Evaluating NHS Mental Health Crisis Hubs in London: Final Report

By Health Innovation Network October 2022

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Camden and Islington NHS Foundation Trust

North East London Foundation Trust

Oxleas NHS Foundation Trust

South London and Maudsley NHS Foundation Trust

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- Southeast London ICB
- South London and Maudsley NHS Foundation Trust
- South London Partnership
- Southwest London and St George's NHS Mental Health Trust
- Southwest London ICB
- West London NHS Foundation Trust
- Whittington NHS Trust

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1.Executive Summary

Overview

The London Mental Health Crisis Concordat made a commitment to work together to improve the system of care and support. This is so that people in mental health crisis *'are kept safe and helped to find the support they need, whatever the circumstances in which they need help, and from whichever service they turn to first'*[1]. During the first wave of the Covid-19 pandemic to deal with emergent issues, new models of emergency mental health crisis hubs were rapidly put in place by service providers. However, there has been considerable variation of approach, due to different local contexts, but also due to the paucity of research evidence available regarding optimal models for crisis care, and the lack of best practice guidelines (London Mental health crisis hub Assessment Framework[2]).

In February 2022, NHSEI London commissioned the Health Innovation Network (HIN) to complete an evaluation with the following aims:

- To gain a better understanding of the different mental health crisis hub models that are still in operation and their potential impact at a service user, carer, practitioner, and service-level within London.
- Determine what factors affect the implementation and sustainability of NHS mental health crisis hubs.
- Determine the principles or core components of effective mental health crisis pathways (as an alternative to ED) for Integrated Care Systems (ICSs) and Integrated Care Boards (ICBs).

Evaluation design

The evaluation design has been directly informed by the London Mental Health Crisis Hub Assessment Framework[3]. This assessment framework was developed in 2020, specifically for mental health crisis hubs in London, to provide a minimum dataset to support monitoring and evaluation activities against six key quality domains:

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Patient Centred

A steering group consisting of three experts by experience (two service users and one carer), representatives from all nine London mental health trusts, the London Ambulance Service (LAS), the London Metropolitan Police (Met Police), Emergency Departments (ED), and NHSEI London also guided and advised the evaluation. This mixed-methods evaluation utilised a range of quantitative and qualitative

[1] National concordat - Mental Health Crisis Care Concordat Mental Health Crisis Care Concordat https://www.crisiscareconcordat.org.uk/national-concordat/
[2] https://healthinnovationnetwork.com/resources/london-mental-health-crisis-hub-assessment-framework/
[3] https://healthinnovationnetwork.com/resources/london-mental-health-crisis-hub-assessment-framework/

data collection methods.

Mental health crisis models in scope

It was agreed that three mental health crisis hubs and a business-as-usual (BAU) service were within the scope of this evaluation. These models provide a service 365 days a year, 24 hours a day:

- North East London NHS Foundation Trust – (NELFT) – Goodmayes Hospital
- Camden and Islington NHS Foundation Trust - (CANDI) – St Pancras Hospital
- Oxleas NHS Foundation Trust – (Oxleas) - Queen Elizabeth's Hospital
- South London and Maudsley NHS Foundation Trust - (SLaM) – Kings College Hospital (Business as Usual service, BAU)

Overview of findings

At the time of this evaluation there were three different mental health crisis hubs operating in London. Two mental health trusts in London (CANDI and NELFT) provide a mental health crisis hub that allows direct access to service users who are in a mental health crisis, through self-referral, signposting or via the emergency services. Several mental health trusts provide a mental health crisis hub that requires service users to attend ED to be referred to the crisis hub - Oxleas hub provides this model. The fourth model included in this evaluation is a Psychiatric Liaison Service, which has been established for 20 plus years, represents the majority of 365-day 24/7 crisis support provided by London mental health trusts termed throughout this report as the business as usual (BAU) model.

Although it is relatively early in the lifetime of the CANDI and NELFT hubs (circa 2 years), this evaluation is able to evidence that both these hubs are able to provide a timely service that enables service users to be seen on arrival by a mental health professional. These hubs have a growing proportion of service users that go directly to the hub and are evidencing that service users who have attended these hubs once, are more likely to self-refer if they need to attend again. This effectively reduces the number of people who attend EDs in a mental health crisis. There are also lower rates of referral to psychiatric liaison services for these two hubs compared with the Oxleas and BAU site. The majority of service users who provided their views and feedback on experience of these hubs said that they felt safe, had privacy, and were treated with kindness and respect by staff within the hubs who had a good understanding of mental health. There is however significant service user, staff, and stakeholder feedback on where improvements can be made for all the hubs included in this evaluation.

Key findings

Where possible and relevant, any comparisons are between the mental health crisis hub(s) and the BAU site. A consistent approach to data collection for each of the 4 sites was used to enable comparisons to be made, where this was not possible it has been stated.

Mental health crisis hubs:

- Two mental health crisis hubs (CANDI and NELFT) offered **direct access** to crisis care for service users
- One mental health crisis hub, Oxleas, required service users to be referred via the ED to access the mental health crisis hub. This is referred to as a **hybrid model** within this evaluation.
- CANDI and NELFT staffing included core trainee doctors, only CANDI located band 6 'nurse navigators' within their referring EDs.
- Locations of the mental health crisis hubs varied in distance and ease of transport from the referring/ ED sites

Safe

- The majority of service users and staff said they felt safe at the mental health crisis hubs
- The emergency services had positive views on the direct access hubs (CANDI and NELFT) reducing incidents of missing from care.
- There were concerns voiced by all about staffing levels and the impact on safety

Timely

- CANDI's hub had significantly higher proportions of patients that were seen within four hours.
- The average length of stay within the mental health crisis hub was significantly lower for NELFT and CANDI hubs compared with the BAU model.
- Service users dissatisfied with the timeliness of care at the mental health crisis hubs were mainly those who stayed in the hub longer than intended due to inpatient mental health trust bed shortages.

Effective

- **Discharge**
  - Discharge outcomes were mixed. CANDI's crisis hub had a higher proportion of attendances that were discharged back to the care of their GP.
  - NELFT had a higher proportion of attendances being discharged to a HTT or crisis team and a slightly higher rate of mental health inpatient admissions compared to the BAU site.
  - Oxleas hybrid model had higher rates of discharge to a mental health inpatient bed compared to the BAU site.
- **Repeat attendances**
  - Service users that re-attend CANDI and NELFT hubs, were significantly more likely to go directly to the hub (self- refer) rather than go to an ED.
  - Repeat attendances were significantly lower for the NELFT crisis hub compared with the BAU site.
- **Workplace satisfaction**
  - The majority of staff were satisfied with their workplace, training, senior leadership and reported feeling treated with dignity and respect by their colleagues and would recommend their service to family and friends.
  - The rate of vacant posts in the NELFT hub were low compared to the Trust as a whole.

Efficient

- The source of referrals to the CANDI and NELFT crisis hubs show that service users are being referred to the hubs through a range of organisations and not just ED.
- There was a higher proportion of self-referrals for the CANDI and NELFT hubs compared with the BAU model.
- There was a high proportion of referrals coming via the police and Home Treatment Team (HTT)/ crisis team at NELFT.
- Only small proportions of crisis hub attendances were redirected back to ED.
- The majority of service users felt that they had not received the treatment and care required, this was often linked with dissatisfaction with their discharge outcome.

Equitable

- **Recording of data**
  - **Age and gender**
    - The demographic profile in relation to age and gender of service users were well recorded at all sites and is broadly aligned between all the hubs and BAU site.
  - **Race**
    - One trust, NELFT, had good data recorded on service user ethnicity.
    - The BAU site had a higher proportion of black service user attendances than all of the crisis hubs and NELFT crisis hub had a higher proportion of attendances from people of Asian ethnicity than the BAU site.
  - **Sexual orientation**
    - One trust, NELFT, had relatively well recorded information on service users' sexual orientation but on the whole trusts' recording of sexual orientation was incomplete.
  - **Existing mental health condition**
    - A lower proportion of attendees at CANDI's crisis hub had an existing mental health condition known to the Trust compared with the BAU site.

Person centred

- 126 service users and carers were surveyed and 9 interviewed to inform this domain of the evaluation.
- A majority of service users said they felt safe, were treated with kindness, had privacy, felt that staff had a good understanding of mental health, were treated with dignity and respect, and felt listened to by staff.
- A majority of service users who attended an ED reported that they had to explain their story repeatedly and that their legal rights were not explained to them

Key recommendations

These key recommendations are intended to inform the core components of an effective mental health crisis hub. A full list of 22 recommendations is available in Section 8 'Recommendations'.

1. Mental health trusts to implement the London Mental Health Crisis Hub Framework to ensure a data driven approach is used to inform continual service improvement against the six quality improvement domains.

Safe

2. Mental health trusts to collect and report safety data to relevant decision-making bodies.

Timely

3. Mental health trusts to ensure ease of access to the location of the mental health crisis hub, by foot, transport, and transfer from ED sites.

Effective

4. Mental health trusts to consider including core trainee doctors within the hub staffing models to provide medical care if required.
5. Mental health trusts to develop an understanding of the impact of discharge outcomes, with the view to improve care within community settings and reduce mental health crisis hub reattendance.
6. Mental health trusts to implement effective methods for regular feedback from staff directly employed within the mental health crisis hub to drive continual improvement.

Efficient

7. Integrated Care Boards (ICBs) to communicate to the public, service users and carers and all stakeholders on how to access the mental health crisis hubs directly, in terms of location and referral criteria, to include why a person may be transferred from ED to a mental health crisis hub through a variety of methods e.g., posters, leaflets, email, texts and websites.
8. Mental health trusts to consider implementing a direct access route to mental health crisis hubs for service users (self-referral) and emergency services, with clear inclusion and exclusion criteria.

Equitable

9. ICBs to engage and communicate with the local community to ensure access to mental health crisis hubs reflect the demographics of the population.
10. ICBs to develop culturally relevant discharge support and recovery services.
11. Mental health trusts to improve recording of service user's ethnicity and sexual orientation.
12. Mental health trusts to ensure they have effective feedback mechanisms in place for services users of all races and ethnicities (in line with Patient and Carer Race Equality Framework) NHS England » Advancing mental health equalities.

Person Centred

13. Mental health trusts to implement effective methods for regular feedback from service users and carers on their mental health crisis hub experience to drive continual improvement.
14. Mental health trusts to ensure staff complete regular cross-team training to continually develop and improve person centred care and where possible consider involving service users and the third sector in the co design and delivery of this training.

2.Introduction

In January 2019, the NHS Long Term Plan made several commitments to improve crisis care nationally. This included working towards 24/7 community-based response, improved liaison services meeting 'core 24' service standards, and increasing alternative forms of provision for those in crisis. For London, the Mental Health Compact Diagnostics report identified that more than half of the people who went to emergency departments (EDs) for help because of their mental health waited more than four hours to get the right care and do not receive the care and support they need. The COVID-19 pandemic had only added to these long-term challenges. To mitigate the infection risk posed to people attending EDs during the COVID-19 first wave, NHS mental health trusts in London rapidly established new services (hereafter, mental health crisis hubs) to enable people with mental health needs to be assessed in spaces separate from ED.

In Autumn of 2020, NHS England, and Improvement (NHSEI) London commissioned the Health Innovation Network (HIN) and UCLPartners (UCLP) to evaluate the crisis models that had been put in place in response to the pandemic. The scoping for the evaluation demonstrated that there was a lack of comparable data provided by the London mental health trusts and it was agreed that the HIN and UCLP would engage with all London mental health trusts, alongside Acute EDs and London Ambulance Service (LAS) and Experts by Experience to develop a London Mental Health Crisis Hub Framework to support any future evaluation. The Framework was completed in December 2020, however, due to the pressures of another national Covid-19 lockdown in January 2021, it was not implemented.

Evaluation of mental health crisis hubs

Whilst many mental health crisis hubs were temporary measures in response to the pandemic, some continue to operate. NHSEI London team and London Urgent Care Board commissioned the HIN in March 2022 to complete an evaluation to gain a better understanding of the different models for mental health crisis hubs and their potential impact at a service user-, carer-, practitioner-, and service-level within London. Throughout this evaluation, the HIN has collaborated with a wide range of stakeholders involved in the commissioning and provision of mental health crisis services across London. The evidence collated will be used by commissioners and providers to establish core principles (or components) for effective mental health crisis hub models to support spread and adoption.

3.Aims and objectives

The aim of the evaluation was to understand the different models for current NHS mental health crisis hubs within London. Specifically, the evaluation will:

- Identify and describe the main types of current mental health crisis hub models
- Assess impact of current mental health crisis hubs (e.g., ED attendance, referrals to psychiatric liaison services)
- Understand service user and staff experience (satisfaction and acceptability) to include mental health clinicians of NHS mental health crisis hubs, and relevant representatives of Metropolitan Police Service and London Ambulance Service
- Determine what factors affect the implementation and sustainability of NHS mental health crisis hubs
- Determine the principles or core components of effective mental health crisis pathways (as an alternative to ED) for ICBs

4.Approach

This evaluation was delivered in three phases: (1) Scoping, (2) Data collection, and (3) Analysis, reporting and dissemination.

4.1 Evaluation scoping

During phase 1, the HIN worked with colleagues within the NHSE/I London team and other key regional stakeholders (e.g., London Urgent Care Board) to scope the approach to the evaluation.

4.1.1 London Mental Health Crisis Hub Evaluation Steering Group

The HIN established a London Mental Health Crisis Hub Evaluation Steering Group. This group comprised of three experts by experience, senior representatives of all nine London NHS mental health trusts, ICB representatives and senior representatives from London Ambulance Service, London Metropolitan Police and NHSEI London. The group met monthly since March 2022 to provide advice and guidance on the evaluation to the HIN.

4.1.2 Scoping the evaluation design

The evaluation design has been directly informed by the London Mental Health Crisis Hub Assessment Framework[4]. This assessment framework was co-developed in 2020 specifically for mental health crisis hubs in London to provide a minimum dataset to support monitoring and evaluation activities against key quality standards of: Safe, Timely, Effective, Efficient, Equitable, and Patient-centred.

A logic model was developed to support the development of the evaluation, which was based on the key elements of the mental health crisis hub model and London Mental Health Crisis Hub Assessment

[4] https://healthinnovationnetwork.com/resources/london-mental-health-crisis-hub-assessment-framework/

Framework (Appendix A).

In scoping the approach, the HIN:

- Set up a London Mental Health Crisis Hub Steering Group
- Engaged with all London mental health trusts to gain an understanding of each trust's current crisis hub model
- Identified the trusts that currently still provide a mental health crisis hub
- Met with trusts' business intelligence and service leads to understand what data can be provided to the HIN that meet the London Mental Health Crisis Hub Assessment Framework
- Recruited three paid experts by experience to both contribute to the Steering Group and co-design all aspects of the evaluation relating to understanding service user perspectives e.g., patient and carer survey, service user interviews

4.2 Evaluation design

This evaluation is a mixed methods service evaluation of three mental health crisis hub models and a business-as-usual (BAU) model of Psychiatric Liaison within ED. The evaluation has used a range of quantitative and qualitative methods, including online surveys, in-depth interviews, focus groups, analysis of routinely collected activity and outcome data, and reviewing documentation (e.g., Standard Operating Procedures for hub models).

4.3 Mental health crisis models in scope

Based on phase 1, three mental health crisis hubs and a BAU service were identified as in scope for the evaluation (**Table 1**). These models provide a service 365 days a year, 24 hours a day. Tables 2-4 provide a description of the three mental health crisis hub models provided by each mental health trust and Table 5 provides a description of the BAU site included in this evaluation.

Table 1 Mental health crisis hubs models in scope for evaluation

Type:	Trust:	Hospital:	Model:
Mental health crisis hub	North East London NHS Foundation Trust	Goodmayes Hospital	Direct access for patients to the mental health crisis hubs. Service Users / Carers are not required to go via the ED to access crisis care.
Mental health crisis hub	Camden and Islington NHS Foundation Trust	St Pancras Hospital	Direct access for patients to the mental health crisis hubs. Service Users / Carers are not required to go via the ED to access crisis care.
Mental health crisis hub	Oxleas NHS Foundation Trust	Queen Elizabeth's Hospital	Service Users go via ED prior to referral to the mental health crisis hub.
Business As Usual	South London and Maudsley NHS Foundation Trust	King's College Hospital	Psychiatric Liaison within ED.

Table 2 Camden and Islington NHS Foundation Trust (C&I): Mental Health Crisis Assessment Service (MHCAS)

Overview:	The core purpose of the MHCAS is to provide an emergency department (ED) diversion service for those with urgent mental health needs that do not require acute medical intervention. The MHCAS acts as the hub for all mental health activity generated by the three local ED's, including all out of hours liaison activity across wards within the three acute trusts. As part of its remit, it also operates a 'walk-in' mental health emergency assessment service for anyone seeking immediate care and attention who may be experiencing a mental health crisis. This service extends to receiving direct referrals from the London Ambulance Service as well as local Police.
Location:	Bespoke building at St Pancras Hospital site.
Capacity:	○ 7 assessment rooms ○ Reception ○ Discharge areas
Hours of Operation:	24/7
Population Served:	All service users who attend the three local EDs and out of hours liaison activity across wards within three acute Trusts: Whittington Health, UCL Hospitals NHS Foundation Trust and Royal Free Hospital NHS foundation Trust.
Staffing:	• 6 Band 6 nurses 24/7 (3 based in MHCAS and 1 in each of the ED's as navigators). • 3 Band 7 team managers who supervise the staffing group (48 clinical staff) • 6 clinical Band 7 nurses who provide senior leadership and act as the nurse in charge in each shift • 3 Band 3 non-registered staff • 1 WTE Consultant Psychiatrist 40 hours a week • 2 Core Trainee Doctors (Medical doctors) provide out of hours medical cover in evenings (5-9pm) at the MHCAS • 2 Core Trainee Doctors as a minimum provide overnight cover at MHCAS, with one having responsibility for medical cover to wards at St Pancras • 1 junior doctor on a flexible rota who, if not called elsewhere because of a rota gap, will add to the numbers at the MHCAS.
Equality Impact Assessment (EIA):	Unable to obtain information about Equality Impact Assessment.
Policy and Procedure:	Available

Table 3 North East London Foundation Trust (NELFT): Integrated Crisis Assessment Hub (ICAH)

Overview:	The main purpose is to avoid unnecessary presentations to the Emergency Department (ED) where service users aged between 18 – 65 years do not have an acute physical health issue and an assessment of their mental health needs can be facilitated elsewhere. It is aimed at improving the service user experience through a single assessment and by creating an alternative space to assess those who are in mental health crisis. The intention of the ICAH is to offer a centralised response to all crisis services (Mental Health Crisis Lines, Acute Crisis Assessment team, Street Triage, Liaison Psychiatry, London Ambulance Service and Police) to determine the need for an assessment of service users in crisis and fundamentally reduce multiple assessments and ED attendance through triage and diversion. All service user presenting to the Hub are specially monitored by staff throughout their stay to promote therapeutic engagement. Service users will be escorted home or to their desired destination if they are discharged following an assessment outcome.
Location:	Goodmayes Hospital
Capacity:	○ A waiting area that can host 8-10 people ○ 4 assessment rooms, which each have the capacity to host 2-3 people at any time ○ A clinical room ○ Office space
Hours of Operation:	24/7
Population Served:	Any person who resides in the 4 local boroughs: ○ Redbridge ○ Barking and Dagenham ○ Havering ○ Waltham Forest
Staffing:	○ 1 Band 7 lead per shift ○ 5 Band 6 Practitioners per shift ○ 2 additional Band 6 practitioners to respond to ED diversion ○ 1 Band 5 Practitioner per shift ○ 1 band 3/4 ICAH Health Care Assistant per shift (supporting service users in mental health reception and assessment rooms) ○ 1 Consultant Psychiatrist 9-5pm ○ 1 Middle Grade doctor Out of Hours ○ 1 security personnel ○ Emergency Duty Worker (Approved Mental Health Practitioners) during out of hours The ICAH team operates as a central team that offers bed management/ gatekeeping assessment to all referrals from the whole footprint of North East London Foundation Trust. Therefore, the above resources cater for the daily operation of the integrated service
EIA:	Unknown.
Policy and Procedure:	Available

Table 4 Oxleas NHS Foundation Trust (Oxleas): Mental Health Assessment Area (MHAA)

Overview:	The purpose of MHAA is to reduce presentation of mental health patients over the age of 18 entering the main areas of Emergency Department. To provide early mental health liaison support through timely assessment in the waiting area. Provide a dedicated, safe, and appropriately resourced space in Queen Elisabeth Hospital where people in mental health crisis can be assessed, provided with short-term management whilst awaiting next steps in their care pathway, or whilst awaiting transfer into a clinically appropriate environment.
Location:	Next to Urgent Care Centre at Queen Elizabeth Hospital (where physiotherapy outpatient area used to be).
Capacity:	○ 7 assessment rooms ○ Reception ○ Discharge areas
Hours of Operation:	24/7
Population Served:	All adults (18+ years old) attending Emergency Department at Queen Elizabeth Hospital. Older adult patients assessed on a case-by-case basis. Young people (0-17 years old) will not be accepted at MHAA. Patients with forensic history will undertake a thorough risk assessment prior to care at MHAA. Not suitable for service users detained under section 135 / 136 of the Mental Health Act.
Staffing:	○ Clinical Lead (Oxleas) ○ Clinical Lead (Queen Elizabeth Hospital) ○ Team Manager ○ Shift Coordinator ○ Health Care Assistant (HCA)
EIA:	Unable to obtain information about Equality Impact Assessment.
Policy and Procedure:	Available

Table 5 South London and Maudsley NHS Foundation Trust: Mental Health Liaison Service -

King's College Hospital

Overview:	The Mental Health Liaison Service assesses service users presenting with mental health conditions in the Emergency Department (ED) at King's College Hospital. If mental health needs are identified following assessment by liaison team, service users are discharged and referred or signposted to appropriate community treatment options or may be referred for a mental health inpatient bed if required. If a service user with a mental health condition needs acute physical health care and requires a medical bed within King's College Hospital, they will be supported by the Mental Health Liaison Service on an inpatient medical ward. The service co-works with the Emergency Department healthcare professionals and works closely with the hospital's Alcohol Care Team, community-based mental health and substance misuse services, the police, and local statutory and voluntary agencies to provide crisis mental health care and treatment. The service has accreditation from the Royal College of Psychiatrist's Psychiatric Liaison Accreditation Network (PLAN).
Location:	King's College Hospital Emergency Department.
Capacity:	○ 2 designated high risk mental health assessment rooms based in majors' area of Emergency Department ○ All areas of the Emergency Department (i.e., capacity is flexible)
Hours of Operation:	24/7
Population Served:	The Psychiatric Liaison Service at South London and Maudsley NHS Foundation Trust will work with patients from any locality presenting to King's College Hospital ED.
Staffing:	○ 2 Band 6 liaison nurses 24/7 in ED (9 in total) ○ 1 Band 7 senior liaison nurse 24/7 who act as the MH nurse in charge in each shift in ED (7 in total) ○ 1 Band 7 team leader for Emergency Department liaison team ○ 1 Band 8a Clinical Service Lead for whole liaison service ○ Consultant cover: 1 or 2 x Consultant Liaison Psychiatrists covering wards and ED in working hours (9-5pm); consultant on call rota out of hours ○ 1 x Higher Specialist Trainee Psychiatrist covering wards and ED in working hours ○ 1 Core Trainee Doctor (Medical Doctor) provides out of hours medical cover in evenings (5-9pm) in ED and medical wards (also assesses CAMHS in ED) ○ 1 Core Trainee Doctor provides overnight medical cover in ED and medical wards (also assesses CAMHS in ED)
Equality Impact Assessment:	No
Policy and Procedure:	Available

Several London mental health trusts[5] have a model where service users/carers access their mental health crisis hub via ED. To manage the scale of the evaluation, those trusts have been represented by the Oxleas' model at Queen Elizabeth Hospital.

