Welcome to the NHS Mental Health Strategy & Reform Conference

07th May 2026
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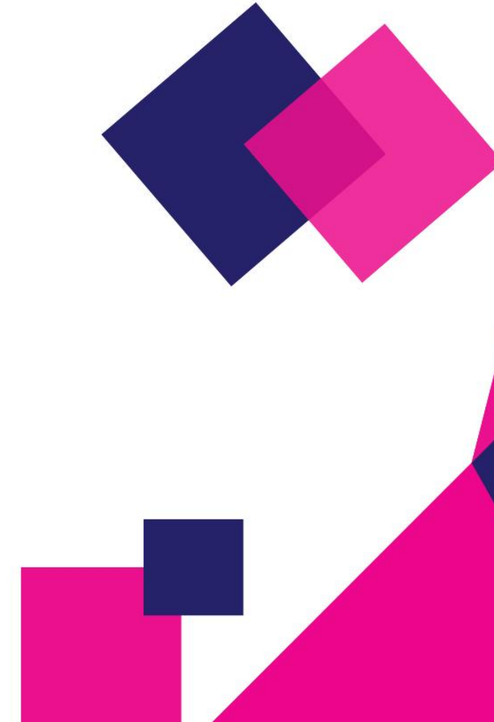


Join the Healthcare Engagement Society (HES)

- **What it is** – A secure, year-round platform bringing NHS professionals together across six specialist communities.
- **Why it matters** – Stay connected beyond today's event, share challenges, and learn from peers facing the same priorities.
- **Your benefits** – Exclusive access to interviews, insights, best practice, and real-time discussion threads with colleagues nationwide.
- **How to join** – Simply scan the QR code, choose your community, and start connecting today.

Chair Opening Address

Alison Blackler
Founder of 2minds – Mind Coach, Tedx Speaker, Author
2minds

Keynote Presentation

Sarah Warmington MBA
Deputy Director of Specialised Mental Health, Learning Disabilities and Autism, Specialised Commissioning
NHS England

Specialised services within the wider mental health pathway

A national and regional perspective

7th May 2026

Presented by:
Sarah Warmington MBA

NHS England

10 Year Health Plan and Mental Health

Mental Health is specifically mentioned relating to:

- 85 dedicated MH emergency departments
- Expansion of MH support teams in schools and colleges
- Modern Service Framework for SMI
- Extra 8,500 MH workers
- Transformation of MH services into 24/7 neighbourhood care models
- Redesign of outpatients inc MH
- Direct access/referral to Talking Therapies

The "three shifts"

- From hospital to community
- From analogue to digital
- From sickness to prevention

How do these relate to patients receiving care from specialised MHLDA services?

Specialised MHLDA services

Which services are in the portfolio

Service area	Range of services	Service line details
Adult Secure	High, medium and low secure	Male and female provision Specific services for Mental Illness, Personality Disorder, Learning Disability, Autistic Spectrum Disorder, d/Deaf and Acquired Brain Injury,
Adult Eating Disorders (AED)	Adult eating disorder inpatient provision	
Children and Young People's Mental Health (CYPMH)	Services that cover provision for the full age range for CYP	Children's services (under 13s), General Adolescent Units, Psychiatric Intensive Care Units, CYP eating Disorders, Low Secure, Medium Secure, fCAMHS, Learning Disability, Autistic Spectrum Disorder
Perinatal inpatient services	Mother and Baby Units (MBUs)	Person who is pregnant, or in the year after they have given birth
Tier 4 Personality Disorder (T4PD)	Inpatient provision	
Obsessive Compulsive Disorder (OCD) / Body Dysmorphic Disorder (BDD)	Inpatient provision	
Offender Personality Disorder Service (OPD)	Delivered in prisons, approved premises and OPD inpatient provision	Joint service in partnership with HMPPS

An example of configuration of service types (adult secure)

Footprint: Provider Collaborative

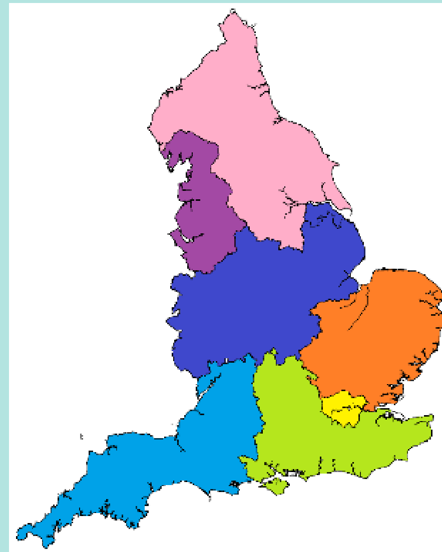
Service types:
- Male Low & Medium MI / PD

At least one service commissioned and provided in each PC geographical footprint *(the capacity and number of services should reflect the PC geographical footprint, originating population and number of ICBs)*

Footprint: Regional

Service types:
- Female Low & Medium MI / PD
- Male Low & Medium LD / A

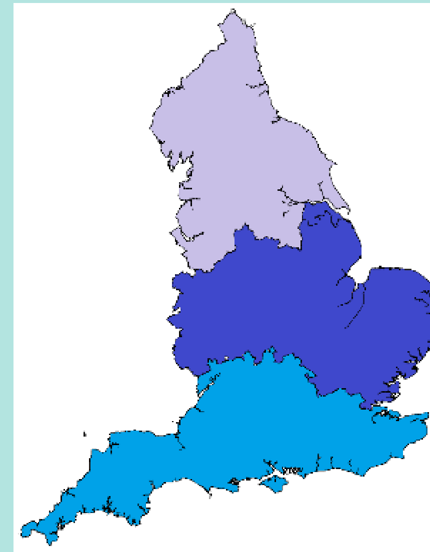
At least one service commissioned and provided in each of the seven NHSE regions: NEY, NW, Midlands, London, SE, SW



Footprint: Super-regional

Service types:
- Female Low & Medium LD / A

At least one service commissioned and provided across two of the neighbouring seven NHSE regions

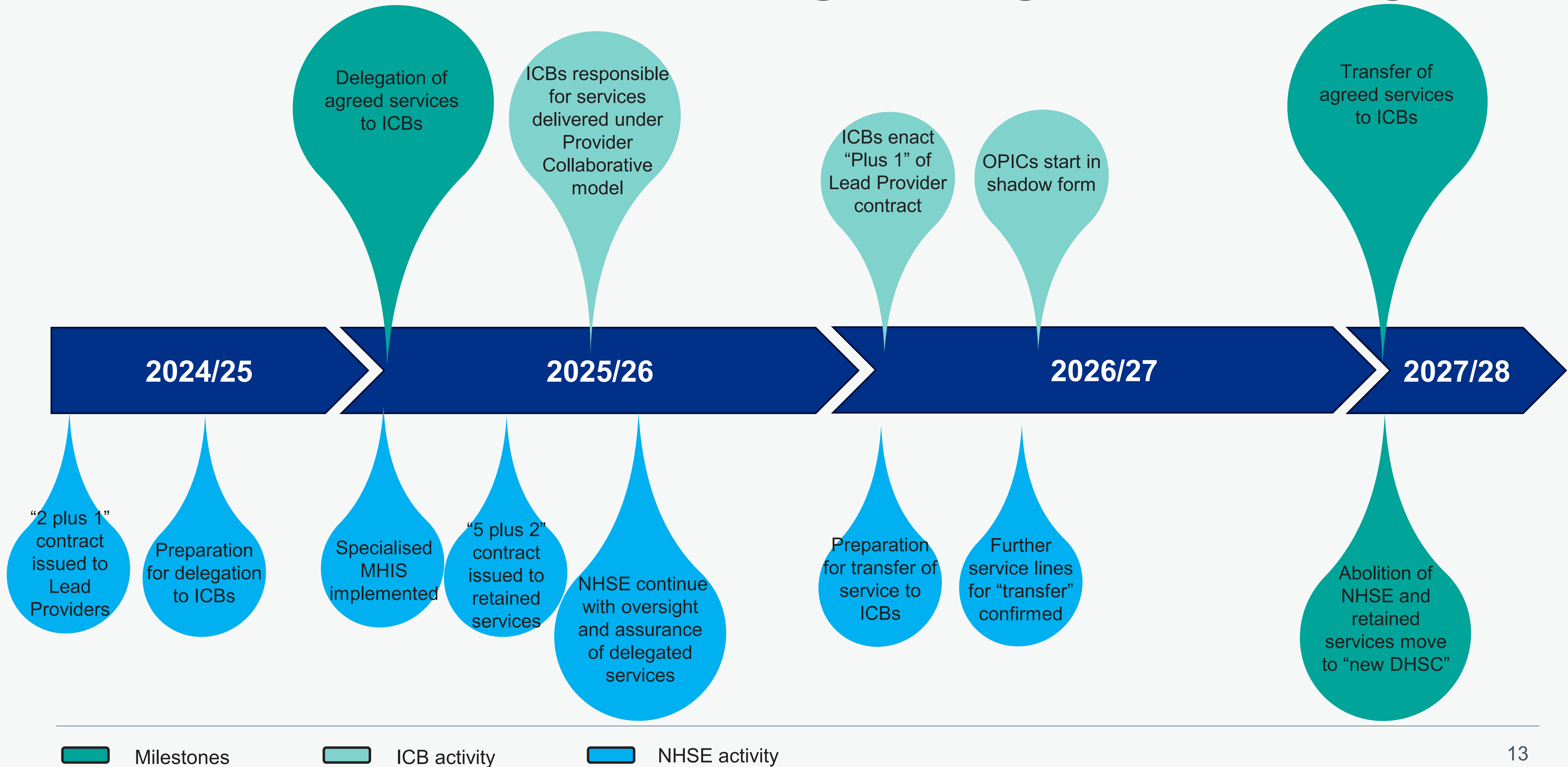


Footprint: National

Service types:
- High Secure
- Secure d/Deaf
- Secure ABI

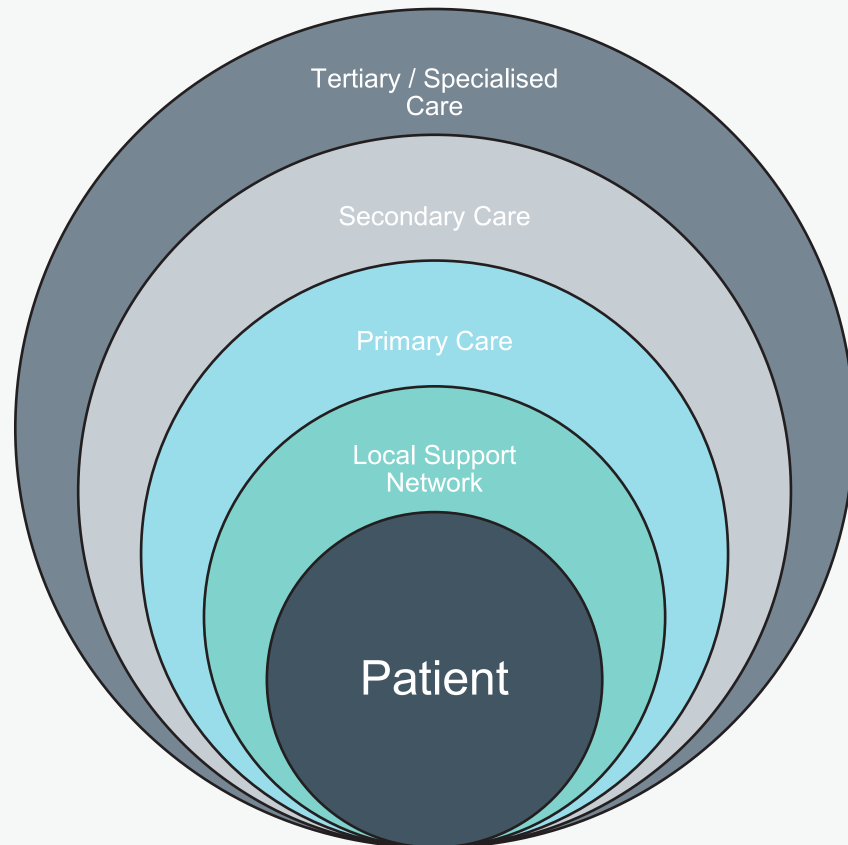
Services commissioned and provided on a national basis

Timeline for commissioning arrangement changes

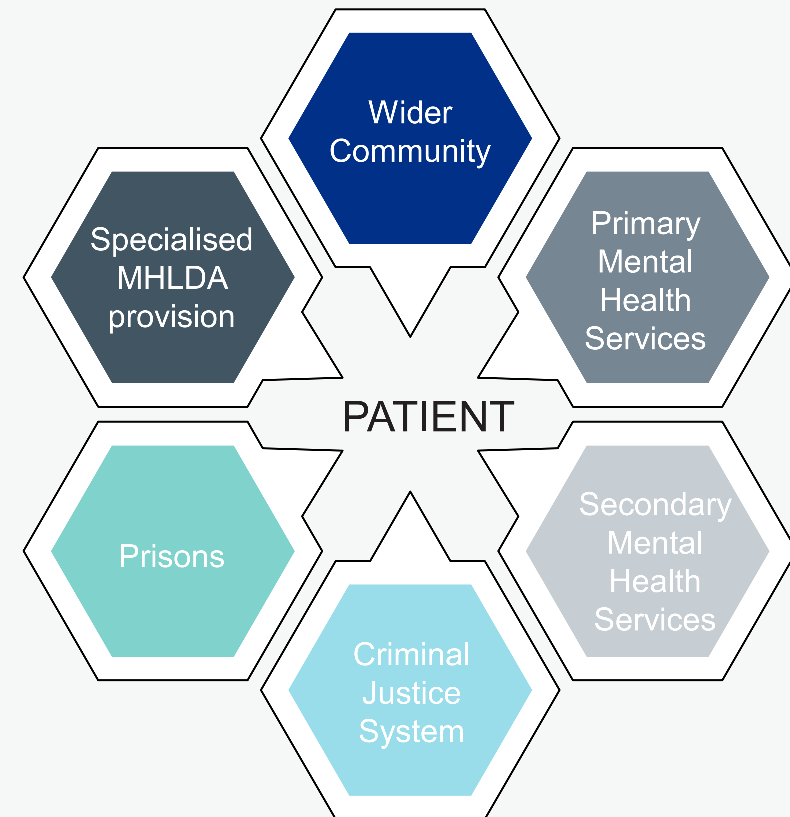


Specialised MHLDA services in the wider pathway

How care is perceived to be arranged / structured



The reality of the patient pathways



Questions to consider across the rest of the day

Patients in specialised MHHLDA pathways remain a cohort to be recognised within the wider population health considerations, so, how do we…..?

- Ensure that our patients are not forgotten when considering local populations needs
- Support their pathway journeys to ensure they are treated / supported in the least restrictive settings
- Ensure patient flow to ensure patients can receive the right care, at the right time in the right place
- Deliver the right outcomes for individuals
- Achieve the aspirations of the 10YP for our patients

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Skill Clinic

Dr Fortune Mhlanga
Mental Health System Improvement Advisor
NHSE

Vicki Baxendale
Mental Health System Improvement Advisor
NHSE

Louise Thomas
Mental Health Improvement Advisor
GIRFT Mental Health Team: NHS England

Getting It Right First Time (GIRFT) Mental Health Team

Dr Fortune Mhlanga

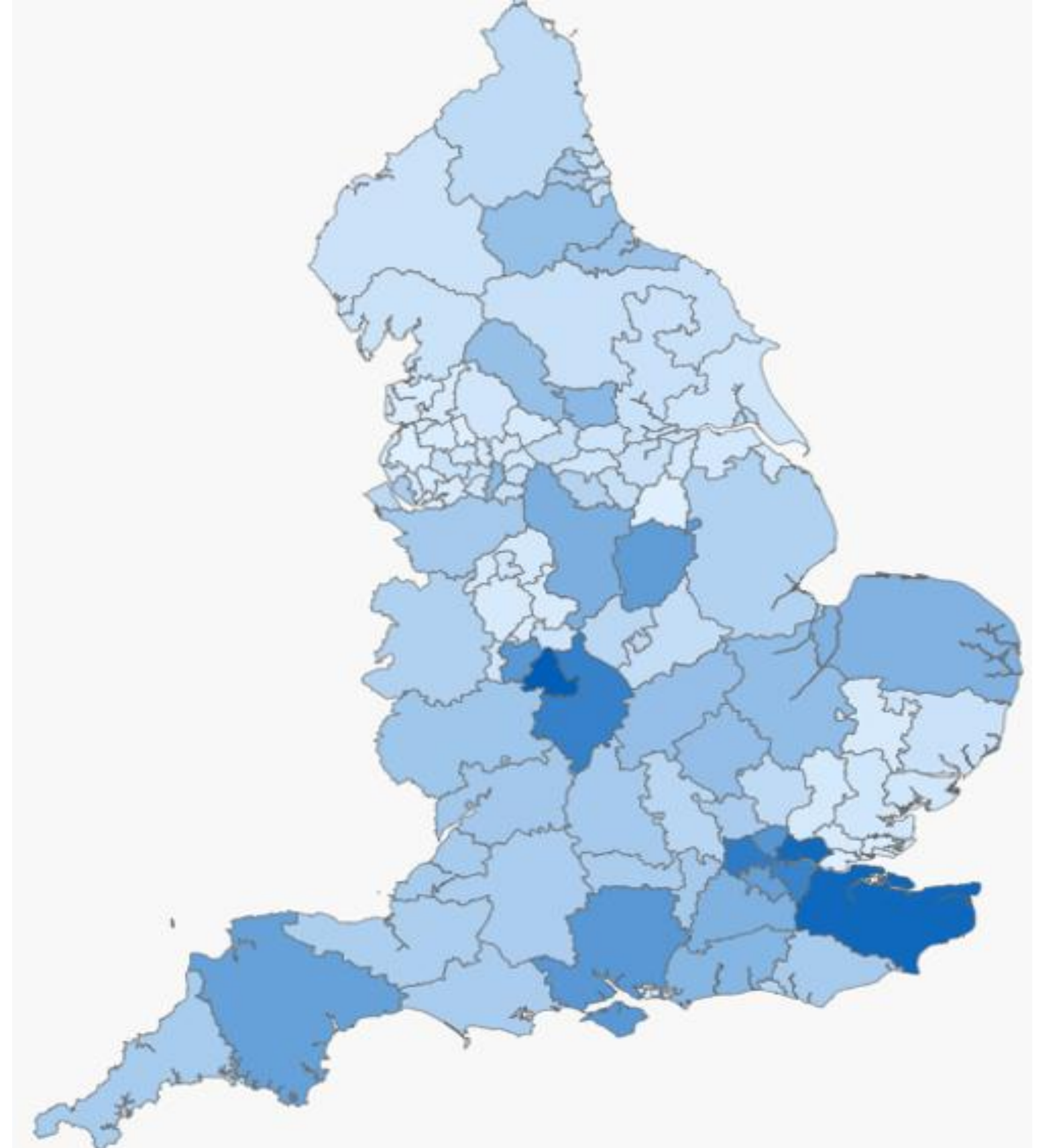
Vicki Baxendale

Louise Thomas

Mental Health System Improvement Advisors, GIRFT Mental Health Team

Our purpose

The GIRFT Mental Health Team will drive transformation by improving access, flow, and experience of care, by undertaking **clinically led**, **data-driven** peer review meetings with providers and systems. The team will provide **hands-on, multi-specialist implementation support** for staff, teams, organisations and systems (including NHS, VCSE and independent sector).



