

NXG Thrive – NHS East of England Crisis Text Service

Stakeholder Frequently Asked Questions

1. Service Model & Integration

Q: What does the delivery model look like?

A: The service operates 24 hours a day, 365 days a year. It is staffed entirely by registered health and care professionals, with a Shift Supervisor on shift at all times and the Clinical Lead available for clinical escalation in and out of hours. Access is free, confidential, and open to all age groups via SMS, WhatsApp, and web chat, delivered through UK-hosted infrastructure.

Q: How will the Crisis Text service integrate with existing local crisis pathways?

A: Two-way signposting arrangements are in place with local voluntary, community and social enterprise (VCSE) organisations and NHS 111 Mental Health options. Direct escalations to statutory and emergency services are made by the Shift Supervisor by phone, with the Crisis Text Responder keeping the text conversation live throughout, and NXG maintains active representation at ICB operational, crisis pathway, and clinical governance meetings.

Q: Will the team be working alongside Crisis Resolution Teams (CRT)?

A: Yes. The service is designed as a front-door de-escalation and triage filter that sits alongside local NHS Crisis Resolution and Home Treatment Teams and NHS 111 Mental Health options. Where a user presenting at Level 2 or Level 3 needs urgent secondary mental health assessment and has no active physical injury, the Shift Supervisor makes a formal clinical handover by phone to a clinician on the NHS 111 Mental Health Option, who completes their own triage before accepting. Three-way telephone patching ("warm transfer") is not used; the Responder stays in the text conversation until the handover is accepted.

Q: Will the text exchange be a full intervention?

A: Yes. The text service is delivered as a single-session, episode-of-care intervention. Within that session it aims to provide complete emotional containment, structured risk assessment, de-escalation, and a collaborative safety plan, rather than ongoing multi-week therapy.

Q: Is the service mainly a signposting service?

A: No. The primary clinical focus is immediate emotional containment, active listening, de-escalation, and collaborative safety planning. When someone texts in acute distress, responders focus on validation, grounding, and reducing emotional intensity. Signposting is never pushed during acute distress; it is introduced gently at the end of a session, once the person is calmer, within their window of tolerance, and working with the responder on their safety plan.

2. Who Can Use the Service

Q: What is the inclusion criteria?

A: The service uses three criteria:

- **Geographic scope:** residents of, or anyone currently located within, the NHS East of England commissioning region.
- **Age:** an all-age service covering children, young people, and adults.
- **Presentation:** anyone experiencing acute mental health distress, suicidal ideation, self-harm urges, anxiety, or emotional overwhelm who needs immediate, low-barrier text-based support.

Q: Can someone who lives in the East of England but is away from the area (for example, on holiday or staying with friends) still use the service?

A: Yes. Anyone who contacts the service through its regional text numbers, keywords or web chat can receive emotional support, de-escalation and safety planning, wherever they are at the time. If emergency help is needed while they are outside the East of England, the Shift Supervisor contacts emergency services and shares the available location information (mobile number or IP address), so that services local to the person can respond.

Q: What happens if someone does not speak English?

A: The platforms web chat and digital channels include real-time translation tools, so responders can communicate in the texter's first language.

Q: What demographic is the target for this service?

A: The primary target is all residents of the East of England, with a specific focus on hard-to-reach and high-risk groups who traditionally face barriers to voice-based services: young people and young adults (13–25); men, reflecting lower rates of verbal help-seeking; neurodivergent individuals (autism/ADHD); LGBTQ+ communities; and people in rural or isolated areas of the region.

Q: What methods ensure the service is equitable and accessible to all?

A: The service is free at the point of use, with no cost barrier. Text-based access removes the vocal, sensory, or environmental barriers that voice-based services can present for neurodivergent people or those unable to speak safely aloud.

3. Risk Assessment & Escalation

Q: How is risk gauged accurately?

A: Risk is assessed using a structured clinical risk formulation model with clinical judgement from the responder. Responders evaluate risk against the three pillars of the C-A-P model: Method (has a method been identified), Access (are the means immediately available), and Timeframe (is there imminent intent). This maps directly onto three triage levels: Level 1 (Routine), Level 2 (Urgent), and Level 3 (Emergency).

Q: What is the risk threshold for escalation?

A: There is no minimum threshold for entry to the service — anyone experiencing emotional distress across the East of England can access it. Escalation is then triggered by triage level:

- **Level 1 (Routine):** distress or low mood with no self-harm or suicidal ideation; up to three concurrent chats per responder.
- **Level 2 (Urgent):** active distress, self-harm urges, or passive ideation; the chat is locked to one-to-one, C-A-P probing is carried out, and a supervisor has real-time visibility.
- **Level 3 (Emergency):** real and immediate risk to life or serious harm. The chat is locked to one-to-one with immediate dual-handling by a Shift Supervisor, who selects the route: Ambulance (999) for an active medical emergency, such as an overdose already taken, active ligature or severe injury, where the location is known; Police (999) where there is a real and immediate threat to life and the location is unknown; or the NHS 111 Mental Health Option for an acute mental health crisis with no active physical injury, where the texter has shared their details. Non-consensual escalation operates under the Vital Interests provision of UK GDPR.

