NHS
Leicestershire Partnership
NHS Trust

Strategic Plan for the Psychological Professions

2025/2030

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1.0 Executive summary

There is considerable evidence of the value of psychological approaches to healthcare. The psychological professions play a significant role in the delivery and implementation of such psychological approaches, within both mental and physical health services. An integrated structure has recently been introduced for this group of psychologists, psychological therapists, and psychological practitioners, both nationally and locally.

This Strategic Plan (2025/30) has been co-produced to describe and provide direction to the work of the psychological professions locally. The content and philosophy have been informed by key strategies and policies, within the current national and local healthcare context. The Plan is closely aligned to THRIVE, the Group Strategy for Leicestershire Partnership and Northamptonshire Healthcare Associate University Group (2025/30), in seeking to offer effective, responsive, innovative, patient centred services whilst promoting a staff culture of inclusivity and psychological safety. In pursuing these aims, the psychological professions in LPT are working ever more closely with their peers in Northamptonshire Healthcare NHS Foundation Trust (NHFT), as part of a regional Group model.

The Plan describes three strategic objectives for the work of psychological professions in LPT over the next five years, which are embedded in the foundational values and principles that guide these professions:

To enhance psychological practice, by fostering psychological mindedness and greater access to shared psychological approaches across the organisation and wider system

To develop psychologically informed environments and staff support, by embedding a culture of learning and reflection that enhances and supports psychological practice.

To strengthen and diversify the psychological professions workforce, by supporting the integration, development, and leadership of this newly established group

There has been an enormous amount of work in each of these areas during the past three years in LPT, during the period of the previous Psychological Professions Strategic Plan (2022/25). The key achievements and some examples of innovative practice from across the psychological professions are included in the Appendices.

The next stage is to use the three strategic objectives to co-design clear, tangible goals, shared between the psychological professions in LPT. Ten workstreams have been created to take forward this work, which are described in the Conclusion. The intention is that these workstreams will support delivery of the Strategic Plan across the Leicester, Leicestershire and Rutland (LLR) health and social care system during the next five years.

2.0 Introduction

Psychological approaches to healthcare can transform lives and communities. They have been demonstrated to be effective in preventing and treating mental health conditions, empowering people to make positive choices about their own health and supporting people living with mental and physical health conditions and neurodiversity. They are also a fundamental part of effective support structures for healthcare staff, fostering psychologically informed environments and psychological safety, which enable a strong clinical culture and are associated with high team performance.

The psychological professions play a significant role in the delivery and implementation of psychological approaches within healthcare. They comprise a broad range of Applied Psychologists, Psychological Therapists, Clinical Associates, Psychological Practitioners and Assistant Positions. There are currently 21 roles that are formally identified within this group nationally. The requirements for training, and the scope of practice of these roles varies considerably. The Psychological Professions Network (PPN), commissioned by NHS England, provides a joined-up voice for the psychological professions nationally in workforce planning and development, and in the support of excellence in practice. Development of this group has been one of the key delivery areas for NHS England.

Leicestershire Partnership NHS Trust (LPT) started to introduce an integrated structure for the psychological professions in 2020, reflecting the national strategy of bringing together the different roles as a centrally commissioned group. This has involved establishing a leadership structure that is positioned within the Medical Directorate, of a Chief Psychological Professions Officer across LPT and the wider LLR healthcare system, together with Psychological Professions Directorate Lead posts within two of the Clinical Directorates. These roles provide clinical and professional leadership to this group.

The LPT Psychological Professions Strategic Plan 2022/25 was created to describe and provide direction to the work of psychological professions locally. The three overarching aims defined in the Plan were to enhance access to psychological therapy and practice, develop the psychological professions workforce and support the culture of psychological safety across LPT. A considerable amount has been achieved in each of these areas in the past three years. This has included the introduction of new clinical pathways based on psychological frameworks, the development of integrated structures across services to enhance continuity of care for service users, the expansion of training places for both psychological professions roles and particular psychological interventions, and the provision of new support structures for staff. A summary of the key achievements is included in Appendix 1, and examples of innovative practice in Appendix 2. There are links to these appendices within the sections on Principles and Strategic Objectives, to provide more detail about implementation.