Some trusts have not been included in the evaluation on the basis that there is insufficient data available due to their mental health crisis hub not having been in operation for a minimum of one year (e.g. South West London St Georges NHS Mental Health Trust, Coral mental health crisis hub), the trust does not currently provide a mental health crisis hub model 365 day a year 24 hour seven day service, or operates alternative crisis services out of scope of this evaluation (e.g., Central and North West London NHS Foundation Trust , West London NHS Trust and East London NHS Foundation Trust).

4.4 Out of scope for the evaluation

Types of crisis intervention services out of scope of this evaluation include all those that do not have a physical hub and/ or do not provide a 24/7 365 day a year service, this includes mental health crisis cafes, mental health crisis teams, crisis houses, and crisis lines.

4.5 Data collection methods

This evaluation used a mixed methods designed to explore how each of the three crisis hubs perform when compared to the BAU hub across the six key domains (Safe, Timely, Effective, Efficient, Equitable, Person-centred). A range of quantitative and qualitative data have been collected and analysed to provide insight for each domain. A summary of the data collection methods is outlined below. A more detailed description of the quantitative metrics used, and the qualitative data collection methods can be found in Appendix B. Data collection tools used can be found in Appendix C-F.

4.5.1 Quantitative data

The evaluation used a range of routinely collected patient-level and aggregated data from sites against key metrics from the London Mental Health Crisis Hub Assessment Framework to address the evaluation objectives.

A standard reporting period of April 2021 to March 2022 was used for all data across all sites, to mitigate variation due to COVID-19 and to allow for comparison. The BAU model was selected to provide a comparison against key metrics. In addition, key metrics were collected for EDs associated with or near to the mental health crisis hubs within the evaluation, to explore any potential impact of hubs on EDs (e.g., diverted patient flow).

Quantitative data from mental health trust systems:

- Data on each service user attendance at crisis hub/ BAU site between April 2021-March 2022 gained from trust electronic patient records
- Data on patient incidents taking place at crisis hub/ BAU site between April 2021-March 2022
- Data on staffing measures for each crisis hub/ BAU site between April 2021-March 2022

Quantitative data from emergency departments:

- Validated data from the Emergency Care Dataset on ED attendances for mental health incidents

[5] South London and Maudsley NHS Foundation Trust (Croydon Hospital and St Thomas' Hospital), Barnet Enfield and Haringey NHS Mental Health Trust (North Middlesex Hospital), South West London St Georges NHS Mental Health Trust (Kingston Hospital)

4.5.2 Primary data collection - qualitative and survey data

The evaluation used a combination of primary data collection methods to explore the perspectives of service users, hub staff and wider stakeholders (i.e., staff working in EDs, home treatment teams, commissioning organisations, London Ambulance Service, and Police). A summary of the primary data collection methods is outlined below:

Participant	Data collection method	Description of sample
Service users and carers	Survey (online) Interviews	• Service user and carer survey – 126 respondents of which 114 were service users and 12 carers. The total number of service users and carers per site included: ○ CANDI n=82 (65%) ○ NELFT n=14 (11%) ○ Oxleas n=8 (7%) ○ Prefer not to say n=18 (14%) ○ BAU n=4 (3%) • Service user in-depth interviews – 9 interviews conducted ○ CANDI n=5 ○ NELFT n=1 ○ Oxleas n=3
MH Crisis Hub / BAU staff	Survey Interviews	• Staff survey to hub staff – 48 respondents ○ CANDI n=3 (6%) ○ NELFT n=24 (50%) ○ Oxleas n=9 (19%) ○ BAU n=12 (25%) • In-depth interviews with hub staff ○ CANDI n=1 ○ NELFT n=1 ○ Oxleas n=1 ○ SLaM BAU n=1
Wider stakeholder interviews	Interviews	• ED, Psychiatric Liaison and Community / Home Treatment Team Staff n=5 • Senior commissioners from each ICB n=7 • London Ambulance Service and London Metropolitan Police n=7

The majority of the service user respondents were CANDI with smaller number of respondents from the two other Mental Health Crisis Hubs, and a low number from the BAU site. Therefore, service user comparisons across the sites cannot be made.

4.6 Data Analysis

The intention is not to undertake a comparative assess of effectiveness of the different hub models, but to provide an in-depth understanding of the different models and determine whether crisis hub models lead to differences in outcomes (defined by the 6 key quality domains) compared to a BAU service where a crisis hub is not present.

4.6.1 Quantitative data

The quantitative data significance testing and comparisons have been made between each of the three mental health crisis hubs (run by CANDI, NELFT and Oxleas) and the BAU site at King's College Hospital (KCH) provided by SLaM. The quantitative data has been collected for the period covering April 2021-March 2022. The data is based on the proportions of crisis hub / BAU site or ED attendances. The data has been analysed using descriptive statistics, and significance testing where appropriate (NOTE: This is not a research study and sample sizes have not been calculated based on statistical power). Quantitative survey data has been analysed descriptively.

4.6.2 Qualitative data

All interviews and free text responses to surveys have been analysed using thematic analysis to identify key themes relating to each of the six key domains. To ensure rigor in analysis multiple researchers undertook coding and theme developing using a framework analysis approach. The emergent themes were developed and refined in discussion with the whole evaluation team.

The aim of the qualitative analysis is to explore the breadth of issues across different perspectives (i.e., service user, staff, stakeholders) and not quantify and/or limit the reporting of themes that are only shared by the majority of participants. Therefore, themes may originate from a small number of participants or in some instances an individual participant and have been reported in the findings because they are considered to have a key relevance to a specific aspect of the evaluation objectives.

Due to the small number of people that were interviewed across the different participant groups reporting will avoid any reference to specific services, locations and/or job roles, in order to maintain confidentiality and anonymity. For example, descriptors such as 'commissioner', 'hub staff', 'London Ambulance Service staff' have been used.

5.Findings

This section sets out the key findings from both quantitative and qualitative data against each of the six quality domains: Safe, Timely, Effective, Efficient, Equitable, Person-centred.

Please note throughout the report the term service user is used as an inclusive term for service users and carers (family /friends).

5.1 Overview of hub activity

Activity data on a range of quantitative measures was collected for the period April 2021 – March 2022. **Table 6** sets out the number of service users seen by each of the hubs and the BAU service.

It is worth bearing in mind that both CANDI and NELFT serve patients that can access three different EDs, whereas Oxleas and SLaM are situated within an ED. The number of patients seen by each service varied, with CANDI seeing 7,587 service users during this period compared to 769 service users seen by NELFT.

Table 6 No of accepted referrals or patients seen at each site

Site	No. of accepted referrals/patients seen	Avg no of service users seen per month
CANDI hub	7,587	632
NELFT hub	769	64
Oxleas hub	1,521	127
SLaM (BAU)	3,836	320

5.2 Safe

5.2.1 Quantitative analysis

Table 7 displays incident rates and numbers for incidents of violence and aggression, suicide and self-harm, restraint, and service users missing from care for the CANDI and NELFT crisis hubs. This data on incidents is recorded through the datix system. Overall, the number of incidents was similar at both sites with 9 incidents per 1,000 accepted referrals at both sites.

Due to a cyber-attack of SLaM's systems that took place whilst this evaluation was being conducted it was not possible to obtain data from SLaM to act as a comparison, so it is unclear whether the implementation of the mental health crisis hubs led to fewer incidents compared to those recorded in ED. Unfortunately, it was not possible to understand the number of patient safety incidents occurring at Oxleas Mental Health Assessment Area as data on incidents are recorded as part of a wider psychiatric liaison service and it is therefore unclear which of these incidents occurred in the crisis hub itself.

Table 7 Rates (n) of incidents per 1,000 accepted referrals to the hub.

	CANDI Hub	NELFT Hub
Incidents of violence and aggression	3.0(23)	1.3 (1)
Incidents of suicide and self-harm	3.0 (23)	5.2 (4)
Incidents of restraint	1.6 (12)	1.3 (1)
Incidents of service users missing from care	1.5 (11)	1.3 (1)
Total incidents	9.1 (69)	9.1 (7)

5.2.2 Service user perspectives

Travel and arrival into the mental health crisis hub

Service users reported using different ways of travel. The service user survey showed that a third, 34% arrived in an ambulance, 20% walked, 13% were driven by a family or friend, 10% took public transport, 9% came in a police car, 8% arrived in a taxi. Service users associated the safety of a hub with how they travelled/arrived at the mental health crisis hub; this included safety of the mode of transport taken and accessibility of getting to the hub. For example, one service user described how transport staff calmed them while being escorted to a place of safety away from the risk of self-harm. Service users suggested safety could be improved by ensuring service users feel comfortable in the transportation from ED and by ensuring that routes to local mental health crisis hubs are easily accessible, particularly at night.

"I don't like using public transport, particularly at night [because I don't feel safe]; thankfully, I'm all right because I can get a taxi".

"The transport people [made me feel safe] because …they said…'you're actively suicidal'…they changed my mind [about going home to going to the hub]."

"It was definitely straightforward [to walk there], but…I wonder [about safety] … it was…slightly off the beaten track."

Self-harm and harm from others at the hub

A common theme linked to all the sites was how safe service users felt from harming themselves and harm from others while at the mental health crisis hub. The majority of service users (56%) agreed that they felt safe at the mental health crisis hub compared to a third (33%) who did not feel safe. From the service users interviewed, a positive sense of safety was related to not feeling stressed by others in the waiting / communal areas and knowing that staff were available to help and undertake regular checks to prevent harm from other service users and self-harm.

"There are people [staff] there if you need them whenever, 24/7, so it was a good safety net [from self-harm] if you like".

"I felt very safe there…[However] there are people who are more vocal or more aggressive or more in distress and that doesn't make the environment that peaceful or safe, but we can't choose who is there with you".

"I sat very much in the corner of the [waiting] room because I [as a female service user] was quite scared [paranoid of a specific male service user] …They [staff] kept coming and checking me. They understood my frustration…they were respectful."

Discharge outcomes

Safety was also linked to how safe service users felt after being discharged from the hub. Feeling safe about discharge outcomes was linked to staff safeguarding measures and ensuring that service users were discharged only when safe to do so and prepared for any onwards care, such as care coordinators and GPs where possible. For example, one service user reported feeling safe about being able to return to the mental health crisis hub.

> *"Usually…if [I] need support or feel not safe, [I] just come back'…Depending on the type of crisis…they [staff] contact my care coordinator …I don't go home unless I am safe enough."*

5.2.3 Hub staff perspectives

Staff safety and building security

Hub and BAU site staff were surveyed on whether they felt safe working within the hubs. Of the 27 hub staff members who answered, 81% agreed that they felt safe working within their service, while 11% disagreed. These proportions were similar in the 8 BAU site staff that answered, of which 75% agreed while 13% disagreed. It was perceived that safety for staff and service users in the hubs could be improved by employing more staff at all levels and providing professional building security staff. For example, one staff member felt that overall hub safety was compromised due to staff shortages.

> *"The workload…you're not just doing the assessment… you are then responsible for providing an intervention for that person the entire time …you can have people that fight… hurt themselves…leave constantly, and it's an enormous amount of resources to keep that building safe. So, I think they definitely need more staff."*

5.2.4 Wider stakeholder perspectives

5.2.4.1 ED staff

ED transfer delays

Due to the logistical delays in arranging transport from ED to hubs, ED staff perceived mental health crisis hubs as potentially less safe than ED for service users in extreme distress. A few ED staff felt making service users wait for transportation to the hub would increase the risk of harm.

> *" It's very unlikely they'd [service user who is extremely distressed] be referred to the hub because of the logistics in transferring people [from ED to a hub]."*

> "Waiting time for transport *is at least three to four hours… I think that's our biggest challenge."*

5.2.4.2 Community Mental Health Teams

Staffing

Community Mental Health Team staff felt mental health crisis hubs were safer compared to ED because they could provide higher quality mental health intervention support compared to ED. However, similar to hub staff, they also felt staff shortages were compromising the safety and quality of care offered at mental health crisis hubs.

"I think overall…the quality of the intervention is a lot higher [in the hubs] than in A&E… but they need more staff."

5.2.4.3 London Ambulance Service (LAS)

Incidents of service users missing from care

London Ambulance Service staff felt mental health crisis hubs were a safer alternative to ED for those with mental health only presentations. One LAS staff member felt that hubs reduce the risk of patients going missing from care and absconding due to hub staff's ability to provide specialist support from the outset and reassure the patient to feel less stigmatised about their mental health.

"The hub is…an opportunity for us to hand over the patient to someone who is able to [support] the patient straightaway…making them feel more comfortable…It minimises stigma; it minimises the situation where a patient would feel estranged and then minimises absconding from the unit."

5.2.4.4 London Metropolitan Police

Incidents of service users missing from care

Similar to London Ambulance Service staff, London Metropolitan Police reported that hub environments could be safer than ED for those who feel anxious and get aggressive in busy environments. Mental health crisis hubs were perceived as less restrictive for service users, reducing the risk of self-harm and harm to others; and minimising the risk of the service user going missing.

"Sometimes the stimulation [in ED] just frustrates them [patient] to the point of where they lash out…and we have to act in legal parameters to keep them safe…it's something that doesn't need to happen…The hub does work better."

"They [service users] end up just walking out [of ED]. And this is where the challenges come for police because, you know, the staff there will call police and say… they've just walked out and at this grave risk [to self and others] …which then leads us to have to look for this person and potentially place them under more [restrictions]."

Staff safety and building security

Similar to the service staff interviewed, London Metropolitan Police felt staff safety at the hubs needed to be improved by having appropriately trained security staffing on site.

"Security they have [at mental health crisis hubs] is inadequate…I think the staff there would benefit from NHS security who are properly trained to deal with somebody in a mental health crisis should they need to."

5.2.4.5 ICB Commissioners

Staff safety and building security

Commissioners perceived EDs to be safer for staff than mental health crisis hubs, due to increased building security and availability of staff. One commissioner suggested that mental health crisis hubs that are co-located in an ED could lower costs of setting up security and safety.

"If there was a risk [in ED], there is a lot of staff on the site who are able to support…Hubs co-located in the same building can lower costs of setting up extra security and safety."

"Difficult to support people that were risks to themselves or other people…particularly…violent presentations because they [mental health crisis hubs] didn't have the kind of security that is available within an A&E department."

5.3 Timely

5.3.1 Quantitative analysis

Data from the Emergency Care Data Set (ECDS) was obtained to look at the length of time patients with mental health presentations spend waiting at ED to see if wait times were significantly reduced where a mental health crisis hub was in place. There is a national target in place to ensure that patients do not wait for more than four hours. Please note it is likely this national target is changing[6].

Table 8 sets out the length of time spent waiting in ED (measured by time of arrival at ED to time of discharge) for ED attendances whereby the patient has a mental health presentation that is considered appropriate for referral to a crisis hub (see Appendix G for more information on the presentations included). The BAU site at KCH had 52.1% of patients with relevant mental health presentations that had waits of less than four hours. All three of the hospitals linked to CANDI's Mental Health Crisis Assessment Service (MHCAS) had statistically significantly higher proportions of patients that were seen within four hours, with an average of 67% of relevant mental health presentations in this patch being discharged from ED within less than four hours. The hospitals linked to the NELFT crisis hub saw lower rates of mental health presentations that met the four-hour target with an average of 25.8% of patients being discharged from ED within four hours as well as Queen Elizabeth Hospital (QEH) ED which discharged 40% of their mental health presentations within the target time frame.

Table 8 Length of time (in hours) spent waiting in ED by ED site.

ED Site	% 0-4	% 4-12	% 12-24	% 24+
King's College Hospital: SLaM	52.1%	35.3%	8.5%	4.2%
Queen Elizabeth Hospital: Oxleas	39.5%	34.5%	17.6%	8.4%
King George Hospital	23.6%	46.6%	22.1%	7.7%
Whipps Cross University Hospital	30.3%	35.9%	23.4%	10.5%
Queen's Hospital	26.7%	49.9%	16.0%	7.4%
NELFT combined	***25.8%***	***46.0%***	***20.2%***	***8.1%***
Royal Free Hospital	65.6%	24.6%	6.5%	3.3%
The Whittington Hospital	70.0%	24.6%	4.8%	0.6%
University College Hospital	64.4%	30.6%	4.5%	0.6%
CANDI combined	***67.1%***	***27.1%***	***4.9%***	***0.9%***

[6] https://www.nuffieldtrust.org.uk/resource/a-e-waiting-times#background

The Length of Stay (LOS) of service users at the crisis hubs and the BAU site was obtained to understand if this differed between the hubs and the BAU site (**Figure 1**). The data included a small number of outliers with very long LOS, so all waits longer than 100 hours were removed from the dataset before analysis took place.

It should be noted that for the Oxleas hybrid model it is not possible to separate out the ALOS at ED and at the crisis hub so length of stays are calculated based on the total length of time in ED/ the crisis hub. For the CANDI and NELFT crisis hubs the length of stays presented below are different time periods to the length of stays at ED.

The average length of stay (ALOS) in ED for those referred to psychiatric liaison at KCH was 7:09 hours. The ALOS was statistically significantly lower at both the NELFT and CANDI hubs with an ALOS at the NELFT hub of 2:25 hours and 6:26 hours at CANDI. The ALOS at the Oxleas hub was slightly higher (7:12 hours) than the BAU site (**Figure 1**). **Table 9** provides a breakdown of the analysis of ALOS.

