THE SAFE SPACE TOOLKIT

What to consider when creating a safe space scheme in your town
DEFINITION...

“SAFE SPACE is an increasingly recognised term for partnership schemes (often based in buses or town centre buildings) that operate to make the night-time economy safer. Typically, safe spaces provide a combination of medical assessment, supervised recovery and discharge. Although safe space clients are relatively limited in number, they often exhibit one or more of the following: injury, intoxication (from alcohol or illegal drugs) and vulnerability. Safe spaces may also provide other services, such as pastoral care, help for rough sleepers and advice to those who are lost or need to get home. A small number of schemes signpost their users to follow-on services, e.g. alcohol brief interventions. Some safe spaces also provide a physical base for partners managing their local night-time economy.
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Front cover image: Swansea Help Point (courtesy South Wales Police & Crime Commisioner)
Getting started...
The Safe Space Toolkit: A step-by-step guide to creating a safe space in your town

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2. Building the case for your safe space: BENEFITS

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10. Can you change your users' behaviour?

The Safe Space Process

MAKE

Portman Group

Local alcohol partnerships
**INTRODUCTION**

This *Safe Space Toolkit* is intended to provide useful information for those towns and cities considering setting up a ‘safe space’ scheme for their night-time economy. It also contains new ideas and best practice that existing safe spaces may find helpful.

The toolkit was funded by the alcohol responsibility organisation, The Portman Group, and was assembled by night-time economy specialists MAKE. It was developed collaboratively with input from the Local Alcohol Partnerships Group (LAPG) members, as well as from exemplar safe space schemes, such as Chelmsford, Clapham, Exeter, Hereford and Swansea. We are grateful for all their input.

This *Safe Space Toolkit* is the practical outcome of a year-long research project into the effectiveness of, and best practice in, safe spaces. A link to the full report on which this toolkit is based can be found in the Resources chapter. The full report contains much more detail on the background to safe spaces, national best practice and demonstrates their impact.

The *Safe Space Toolkit* is intended as a practical guide on the issues to consider when setting up a safe space. It is not intended to be definitive, but rather a way to avoid ‘reinventing the wheel’ and speeding up the process of getting your safe space operative.

**WHAT ARE SAFE SPACES?**

There is no ‘official’ definition of a safe space, but the one included at the start of this research was shaped during the research process that underpins this toolkit. It tries to best capture the varied safe space models operating at present.

Safes spaces can operate from a building or vehicle or combination of both. Schemes have trained staff (often a combination of volunteers and paid members) who provide the main services. Other services can be as varied as mobile phone charging or the referral of users to alcohol or drug interventions to help them change their behaviour.

The research shows that safe spaces deliver a range of benefits, both to their users and to the public and private sector. In the next section ‘Building the case for a safe space’, these benefits are outlined further because they are the foundations on which an effective safe space can be developed.

At the time of writing there were 45 safe spaces in the UK. However, the report on which this *Safe Space Toolkit* is based, highlights a further 100+ town and city centres that could benefit from a safe space. There is huge scope for expansion.

This *Safe Space Toolkit* is intended for those considering a safe space in the UK, but the principles - providing local conditions are considered - probably apply anywhere in the world.

**YOUR JOURNEY BEGINS**...

If you think a safe space could be right for your town or city, then what comes next after reading the toolkit? To answer this, we've provided a list of contacts and resources at the rear of this document.
Safe spaces typically help between 4 and 20 people during a weekend night.

Hereford’s NTE has about 8k visitors on a Saturday, meaning just 1 in 1,600 people end their night in Emilia’s Place.

Cardiff typically sees 40k visitors a night (100k on busy weekends). Its safe space helps an average of 7 to 8 visitors a night (less than 0.02% of those using the city centre’s NTE).

So, whilst the numbers using safe spaces are small, they can play a key role helping an NHS under increasing pressure.
STEP ONE
Does your town need a safe space?
**INTRODUCTION**

Before embarking on the work to ‘build the case’ for the creation and funding of a safe space in your town or city, it’s imperative to work out whether it’s a project that will genuinely help.

**DO YOU NEED A SAFE SPACE?**

The most obvious starting point is to ask whether your town has a night-time economy (the presence of street pastors or angels is usually a reliable indicator). If so, are there challenges associated with it? Even some of our smallest towns now have a night-time economy, but often issues around alcohol misuse, illegal drug taking, violence and vulnerable people are not of a scale that warrants a safe space.

However, it’s easy to get a feel for whether there may be demand by talking with colleagues in the police, council, hospital, ambulance service, night-time business e.g. PubWatch and street pastors, as well as colleges and universities. These informal conversations are often the best place to start.

So, whilst very small towns may not be able to justify a scheme, once a settlement reaches a certain size, a safe space may be a worthwhile.

The research shows that towns with a population of just 50,000 have created a viable safe space scheme. For example, one of the most developed schemes in the UK, Emilia’s Place, is in Hereford, which has a population of less than 60,000 residents.

Once you sense that there might be a case for a safe space in your town, it’s then time to ‘build the case’ and see if the figures stack up.

The research shows many safe spaces have resulted from an individual who, having seen a safe space operating elsewhere, has proposed the idea to other frontline professionals and decision makers in their own town or city.

In some existing schemes the process of planning for a safe space has been extremely ad hoc and, whilst this hasn’t always resulted in failure, the more systematic the process of building the case is, the more likely partners will back it. This means that, in turn, the quicker it can be up and running.

A critical element at this stage is establishing demand and setting out expenditure in a business plan (however simple) that can be presented to backers and funders.
STEP TWO
Building the case for your safe space: benefits
INTRODUCTION

A crucial part of your business planning will be to establish likely demand and the resulting benefits to the public sector. This can be done using a range of local and national data. Examples of these are set out below.

DEMAND

Estimating the likely number of users cannot be precise because your scheme is not yet open. Schemes have also tended to overestimate user numbers in the planning stage. However, you can use figures from other safe spaces in similar sized towns (and scale up or down proportionately).