This new Strategic Plan (2025/30) replaces the previous Plan (2022/25) now that it has reached the end of its term, but broadly seeks to continue the same trajectory. The clearly formulated principles, commitments and strategic objectives will guide and inform the work of the psychological professions for the next five years. The Plan is nevertheless intended to be a “living document” which can be extended and revised with the introduction of new national and local directives, and further developments in psychological knowledge and understanding.

The three strategic objectives that represent the central body of this Plan (2025/30) were drafted through a process of co-production over an extended period. There have been discussions in team

meetings and on directorate away days with the psychological professions across the Trust, as well as with clinicians from different professional backgrounds who have completed additional training in psychological models and approaches. This process has allowed the strategic priorities of different psychological services to be understood and incorporated into the detail of the Plan. There have also been meetings with wider staff groups, service users and carers, and other interested parties to gain their perspectives and ensure the Plan has relevance and resonance to the wider community and other health and social care providers.

The content and philosophy of the Plan has also been informed by key local and national strategies and plans, including the NHS Long Term Plan; Mental Health Implementation Plan (2019); Psychological Professions Vision for England (2021); Psychological Professions Workforce Plan for England (2021). It is closely aligned to the recently introduced Group Strategy of Leicestershire Partnership and Northamptonshire Healthcare Associate University Group (2025/30), in seeking to promote effective, responsive, innovative, patient centred services as well as a staff culture of inclusivity and psychological safety. It recognises the current risks to the strategic objectives of the Trust, and the need for timely access to services that offer high quality standards of care, strong outcomes and financial stability. It attends to the objectives of the Clinical Strategy and Five-Year Plan of the LLR Integrated Care Board (ICB), by focusing on ways to develop partnerships with local communities that acknowledge the social determinants of health difficulties, and aim to address health inequalities and improve population health. It also acknowledges the wider context of the NHS and the need for productivity and efficiency, by considering the multiple factors within these current drivers of healthcare. The expectation is that the Plan will align with the upcoming NHS 10-Year Health Plan, and it promotes the three key shifts that have been described as the core themes: Moving care closer to communities; Harnessing technology to improve care; Prioritising prevention over treatment.

3.0 The Psychological Professions in LPT

The Psychological Professions in LPT have seen significant development in recent years, through the introduction of new roles, an increase in training places and recruitment to vacancies. These changes reflect the national picture of adaptation and expansion within the psychological professions. This workforce growth was cited in the Mental Health Implementation Plan (2019) as the ambitious roadmap to improve access to evidence-based psychological interventions, and has enabled the implementation of specific national work programmes such as the ‘roll out’ of Mental Health Support Teams for schools. This development may be understood as part of the work to establish parity of esteem for mental health alongside physical health services, an ambition that was established in law by the Health and Social Care Act (2012).

The psychological professions work into a vast array of services across LPT, but are hosted primarily within two clinical directorates, the Mental Health Directorate (DMH) and Families, Young People, Children’s, Learning Disability and Autism Directorate (FYPCLDA). As well as working into clinical services in LPT, there are several psychological professionals employed by LPT who work into physical health services within the University Hospitals of Leicester NHS Trust (UHL). They are primarily hosted within the Medical Psychology, Neuropsychology and Paediatric Psychology Services.