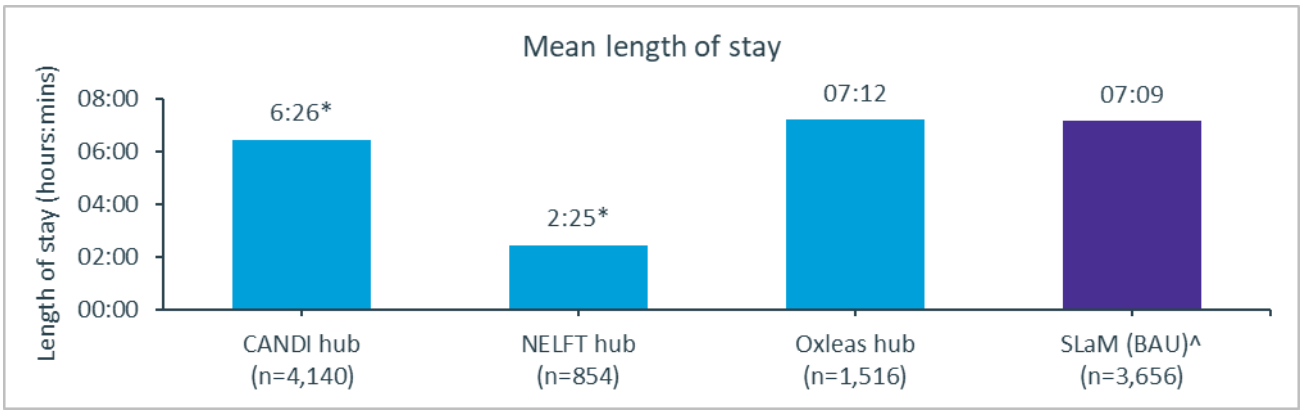


Figure 1 Average length of stay in hours and minutes at crisis hub sites and SLaM psychiatric liaison service

Table 9 Length of stay data for crisis hub sites and SLaM psychiatric liaison service

	CANDI hub	NELFT hub	Oxleas hub	SLaM (BAU)^
N	4139	769	1514	3640
Mean (hours:minutes)	6:26	2:25	7:12	7:09
Standard deviation	8:31	2:11	9:03	10:35
Min	0	0	0	0
Max	79	21	73	94
p value (vs SLaM)	0.000*	0.000*	0.306	

**Statistically significant differences at the 0.95 confidence level when compared to SLaM (t test).*
^Length of stay for SLaM was defined as time from referral to discharge from the psychiatric liaison service.

5.3.2 Service user perspectives

Travelling to a mental health crisis hub

For service users, the timeliness of receiving care was associated with how quickly they could reach a place of safety during a crisis. The majority of service users surveyed said their journey to a mental health crisis hub was timely: 48% travelled less than 30 minutes, 20% travelled 30-60 minutes, with 13% saying it took them over an hour to get to a mental health crisis hub. A further 20% said they didn't know how long it took them. For service users who attended ED first, satisfaction was linked to how quickly they were transferred from ED to a mental health crisis hub.

"The time it took [30 minutes] to transfer from the hospital to the hub... Being honest, it was the best one - timing wise – it was better than previous places."

" I was transferred by their [ED] transport after about four hours...I couldn't sit still."

Timely care at the hub

In the survey, service users reported that waiting times to be seen by a healthcare professional varied. Two-thirds (67%) of service users reported being seen within 4 hours (28% waited less than 30 minutes, 22% waited 30 minutes-1 hour, 17% waited 1-4 hours). A further 11% waited 4-8 hours, 7% waited more than 8 hours, and 15% said they didn't know how long they were waiting to be seen.

In interviews several service users said mental health crisis hubs were better in providing care than ED due to shorter waiting times. One service user felt they received timely care at the mental health crisis hub compared to ED because staff understood their needs quicker as a repeat attendee. Even for those who were satisfied with timely care at the hub, some felt that they could have been seen even faster if it was not for staff shortages. Therefore, service users suggested that waiting times at mental health crisis hubs could be improved with adequate staffing levels.

"They know me very well, so they know what it is I need as help, and I tend to get it pretty quick [10-15 minutes] ... A lot better than if I were in A&E where I would have to wait for hours."

"A&E, there's longer waiting time to see...attend...triage people. In my view, comparatively, the crisis hub is quicker."

"I tend to get it [care] quickly...Sometimes I feel they are short of staff...you have to wait a bit more to access the help then."

Discharge delays due to bed shortages

Service users dissatisfied with the timeliness of care at the mental health crisis hubs were mainly those who stayed in the hub longer than intended due to bed shortages at the hospital inpatient wards.

"I stayed there for four days!...No beds. Other people were there a long time...It's whoever gets there first."

"They just said, we've found you a bed'...It was quite late, about nine o'clock at night. I think they should have let me go in the morning...But that bed would have gone, and I'd have ended up waiting."

5.3.3 Hub staff perspectives

Timely mental health care

Staff members were surveyed on whether they felt service users were given timely care. Of the 32 hub staff members that answered, 84% agreed that they provided their service users with timely care, while 9% disagreed. In comparison, of the 10 BAU staff who answered, a lower proportion (60%) agreed while a higher proportion (30%) disagreed. A few staff members who commented in the survey felt that while the quality of care in ED is good, the timeliness of care is reduced due to service users with physical needs being seen more quickly than those with mental health needs.

"Patients and carers are provided with timely assessment in a calm environment as opposed to what they would experience in a busy A&E department."

"Care from psychiatric service is good, but difficult to balance with often busy A&E departments where psychiatric patients aren't seen as (quickly) compared to physical health patients."

ED processes can prolong and duplicate care

Staff felt there was a risk of prolonging and duplicating care if service users go via ED to a mental health crisis hub.

"The biggest problem with this model [going to a mental health crisis hub via ED], is the risk of duplication, and delaying the patient journey, and somebody having to repeat themselves…five hours later in a hub when they've had to wait all that time."

Bed shortages leading to delays in timely care

Staff said the initial assessment and treatment at ED is timely. However, due to bed shortages in mental health units, there is a delay in treatment for service users.

"Although the assessment and initial treatment is timely [in ED], there are marked delays in getting appropriate beds for patients leading to long bed waits."

5.3.4 Wider stakeholder perspectives

5.3.4.1 ED staff

Impact of ED transport delays on timely care at mental health crisis hubs

Due to logistical delays in arranging transport from EDs to mental health crisis hubs, ED staff felt it was quicker and safer to treat service users in ED than to transfer them to a mental health crisis hub. According to one staff interviewed, they said booking transport could take up to four hours, increasing the risk of harm to service users.

" Waiting time for transport is at least…about three to four hours… when we have patients that need to be sedated, [they] are unsafe for transfer at the back of a van… *I understand it's only down the road, but a lot can happen."*

"Rather than seeing somebody, then booking an ambulance, and waiting…You're talking about a couple of hours of somebody's time."

5.3.4.2 Community Mental Health Teams

Mental health crisis hubs are a timely care intervention while waiting for a bed

Staff from community mental health teams reported that due to the high levels of bed shortages in inpatient mental health wards, mental health crisis hubs were a timely care intervention away from ED to help alleviate the stress experienced by service users while waiting for a hospital bed. Mental health crisis hubs allow service users to recover and consider whether the hospital is the best option. Therefore, potentially reducing the number of service users going to the hospital.

"Patients are usually in [ED] for a very long time, waiting for beds…The [mental health crisis hub] environment is more conducive to recovery [than a busy ED] …allowing people space to calm down and think about what they want."

5.3.4.3 London Ambulance Service

Mental health crisis hubs can reduce handover time

London Ambulance Service staff said mental health crisis hubs reduce waiting times compared with ED, as patients do not have to undergo additional physical checks. Therefore, reducing the handover time for London Ambulance Service staff.

"It's a better model…it can fast-track things a bit more, so we don't keep people waiting in EDs for very long."

"Rather than conveying a service user to A&E departments, it's been easier just to take them there and relieve them from having any other physical health tests that they don't need…Where it's just been mental health, and we have medically cleared them… it's preventing another person in the queue from being seen in A&E".

5.3.4.4 London Metropolitan Police

Mental health crisis hubs can reduce handover time

London Metropolitan Police reported that mental health crisis hubs offer timelier care than ED, potentially reducing waiting times. Police officers said service users can get checked by a healthcare professional faster at a hub. Therefore, reducing handover time and allowing staff to attend to other service users in crisis.

"Instead of us sitting at a hospital for 10 hours, it'll be an hour [at the mental health crisis hub]. Get the person, drop into the hub…handover…and then we're back out…to help other people…it's only a positive for us"

Cross-teamworking between hubs and ED

London Metropolitan Police officers interviewed felt overall the mental health crisis hubs were a timely intervention. However, they felt the communication between ED and mental health crisis hubs could be improved through cross-team working. A suggestion was made to employ navigators and medical staff who could assess both physical and mental health issues between the sites to reduce waiting times for minor physical issues.

"If you had like a designated duty nurse or doctor…to get the patient with low level physical issues like superficial cuts cleared…a bit of compromise like that in the middle"

"I think if you did have a nurse there…you won't have to wait for the site nurse or wait there 23 hours…it's not good for our resource and mainly it's not good for the person… have some sort of medic checking them… you would just set yourself apart…Even London Ambulance Service, wouldn't need to come and clear the person"

5.3.4.5 ICB Commissioners

Mental health crisis hubs help reduce ED waiting times

Commissioners perceived mental health crisis hubs as a positive alternative to ED mental health care. It provides a means to divert service users with mental health needs away from long ED waiting times toward specialist mental health support. Therefore, reducing the burden on ED staff and allowing them to attend to other patients more quickly, particularly those with physical presentations.

"The [mental health crisis hub] …offers a much better patient and a staff experience, particularly for our (ED) staff who don't always feel comfortable with some of the mental health patients they're then presented with."

5.4 Effective

5.4.1 Quantitative analysis

Each crisis hub has their own set of codes for recording the discharge outcomes for their service. Whilst the evaluation team (including the HIN's Mental Health Clinical Director) have spent time categorising these codes into meaningful groups of outcomes (as can see in the analysis below), there will still be inconsistencies in the way that discharge outcomes are recorded in each hub, so these comparisons should be treated with some caution. **Table 10** provides an overview of the discharge outcomes.

CANDI:

CANDI's crisis hub had a higher proportion of attendances that were discharged back to the care of their GP (55%) and Home Treatment Team (HTT) or crisis team (18%), compared to the BAU site. They had a lower rate of discharges to a community mental health team (9%), a mental health inpatient bed (11%) and to an acute hospital bed (0.7%).

NELFT:

NELFT had a higher proportion of attendances being discharged to a HTT or crisis team (40%) and a slightly higher rate of mental health inpatient admissions (19%). They had lower rates of discharges to the care of a GP (12%), to a community mental health team (21%), and to an acute hospital bed (0.3%) in comparison to KCH.

Oxleas:

Oxleas hybrid model had higher rates of discharges to a mental health inpatient bed (34%), and a HTT or crisis team (28%) compared to the BAU site. They had lower rates of discharges to the care of a GP (23%), a community mental health team (6%), and to an acute inpatient bed (1%).

All the hubs had higher rates of attendances that left the service without being formally discharged. Although this may be due to differences in the recording of outcomes within the SLaM psychiatric liaison service. Both NELFT and Oxleas had a small proportion of patients that were discharged back to ED for treatment of a physical health concern or due to aggressive behaviour.

Table 10 Discharge outcomes of accepted referrals by crisis hub.

Discharge outcome	CANDI hub (n=7,429)	NELFT hub (n=745)	Oxleas hub (n=1,520)	SLaM (BAU) (n=3,400)
GP	55.3%*	11.8%*	22.6%*	31.8%
Community mental health team	9.3%*	20.9%*	5.7%*	31.2%
Mental health inpatient admission	10.5%*	18.9%	34.4%*	16.0%
Home treatment team/Crisis team	18.2%*	39.5%*	27.9%*	12.1%
Acute hospital admission	0.7%*	0.3%*	0.6%*	2.1%
Criminal justice system	1.0%	0.1%*	0.3%*	1.5%
S136 suite/Place of safety	1.5%	0.1%*	0.5%*	1.1%
Left	2.6%*	1.7%*	4.9%*	0.0%
ED	0.0%	3.4%*	2.6%*	0.0%
Other	0.9%*	3.2%	0.5%*	4.1%

* Indicates a statistically significant difference compared to SLaM at 95% confidence level (t test)

The higher rate of service users being discharged to a GP at CANDI may be due to the higher proportion of patients at CANDI that do not have a known prior mental health diagnosis and are therefore not already known to the mental health trusts. At CANDI, 24% of patients that were discharged to their GP were known to the trust, compared to 33% at SLaM.

In seeking to understand the significantly higher rate of service users at NELFT discharged to secondary care mental health services such as Home Treatment Teams and Community Mental Health Teams, the proportion of service users already known to NELFT were looked at. At NELFT, 48% of discharges to Home Treatment Teams or Community Mental Health Teams had a known mental health diagnosis, compared to 60% at SLaM, which suggests that there was no link between the higher rate of discharges to known services and the familiarity of service users to these services.

Data on the number of attendees that had attended the hub/ BAU site already within the period of interest (April 2021- March 2022) and within 28 days of a previous attendance at the crisis hub/ BAU site was collected. Please note that data on the 28 days metric is missing for the BAU site so it is not possible to understand how reattendances within 28 days at crisis hubs compare to the BAU site.

The proportion of attendances that were repeats within the year was 42% at the BAU site, with similar rates at the CANDI hub (39%) and the Oxleas hub (38%), there was a much lower rate of repeat attendances in year at the NELFT crisis hub with 23% of attendances being reattendances within the year (**Figure 2**). Oxleas (13%) and NELFT (14%) had similar levels of reattendance rates within 28 days of a prior attendance, with CANDI having higher levels of 28-day reattendances (21%).

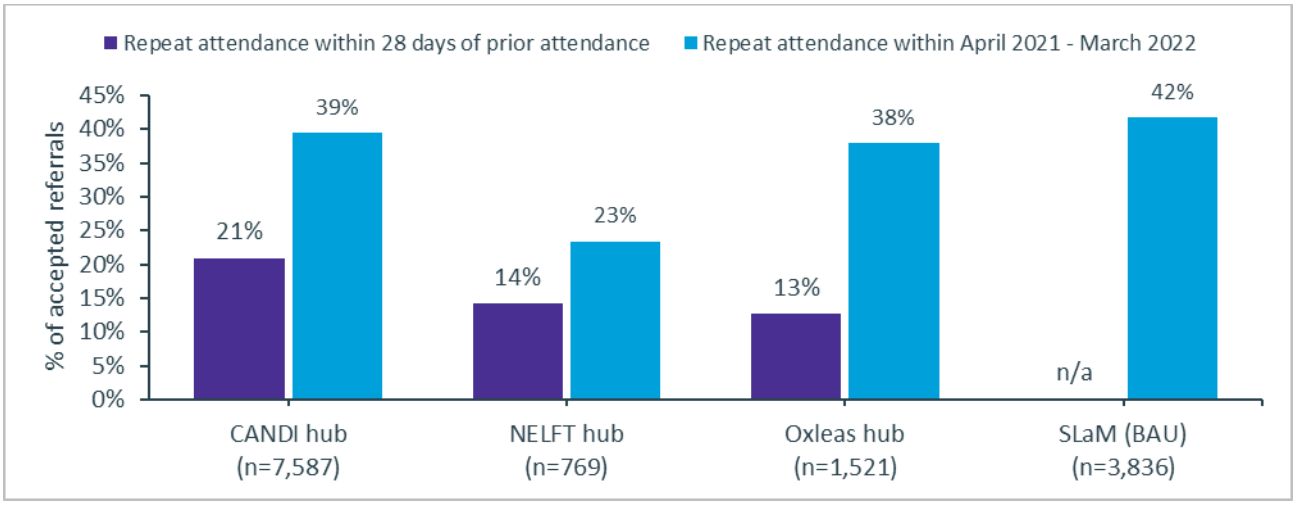


Figure 2 Percentage of accepted referrals to the crisis hubs and SLaM psychiatric liaison service that were repeat attenders within 28 days, and within the period of April 2021 to March 2022

At both CANDI and NELFT hubs, attendees who had a single attendance within the time period (April 2021 – March 2022) were less likely to self-refer than attendees who attended the hub more than once within this time period (**Figure 3**). This difference was statistically significant for both CANDI and NELFT. It should be noted that some those with a single attendance may have attended the hub previously but not within the time period of the data produced for this evaluation. This indicates that when people re-attend these hubs, they are more likely to go directly to the hub rather than going to ED.

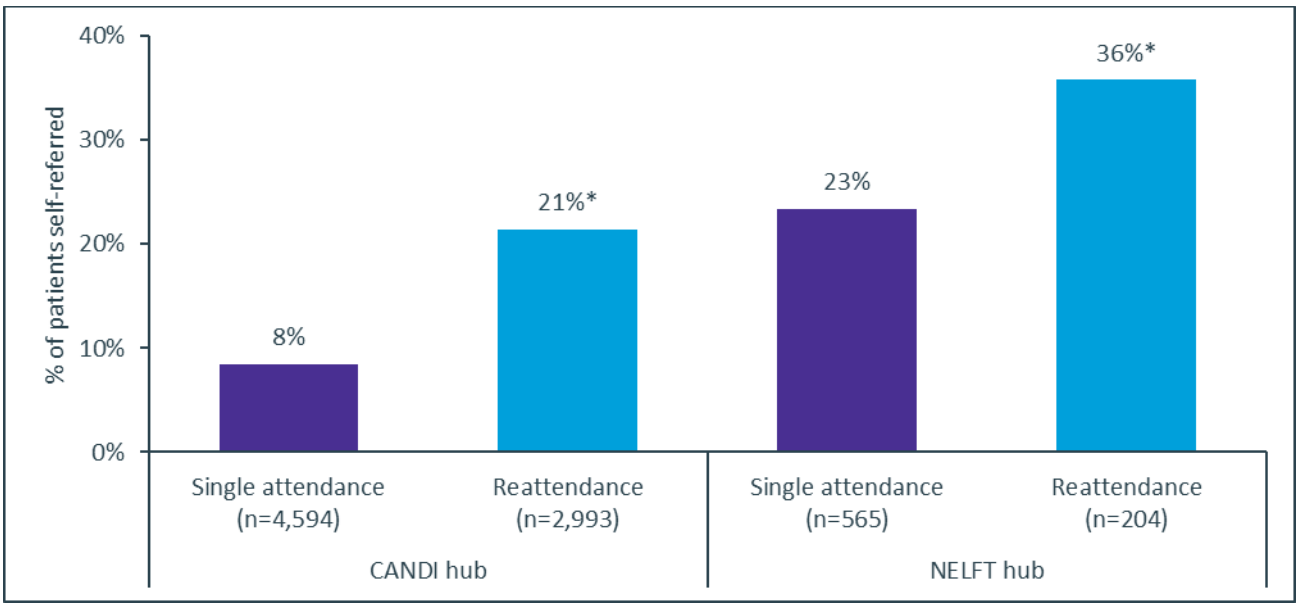


*Figure 3 Reattendance rate by self-referral. * Indicates a statistically significant difference between single attendances and reattendances at the 95% confidence level (chi-square test).*

Data from staff records was obtained for each of the hubs to help understand staff resourcing and sickness rates (**Table 11**). Unfortunately, it was not possible to obtain this information for the BAU site due to a cyberattack that took place at the Trust while the evaluation was taking place. For this reason, it is not possible to understand how these measures differ between the hubs and the BAU site. The information below has been included for contextual purposes. Where possible, data on staffing was also obtained for the whole trust, in order to compare how hub staffing differed from trust staffing.

CANDI – the key differences noted were that there was a higher rate of vacant posts (29%) at the hub compared to across the Trust (8%), this coincided with a higher dependency on bank staff with 33% of hub staff being from the bank, compared to 15% across the Trust.

NELFT – the rate of vacant posts in the NELFT hub were low (4%) compared to the Trust as a whole (17%), staff sickness rates remained relatively constant across the hub and the Trust.

Oxleas – the Oxleas hub was resourced entirely using bank staff, with their 100% vacancy rate being filled by bank staff members. This was much higher than the Trust vacancy rate of 9%, with bank staff usage at 10%.

Table 11 Staff sickness and vacancy rates at hubs

	CANDI Hub	NELFT Hub	Oxleas hub
Staff sickness rates			
Hub staff sickness rate	6.4%	4.0%	No data available
Trust staff sickness rate	4.5%	4.6%	5.1%
Bank staff rates			
Hub bank staff rate	32.6%	19.5%	100.0%
Trust bank staff rate	15.2%	No data available	9.8%
Staff vacancy rates			
Hub vacancy rate	28.8%	4.4%	100.0%
Trust vacancy rate	8.4%	17.2%	8.7%

5.4.2 Service user perspectives

Communication and engagement about the hub

As discussed earlier, service users came through multiple referral pathways. One service user suggested that despite good guidance from their GP to attend the mental health crisis hub, the effectiveness of the Mental health crisis hub signposting and communication strategy could be improved. They perceived that local service users often walk past their local mental health crisis hub but do not know what it offers. Therefore, they suggested that mental health crisis hubs could do more to communicate and promote their services more locally.

"I've passed it, generally, walking around the area…I never knew, fully, what it was for."