The GIRFT Mental Health Team

Credible expert support

- Senior experience of **clinical and operational delivery** and **service improvement**
- **Technical knowledge and expertise** to assess service quality, pathway processes and efficiency
- Knowledge of **good practice** and the **critical success factors to deliver national targets** and the conditions that sustain them
- **Expertise** in sound **data management** and how to develop robust governance and reporting systems for **effective oversight and decision-making**

Empowering improvement

- **Collaboration and system focus** – we secure senior level engagement and bring staff together to develop a shared purpose
- **Friendly and approachable, inclusive and empowering** – we model inclusive leadership behaviours and values to draw on the assets of all staff
- **Clarity and alignment** – we help systems join the dots between governance, roles and responsibilities, performance and support needs

Capability building

- We deliver **clear recommendations** that enable **sustainable improvements**
- We provide **practical tools and guidance** to improve patient care
- We promote **knowledge transfer and capability building** of local teams through our use of tools, KLoEs, webinars, workshops and coaching
- We **champion and mentor local leaders** at all levels, helping them to build confidence in their improvement role

Our operating model: Building on proven success

Builds

- We focus on driving transformation by improving access, flow, and experience of care through clinically led, data driven peer review meetings with providers and systems
- Over a decade of impact, supporting national priorities:
  - Dementia diagnosis rate
  - Talking Therapies (IAPT)
  - CYPMH, and EIP standards

Strengthens collaboration and impact

- Integration brings together GIRFT, MHIST and related improvement functions within one directorate
- Enhances coordination, knowledge sharing, and collective impact
- Aligns with NHS Long Term Plan and UEC Plan 2025/26
- Builds a single, cohesive approach to system transformation
- Brings together strong collaboration with national partners and NHS England improvement teams

Why it matters

- Combines data-driven clinical insight with hands-on improvement support
- Strengthens national and regional capability across the mental health pathway
- Reduces duplication and maximises expertise
- Enables consistent, high-quality improvement from crisis to community care

Today we will provide

- An overview of our system maturity tools which enable whole-system operational improvement across adult acute inpatient care, urgent and emergency care (UEC), and crisis pathways.
- Summary of the design, development, and deployment approach used to embed the UEC MenSAT and IP MenSAT maturity assessments across UEC and inpatient settings.
- Share headline findings and cross-system themes with recommendations to accelerate improvement and address unwarranted variation.
- Highlight key foundations for sustainable improvement including leadership, capability, data and system integration required to support long-term performance and resilience.

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NHS England

Inpatient Mental Health Self Assessment Tool (Men-SAT)

Background and Context

- Increasing demand on mental health inpatient services in England
- Bed occupancy being consistently above the recommended maximum of 85%
- Reported variation in the quality of care received by patients admitted to these services with some patients placed in situations that create safety risks associated with mental, physical or sexual harm and where shared decision making is lacking and person-centred care lacking
- The 2025/26 national priorities and operational planning guidance prioritises improvements in patient flow through mental health crisis and acute pathways and reducing average length of stay in adult acute beds.
- Evidence from work led by the MH Transformation Team, recovery support work with challenged systems, investigations into quality of care and review reports such as the Oliver Shanley Report suggest the need for a proactive approach to improvements in quality, safety and experience for inpatient services.

Recent investigations into mental health care have raised concerns about :

- the quality of care received by autistic people, people with learning disabilities and people from an ethnic minority
- the disproportionate use of restrictive interventions
- a lack of family and patient involvement
- closed cultures and a culture of blame
- workforce issues
- lack of governance and oversight from board to floor
- lack of system integration and accountability with fragmented service coordination including issues relating to discharge and crisis planning
- suboptimal infrastructure and facilities in the mental health inpatient settings

The Inpatient Men-SAT- Overview

Provide a system-level view of the conditions for sustained improvement.
Our tool helps assess each part of the system's readiness and capability, highlighting variation in:

- leadership and decision-making
- data and analytical capacity
- workforce stability and skill mix
- cross-agency coordination (e.g., social care, housing, crisis pathways)

Providing senior leaders clarity on why progress varies and supports more targeted, strategic action.

Identify system-level enablers.
The breadth of Key Lines of Enquiry's(KLoEs) included helps reveal interdependencies across the pathway and provides a holistic system picture.

Create a roadmap for sustainable, scalable change at system—not just organisational—level.
The tool supports understanding of system resilience and maturity, which are critical to sustaining and scaling improvements.

Cross organisational matrix working to avoid duplication and act as a complementary resource to programmes such as the Learning Improvement Networks (LINS).

Support shared learning, including the opportunity to draw on LINs case studies.

Aims, Objectives & Outputs

Aim: Improve patient experience and outcomes, reduce unwarranted variation, improve flow and shorten length of stay

Objectives:

Objective 1: develop shared understanding of system maturity, including gaps and successes.

Objective 2: enable benchmarking, promote good practice and support shared learning

Objective 3: System level appreciative enquiry into quality and safety

Outputs:

Ascertain system maturity

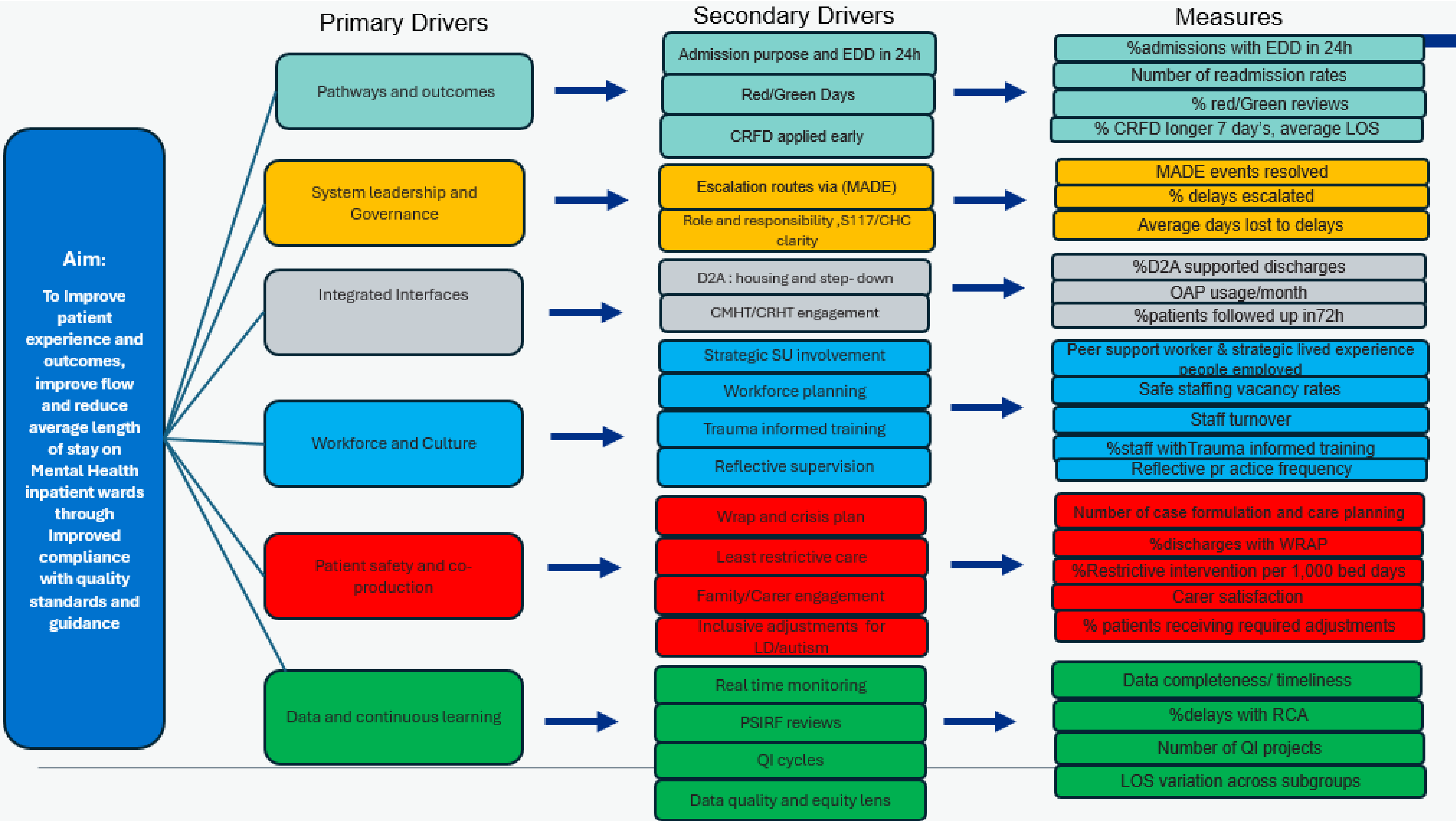
Identify strengths and improvement opportunities

Provide actionable recommendations

Support strategic decisions and resource allocation

Foster continuous learning and reflection

Driver Diagram



Literature

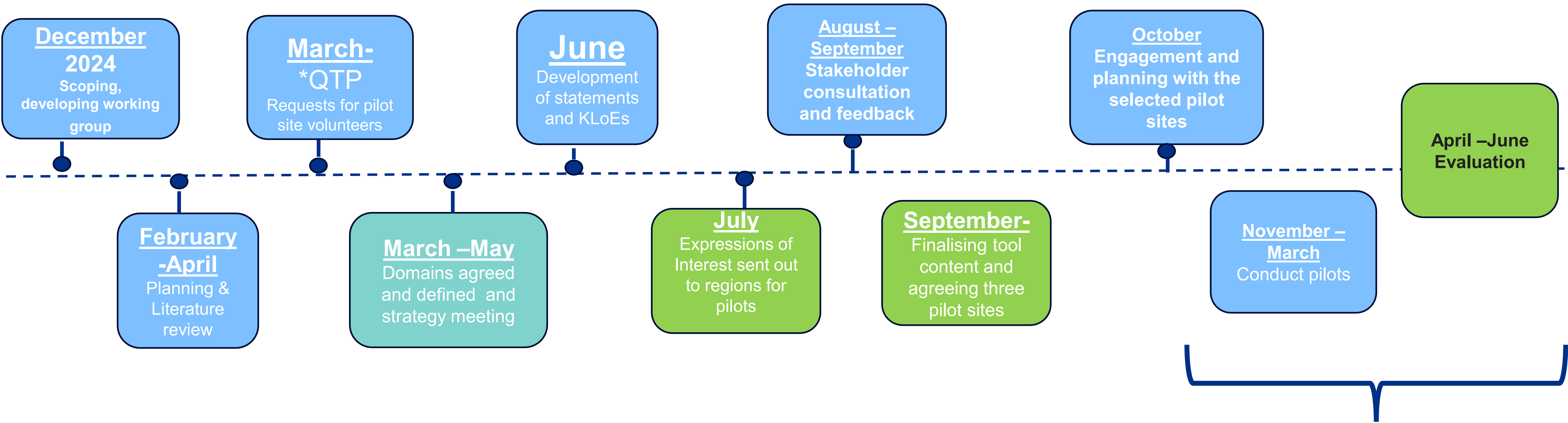
Stakeholder Engagement and Consultation

The GIRFT MH team have collaborated with several partners including having an Expert by Experience and a Nurse Consultant from a Provider Trust on the Working group to ensure a co-produced output.

Consultation on tool with the following stakeholders:

- Mental Health, Learning Disability and Autism Quality Transformation Programme, Mental Health Policy team.
- East London Foundation Trust Tower Hamlets Inpatient Steering Group
- Midlands Mental Health and Community Pharmacist Network
- Senior Specialist for Mental Health
- Oxford Health Foundation Trust Buckinghamshire Ops and Governance Forum with MDT
- Cumbria, Northumberland Tyne & Wear – Associate Director of Social Care
- Devon MH, LD&A Collaborative Co-production steering group
- Advocacy Focus
- Berkshire NHS Foundation Trust Nurse Consultant

Inpatient Maturity Tool Development



Various external factors and unforeseen circumstances have slightly impacted the above timescales which were agreed when the initial PESTLE analysis was conducted.

Inpatient System Maturity Tool process

Planning

Initial engagement
Describe Inpatient Improvement Tool and agreement to proceed with Executive MH SRO and ICB support.

Agree and review scope and objectives with ICB, regional and provider leads.

Preparation: Agree the following ;

- Agenda for face-to-face and online sessions.
- Venues
- Communications
- Attendees with relevant leads.
- Coordination of 1-hour virtual meeting with ICB and provider(s) key stakeholders.

Connect and collaboration

Stakeholder introduction session: This is a **face-to-face** half-day (4 hours) session with all key stakeholders to introduce and showcase the tool and provide clarity on the process of the tool.

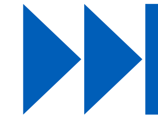
The team will facilitate completion of two of the domains during this session.

Facilitated online sessions: Approximately two weeks later the GIRFT MH team will facilitate two online sessions to complete two domains.

Summit and site visits

Site visits : GIRFT MH Team will conduct site visits of the Mental Health trusts, as agreed during the planning phase.

Summit: GIRFT MH Team will facilitate a face-to-face summit meeting with all key stakeholders to complete the remaining domains of the tool, agree scores collectively and start the development of the improvement actions.

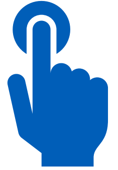


Recommendations& Next Steps

GIRFT MH Team produce a detailed system Improvement report and present to the system within approximately 2 weeks of the Summit.

The system have 2 weeks to review the report for factual accuracy and agree a final version of the report and recommendations.

Once agreed, the final version of the tool and recommendations is circulated to the system, and regional colleagues.



Follow up support (6-months)

GIRFT MH Team will review improvement actions and identify any good practice and identify any case studies. Any opportunities for support will be discussed.

The Inpatient Tool

Continuous Learning (QI, Audits, Incidents) - The Inpatient MeH-SAT (Mental Health Services Assessment Tool)

Domain 8 - Continuous Learning (QI, Audits, Incidents)

	Element	Initial Score	Notes/Evidence	Rough Improvement Ideas
8.1	**Processes and structures to support continuous learning and improvement are in place**			
KLOEs	Are regular audits conducted on operational and clinical practices to inform improvements?			
	Are audit results, issues, and risks immediately available to ward teams for early action?			
	Are routine audits carried out regarding high-risk areas of prescribing and medicine administration to maintain quality standards and alignment with nation			
	Are audit findings shared with both staff and service users?			
	Is there a well-established audit framework consistently followed by all staff?			
	Are staff and patients involved in shaping audit frameworks to ensure practicality and impact?			
	Is effective governance in place to oversee audit implementation and quality standards?			

Domain Descriptors

Domain	Descriptor
1. Strategic Planning	Assesses whether there is a clear, well-communicated strategy for mental health inpatient care that aligns with organisational and system-wide goals
2. System Leadership and Governance	Evaluates leadership accountability, governance structures, and integration across inpatient and wider mental health systems.
3. Workforce	Examines staffing levels, skill mix, training, staff well-being, and organisational culture.
4. Pathway, Evidence Based Practice and Outcomes	Examines transitions and continuity of care, the structured journey of a patient through the inpatient care process, from admission to discharge and beyond. This domain assesses how mature, standardised, and patient-centred these processes are.
5. Promoting Safety and well-being	Assesses risk assessment and management structures and processes, medicines management, physical health, restrictive practice and other key components of safety.
6. Rights, Safeguards and the Mental Health Act	Focuses on legal compliance, human rights, safeguarding from harm, and minimising restrictive practices.
7. Working alongside Lived Experience	Assesses how people with lived experience contribute to service design, delivery, and evaluation
8.Continuous Learning (QI, Audits and Incidents)	Evaluates quality improvement, audits, incidents/complaints/near misses and how they are managed and learned from.
9.Digital and Informatics	Evaluates how well data is used for decision-making, performance monitoring, and patient care.
10. Environment	Assesses whether the physical environment supports dignity, privacy, recovery, and safety.

The Scoring process

Good Practice Domain	20/1/26	20/1/26
Strategic Planning	13/24	13/24
System Leadership and Governance	31/48	31/48
Workforce	29/40	29/40
Pathway, Evidence Based Practice and Outcomes	33/44	33/44
Promoting Safety and Well-being	33/40	33/40
Rights, Safeguards and the Mental Health Act	21/24	21/24
Working alongside lived experience	4/8	4/8
Continuous Learning (QI, Audits, Incidents)	13/16	13/16
Digital and Informatics	10/12	10/12
Environment	9/12	9/12
Total	**196/268**	**196/268**

System 1 and 2 -Initial Findings Spidergram

Initial Findings

Findings	
There are strong foundations for good practice but inconsistent delivery	There is robust governance, policy compliance and intent (e.g. MHA, safeguarding, safety, audit and leadership visibility). However, translation into consistent ward-level practice and lived experience remains variable, particularly under operational pressure. The core challenge is embedding what "good" looks like every day, not designing new frameworks.
System pressure is eroding therapeutic care and recovery focus	High bed occupancy, workforce shortages, discharge delays and housing constraints are persistent across pilot sites. These pressures undermine purposeful admission, therapeutic activity, trauma-informed practice and recovery-focused use of statutory powers, shifting care towards risk management rather than healing.

Initial Findings

Findings	
Workforce sustainability and capability are critical enablers and key levers for quality and safety	Both pilot sites face ongoing recruitment, retention and skill-mix challenges, especially in psychology, LD/autism expertise and peer support. While staff commitment is strong, workforce fragility limits consistency, supervision, reflective practice and therapeutic engagement.
Lived experience, data and learning are valued but under-used systemically	There is good ward-level engagement, data collection and learning activity, but limited system-level integration. Lived experience involvement is often ad-hoc, data is not always usable for frontline teams, and learning is not consistently tracked for impact. The opportunity lies in turning insight into sustained improvement, not generating more information.

Emerging Themes

Theme	
Strategic planning and commissioning alignment	• Outdated service specifications and limited strategic linkage between Joint Strategic Needs Assessments -derived population needs and commissioning decisions. • Impact of ongoing ICB restructuring presents risk to commissioning continuity and locality responsiveness.
Lived experience integration	• Lack of consistent system-wide policy for lived experience roles. • Inconsistent remuneration structures. • Good pockets of practice such as Recovery College, involvement in ad-hoc projects, peer educators but not systematised not sustained.
Workforce strategy and capability	• Workforce strategies not clearly aligned or jointly owned at ICB level. • Gaps in LD and autism-informed skills needed to support client group in an acute ward setting. • Gaps in peer support roles even though they are valued. • There is a need to strengthen workforce diversity and embed job planning across all professional groups

Emerging Themes

Theme	
Cross-system governance and integration	• Lack of mental-health-specific system governance forum and limited mental health visibility in system operational structures such as OPEL (mental health does not have a strong voice in the existing forums) as focus tends to be on acute hospital trusts challenges.
Inequalities and specialist needs	• Autism and learning disability pathways require strengthening and there is variation in reasonable adjustments and infrastructure to support neurodivergent patients.
Environment and infrastructure	• Outdated buildings and staff having to create workarounds to ensure safety of patients e.g mitigating for blind spots • Pressure on beds leading to quiet rooms used as bedrooms • Limited sensory-friendly adaptations.