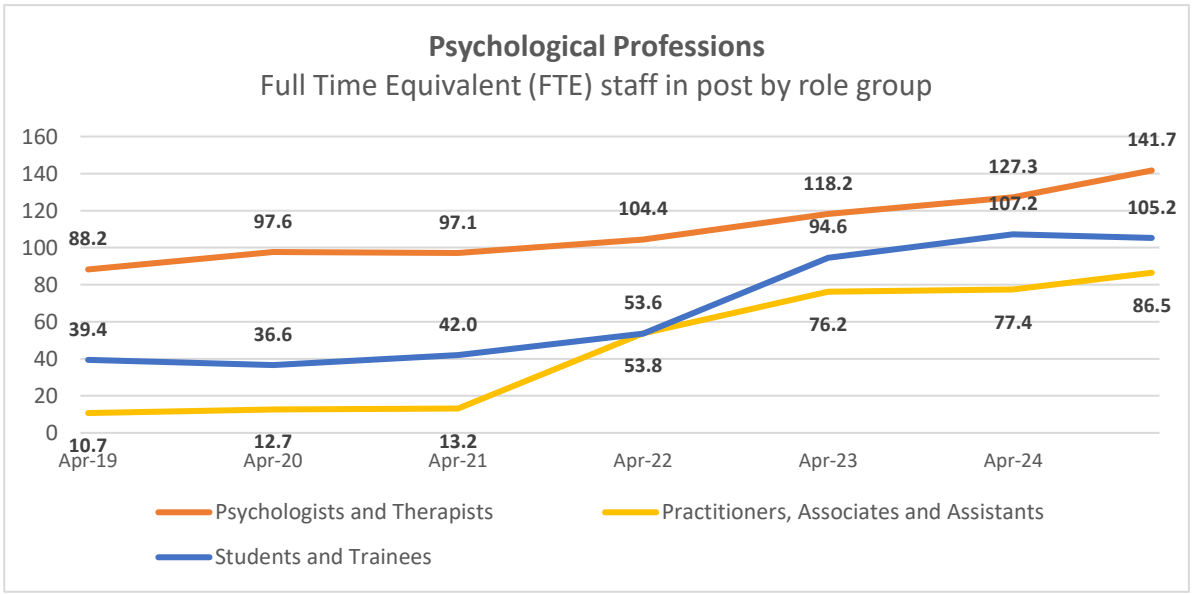
There are many staff in LPT from different professional backgrounds including nursing, social work, and occupational therapy, who have undertaken additional training in psychological models and deliver psychologically informed approaches such as Mentalisation-Based Therapy or Family

Intervention, but who are not working into one of the twenty-one psychological profession roles. There are other staff who have trained as psychological professions, for example cognitive behavioural therapists, but are currently employed in relation to their original professional background such as nursing. The work of these staff is a hugely significant part of the broader psychological offer in the Trust, but these roles are not included in the numbers discussed below, because of the current national arrangements for workforce configuration.

In January 2025, there were 228 full time equivalent (FTE) psychological professionals in LPT who were not in training roles. Of these, 194 were in qualified positions that required a period of clinical training. This is a 123% increase from 87 FTE in April 2016. There has been a comparable 115% increase in the psychological professions nationally during this period, highlighting that the expansion in LPT has mirrored the national pattern. Most of this growth has taken place since 2019, when the NHS Long Term Plan was published. There has been a steady growth over this six-year period in the number of applied psychologists and psychological therapists, and a more accelerated growth in the number of practitioners and associates, essentially the new roles. There has also been a significant expansion in the number of students and trainees in psychological profession roles in LPT, the majority of which are commissioned by NHS England. This has helped to enhance skill-mix and allow vacant positions to be filled, creating a current total workforce of 333 FTE psychological professions in training and qualified roles.

The second national Psychological Professions Census was carried out in March 2024, providing the opportunity to compare benchmarked positions in different NHS Trusts. As well as qualified staff in Mental Health Trusts, the figures include psychological professions in NHS Talking Therapies and trainees. In England, the average number of FTE psychological professions was 56 per 100,000 resident population. There were some regional variations, with an average of 78 per 100,000 in London, and 47 per 100,000 in the Midlands. In LLR, there were only 42 FTE psychological professions per 100,000 resident population, that is 75% of the national figure.

This represents a shortfall of 154 psychological professions in LLR, or 119 in LPT, compared to the average benchmarked position in the country. Given that recent growth in the psychological professions locally has been comparable to the national pattern, this shortfall reflects a historical position of reduced numbers of psychologists and psychological therapists within LPT.



4.0 Principles and commitments

The Psychological Professions Vision for England (2021) specifies five commitments which underpin the vision. These commitments describe the overarching values that transcend different psychological services and pathways and guide the collective work of the community of psychological professions and wider clinicians providing psychological healthcare. These are the principles that also inform and underlie this Strategic Plan.

1) **Put people first**. Psychological professions seek to work in genuine partnership with service users, carers and families to understand their needs, and to design and deliver services that meet these needs. We work from a strengths-based stance that recognises and draws on the resources within and around the individual including families and social networks. This approach increases the capability of the individual and their network to support themselves going forward, reducing reliance on services.