Discharge outcomes and onward care

For service users, the perception of the effectiveness of a mental health crisis hub was also affected by the quality of the discharge outcome and communication after they left the hub. In the survey, 36% of service users felt they received the support and treatment needed for their mental health at the mental health crisis hub. However, around half (51%), thought they did not, and a further 13% were unsure. In interviews, a few service users reported that they did not receive all the support and treatment they needed because they were discharged to a hospital ward for the rest of their treatment and support. One service user said they were dissatisfied with the disjointed communication between the mental health crisis hub and ongoing care providers and reported that they did not receive the follow-up support they needed and, as a result, felt they did not receive the appropriate care they needed.

"They [Hub staff] never got in contact with me again, but I heard…they had emailed [my support team], but I never got cc'd. I don't know what they said… It just felt like a whole waste of time because I didn't need to have gone [to the hub]."

"They [hub staff] booked me a black cab, got one of their staff in the cab to take me home…The care coordinator I was given wasn't the best…and that was it. "

5.4.3 Hub staff perspectives

Specialist mental health support

A few hub staff interviewed reported that hubs provided more effective care that delivered clear benefits to people in mental health crisis, because hub staff were more confident and expert in providing specialised mental health assessment and support compared to ED

"[ED] don't necessarily have confidence with mental health issues…if they come into the hub, it's a quick conversation…rather than that whole triage process and the patient waiting for hours."

"[In the hub] they're [service user] immediately out of the…crowded nature of ED… they're talking to a mental health clinician… and… own private space to be assessed."

Staffing

Of the 36 hub staff members who responded to the survey, the majority (86%) had been working at their hub for at least a year. At least two thirds of respondents had worked at the hubs for a year or more across all sites. A higher proportion (92%) of the 12 BAU site staff who responded had been working there for at least a year. Respondents had varying job roles, with around half (22 out of 40 respondents) in senior nurse positions, and 28 out of 38 respondents in NHS Agenda for Change band six or seven roles.

Of the 32 hub staff who responded, 66% agreed that their service was appropriately staffed compared with 22% who disagreed. BAU site staff were more likely to feel their service was not appropriately staffed, of the 10 BAU site staff that responded, 50% agreed and 50% disagreed. However, hub staff were more likely to report working paid overtime than BAU site staff, with 65% (out of 34 survey respondents) of hub staff and 36% (out of 11 survey respondents) reporting that they worked more than 10 paid hours per week over their contracted hours. However, they were equally likely to report working unpaid overtime, with 24% (out of 34) of hub staff and 20% (out of 10) of BAU site staff reporting that they worked more than 10 unpaid hours per week over their contracted hours.

A few service staff interviewed felt mental health crisis hubs provided more timely and effective care to

service users than ED. However, this was perceived to be at the cost of staff working extra hours to offer good quality care. Staff interviewed said increases in staff resourcing could improve mental health crisis hub services.

"The difficulty we sometimes have is…everybody's [service staff] so stressed and so stretched…that needs to improve."

"We need enough staff to deal with the patients in the unit."

Workplace satisfaction

The majority (82% out of 28 survey respondents) were satisfied working in their service, which was slightly higher than the proportion of BAU site staff that reported they were satisfied (75% out of 8 respondents). 93% of 27 hub staff respondents felt suitably trained to provide care to service users, 78% of 27 said that they are kept informed about changes happening in their service, and 64% of 28 said they are involved in decisions about what happens within the service. These proportions were higher than the responses from 8 BAU site staff, of which 88% felt suitably trained, 50% agreed they were kept informed of changes, and 25% agreed that they were involved in decisions. Additionally, 71% of 28 hub staff respondents agreed that they receive the support needed for their health and wellbeing from their trust, compared to 63% of 8 BAU site staff.

89% of 27 hub staff agreed that they are treated with dignity and respect by colleagues within the service, which was a similar proportion to BAU site staff (88% of 8 respondents). 85% of 27 hub staff respondents would recommend their service to family and friends, which was higher than for the 7 BAU site staff who responded, of which 57% would recommend the service.

Hub staff surveyed and interviewed said the effectiveness of mental health crisis hubs was due to the high quality of the skills within the team and good working relationships with other staff, particularly senior management teams.

"Key in how everything's been working so well is our service manager."

"We have a very high skilled and motivated team of band 6 and 7 nurses."

"The service has recently received a positive CQC report. The patient satisfaction survey has been good."

5.4.4 Wider stakeholder perspectives

5.4.4.1 ED staff

Multidisciplinary and cross-team working between ED and hubs

One ED staff member interviewed felt mental health crisis hubs provide better specialist mental health support than ED due to on-site multidisciplinary mental health staff teams. However, another ED staff member said what works well is access to multidisciplinary teams between the ED and the mental health crisis hubs when there are staff shortages in ED. They felt the ability to work across services, sharing resources and undertaking joint training could help to alleviate the pressure on overall waiting times.

"The hub has access to the doctors and social workers, whereas in A&E, sometimes, you don't always have access to the psychiatrist."

" We have an [established]relationship with [local mental health crisis hub] …It just takes a phone call [to

the hub] saying, 'We are under pressure. Do you think you could send more staff members to assess these patients?' We do have that support and [joint] mental health study days."

5.4.4.2 Community Mental Health Teams

Staff training and cross-team working

Community mental health service staff said mental health crisis hubs could better support service users through cross-team working and signposting between alternative services. However, they highlighted that more specialist staff training is needed to help teams work together and reduce referrals to ED.

"Helpful to have away days to strengthen the relationship between mental health crisis hubs and Community Mental Health Teams."

"It would be quite helpful to have joint away days because inevitably, services work very close together... Sometimes, if clinicians haven't got maybe the right training or experience, they might then bring people to A&E because they think the risk is really high... Perhaps if we had training, that would happen less."

5.4.4.3 London Ambulance Service

Building relationships

London Ambulance Service staff felt building direct working relationships with hub staff has helped them deal with concerns around whether a service user meets the mental health crisis hub criteria.

"We've worked with [hub staff] quite a few times, so we know this person is or isn't appropriate for [the hub] ...Good to have that clinician-to-clinician conversation over the phone."

5.4.4.4 London Metropolitan Police

Staff changes

London Metropolitan Police officers felt mental health services are not as effective as they could be due to staff shortages and changes resulting from staff moving across departments during the pandemic. However, the Police officers interviewed thought the services have developed and improved since being set up.

"Took a while for mental health crisis hubs to run effectively due to staff changes and a new service."

5.4.4.5 ICB Commissioners

Workforce challenges

Commissioners thought mental health crisis hubs are a beneficial alternative for service users away from busy ED environments. However, they were concerned that the services were not as effective as they would like due to staff shortages and existing staff working across too many services. Therefore, there was a perception that it reduced the effectiveness of care (i.e., less timely and lower quality care).

"It's so difficult to get workforce at the moment. It's making sure that you have the right workforce deployed in the right place and that they're not spread so thinly that you are impacting our ability to do things in the way we want to."

5.5 Efficient

5.5.1 Quantitative analysis

CANDI and Oxleas attendance data were only based on accepted patient referrals to the hub. However, NELFT attendance data included 90 referrals that were rejected by the hub, which showed an acceptance rate of 88% of referrals to the hub.

The main reason for rejecting referrals was due to patients requiring medical intervention due to physical health needs, with 44% of referrals being referred to ED (**Table 12**). A further 31% of rejected referrals were for patients that did not attend the hub following their referral, 14% of referrals left and 10% were rejected due to agitation or aggression.

Table 12 Reason for rejection from the NELFT crisis hub

Reason for rejection	NELFT hub	
	Count	%
Referred to ED/medical health needs	40	44%
Did not attend	28	31%
Patient left	13	14%
Agitation or aggression	9	10%
Other	20	22%
Total	***90***	

Only small proportions of crisis hub attendances were redirected back to ED, with 0.6% of crisis hub attendances at CANDI being redirected to ED, 2.3% at Oxleas and 5.1% at the NELFT hub (**Figure 4**).

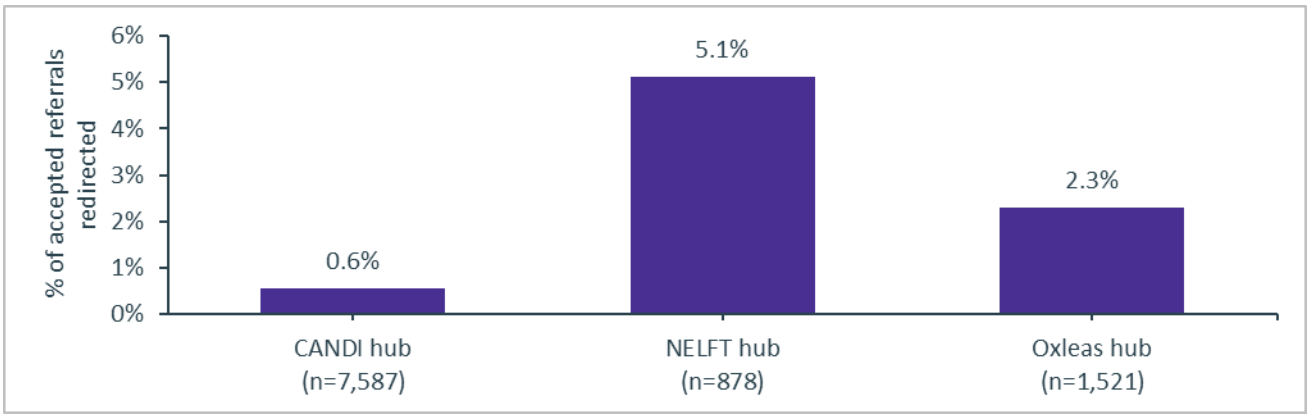


Figure 4 Percentage of accepted referrals that were redirected to ED from crisis hubs

Data from the Emergency Care Dataset was used to understand whether the mental health crisis hubs had impacted on the number of presentations to ED with a mental health condition that would be appropriate to be seen by the mental health crisis hub. These conditions have been defined in Appendix G. In order to be able to compare the number of patients with mental health presentations attending ED at different sites, the numbers of presentations have been turned into rates. The rates measure the proportion of all adult ED presentations that are for relevant mental health conditions.

As the Oxleas' mental health crisis hub is a hybrid model with the crisis hub based within the ED at Queen Elizabeth Hospital, we would not expect to see a lower rate of mental health presentations at Queen Elizabeth Hospital.

Table 13 shows that the proportion of relevant mental health presentations remained the same for hub sites as for the BAU site, with 1.4% of ED attendances being for a relevant mental health condition at KCH and the same proportion being averaged across all NELFT and CANDI sites. When looking at site level data there was some variance with both Whipps Cross Hospital and the Royal Free Hospital having statistically significant lower rates of relevant mental health presentations, whilst King George Hospital and The Whittington Hospital had significantly higher rates of hub appropriate mental health presentations than KCH, bringing the mental health trust averages up.

Table 13 Proportion of ED attendances that are for a relevant mental health presentation by site

ED Site	% of ED attendances for crisis hub appropriate conditions
King's College Hospital	1.4%
Queen Elizabeth Hospital	2.0%
King George Hospital	3.1%
Whipps Cross University Hospital	0.5%
Queen's Hospital	1.5%
NELFT (combined)	***1.4%***
Royal Free Hospital	0.6%
The Whittington Hospital	2.3%
University College Hospital	1.5%
CANDI (combined)	***1.4%***

When looking at the proportion of ED presentations that were for crisis hub appropriate mental health conditions there was no clear trend (**Figure 5**).

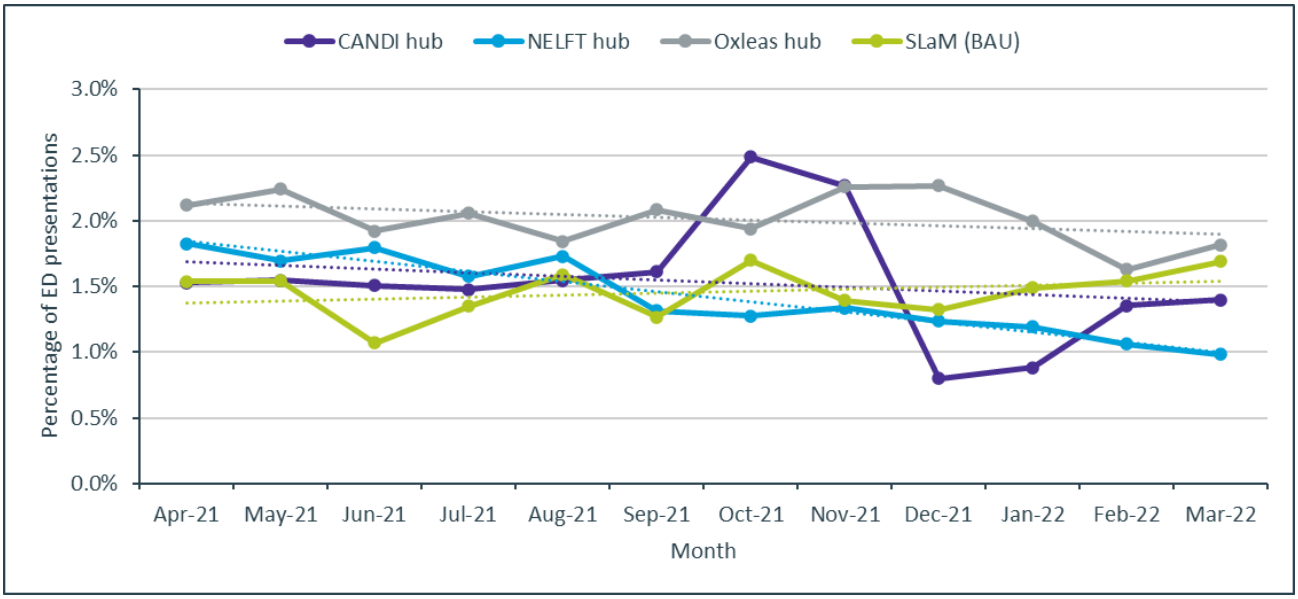


Figure 5: Proportion of ED attendances that are for a crisis hub appropriate mental health presentation by site – time series

Despite differences at a site level in the proportion of mental health presentations it is clear from information on the source of referrals to the crisis hubs that patients are being referred to the hubs through a range of sources and not just ED. **Table 14** sets out the proportion of crisis hub attendances that are presenting at ED in a mental health crisis compared to those that are being referred via other channels. This gives a sense of the numbers and proportions of ED attendances that have been avoided completely.

Information on the source of referral of each attendance at the crisis hubs was recorded (**Table 14**). For the BAU site all referrals come via ED. The hybrid model run by Oxleas at QEH had a high proportion of referrals coming from ED which is expected as the service sits in ED and is reliant on referrals coming through the usual ED presentation route rather than getting direct referrals to the hub. Just over three-quarters (76%) of referrals to the CANDI crisis hub came via ED, whilst the NELFT crisis hub had a much lower proportion coming via this route with 42% of their attendances being referred by ED (**Figure 6**).

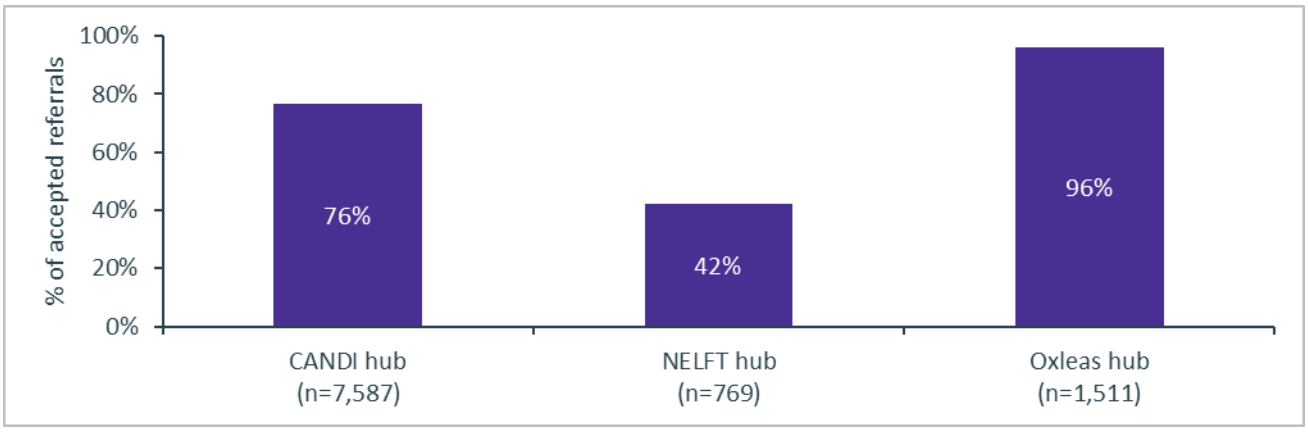


Figure 6 Percentage of accepted referrals to the crisis hubs that are from ED

The referrals at Oxleas that did not come via ED were mostly coming from the home treatment team (HTT) or crisis team (3.6%).

Both CANDI and NELFT had high proportions of self-referrals (14% and 27%, respectively). NELFT crisis hub also had a high proportion of referrals coming via the police (14%) and Home Treatment Teams/ Crisis Teams (6%). Both these hubs also had referrals coming via the London Ambulance Service (4% of CANDI referrals and 6% of NELFT referrals). The full breakdown of referral source can be seen in **Table 14**.

Table 14 Breakdown of accepted referrals by referral source

Referral source	CANDI hub (n=7,587)	NELFT hub (n=769)	Oxleas hub (n=1,511)
ED/Mental health liaison team	76.4%	42.4%	95.9%
Self	13.6%	26.7%	0.0%
London ambulance service	4.3%	5.9%	0.0%
Police	4.1%	13.8%	0.4%
Other	0.5%	1.0%	0.0%
Home treatment team/Crisis team	0.8%	6.2%	3.6%
Community mental health team	0.2%	4.0%	0.1%

Figure 7 shows the percentage of referrals that came from ED over the period of April 2021 to March 2022 for the CANDI and NELFT hubs. The proportion of referrals coming from ED remained relatively stable throughout the reporting time period.

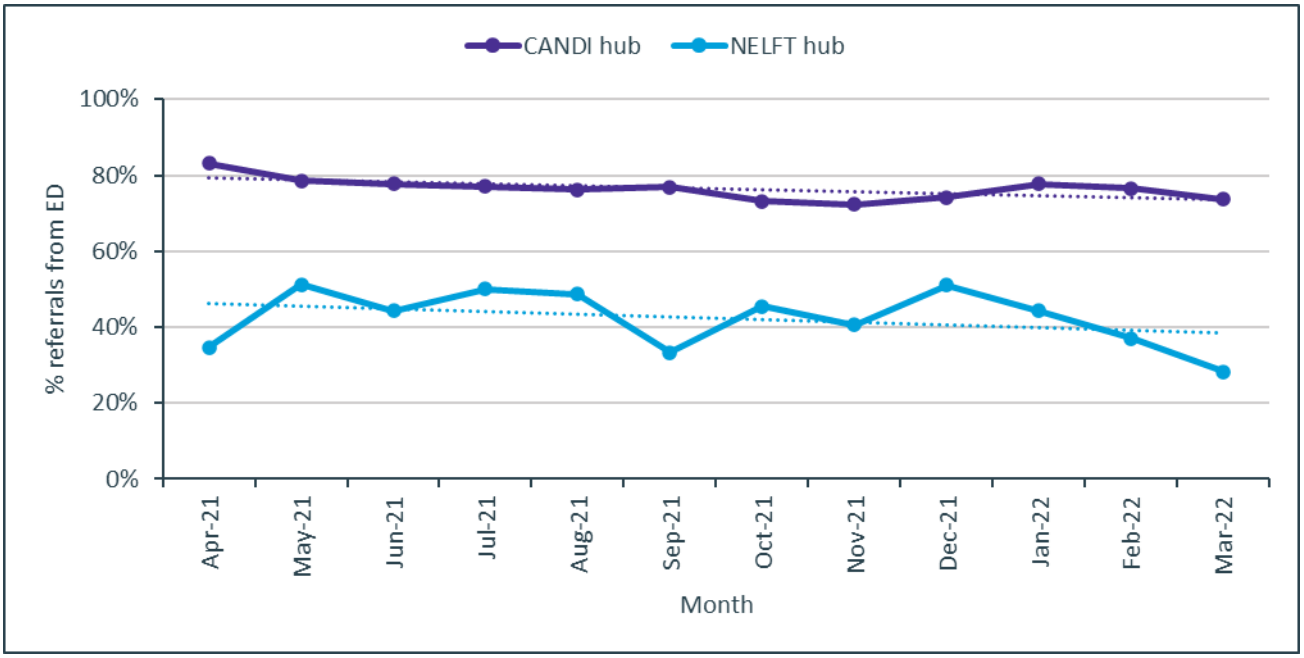


Figure 7: Percentage of referrals that came from ED for CANDI and NELFT hubs, over time. The dotted lines show the trends.