Recommendations

Strengthen strategic planning to move from historic provision to population-led design

Opportunity:

Create a shared understanding of what inpatient care is designed to deliver, enabling more intentional decisions about beds, workforce and pathways. This could be achieved through:

- Using existing system intelligence (JSNA, bed modelling, OAP data, CRFD, equality data) to produce a single, refreshed system narrative on inpatient need.
- Convening a time-limited system task group (ICB, providers, local authority, lived experience) to update inpatient service specifications with clear ownership and review cycles.
- Explicitly linking refreshed specifications to workforce, estate and discharge assumptions so planning decisions are aligned rather than siloed.

Protect purposeful admission and therapeutic care during operational pressure

Opportunity:
Maintains recovery focus during pressure and improves consistency of patient experience across the system through:

- Agreeing a small number of core expectations for purposeful admission (for example formulation within x days, MDT review, agreed therapeutic goals).
- Supporting wards to use Red to Green (or similar principles) and EDDs as clinical tools - not just performance measures.
- Using peer review and QI forums to share how wards protect therapeutic care under pressure.

Recommendations

Stabilise the inpatient workforce to support consistency and sustainability

Opportunity:

Reduces unwarranted variation in workforce across providers, improves staff morale, continuity and the system's ability to deliver trauma-informed, least-restrictive care through:

- Developing a system-wide inpatient workforce position statement setting expectations for skill-mix, leadership.
- Prioritising retention actions (preceptorship, supervision, leadership continuity) alongside recruitment.
- Embedding lived experience consistently at ward, pathway and system levels, with clear governance, support and feedback.

Prioritise the inpatient environment as an enabler of safety, dignity and recovery

Opportunity:

Improves patient experience, reduces distress and restrictive practice and supports staff to deliver trauma-informed care now, not just after redevelopment through:

- Distinguishing clearly between capital and non-capital improvements - acting immediately on what can be changed (sensory adjustments, parabolic mirrors, access to quiet spaces).
- Working with lived experience including autistic people to identify and prioritise environmental changes with the greatest impact.

Recommendations

Strengthen clinical practice, digital infrastructure, and pathway coordination

Opportunity:

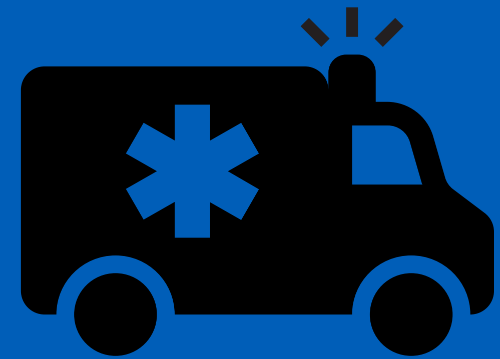
Improve continuity of care, documentation, and discharge processes by:

- Embedding consistent use of Dialog+ and recording nurse 1:1 time to strengthen therapeutic practice.
- Enhancing digital systems and infrastructure such as better Wi-Fi, digital note-taking with patients.
- Optimising EPR workflows and improving dashboard refresh and usability.
- Increasing access to formulation training, improving consistency in capacity assessments, and supporting transition pathways.

Next steps

- Reports with recommendations shared with two pilot sites to inform improvement plans.
- Ongoing collation of findings and emerging themes to inform development of resources for improvement and shared learning.
- Continued engagement with regional Learning Improvement Networks (LINs) to ensure alignment with existing improvement initiatives and to share good practice case studies.
- Ongoing evaluation to inform further refinement and evidence for validity and credibility of the tool.

GIRFT Mental Health: UEC Programme



MH UEC Further Faster programme

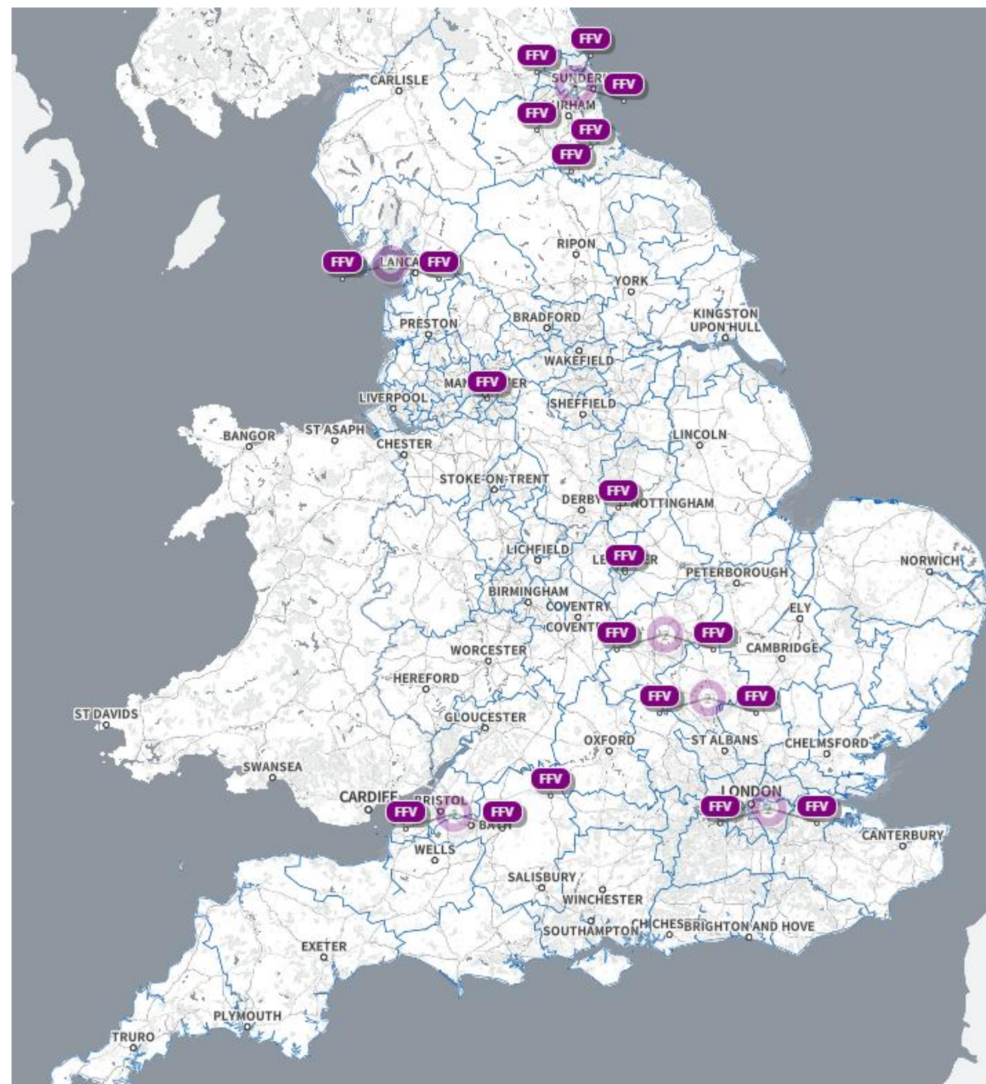
- The GIRFT adult crisis & acute mental health team are collaborating with the GIRFT Further Faster Urgent and Emergency Care programme to offer follow up visits focused on mental health related ED flow, commenced 6th November 2025.
- The aim of the programme is to improve mental health delays in EDs by identifying targeted, evidence-based high impact interventions to improve the experience, safety and flow of mental health patients.
- Meetings involve SRO's from both the acute and serving MH trusts, alongside senior clinical and operational teams to review key indicators and identify recommendations.
- Visit format: clinically led, peer-review of key performance indicators on GIRFT dashboard and adherence to clinical operational standards, walkaround ED / MH assessment room and speak to staff, provide reflections and agree actions for improvement.

GIRFT UEC Further Faster programme

The programme includes 20 sites split into three cohorts.
Sites chosen based on various levels of performance to enable shared learning.

3 Tier 1 providers.

Each site has committed to participating in the programme and has received funding (£25k per site) to deliver high impact changes.



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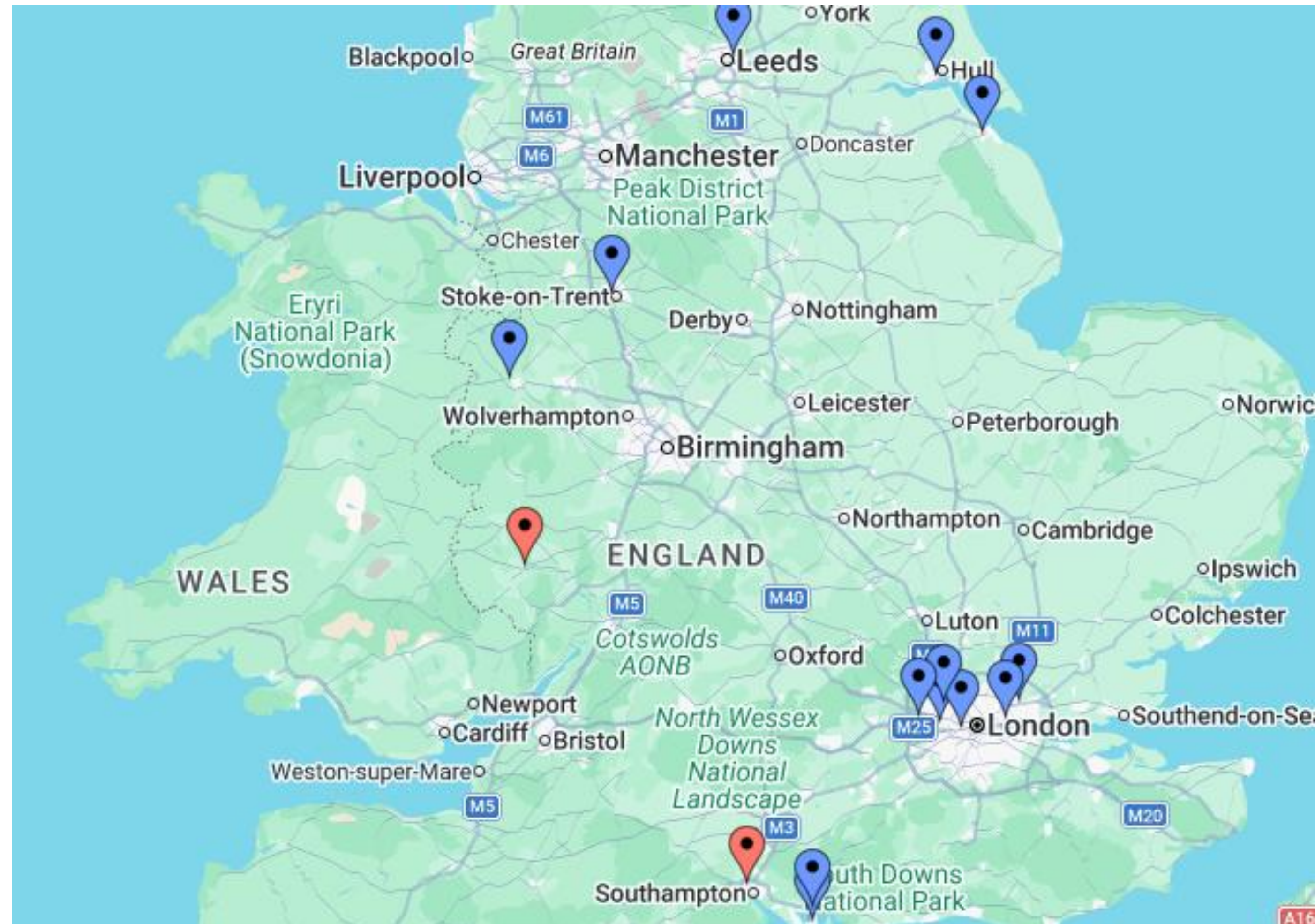
GIRFT UEC Additional Site visits

The GIRFT MH team have carried out 13 additional site visits across the country, visiting emergency departments and Mental Health Trusts.

GIRFT MH team summary reports and recommendations have been made to each health system.



Key	
	Visited
	In contact

UEC Mental Health Service Assessment Tool (Men-SAT)

The UEC Mental Health Services Assessment Tool (Men-SAT)

Background

- The GIRFT Mental Health Team (previously MHIST) collaborated with key partners, including the Mental Health Policy team, National iUEC team, GIRFT, National High Intensity User team, ECIST, as well as police and ambulance colleagues, to create a comprehensive UEC Mental Health Services Assessment Tool (Men-SAT).

- In March 2023, the UEC Men-SAT was approved by the iUEC Special Interest Group. The tool has been piloted across several systems in England, with ongoing refinements to ensure it effectively supports improvements in the UEC Mental Health pathway, with an internal full evaluation taking place in October 2024.

- Developed in alignment with national guidance and best practice standards, such as PLAN, Royal College of Psychiatrists, and GIRFT recommendations, the UEC Men-SAT benchmarks crisis pathways for children, adults, and older adults against national standards and NICE guidance. The tool has helped give parity to Mental Health Services in the UEC pathway and the importance they play.

- The UEC Men-SAT tool is designed to identify critical gaps within pathways, supporting commissioning efforts, including winter planning. It provides systems with tailored improvement plans aimed at enhancing mental healthcare delivery and reducing demand and delays in emergency departments across England, ensuring improvements are long term and sustained.

Literature

British Red Cross
Nowhere else to turn
Exploring high intensity use of Accident and Emergency services
Summary report
The power of kindness

A just culture guide

Department of Health & Social Care
NHS England
Delivery plan for recovering urgent and emergency care services
January 2023

NHS
Mental Health – Adult Crisis and Acute Care
GIRFT Programme National Specialty Report
April 2023

NICE guideline
Self-harm: assessment, management and preventing recurrence

NICE guideline
Self-harm: assessment, management and preventing recurrence

Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983
Position Statement PS2/2013
April 2013
Royal College of Psychiatrists
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NHS
Mental health clinically-led review of standards
Models of care and measurement: consultation response

THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH
A report from the independent Mental Health Taskforce to the NHS in England
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NICE guideline
Borderline personality disorder: recognition and management

The Royal College of Emergency Medicine
Mental Health in Emergency Departments
A toolkit for improving care
Revised: April 2021

RC PSYCH
PLAN
PLAN
7th Edition Standards

RC PSYCH
QN-CRHTT
Practice Guidelines for Crisis Line Response and Crisis Resolution and Home Treatment Teams

Side by side:
A UK-wide consensus statement on working together to help patients with mental health needs in acute hospitals
February 2020
RC PSYCH
Royal College of Nursing
The Royal College of Emergency Medicine
Royal College of Physicians

UEC Men-SAT

Key elements of the tool

- The Men-SAT **is NOT an assurance tool**
- **It is an improvement tool** which enables you and your system partners to self-assess your joint current position against national policy and guidance i.e., Long Term Plan policy, Right Care Right Person guidance, Quality Network CRHT guidance and PLAN guidance
- It provides an opportunity to bring system partners together to focus on the UEC Mental Health pathway and look at where services are working well and where services can be improved e.g. improving communication/ awareness of what is available across an ICB footprint, gaps in the pathway, triangulation of data to meet the needs of the population
- It is vital that the UEC Men-SAT is completed collaboratively and not in isolation to ensure that all system partners agree with the self-assessment
- It allows systems to look at the views of all system partners and professional challenge where things are not working well and looks at how it can be improved. It is vital stakeholders are open and honest about what is and isn't working for their organisation.
- The UEC Men-SAT improvement plan, generated from the discussions, is owned by the system and delivered by the system, hence the importance of system buy in.
- It is important for system partners to agree key performance indicators to measure improvement.

How do you know that things have improved across the UEC MH pathway?

UEC Men-SAT review process

WEEK 0-3	WEEK 4-7	WEEK 8-9	WEEK 10-12	6 MONTHS +
GIRFT Further Faster programme Identification of Mental Health issues- recommendation to undertake a Men-SAT review. **Pre-scoping:** Describe GIRFT: Mental Health Team UEC Men- SAT diagnostic and agreement to proceed with Executive MH SRO ICB support. **Scoping:** Agree review scope and objectives with ICB, regional and provider leads. **Preparation:** Agree visit agenda, venue and attendees with relevant leads. ICB and provider(s) leads to schedule 2-hour virtual meetings with all key stakeholders. **UEC Men-SAT stakeholder introduction session:** GIRFT: Mental Health Team to meet with all key stakeholders and introduce the UEC Men- SAT tool, to run through the involvement and participation domain and to answer any questions about the process.	**UEC Men-SAT pre-populate domains** ICB lead and system partners to complete domains: 1.Access and Waits 8.Productivity 9.Outcomes 10.Data Quality 11.Culture 12.Digital and informatics **The system are given 4 weeks to complete and return to the GIRFT: Mental Health Team within week 8**	**Launch of the UEC Men-SAT Summit** **Day 1**: GIRFT: Mental Health Team to facilitate a UEC Men- SAT full day summit meeting with all key staff (face to face) to share initial findings from prepopulated domains, to complete the remaining sections of the tool and agree Men-SAT scores and look collectively at improvement actions. **Day 2:** GIRFT: Mental Health Team will undertake sites visits observing the services that they have read and heard about during the completion of the Men-SAT tool. **Day 3:** 2-hour stakeholder feedback session. GIRFT: Mental Health Team will be on sit to provide high level feedback of what we have heard and seen	**Finalised UEC Men-SAT Tool** GIRFT: Mental Health Team produce a detailed system UEC Men- SAT tool and present this to the system within approximately 3 weeks of the Summit. The system have 2 weeks to review the report for factual accuracy and agree a final version of the report and recommendations. Once agreed, the final version of the UEC Men- SAT tool is circulated to the system, and regional colleagues.	**6 month follow up with system** GIRFT: Mental Health Team will schedule a face to face 6 month follow up with the system to look at: • What progress has been made? • What has changed? How do you know? • What evidence are you using to measure sustainable change/ improvements? • What has gone well? • What hasn't worked and why?

UEC Men-SAT

Key domains

The improvement tool has been built around 12 domains, with key statements and KLOEs:

- Access and Waits
- Strategy and Collaboration
- Workforce
- Evidence based practice
- The Pathway
- Environment
- Involvement and Participation
- Productivity
- Outcomes
- Data Quality
- Culture
- Digital and informatics

Access & Waits - The Men-SAT (UEC Mental Health Services Assessment Tool) NHS

Domain 1 - Access & Waits

	Element	Initial Score	Notes/Evidence	Rough Improvement Ideas	Rescoring		
1.1	There is a published and effective, high-quality patient access policy in place which is consistent with national rules (Provider)						
KLOEs	A patient-friendly summary of the access policy is available (Provider) There are documented standard operating procedures (SOPs) in place that underpin the access policy. Has the access policy been signed off by ICB board (or equivalent) and is it reviewed at least annually? Have service users, representative of the local population been included in the development and review of the Access Policy? Is there a clear coordinated offer, and clear referral routes and pathways into services delivered by different organisations who are working well collaboratively? Are the access policy rules consistent with national rules and definitions, including waiting list definitions? Is the access policy published on the provider and/or commissioner website? Does the Access policy include a description of how to make a self-referral? Is the local health system offering choice in regards to venues, geographical locations as well as online and face-to-face offers for service users to access urgent and emergency mental health services?						
1.2	There are processes to monitor equity of access which enables a flexible, efficient and timely use of resources (Provider)						
1.3	There are documented effective standard operating procedures (SOPs) in place that underpin the access policy (Provider)						
KLOEs	Are there signed off written pathways that define what constitutes 'first treatment' to guide accurate coding? Are there signed off written pathways in place with agreed internal waiting standards to assessment, first and subsequent treatment? Are there choice points and escalation points at each step? Are SOPs reviewed and updated annually or sooner in the event of any national rule change? Do booking processes aim to maximise the availability so patient choice of dates/times and promote dialogue with patients i.e. interactive booking rather than issuing predetermined appointments by letter? Is there evidence of consistent booking processes across the organisation through audit for example? Is adherence to the access policy regularly monitored? Where operational issues prevent compliance, are exceptions to the rules understood and recorded?						
1.4	All age (CYP/ Adults and Older Adults) 24/7 Urgent and Emergency Mental Health Care services and Crisis Alternatives are mapped onto the Directory of Service						

Introduction | Welcome | Guidance | Participant Register | Access & Waits | Strategy & Collaboration | Workforce | EBP | The Pathway | Environment | Involvement & Participation | Productivity | ...

