al. (2021) Emerging models and trends in mental health crisis care in England: a national investigation of crisis care systems. *BMC Health Serv Res* 21, 1174 (2021). https://doi.org/10.1186/s12913-021-07181-x

Dorset Retreat (date unknown), inhouse evaluation – no author.

Jacobson, N., Trojanowski, L., & Dewa, C. S. (2012). What do peer support workers do? A job description. *BMC Health Services Research*, *12*(1), 205. https://doi.org/10.1186/1472-6963-12-205

Lyons, N., Cooper, C., & Lloyd-Evans, B. (2021). A systematic review and meta-analysis of group peer support interventions for people experiencing mental health conditions. *BMC Psychiatry*, *21*(1), 315. https://doi.org/10.1186/s12888-021-03321-z

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S. E., Ryan, R., & Berends, L. (2013). Consumer-providers of care for adult clients of statutory mental health services. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.CD004807.pub2

White, S., Foster, R., Marks, J., Morshead, R., Goldsmith, L., Barlow, S., Sin, J., & Gillard, S. (2020). The effectiveness of one-to-one peer support in mental health services: A systematic review and meta-analysis. *BMC Psychiatry*, *20*(1), 534. https://doi.org/10.1186/s12888-020-02923-3

Walmsley E. (2020) A Review of the Evidence of the Effectiveness and Factors for Success of Mental Health Crisis Lounge Style Services. January 2020 Southampton City Council.

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Annex A

	Aldershot Safe Haven report (2017	Dorset Retreat
Service details	An evening drop-in service for people who need out of hours mental health crisis support in a safe environment, the main aim was prevention of use of emergency services by those in mental health distress. The service was provided by both trained professionals and peer support workers.	An out of hour service 365 days per year service with cafe, the aim was to assess what impact the Retreat had on the people using the service and the impact on other local services since its inception.
Benefits identified	• An overall trend downwards to attending the Emergency Department by service users that attended the Safe Haven service. • Psychiatric admissions reduced for the Safe Haven service catchment area; however other factors may explain the reduction. • If the service prevents 5% of those attending in crisis from being admitted to a psychiatric bed, it results in £439,088 of avoided costs (based on an average length of stay of 42.2 days). • Mental Health related police deployments reduced within the Safe Haven catchment area. Section 136 suite detentions have declined for Northeast Hampshire, which goes against the national trend and the trend seen across the wider Surrey and Borders Partnership NHS Foundation Trust.	• 43% are regular attendees and use the café space to socialise or seek peer support. • 26% of the people attending the Retreat five or more times make up 85% of the total visits. • Average length of attendance is 3 hours. • 66.4% are using the Retreat successfully and have not been seen again by PLS since using the Retreat. • There is a downward trend in the use of Section 136 during 17:01 to 00:00 which could be attributed to the fact the Retreat is open during this timeframe and police are choosing the Retreat as an alternative. • The overall number of calls to the Crisis Team has increased in 2018 compared to 2017, which is in line with increased demands on all Mental Health services, albeit the trend is slower during the hours when the Retreat is open. • 80.95% of visitors are extremely likely and 17% likely to recommend the service to family and friends. • 35% of visitors self-reported avoiding using ED as a result of using the Retreat. • 40% of visitors self-reported avoiding using the Crisis Team as a result of using the Retreat. • 16% self-reported avoiding calling the police as a result of

		using the Retreat. • 76% of visitors rated the service as excellent and 21% as very good.

Key lessons	• Understanding why some service users used the service repeatedly and how to best to gather this and manage in the dataset, so as not to skew findings.
	• A comparative group would strengthen attribution in the findings.
	• Provide a description of the type of care provided on visit.
	• Consider wider community impacts
		• Impacts on retreat workforce in working in this type of service
		• Diagnosis codes to ensure different categories are captured by service
		• Quality of routine data collection important
		• Improvements to service needed include:
		  ○ Separate entrance for those arriving by police or ambulance
		  ○ Better connectivity with follow on services and better networking with other relevant agencies
		  ○ Training for staff
		  ○ Opening hours stop at midnight but open earlier at the weekend
		  ○ Ensure boundary setting on service limits with attendees and restrict staff time with individuals
		  ○ Service needs to be able to manage mental health emergencies that might require calling an ambulance
		  ○ Provide a safe environment
		  ○ Provide effective promotion of service