2) **Help communities to thrive**. Psychological professions recognise that wider social factors such as poverty, discrimination and inequality have a significant impact on general health and wellbeing including levels of emotional distress. We also recognise national and local disparities in access to and experiences of psychological healthcare, for example for racialised minorities, those with socioeconomic disadvantage, those with neurodiversity and/or learning disabilities, and where there is intersectionality with other disadvantaged characteristics. We therefore seek to respond to health inequalities and the social determinants of mental health difficulties in the design of services.

3) **Make all mental and physical health care psychological**. While psychological professions play a significant role in delivering psychological healthcare directly, we also seek to enhance psychological knowledge and practice across services, by sharing evidence-based psychological models and skills through training, supervision, reflective practice and co-working.

4) **Unite and increase diversity in the psychological professions**. Psychological professions seek to be a unified group with a strong and diverse voice, which recognises common goals and different specialisms, and works collaboratively with other professionals of all disciplines. Part of this approach involves increasing fairness of entry to psychological professions to people from racialised minorities and across all protected characteristics so that our workforce better reflects the communities we serve. Another aspect is to support those within the psychological professionals and other colleagues delivering psychologically informed ways of working.

5) **Transform and innovate**. Psychological professions seek to ensure there are sufficient highly trained and experienced psychological professionals to lead and supervise the safe expansion of psychological healthcare. We are committed to speaking up and challenging where necessary, adopting leadership positions and working as part of multi-professional management teams to support the transformation of mental health services.

5.0 Strategic objectives

This section describes the Plan's three strategic objectives. It highlights the current approaches and further aspirations within each of these areas. The intention is to spend the first year of the plan (2025-26) co-designing clear goals, with targets and timescales where appropriate, through collaboration with Multi-disciplinary Team (MDT) colleagues, service users, carers, and other interested parties, to allow the objectives to be realised. The ten workstreams are the vehicle for this work.

Objective 1: Enhance psychological practice across LPT.

This objective seeks to address the mental health needs of the LLR population by enhancing psychological practice across the Trust, both within pathways led by the psychological professions and wider services. The aspiration is to support the development of a needs-led approach, which works from a strengths-based rather than illness or deficit-driven stance, acknowledges the social determinants of mental health difficulties, and adheres to the principles of trauma-informed care and social justice. It is acknowledged that services may find it difficult to maintain this approach in certain contexts, for example when engaging in risk management processes where there may be increased organisational anxiety and limited space for holding multiple perspectives. It will be important to support services to hold this stance at such times, which understands relationships to be the principal tool for change.

It is recognised that the resource available within the psychological professions is not sufficient to implement this vision alone, and that psychological professions will need to work closely with colleagues and wider partners to develop shared models and frameworks of psychological practice. This will include supporting the capacity of community and voluntary organisations to deliver psychologically informed care to those who may not access mainstream mental health services or whose needs are best met by other organisations, as part of work to tackle health inequalities. This approach to enhancing psychological practice both appreciates the value of direct psychological interventions to the wide range of clinical presentations within LLR, and recognises the need for partnership working and collaborative pathways to develop responsive psychological care that improves outcomes more broadly.

One implication is that the work of the psychological professions should be focused both on supporting psychological practice in services and working directly with service users. Psychological practice has been described as existing on a continuum from promoting psychologically informed environments (considered in the next section, Objective 2), through offering psychologically informed interventions, to providing specific model-based psychological therapies and bespoke psychological practice (Kell & Self, 2024). Some roles such as practitioner psychologists may work in each of these realms, while others such as psychological practitioners will focus on one or two. It will be important to establish the most appropriate skill mix within services, to facilitate 'less intensive' psychological practice including 'stabilisation' and integration with other psychological work where appropriate, so that more specialist assessments and interventions of 'higher intensity' are only provided as needed with more complex presentations. This stratification of psychological practice will facilitate the best outcomes with the limited resources, thereby maximising productivity and ensuring service users receive the level of input appropriate to their needs.