As well as looking at mental health presentations to ED, data was also obtained from each mental health trust regarding the number of referrals to psychiatric liaison services.

Figure 8 shows that the rate of referrals to psychiatric liaison as a proportion of all adult attendances at ED was 4% at both the BAU site and the Oxleas hybrid model. It should be noted that all attendances at the

Oxleas hub are sent to the hub via the psychiatric liaison service so the number of referrals to psychiatric liaison in Oxleas would not be expected to be impacted by the crisis hub.

CANDI and NELFT (both direct access models that allow patients to bypass ED) had statistically significant lower rates of referrals to psychiatric liaison with 2% of all adult ED attendances being referred to psychiatric liaison ($p < 0.05$, t-test). When split out by ED, most EDs linked to the CANDI and NELFT hubs had referrals rates of 2% to psychiatric liaison. The exception was King George Hospital where the rate was 3.2%, although this was still lower than the BAU site.

However, it should be noted that two of the three EDs linked to the NELFT hub (King George's and Queen's hospitals) picked up on a recording issue regarding psychiatric liaison referrals from these EDs. For this reason, data from the daily ED situation report (sitrep) was used to measure the rates of referrals to psychiatric liaison. It is believed that this data is not as accurate as extracting data from the Trust's patient record system. It is difficult to understand the extent to which the data from trusts' systems and the ED sitrep differ.

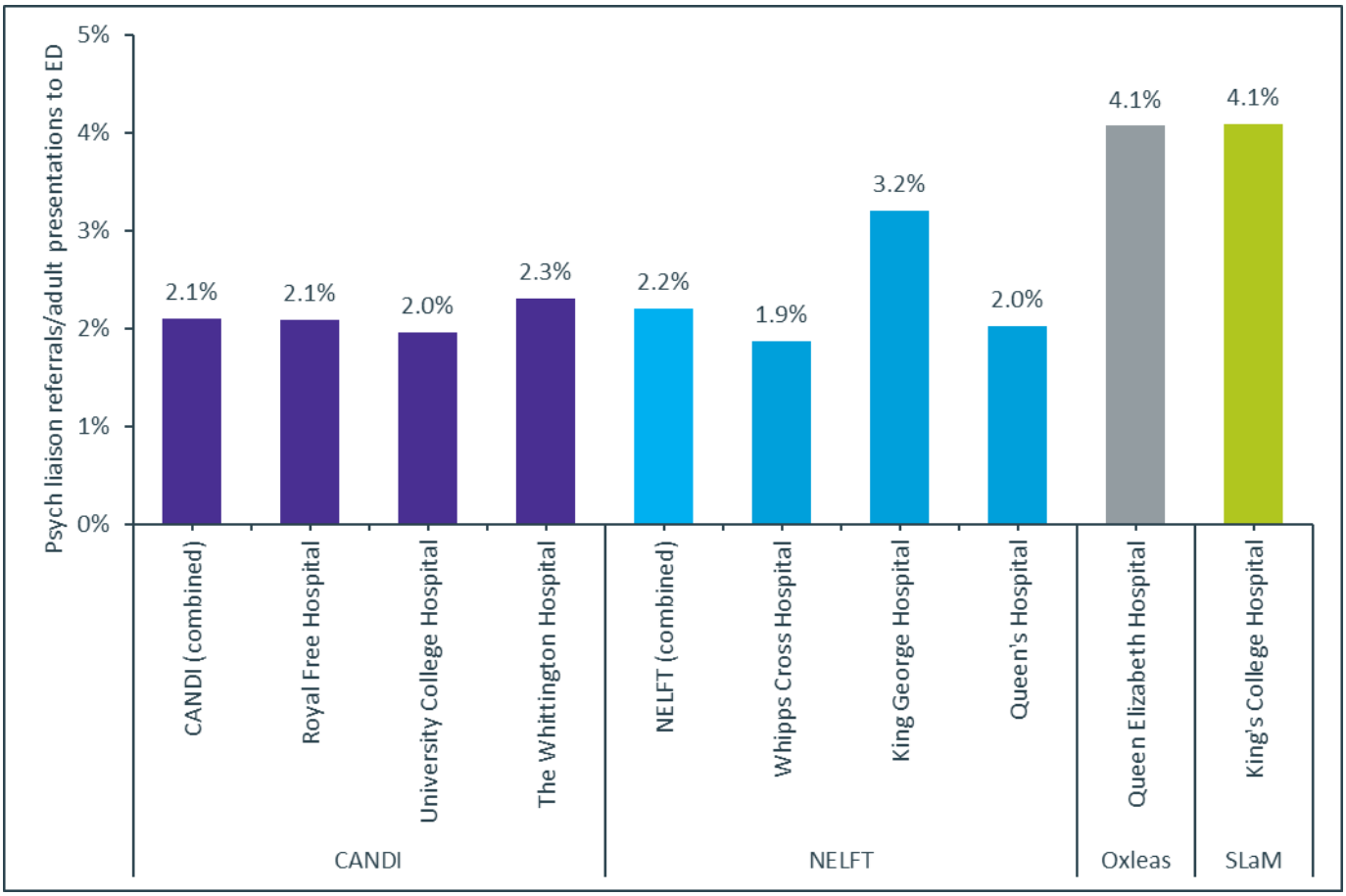


Figure 8 Percentage of referrals to psychiatric liaison as a proportion of all attendances at ED

When looking at the proportion of ED attendances that were referred to psychiatric liaison over time (throughout April 2021-March 2022) there was a big increase in referrals at the BAU site during the winter months (October 2021 – March 2022); whereas the hub sites had fairly stable rates of referrals throughout the year (**Figure 9**).

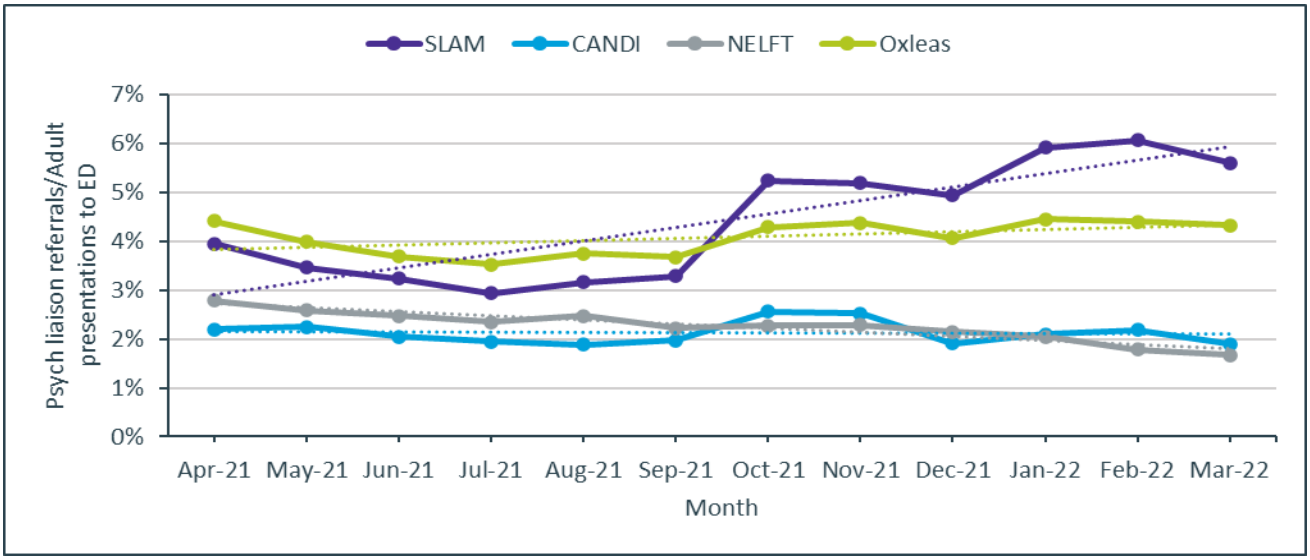


Figure 9 Percentage of referrals to psychiatric liaison as a proportion of all attendances at ED - time trend

5.5.2 Service user perspectives

Multiple channels for signposting to mental health crisis hubs

Service users who responded to the survey gave views on a hub's efficiency based on how well they were diverted away from ED and how they found out about the hub. Service users heard about the hubs through multiple channels. About a quarter (24%) of service users found out about their local hub through the Mental Health Crisis Line and emergency 999 services, including police and ambulance (23%). Some (31%), service users found out about the mental health crisis hub through ED and GP referrals, 9% found the hub through NHS 111, and 9% through friends and family. A few service users that were interviewed said they were directed to the hub through their GPs and mental health support teams and found it convenient to get an appointment.

> "I contacted the mental health services through my GP, initially, just to ask for some navigation… advice, and…guidance…that's how I found out about the hub."

One service user, a repeat attendee, felt the efficiency of mental health crisis hubs was reduced because they had to go through a busy ED environment and the processes of ED checks. They said they would have preferred to go directly to the mental health crisis hub.

> *"Yes [I would have preferred to go direct to the hub] … [ED] is always where I go first…but I'm not keen on going to the hospital…They're usually fairly chaotic."*

5.5.3 Hub staff perspectives

Staffing model challenges

Service staff felt the efficiency of mental health crisis hubs is reduced by fluctuations in patient flow, especially relating to the number of referrals to mental health crisis hubs via ED. They thought it was

challenging to predict the number of referrals balanced against the number of staff and level of skills required on-site at any one time. Another staff member interviewed reported that on-site consultants who can attend to service users with both physical and mental presentations could reduce staffing inefficiencies.

"Our consultant is based here as well, so it's really easy to attend to issues with medication or physical health. [They'll] assess with a nurse, jointly, in case they do need Home Treatment Team. It's done within 15, 20 minutes…It's all contained…which makes it really good [for the patient]."

"Sometimes, because we pitch it at, let's say, having two qualified staff and two unqualified staff on, just in case patients come in and it's full. That's flawed because, for a lot of the time, they are sitting there redundant…you can't redeploy those staff to anywhere else, in a practical way…which is a real waste of resources…I've yet to see a model that has got it right."

Referral pathway for emergency services

Staff said they are seeing more referrals directly from emergency services staff to the hubs and believed the handover process between emergency services and hubs staff was more straightforward than with ED.

"Ambulance service and police started to pick up on something called a hub, and said, so let's bring our patient here. "

5.5.4 Wider stakeholder perspectives

5.5.4.1 ED staff

Mental health crisis hubs referral criteria

ED staff interviewed felt only a small number of service users that come to ED with mental health presentations meet the mental health crisis hub criteria. They felt the mental health crisis hubs criteria for accepting service users was lengthy and potentially duplicated assessment and prolonged service users' waiting times.

"The criteria is quite lengthy… It would be like you're doing half an assessment before you convince the patient to travel to the hub."

"They [mental health crisis hubs] …pick who they want to work with because of all these exclusion criteria."

5.5.4.2 Community Mental Health Teams

Referral pathway to Home Treatment

Community mental health teams felt mental health crisis hubs were an efficient alternative to ED as they diverted service users away from busy EDs and offered alternative care while service users wait for a bed or to be seen by Home Treatment Teams

"In terms of overnight stays [mental health crisis hubs], people [service users] feel like they've had an admission, they feel like they've been taken seriously and listened to, and then we can follow it up with the home treatment, which for most people, is a pretty good balance."

5.5.4.3 London Ambulance Service

Referral pathway for emergency service*s*

London Ambulance Service staff felt mental health crisis hubs were an efficient alternative to ED for service users who did not require any physical checks and met the mental health crisis hub criteria. They felt it reduced the time spent referring service users to the appropriate service and the burden on ED queues.

"It's been easier just to take [service users to the hub] and relieve them from having additional physical health tests that they don't need…Where it's just been mental health, and we have medically cleared them… it's preventing another person in the queue at A&E."

5.5.4.4 London Metropolitan Police

Police handover time

A few London Metropolitan Police officers interviewed felt that mental health crisis hubs reduce unnecessary time spent with service users in ED due to the longer waiting times. Police officers said service users can get checked by a healthcare professional faster at a hub. Therefore, reducing handover time and allowing police staff to attend to other service users in crisis.

Mental health crisis hubs referral criteria

They reported that mental health crisis hubs work well; however, they felt the requirements for accepting service at times can be restrictive and reducing the efficiency of the hubs to managing demand for people in mental health crisis.

"I've had a little bit of kickback [from hubs] …the situation is this person is medically clear, and the ambulance has done the same, but then the hub will say no, and I'll have to take this person to the hospital… It's a drain on our resources…defeats the object of why hubs are so brilliant."

Link with Community Mental Health teams

Police felt that mental health crisis hubs had helped highlight the positive work of Home Treatment Teams and Community Mental Health Services and how they help with better integration across services for service users. For example, supporting service users with their mental health in the home therefore reducing the need for service users to attend mental health crisis hubs and emergency departments.

"Home treatment teams have been a really good side of the crisis hub because [their work] often reduces the need for people to come into contact with hospitals and police officers because they're often given advice over the phone, at home, reducing emergencies [mental health crisis situations] with police and with hospitals."

5.5.4.5 ICB Commissioners

Data on ED waiting times

Commissioners interviewed felt that overall mental health crisis hubs can lessen the burden on ED waiting lists. However, they thought it was difficult to assess the impact of mental health crisis hubs on ED waiting times due to data gaps. Commissioners felt that many factors must be considered, especially the impact of diverting presentations to other pathways, such as crisis houses, crisis cafes and community mental health services. Commissioners suggested that capturing and analysing real-time data could help understand gains in efficiencies relating to referral pathways, presentations, and wider pressures in the system.

"The last piece of data I saw, people who would normally go to ED are now going to mental health crisis hubs…but of course, it is difficult to understand the impact as there are so many variables."

"We have a gap in data…We need to make sure that we're looking at indicators of crisis pathway presentations and pressure in the system and…in more real-time to address any pressures…?"

5.6 Equitable

5.6.1 Quantitative analysis

The section provides an analysis that compares the demographic profile of crisis hub attendances. This analysis has been done at an attendance level rather than an individual service user level, as it was not possible to identify within the data those service users that had attended more than once within the period of interest April 2021- March 22.

Whilst the analysis sets out the profile of patient attendances at each of the crisis hubs compared to the BAU site, there is variation in the populations living in different parts of London being served by the different hubs. Therefore, it is possible that any variation could be explained by the profile of the local population that the crisis hub serves.

Table 15 gives a breakdown of crisis hub / BAU site attendances by age group. The NELFT hub has a slightly younger demographic profile of attendees compared to the other hubs and BAU site, but the profile is broadly aligned between hubs.

Table 15 Breakdown of accepted referrals by age group

Age group	CANDI hub (n=7,568)	NELFT hub (n=768)	Oxleas hub (n=1,464)	SLaM (BAU) (n=3,836)
<18	0%	0%	0%	1%
18-24	20%	26%	21%	20%
25-34	27%	32%	27%	32%
35-44	20%	19%	21%	18%
45-54	17%	15%	16%	15%
55-64	11%	7%	11%	10%
65-74	3%	1%	3%	3%
75-84	1%	0%	1%	1%
85+	0%	0%	0%	0%

As with age the gender profile was similar between hubs and the BAU site with no notable differences in gender profiles of hub attendees compared to attendees at the BAU site (**Figure 10**).

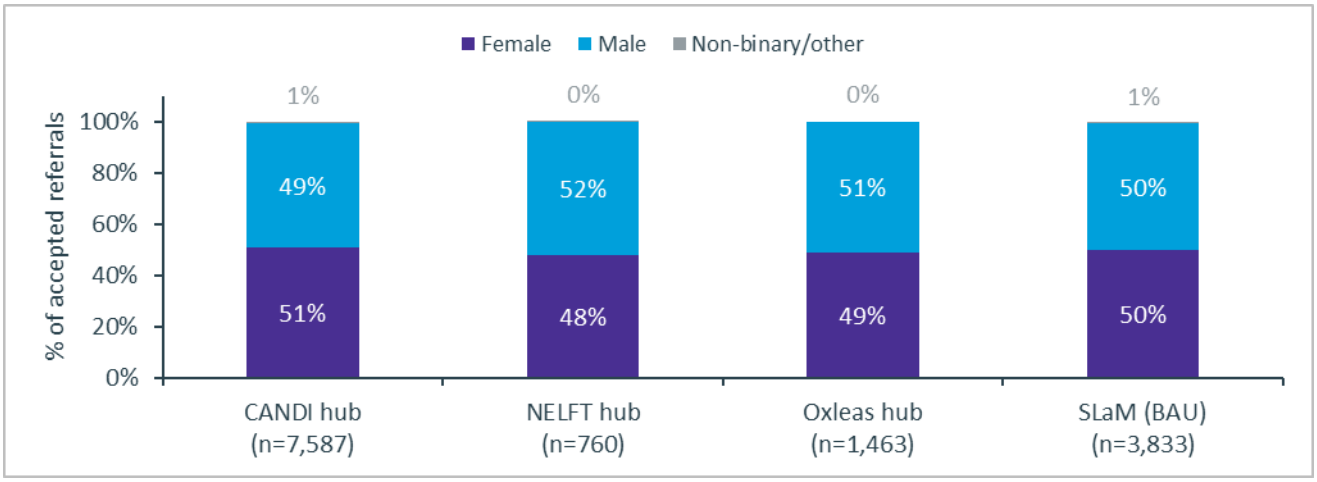


Figure 10 Breakdown of accepted referrals by gender

There were some differences noted in the ethnic profile of attendances at the hubs compared to the BAU site, with CANDI and Oxleas hubs having a higher proportion of white service users attending their crisis hubs than the BAU site (**Table 16**). The BAU site had a higher proportion of black service user attendances (32%) than all of the crisis hubs and NELFT crisis hub had a higher proportion of attendances from people of Asian ethnicity (19%) than the BAU site (4%).

Ethnicity of patients is not always well recorded, so the analysis does not give the full picture regarding the ethnic profile of crisis hub attendances, with 34% of attendances at the CANDI hub having no ethnicity recorded, 27% at the Oxleas hub and 22% at the BAU site. Ethnicity was well recorded at NELFT with only 6% of crisis hub attendances having no ethnicity recorded.

Table 16 Breakdown of accepted referrals by ethnic group

Ethnic group	CANDI hub	NELFT hub	Oxleas hub	SLaM (BAU)
White	64%	55%	64%	53%
Black	15%	19%	18%	32%
Asian	7%	19%	6%	4%
Mixed	5%	2%	5%	5%
Other	9%	6%	8%	7%
Total with ethnicity recorded	5,017	724	1,114	3,001
Unknown ethnicity (n)	2,570	44	407	835
Unknown ethnicity (%)	34%	6%	27%	22%

Information on the sexual orientation of crisis hub attendances was obtained (**Table 17**). Overall, sexual orientation is not well recorded across NHS services and the data does not give the full picture of the sexual orientation profile of hub attendances, with sexual orientation being unknown for 91% of attendances at the Oxleas crisis hub, 73% at the CANDI hub and 17% at the NELFT hub. Generalising the sexual orientation of attendances at the Oxleas and CANDI hubs should be treated with caution due to the high proportion where this is unknown. It was not possible to obtain data on sexual orientation from BAU site, so it has not

been possible to compare the sexual orientations of hub service users to the BAU site.

Table 17 Breakdown of accepted referrals by sexual orientation

Sexual orientation	CANDI hub (n=2,079)	NELFT hub (n=638)	Oxleas hub (n=138)
Straight/heterosexual	86%	96%	91%
Gay or lesbian	10%	1%	4%
Bisexual	3%	2%	5%
Other	1%	0%	0%
Total with sexual orientation recorded	2,079	638	138
Unknown sexual orientation (n)	5,508	128	1,383
Unknown sexual orientation (%)	73%	17%	91%

Information on the mental health diagnoses of attendees was obtained from sites for those attendees already known to the mental health trust providing the crisis hub/ BAU site service that had an existing diagnosis (**Figure 11**). Just over half (53%) of attendees at the BAU site had a known mental health condition, with higher rates of diagnosis at Oxleas hub (58%). Although this may be due to Oxleas including suspected diagnosis as well as confirmed diagnosis in their data. A lower proportion of attendees at CANDI's crisis hub had an existing mental health condition known to the Trust (29%).