Area’s completed

14 ICB systems have now completed the UEC Men-SAT process and bespoke reports and recommendations have been made to each health system to support improvements across the UEC Mental Health Pathway.

UEC Mental Health Programme Emerging Themes

Further Faster and Additional site visits: Key issues identified

Data Intelligence	Governance and Oversight	Pathway	Environment and Workforce
• Data quality was poor, with variation in parallel datasets and clock-start times between mental health and acute providers. • Poor quality ECDS and MHSDS data and a lack of a dataset a to be able to analyse MH patient flow through EDs • Limited understanding of the root causes and contributory factors driving 12+-hour mental health ED breaches.	• Mental Health Trust Boards often lacked visibility of ED issues affecting mental health patients, and these issues were not consistently reported in Board papers. • Information sharing between mental health and acute providers was problematic, frequently resulting in dual data entry and constraints on front-door co-streaming.	• Second-opinion doctor and AMHP availability consistently constrained timely MHA assessments in ED. • EDs were too often used as de-facto places of safety for patients awaiting mental health bed admissions, while community-waiting patients were prioritised - contributing to safety risks and ED breaches. • Section 136 presentations were often hampered by inconsistent police practice and handover; patients were sometimes left in ED without s136 or placed under informal Section 2.	• Many ED mental health assessment rooms (or equivalent spaces) were inadequate in terms of safety, risk mitigation, and privacy and do not meet PLAN standards. • There was a significant training gap for ED staff in managing complex mental health needs, negatively affecting staff wellbeing and satisfaction

UEC Men-SAT: Key issues identified

Themes & findings

Fragmented care	Timely action	Strategic Commissioning	Achieving embedded change
• Disjointed UEC MH pathways • Lack of awareness of services available • Lack of 24/7 Crisis MH services • Delayed access to support • No clear escalation policies for delays and breaches	• Lack of visibility of shared data to see system pressures and inform decisions • Lack of proactive capacity and demand analysis • Limited insight on impact and outcomes	• Strategic planning and commissioning alignment • Outdated service specifications and limited strategic linkage between JSNA-derived population needs and commissioning decisions. • Impact of ongoing ICB restructuring presents risk to commissioning continuity and locality responsiveness.	• Lack of parity in oversight and resourcing • Issues and gaps in pathway infrastructure: trained workforce, policies and procedures • Limited leadership and staff capacity, dedicated resources to embed new practice

Key Actions systems should take:

Theme	Key Actions systems should take:
System working- system level governance, oversight and coordination.	• Development of ICB system boards, review of existing governance structures, ensuring clarity of escalation points • Development of a system-wide involvement strategy, workforce and training strategy, overarching access policy and agree system level local Key Performance Indicators (KPIs) • Completion of system-wide demand and capacity planning • Availability of joined up system level data, visible system level dashboards that display mental health pressures (levels of acuity, demand and pressure across the pathway) • There is a clear escalation framework between organisations for potential 12-hour+ breaches • Acute and MH trusts boards are aware of breaches and the causes e.g. from board papers and whether Exec to Execs and Board visits to the ED have occurred • Parity of esteem of MH pressures with UEC board meetings.
Collating and using data and Intelligence to inform service development and improvement.	• Robust recording of outcome and demographic data • Systems should use the Breach Analysis tool • Recording and using patient experience and outcomes meaningfully • Triangulation of data at system level to inform service development and improvements • Using data to review pathway to assess alignment with population needs • Mapping the patient journey through the pathway to understand and identify gaps and barriers.

Key Actions systems should take:

Theme	Improvement ideas generated from the UEC Men-SAT summit days
Fidelity and quality standards in pathway	• Reviewing fidelity to model and benchmarking against standards (e.g. Quality Network Crisis Resolution Home Treatment Standards (QNCRHT) and PLAN) • Improve resourcing (workforce and estates -rooms for assessment). • Ensuring MH triage at front door and parallel assessment is in operation and staff know what the alternatives are and operating/opening hours • Checking MH care and treatment plans for breach patients by Tier 2/3 clinicians is occurring every 24 hours • At least one PLAN accredited interview room is available • MH Observations are being undertaken by suitable clinical staff • Review of the use, accessibility and awareness of existence of Crisis New models across partners. • Ensuring parity of provision across age ranges
Partnership working and coproduction	• Ensuring visibility and accessibility of data and information across agencies including Police, Local Authority and VCFSE partners. • Developing accessible, patient friendly coproduced access policies • Improving shared understanding and knowledge of the services offered by the different agencies/partners in the pathway • Training needs analysis to inform multi-agency training co-designed with Experts by Experience. • Involvement of patients in commissioning, designing and improving services.

UEC Mental Health Programme Outputs

GIRFT
GETTING IT RIGHT FIRST TIME

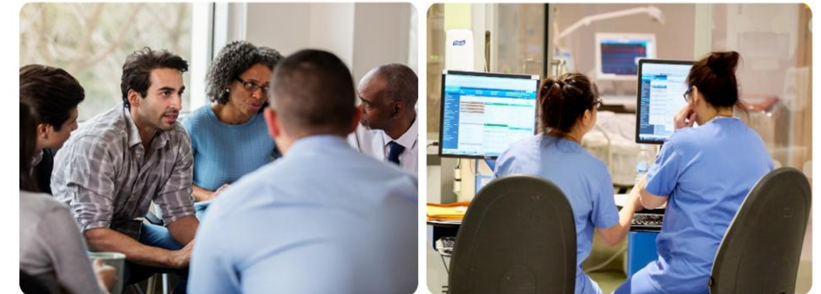
GIRFT Clinical Operational Standards Mental Health Urgent & Emergency Care

- New GIRFT standards set out best practice for timely, safe and effective care for people presenting in mental health crisis across urgent and emergency pathways.
- Developed in response to sustained service pressures, variation in performance, long waits and poor patient experience.
- Aim to improve patient flow, reduce delays, and deliver a safer, more responsive crisis experience.
- A practical framework to support consistent decision-making and escalation.
- Designed for system-wide use, with clinical teams working collaboratively across EDs, acute services and mental health services, covering 4 key pathways:

✓ **Community & pre-admission** – early identification, crisis planning, timely senior decisions.
✓ **Emergency response** – 24/7 crisis services, rapid face-to-face assessment, appropriate use of HBPoS.
✓ **Emergency departments** – timely liaison psychiatry, parallel physical and mental health assessment, trauma-informed care, clear escalation.
✓ **Inpatient flow** – purposeful admission, early senior review, daily MDT oversight, proactive discharge planning.

GIRFT Clinical Ops Standards

GIRFT Clinical Operational Standards:
Adult Acute Mental Health Urgent & Emergency Care
Standardising best practice to improve patient flow and reduce waiting times in emergency and acute care
April 2026



To support awareness, understanding and implementation of the standards, GIRFT will be running a webinar on
Thursday 21st May, 12:00-13:00.
Register here.

Programme outputs

- GIRFT 12+ Hour MH ED Breach Analysis Tool: to be rolled out to all participating sites in the FF programme, and additional priority sites visited. Sites will be asked to complete a comprehensive breach analysis of 10 patients within the months of June 2026 and January 2027. Data will be submitted to GIRFT to undertake a thematic analysis of the key drivers impacting breaches and inform national priorities.
- An online gap analysis tool to enable systems to benchmark adherence to the Clinical Operational Standards for Mental Health in Urgent and Emergency Care, identify gaps, and put in place actions for improvement (May 2026).
- A national thematic report of findings from all areas of GIRFT MH UEC work programmes, co-produced with NHS Alliance, RCPsych.
- A GIRFT hosted MH UEC Community of Practice Network.

UEC Mental Health Case Studies

The GIRFT Mental Health Team have worked with systems across the country to develop UEC case studies to highlight areas of best practice.

There are now 10 published case studies which can be accessed at:

https://future.nhs.uk/connect.ti/MentalHealthSystemImprovement/view?objectID=58498128

These include:

- **Crisis Alternatives:** Kent and Medway ICB
- **Using Personal Health Budgets**: Cornwall Partnership NHS Foundation Trust
- **Reducing OAPs and Mental Health Urgent Assessment Centre:** Lincolnshire Partnership NHS Trust
- **111 option 2:** Tees, Esk and Wear Valleys NHS Foundation Trust
- **Integrated Access Partnership**: Avon and Wiltshire Mental Health Partnership NHS Trust
- **Embedding AI into Crisis Access Lines:** Mersey Care Foundation Trust

Foundations for sustainable improvements

SYSTEM LEADERSHIP

Visible Leadership Advocacy – Senior leaders must actively communicate and champion change to inspire engagement ('winning hearts and minds').

Unified Leadership Accountability – A unitary leadership approach minimises silos and fosters a collaborative culture.

Stable Leadership Support – Consistent leadership at the board and senior levels ensures sustained improvement and rapid progress at the frontline.

Board Development & Cultural Change – Equipping leaders with the right tools, behaviours, and capabilities drives cultural transformation and accelerates delivery.

Capacity for Improvement Leadership – When internal staff leading improvement efforts have dedicated capacity, progress is more sustainable.

SYSTEM GOVERNANCE AND OVERSIGHT

Effective Escalation Mechanisms – Ensuring systems have clearly agreed escalation protocols across system partners including clearly defined escalation times to support services who are waiting for long periods.

Effective Governance & Reporting Structures – Well-established governance, reporting, and escalation routes ensure quality governance and risk management are embedded effectively.

System Oversight of the whole pathways i.e. UEC Mental Health pathway – Taking a whole system pathway approach is about developing a shared understanding of the system level issues using the data and valuing each other's viewpoints.

SYSTEM INTELLIGENCE LED

Proactive demand and capacity – A comprehensive view of demand across key system partnerships should form the foundation of clinical and operational leadership discussions and decision-making processes to ensure more coordinated and effective service delivery.

Reducing Health Inequalities – A clear system overview of health inequalities within local populations is incorporated/considered into governance and KPIs reviews/developments so that the information that's available is used to improve services and outcomes.

Outcome Monitoring – Standardisation of outcomes across all stakeholders enables meaningful comparisons and ensures that data can be used effectively to monitor impact of services and drive improvements across the entire system.

SYSTEM ENGAGEMENT

Staff Involvement in Change – Engaging frontline staff directly affected by change to improve buy-in and ensure practical implementation.

Clear and Continuous Communication – Regular updates on intent, progress, and upcoming changes keep stakeholders aligned and engaged.

Awareness & Coordination – A broad understanding of the scale of actions, necessary resources, and interdependencies to prevent conflicts and inefficiencies.

Urgency & Responsiveness – A strong sense of urgency to act, a proactive approach to support, and a deep understanding of the consequences of inaction.

SYSTEM RESOURCES

Sustained Resource Allocation – Ensuring resources are safeguarded for embedding new practices, even in financially constrained environments.

Organisational Readiness – A strong cultural foundation and robust infrastructure (e.g., IT and clinical systems) are critical for successful implementation.

Robust Quality Improvement (QI) Resources – A well-developed QI infrastructure within the organisation to support continuous improvement.

Dedicated Project Management Office (PMO) Support – Essential resources to drive rapid improvements, especially in large, complex initiatives.

Acknowledgment of Internal Capacity Needs – A system-wide commitment to recognising and providing the internal resources necessary for sustained improvement.

LEARNING CULTURE

Leveraging Existing Best Practices – Identifying, harnessing, and spreading proven successful practices enhances overall efficiency.

Sustainable Improvement Actions – Focus on long-term solutions that address root causes, rather than short-term fixes to meet regulatory demands.

System-Wide Improvement Approach – Improvement efforts should extend beyond individual providers, fostering system-wide capability and collaboration.

Essential foundations to change that lasts

Leadership & Collaboration

Governance & Oversight

Data & Intelligence

Essential foundations to change that lasts

Visible collaborative leadership

- A focused set of shared priorities and objectives between system partners (less is more).
- Advocates for parity and resources to enable change
- Empowers staff, enables them to speak up, provide them with tools to respond effectively to pathway pressures
- Takes impactful action and influences beyond organizational boundaries
- Nurtures relationships with partners to enable effective action

Governance and oversight

- Clearly defined accountability for action: leaders and system partners
- Shared understanding of roles and responsibilities, and services in the pathway
- Clearly defined pathway for escalation of issues, responsive and coordinated multiagency action
- Active and visible engagement of stakeholders and promotion of user engagement
- Coordinated improvement, active links and structures from project to operational implementation
- Effective communication of pathway developments, benefits, and what has been learnt

Moving from data collection to intelligent insight

- Shared data to inform decisions
- Contextual measures for insights on the pathway to ascertain outcomes and any differences in outcomes between population groups
- Equal value placed on staff and patient feedback
- Clearly agreed and defined measurement of improvement

Thank You

@NHSGIRFT

Getting It Right First Time (GIRFT)

gettingitrightfirsttime.co.uk

Refreshments & Networking

Chair Morning Reflection

Alison Blackler
Founder of 2minds – Mind Coach, Tedx Speaker, Author
2minds

Case Study

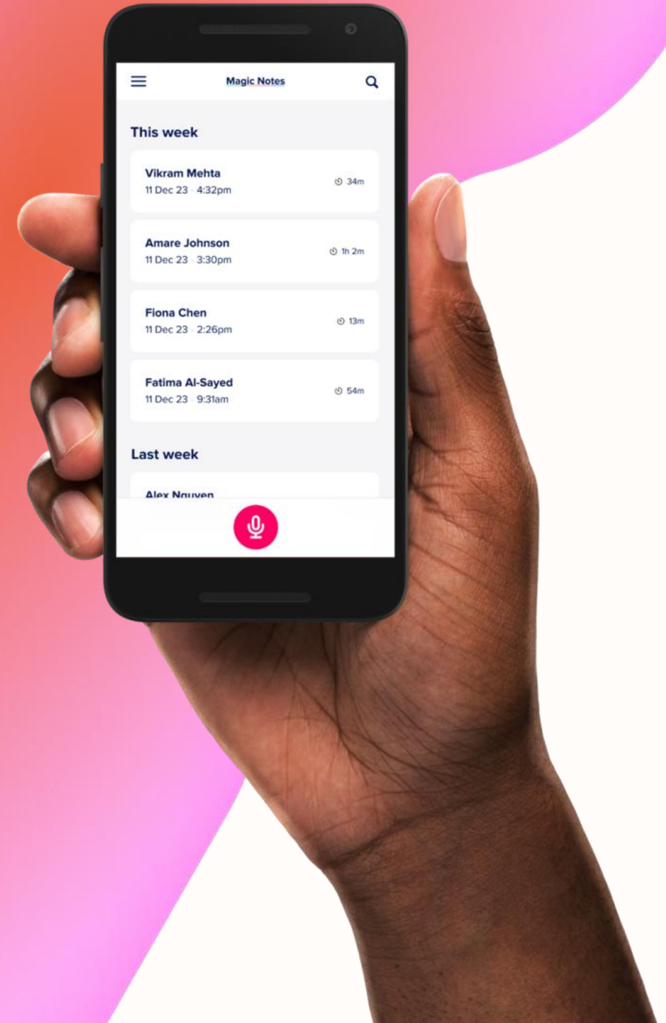
beam

Case Study

Aoife Clarke
Partnerships Lead: Healthcare
Beam

beam

From Conversation to Action: Leveraging AI to reduce delays in Mental Health Care Delivery



Aoife Clarke
Partnerships Lead
aoife@beam.org

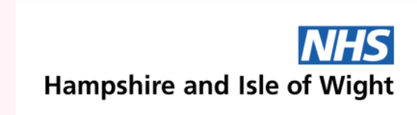
beam

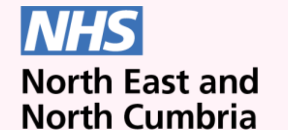
Beam is a social enterprise using AI to free up frontline time in health and social care.

3.6 million
Beam Notes recorded

85,000+
Users across our tools

Trusted by 200+ health and social partners





During that it came out that there was a really clear emergency situation that needed rectifying instantly for their wellbeing in the home situation. It involved bailiffs and the person had a learning disability and was living in squalor. It was a horrendous situation for her.

I **would never have been able to do something like that without Beam Notes.** It would have been me typing for hours. I wouldn't have done it that day.

It was **because of the quality of the risk assessment that they were able to action with police and the services to get it sorted within the hour.**

And that was my morning appointment. I had a text and email back before my afternoon appointment saying the situation was organised and things were in place. And it would never have happened without Beam Notes. **It wouldn't have.**

- **Specialist Practitioner, Autism Spectrum**

beam

NHS
Northamptonshire Healthcare
NHS Foundation Trust

Reducing CYP waiting lists

- CAMHS
- ADHD and Autism Services
- Speech and Language Therapy
- Community Paediatrics
- Looked After Children Services
- Continence Pathways

> *This has been a game changer. I use Beam Notes for everything I do, including cons line, clinical reviews, IA's and other meetings.*

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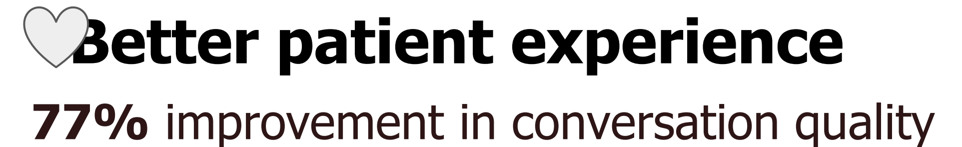
Key results

6.5 hours saved a week

40% reduction in admin time



Better patient experience

77% improvement in conversation quality

Increased quality

65% improvement in detail capture

Loved by clinicians

9.30/10 average recommendation

Digitising a bottleneck isn't innovation.

We need to move beyond "typing speed" and address the broader movement of information through clinical systems

Burden

Documentation debt from high-stakes, hour-long complex meetings & assessments.

Communicate

Language barriers and fragmentation across multi-agency teams.

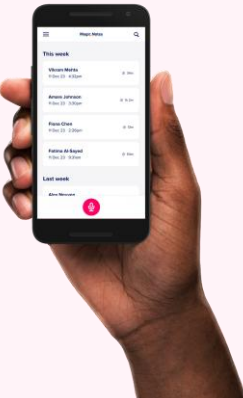
Triage

Access bottlenecks at the "front door" of mental health services.

Beyond the Pilot: Solving the Pathway, Not Just the Note

Notes

Turn conversations, documents and scattered notes into clear, detailed reports or casenotes

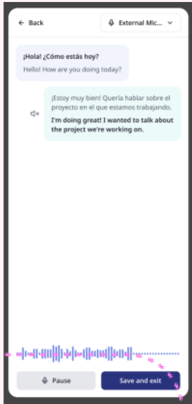


Talk

Assess, triage and resolve queries with an empathetic AI assistant

Interpret

Real-time interpretation, designed with frontline context



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Thank you.
Any questions?