Kell & Self (2024)

Other approaches that may help to enhance and improve access to psychological practice include:

- Offering a range of modalities such as group and family work, alongside individual practice.
- Working to specific periods for intervention which are transparent to service users and reviewed regularly during contact.
- Supporting the autonomy and self-sufficiency of service users and their wider social network rather than leaning towards dependence.
- Introducing a stepped care model where appropriate.

Many of these strategies are already well embedded within psychological professions services, but it will be important to further enhance a clinical culture of graded, time-limited intervention, thereby enabling access for increased numbers of service users. The principles of promoting face-to-face practice and service users choosing their mode of interaction should continue to be adhered to, but innovative approaches and technological developments should also be utilised when appropriate. Closer work with primary care and community organisations, potentially through Neighbourhood Leads, may also help to develop preventative approaches that lessen demand for services.

Another key focus will be the continued implementation of the ‘no wrong door’ approach, with services working closely together to enable service users to be directed to the appropriate clinical pathway, thereby improving the experience of and engagement with healthcare. Approaches such as trusted assessments, ‘warm handovers’ and complex case discussions will enhance the identification of suitable pathways. One example is the Psychological Consulter model in Planned Care in the Directorate of Mental Health (DMH). Systems to support smooth transitions and closer working across Child and Adult Services and Physical and Mental Health are another priority area of work. This approach of consultation and collaboration ethically places the person at the centre of care and is highly valued by service users as it reduces the number of referrals to different services and limits the requirement to repeat histories. It is also endorsed by NICE Guidance, particularly where there is considerable complexity and effective collaboration across systems is essential for successful outcomes or the highest level of productivity (e.g. NG 213). It will be important to establish processes for this activity to be systematically recorded and recognised, as well being explicitly added to job plans.

To ensure the most effective use of the psychological professions resource, systematic monitoring of the impact of psychological practice will be required, for example by embedding routine outcome measures that are shared across services. Accurate recording of activity via the Mental Health Services Data Set (MHSDS) and Systemised Nomenclature of Medicine (SNOMED) codes is another goal. Assessment and interventions will follow best practice guidelines and be evidence-based. In situations where the evidence is still emerging, a practice-based evidence approach will be adopted. Quality improvement projects and service evaluation will consider impact, to learn more about how the enhancement of psychological practice benefits service users.

Objective 2: Develop psychologically informed environments and staff support.

In order to provide timely and responsive psychological practice with complex presentations, staff need to work within environments that are psychologically supportive. There are several aspects to establishing and embedding this fundamental requirement of psychologically informed cultures.

Staff require training and supervision in evidence-based models that support and develop practice. Such training will continue to be accessed through NHS England commissioned courses, as well other providers of evidence-based approaches. Supervision frameworks have been established within and across psychological professions teams, where the necessary supervisory resource is available internally within LPT. Where this is unavailable for specific therapeutic approaches, plans will be sought for training psychological professions as supervisors, prior to seeking funding from Learning and Development for external supervisors.

Additional support structures will be established as required to facilitate the on-going development and governance of good practice. Embedding a framework of peer support meetings, Communities of Practice and other forums will allow staff to connect with other psychological professions and MDT colleagues in similar roles, both within the Trust and in wider areas, including through professional bodies such as the Psychological Professions Network (PPN). This will support both current approaches, and new and emerging practice. In addition to supporting clinical governance and professional development, such forums will enable focus on priority areas such as enhancing cultural competence and fostering cultural humility within services, allowing individual practitioners to engage more fully in culturally informed work.

As well as training and support structures for the psychological professions, systems will be established and strengthened to effectively enhance psychological knowledge and practice across the Trust and wider LLR system. This will support MDT colleagues to provide stabilisation and integration of psychological work, which may sit alongside the model-based or bespoke psychological practice (Herman, 1992). This will include a range of training and support for MDT colleagues, for example 5P formulation sessions, the use of Decider Skills, trauma training, including being attentive to power, and Stage 1 neuropsychological training. This will be most effectively facilitated when psychological professions are well integrated within MDT teams. Other developments to support 'indirect' work by psychological professions include the development of psychological resources and information for colleagues and service users, and a stronger digital offer for service users.