For example, Hereford operates on Friday and Saturday nights (around 100 nights a year) and sees around 500 users. Exeter, in its first 50 nights, received about 250 users. Chelmsford operates on around 50 nights a year and sees over 300 users. Clapham saw 780 users in its most recent year of operation. The pilot for Cardiff’s Alcohol Treatment Centre saw 18 patients a night on average, reflecting its status as one of the UK’s largest night-time economies.

Five users taken out of the A&E and ambulance system on any given night may not seem a lot, making a safe space seem a hard sell. However, the evidence shows even these small numbers make a seriously positive impact on the emergency department environment, ambulance response times and A&E patient experience.

Therefore, you may want to model demand, expenditure and offsets to the public sector on 5 and 10 users a night in smaller towns, and 10 and 15 in larger towns and cities. NB these figures are for those who receive treatment and/or recovery (as opposed to those who come in for a chat or who are referred to hospital).

With these estimates, it’s possible to model likely benefits to the public purse using the following costs per incident.

BENEFITS TO THE PUBLIC PURSE

Ambulance benefits

Ambulance call-outs, at an average of £236 each (2017 inflation adjusted Department of Health figures), are one of the main areas safe spaces can help the public-sector in the NTE. Data can be sought from ambulance trusts for call outs and pick-ups over your NTE times and geographies to support your estimates.

Aggregation of data from the research’s case study areas suggests that for every 10 users brought in to the safe space, 1 will still need to be taken to hospital, 5 would have been taken to hospital (and thus allows the deployment of NHS resources). The remaining 4 are a combination of those who would have somehow found their way home (albeit in much more precarious circumstances) and, in a small number of cases, would have been a victim of crime.

It may be worth highlighting the numerous high-profile examples (e.g. Durham, Norwich, Edinburgh) where nightlife users have tragically died, through their inebriated condition. Safe spaces would certainly prevent some of these.

It is also worth flagging up in your business plan the unquantifiable but important reduction in aggression towards paramedics, the reduction in pressure on scarce resources, and their improved ability to focus on more ‘serious’ incidents. This is well proven by the research (see Resources).
A&E benefits

The same principles apply to A&E presentations (and those that lead to admissions). Not all night-time economy A&E presentations and admissions are from ambulance journeys, so ascertaining figures from the local hospital (or hospitals) will be useful. However, you can use an inflation adjusted 2016 cost from Cardiff’s own research of £115 per A&E admission prevented both for those individuals who are managed in your safe space and those who would have got to hospital under their own steam (see Resources).

A more recent (2015) study by Kathryn Parkinson et al of Newcastle University puts the cost of alcohol hospital admissions at £249, so it is reasonable to use this figure as a multiplier in an upper estimate alongside that above).

It is also important to note in your business case the prevention of secondary injuries. For example, when a customer leaves a pub or club intoxicated, despite the best efforts of staff, and is found and cared for by the safe space. The result is that they can’t then become a victim of a violent crime. As well as the obvious benefits to the police, this saves considerable intensive care and surgery resources. Research has yet to quantify this gain, but do include it as a general benefit.

As with the ambulance service, there is strong evidence that a safe space can aid in the reduction of chaos in waiting areas and the emergency room (particularly from intoxicated friends). This allows staff to focus on priority patients, as well as potentially helping hospitals hit their A&E waiting times. The research suggests these are even greater benefits in the eyes of healthcare professionals than monetary benefits alone.

Police benefits

Financial benefits for the police service are harder to quantify, but it is possible to calculate officer time that can be re-allocated by the presence of a safe space. This can be built into the ‘benefits’ section of your business plan.
Research in Cardiff suggests that officers escorting patients to hospital reduced NTE policing presence in the city’s by about 15% on Friday and Saturday nights.

If you have 15 officers on duty this means at least two taken away from the frontline at any one time. But if you are a smaller town, two officers could be a third of your police presence! Using this 15% figure you should be able to calculate a robust financial benefit to the police.

Other benefits

Your business plan should also include the other benefits that the research uncovered, even if they are ‘soft’ or, as yet, unquantified. These include:

- Reducing the burden on the justice system (courts and probation).
- The positive involvement of young people (as volunteers).
- Reduction of the time street pastors must wait with people in the street until an ambulance arrives.

- Night-time businesses are increasingly subject to regulatory pressures and by supporting a safe space scheme they are reducing the likelihood of further regulations being introduced, such as a late-night levy.

THE BIG FIGURE

By undertaking the simple modelling above, it is possible to arrive at a costed benefits figure that your safe space can deliver to local public services. This can be the headline figure for inclusion in your business plan.

For example, the research estimates that, before operating costs, safe spaces allow A&E and ambulance services alone to reallocate between £500k and £900k of staff and resources per year (depending on the size of the night-time economy, number of users, number of nights the safe space operates).
STEP THREE
Building the case for your safe space: costs
**Introduction**

If you believe demand exists locally, then identifying realistic costs is critical at this stage.

Even though every safe space goes through a process of change (e.g. Chelmsford’s went from pop-up gazebos to a full-on bus solution), at this stage it’s also worth thinking about the type of operation that will work in your town.

For example, do you want it to be medical-led i.e. able to provide treatment of all but the most serious injuries and conditions (e.g. Cardiff)? This will likely be a more expensive model. Or do you want to start with a care-led (e.g. Hereford) model that is about recovery and pastoral care (possibly with basic first aid)?

The research doesn’t suggest that either model is necessarily better, just different. The latter may be easier to get off the ground but may not divert as many users away from hospital and A&E. NB with a care-led model, non-medical staff and volunteers must still be rigorously trained and a medical-led model will still need recovery space.

**Expenditure**

In terms of calculating your likely set-up costs and annual expenditure, this will to some extent be locally contingent. But in principle, you will need to include the following.

**Premises (building or vehicle)**

You may be able to secure a building for free or at a low or peppercorn rent from a partner (e.g. Clapham Night Hub uses the local Methodist church hall). Otherwise, the rent could be anything from £5k-£30k, depending on who is the freeholder, its condition, its location in your town and where you are situated in the UK.

A smaller panel van / ambulance size vehicle will be in the region of £50k new, whilst a single deck bus will be more than £100k if purchased and fitted out new. You may be able to secure a bus from a local transport operator at a reduced price (or even free) as part of their corporate social responsibility programme. But beware, older vehicles can be expensive to maintain!