Come find us at Stand 2

Aoife Clarke
Partnerships Lead
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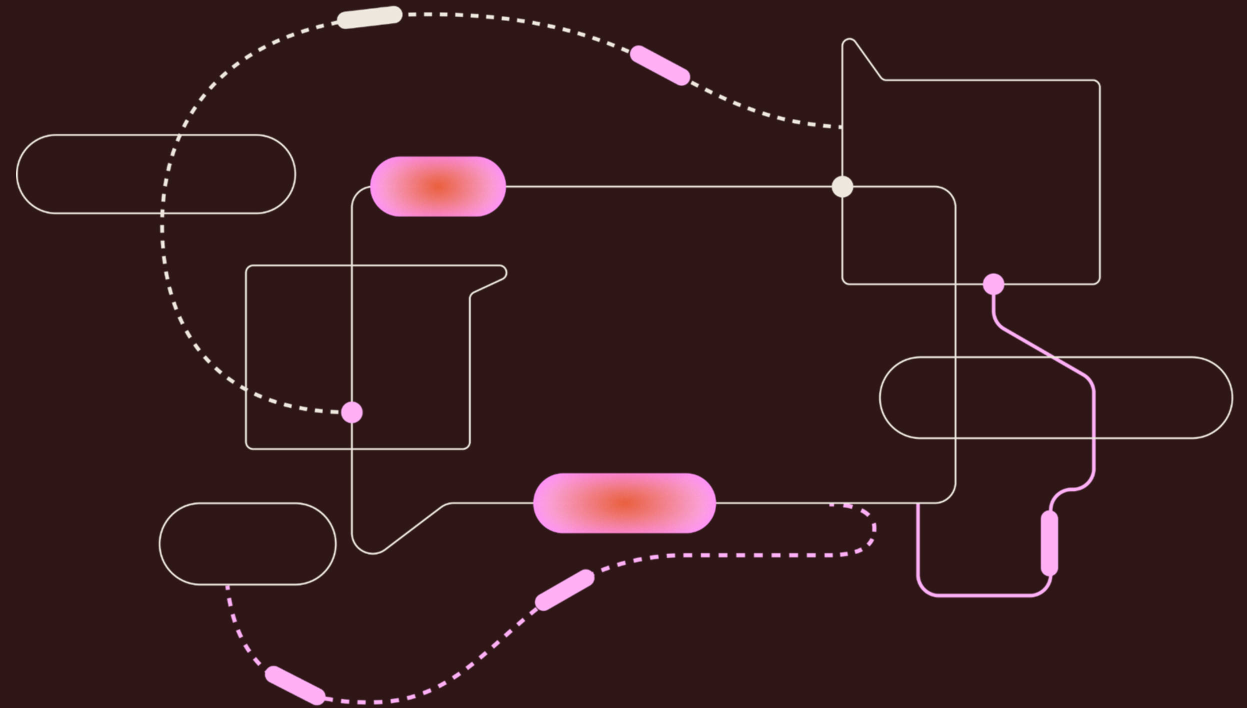

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Europe's Top Financial Inclusion Startup

Best Technology Social Enterprise

Queen's Award for Enterprise Promoting Opportunity

Case Study

Patient and System Level Challenges in the Care of People with Schizophrenia

Chair: Matthew Elswood, Medical Advisor, Neuropsychiatry - Teva

Expert Speaker: Dr Ananta Dave, Consultant Child and Adolescent Psychiatrist and Chief Medical Officer – Black Country Integrated Care Board

Job Code: NPS-GB-NP-00898

Date of Prep: May 2026

Leadership Lessons from the Front Line

Jo Hillier
Chief Clinical Information Officer
Sussex Partnership NHS Foundation Trust

Using AI & Digital Tools safely in Mental Health Care

Jo Hillier
Chief Clinical Information Officer

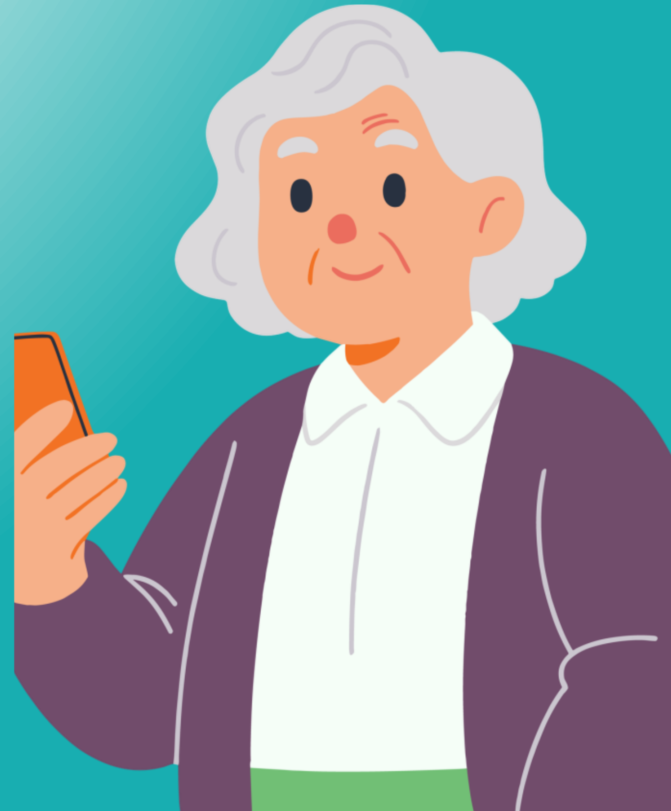
Why this matters now?

- Parity of esteem
- Unregulated AI outside organisational governance
- Heightened safety and security
- Pressure on leaders to adopt quickly
- 10 year plan - analogue to digital

Mental Health is not a Single Pathway and every patient needs indivdualised care and support

What does this mean for safe digital use?

Which digital tools fit where?



Best fit for digital / AI

- Admin, letters, summaries - NHS App
- Booking, messaging, PROMs and PREMs
- Insight from aggregated data

Higher caution

- Diagnosis
- Shared decision tools
- Risk formulation
- Treatment decisions

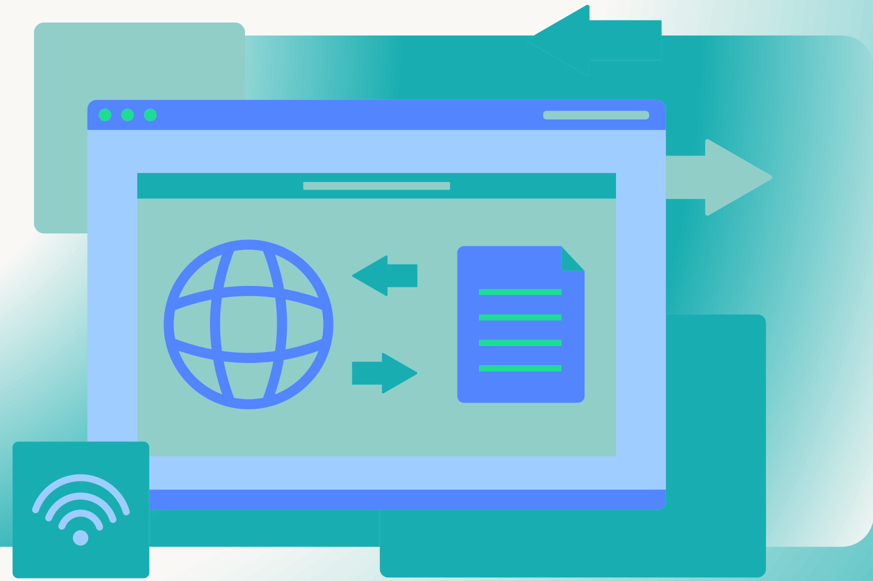
Decision, Not Disruption

Disruptive Implementation

- Tool-led
- Pilot heavy
- Not attending to clinician anxiety or change fatigue
- Governance added later
- No expert by experience involvement
- No adoption plan

Decision Mindset

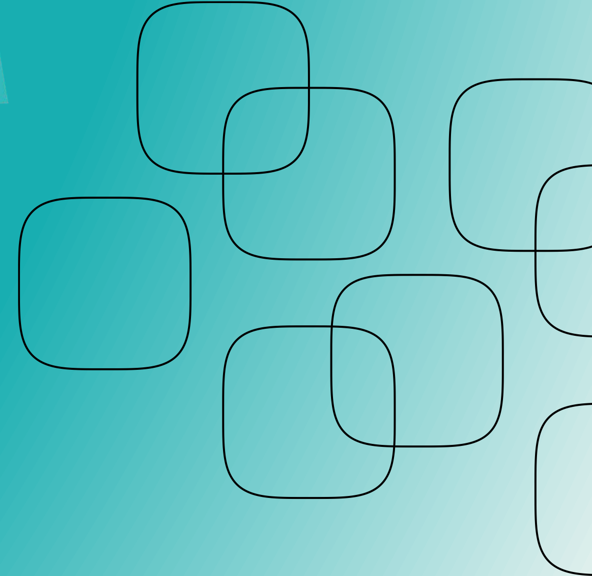
- Problem-led
- Value and risk explicit to all stakeholders
- Safety designed in
- Delibrate adoption
- Governance first



The Real-World Journey

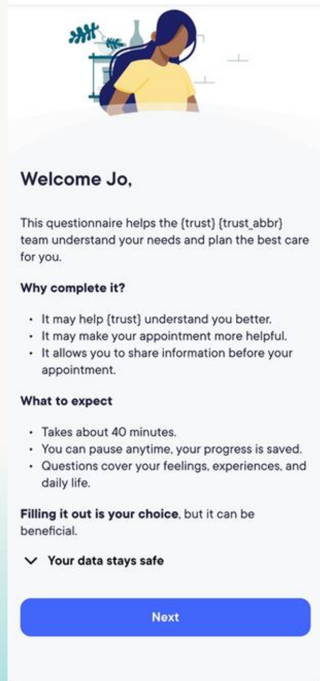
Stepped Timeline and Road Map

- Exploration & curiosity
- Leverage what you have already
- Ensure the foundations are in place
- Intentional collaboration between digital experts, users of digital and experts by experience
- Digital clinical Safety & IG imperative
- Licensing & controlled use - data informed



BeSeen Triage Tool

Sussex Partnership Journey



Key Lesson:
The tool has not changed significantly but our approach has

April 2025

Pilot
- Low engagement from medical staff
- Seen as "another digital tool"
- Strong safety case developed

September 2025

Evaluation and Review
- Reframed as patient support
- Visible clinical ownership
- Increased use case - children and young people
- Experts by Experience supported evaluation and next steps

Feb 2026

Trust Wide Launch - Pause
- Too much change with EPR go-live
- Tool needed better integration
- Pause to resolve adoption and integration issues

July 2026

Relaunch with disciplined adoption and ownership
Across all 15 neighbourhood teams

Safety, Hazards and Governance - myths v's reality

AI decides clinical care
v's
Humans remain accountable

Governance blocks innovation
v's
Governance enables safe scale

One policy fits all tools
v's
Use-case specific safety matters

Decision Checklist

- What decision does this support?
- Where does it fit - process map?
- Who remains accountable?
- Is this patient facing or operational?
- What could go wrong (Hazard Log - safety case)?
- Are staff ready?
- What is the adoption plan?
- What will we stop or replace?

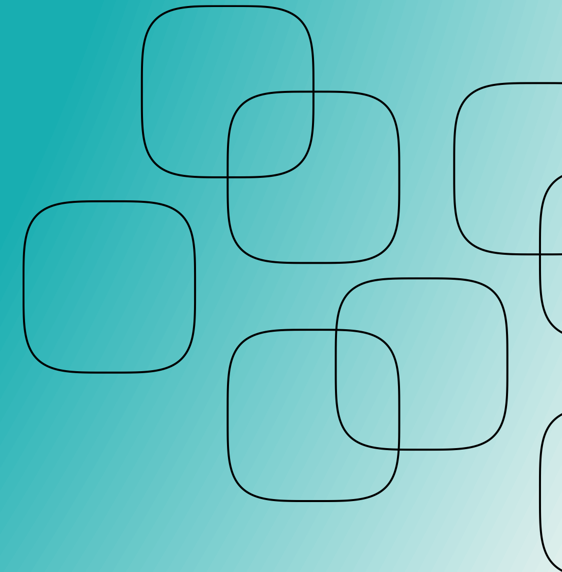
What good looks like

Decisions before tools

Safety before scale

Patients and staff before hype

Digital innovation in mental health isn't about being bold. It's about being deliberate.



Thank-you very much

Any Questions?

Keynote Presentation

Sarah McCulloch
Pathway Lead, Barnet 18-25
Transitions Pathway
North London NHS Foundation Trust

Designing a Practical Bridge Between CAMHS and Adult Mental Health Services

The Barnet 18-25 Transition Pathway

THE PROBLEM

An implementation gap, not a knowledge gap

> *"Services know what should happen but often lack the mechanisms to deliver it."*

Roberti et al., BMC Psychiatry 2024

01

Fragmented care

Premature discharge before a safe destination is confirmed

02

Loss of engagement

Young people fall through the gap at their most vulnerable point

03

Age-bound thresholds

Administrative age cut-offs override clinical and developmental need

HSSIB (2024) national investigation highlighted unsafe handovers -- calling for earlier preparation, joint working, and named transition coordinators.

Nonita Grabovskyte

December 2023 | Aged 18 | Barnet catchment area

Nonita had experienced long-standing mental health difficulties and had been known to CAMHS in North London for several years.

When she turned eighteen, her care was discharged from all children's services without being opened to adult services.

Information was poorly shared. Nonita was placed out of area and was isolated from her old services and not picked up by her new ones. Transfers of care between trusts is particularly difficult.

Her preventable death prompted renewed scrutiny of how young adults are transferred between services.

"Had the 18-25 Transition Pathway existed at the time, Nonita could not have been discharged from CAMHS until she had been accepted to the appropriate service -- with a friendly face to go to for reassurance."

The Barnet 18-25 Transition Pathway: what we built

Context

- Established 2023 within North London Foundation Trust
- Part of the wider NCL 16-25 Young Adult Programme -- equitable provision across all five boroughs
- Co-produced with clinicians, managers and experts by experience
- Draws on learning from Camden's Minding the Gap programme (2012) -- and goes further

The founding principle

"Bridge, not containment"

Young people remain open to a destination team but receive structured support from a transition worker -- to prepare for adult systems and sustain engagement once transferred.

The goal: not a new service, but a structured bridge between existing ones.

Three design priorities

1

A clear operational pathway

Every young person approaching 18 in Barnet CAMHS has an identified destination team, a documented transition plan, and an allocated keyworker.

2

A dedicated bridging function

Relational and practical support during handover -- preparing young people for adult systems and sustaining engagement through the gap.

3

An embedded feedback loop

Three KPIs monitored: referrals received, transition plans completed by CAMHS clinicians, and evaluation forms returned. Data drives continuous improvement.

THE TEAM

A small, specialist multidisciplinary team

Embedded within adult community services -- enabling direct liaison, rapid information exchange and accountability across CAMHS, adult core teams, psychology and social care.

Pathway Lead

Band 8A. Oversees the pathway, chairs the Transition Panel, manages stakeholder relationships and service development.

Clinical Lead

Registered mental health nurse and psychotherapist. Provides brief psychotherapeutic input for complex cases and clinical oversight.

Community Engagement Practitioners

Person-centred, recovery-based keyworkers. Support young people to achieve practical goals -- independence, confidence, engagement.

OT Apprentice

Provides functional support and specialist interventions.

ELIGIBILITY

Who the pathway works with

17.5-25
Age range

~ 200
Referrals per year

~ 60
Active caseload at any one time

~ 50%
Of CAMHS 18s transition to the pathway

We work with young people who are...

- Preparing to leave CAMHS (referred from 17.5)
- Re-engaging after CAMHS discharge
- Presenting for the first time with transition-cohort needs: ADHD, autism, emotional dysregulation, OCD, dissociation, trauma
- Between 18-25 with complex needs benefitting from our specialist skills

We cannot work with young people who...

- Have no destination team (we coordinate -- we don't hold cases alone)
- Are high risk without an allocated clinician from a core team
- Are over 25 or not resident in Barnet

PANEL

The Monthly Transition Panel

What it is

A monthly multi-agency forum where all transition cases are discussed and decisions made. No delays -- plans are agreed in the room.

Who's in the room:

- Adult core teams
- Psychology
- Talking therapies (IAPT)
- Drug & alcohol services
- ADHD & eating disorder pathways
- Local authority social care

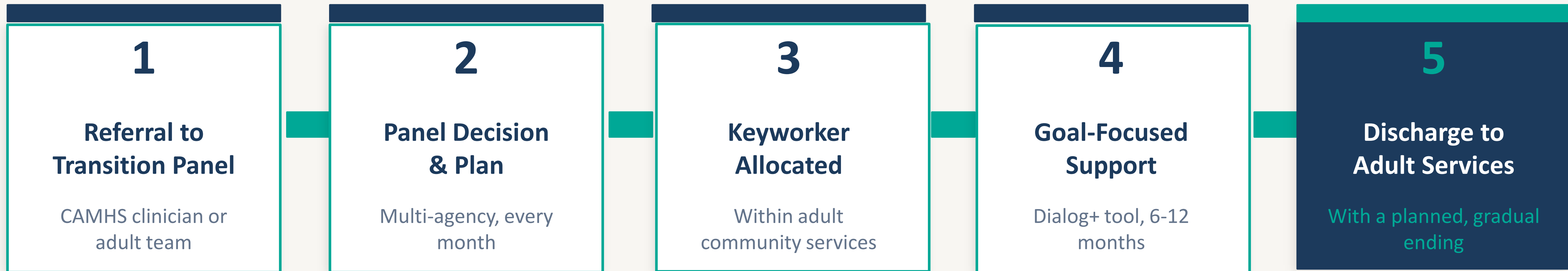
The guarantee

"No young person turns 18 without an identified plan or destination team."

How referrals work:

1. Consult Transition Lead first -- decision may not need full panel
2. Complete referral form
3. Agenda and time slot confirmed before meeting
4. Decision made by MDT -- plan documented immediately

Keyworking in practice: the pathway



The keyworker function

- First meeting: establishes practical arrangements, boundaries, expectations and confidentiality
- Two or three goals identified collaboratively using the Dialog+ care planning tool
- Emphasis on autonomy -- preparing young people to engage confidently with adult teams
- Short, regular check-ins during key periods (e.g. exams) -- balancing autonomy with emotional safety

CASE STUDY 1

Case study: Supporting a planned transition

Samuel, 17

Composite, anonymised case example

Autism spectrum condition, ADHD, low mood
Social anxiety -- mostly gaming at home
Under CAMHS since age 14, strong relationship with keyworker
Parents anxious about losing familiar professionals

Destination teams identified:

Adult CMHT | ADHD service | Barnet Autism Hub

Goals (Dialog+): routine, sleep hygiene, reducing isolation

What the pathway did

- Joint meeting with Samuel and family: explained differences between CAMHS and adult services, set expectations
- Fortnightly keyworker sessions over five months, liaising with parents and college on attendance and adjustments
- Samuel's sleep and confidence improved -- joined a local football club
- Gradual planned ending over three sessions, ensuring a natural close
- Discharged from 18-25 Pathway -- continuing care with adult services

Case study: Repairing a failed transition

Amina, 20

Composite, anonymised case example

Referred by CMHT for community engagement support
Goals: process a past sexual assault; obtain autism assessment
Flashbacks, emotional distress, mistrust of professionals

What had gone wrong:

Previously under CAMHS elsewhere. Discharged to GP at 18 after moving home. Since then: intermittent A&E presentations for self-harm, no onward referral to secondary care.