Consideration should also be given to developing physical environments that are as psychologically healthy as possible, within the existing constraints of funding and current footprint. There is the need for work with estates and facilities, to translate psychological principles for effective clinical work into suitable working environments, including the need for confidential clinical space and a 'safe base' for staff. Some important questions to consider include:

- How can our buildings encourage collaboration, participation, and trust?
- Do our buildings reflect our organisational values?
- Do we have quiet spaces for reflection, and access to green space?

Psychological support at both a team and individual level will be provided, with the aim of enhancing the trauma preparedness and resilience of teams and strengthening cultures of psychological safety. This will include:

- The implementation of the post-incident pathway for staff support.
- The offer of Post Event Team Reflections (PETR), both debriefs and pre-briefs, for staff groups, managers and individuals following and prior to traumatic incidents.
- Wider support for staff welfare at critical times to manage 'burnout'.
- The provision of the Heads and Hearts model of reflective practice (Kurtz, 2025), both routinely and in response to specific requests where teams feel 'stuck' or challenged.
- Supporting the embedding of a learning, no blame culture.

There will also be training, support and supervision for managers and other clinicians, as well as the psychological professions, in models such as PETRs, defusion, and reflective practice, so that there are staff trained in consistent models applied across the organisation. A clear, consistent process for reviewing this work will be embedded, to learn about the need for and the themes of post-incident support, so this work can be suitably resourced. Strategies and activities for promoting psychological safety will also be facilitated, such as creating space for current ideas and discussion of 'failure', where 'productive conflict' may be encouraged. The psychological professions will also support the Trust's work on the prevention of self-harm and suicide, and postvention, including the shift in practice from the stratification of risk to a formulation-based approach to risk assessment and management, based on NHS England's best practice guidance.

It will be important to record and evaluate the impact of this staff support, as well as the other key initiatives described in this plan. Research activity will be an integral part of the work of the psychological professions, to understand the outcome, efficacy and experience of clinical interventions, psychological support, and service development programs. It will be important to use resources that are available across LLR, such as within the Research and Development (R&D) Department, the Quality Improvement (QI) Team, and Higher Education Institutions to support this research activity. The psychological professions will continue to also offer support for the application for University Hospital Status for the Leicestershire Partnership and Northamptonshire Healthcare Associate University Group.

Objective 3: Strengthen and diversify the workforce.

Establishing a local workforce plan that considers how to strengthen, integrate and diversify the psychological professions is important, given the recent establishment of this group and the increase in staff working into a broader number of roles. Some of the aspirations are to establish greater clarity about the scope of practice and professional registration for new roles, to identify opportunities for the diversification of the workforce, and to highlight possibilities to enhance governance and leadership. The Psychological Professions Workforce Plan for England 2021/24 describes five key areas of focus; to grow, develop, diversify, lead and transform the workforce. This section of the plan similarly adopts this framework.

To grow the psychological professions workforce effectively, strategies to enhance recruitment opportunities for the local LLR population including Grow-Our-Own initiatives have been implemented alongside wider recruitment procedures. This has been effective in enhancing skill-mix and reducing the number of vacancies. The present organisational and financial context limits the possibilities for further growth currently, but retention of staff and the development of resources that enhance greater equity of opportunity such as generic job descriptions will remain aspirations. There will also be a review of workforce data, to consider the effect of the recruitment frameworks that have been implemented such as recruitment and retention premia and preceptorship schemes, to inform future developments.

Development of the workforce is to be achieved through a range of measures. Job Plans will be implemented for all staff, constructed collaboratively with both the professional lead and line manager and using standardised frameworks from professional bodies, to guide activity within roles. Appropriate governance is to be achieved through developing clear expectations and policy regarding registration with professional bodies and establishing comprehensive scope of practice documents for new roles. In addition, there will be continued efforts to enhance staff experience of joining the organisation, through the implementation of appropriate welcome and induction processes, as well as learning from staff who are leaving about their experience in the Trust.

A key national and local priority for psychological professions is to both unite and diversify the group. Some progress has been made in increasing the proportion of staff from racialised minorities, and this will continue to be something we strive towards, both generally across the psychological professions and in leadership positions. Consideration will also be given to enhancing opportunities for the recruitment of more diverse groups of staff, for example with disabilities and long-term health conditions, from different socioeconomic backgrounds, male staff, and staff with other protected characteristics not currently well represented in psychological professions. Possibilities are to develop mentoring schemes for both graduates and staff from minoritised backgrounds in leadership positions, to work closely with Higher Education Institutions (HEIs) to promote psychological careers with local students, and to use resources to enhance equity of opportunity such as the No More Tick Boxes recruitment framework. Processes for regularly monitoring levels of diversity will also be established, to understand the impact of such initiatives.