(See Building, Bus or Both for a summary of the pros and cons of each).

**Repairs**

Repairs to your safe space, be it building or vehicle, will be required and these should not be considered lightly, particularly if you plan to use an older vehicle (a set of tyres will be over £2k) or a building with a rent and repair lease.

**Replacement**

Schemes with vehicles should also build in a contingency to replace them. This will be dependent on how new the vehicle was when it came into service, but schemes tend to replace them every three to five years if second hand. A new vehicle might operate for ten years.

**Depreciation**

There will be annual depreciation on capital expenditure that should be factored in – this is particularly true if buying a bus.

**Fit out**

Unless you are buying / leasing a vehicle that is already fitted out, there will almost certainly be some costs associated with converting a building or second hand vehicle. This may be as simple as putting in some partitions to divide up a space or it may involve building walls to create rooms.
appropriate for assessment and recovery, toilets, a kitchen, space for staff if possible. (Don’t underestimate secure storage space for kit). The solution may be permanent, like the building used by Emilia’s Place in Hereford, or it may be temporary partitions like Clapham’s NightHub.

**Financing**

Any interest payments should be included, e.g. the financing of any vehicle purchase or loans required for capital expenditure.

**Staffing**

As the section on staffing your scheme later in the toolkit notes, the safe space team may be a mixture of paid and volunteer workers, or it could be all paid staff. You may wish to contract in a provider e.g. St John’s Ambulance.

Even if you plan to rely predominantly on volunteers, you will almost certainly need a paid coordinator. Even if this is part-time (which should be adequate) expect to budget around £10k to £25k a year. For example, the Clapham NightHub coordinator is funded by the local church and BID part-time for £15k a year. Even if seconded from the council, ambulance or the local hospital, this may require re-charging.

Paying overtime is something to be wary of. In getting the scheme off the ground it may be unavoidable, but in the long-term it will make virtually all safe space schemes unviable.

**Training**

This is one of the most important aspects of setting up the safe space. At present, there is no officially recognised training programme for safe space staff. The absence of a robust alcohol and illegal drug component in existing first aid training is a real concern.

Hereford’s Emilia’s Place have developed a bespoke safe space training comprising 1, 2 and 6-day courses for their staff and volunteers. This includes specialist first aid, but also manual handling of inebriated users and safeguarding. They also train door supervisors so they become components in the safe space system.

**Supplies**

The costs of supplies are relatively low and usually limited to medical provisions, cleaning products, tea and coffee. A small amount should be built in each month – around £100-£200 – for these. If they don’t come included with a contracted medical service, it’s a good opportunity to seek sponsorship where they can be gifted by a local business or hospital.

**Other costs**

There are other costs which you also need to factor in, where relevant. These include:

- Vehicle excise duty
- Vehicle fuel and servicing
- Business rates for buildings (discounts are available for charities)
- Heating, electricity and other utilities
- Marketing and promotional materials
- Risk assessment
- Vehicle or buildings insurance and, additional to this, public and employee liability insurance for operating your safe space.

The latter is crucial: Emilia’s Place worked with Lloyd’s of London to create a bespoke policy for their safe space.
**Contingency**

Like any business plan or project costing, a 10% contingency is a minimum. If converting a building or vehicle, 20% would be sensible!

**Contracted services**

If you choose to contract a medical provider, such as St John’s Ambulance or Emergency Medical Doctors Service, then most of the costs are included. But a coordinator is still needed to manage the contract, market the service, collate data and report upwards.

**Income**

It is possible with a vehicle to earn revenue from hiring it out.

Medway rented out its bus to other council directorates who wanted to deliver outreach work.

However, whilst generally successful, it brought in much less revenue than expected. As such, it is probably best to see this as the ‘cherry on the cake’ - if it happens, great - rather than an integral part of your business plan.

**What’s next?**

Once you’ve built a skeleton business plan, it’s time to start pitching it to partners.
STEP FOUR
How do we secure backing?
**INTRODUCTION**

The process of creating a business plan to ‘build the case’ for your safe space and ‘securing backing’ will probably take place concurrently. However, the more evidence you have of why safe spaces work and what they can do for your town, the easier securing support will be.

There is a good reason for this. Our case studies, as well as some other safe spaces, faced considerable scepticism. All the UK schemes have also emerged during a climate of public sector austerity, making financial backing harder than ever to achieve.

More positively, some schemes found that certain partners ‘got it’ (the safe space concept) straight away. But even with a favourable tailwind, be prepared for hard work!

**BUILDING A PARTNERSHIP**

You will need a broad range of partners (regardless of whether they end up funding your space). There are three reasons why engaging broadly with partners with is crucial:

1. Partners often have experience, good ideas and assets that can help speed up time to launch.
2. Partners invariably get annoyed if they’re left out (and can even frustrate your well-intentioned plans).
3. Some, not many, but some may even have money!

To this end, we would recommend the following partners (where present) are invited to be part of your safe space working group:

- Council (community safety and public health)
- Hospital (A&E)
- Ambulance service
- Police
- Street pastors and local faith organisations
- Clinical commissioning group
- NTE businesses (e.g. via PubWatch, Best Bar None or the local BID)
- The town centre manager.

Other partners that may be able to help should also be engaged:
- Other business e.g. via town centre management company or chamber
- Public transport providers (who may be able to offer an old bus)
- Local university or colleges (who may want to involve their students as volunteers)
- CVO (council for voluntary organisations, to advise on volunteering)
- Council (marketing and PR to raise profile of the scheme).

Initially, the more senior the individuals from each stakeholder, the better (i.e. because they have more influence). They can always delegate membership to a colleague later.

The research tells us that, with notable exceptions (e.g. Exeter safe space which is led by a paramedic), that the ambulance service and police will be most wary (possibly viewing you as well-intentioned ‘do gooders’), whilst hospitals often say they are too busy. Crucial to Emilia’s Place getting Hereford’s A&E and ambulance service on board was their rigorous approach to risk assessment and risk mitigation.