What the pathway did

- Keyworker helped Amina clarify goals and retrieved previous CAMHS records
- Case presented to psychology panel -- accepted for therapy
- Supported Amina to self-refer for autism assessment under Right to Choose
- Clinical Lead provided stabilisation work while Amina awaited therapy
- Amina secured employment, asked to be discharged -- case formally closed after six months with goals achieved

LEARNING

What we've learned

What works

- Scale matters less than clarity of remit -- small, well-connected teams can have outsized impact
- Relational continuity is the core intervention, not clinical treatment
- Short, regular check-ins (e.g. during exams) balance autonomy with emotional safety
- Embedding the team within adult services builds relationships and credibility with both sides
- Most clients complete transition in 6-12 months with high satisfaction (Dialog+ evaluations)

What didn't work at first

- Late referrals -- CAMHS awareness was low initially, leading to last-minute requests after young people had already turned 18
- Scope creep -- the team initially received referrals for all 18-25s in adult services, rather than those with complex transitions
- Early assumptions about engagement -- many young people wanted light-touch contact, not formal sessions
- Autistic young people's needs were underestimated -- prompted creation of the Autistic Identity group

Implications for practice

What this model demonstrates for those considering implementation elsewhere:

You don't need to create new services

The innovation is coordination and structure -- bridging existing services so young people experience continuity. The team connects services; it doesn't replace them.

Embed the team in adult services

Location within community adult services builds the relationships, credibility and knowledge needed to guide young people confidently into adult care.

A named coordinator is the single most powerful intervention

One person who holds the knowledge, maintains the relationships and ensures responsibility is explicit -- not assumed -- makes the difference.

Co-production is not optional

Young people and experts by experience shaped the visual identity, information materials and evaluation tools. It makes the service feel approachable and relevant.

Forthcoming publication

Bridging the Gap:

Developing the Barnet 18-25 Transition Pathway

RCN Mental Health Practice | Forthcoming September 2026

The full model rationale, design, case examples and implications for nursing practice.

The paper covers: background & rationale . service design . case examples . early QI data . implications for nursing practice

Thank you

Barnet 18-25 Transition Pathway

sarahmcculloch@nhs.net

Key messages

- Every young person deserves a named coordinator and a plan
- Small, well-connected teams can close the implementation gap
- Bridge, not containment -- connect services, don't replace them

Lunch & Networking

Chair Afternoon Address

Alison Blackler
Founder of 2minds – Mind Coach, Tedx Speaker, Author
2minds

NHS Deep Dive

Jim Barwick
Chief Executive Officer
Leeds GP Confederation

Sharon Prince
Senior Responsible Officer
Synergi Leeds Partnership
Leeds ICB/ Leeds & York
Partnerships NHS
Foundation Trust

Our Approach

"At Synergi Leeds, it's not just what we do—it's *how we do it*. Our methodology is rooted in psychologically informed practices, anti-racist principles, and epistemic justice, led by a diverse team that ensures every voice shapes the outcome.

We create spaces for honest, challenging conversations so that the solutions we deliver aren't just more of the same—they're truly different, thoughtful, and impactful."

Whole systems, life course approach

Surfacing the impact of racism and discrimination

Epistemic justice

Psychologically informed

Diverse and inclusive leadership

IN PARTNERSHIP WITH

LEEDS

PART OF THE SYNERGI COLLABORATIVE NETWORK

Synergi-Leeds Partnership Theory of Change

Structural Racism & Wider Determinants

- Structural barriers including racism
- Wider determinants affecting health:
  - Education, employment, criminal justice system, housing, deprivation

Prevention and Community-centred Approaches

- Address wider determinants through **targeted community-centred prevention programmes**
- Ensure the voice of lived experience is at the centre of all programmes

Early Intervention & Improved Access

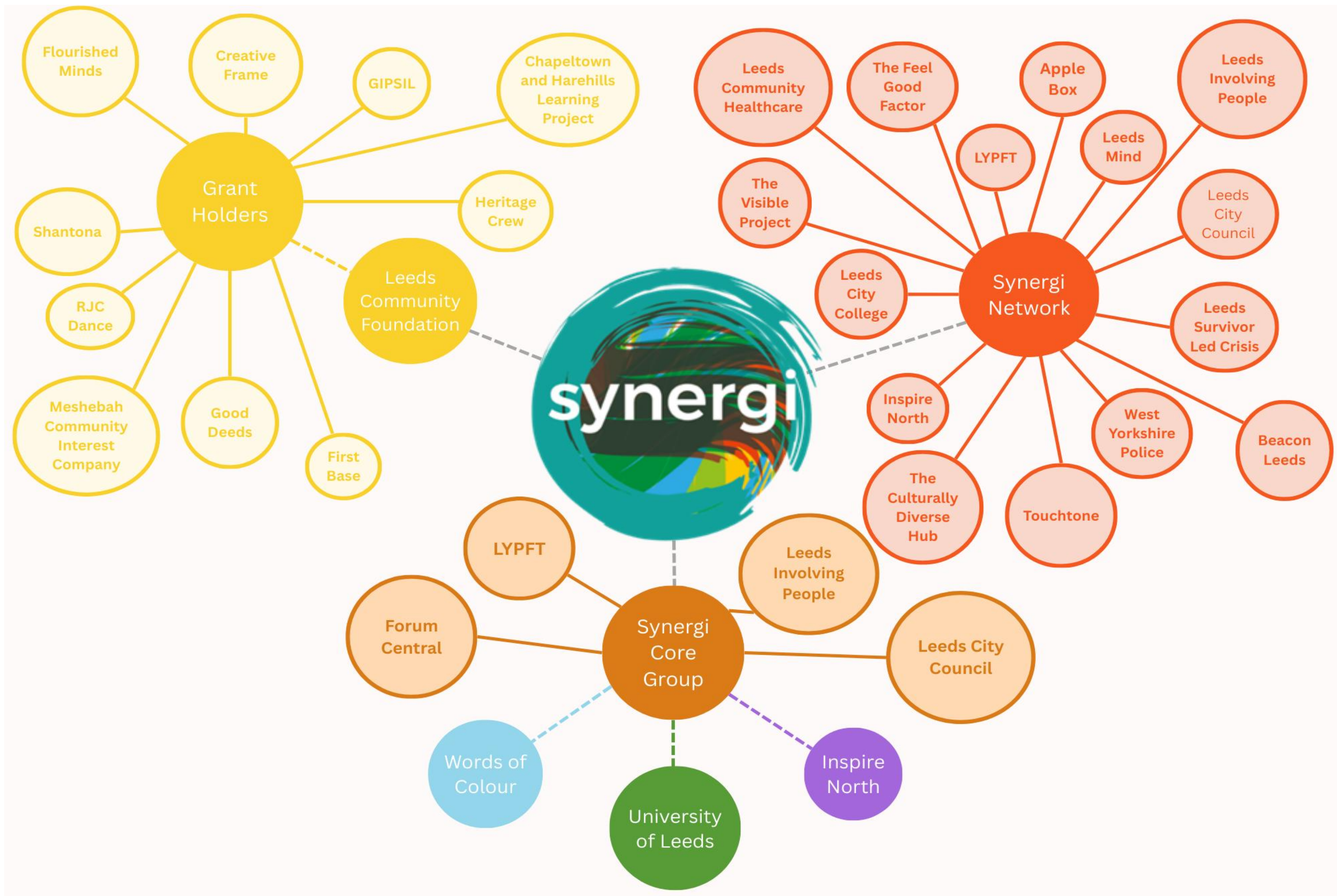
- Improved access to culturally appropriate support
- Reduced chronic stress and exposure to deprivation
- Early intervention rather than crisis-led responses

Better Engagement & Reduced Crisis Interventions

- Re-design services to be equitable, preventative, and community-centred
- Better engagement with mental health services
- Reduced reliance on coercive or crisis interventions

Improved Mental Health Outcomes & Reduced Inequalities

- Improved mental health outcomes for ethnically diverse communities
- Narrowed racial inequalities in mental health



Flourished Minds
Creative Frame
GIPSIL
Chapeltown and Harehills Learning Project
Grant Holders
Heritage Crew
Shantona
RJC Dance
Leeds Community Foundation
Meshebah Community Interest Company
Good Deeds
First Base
Leeds Community Healthcare
The Feel Good Factor
Apple Box
Leeds Involving People
LYPFT
Leeds Mind
The Visible Project
Leeds City Council
Leeds City College
Synergi Network
Leeds Survivor Led Crisis
Inspire North
West Yorkshire Police
Beacon Leeds
The Culturally Diverse Hub
Touchtone
synergi
LYPFT
Leeds Involving People
Forum Central
Synergi Core Group
Leeds City Council
Words of Colour
University of Leeds
Inspire North

Keynote Presentation

Alison Johnson
UK Health Lead
ORCHA

TRANSFORMING CARE WITH TRUSTED PATIENT FACING DIGITAL HEALTH:

Closing the Gap – how digital solutions can support patients between referral and recovery

Alison Johnson
UK Health Lead

ORCHA

The digital opportunity

4.88bn+

people own a smartphone around the world (roughly 60% of the global population) and many already use them to manage their health

---

5m

health app downloads happen every single day without any clinical guidance

93%

of clinicians believe digital tools can **improve patient outcomes**

65%

of people aged 65 years and above **want to engage with Digital Health**

Digital health is critical to solving the healthcare crisis

Digital Health drives demand and capacity

Demand Drivers

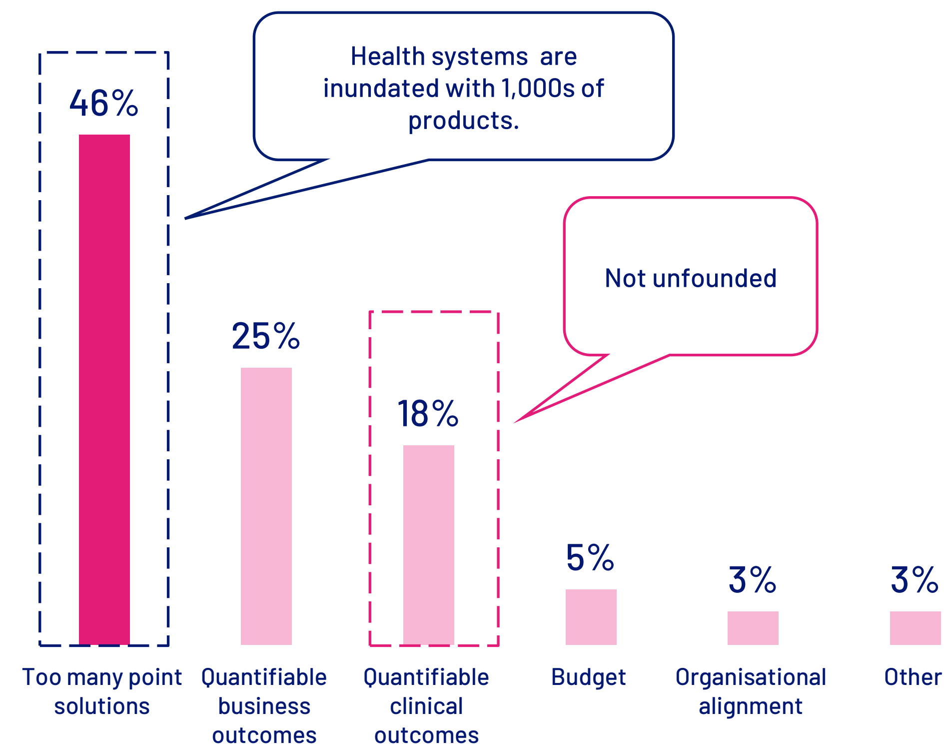
- Self care and self management approach to healthcare
- Enabling access while waiting
- Support between therapy
- Preventing crisis

Capacity Drivers

- Automation
- Admin support
- Decision support

...but there are barriers

Despite the opportunities in digital health, persistent challenges and concerns about data privacy, clinical evidence, interoperability and compliance with regulations exist as a main barrier to healthcare systems



Barriers to a Successful Digital Health Strategy

ORCHA

Without trusted curation, digital health adds risk to a system that can't absorb more

WHO ARE WE

The global leader in AI and digital health assessment & distribution

38,000+
Digital health technologies reviewed

9,000+
Products assessed

625k+
Global professional network

120k+
Patient referrals made

Trusted by **90+ health systems** across **20+ countries,** including...

ORCHA

FACT

Only

20%

of the 350,000 Digital Health technologies available meet quality thresholds.

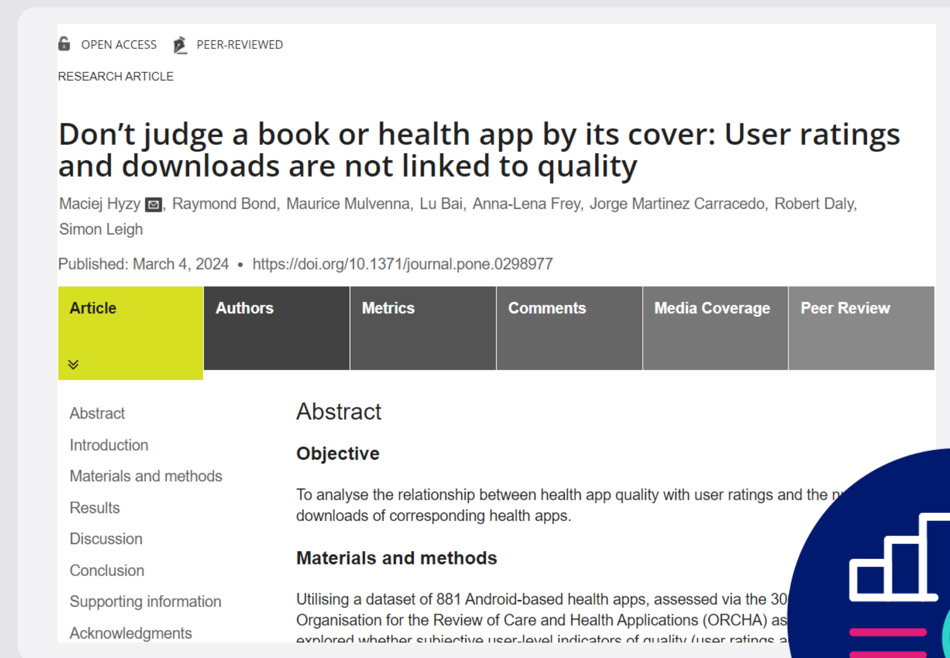
Condition	Percentage achieving **65% ORCHA score** or more
Mental Health (All)	32%
Addiction	52%
Cognitive Behavioural Therapy	45%
Self Harm Prevention	44%
Panic Attack	42%
Stress and Anxiety	38%
Insomnia	32%
Eating Disorders	30%
Suicide Prevention	29%
Bullying	29%
Depression	28%
Schizophrenia	26%
Bipolar	20%
Borderline Personality Disorder	18%
Obsessive Compulsive Disorder	14%

Only **32%** of mental health apps that ORCHA has reviewed meet our quality thresholds

DO USER RATINGS HELP HCP know which are safe?

ORCHA

Recent Research in March 2024 showed that user ratings and download numbers on the App Stores are NOT good measures of a health app's quality and that patients need help in knowing more about digital health and by creating trusted lists of good apps.



OPEN ACCESS PEER-REVIEWED

RESEARCH ARTICLE

Don't judge a book or health app by its cover: User ratings and downloads are not linked to quality

Maciej Hyzy, Raymond Bond, Maurice Mulvenna, Lu Bai, Anna-Lena Frey, Jorge Martinez Carracedo, Robert Daly, Simon Leigh

Published: March 4, 2024 • https://doi.org/10.1371/journal.pone.0298977

Article	Authors	Metrics	Comments	Media Coverage	Peer Review

Abstract
Introduction
Materials and methods
Results
Discussion
Conclusion
Supporting information
Acknowledgements

Abstract

Objective

To analyse the relationship between health app quality with user ratings and the n
downloads of corresponding health apps.

Materials and methods

Utilising a dataset of 881 Android-based health apps, assessed via the 30
Organisation for the Review of Care and Health Applications (ORCHA) as

THE PROBLEM

ORCHA

AI in mental health is growing and governance hasn't kept pace

37%

HAVE ALREADY USED AN AI CHATBOT TO SUPPORT THEIR MENTAL HEALTH

Mental Health UK

4 in 10

UK ADULTS WOULD USE AI FOR MENTAL HEALTH SUPPORT

Bournemouth University, 2026

Hallucination & overconfidence

Bias & inequity

Lack of accountability

Governance gaps

ORCHA

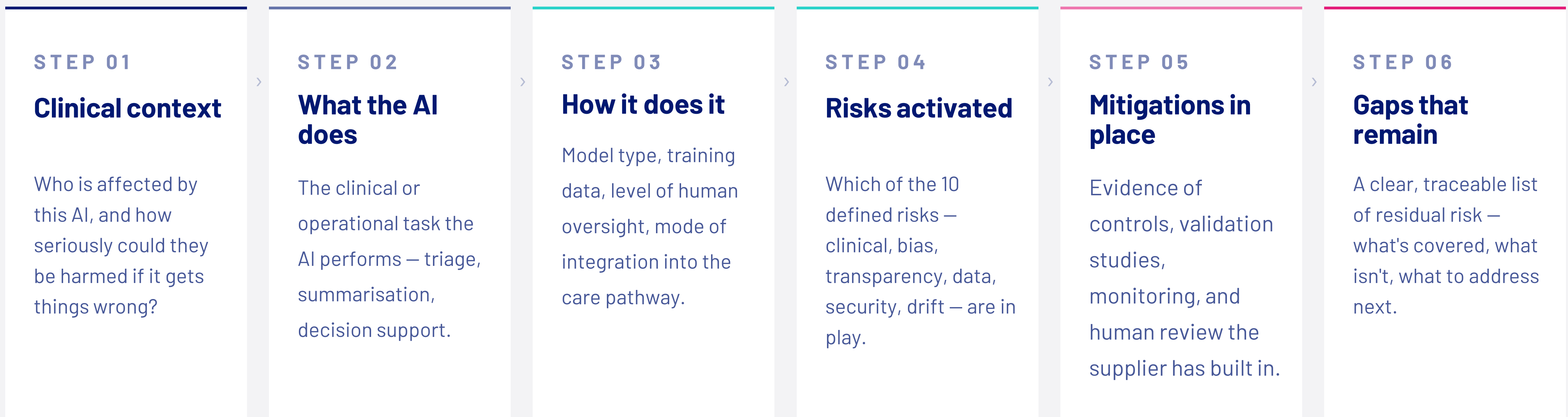
A research initiative led by clinical, technical, governance and research experts