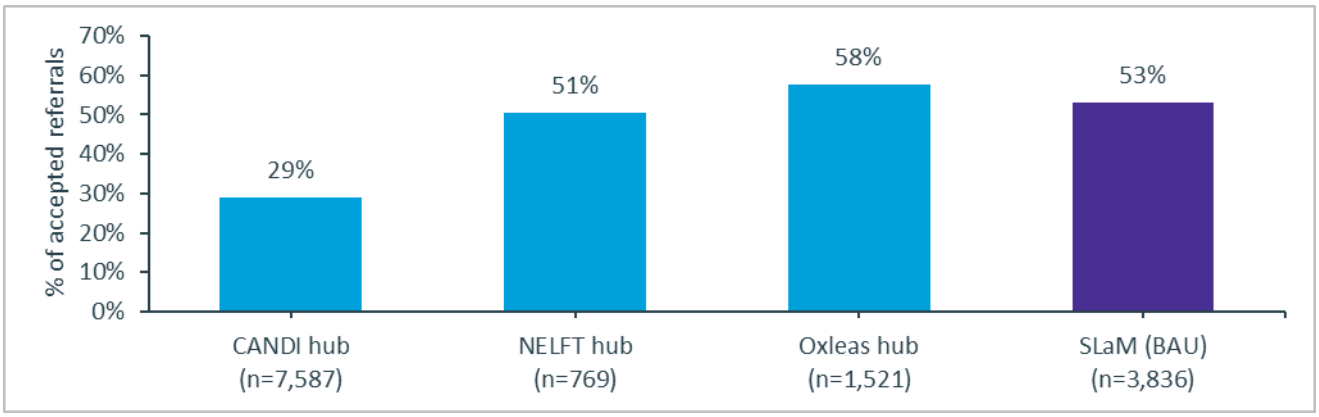


Figure 11 Percentage of accepted referrals who had a mental health diagnosis

There was variation in the proportion of attendees with different mental health conditions between trusts, although this may partially be due to the way this data was recorded with CANDI and SLAM sending data on the primary mental health diagnosis of each attendance, whilst NELFT and Oxleas set out all known mental health diagnoses linked to their attendances and Oxleas included both suspected and confirmed diagnoses. For this reason, it is difficult to make meaningful comparisons in the types of mental health conditions that those attending the hubs had compared to the BAU site. However, the full breakdown has is outlined in **Table 18**.

Table 18 Breakdown of accepted referrals by ICD-10 mental health diagnosis category

Diagnosis category (ICD-10)	CANDI hub (n=7,587)	NELFT hub (n=878)	Oxleas hub (n=1,521)	SLaM (BAU) (n=3,836)
No/unknown diagnosis	71.1%	43.3%	42.4%	46.8%
F20-F29 - Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	7.8%	9.7%	18.4%	15.5%
F30-F39 - Mood (affective) disorders	5.3%	4.6%	27.0%	9.2%
F60-F69 - Disorders of adult personality and behaviour	7.8%	4.3%	25.4%	8.2%
F10-F19 - mental and behavioural disorders due to psychoactive substance misuse	3.5%	19.2%	37.0%	7.3%
F99 - Unspecified mental disorders	0.0%	1.5%	0.0%	6.8%
F40-F48 - Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	3.1%	4.2%	25.0%	4.3%
F70-F79 - Intellectual disabilities	0.1%	0.8%	3.6%	0.5%
F80-F89 - Pervasive and specific developmental disorders	0.5%	0.6%	5.8%	0.4%
F50-F59 - Behavioural syndromes associated with physiological disturbances and physical factors	0.2%	1.3%	3.3%	0.4%
F01-F09 - mental disorders due to known physiological conditions	0.6%	2.7%	1.4%	0.4%
F90-F98 - behavioural and emotional disorders with onset usually occurring in childhood and adolescence	0.0%	1.0%	3.6%	0.2%

5.6.2 Service user perspectives

There were no specific responses by service users relating to the issues of equity.

5.6.3 Hub staff perspectives

Culturally sensitive care

Of the 32 hub staff who responded, 91% agreed that their service was culturally sensitive to service users and their carers from diverse backgrounds and ethnicities, which was higher than the 33% of 9 BAU site staff. If service users or carers did not speak English as their first language, both hub and BAU site staff reported that they could offer an interpreting service and leaflets in languages other than English.

Despite high referrals to community mental health teams and perceiving their service is culturally sensitive, staff interviewed felt there is room for improvement in reaching those from underrepresented backgrounds. A few staff felt mental health crisis hubs could provide an inclusive service by working more closely third-sector partners. Another member of staff felt the effectiveness of providing an equitable service is determined by staff knowledge of available services.

"We're trying to build all our relations with third sector partners. There is a litany of charity organisations…women's issues, LGBT, or underrepresented groups…we're building all that resource, that also the crisis teams can use then."

"In my experience of working at different hospitals, it depends on how good that particular [staff] is and how much they know about what is available in your local area."

5.6.4 Wider stakeholder perspectives

5.6.4.1 Community Mental Health Teams

Reaching underrepresented populations

Community Mental Health Team staffs felt the current levels of signposting from mental health crisis hubs to community teams were good. Without the signposting, service users would end up back in ED. However, they felt mental health crisis hubs tend to see service users from a similar demographic background. Therefore, reaching diverse populations and those unknown to the services remains challenging.

"We probably have one or two referrals a week from a hub, sometimes more…If we didn't exist, the patient would be in hospital. The signposting is generally very good…"

"I suppose we probably only see similar cohorts of patients. The people we don't see are the quietly depressed people who wouldn't tell anybody what's going on or wouldn't attend services. They're probably the people we're not seeing, but it's hard to know how to reach out to them."

5.6.4.2 ICB Commissioners

Engagement and communication with the local community

Commissioners interviewed felt providing equitable mental health support services was a key area for improvement across mental health services. One Commissioner felt better engagement and communication with Community Mental Health teams could ensure that mental health crisis hubs reach the demographics of the population their ICB represents. Another Commissioner felt as part of their ongoing work; they would like to look at best practices and data across other ICBs to identify equitable mental health crisis models that could reach as many service users as possible. Another Commissioner suggested investing more in community mental health teams to support prevention and long-term reduction in ED presentations.

"Prevention is quite key…There's been a real shift over the last few years, showing that interventions such as investment in home treatment teams and investment in community teams work. So, if you're known to mental health services, we see a reduction in those patients presenting to ED."

"So, prevention and focusing more on local communities, embedding programs to help people have good mental health in their local communities could be the better area of focus."

"We need to capture data to understand different groups of users, reduce health inequalities and tailor support through community mental health teams."

5.7 Person centred

5.7.1 Service user perspectives

Overall experience and satisfaction of care

Service users who responded to the survey were asked a range of questions regarding their satisfaction of the care they received at a mental health crisis hub and the experience of the hub. Overall, 46% of service users were satisfied with the support and treatment they received at the mental health crisis hub; however, an equal percentage (46%) were dissatisfied. Just over a third (36%) felt they received the support and treatment needed for their mental health compared to 51% who thought they did not.

The survey also explored specific aspects of the service users' experience of care (**Figure 12**), which are explored in more details below.

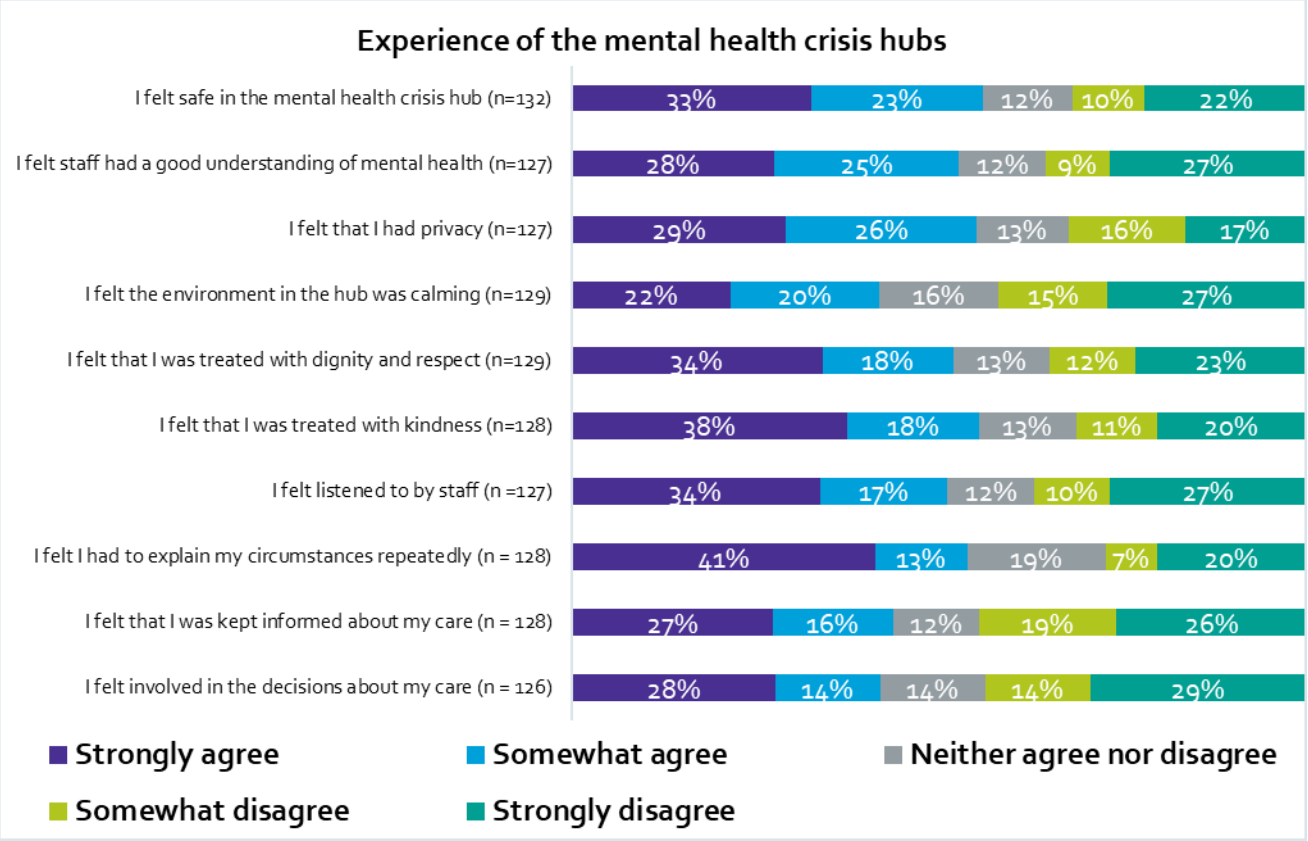


Figure 12 Experience of mental health crisis hubs

Communication within ED

The quality of person-centred care received by survey respondents and interviewees differed across the service user journey. Leading up to the hub, satisfaction with person centred care was influenced by how well service users were treated before attending a mental health crisis hub. These relate to service users having to repeat their story, understanding of legal rights and why they were being referred to a mental health crisis hub.

Of those service users who attended ED (n=42), 12 stated they had to explain their circumstances repeatedly in ED and 28 felt their legal rights were not explained in ED (N.B. 5 stated they did not know if their legal rights were explained). One service user interviewed said they felt distressed because ED staff did not explain why they were being sent to a mental health crisis hub instead of an inpatient ward.

"They [A&E staff] never told me I would have to go to a [mental health crisis hub] …I was used to going straight to a hospital ward. I'd never experienced anything [distressing] like that."

Another service user interviewed felt ED staff were rude, and the transport staff from ED to the mental health crisis hub helped improve that experience. Another service user felt better understood and treated with kindness and respect by the mental health crisis hub staff compared to ED staff.

"When I was in A&E, the nurse was very rude to me…The transport [from A&E] gentleman… they were so lovely. They made that experience in the hospital better. It was almost like they wiped that out."

"They [mental health crisis hub staff] were respectful…they understood my frustration…Compared to A&E…they weren't respectful."

Being treated with kindness, dignity, and respect

Over half (56%) of survey respondents felt they were treated with kindness, and 52% were treated with dignity and respect. Kindness was linked to compassion, empathy, and making a situation as comfortable and calm as possible for service users in distress. This was one of the most positive aspects of person centred care offered at the hub. Service users described how they had felt cared for and treated with respect, dignity kinds by Mental Hub Crisis Hub staff as they were made to feel comfortable about their situation and provided amenities such as blankets, food, and drinks to make waiting for treatment or a bed.

"Because there were no beds…She [mental health crisis hub staff] passed me a load of towels and blankets to try and make [the sofa] as comfortable as can be in the situation."

"I stayed for four days…They [hub staff] were very helpful and took me out to get something to eat…and a bit of fresh air."

"I felt quite comfortable actually and looked after…People talking to me…offering me something to drink… It was really good."

Feeling listened to

Of the survey respondents, majority, 51% felt listened to by staff compared to 37% who did not. In interviews, service users highlighted different ways that they felt listened to by hub staff. For example, they described having their questions answered when they did not understand something relating to their care,

staff checking with them whether they felt well enough and ready to leave the hub, and generally feeling they knew that staff were always available to listen and/or talk to them. Service users also described feeling 'listened to' (and understood) in non-verbal ways e.g., feeling that staff sensed that the service user did not want to talk.

"I went there [mental health crisis hub] multiple times during the day, and the lady who looked after me, she stayed there until I was fine. Even though I was there earlier, she still looked after me and made sure I was fine and listened to me until I was okay to leave."

"I didn't understand the specific treatments, or specific plan…so I asked the question, and they would happily expand on it and explain how that will work, how that will last, or what I need to do…or anything around that."

"The staff that are not doctors [ED doctors] … They would sit in the room… they could see that I don't want to talk, but they were still there and made it known to me that they're there if I want to talk."

Although most service users felt listened to, interviews with service users revealed varied experiences that highlighted that some staff could benefit from training in listening skills to improve the quality of person centred care at mental health crisis hubs. Service users linked not being listened to their negative experience of having to explain their circumstances repeatedly. Over half (54%) of survey respondents felt they had to explain their circumstances repeatedly. One carer felt they had to explain the service user's mental health needs continuously and had to get a second opinion before they felt the service user and their needs were understood. Another service user reported feeling belittled by staff, and felt staff were not listening and that they had to justify themselves repeatedly.

"It just felt they weren't listening at all…then I had to sit there and justify [to staff and myself], like, no, I am worthy of being here."

"I don't feel like they were listening [to me] …they were more listening to their colleagues."

"They did not listen until my other daughter asked for a second opinion…they [hub staff] were interested more in tick box exercises."

Being informed and involved in care

Of the survey respondents, 43% felt they were informed about their care, and 42% felt involved in decisions about their care. Service users interviewed who were satisfied with the decision-making process felt they were informed about their care at different stages of their service user journey, whether at the referral stage, at the assessment or with discharge outcomes.

"There is a kind of two-stage care; there is support work and looking after me when I am in crisis, and then I speak to the nurse once I've passed the stage of the crisis. I get the care [from the hub] I need…When there is someone who doesn't know me, they read my care plan."

"I can't remember word by word, but they [hub staff] explained my rights…for safeguarding and safety. They said they must inform other agencies but would inform me first."

Conversely, 45% did not feel involved in decisions about their care. Those who were dissatisfied were generally dissatisfied with certain parts of their care. Dissatisfaction occurred when service users felt they did not know what was going to be happening to them next. One service user interviewed felt dissatisfied when they were not informed about useful community support services or provided follow-up care. Another service user said they felt uninformed about their discharge outcome, therefore, despite a staff member accompanying the person back home, they did not receive the quality of care they expected.

"I would have liked to have been better informed of the options available and what was happening while I was at the hub."

"I don't feel like I had support… they [hub staff] just literally booked me a black cab, got one of their staff in the cab to take me home, and that was it."

ED and mental health crisis hub environment

There was an even split in survey respondents about the extent to which the environment in a mental health crisis hub was calming, with 42% agreeing and 42% disagreeing. Mental health crisis hubs were perceived to be more calming than a busy ED environment because of a less busy environment and better treatment by staff members. A few service users who went to the mental health crisis hub via ED felt that both the mental health crisis hub and ED were chaotic due to the other service users in distress. One service user felt the space was too small and not relaxing if they needed to sleep.

"It [mental health crisis hub waiting room] wasn't calm…a lady was playing for hours…It was chaos."

"I never got the opportunity to relax and sleep properly [at A&E and the hub] …it was not comfortable enough to sleep in, so I felt even more distressed when I got an assessment because I was so tired."

"The space was too small to have a hub."

However, as described above, service users did provide specific examples of how they were made to feel comfortable and provided amenities such as blankets, food, and drinks.

5.7.2 Hub staff perspectives

Caring Environment

In the staff survey, of the 32 hub staff who answered, 81% agreed that service users who attended their mental health crisis hub received person centred care, similarly 90% of 10 BAU site respondents also agreed. 84% hub staff agreed that service users were treated with respect and dignity at their hub, which was similar to 80% of 10 BAU site respondents. 93% of 27 hub staff agreed that they were suitably trained to provide care to service users and their carers, a similar proportion to 88% of 8 BAU site respondents.

"The team is very caring, and patient focused. We are always trying to reflect and improve."

"Service users are welcomed into the hub by a member of staff who remain with the client during their stay. They are offered beverages and something to eat, and we keep letting them know the process of what happens in respect of support."

Some staff interviewed felt it was easier to provide person centred care within a mental health crisis hub setting than within a busy and complex ED environment. This was reflected in the staff survey responses,

where 66% of 32 hub staff agreed that their service is a calming environment for service users and their carers, compared to only 40% of the 10 BAU site respondents. Conversely, 60% of the BAU site respondents disagreed with the statement that their service was a calming environment, compared to only 13% of hub staff respondents. One staff member interviewed said mental health crisis hubs were more calming and less busy than ED, allowing service users time to process and recover. Some staff felt mental health crisis hubs were more person centred than ED because of the more contained environment and ability to regularly check and provide individualised care. A few staff felt mental health crisis hubs were more therapeutic and individualised (e.g., service users were offered food and drink), allowing service users time to process and recover better.

"So, the main benefit is that, that it [mental health crisis hub] allows [service users] time to decompress…in a more therapeutic environment. "

"There is less pressure here [mental health crisis hub] …it's smaller, calmer, the person knows who's assessing them… Emergency department is less person centred because it's a much bigger system with much more different demands. "

" The environment is more conducive to recovery, and…allowing people space to calm down and be able to really think about what they want, whereas in the ED, there was constant pressure, because they have to, so they used to keep moving people through the department. "

Despite the benefits of mental health crisis hubs as a more calming environment, one hub staff member interviewed felt that person centred care in mental health crisis hubs is compromised by unprecedented waiting times, availability of space and resources.

"[Staff] try to be patient-centred, but potentially for reasons of cost or environment, estates, availability of space one might have marginal gains… [Service users] might wait in a quieter area, but that's only a marginal gain… Especially if somebody is staying beyond five hours."

Continuity of care and communications with Community Mental Health services

A few service staff interviewed felt that mental health crisis hubs could provide more person centred care than ED through their ability to work with Community Mental Health teams more regularly.

"I'm trying my best to pick up the complexity around social issues which impact mental health…everything will run smoother if you have a small team looking at complex social issues…Additional training in specific issues would be really helpful."

Parity of esteem

Hub staff interviewed felt mental health crisis hubs are person centred because they communicate to service users that mental health is valued equally to physical health. They felt, mental health crisis hubs provide service users with the option to attend a mental health-specific ED, away from the stigma of a typically busy ED environment. However, they also felt that it is crucial for mental health crisis hubs to exist as an option and not a replacement for the current ED-Psychiatric Liaison model to avoid additional divisions or stigmatisation. They suggested making the process more person centred by employing navigators who could help service users decide for themselves whether to go to ED or divert to a mental health crisis hub.

"Mental health crisis hubs are navigating away from the stigma of A&E and giving [service users] their

own A&E which is mental health specific…It's person centred from the beginning…[Although] we shouldn't be dividing mental health from physical healthcare…Creating a separate mental health A&E can kind of just extend the stigma we're trying to push away from."

Staff also suggested that person centred care within mental health crisis hubs needs to be looked at through a perspective, which moves away from comparing waiting times with ED to a focus on addressing the needs of service users in distress.

"We need to move away from this idea that there's a clock ticking and there's a quick way to reduce mental health delays by moving service users out of ED…We need to view what provisions we need for people in mental health distress. We cannot view it through the prism of 12-hour delays…It completely skews [the service], and we end up with models which are truly not patient centric and wasteful."

5.7.3 Wider stakeholder perspectives

5.7.3.1 ED staff

More service user feedback required

Some ED staff interviewed felt it is unclear whether ED psychiatric liaison services or a mental health crisis hub is the most person centred pathway for service users. They suggested that more service user feedback is obtained to understand which service is better.

"We have regular patients that re-attend ED, be it for mental health-related reasons or be it for a small medical health need. We have not been able to obtain patient feedback in terms of how they feel that the ED is a better place for them to be cared for versus a mental health crisis hub. We've not had that feedback… I think we need to look into that."

5.7.3.2 Community Mental Health Teams

Working alongside Community Mental Health Teams

Community mental health service staff interviewed felt mental health crisis hubs are more patient-centred because they were able to build relationships and work more regularly with community mental health teams, which supports better integration and continuity of care across services compared to ED.

"The interchange of patients [between mental health crisis hubs and Community Mental Health teams] works really well."

5.6.3.3 London Ambulance Service

Parity of esteem

Similar to hub staff, London Ambulance Service staff felt that mental health crisis hubs were more person centred than ED as they offered service users the option to attend a mental health-specific ED for timely and specialist mental health support.