Generally, late night businesses will help, even if it’s just providing free security staff, but they tend to see the benefits straight away.

Finally, it’s important to remember that in your organisation, it’s not just you. There are numerous examples where a frontline council officer, paramedic or nurse has built support for a safe space in their town but the scheme has failed to gain traction because they have been unable to convince senior management of its value. Work with internal partners as well as external ones.

**Funding**

Despite the many benefits and public sector resource redeployments, safe spaces cost money, particularly if you are going to operate it on a sustainable basis (see Making Your Safe Space Sustainable). You will know this from your business plan. So, make sure all your partners also know this.

Volunteering, goodwill and in-kind contributions go a long way (volunteer hours can count as ‘cash in kind’ for match funding from some streams); indeed, they can make a service possible that would otherwise be uneconomic. However, gaining commitment to fund from partners remains critical.

**Naming**

Don’t forget to choose a name! That’s the fun bit. The term ‘safe space’ is a useful catch-all, not prescriptive. Locations across the UK have used names including help point, help zone, safe bus, SOS bus, safe place, safe haven, night safe and oasis.

Cardiff’s Alcohol Treatment Centre is the only safe space that uses the word alcohol. The reason other schemes have eschewed the words alcohol or drugs is that they wanted to take the focus away from their project being solely about intoxication (most provide other services), as well as making the space about the welcome and safety rather than ‘medicalising’ the project.
STEP FIVE
What staff will our safe space need?
**INTRODUCTION**

The evidence suggests there is no right or wrong way to staff a safe space. Most commonly schemes use a combination of paid and volunteer staff but some schemes seconded staff from councils and BIDs. In other locations staff are provided by outside contractors. It also depends on whether you want to implement a medical-led model or a recovery model. Each variation on the model has its strengths and weaknesses, and we outline these below.

**PAID STAFF**

The advantage of paid staff is the expectation that they will deliver on their role or obligation. However, there is the obvious cost over volunteer staff, and paid staff still require line management and external contractors need performance management. These are areas where some schemes have struggled.

**Volunteers**

Volunteers are often critical to the sustainability of a safe space scheme. But, crucially, they should not be looked on as a source of free labour. Yes, they can bring down costs, but training and volunteer management requires money and hard work from the coordinator.

Volunteers in existing schemes come from a range of sources e.g. local faith groups, universities and colleges. Street Pastors have sometimes contributed to staffing schemes, but in most cases, they need to focus on their role out in the street – it’s hard enough recruiting volunteers without them having to staff safe spaces as well. However, they are a key partner.
Roles

Coordinator

“If you want to fail, fail to employ a coordinator” was a quote from the research. Although not a guarantee of success, the research shows that every safe space that has thrived has been driven by a coordinator. They may be seconded from another organisation, or employed specifically for this role. Their job description (which should be agreed upon in advance will include most or all the following (in addition to any tasks specific to your local situation):

- Business planning
- Securing a building or vehicle and any conversion and repairs
- Fundraising, lobbying and stakeholder engagement
- Procuring contractors, insurance and other services
- Volunteer recruitment and management (if this model is chosen)
- Organising volunteer training
- Staff rostering
- Risk assessment and risk management
- Performance data and reporting to the board
- Communications, PR and marketing
- Ordering and managing supplies
- IT systems
- Arranging parking, if vehicle-based (for a single decker bus this can be a major issue)
- Repairs to the vehicle or building
- Arranging data collation and producing performance reports
- Ensuring management of the safe space on the night and ensuring staff get home safely
- Following-up safe space users.

Frontline medical staff

Safe spaces either fall into medical-led schemes (e.g. Cardiff Alcohol Treatment Centre) or assessment-led (Hereford’s Emilia’s Place). The former model can treat (and discharge) a proportion of users in-situ, whereas the latter, basic first aid aside, specialise in recovery and pastoral care and follow an “if in doubt, get them out” (i.e. to hospital) care pathway.

In the case of the medical-led model a medical decision maker is required. In the research this tends to be a paramedic, emergency nurse practitioner or, in some cases, a doctor with emergency department experience. Sources for your medical lead could be from a ‘private’ provider, such as St John’s Ambulance, although on occasions, the local hospital or ambulance service has provided this individual.

Whether medical-led or care-led, the assessment by the safe space lead of those who cross the threshold is the most important function of your safe space. This is because they are (or should be) the expert. They not only ensure that the care given in-situ is first class, but most importantly, they can make the decision on whether a user needs to go to hospital.
This is the most significant decision anybody ever makes in a safe space. It could be fatal if a user with an undiagnosed head injury was left to recover after less qualified staff made the decision that they were simply intoxicated and needed to ‘sleep it off’.

Medical support staff

Most safe spaces will usually have two or more trained first aiders who manage minor injuries in a care-led model or support the senior medical worker in a medical-led safe space. They should be appropriately trained and capable of delivering CPR and competent in the use of a defibrillator.

Security

Security of safe space users and staff is of paramount consideration. Virtually every single safe space has some security provision. You may only need one member of staff, but some schemes in very busy locations have two. They can often help with other tasks around the safe space as well as performing their security role.

The main question you will need to answer is whether to use the police (if willing) or hire private security. Both have benefits and drawbacks.

The police are often willing to support safe spaces once they understand the concept and its benefits to the force and the community. And, whilst some forces charge, others, because they are unable to contribute financially, have provided an officer gratis as their input. The advantage is that they are highly trained and are plugged into the emergency services network.

However, anecdotal research suggest that their official presence can deter some in need from using a safe space - several schemes started with police but moved to private security because of this situation.

Many schemes have found that private security is generally a better option and lower cost (if the police aren’t prepared to fund an officer). Many schemes have also received security in-kind from a local night-time business.

It is worth noting that one scheme, Hereford, has chosen not to operate with security as they feel it can provoke not prevent security and are confident in the rigour of their model and assessment procedures.

Type of person

It goes without saying that all your safe space staff should be DBS checked, but after this, the most important quality is attitude. They will be getting home late – possibly 4am or 5am, so it’s not for everyone. This applies both to paid staff and volunteers.