To enable effective leadership within the group, opportunities for career progression and support for managers and leads will be key. Leadership and mentoring schemes will be promoted, to aid the transition from roles with a clinical focus to a leadership focus and to embed management competencies. It will be important that psychological professions are included in leadership structures in the Trust in order to contribute to ongoing service organisation and development, to assist the shift from reliance on traditional triumvirate models of leadership to broader multi-

professional frameworks. Greater representation of psychological professions in committees and groups across the healthcare system, from co-chairing local meetings with Patient Experience Partners to working closely with the Executive Teams in LPT and LLR ICB, will facilitate the development of psychological informed services and pathways. It will also afford opportunities to contribute effectively to planning at service, directorate, Trust and System level.

Areas for transformation include the ongoing extension of psychological professions and psychological practice in physical healthcare settings. This includes the development of organisational structures that support leadership and consultancy, and improve communication and joint working at points of interface, allowing physical and mental health services to work more closely together. Another longer term aim will be further development of new positions including the role of Psychologist Approved Clinician (AC) in settings where there would be clinical benefits for practitioner psychologists to work as ACs alongside medical ACs. Finally, efforts will continue to enact anti-oppressive practice wherever possible, such as through the ongoing co-leadership and support of the anti-racism reading group.

6.0 Conclusion

The development of the work of the psychological professions is an evolving process, to increase psychological knowledge and models across LLR and enhance learning cultures that support psychological practice. This Plan highlights the considerable progress that has been made in recent years, and describes the revised strategic objectives and principles that are now being worked to, to consolidate and build on this work. Further conversations will be required between the psychological professions and MDT colleagues, operational leads, service users and carers, and other interested parties, to ensure the approach continues to fit with the people that the psychological professions work with.

Ten workstreams have been established as part of that conversation, which are co-designing and working towards clear and tangible outcomes, to allow the strategic objectives to be realised over the next five years. The first four workstreams fit with the objective of Enhancing Psychological Practice: *to review and support Trauma Informed Practice; to foster productivity; to enhance information sharing and the digital offer; and to promote access to services by minoritised groups*. Three workstreams link to the objective of Developing Psychologically Informed Environments and Staff Support: *sharing psychological models with teams; promoting a culture of psychological support; enhancing the research culture*. The final three workstreams relate to the objective to Strengthen and Diversify the Workforce: *to develop; to diversify; and to create leadership frameworks for the psychological professions*.

It will be important that this work aligns with the goals of the NHS 10-year Health Plan, with the proposed shifts to digital, prevention, and work with communities. The capacity to adapt over time, to reflect societal changes in the digital age including the use of Artificial Intelligence, will ensure that psychological professions remain relevant and impactful. Ultimately, the aim of the Strategic Plan is to foster a range of benefits over time for service users and their social networks, including more timely access to a wider range of psychological assessments and interventions, a reduced reliance on service provision and a more positive experience of mental health care.

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8.0 Appendices

Appendix 1

The Psychological Professions Strategic Plan 2022/25: notable achievements

The psychological professions have led, or contributed to as part of multiprofessional leadership, considerable developments in service organisation, clinical practice, staff support and workforce arrangements during the last three years. This has been both within our immediate spheres of work and wider service areas. All of these developments have been achieved collaboratively with patient and carer experience partners, multi-disciplinary colleagues, and wider networks. The aim of all the work has been to address gaps in service provision, to improve the quality and safety of psychological practice, to enhance working cultures and develop the workforce, in order to the realise the underlying aims of the NHS Long Term Plan v1.2 August 2019 and the Psychological professions vision for England, 2021-2024 of embedding psychological knowledge and practice across the health and care system so it is better able to meet the needs of service users.

While not an exhaustive list, some recent key achievements and notable developments are described below.