"I think it's [mental health crisis hub] is a brilliant service. I call it the site liaison for mental health…the A&E for mental health…patients with mental health can get the quicker, appropriate, faster care."

5.6.3.4 London Metropolitan Police

Less restrictive option

A few London Met Police officers felt that signposting or transporting service users directly to a mental health crisis hub allowed them to provide better care. They felt they could quickly hand over service users to mental health specialists without frequently resorting to restrictive options such as detaining them under section 136.

"Police officers, we're limited with our powers, so we only have 136. But this is where these crisis hubs really come into play. We have got the option to signpost [service users] to an offer to go voluntarily…which ultimately ensures least restrictive care."

5.6.3.5 ICB Commissioners

Parity of esteem

Commissioners interviewed felt that mental health crisis hubs are more welcoming than busy EDs, therefore a more conducive environment for those in a crisis. They also thought it was essential for future investments to balance physical and mental health support. At this stage, it was unclear whether one model was better than another for patient centred care.

"Strategy will look at how we can keep people where appropriate…whether back into the Community or to specialist placement or an inpatient ward".

"We are trying to balance this concept of segregating mental health away from A&E… In the case of the Crisis Hub, they get a better experience… or do we look at making sure that a generic department can respond to the breadth of needs?"

Continuity in care

It was thought that mental health crisis hubs were more person centred because they provided better continuity in care to repeat attendees because hubs staff would become more familiar with service users.

"If you are a known service user or returning service user, you will most likely always see the same staff. I think that has to be a good thing in terms of continuity of care."

Data-driven approach

Some commissioners interviewed believed significant investment has gone into crisis care over the past three to four years. Therefore, they suggested investing in data-driven approaches to better understand their systems' effectiveness and have a more targeted conversation on ways to improve person centred care.

"I think it is important to see what impacts some of these services are having…the number of people going to ED and percent change [since investing in the mental health crisis hub] would be interesting…"

"What works and what doesn't?…We need to use a lot more data to drive conversations about interventions that are more targeted about how do we really improve care for our population?"

6.Conclusion

This evaluation has been conducted over a eight-month period (March-October 2022) using quantitative data from the period April 2021-March 2022 from the four mental health trusts included in this evaluation and qualitative data gathered by the HIN. The evaluation was based on the six quality domains of the London Mental Health Crisis Hub Framework: Safe, Timely, Effective, Efficient, Equitable and Person Centred. The evaluation used different data methods to capture a wide range of perspectives about mental health crisis hubs, which included service users and cares, hub staff, and wider stakeholders involved in mental health crisis hubs, such as London Ambulance Service, London Metropolitan Police, senior ICB commissioners, ED staff and Community Mental Health Teams.

Findings indicate that the mental health crisis hubs that were established for approximately two years are providing a service that is regarded by the majority of service users as safe and are a place where they were treated with kindness, dignity, and respect, by staff that listened and had a good understanding of mental health. Overall, this experience is echoed by hub staff and other stakeholders. This provides an optimistic outlook for the continuation of the mental health crisis hubs as a model for London. However, the quality of care being delivered needs to be viewed alongside concerns about staffing and paid and unpaid overtime within hubs.

The evaluation highlights a number of strengths in the mental health crisis hub approach, particularly the two hubs that provide direct access to people in a mental health crisis (not via an ED) in terms of timeliness, length of stay, and repeat access for service users who require support in a mental health crisis. Additionally, both Police and Ambulance services report mainly positive interactions with the direct access hubs. There was a more mixed response on mental health crisis hubs from ED staff interviewed, which highlights the need to ensure changes in mental health crisis service provision closely involve the expertise of psychiatric liaison and ED staff to mitigate for issues relating to the six quality domains (Safe, Timely, Effective, Efficient, Equitable and Person Centred). Cross-service working between hubs, ED, and communities services combined with effective engagement with local communities and service users is imperative to provide clarity and guidance to service users on what they can expect for all services. This is key to honour the commitment made to the London Mental Health Crisis Concordat to work together to improve the system of care and support, so that people in mental health crisis *'are kept safe and helped to find the support they need, whatever the circumstances in which they need help, and from whichever service they turn to first'*[7].

[7] National concordat - Mental Health Crisis Care Concordat Mental Health Crisis Care Concordat https://www.crisiscareconcordat.org.uk/national-concordat/

7.Limitations

There are a number of limitations to this evaluation.

Whilst efforts were made to obtain data in a way that was possible to compare across sites it must be noted that each mental health trust uses a different convention for coding their data. This was most important when looking at the source of referral and discharge outcomes. The evaluation team worked closely with the HIN's Clinical Director for Mental Health to design a meaningful way of aggregating codes to enable comparability but there will still be some differences in the ways that trusts have recorded this data.

The approach taken to the quantitative data was to obtain data over a set time period for each of the mental health crisis hubs and then compare this to data from the BAU site. This approach was selected over looking at ED data from the same sites pre and post the introduction of the crisis hubs due to a number of factors that would not be possible to control, most notably the impact of COVID-19 on ED attendance rates. Whilst this approach seemed like the most meaningful way of measuring the impact on ED it does not give any sense on whether the trusts ED attendances were reduced due to the introduction of the hubs.

Due to a cyber-attack that took place at the BAU site at SLaM during this evaluation it was not possible to obtain some data on staffing measures, patient safety incidents, 28-day reattendances and sexual orientation of hub attendees. This data would have been useful in comparing this data to the BAU model of crisis care.

The Mental Health Crisis Hub Framework includes a small number of measures that have not been included within the scope of this evaluation. This evaluation was done retrospectively using quantitative data that had already been recorded within trust systems. Where data was not being recorded or was not being recorded accurately enough by a sufficient number of the trusts the decision was taken to not include this in the evaluation, as there was not time to introduce new data fields for staff to collect.

Whilst a BAU site was used as a comparator it should be noted that a BAU model has a less stringent criteria for referrals. For example, they also see patients that have coexisting physical health needs and those that are agitated. The BAU site sees all referrals and does not have a process for rejecting any referrals. This may well impact on the longer wait times for the BAU model.

There were a number of data gaps where data had not been recorded for all service users. This was most notable in terms of service user ethnicity and sexual orientation, where this was unknown for quite a large proportion of service users.

The service user and carer survey were sent out to service users via the mental health trusts. A different approach to sending out the survey was taken for each trust, depending on the ways that they are able to communicate with service users. These methods greatly impacted the level of response received, which meant it was not possible to undertake a comparative analysis between the different hubs and BAU site. Nevertheless, the service user and carer surveys captured responses from all hubs and from a varying range of demographic backgrounds.

Despite multiple approaches to recruitment (including the use of incentives) and extending the period of fieldwork, there were challenges engaging service users and carers to participate in interviews. A total of 25 service users from a range of demographic backgrounds were invited to interview. However, only 9 interviews were completed. Most service users and carers did not attend their interview, despite efforts to follow-up and rearrange interview times. It was not possible to secure an even distribution of service users

interview across all the sites.

The staff survey was sent to staff members across all 4 sites with 53 responses received. However, there was an uneven response rate across sites, which meant it was not possible to undertake a comparison between the sites. There were also challenges engaging hub staff to participate in interviews, which was largely due to the pressure hub staff are currently experiencing. However, a good breadth of interviews was undertaken with wider stakeholders, such as ED staff, Psychiatric Liaison and Community/Home Treatment Teams, commissioners, London Ambulance Service staff members, and London Metropolitan Police officers.

8.Recommendations

These recommendations are intended to inform the core components to deliver a high performing mental health crisis service based on the findings from this evaluation, they should be considered alongside the existing London Mental Health Crisis Hub Framework

1. Mental health trusts to implement the London Mental Health Crisis Hub Framework to ensure a data driven approach is used to inform continual service improvement against the six quality domains.

Safe:

2. Mental health trusts to collect and report safety data to relevant decision-making bodies.

3. Mental health trusts to review staffing levels, to including the ability to adapt staffing according to service user flow.

4. Mental health trusts to review the building, service user and staff security of their mental health crisis hubs

5. EDs and mental health trusts to work together to address delays in arranging hospital transport to the mental health crisis hubs to avoid compromising safety and increasing the risk of service user harm.

Timely:

6. Mental Health Trusts to ensure ease of access to the location of the mental health crisis hub, by foot, transport, and transfer from ED sites.

7. ICBS to review the availability of mental health inpatient beds to ensure timely discharge of service users from the mental health crisis hubs

Effective:

8. Mental health trusts to consider including Core Trainee doctors/physical health clinicians within the hub staffing models to provide medical care if required.

9. Mental health trusts to develop an understanding of the impact of discharge outcomes, with the view to improve care within community settings and reduce mental health crisis hub reattendance.

10. Mental health trusts to implement effective methods for regular feedback from staff directly employed within the mental health crisis hub to drive continual improvement.

11. Mental health trusts to review inclusion and exclusion criteria for the mental health crisis hubs and clearly communicate these with all stakeholders and service users and carers.

12. Where possible hubs should be sited close to EDS and or Trusts and EDs to review transport provision to facilitate more timely transfer to mental health crisis hubs, where possible hubs to be sited close to EDs.

Efficient:

13. ICBs to communicate to the public, service users and carers and all stakeholders on how to access the mental health crisis hubs directly, in terms of location and referral criteria, to include why a person may be transferred from ED to a mental health crisis hub through a variety of methods e.g., posters, leaflets, email, texts and websites.

14. Mental health trusts to consider direct access to the crisis hubs to service users (self-referral) and by emergency services for people in a mental health crisis

15. Mental health trusts should continue to invest in senior leadership and consider reducing the use of bank staff and continue building on the existing skills of the of the mental health crisis hub team

Equitable:

16. ICBS to engage and communicate with the local community to ensure access to mental health crisis hubs reflect the demographics of the population.

17. ICBS to develop culturally relevant discharge support and recovery services.

18. Mental health trusts to significantly improve data recording of ethnicity and sexuality.

19. Mental health trusts to ensure they have effective feedback mechanisms in place for services users and carers of all races and ethnicities (in line with Patient and Carer Race Equality Framework) NHS England » Advancing mental health equalities

Person Centred:

20. Mental health trusts to implement effective methods for regular feedback from service users and carers on their mental health crisis hub experience to drive continual improvement.

21. Mental health trusts to consider working in partnership with service users to co design information to explain what to expect at the mental health crisis hub, to include for example, key staffing roles, legal rights, possible discharge outcomes / support after attending the hub.

22. Mental health trusts to ensure staff complete regular cross-team training to continually develop and improve person centred care and where possible consider involving service users and the third sector in the co design and delivery of this training

9.Appendices

Appendix A: Mental health crisis hub logic model

Appendix B: Detailed description of data collection methods and data sources

Appendix C: Service user and carer survey template

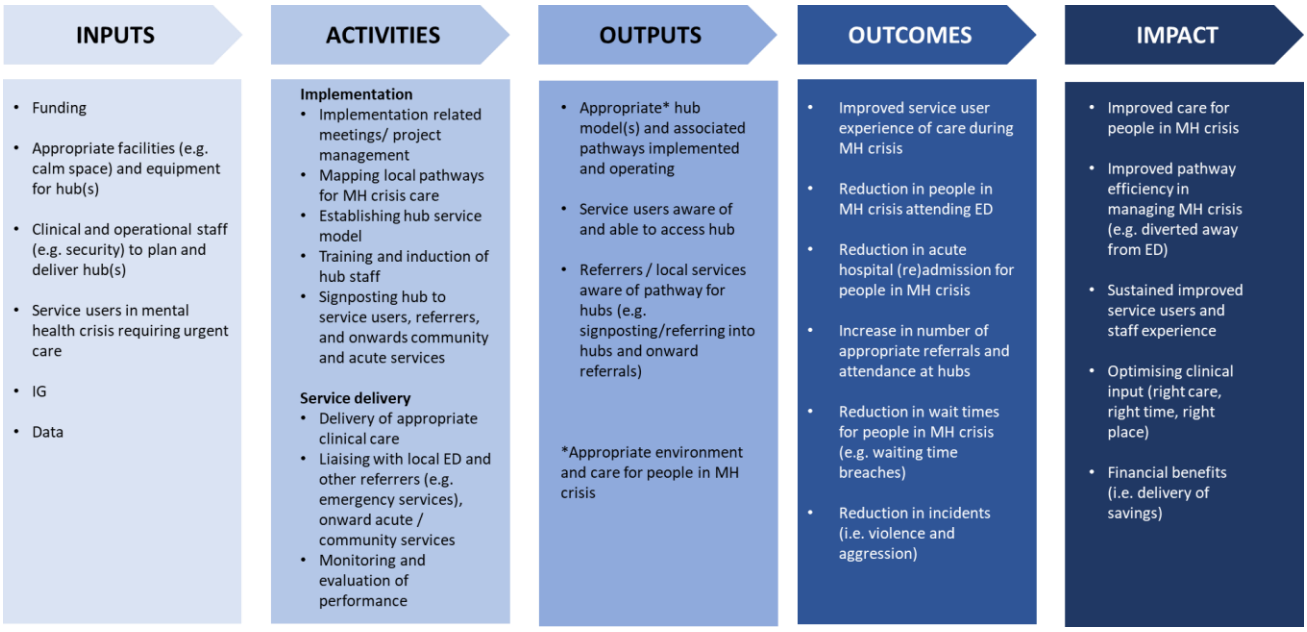
Appendix D: Service user and carer interview discussion guide

Appendix E: Staff survey template

Appendix F: Staff member and stakeholder interview discussion guide

Appendix G: SNOMED coding categorisation for mental health presentations to ED

Appendix A: Mental health crisis hub logic model



Appendix B: Detailed description of data collection methods and data sources

A detailed description of the quantitative measures used in the evaluation is provided in tables 19-21.

Table 19 Service Attendance Data from Electronic Patient Records

Demographic data:	○ Age ○ Sex ○ Ethnicity ○ Sexual orientation ○ ICD-10 Mental Health diagnosis (i.e., F01-F09, F10-F19, F20-F29, F30-F39, F40-F48, F50-F59, F60-F69, F70-F79, F80-F89, F90-F98, F99)
Activity data:	○ Month of crisis hub attendance (April 21-March 22) ○ Whether referral accepted or rejected (if collected) ○ Reason referral rejected (if collected) ○ Referral source ○ Discharge outcome ○ Whether redirected to ED during crisis hub attendance episode (y/n) ○ Whether repeat attendance within April 21 – March 22 (y/n) ○ Whether repeat attendance is within 28 days of prior attendance (y/n) ○ Length of Stay at crisis hub (in hours)

Table 20 Patient Incidents and Staffing Measures

Metric	Source	Numerator	Denominator	Comments
Rate of incidents of Violence and Aggression taking place at Mental Health (MH) Crisis Hub	Datix	No. of recorded incidents of violence and aggression taking place at MH Crisis Hub	No. of accepted referrals to MH Crisis Hub	No. of Incidents (to include alleged). Which may include but not limited to: • Acts of Violence • Aggressive incidents • Assault • Harassment • Sexual Violence
Rate of incidents of suicide and self-harm taking place at MH Crisis Hub	Datix	No. of recorded incidents of suicide and self-harm taking place at MH Crisis Hub	No. of accepted referrals to MH Crisis Hub	No. of incidents of self-harm recorded as: • attempted suicide • actual self-harm • alleged/suspected self-harm • attempted self-harm • Number of suspected suicides

Rate of incidents of restraint taking place at MH Crisis Hub	Datix	No. of recorded incidents of restraint taking place at MH Crisis Hub	No. of accepted referrals to MH Crisis Hub	No. of incidents recorded where restraint has been used.
Rate of incidents of Absent Without Leave (AWOL) taking place at MH Crisis Hub or on journey to MH Crisis Hub	Datix	No. of recorded incidents of AWOL taking place at MH Crisis Hub or on journey to Crisis Hub	No of accepted referrals to MH Crisis Hub	Number of service users' AWOL Including status: • AWOL from MH Crisis Hub • AWOL transferring from ED to MH Crisis Hub • AWOL from transport
Percentage of staff sickness in MH Crisis Hub	MH Trust staff/ HR records	No. of Full Time Equivalent (FTE) days sickness absence amongst MH Crisis Hub staff	No. of FTE days available within MH Crisis Hub	
Percentage of staff sickness across Trust	MH Trust staff/ HR records	No. of FTE days sickness absence amongst all Trust staff	No. of FTE days available across the Trust	
Percentage of Bank staff contracted in MH Crisis Hub	MH Trust staff/ HR records	Number of FTE posts that were filled by bank and agency staff within the MH Crisis Hub	Number of FTE posts (incl. bank, agency, and substantive posts) within the MH Crisis Hub	
Percentage of Bank staff contracted across Trust	MH Trust staff/ HR records	Number of FTE posts that were filled by bank and agency staff across the Trust	Number of FTE posts (incl bank, agency, and substantive posts) across the Trust	
Staff vacancy rates in MH Crisis Hub	MH Trust staff/ HR records	No of FTE vacant posts at MH Crisis Hub	Total no of budgeted FTE posts in MH Crisis Hub	
Staff vacancy rates across Trust	MH Trust staff/ HR records	No of FTE vacant posts across Trust	Total no of budgeted FTE posts across Trust	

Table 21 Key metrics for EDs associated with MH Crisis Hubs and BAU site

Scope of data	Emergency Department (hubs site): ○ King's College Hospital (BAU) ○ Queen Elizabeth Hospital (Oxleas) ○ Queens Hospital (NELFT) ○ King George Hospital (NELFT) ○ Whipps Cross Hospital (NELFT) ○ Royal Free Hospital (CANDI) ○ Whittington Hospital (CANDI) ○ University College Hospital (CANDI)
Metrics (source: Emergency care Data Set, mental health trust records)	○ Proportion of all adult ED attendances that presented to the ED with a mental health condition that could be supported by a mental health crisis hub ○ Proportion of all adult ED attendances that were referred to the Liaison Psychiatry Service within the reporting period. ○ Proportion of attendances with a mental health condition that could be supported by a mental health crisis hub that had waits in ED of less than 4 hours
Reporting period	April 2021-March 2022
Level of aggregation	Numbers per ED for each month within the reporting period
Additional data	To ensure data for EDs that have a MH crisis hub attached or nearby versus the BAU site are comparable, data are needed on the number of total adult ED attendances as a denominator. This is to be able to say there were X% of MH presentations at ED or X% of referrals to psych liaison. This will act as a control for how busy an ED department is in general.

An overview of the primary data collection (i.e. qualitative and survey) methods used in the evaluation are outlined in tables 22-25.

Table 22 Primary data collection for service users and carers

Data collection methods	Participant	Site(s)	Delivery method
Service user and carer online survey (one off)	All people presenting at Mental health crisis hub and/or BAU site	All hub sites and BAU site.	○ Services identified service users and carers who attended Mental health crisis hubs / BAU site from January – June 2022 and disseminated links to survey. Dissemination varied across sites from SMS text messages directly to service users and carers to contacting service users and carers signed up to trust involvement registers via Public and Patient Involvement Leads. ○ One-off survey, 2-week reminder, closed after 3 weeks. ○ Co-designed with service users and carers.
Service user interviews	Service user with experience of Mental health crisis hubs. Demographically mixed. Target: 3-4 service users per site	All hub sites.	○ Co designed with experts by experience ○ Service users for interviews recruited via survey, poster via Mental health crisis hubs and through Trust's Involvement Register and text messaging service if available ○ Payment offered to service users who participated. ○ Location – online as advised by our Steering Group Experts by Experience ○ Up to 60 mins

Table 23 Primary data collection for staff

Data collection methods	Participant	Site	Delivery method
Online staff survey	All staff at Mental health crisis hubs	All hubs	○ Services identified staff and disseminated link to survey ○ One-off survey, 2-week reminder, closed after 3 weeks. ○ Co-designed with steering group
Hub staff interviews	Professional mix	All hub sites (2-3 per site)	○ Recruiting by email via service lead and survey. ○ Interviews were held virtually or face to face
EDs associated with hubs - staff interviews	Professional mix Target: 1 interview per site.	All hub sites. BAU site to explore attitudes toward hub models.	○ Recruiting by email via service lead and survey ○ Interviews were held virtually or face to face

Table 24 Primary data collection for stakeholders

Data collection methods	Participants	Site	Delivery methods
Interviews	Mix of roles/professions i.e., commissioners, London Ambulance Service, London Metropolitan Police, home treatment teams Mix of seniority – strategic and operational roles Target: 10-15 x stakeholders	London Ambulance Service/ London Metropolitan Police – not possible to link to specific hubs due to these roles not being linked to a specific hub geography Commissioners – linked to hubs	Virtual/phone interviews Advice and support for recruiting frontline staff in London Ambulance Service / London Metropolitan Police via Steering Group members.