Given the complex situations they find themselves in, it is also important that they have aptitude for decision making in stressful circumstances. They need to be ‘people people’ and sometimes they will have to witness difficult or unpleasant situations.

On the upside, those who work in safe spaces tend to be hugely satisfied in their work and almost universally recommend it to others. Safe spaces also tend to have low levels of staff and volunteer turnover. This is particularly the case where individuals have been carefully recruited.
STEP SIX
Bus, building or both?
INTRODUCTION

Firstly, there is no right or wrong answer to whether a bus or building is better! And, often, more than any other part of the safe space process, the decision is driven by pragmatism.

For example, if an old bus or empty building is available. Great, but stop! This could be the road to disaster. Often the cost of repairing a building or the maintenance costs of an old vehicle can (and have) threatened a scheme before it’s even opened its doors. Therefore, it’s vital that if a ‘free’ vehicle or building is offered, the appropriate conversion and maintenance costs are built in to the business plan.

VEHICLES

Vehicles can range from small paramedic ‘rapid response vehicles’ (RRV), medium-sized ambulances such as those provided by St John’s and the local ambulance service, through to a converted single deck bus like those in Bournemouth and Colchester.

All three types have both advantages and disadvantages. For example, smaller vehicles can get around town when called out by Street Pastors, the police or security staff. But they offer no space for users to recover.

Chelmsford tried pop-up gazebos alongside a paramedic RRV and whilst this was a workable solution in summer, by winter it became quickly apparent it didn’t offer enough protection and they brought in a larger vehicle.

Medium-sized vehicles (ambulances) can provide space for treatment and perhaps one person to recover but are limited beyond this.

Long vehicles are much better suited to the safe space role as they have space for assessment, treatment and recovery. Although vehicles need to remain in one location during the night and cost considerably more to purchase and convert.

Also, buses can be rented out during the day for other community uses to increase their viability.

However, schemes should be careful not to overvalue the income that can be generated from this - Medway overestimated this by many times.

Hereford have achieved, what for them is the best of both worlds, by having a response vehicle and building. They can support people on the street or, if they need recovery and supervision, then they can be brought back to their fully equipped building – Emilia’s Place.

Regardless of the solution, CCTV (capturing both sound and vision) is imperative in the safe space for incident recording and safeguarding.

BUILDINGS

In some circumstances, buildings may have some advantages over vehicles (see below), but come with their own issues. For example, they can be expensive to convert and to configure into an appropriate set up for a safe space.

Likewise, the repair bill on a building that is gifted or leased at a peppercorn rent could be huge, so signing a rent and repair lease, however low the rent, should be very carefully considered.

PRACTICALITIES

If a scheme is gifted a building in good condition, then it may just be heating and electricity that needs to be paid for. Alternatively, renting a space in a city centre with high land values means the bill could be in the tens of thousands.

For a vehicle, it may be the rental cost as part of a contracted service or it may be that a new or
second-hand bus needs to be procured. This could cost from the low tens of thousands to well over £100k for a new bus conversion. Many schemes started out with an old bus from a local transport company and converted this into a safe space. The advantage of this is that even if the bus needs to be replaced within two or three years (which it almost certainly will need to be if an old vehicle) the scheme will have had time to prove itself. This provides a valuable platform on which partners can then decide whether to invest in a new vehicle.

It must be reiterated: a ‘free’ vehicle will almost certainly require at least several thousand pounds to keep it roadworthy each year. Parking and security should also be considered, and a decision made about who will drive it (and who will drive it if the main driver is unavailable).

Overall there is no perfect solution. What is right for your location depends on local demands and what building or vehicle options are available.

**LIST OF PROS AND CONS**

**Buildings**

**Advantages**
- Buildings tend to be larger than vehicles, potentially providing more space.
- Buildings can be more flexible e.g. separate rooms for admission and assessment, recovery and interviewing.
- The building is always in the same location.
  Both users and partners know where to come.

**Disadvantages**
- A building’s location is fixed and if the night-time economy changes this might mean they are more difficult to access.
- They can be high maintenance; particularly if the building is in poor repair.
- Configuring rooms to function as a safe space may be difficult and costly (or even impossible if the building is listed).
- Once fitted out buildings cannot be used for other purposes, unless the design is flexible.

**Vehicles**

**Advantages**
- Flexible location as night-time economy changes.
- Vehicles are mobile, allowing multiple sites even during the same night.
- They can be placed in the highest visibility location to maximise walk-ins.
- They can be visibly branded to communicate their purpose to potential users, the services being offered and the sponsor’s brand.
- Vehicles can be used across several towns to spread the cost.
- They can also be used for purposes other than safe spaces, such as youth work, community health provision and outreach during the day.

**Disadvantages**
- Vehicles, particularly large buses, can be costly to purchase, operate and repair.
- Ambulance vehicles may allow assessment and triage but due to size not recovery, which is a key part of the safe space model.
- Large vehicles can be difficult to position in town centres. Smaller vehicles tend to be more agile but have much less functionality.
- Driver training and vehicle insurance (in addition to public liability insurance) are additional costs
- Vehicles need a parking solution. For a large bus this may be problematic.
STEP SEVEN
What services can our safe space offer?
**INTRODUCTION**

The research that underpins this toolkit did not prescribe a definitive list of ‘must have’ safe space services – it’s very much your decision. However, all safe spaces currently provide some form of assessment, first aid and recovery. Some schemes provide additional services, ranging from mobile phone charging to referring users on to other services, e.g. alcohol brief interventions.

**ASSESSMENT**

Assessment of users (whether they walk through the door, are accompanied by the police, friends or dropped off by a taxi driver or paramedic) is the crucial first step. At this point, personal details are also taken (this is not always easy!).

In a medical-led scheme assessment should be undertaken by the senior medical practitioner (e.g. emergency medical practitioner, paramedic or doctor) or in a care-led model by staff or volunteers trained by those above.

Most schemes divide users into three categories:

1. Those with life-threatening injuries or intoxication.
2. Those that are moderately intoxicated or may have taken illegal drugs, but may have concussion and require full A&E assessment and supervision in a hospital environment.
3. Those with minor injuries that can be triaged in-situ and/or who are mildly to moderately intoxicated and need to recover in a supervised environment.