WHAT IS IT

A six-step methodology from clinical context to gap analysis

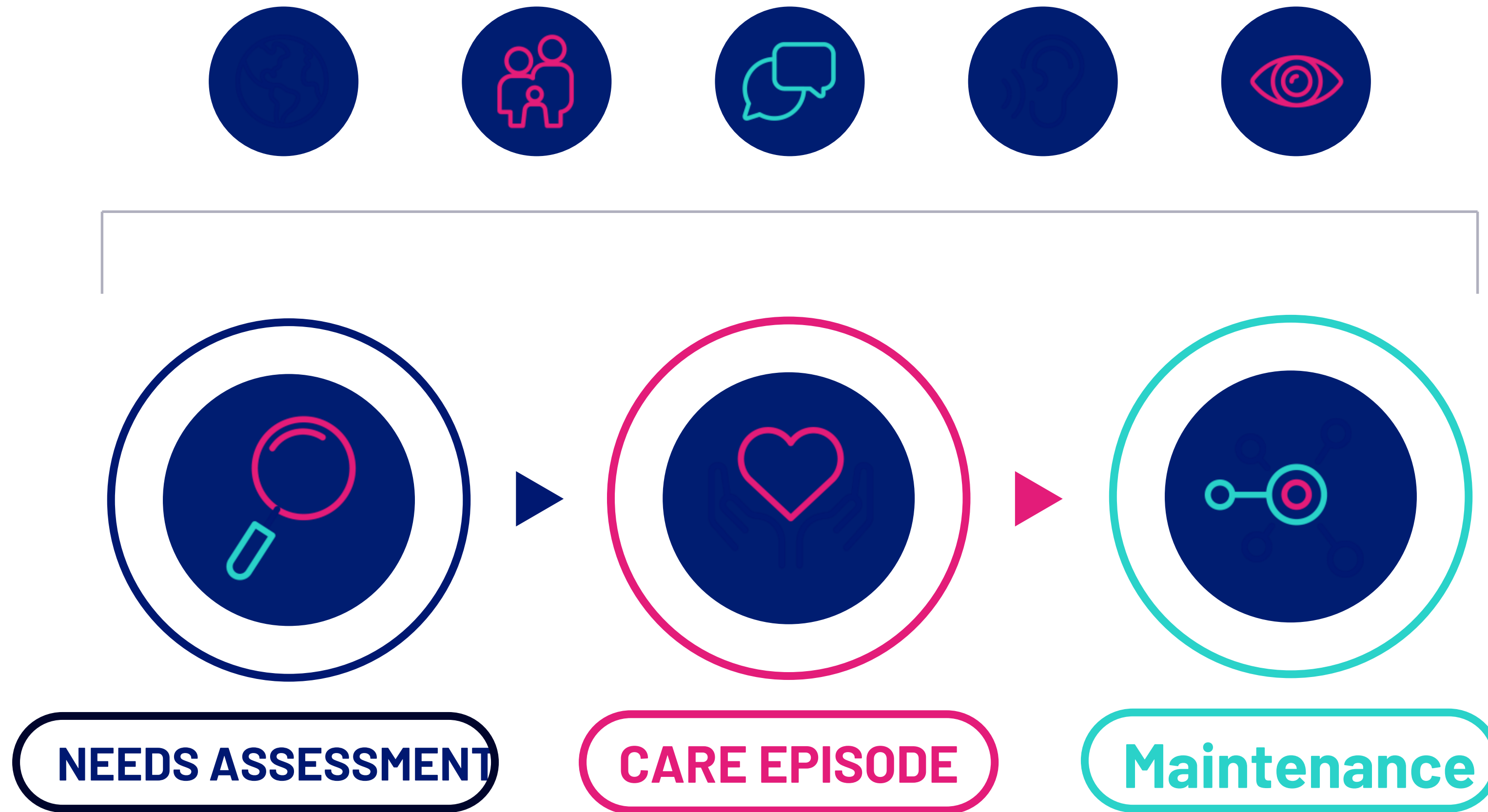
Suppliers complete a structured questionnaire.

The output is a detailed risk profile report — not a pass-or-fail verdict.



THE MYTH –
THERE IS ONE BEST TECHNOLOGY

ORCHA



ORCHA

A system to deploy technologies

WHAT PATIENTS FACE TODAY

The scale of the gap

Mental health demand is rising. Waits are deepening. Pressure is spilling into urgent care.

Sources: NHS England MHSDS · NHS Talking Therapies quarterly · NHS Digital MHCYP · Royal College of Psychiatrists

From Passive Waiting to Active Preparation

ORCHA

- Digital Health technologies help NHS teams turn waiting time into preparation time for patients whilst they wait– from outpatients – through treatment – and for use on discharge.
- High quality, safe, patient facing technologies empower patients with personalised digital tools to 'wait well' and get treatment-ready.
- By greater self-management and optimisation, a reduction in cancellations and boost in efficiency, it accelerates elective recovery, and waiting list management.

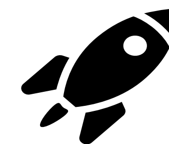
Maximise Productivity

Engage patients early with ongoing communication and targeted digital support to reduce wasted capacity.

Empower Patients

Deliver personalised self-care tools aligned to elective pathways to boost treatment readiness and confidence.

Boost Operational Efficiency



Minimise cancellations and DNAs, shorten hospital stays, and free up bed days, driving measurable ROI.

CAREQ

HOW TO UNLOCK THE POWER OF DIGITAL HEALTH

01

Empowering patients with targeted Digital Support Packages

02

Provide improved healthcare services to more people at low cost

03

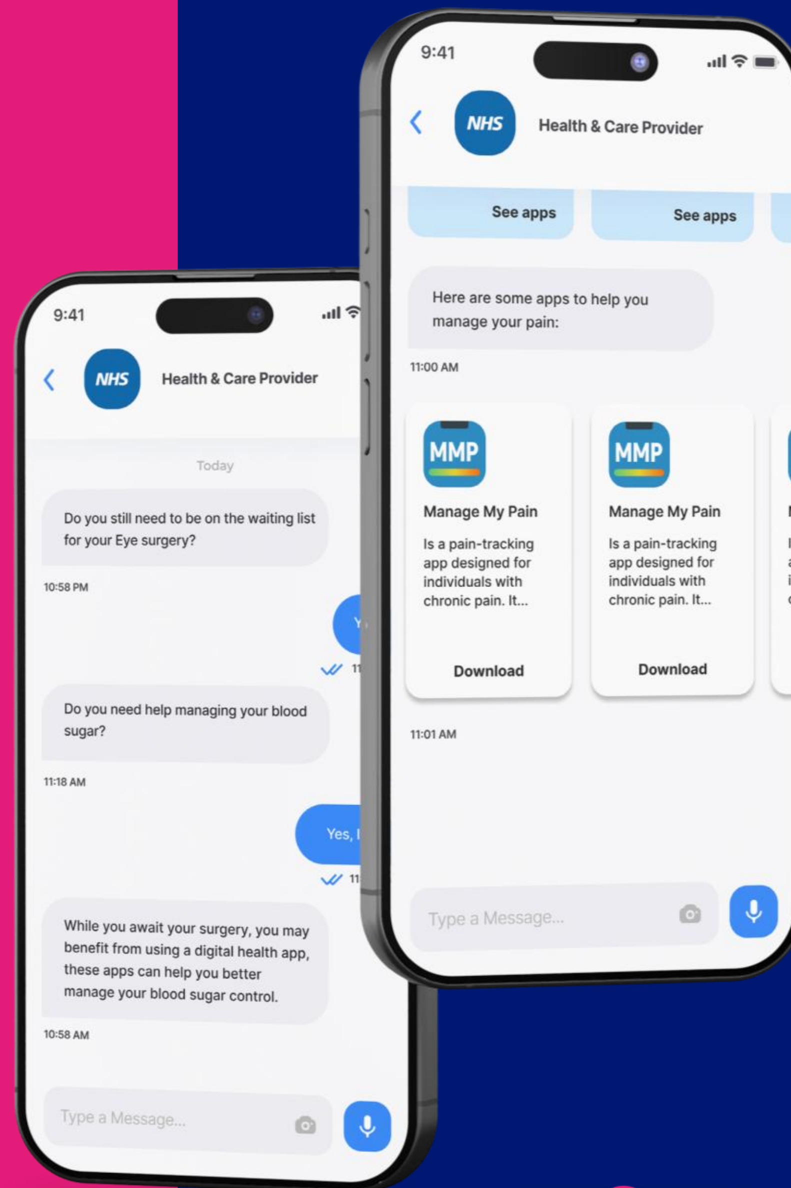
Supercharge self-care and self-management strategies with high-quality digital health interventions

04

Target high-need and high-impact patient cohorts and proactively manage co-morbidities and chronic conditions

05

Reducing strain and improving system efficiencies

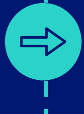


ORCHA

CAREQ

Personalised, Curated Bundles of Apps Support:

Mental Health and Crisis Support


Pre-Operative Preparation

Long-Term Condition (LTC) Management

Pain Management

Post-operative recovery and rehab

Continuity of Care

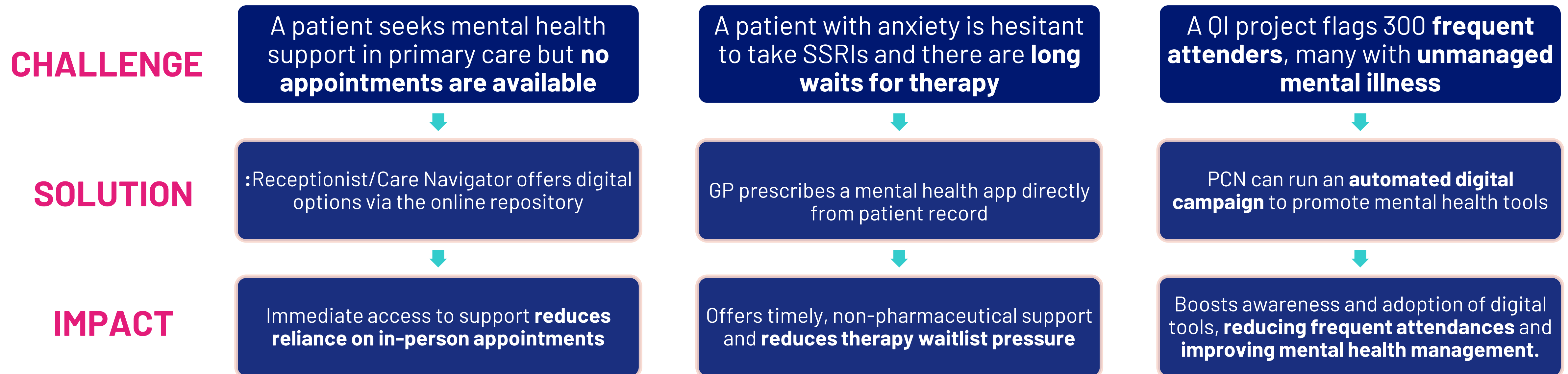
Support sustained lifestyle improvements

Self guided exercise

ORCHA

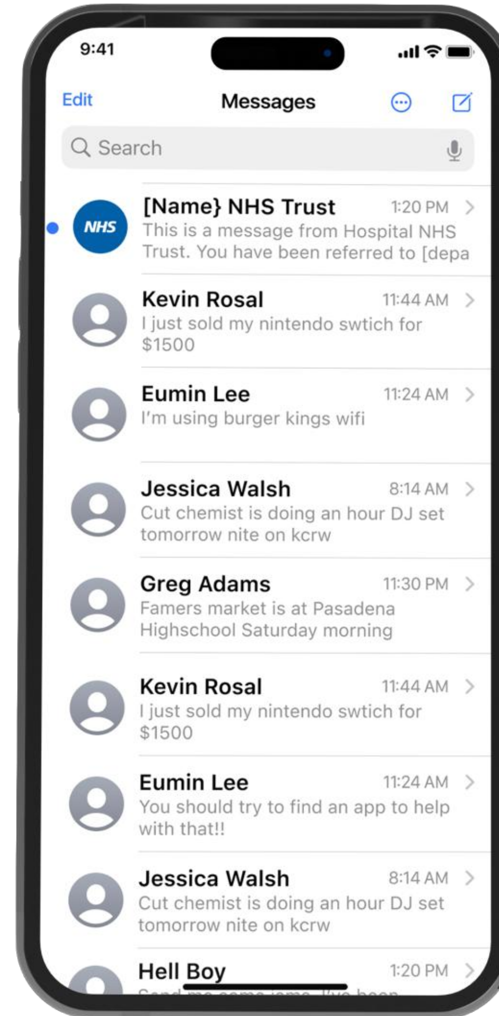
CAREQ

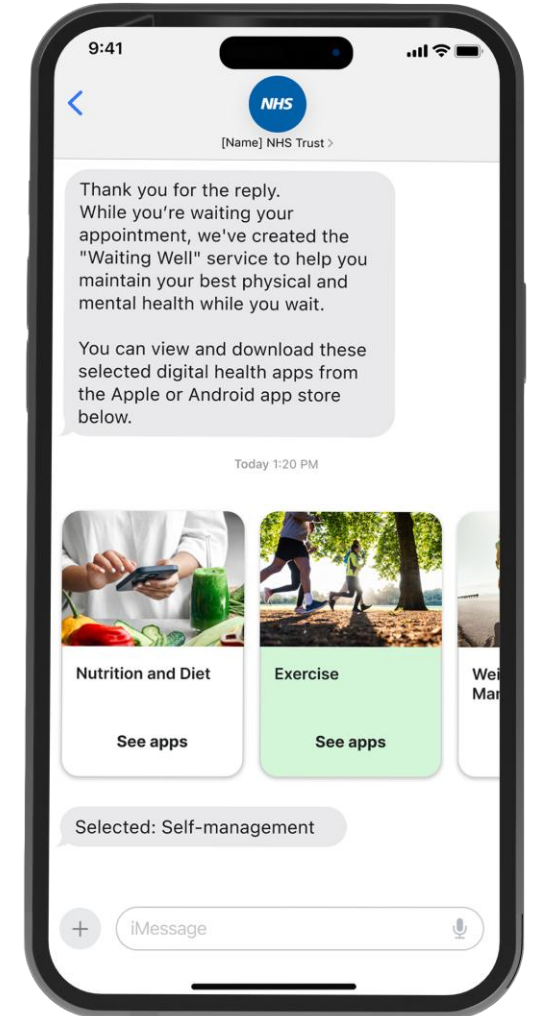
EXAMPLE: MENTAL HEALTH



PATIENTS RECEIVE TARGETED AND BESPOKE MESSAGING

Using optimised direct patient communication channels, and ORCHA's personalised pathway tool, patients receive a bespoke offer to a targeted solution to support their needs





ORCHA

Some examples of use cases

MIND, Mental Health Charity

MIND has a library, powered by ORCHA where the digital solutions featured have gone through an enhanced layer of assessment covering enhanced professional assurance, data privacy and technical security.
The library averages over 7000 visits per month, and 1500 downloads per month.

Health and Social Care, NI

Included as part of the MH strategy for the population of NI with focus on Adults, CYP and Ageing population. Embedded into Steps to Wellness service as part of steps 1-3. All patients receive bundle of Apps at point of acceptance of referral.

Hywel Dda Health Board, Wales

Bundle of Apps for crisis and suicide prevention used by the Mental Health Single Point of Contact (SPOC) team. Averaging 68 recommendations per month to patients with over 628 recommendations since service commenced 12 months ago. Use alongside SilverCloud.

Papyrus (National Charity for Suicide Prevention in Young People)

Papyrus use the Apps as part of their 24/7 telephone support, and average 150 downloads per month.

TAKEAWAYS

Three principles for safer, more effective digital mental health in the NHS.

01 ASSURE

Don't trust app store ratings

- Apply structured assurance to every digital tool you offer patients
- DTAC, baseline review and AI risk assessment — not user stars
- If you can't see the evidence, neither can your patients

02 CURATE

There is no single best technology

- Match the tool to the patient need, not the other way around
- Build pathway-aligned bundles across needs assessment, care episode and maintenance
- Curation is a clinical decision, not a procurement one

03 MEASURE

Track outcomes, not downloads

- Activity metrics tell you nothing about clinical impact
- Build governance and outcome reporting in from day one
- Models that work: Health & Social Care NI, Hywel Dda, MIND

Happy to continue the conversation — find me after the session.

Alison Johnson, UK Health Lead | ORCHA

THANK YOU

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@orcha

DIGITAL HEATH. **UNLOCKED**

NHS Skill Exchange

Dr **Helen Garr**
Medical Director
NHS Practitioner Health

OWN OXYGEN MASK FIRST

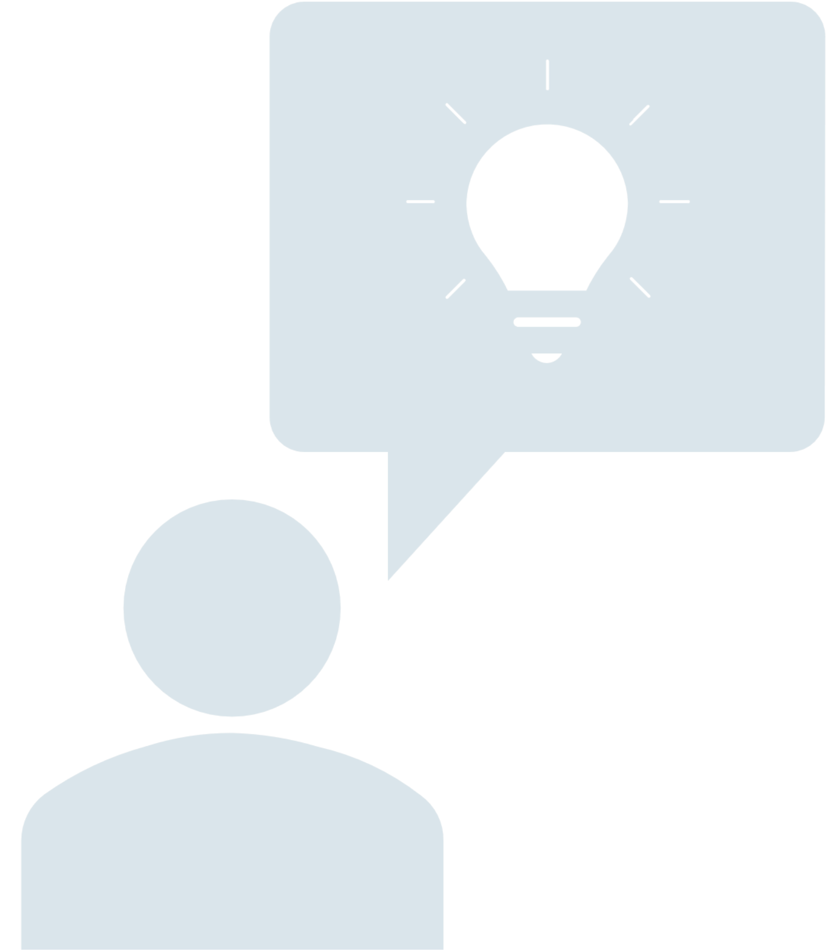
Dr Helen Garr

Medical Director

NHS Practitiner Helath

Practitioner Health

When you think about the last 6 months in work — what has drained you most?”