Annex B

Scoping objectives and how they have been met

Objective	Action
1. To review relevant commissioning documentation, including service specifications, which provides the context for this work and commissioning expectations.	All documents in NHS Futures folder reviewed and key information extracted: (master table Evalution scoping excel - Futures folder) • Location & Target • Population Brief • Summary Overview • Opening Hours • Staffing Service • User Data Collected • Access / Route In • Onward Care • Feedback collected by service
2. To understand the 'theory of change' that underpins the programme of services and their expected impacts.	• Conducted programme Theory of Change/Logic modelling meeting • Developed draft programme Logic Model. • Drafted individual project logic models • Reviewed with updates from the project teams.
3. To understand the aspects of 'inequalities' that this programme is aiming to address	https://www.england.nhs.uk/wp-content/uploads/2015/03/monitrg-ehi-pos-paper.pdf Objective is to demonstrate A to C services support the agenda for addressing inequitable access to services for people based on their gender, race, disability, social status etc. Wessex AHSN are developing a tool for our programmes and projects (HEAT). We also benefitted recently from an inspiring talk from Dr Bola Owolabi Director Health Inequalities NHS England and NHS Improvement – In summary raises the point that both access and experience of care is important to ensure health seeking behaviour. Leadership is key and engagement of those identified as representing those disadvantaged due to core characteristics above – "talk to the people." Second data is key. For HIOW and access to A to C services, who specifically might these people be and how do we best engage them in the evaluation process. N.B. Annual Health checks for SMI. We will need to consider further input on gathering data to establish a very specific question about who is able/not able to access A to C services and whether that is based on "location", "project type/ interface", "knowledge or experience of service/project". Example Q. Do peer workers represent those known to have mental

	health issues in HIOW?
4. To understand what data is currently collected (e.g., activity data, surveys) and what <u>new data</u> would be desirable?	• Data table set up in Futures folder to gather routine data collection activities across • Missing 1 project (Lighthouse East) – see Annex B as to how data collection meets inequalities agenda.
a. Are current datasets in common between the different services?	• There is some overlap between the services, IOW integrated Hub focussed on peer workers so will need a different approach to data collection. • Some overlap but also differences, and some differences relevant to service. • Design should consider some standardisation as well as what data to answer questions.
b. To what extent can opportunities for data capture be replicated across the different services?	• Need to agree core data that is reasonable for all projects and subsequently separate for specific projects. Therefore, a tiered approach with a core set of data from all and then specific to type of service. • A certain pragmatism might be required given the 'drop in' nature of the services.

c. Are all services collecting service user feedback, is this standardised across all services and is it collected digitally? Is it self-selecting or is everyone encouraged to provide it? Does this require development or new data collection?	• Various service user feedback tools used
	  ○ Appears to be no standardisation
	  ○ Consider benefit for standardised approach not just for this evaluation but ongoing and can be "tested" as part of this evaluation.
	  ○ Service user stakeholder engagement would aid development of a suitable questionnaire and how it should be delivered to encourage the service user to complete it.
	  ○ Interesting question to ask service user: "If you hadn't been able to access The Lighthouse, which of the following would you most likely have done instead? Please select all that apply (Lighthouse Southampton – Alison slides). The data table does provide "Alternative action" as measure, but this does not seem to be consistently applied – and whether that is relevant or not. However, this can provide impact on other services data.
	  ○ Two templates in Futures folder. Southeast Haven the most developed.