In most circumstances, and certainly in care-led schemes, only category 3 should be dealt with in the safe space. There is room in a medically-led scheme for a practitioner of sufficient seniority to make decisions to ‘treat’ patients and offer them a more sophisticated level of in-house care.

However, all other cases require an ambulance or transporting to A&E in a safe space vehicle, whichever is the most appropriate. As Hereford say, “If in doubt, get them out”.

**FIRST AID**

For those that have minor scrapes, cuts and twisted ankles the, first aid and recovery (see below) are the bread and butter of the safe space programme. To this end you will need multiple first aid kits and the space with chairs and at least one bed to attend to users (now patients).

Most schemes also have a defibrillator and staff (not just senior medics in medical-led schemes) are trained to use it.

**RECOVERY**

Recovery space is crucial. Most schemes offer beds or mattresses where intoxicated individuals are monitored for vital signs every ten or fifteen minutes - take advice from your medical lead.
To ensure that users can recover and be discharged as quickly as possible, Hereford’s Emilia’s Place turns users every 30 minutes.

Whilst it is possible, if space is very tight, to allow for recovery in a chair, a horizontal bed to facilitate the user to be placed in the recovery position, is best. This can be, and usually is, as simple as mattresses on the floor.

A space should be warm and blankets provided to ensure users, who may have been out in the cold for hours, do not suffer from hypothermia and recover as quickly as possible. Rehydration is key to recovery.

**Pastoral Care**

A critical element of safe spaces is creating a non-judgmental environment in which users can feel safe, just as street pastors operate in their role.

Having staff who are inherently ‘good listeners’ or better still, trained, is crucial.

There is a crossover here with safeguarding (below) where listening and asking the right questions may allow your staff to uncover more serious issues that may be driving their behaviour.

A good example if this approach working was a repeat user of Brighton’s Safe Space (repeat users are themselves unusual in schemes). Through effective listening it transpired that the user had been sexually assaulted and was using excessive alcohol consumption to cope with the problems this had brought. The user was signposted to the appropriate mental health services and was offered the appropriate counselling.
The Safe Space Toolkit: A step-by-step guide to creating a safe space in your town

Taking people home

Every safe space needs one or more methods to ensure those users (who aren’t taken to hospital) get home safely, once they’ve recovered. The default method is to call a friend or family member.

However, it may be that they can’t come immediately or are away. In this scenario, some safe spaces user their own response vehicle, if they have one (though this means it will be unable to respond to incidents).

The default option is to work with a local taxi company with DBS checked drivers who have been trained by you in your protocols, e.g. handing over users to friends and family / confirming that they are home safely.

Referral services

One area (which the Toolkit expands further in the Behaviour Change section) is signposting people to other services. The research suggests that it may be very hard to deliver normal brief intervention services on alcohol and illegal drug use in safe space settings. However, users can be signposted to local services using leaflets and business cards. There is no evidence at present whether this is effective in users seeking advice and subsequently changing their behaviour.

Many schemes, have found that rough sleepers, often with drug and alcohol problems, use their safe spaces as a place to keep warm, get some food and drink and for companionship. This can be challenging as they nearly always have complex needs and safe spaces should have a clear route into homeless services and an approach to managing them if they visit.

Safeguarding

Safeguarding is critical given the vulnerability of users when they arrive at your safe space. You may also have to occasionally care for under 18s and there is a chance that you could find your scheme involved with a user who has been the victim of child sexual exploitation (CSE).

There is now a duty on all local authorities, police and charities to ensure that any interventions they are involved with have a duty of care towards children and certain ‘vulnerable’ adults.

But safeguarding procedures and protocols should apply to every individual entering your safe space. You should develop effective safeguarding protocols and record keeping and advice can be sought from your local adult and children safeguarding boards.
STEP EIGHT
How do we manage risk?
INTRODUCTION

Before the doors open, it is critical that rigorous internal procedures are developed between partners. At the core of this is creating the safest safe space possible and key to this is managing risk. This is particularly important if your space is care-led rather than medical-led and it’s not headed up by a high level medical professional.

‘Safety’ is defined by removing or recognising and reducing risk to an acceptable level.

Many safe spaces, particularly in their early stages, overlooked risks of bringing people, often in a highly-intoxicated condition, into their facility. Once you bring people into your building or on to your vehicle you are almost certainly responsible for their safety, legally!

Calling it a safe space does not make it safe; you are bringing inherently unpredictable, medically unstable people into a confined space to mix with other people some of which may also be unpredictable with volunteers who may be naïve about risks. Risk needs to be recognised, mitigated and proactively managed by clearly defined protocols and rigorous on-going training.

RECOGNISING RISKS

The first task is to properly risk assess every aspect of your operation and document it. Involve partners – each view risk very differently and each view needs to be considered, e.g.

- Police – risk of disturbance
- Health – medical risk
- Social services – vulnerability
- Fire - evacuation
- Volunteer organisations – safe working.

For example, in Hereford, achieving partner sign off took over 3 months.

GENERAL RISK MANAGEMENT

There are at five key steps to managing risk:

1. Appraise and make sure your risks are captured and use this to inform your operating protocols, always remembering the goal is to prevent not respond to situations. Make mitigating risk a way of working!

2. Invest in training and briefing people properly - consistently and constantly.

3. Make sure you capture feedback on any times people felt ‘unsafe’ – usually this indicates an unmanaged risk needs addressing in your protocols.

4. Have a means of rigorously reviewing any ‘near-misses’ when things have gone wrong and create a culture of honest sharing where the emphasis is on learning not passing judgement or allocating blame.

5. Keep a risk register that includes an annual review process.

SAFE SPACE-SPECIFIC RISKS

The research suggests there are four categories of risk specific to safe spaces.

Legal

Bringing people over a threshold changes the rules.

- Caring for people on the street is about applied common sense but in passing over a threshold there is a clearly implied higher level duty of care and legal liability in the event something goes wrong.
When lots of people are working together it is important to know clearly who is responsible for what and where the buck stops, as even professional agencies will have different ways of dealing with what appears to be the same incident or problem.