A user going silent or refusing to answer does not on its own trigger a 999 call; escalation is based on the risk disclosed before contact was lost. A mandatory safeguarding override also applies at any triage level where there is significant harm, child sexual or criminal exploitation, or familial abuse, in line with Section 47 of the Children Act 1989, and any child confirmed as aged 9 or under is treated as an automatic safeguarding trigger.

Q: What happens to a responder's other conversations if one of them escalates?

A: Responders handle a maximum of three conversations at once, and only at Level 1 (Routine). As soon as a conversation escalates to Level 2 (Urgent) or Level 3 (Emergency), the responder's queue is locked to that one conversation.

- Any other active Level 1 conversations are passed to another available responder.
- At Level 3, the Shift Supervisor joins the conversation and makes the emergency call, while the responder stays fully focused on supporting the texter.

Q: What are the wait times?

A: The platform prioritises conversations by clinical need. We aim for human triage to assess the level of need within the first five minutes of contact being made. Staffing is weighted to match expected peak demand, particularly evenings and weekends.

Q: Will there be links to safeguarding and emergency services?

A: Yes. Standardised escalation pathways are in place for statutory safeguarding referrals (MASH/LADO) and for emergency Active Rescues (999 police/ambulance). Non-consensual emergency overrides operate under UK GDPR Article 6(1)(d) and Article 9(2)(c) (Vital Interests) and Caldicott Principle 3. Every escalation is followed by a written referral record. All Level 3 escalations are recorded by route, response time and outcome, and a summary is reported monthly to Commissioners and emergency service partners.

Q: How does the service align with Right Care, Right Person (RCRP)?

A: Escalation pathways align with the National Partnership Agreement: Right Care, Right Person (2024). Ambulance is requested for medical emergencies and physical harm; Police are requested only where there is a real and immediate risk to life and police powers or search/geolocation are needed. The service does not request welfare checks, and does not ask ambulance services to attend where the location is unknown or where someone has expressed only a future intention to self-harm.

Q: How are 999 calls made, and what response should be expected?

A: The Shift Supervisor makes the call. NXG clinicians are not on the ambulance service's approved Healthcare Professional list, so calls are triaged as standard 999 calls. The ambulance service decides the response category; most mental health presentations, including many overdoses, are Category 3. Responders do not promise the user an immediate response and continue to support them in the text conversation.

Q: How are referrals to the NHS 111 Mental Health Option made? Will you use professional lines?

A: For an acute mental health crisis with no active physical injury, the Shift Supervisor calls the NHS 111 Mental Health Option (Option 2) on the texter's behalf, using dedicated professional lines where these are in place. The Supervisor shares the C-A-P risk assessment and gives a direct verbal handover to the receiving 111 clinician. Warm transfers (connecting the texter into a three-way phone call) are not used, so professional lines are never used to talk to patients. Access routes differ between areas.

Q: What happens if a user's location is unknown?

A: Available platform metadata (mobile number or IP address) is passed to Police via 999, who decide whether the case meets their threshold to trace. Tracing can take from around 10 minutes to over an hour and may only identify a broad area, so the Responder keeps the conversation going and continues to gather location information. Where there is also an active medical emergency, the ambulance service is informed alongside, and dispatches once a location is established.

Q: When does responsibility transfer to the receiving service?

A: NXG retains clinical risk until the receiving service formally accepts the handover — for example, by issuing a CAD or incident number, by emergency personnel arriving, or by an NHS 111 clinician accepting transfer. Once an ambulance service has accepted a handover and issued an incident number, responsibility sits with it even if a low-priority category is assigned. If the user's risk changes while the conversation is still live, the Supervisor calls back with the update.

Q: What support is there for people after they have been escalated to 111 or A&E?

A: The service works to a no-drop handover principle:

- During a 999 or 111 escalation, the text conversation is not closed because a call has been made. The responder stays with the person on the platform, providing continuous emotional support, until emergency services arrive or the clinical handover has been formally accepted.
- If someone leaves A&E or feels unsupported after contact with another service, they can text the service again at any time. Every contact is triaged afresh, so responders can pick up safety planning, provide emotional support, and explore other community crisis options, such as local crisis cafés or CAMHS crisis teams.

Q: What level of Active Rescue demand is expected?

A: Data from the previous provider shows 4 active rescues across 264 conversations (208 individual texters) over five months — around 1.5% of conversations. Demand will be monitored from go-live and shared monthly with partners.