d. Are services collecting attendance information as standard practice on all users attending including reason for presenting (and is this collected electronically)? What data is collected on service user profiles and pathways? This will be important to understand who uses what service and who is not using the services provided, to	• Presenting information appears not to be gathered across all services. • Service user pathways and profiles limited – protected characteristics age and gender only, with one Safe Have capturing ethnicity. See Annex B. How they are capturing this information is not known. • Of services 4 capture referral data. • Lighthouse West just collects presenting information on whether suicidal or self-harming. • All capture except Lighthouse West, referral route • All capture capture post code and geographical area. • Is understanding peak times important to capture and numbers attending – how best to capture see

address in particular the requirement to understand the impact on inequalities.	Dorset Retreat.
5. To identify an appropriate list of stakeholders, or stakeholder groups, to involve in the evaluation co-design. We would like to involve service users and identify how these users could be engaged in the planning stage of the evaluation.	Documentary review and Retreat report suggest the following stakeholders: • GP services and other primary care contacts • Ambulance services • Police • Emergency departments in secondary care • Crisis mental health services • Service users and also those might struggle to access services • Workforce of the services (all levels) including peer support workers Proposal to run a Rapid Insight event to inform the Evaluation specification.
6. To identify risks associated with the evaluation e.g., capacity of key staff to be engaged in data collection, data availability and quality.	Current level of engagement: • Attendance at LM event and engagement was good. • Detailed information held in folder for most services • Data table incomplete Lighthouse East, reason unclear e.g., lack of data to enter, still developing service, documentary review indicates some recruitment issues
7. To identify and review other similar evaluations e.g., Dorset Retreat for any learning on evaluation design.	Retreat report (Dorset) and Safe Haven (Aldershot, Hampshire): Key learning points are: • Once data collection activities are agreed by the projects it is important to ensure completion. Data quality can be an issue. Therefore, what is the best approach e.g., using tablets (mobile and data can be collected in real time as patient is managed). • Impact on other services e.g., mental health crisis teams, Emergency departments, police, and use of Section 136.

Annex C

Questions drawn from NHS E Monitoring Equality and Health Inequalities: A Position Paper (section 4) mapped to data collected by A to C services

Consideration will need to be given to what data needs collecting at service level and whether this data needs to be comparative to data collection in other datasets.

*Data collection not registered for Lighthouse East, and IOW integrated hub/peer support workers

Category of protected characteristic	**Rationale**	**Measurement proposed (examples)**	**A to C project priorities and data collection***
1. Age **A to C – should ask this question to address**	Key demographic – need to understand whether individuals are in older or younger populations for example.	DOB dd/mm/yyyy Age exact Age by age bands	**Lighthouse East** = BAME (please specify in other box, for example, young black men) Middle-aged men, older adults, young people who self-harm **IOW Mental Health Hub** = The IOW has an older and more socially isolated population compared to the rest of England. There are areas of significant deprivation in IOW, and life expectancy is lower in the most deprived areas **Southeast Safe Haven =** middle-aged men. **Data collected actual** Southeast Safe Haven, North and Mid Hants safe haven, Light house West, Harbour, Lookout
2. Disability	The Equality Act 2010 defines disability as a physical or mental impairment that has a 'substantial' and 'long-term' negative effect	ONS 2011 Census questionnaire for England : Are your day-to-day activities limited	**Lookout** = homelessness and with co-occurring conditions of mental health problems and substance misuse or

	on your ability to do normal daily activities (see paper for more). **A to C – should ask this question, although of course the mental health will be ticked but further information on this would be obtained.**	because of a health problem or disability which has lasted, or is expected to last, at least 12 months? (include any issues problems related to old age) □ Yes, limited a lot □ Yes, limited a little □ No □ Prefer not to say ONS harmonised suite of disability follow-up questions: If ticked "Yes" to the above, please indicate your disability: □ Vision (e.g. due to blindness or partial sight) □ Hearing (e.g., due to deafness or partial hearing) □ Mobility, such as difficulty walking short distances, climbing stairs, lifting and carrying objects □ Learning or concentrating or remembering □ Mental Health □ Stamina or breathing difficulty □ Social or behavioural issues (e.g. due to neuro diverse conditions such as Autism, Attention Deficit Disorder or Asperger's Syndrome) □ Other impairment	dependency issues. **Lighthouse East** = Services for people with a diagnosis of personality disorder, Services for people with dual diagnosis / co-occurring drug/alcohol needs, People with learning disabilities and/or autism **Southeast Safe Haven** = people with PD and dual diagnosis **Data collected actual** Southeast Safe Haven is collecting MH diagnosis across all categories Light house West is collecting suicidal and self harm. The Lookout collects mental health crisis, suicidal and self harm. The Harbour and North and Mid Hants safe haven do not collect any data on diagnostic categories.
3. Race and Ethnicity	ONS have conducted extensive testing on the question and response categories for religion or belief. Testing has found that the question "What is your religion?" best met the requirements of collecting good quality data	The NHS Data Model and Dictionary approved National Codes for ethnicity: National Codes: White A. British B. Irish C. Any other White background Mixed D. White and Black Caribbean E. White and Black African F. White and Asian G. Any other mixed background Asian or Asian	**Lighthouse East** = BAME (please specify in other box, for example, young black men). **North and Mid Hants Safe Haven** = The service will aim to work specifically with people from BAME communities. **The Harbour** = BAME communities and