**Physical**

Make sure your space is fit for purpose, so think about:

- **Appropriate space** One of the largest risks is putting people into a confined space, so it’s important to think carefully about that space.

- **Configuration** Segregating people – male and female; those being helped and any ‘helpful’ friends.

- **Hazards** Removing objects that could harm people – glass, sharp cornered objects, things that could easily be picked up and used as a weapon.

- **Flexibility** Specific areas to perform specific tasks e.g. medical treatment vs soft interview area for police.

- **Mess** How you will manage medical contaminants such as blood and vomit and medical waste?

**Medical**

Medical risks of running a safe space are high – you will be the first people to assess those with injuries and / or intoxication and decide whether to send to hospital or monitor recovery.

- **Obvious risk** Many people die from choking on or inhaling their own vomit so making sure everyone is placed in the recovery position and checking them ‘regularly’ is essential.

- **Dynamic risk** Alcohol and/or drug impaired people are ‘dynamic casualties’ – their condition is constantly changing depending on what they have taken, in what quantity or format and when. A focus on their safe recovery can blind us to the risk that they can easily and rapidly deteriorate.

- **Disguised conditions** Many common conditions have the symptoms of someone appearing drunk. For example, hypothermia, epilepsy, concussion and stroke. Some schemes breathalyse and drug test everyone so the team know what they are dealing with.

- **Underlying conditions** Hereford’s Emelia’s Place checks carefully for underlying conditions. Between 1 in 2/3 of those assessed have been discovered to have underlying conditions – some very serious: a girl with an inherited heart condition; several epileptics and many on prescription drugs.

- **Emerging risks** It is important to keep abreast of ‘what is out there’ – especially ‘lethal’ highs or new trends in drugs. Make sure the police and health service alert you to any relevant intelligence.
Practical

Managing the non-medical response is almost as important as the medical. Almost!

- **Friends** Often the friends of those being helped can present the biggest risks. As one police inspector said, ‘After a couple of pints everyone can be a medical expert or even brain surgeon.’ Interfering or difficult friends must be considered.

- **Getting people home** Once you have taken someone in you have a ‘duty of care’ to make sure they leave safely. There is a risk they are not well enough to leave, their friends are not trustworthy, their home is not safe to go back to or they become a ‘missing person’.

- **Responses** It’s easy to think the main risks are with those brought into the safe space but helpers also can present a risk – especially if they are new to situations where things can change suddenly. People respond to challenging circumstances differently: some freeze; some flee and some fight.

- **Training** It’s important that people are capable in the task that they are responsible for – especially when dealing with high risk dynamic casualties. In Hereford, everyone is required to complete specialised training, but only those who are sufficiently skilled and experienced are selected to be responsible for making ‘triage’ decisions.

- **Trauma** Safe spaces often expose well-meaning helpers to things they may never have encountered: someone making a disclosure of abuse or domestic violence; a medical emergency involving a serious wound or demanding CPR; someone becoming threatening or violent. The risk of trauma (mental and physical) is real and needs to be managed.
STEP NINE
How do we make our safe space sustainable?
**INTRODUCTION**

If you thought getting your safe space off the ground was hard work, then making it sustainable will be even harder. The research shows that virtually every scheme’s funding streams are insecure and some projects live hand-to-mouth. If your scheme is to survive, the more you address sustainability at the earliest opportunity the better chance you have of making it past year two.

**PILOTING**

A critical element of ensuring the long-term sustainability is to undertake a short-term pilot. Nearly all the schemes in the research started with a pilot of some kind. This acted as ‘proof of concept’, particularly to funders unsure of whether to invest.

Piloting is also key to evidencing whether a safe space concept can work in your town or city, and establish if there is enough user demand, particularly if yours is a small town.

The research also shows that piloting can help in several other areas that contribute to sustainability, such as data gathering (see below), gauging local political, business and public support and ‘sense-checking’ your business plan predictions.

As well as addressing sustainability, piloting will allow you to quickly evolve practical solutions, such as the location of the safe space, internal management systems and protocols, marketing and social. For example, Chelmsford found that their gazebo space was great in summer but by the autumn they needed a vehicle-based solution.
By piloting you should aim to demonstrate value for money and revise your business plan to pitch for continued funding. This is key to sustainability. The length of pilot is up to you but most locations in the research used periods of six to nine months.

**Governance**

For the ongoing sustainability, good governance is crucial. A structure should be considered at the outset, it can always be modified later.

Safe spaces can use different approaches to ensuring good governance of the scheme. This may be via existing democratic structures such as a community safety board or a police and crime commissioner. Other solutions involve reporting to a BID or town centre management organisation.

Regardless of the specifics, what matters is that an accountable body oversees your safe space’s direction. It’s also important that a broad range of interests are represented in its governance, even if only a single organisation is funding it.

This is important for propriety (accounts, appointments and so on), but also because regular meetings between partners means they remain abreast of issues and are actively engaging with the safe space agenda.

Some safe spaces have set up as companies limited by guarantee or CICs, whilst others are simply extension of the local authority or a registered charity / voluntary organisation.

**Measuring performance**

There are three reasons to collate data about safe users.

1. One is to ensure you have the figures for the number of ambulance call outs and A&E visits prevented.
2. To build the evidence base for the impact of the safe space and to make the case for ongoing funding.
3. To help monitor any trends and allow service planning e.g. volunteer numbers on busier times e.g. ‘payday’.
4. To identify any premises from which a disproportionate number of individuals are ending up in your safe space.

The types of data collected by the safe spaces that participated in the research included:

- Date of birth / age
- Gender
- Ethnicity
- Address (or if homeless)
- How they arrived (e.g. alone, friends, police)
- Intoxication (alcohol, drugs, both and level)
- Reason for visit
- Treatment, where relevant
- Time of visit and of discharge
- How they were discharged (inc if arrested)
- Where they had their last drink (may be home)
- If they had been pre-loading at home
- Student or not (useful in university towns)
- Any specific observations and recovery and discharge notes.
- What would users have done if they hadn’t attended the safe space (useful for calculating the number of A&E visits avoided).