BURNOUT CLIFF

- CARELESS MISTAKES
- CAN'T STOP THINKING ABOUT WORK / LACK OF INTEREST
- WORKING LONGER
- POOR SLEEP/TOO MUCH SLEEP
- EXHAUSTED
- FREQUENT ILLNESS
- IRRITABILITY OR TEARFULNESS
- CYNICISM
- BAD MEDICINE - UNHEALTHY COPING STRATEGIES
- POOR MOTIVATION
- BRAIN FOG
- LOSS OF CONFIDENCE

Name it to tame it

LOOKING BACK THE SIGNS WERE THERE

(Green)

DEFINITION

- Optimal functioning
- Adaptive growth
- Wellness

FEATURES

- At one's best
- Well trained and prepared
- In control
- Physically, mentally, and spiritually fit
- Mission focused
- Motivated
- Calm and steady
- Behaving ethically
- Having fun

(Yellow)

DEFINITION

- Mild and transient distress or loss of functioning
- Always goes away
- Low risk for illness

CAUSES

- Any Stressor

FEATURES

- Feeling irritable, anxious, or down
- Loss of motivation
- Loss of focus
- Difficulty sleeping
- Muscle tension or other physical changes
- Not having fun

(Orange)

DEFINITION

- More severe and persistent distress or loss of function
- Leaves a "scar"
- Higher risk for illness

CAUSES

- Life Threat
- Loss
- Inner Conflict
- Wear and Tear

FEATURES

- Loss of control
- Panic, rage, or depressed mood
- Substance Abuse
- Not feeling like normal self
- Excessive guilt, shame, or blame
- Diminished sense of purpose, meaning, or hope in the future

(Red)

DEFINITION

- Unhealed stress injury causing life impairment
- Clinical mental disorder

TYPES

- PTSD
- Depression
- Anxiety
- Substance Dependence

FEATURES

- Symptoms persist and worsen over time
- Sever distress, social or occupational impairment

Unit Leader

Individual, Peer, Family

Caregiver

Wrap Plan

What things do I enjoy doing?

Things I need to AVOID to stay well

What are my non negotiables?

Is there anything I need others to do?

What steps can I take to stay well at work ?

What things make me feel good when I have achieved them?

Leaders – how can we get the best from you?

Leaders - what would we do that would bring out the worst in you?

What are my warning signs when I am not at my best ?

What do I need to do less often?

Who am I when I am at my best?

What things do I know help but I am not doing right now?

What are my daily needs to keep well?

Wellness Action Plan

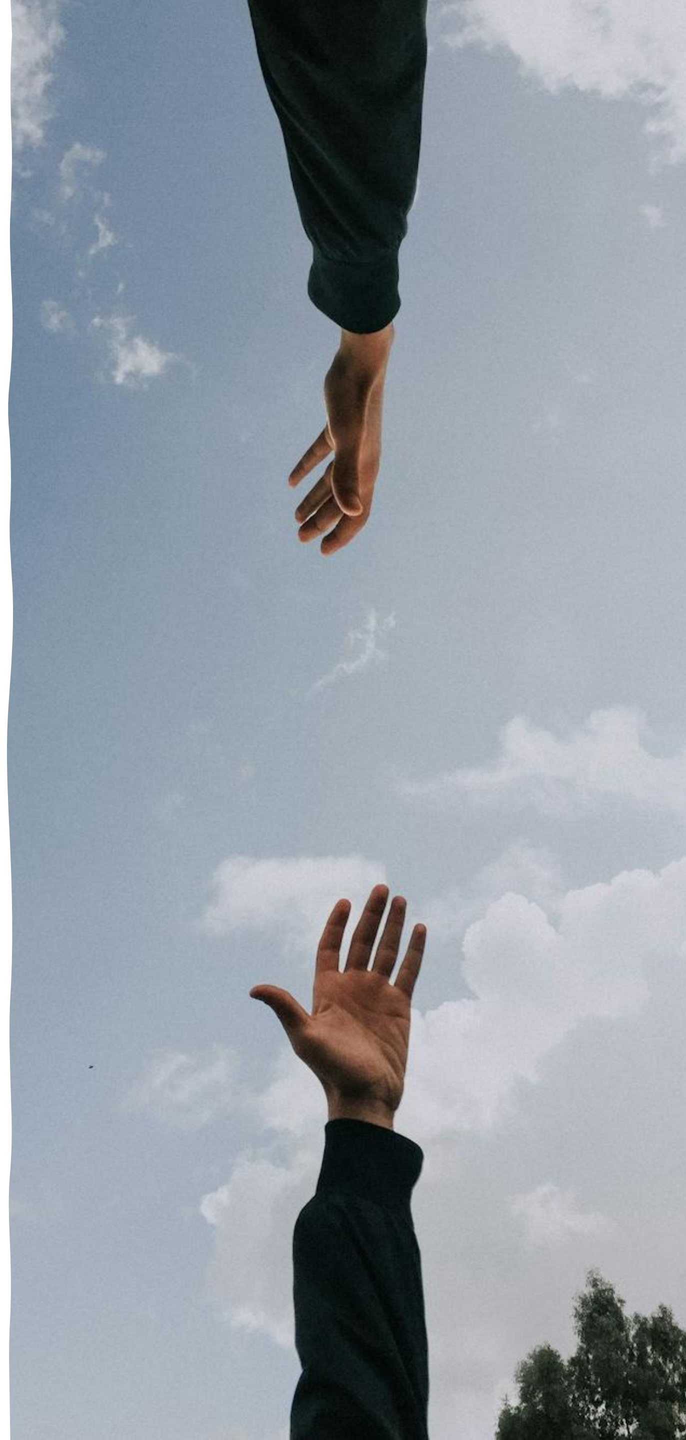
Guide for people working in a workplace

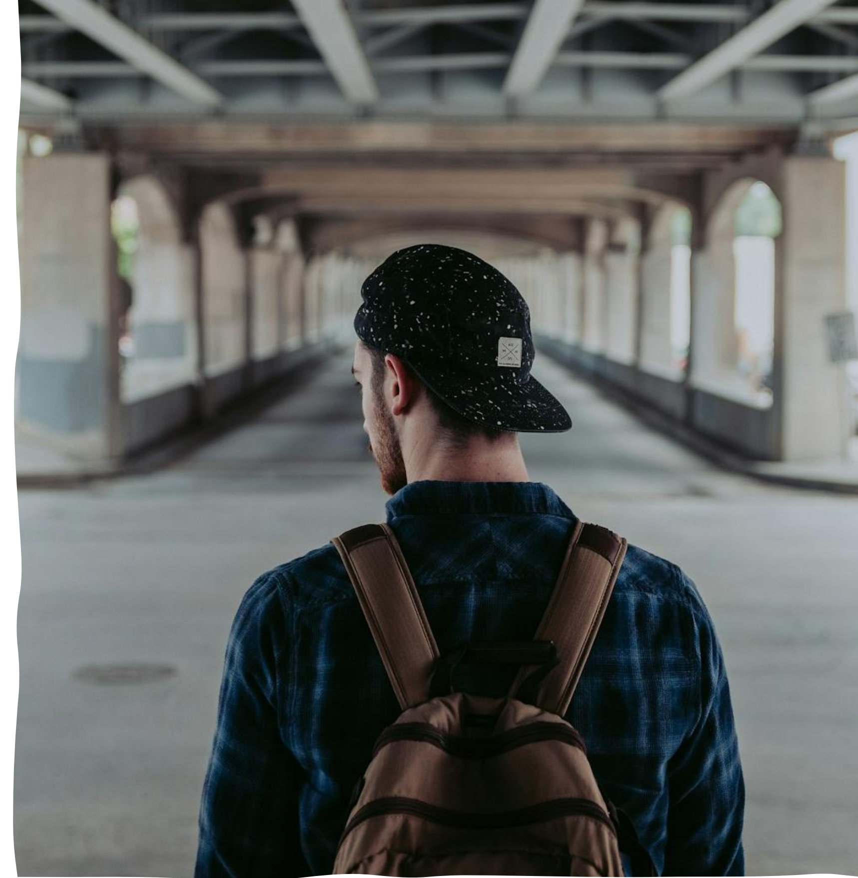
If your team copied your behaviour at your worst – what culture would you create?

What about at your best?

Social bonds and a sense of belonging is the top driver for wellbeing at work

REACH IN.
ASK TWICE.
ASK OVER TIME.





Put your own oxygen mask on first

Practitioner Health

NHS Practitioner Health

Supporting the health of health professionals

Dr Helen Garr
Medical Director

www.practitionerhealth.nhs.uk

The tragic catalyst behind NHS Practitioner Health

What is NHS Practitioner Health?

Free confidential service mental health and addiction treatment service for health and care professionals in England & Scotland who face a barrier to seeking care due to their role

WHY- is it so hard to seek help?

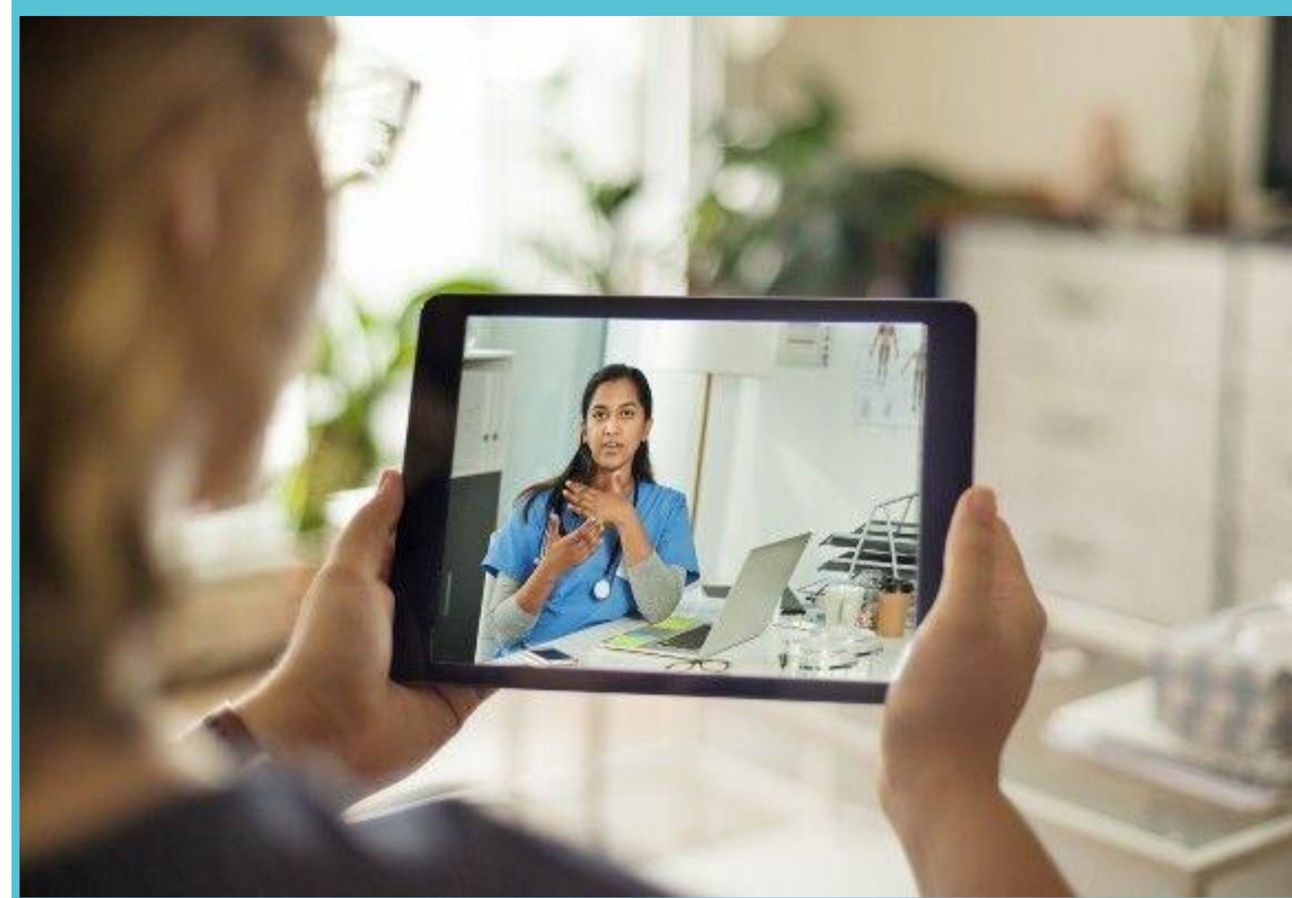
Shame
Stigma
Confidentiality
Culture
Guilt

NHS Practitioner Health

What do we offer?

Assessment followed by:

- Case Management
- Prescribing
- Therapy - individual and groups
- In-patient rehab and detox
- Liaison with regulators, OH and employers
- Letters/reports
- Therapeutic testing
- Onward referral where necessary



Inpatient rehabilitation

WHAT MAKES US UNIQUE?

- Confidentiality
- Tailored care
- Judgement free environment
- MOUs

OUTCOMES: 24/2025

Anxiety

12.76 → 4.74

Average GAD7 score of patients with anxiety reduced by 8.01 between registration and completion of treatment.

Depression

13.25 → 5.02

Average PHQ9 score of patients with depression reduced by 8.23 between registration and completion of treatment.

Addiction

90% of people being treated for alcohol or drug misuse are abstinent or are maintaining controlled drinking

Return to Work

11% of patients accessing Practitioner Health are not in work at time of registration.

IN THE LAST YEAR, WE RETURNED MORE THAN 800 PEOPLE TO THE WORKFORCE FOLLOWING TREATMENT.

TRANSFORMING LIVES

HEALTHCARE PROFESSIONALS CREDIT PH WITH NOT ONLY CHANGING THEIR LIVES BUT WITH SAVING THEM.

SEVERAL BELIEVE THEY WOULD NOT BE ALIVE HAD THEY NOT FOUND THE SERVICE.

"Without PH I think I would have either hung up my stethoscope or would not be in this world"

"Incredibly valuable service. I would probably not be working in Medicine if it wasn't for my contact with NHS PH"

"I have already recommended the service to several friends and colleagues. This is a truly exceptional service that provided me with a quick and effective level of care. Thank you so, so much for all the help you have provided me with"

"THIS SERVICE SAVED MY LIFE"

"I feel this service is essential as it provides a truly bespoke intervention for health professionals who can have complex needs and who face specific barriers and difficulties in accessing appropriate care"

Thank you for everything. I am grateful for the support I have received. It has given me the strength to carry on. The service saved my life"

"[PH] has saved my life and my career. I am incredibly grateful"

"This service helped me so much. Having something tailored to and to include the understanding of your role and the impact it can have on you was invaluable. The benefits have stayed with me. Thank you for being there for me when I needed you."

Practitioner Health

Understanding and managing your emotions:

A guide and toolkit for Health and Care Professionals by NHS Practitioner Health

DOWNLOAD HERE

Suicide Prevention & Postvention Navigation Guide

Touched by Suicide

A Guide for Health and Care Professionals: Preventing, Responding, and Recovering

Worried About Yourself?

Signs to look out for, how to start a conversation, and where to get help through Practitioner Health, OH, or local crisis services.

Worried About a Colleague?

Signs to look out for, how to start a conversation, and where to get help through Practitioner Health, OH, or local crisis services.

If a Patient Dies by Suicide

Steps to take, support for clinicians, legal and clinical considerations, and how to access emotional support and reflective practice.

If a Colleague Dies by Suicide

What to do immediately, how to support your team, guidance for compassionate communication, and accessing psychological support.

DOWNLOAD HERE

Thank you for all that you do

Practitioner Health

NHS PRACTITIONER HEALTH

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EMILY

My name is Emily.

I am a 46 year old GP in Yorkshire and a mother of three children.

I am also recovering from addiction to alcohol and cocaine.

November 2021

I had reached a point of desperation.

I found myself unable to stop drinking and using drugs

I was unable to cope with life.

How did this happen?

In my teens and twenties I liked to drink. Whilst there were a lot of hangovers, I always turned up for my commitments, and could stop when required.

In my thirties I had three pregnancies and drank very little.

In my 40s, things started to change.

I didn't see it at the time, but with the benefit of hindsight, I had many symptoms of burnout as a consequence of juggling three young children, increasing pressure of work and a failing marriage.

I began to drink heavily at weekends and was introduced to cocaine, which seemed to offer instant escape and relaxation

My marriage had ended, work load was overwhelming, I no longer felt I wanted to be a doctor.

I was desperate, isolated, and deeply ashamed of being a drug addict.

My behaviour was erratic and I was becoming argumentative and aggressive with friends and family, who mostly knew nothing of my shameful secret drug use.

I was acutely aware that I needed to stop and tried unsuccessfully on multiple occasions.

I went to therapy but was not honest or stable enough to do any meaningful work.

I considered Alcoholics Anonymous meetings but was terrified of meeting my own patients there.

The same applied to the local drug and alcohol services

I felt unable to talk to my own GP due to my shame and fear of the implications for my career and social situation, were my problems to become known among GPs in my community.

One night in late 2021, in crisis, and searching online for help for doctors with addiction, I found PH.

It’s difficult to recapture and explain how terrified I was at that time.

Taking the step of referring myself felt like leaping off a cliff. For the very first time I was honest about the extent of my problems and had no idea whether this honesty would end my career or jeopardise my custody of my children.

I felt hopeless and a failure, and knew I couldn’t cope alone any longer.

I am so thankful you were there to catch me.

The day after I self referred, I received a call from PH and my first assessment was organised.

From the very first contact, I was met with phenomenal compassion, free of judgment, and perhaps most importantly, reassurance that help was available, and that I was not alone in my experience.

The doctor I spoke to helped me so much; her kindness, expertise and experience with others who had been in my position gave me the vital confidence that there might be a way out of the seemingly hopeless black hole I was in.

She let me know that PH would be there to support me.

I felt safe enough to put my trust in her guidance.

I was offered six weeks of residential detox and rehabilitation. This was a shock. I did not personally know anyone, let alone another doctor who had been to rehab.

Leaving the children for that long seemed impossibly painful. And what if anyone at work discovered?

My PH doctor helped me to see that these weeks would offer me the best chance to recover. At that point in time I was barely capable of any decisions, and I am grateful that she could see the big picture which eluded me.

With encouragement I accepted and went to Castle Craig in Scotland and have been clean and sober since my arrival there almost 18 months ago.

PH continued to help me after discharge from treatment, when the hard work really began in earnest.

My PH doctor guided me through self-referral to the GMC, and supported me through the subsequent fitness to practice investigation.

Her familiarity with this process and understanding of the inevitable stress involved was reassuring and invaluable.

I cannot imagine that any other service would have been able to offer me the same care in that situation.

Group Therapy with the Anchor Group offered by PH has also been a critical part of my recovery.

The facilitator, Fernando, is a warm, insightful, compassionate therapist and I would strongly recommend his groups.

Validation of my need for time away from work enabled me to commit to the process of recovery.

Alongside support from PH, I attend meetings of Cocaine Anonymous and work a 12 step program, engage with the British Doctors and Dentists Group, and have a regular program of yoga, cold water swimming and walking.

After a year off work, and a positive outcome from my GMC investigation, my PH doctor helped me navigate a phased return to work.

She has continued to be alert to the risks of work stress as a trigger for relapse, and supports me in forming realistic goals for my planned next steps, sometimes seeing risks on the horizon before I do!

It’s hard to know where I would be without your service and the kindness, support and expertise you have offered.

I am so deeply grateful to have had access to your service and to have been so well supported by you at my darkest hour.

Without you, it might look very different.

I am present for my children, family and friends, working and contributing, and slowly rebuilding confidence in myself.

In case there are any doubts- Practitioner Health really do save and change lives.

Because of Practitioner Health……….

Today I am alive.

Workshop

Ruth Jacobs
Registered Mental Health Nurse Educator
In partnership with UHSx

Gurnak Singh Dosanjh
Deputy CCIO | Digital Healthcare Consultant | CSO | ICB Clinical Lead
NHS Leicester, Leicestershire and Rutland