4. Referral, Signposting & Additional Support

Q: What is the referral and signposting process?

A: Two-way signposting is in place with local VCSE organisations, NHS 111 Option 2, CRHTTs, and CAMHS. Direct handovers are made by the Shift Supervisor by phone. Alongside statutory handovers, the service also signposts to local VCSE and sanctuary provision such as crisis cafes and Mind hubs, and to statutory services including NHS 111 Mental Health options, CAMHS, Adult/Children's Social Care (MASH), and 999 emergency services.

Q: If someone has a health problem, will they be told to contact their GP?

A: For non-emergency physical or mental health concerns, once the person's distress has eased, responders support them to contact the right primary care service, including their GP or NHS 111. If the health problem is an active medical emergency (for example, an overdose already taken, a severe injury, or a toxic ingestion), the Shift Supervisor calls 999 for an ambulance on the person's behalf, while the responder keeps supporting them in the text conversation.

Q: Does signposting include NHS Talking Therapies, and do responders know each service's criteria?

A: Yes. The service's resource directory maps NHS Talking Therapies providers across all three East of England ICB areas. Responders are trained on the main inclusion criteria (for example, mild-to-moderate anxiety, depression and PTSD) and exclusion criteria (for example, active psychosis, or an acute crisis needing secondary crisis team input), so that texters are directed to the right local self-referral route.

Q: Will the service use Essex Frontline for signposting?

A: Yes. Essex Frontline is a key signposting resource for social care, wellbeing and VCSE support across Essex.

Q: Will there be additional resources supporting this service, and who do they run alongside?

A: Yes. The text service runs alongside:

- **Local VCSE & sanctuary services:** direct signposting to local crisis cafes, Mind hubs, and community support.
- **Statutory services:** NHS 111 Mental Health option, CAMHS, Adult/Children's Social Care (MASH), and emergency services (999).

Q: How are inappropriate referrals managed?

A: Three scenarios are managed as follows:

- **Out-of-area users** (people who neither live in nor are currently in the East of England): re-routed or signposted to national text services or their own local crisis lines.
- **Chronic or frequent texters:** the platform flags repeat contacts from the same number, and every contact is triaged afresh: frequency of contact never lowers the threshold for risk assessment. For high-intensity users, the Clinical Lead agrees an individual, trauma-informed crisis care plan, recorded on the platform. This sets clear, warm, time-bounded session frames (for example, 30-minute sessions) to prevent dependency while keeping boundaries safe and consistent.
- **Malicious or abusive threads:** responders use a "Boundary Pivot" protocol to set clear rules on acceptable behaviour. Persistent abuse triggers supervisor review and potential blocking from the platform, once it has been confirmed that no genuine distress is being masked underneath.

Q: What happens if a texter is worried about someone else?

A: The texter is supported in their own right, and the concern for the other person is assessed using the same thresholds. Real and immediate risk to life follows the Level 3 routes. Other safeguarding concerns go to the Designated Safeguarding Lead, who makes a MASH referral where the person can be identified, or decides whether to contact Police via 101 where they cannot.

Q: What information will be shared with CAMHS, and what follow-up is expected?

A: This is the onward referral route for under-18s whose needs exceed what text support can provide. Information is shared with the young person's consent, in line with Fraser Guidelines, or via statutory safeguarding escalation where the significant harm criteria under Section 47 of the Children Act 1989 are met.

Q: Will onward referrals be made to the Single Point of Access / Social Care?

A: Yes. Responders facilitate onward referrals with the user's consent, or support them to self-refer. Statutory MASH/Social Care referrals are made directly by the Designated Safeguarding Lead or Supervisor where safeguarding thresholds are met.

Q: Will CAMHS be contacted to help divert an A&E presentation?

A: Yes. Registered clinicians use the triage and onward referral pathways to connect users with appropriate community or CAMHS support, reducing inappropriate A&E presentations wherever it is safe to do so.

5. Children & Young People

Q: Is it appropriate to signpost young people who are already receiving early-intervention or CAMHS support?

A: Yes. As a 24/7 service, it complements early-intervention and CAMHS care by giving young people a safety net in the evenings, at weekends, and between appointments. Responders support the young person's existing care plan and encourage them to stay connected with the team supporting them.

Q: Will there be work with secondary schools and colleges, so they can signpost young people to the service?

A: Yes. ICBs are working with Local Authority partners to promote the service. NXG also works directly with schools and colleges (for example, through its Wellbeing Workshops and transition toolkits in Milton Keynes and East of England secondary schools). Digital promotional materials, flyers and text keywords will be provided to SENCOs, pastoral leads and college wellbeing teams so they can signpost students directly.

Q: Will face-to-face group sessions for 11–19 year olds be offered at a later date?