Data should be anonymised if shared and you should be on the Data Public Protection Register with the Information Commissioners Office and follow best practice protocols about use of and storage of personal data.
STEP TEN

Can you change your users’ behaviour?
**Introduction**

The research shows that there has been very little attempt to change the behaviour of those who end up in safe spaces because of alcohol or illegal drug misuse. Certainly, delivering brief intervention services to a safe space user recovering from intoxication has not been tried by any of the schemes in this research.

What we do know, is that not many safe space users return – they are not ‘frequent flyers’. But we don’t yet know whether this is because their first safe space visit has been a ‘wake-up call’ and they are being more careful, or that they have simply carried on with their unhealthy drinking and / or illegal drug taking in other settings e.g. at home or at house parties but are too embarrassed to use the safe space again.

The anecdotal evidence from schemes such as Emilia’s Place suggests that users are cognisant of the gravity of the situation they found themselves in and are extraordinarily grateful towards staff for their help.

One of the recommendations from the research on which this toolkit is based is to undertake more research with users and to develop a bespoke behaviour change programme for those who find themselves in a safe space having drunk too much or having taken illegal drugs. It is anticipated that this will be available in due course for you to use in your safe space.

Until then, this is an area where your safe space could be at the cutting edge by developing a unique approach to behaviour change. However, this should be approached with caution, for example, in liaison with experts at a local university to devise, implement and measure the effectiveness of a behaviour change programme, as well as ensuring it is ethically appropriate.
**What can you do now?**

In the absence of an evidenced-based approach to behaviour change, there are several interventions you can consider, which may have some impact on future behaviour.

**Giving out information**

About a third of the schemes in the research gave out printed materials to users suggesting how they could avoid ending up in safe spaces again. The materials included responsible drinking messages and where to get help via their GP or local drug and alcohol services.

**Following up**

Around a quarter of safe spaces ‘follow up’ those who have used their scheme (checking they got home and that they were now recovered). Sometimes they might broach the subject of behaviour change but it appears rare.

**Alcohol worker**

Cardiff’s Alcohol Treatment Centre has a nurse practitioner with experience of ‘alcohol brief intervention’ who can give advice on the night to users or their friends.

However, ‘alcohol brief interventions’ (ABI) are not a formal part of the Cardiff scheme. This is an opportunity that new schemes may wish to explore because we know that ABIs do work in changing people’s behaviour in other settings.

**Peer influencers**

Hereford (below) – has been using sixth form students as highly trained volunteers and they get to see others around their own age who have misused alcohol.

Whilst unmeasured, it is thought that these individuals understand that, if they choose to drink, why moderate alcohol consumption is the only appropriate behaviour to adopt.

In turn they return to their educational and social settings as advocates for moderation. This is an area that requires further evaluation as it shows promise.
Resources
**SAFE SPACE STUDIES**

Here are the studies on which this *Safe Space Toolkit* has drawn. All show the positive benefits of safe spaces as well as the challenges schemes face. We suggest you read them… all! You can learn *almost* as much from them as you can from the toolkit!

<table>
<thead>
<tr>
<th>WHAT</th>
<th>WHY</th>
<th>WHERE</th>
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<tbody>
<tr>
<td>Moore et al  <em>Cardiff Alcohol Treatment Centre Evaluation</em>  2013</td>
<td>The most detailed and robust academic evaluation of the impact of an individual safe space conducted so far. An excellent source.</td>
<td><a href="http://bit.ly/2ncbiAN">http://bit.ly/2ncbiAN</a></td>
</tr>
<tr>
<td>Jarrett &amp; Murray  <em>Soho Alcohol Recovery Centre: An Economic Evaluation</em>  2012</td>
<td>Early study flagging positive impact of Soho’s safe space. Yet despite this, the scheme closed. This highlights that evidence alone is not sufficient – partnership is crucial.</td>
<td><a href="http://bit.ly/2mLU2aa">http://bit.ly/2mLU2aa</a></td>
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Contact
**NEED MORE INFO?**

Here are some people and organisations you may find useful in your quest to set up a safe space.

<table>
<thead>
<tr>
<th>WHO</th>
<th>WHY</th>
<th>WHERE</th>
</tr>
</thead>
</table>
| Portman Group                      | Funder of this *Toolkit*, promoter of responsible alcohol consumption and key partner in Local Alcohol Partnerships Group. | Rita King  
Local Partnerships Director  
rking@portmangroup.org.uk |
| MAKE Associates                    | Authors of this *Toolkit* and undertook the research on which it is based. Experts in night-time economy. | Alistair Turnham  
Founder  
alistair@makeassociates.com |
| Street Pastors and The Ascension Trust | Discussions with your local Street Pastors can be a useful first step in understanding how they might be able to help get your safe space off the ground. | www.ascensiontrust.org.uk |
| Purple Flag / ATCM                 | There are around 20 Purple Flag towns with safe spaces. The ATCM is happy to put you in contact with them. | Sarah Walker, Purple Flag  
sarah.walker@atcm.org |
| Chelmsford SOS Bus                 | Innovative scheme on a small budget that was up and running quickly and which adapted fast. | Spencer Clarke  
Community Safety Manager  
Chelmsford City Council  
spencer.clarke@chelmsford.gov.uk |
| Clapham NightHub                   | Perhaps the best example of partnership working within a safe space context. | Diane Grano  
NightHub Manager  
diane.grano@holytrinityclapham.org |
| Emilia’s Place, Hereford           | Possibly the most developed safe space solution nationally. Highly process and outcome driven. | Robert Thomas  
Chief Executive  
Vennture  
robert.thomas@vennture.org.uk |
| Swansea Help Point                 | An exemplar of public sector led and evidence driven safe-space operation. | Dan Jones  
Office of South Wales Police & Crime Commissioner  
Daniel.Jones10@south-wales.pnn.police.uk |
The authors would like to thank to all those stakeholders, interviewees and particularly the case study locations that have given their time to the project.

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The authors of the Safe Space Toolkit provide it free of charge as a resource. It is for informational purposes only and does not constitute advice. The authors do not accept any responsibility for its subsequent use and those setting up a safe space do so at their own risk.

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