Table 25 Qualitative data collected for evaluation

Participant	Data collection method(s)	Comments
Service Users and Carers	Survey n=126 Interviews n=9	Included a range of service users and carers with varying demographic backgrounds. Survey: 2/4 sites were unable to send survey via SMS Text message. Alternative methods were advised. Interview: 25 interviews originally scheduled. The majority of service users and carers did not attend their interview, despite follow up and rearranging interview time slots. Payment was increased from £15 to £30 online shopping voucher to encourage participation.
MH Crisis Hub Staff	Survey n=58 Interviews n=4	Included a range of hub staff with varying job roles and demographic backgrounds. Challenges faced encouraging staff to complete survey and attend interviews. This was due to time constraints and some staff members being bank staff.
ED Psych-Liaison and Home Treatment Team Staff	Interviews n=5	Included a range of hub staff with varying job roles and demographic backgrounds. Stakeholders recruited via steering group members and hub service leads. Project team followed up numerous times to encourage participation in interviews.
Stakeholder interviews (Senior Commissioners, London Ambulance Service, and London Metropolitan Police)	Interviews n=14	Included a range of stakeholders with coverage across various geographies. Senior commissioners from all 5 London ICBs were consulted.

Appendix C: Service user and carer survey template

Mental health crisis hubs – Service user experience survey

This survey is to help the NHS understand service users' experiences of using alternative services to A&E during a mental health crisis. These alternative services are called mental health crisis hubs. Specifically, we want to hear from people with experience of any of the following services over the last 6 months:

- **Mental Health Crisis Assessment Service at St Pancras Hospital**
- **Integrated Crisis Assessment Hub at Goodmayes Hospital**
- **Mental Health Assessment Area at Queen Elizabeth Hospital**

The results will be used to help improve mental health services and has been co-designed with people with lived experience of mental health crisis.

The survey will take about 10 minutes.

Your responses will remain anonymous and no personal information about you can be linked back to you.

We are interested in your most recent experience of receiving care at mental health crisis hub.

How will my responses help and what does it mean to me?

Completing the survey is voluntary and your care will not be affected if you choose not to complete it. By completing it you are agreeing for the Health Innovation Network, an independent NHS organisation to collect, store and use the information that you provide. The Health Innovation Network will do so in a way that ensures your confidentiality and complies with the relevant General Data Protection Regulation (GDPR) and other data protection laws.

Support completing the survey

The survey is asking you about a time when you were unwell, which you may find upsetting and distressing to recall. You may want to have a friend or family member with you or on hand for support. You can stop at any point. If you feel you need more support, please contact your local NHS urgent mental health helpline:

- Camden and Islington NHS Foundation Trust - 0800 917 3333
- Northeast London NHS Foundation Trust - 0800 995 1000
- Oxleas NHS Foundation Trust - 0800 330 8590

Or text 'SHOUT' to 85258 for free confidential support 24/7 via text with a trained volunteer.

Are you completing this survey as a carer or family member on behalf of a service user?	Yes No
Which mental health crisis hub did you visit most recently?	MHCAS ICAH

	KCH Oxleas
Part 1: The following statements relate to your experience at the mental health crisis hub. Please state to what extent you agree or disagree • **I felt safe in the mental health crisis hub** • **I felt staff had a good understanding of mental health** • **I felt that I had privacy** • **I felt the environment in the mental health crisis hub was calming** • **I felt that I was treated with dignity and respect** • **I felt that I was treated with kindness** • **I felt listened to by staff** • **I felt I had to explain my circumstances repeatedly** • **I felt that I was kept informed about my care** • **I felt that I was involved in the decisions about my care** • **I felt safe in the mental health crisis hub**	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
Did you have your legal rights explained to you in the mental health crisis hub?	Yes/ No/ I Don't Know
How do you feel about the support and treatment you received for your mental health?	1-Extremely Satisfied 2-Satisfied 3-neither satisfied nor dissatisfied 4- dissatisfied 5-extremely dissatisfied
Did you get the support and treatment you needed for your mental health?	Yes/ No/ I Don't Know
Would you have wanted any other support or treatment? Please specify	Open text box
Were you given advice on support services or activities in your local community for your mental health?	Yes/ No/ I Don't Know
How useful was the advice on these local community services?	1-Extremely Useful 2- Very useful 3-moderately useful 4-slightly useful 5-not at all useful
Did you receive any treatment in the A&E Department on this occasion?	Yes/ No/ I Don't Know
Did you feel you had to explain your circumstances repeatedly in the A&E Department?	Yes/ No/ I Don't Know
Did you have your legal rights explained to you in the A&E Department?	Yes/ No/ I Don't Know
How did you find out about Mental health crisis hub?	Mental health crisis Line NHS 111 Hospital webpage Patient leaflet A friend / family member

	Emergency Services 999 (e.g., ambulance or police) I do not know Other, please specify
How did you travel to the Mental health crisis hub?	Ambulance Police car Driven by family /friend Public transport Taxi Walked Scooter/bike Other, please specify
What time do you arrive at the mental health crisis hub?	Morning (6am-12noon) Afternoon (12noon-6pm) Evening (6pm-9pm) Night (9pm-6am) I don't know
How long (approximately) did it take you to get to the Mental health crisis hub?	Less than 30 minutes 30 - 60 minutes More than 1 hour I don't know
Once you arrived at the Mental health crisis hub how long (approximately) did it take until you were seen by a healthcare professional?	Less than 30 minutes Between 30 minutes and 1 hour Between 1 - 4 hours Between 4 - 8 hours More than 8 hours I do not know
Please share any suggestions for improving the service or care offered	Open textbox
How old are you?	18-24 years old 25-34 years old 35-44 years old 45-54 years old 55-64 years old 65+ years old Prefer not to say
What is your ethnicity?	White - any background Asian or British Asian Black, African, Caribbean, or Black British Mixed or Multiple ethnic groups Other ethnic group Prefer not to say
What is your gender?	Male Female Non-binary Prefer to self-describe – Open textbox
What is your sexual orientation?	Prefer not to say Gay or lesbian Bisexual Other

	Prefer not to say
Do you consider yourself to have a disability or disabilities? By disability we mean a physical or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities	Yes - physical only Yes - mental health only Yes - both mental health and physical impairment No Prefer not to say
Which of the following best describes your current housing situation?	Renter – private Renter – council / housing association / social housing Owner Living with a friend or relative and helping with the rental or mortgage payments Living with a friend or relative and not helping with the rental or mortgage payments No fixed abode/homeless Other (specify) Prefer not to say
Which of the following best describes what you are doing at present?	Full-time paid work (30 hours or more each week) Part-time paid work (under 30 hours each week) Full-time education at school, college, or university Unemployed Permanently sick or disabled Looking after the family or home (e.g., home makers and/or carer) Doing something else (specify) Prefer not to say
Part 4 - Future contact. Would you be willing to talk to someone from the team conducting this survey about your views of using a Mental health crisis hub? This would be via a small group discussion (6-8 people), and you would be paid £15 per hour for your time. If you are willing to be contacted, click 'yes', and give us your contact details. Your contact details will not be linked to your answers in the main survey i.e., your responses to the survey will remain anonymised.	Yes/No If Yes: Please enter your email/contact number

Appendix D: Service user and carer interview discussion guide

Mental Health Crisis Hub (MHCH): Service User Interview Topic Guide

This discussion guide is designed for interviews with Service Users & Carers of Mental Health Crisis Hubs (MHCH). The interview is to help NHSEI understand the patient/service user experience of attending a Mental Health Crisis Hub (MHCH) during April 2021- to March 2022. Specifically, we want to hear from Service Users & Carers attending the following services:

- Mental Health Crisis Assessment Service at St Pancras Hospital (CANDI)
- Integrated Crisis Assessment Hub at Goodmayes Hospital (NELFT)
- Mental Health Assessment Area at Queen Elizabeth Hospital (OXLEAS)
- Kings College Hospital Psychiatric Liaison within Emergency Department (ED) (SLaM).

The interview is part of a wider evaluation of these services. The report from this evaluation will inform future improvements of your Mental Health Crisis Hub.

This guide is intended to help steer the discussion, but this will also depend on the participant's experience; therefore, not all topics and questions will be covered in every interview or in the order in which they appear here. Suggested timings are provided alongside each section, but these will also vary depending on how much time Service Users & Carers spend on each question.

Interviews will last 30-45 minutes over MS Teams at an agreed time, which is convenient for the service users and carers.

Objectives:
The objectives of these interviews are to understand Service User & Carer experiences of receiving treatment at a Mental Health Crisis Hub by exploring:

- Service Users & Carer's experiences of attending Mental Health Crisis Hubs from April 2021 -March 2022
- Service User & Carer perceptions of the quality of care at the Mental Health Crisis Hub and whether they are: **Safe, Timely, Efficient, Effective, Equitable and Person Centred** *(based on/see the London Mental Health Crisis Hub Assessment Framework)*
- Service Users & Carer's suggestions for improvement of the Mental Health Crisis Hub attended and follow-up services

Please note that the Service User & Carer has been selected based on the hub they said they attended in the Survey and MS Form. If required, check the site with each participant to tailor the questions better. If the participant has attended several hubs, gently probe for discussion around the hub being evaluated. However, if uncomfortable or the participant cannot remember, ask for general feedback and experience of MHCHs.

General Outline of Service user and carer interviews (approx. 30-45 mins)

Section	Detail	Timing
Introduction	• Interviewer introduces their role and thanks the participant for completing the service user and carer survey and MS Form • Ensure participant understands the purpose of the interview (*mention that it's a follow-up from the survey if applicable*) and confidentiality • Re-obtain consent for participation – check whether the participant is happy with the consent information sent beforehand and ask if they have any questions and if it is okay to start the recording.	5 minutes
About the Service User & Carer /background	• Find out a bit more about the participant experience of MHCH	5 minutes
Pre-MHCH experiences	• Explore participant experiences leading up to attending a MHCH. How did they find out about the MHCH? • Explore how they travelled to the MHCH, whether sent to a hospital/hub locally or further away from home. Time of arrival, how long they spent at the MHCH.	10-15 minutes
MHCH experience	• Explore Service User & Carer experiences with the MHCH service and experience related to: Safe, timely, effective, efficient, equitable and person centred • Understand their perspectives on the quality of care received, what worked, and what didn't. If relevant, what could have improved their experience?	10- 15 minutes
Post-MHCH experiences	• Explore Service User's & Carer's experiences after their attendance at the MHCH and perspectives on follow-up advice and support services	5- 10 minutes
Additional information and close	• Collect final overall thoughts • Thank participant. Ensure HIN have the correct email address for the £15 voucher	5 minutes

Appendix E: Staff survey template

Mental health crisis hub – Staff Survey

This survey is to help NHS England understand the experience of staff working in a mental health crisis.

Specifically, we want to hear from staff who work (or have worked) in the following mental health crisis services:

- **Mental Health Crisis Assessment Service at St Pancras Hospital (CANDI)**
- **Integrated Crisis Assessment Hub at Goodmayes Hospital (NELFT)**
- **Mental Health Assessment Area at Queen Elizabeth Hospital (OXLEAS)**
- **Kings College Hospital Psychiatric Liaison within Emergency Department (SLaM)**

We are interested in hearing about your most recent experience.

This is part of a wider evaluation of these services, as part of understanding alternatives to ED for people in mental health crisis, which are called Mental health crisis hubs. The evaluation will inform future commissioning for Mental health crisis hubs.

The survey will take about 10 minutes to complete.

The survey is anonymous and confidential – no one in your organisation or NHS England will be able to identify you based on your responses.

There are only two mandatory questions at the start, because we need to know which service you are giving feedback on and whether you currently or used to work in the service.

Completing the survey is voluntary and you will not be affected if you choose not to complete it. By completing it you are agreeing for the Health Innovation Network, an independent NHS organisation to collect, store and use the information that you provide. The Health Innovation Network will do so in a way that ensures your confidentiality and complies with the relevant General Data Protection Regulation (GDPR) and other data protection laws.

Part 1: Your Location and Job	
Which services do you work for	Mental Health Crisis Assessment Service at St Pancras Hospital Integrated Crisis Assessment Hub at Goodmayes Hospital Mental Health Assessment Area at Queen Elizabeth Hospital Kings College Hospital Psychiatric Liaison Services
Do you currently work in the service?	Yes/NO If No: The survey questions are asked in a way that assumes people are currently working in the service – please answer the questions based on your most recent experience of working in the service.
What is your job role in the service?	Senior Nurse Clinical Nurse Specialist Assistant Practitioner Clinical Support Worker Peer Support Worker Healthcare Assistant Consultant Psychiatrist

	Doctors in Training Specialty Doctors and Associate Specialists Other, please specify Prefer not to say
Please indicate your NHS Agenda for Change band	2 3 4 5 6 7 8 9 VSM – Very Senior Manager Prefer not to say Not applicable
How long have you worked in the service	Less than 3 months 0-6months 7-11 months 1-2 years 3-4 years 5-6 years 7-8 years 9-10 years
In general, what shifts patterns do you work in the service (Select all that apply)	Core hours Out of hours
On average, in the past 6-12 months, how many *additional* PAID hours did you work per week for your Trust, over and above your contracted hours	0 hours Up to 5 hours Between 5-10 hours More than 10 hours
On average, in the past 6-12 months, how many *additional UN*PAID hours did you work per week for your Trust, over and above your contracted hours	0 hours Up to 5 hours Between 5-10 hours More than 10 hours
Part 2: The statements below relate to the care provided in your mental health crisis service. Please state to what extent you agree or disagree with the following statements based on your most recent experience.	
Service users and their careers are treated with respect and dignity	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
Service users are given quality person centred care	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree

The service is a calming environment for service users and their carers	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
The service is a calming environment for service users and their carers	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
The service is appropriately staffed	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
What works well about how care is provided in the service (thinking about your answers to the statements above)?	Open text
What could be improved about how care is provided in the service (thinking about your answers to the statements above)?	Open text
How confident are you at signposting service users and their carers to local support services or activities?	Somewhat confident Neither confident nor unconfident Somewhat unconfident Extremely unconfident If unconfident: Why do you feel unconfident signposting service users and their carers to local services?
Where do you signpost users and their carers?	I don't signpost to any services Mental Health Crisis Line GP Emergency Department Hospital webpage Service user/Carer leaflet Community Mental Health services Mental Health Crisis Response Team Mental Health Home Treatment Team Improving Access to Psychological Therapies (IAPT) Social Care Peer support Drug and alcohol /gambling support Carer support agencies Mental Health Voluntary Organisation Other referrers/ services/pathways [please specify]
To what extend do you agree that the service is culturally sensitive to service users and their carers from diverse backgrounds and ethnicities?	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree, 5 strongly disagree

What could help your service to be more culturally sensitive?	Open text box
What support can you offer service users and their carers when English is not their first language (Select all that apply)	Less than 30 minutes Interpreting service Leaflets in languages other than English Other, please specify
Part 3: The statements below relate to the working environment in your mental health crisis service. Please state to what extent you agree or disagree with the following statements based on your most recent experience.	
• **I feel safe working within the service**	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
• **I am suitably trained to provide care to service users and their carers**	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
• **I am treated with dignity and respect by colleagues within the service**	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
• **I am supported to work efficiently (in a timely manner)**	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
• **I am kept informed about changes happening in the service**	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
• **I am involved in the decisions about what happens in the service**	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
• **I get the support I need for my health and wellbeing from my Trust**	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree

• **I am satisfied working in the service**	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
• **I would recommend working in the service to other people (e.g., friends and family)**	1-strongly agree 2-agree 3-neither agree nor disagree 4-disagree 5 strongly disagree
What is positive about the working environment in the service (thinking about your answers to the statements above)?	Open text
Please share any suggestions for improving the service or care offered	Open textbox
What could be improved about the working environment in the service (thinking about your answers to the statements above)?	Open textbox
Is there anything else you would like to tell us about your experience working at the mental health crisis service?	Open textbox
Part 5: Future Contact **Would you be willing to talk to someone from the evaluation team about your views on the Trust's mental health crisis service? Your feedback would help to improve this and other services. Your involvement would be confidential.**	Yes/No
If yes, please provide your name and contact details. Your details will only be used to contact you about your experience working in a mental health crisis service and will not be linked to your survey responses. Your contact details will not be shared and will be stored securely.	Your name Your email address Your contact number
Preferred for of contact	Your name Your email address Your contact number
Part 4: About you **Finally - About you. We'd like to know more about you to make sure we're getting experiences from a range of different people. If you are not happy giving any personal information, there's always the option to not answer these questions.**	
How old are you?	18-24 years old

	25-34 years old 35-44 years old 45-54 years old 55-64 years old 65+ years old Prefer not to say
What is your ethnicity?	White - any background Asian or British Asian Black, African, Caribbean, or Black British Mixed or Multiple ethnic groups Other ethnic group Prefer not to say
What is your Gender?	Male Female Non-binary Prefer to self-describe – Open textbox Prefer not to say

End of Survey. We thank you for your time spent taking this survey. Your response has been recorded.

Appendix F: Staff member and stakeholder interview discussion guide

Mental Health Crisis Hubs: Staff/Stakeholder Interview Topic Guide

This discussion guide is designed to be used for interviews with staff members and stakeholders working with Mental Health Crisis Hubs. This guide is intended to help steer the discussion, but this will also depend on the participant's role. Therefore, not all staff members and stakeholders will have the same insights into the questions, and not all topics and questions will be covered in every interview or in the order in which they appear here. Suggested timings are provided alongside each section, but these will also vary depending on who is being interviewed.

Interviews will last 15-20 minutes over the telephone/MS teams.

Objectives:

The objectives of these interviews are to understand staff members/stakeholder views on whether mental health crisis hubs are:

- **Safe, timely, effective, efficient, equitable and person centred** *(based on the six domains of the London Mental Health Crisis Hub Assessment Framework)*
- **And overall views on the opportunities for improvement and benefits of mental health crisis hubs**

Please note that staff members and stakeholders will have varied experiences and roles linked to mental health crisis hub/BAU site. Therefore, check the role and site of each participant to tailor the questions better. As such, it is important to use this guide flexibly.

Context:

In February/March 2022, NHS England and Improvement London and the Urgent Care Board commissioned the HIN to deliver a qualitative evaluation of the Mental Health Crisis Hubs currently operational in London. This evaluation aims to understand staff/stakeholder experience working with mental health crisis hubs or mental health psychiatric liaison services. But it does not seek to look at and compare how staff members or stakeholders perform, but specifically the experience of working with [relevant hub] or any of the four evaluation sites [insert appropriate hub names]

General outline of staff member/stakeholder interviews (approx. 15-20 mins)

Section	Detail	Timing
Introduction	• The interviewer introduces their role and thanks the participant for offering an interview/completing the Staff Survey. • Ensure participant understands the purpose of the interview (mention follow-up from the survey if applicable) and confidentiality • Seek and (re)obtain consent for participation –*check whether the participant is okay with everything and begin the interview and recording.*	2-3 minutes
Overview of job role and background and understanding of mental health crisis hub pathways	• Explore the participant's job role • Understand the participant's ways they work with the site(s). Specifically: [insert appropriate hub(s) names]	2-3 minutes

Explore staff/stakeholder view of the quality-of-service user care provided at the Mental Health Crisis Hub	• Explore staff member/stakeholder view of Mental Health Crisis Hubs related to the six domains: *Safe, Timely, Efficient, Effective, Equitable and Person Centred framework.*	3-5minutes
Explore staff member/stakeholder experience of working at/with a Mental Health Crisis Hub	• Explore satisfaction with working with a mental health crisis hub. What do they think are the specific challenges, benefits, and opportunities of working with that hub/site? Do they have suggestions for improvements? • *If applicable,* ask about their experience working at BAU, ED/A&E psychiatric liaison services • *If the participant has no direct experience* of working with a mental health crisis hub, explore general feedback on what they think are the benefits, challenges, and opportunities of mental health crisis hub	3-5minutes
Wrap-up	• Collect final overall thoughts • Thank the participant, ask if they have any further questions and explain how the findings will be used	2-4 minutes

Appendix G: SNOMED coding categorisation for mental health presentations to ED

The below table categorises the SNOMED CT codes used to understand mental health presentations to ED and the wait times at ED from the Emergency Care Dataset (ECDS). Data on all mental health diagnoses have been categorised into those diagnoses that are most likely to be referred to a mental health crisis hub, those where a referral to a mental health crisis hub would not be appropriate and those where a physical health symptom is present so it is likely that this would need to be explored before referring to mental health services.

Group	Diagnosis name
Crisis hub appropriate	Bipolar affective disorder
	Adjustment disorder
	Personality disorder
	Depressive disorder
	Schizophrenia
	Psychotic disorder
	Anxiety disorder
Not appropriate for the hub	Delirium (acute confusion)
	Dementia
Patients presenting with physical health symptoms related to MENTAL HEALTH condition	Somatoform pain disorder
	Dissociative (conversion) disorder
	Factitious disorder
	Eating disorder
	Somatisation disorder