A: Not as part of this service. The Crisis Text Service is a 24/7 digital, text-based crisis service. NXG delivers separate face-to-face wellbeing workshops and community youth sessions in some commissioned areas, but any future face-to-face provision for 11–19 year olds in this area would need separate commissioning and agreement with partners.

6. Data, Records & Confidentiality

Q: Will the messages be documented on PARIS (the NHS clinical record system)?

A: No — live text conversations are not written directly into PARIS in real time. They take place within the secure, UK-hosted Hubbub contact platform. Where a conversation escalates to a secondary NHS mental health service (for example, Crisis Resolution and Home Treatment Teams or NHS 111), a structured clinical summary or case note is passed to local NHS clinical systems in line with regional referral protocols and data-sharing agreements, and a written referral record is completed for every escalation.

Q: Can people stay anonymous when they text?

A: Yes. The service is low-barrier: people do not need to give their name or address to get support. The platform does automatically log the mobile number or web IP address. If someone presents with a real and immediate risk to life (Level 3) and becomes unresponsive or will not agree to emergency help, the Shift Supervisor shares this information with Police or Ambulance under the Vital Interests provision of UK GDPR, to protect life.

Q: How is patient data managed and shared?

A: The service operates under UK GDPR, the Data Protection Act 2018, and the Caldicott Principles. Information is shared with the user's consent, unless the non-consensual "break-glass" threshold is met. A full privacy notice is published online, alongside text prompts that set out the limits of confidentiality upfront.

Q: How are texts recorded and information stored?

A: Conversations are hosted securely on UK-based, encrypted platform infrastructure, with native reporting used for KPI analytics. Safeguarding overrides and incident records are logged separately in secure, restricted-access registers and retained for statutory audit periods.

Q: What information will be taken and given?

A: The minimum data collected is network metadata (mobile number/IP address) plus whatever the user chooses to share. In return, the service provides emotional containment, micro-validation, C-A-P risk probing, a co-created safety plan, coping strategies, and onward signposting.

7. Performance, Outcomes & KPIs

Q: What are the KPIs set against?

A: KPIs are split into two groups:

- **Primary KPIs (structured platform data):** total service volume and repeat user re-access rates; queue abandonment rates and response latency for Level 2/3; triage categorisation outcomes across Levels 1–3; active rescues carried out, by route (Ambulance, Police, NHS 111 Mental Health Option) and outcome, including declined dispatches; and statutory safeguarding referrals logged.
- **Secondary KPIs (patient experience & equity):** patient experience and Net Promoter Score; equity and reach across demographics, age, and local authority area; and onward referral/signposting metrics.

Data is drawn from the platform, post-session wrap-up forms, and website feedback, and is monitored through weekly Commissioner assurance meetings.

Q: What young people's engagement has there been, and how will this be evaluated?

A: Children and young people's teams, local authority leads, and youth mental health leads have contributed to service design through ICB working groups. Post-session intake prompts capture age data to track youth engagement specifically, and data from the incumbent service (showing around 26.6% of users are under 18) is being used to plan clinical workforce, CYP-specific training, and supervisor rotas.

8. Workforce & Training

Q: What training is provided to Crisis Text staff, and what experience or qualifications do they have?

A: All responders hold current, unrestricted UK registration (BACP Accredited or above, HCPC, UKCP, NMC, or Social Work England; staff registered with the BPS (Chartered or Graduate Member) complete additional clinical training with the Clinical Lead) and a minimum of three years' post-qualification experience handling high-risk or complex mental health cases. Mandatory external onboarding covers Prevent Duty and Safeguarding Level 3, suicide awareness and internet safety, child sexual and criminal exploitation (including county lines), and autism/neurodiversity awareness. Internal clinical onboarding covers platform operations and dual-handling, text-based de-escalation, biopsychosocial risk assessment and C-A-P probing, safety planning and equality duties, plus ongoing supervision and CPD.

Q: Will staff have training to support young people and neurodiversity, and to de-escalate?

A: Yes. This is fully covered in induction training and supported by clinical guidance packs written by the Clinical Lead and Clinical Supervisors.

Q: How will Crisis Text staff introduce themselves when contacting other teams?

A: Escalation calls are made by the Shift Supervisor, who introduces themselves as a "Shift Supervisor from the NHS Crisis Text Support Service (NXG Thrive)". Other staff introduce themselves as "Crisis Text Responders from the NHS Crisis Text Support Service (NXG Thrive)."

9. Implementation & Future Development

Q: Will this be widely advertised with clear thresholds and remit?

A: Yes, through a two-phase communications approach. Phase 1 (pre-launch) covers stakeholder and provider alignment meetings and partner comms. Phase 2 (launch on Wednesday 28 October 2026) covers public marketing, paid search advertising, social media, and toolkits such as leaflets, posters, and hospital slide decks — all of which clearly state the service's remit and emergency signposting.