	on religious affiliation. **A to C – should ask this question**	British H. Indian J. Pakistani K. Bangladeshi L. Any other Asian background Black or Black British M. Caribbean N. African P. Any other Black background Other Ethnic Groups R. Chinese S. Any other, please write in 99. Not known Z. Not stated Religion question taken from the ONS 2011 Census questionnaire for England: What is your religion? □ No religion □ Christian (including Church of England, Catholic, Protestant and all other Christian denominations) □ Buddhist □ Hindu □ Jewish □ Muslim □ Sikh □ Any other religion, please write in □ Prefer not to say	other hard to reach groups. **Data collected actual** North and Mid Hants Safe Haven and The Lookout capture ethnicity. There are no templates to see if there is commonality in categories etc.
4. Sex and Gender re-assignment	"sex," "sexual orientation" and "gender re-assignment" separate distinct categories and good data systems treat them as such. **A to C – should ask this question**	GIRES: What is your sex? • Male • Female • Intersex Prefer not to say Have you gone through any part of a process, or do you intend to (including thoughts or actions) to bring your physical sex appearance, and/or your gender role, more in line with your gender identity? (This could include changing your name, your appearance, and the way you dress, taking hormones or having gender confirming surgery) □ Yes □ No □ Prefer not to say	**Data collected actual** Southeast Safe Haven - gender
5. Sexual orientation	As above	Question informed by the research	**Lighthouse East** = Young people who self-

	A to C – should ask this question	conducted by ONS: Which of the following options best describes how you think of yourself? □ Heterosexual / straight □ Gay / Lesbian □ Bisexual □ Other □ Prefer not to say	harm (including for example, LGBTQ+ groups and students) **Data collected actual** Southeast Safe Haven - orientation
6. Religion or belief	**A to C – should ask this question**	Recommended for England only. Religion question taken from the ONS 2011 Census questionnaire for England : What is your religion? □ No religion □ Christian (including Church of England, Catholic, Protestant and all other Christian denominations) □ Buddhist □ Hindu □ Jewish □ Muslim □ Sikh □ Any other religion, please write in □ Prefer not to say	**Data collected actual- Nil**
7. Marriage and civil partnership;	**Unclear as to whether this is a question that needs to be answered**	-	-
8. Pregnancy and maternity	**No standard approach currently, possibly more applicable to workforce than patients**	Data collection category (for patients) may take the form of: Are you pregnant or have you given birth in the last 26 weeks? □ Yes □ No □ Prefer not to say	**Data collected actual - Nil**
Other categories of interest			
9. Deprivation and social economic	Relevance	Postcode Employment status	**Lookou**t = homelessness and with co-occurring conditions of mental health

status	**A to C – Should ask this question. People with mental health can fall into this category or arise from it?**	Employment type Educational attainment	problems and substance misuse or dependency issues. **IOW Mental Health Hub** = The IOW has an older and more socially isolated population compared to the rest of England. There are areas of significant deprivation in IOW, and life expectancy is lower in the most deprived areas **Data collected actual** Post code = Southeast Safe Haven, Light house West North and Mid Hants Safe Haven.