Objective 1 - Enhance psychological practice and access to therapy

There has been an extensive focus on introducing and strengthening partnerships and clinical pathways that are grounded in evidence-based models of psychological practice. A core aim has been to reduce health inequalities, by enhancing access to psychological assessment and intervention, and improving outcomes. A key aspect of the approach has been to work more closely across services, to improve the continuity of the patient journey through psychological pathways.

New services and recently restructured / strengthened clinical pathways, established to address gaps in service provision, led by the psychological professions:

DMH

- LLR Psychological Therapies (LLR PT), for anxiety disorders and depression with a complexity of presentation that exceeds provisions within NHS Talking Therapies (e.g. co-morbid with neurodiversity). This new service is located 'in the gap' between primary and secondary care, operational from 2023.
- Consistent clinical pathways for people with a diagnosis of personality disorder, informed by Structured Clinical Management and Mentalisation Based Therapy, frequently employed by MDT staff supported by the psychological professions, in development since 2020. Also embarking on development of a primary care offer, with a focus on reducing waiting lists whilst also developing a model of care to better meet needs that target the spectrum of severity.
- Psychological Awareness of Unusual Sensory Experiences (PAUSE). A new service for 14–35-year-olds who are at high risk of developing psychosis, operational from 2023.
- Maternal Mental Health Service, for mothers with trauma associated with childbirth, operational from 2022.
- Psychoanalytically informed, evidence-based treatments including Transference Focused Psychotherapy (TFP) and Dynamic Interpersonal Therapy for Complex Care (DITcc), in development since 2022.
- Community Enhanced Rehabilitation Team (CERT) – community rehabilitation for severe and enduring mental health problems, a 'beacon' service other systems are consulting about and modelling services on, in development since 2020. This service has focused on a needs led approach opening its provision to people with complex rehabilitative needs beyond psychosis.
- Acute Inpatient Psychology Pathway, for inpatients at the Bradgate MH Unit, in development since 2022 together with wider work into the over-arching therapeutic pathway at the Bradgate unit.
- Embedding a consistent approach and continuity of care across all psychological pathways that is in line directorate transformation e.g. embedding 5P formulation as part of developing a culture of trauma informed working, supporting use of Decider skills and goal oriented/purposeful interventions using needs led approaches such as DIALOG+.
- Regional infected blood service for patients impacted by infected blood, as well as pathways for cancer care, haemoglobinopathy and haematology, weight management and Lynch syndrome, all hosted by Medical Psychology.
- The functional neurological disorders (FND), major trauma and neuro-rehabilitation pathways, all hosted by Neuropsychology

FYPCLDA

- Mental Health Support Teams in schools, improving access to psychological intervention for children and young people, implemented gradually across LLR since 2020.
- CAMHS Paediatric Psychology Liaison Service, working closely with colleagues in physical health for young people with persistent physical symptoms without a medical explanation, established in 2023.
- CAMHS ARFID Pathway, for young people with avoidant or restrictive food intake, operational since 2023.
- An intensive community pathway delivered through the CAMHS Intensive Community Support Team and PBS support pathway, which has contributed to a significant and sustained reduction in inpatient admission and length of stay for CYP, operational since May 2022.
- Urgent Support Pathway for Residential Children's Homes in CAMHS Young People's Team, working directly with staff groups supporting looked after children in residential care at risk of placement breakdown. Through consultation, psychological formulation sessions, staff support and training, the pathway has reduced placement breakdown and crisis attendance at A&E. Operational since 2023.
- CAMHS Eating Disorders Home Intervention Team, providing wrap around support, including meal support and supervision to prevent avoidable admission to hospital.
- Extensive investment in the CAMHS digital offer, which includes the development of psychologically informed digital interventions via Guidance and the implementation of online parenting intervention for anxiety (OSI-A) in MHST.

Supporting work to address health inequalities:

- Improving access to CYP mental health services through investment in early intervention services and the smart use of data to target areas of high need, leading to LLR achieving the second highest access rates nationally and the highest regionally.
- Engagement with partnership projects between services and community organisations to facilitate other ways for people to access services, e.g. CAMHS and Leicester City Football Club ("Play-on"), "My Voice" project in CAMHS YPT, Community participation lead post in CAMHS.

Co-construction of service design and organisation with service-users and carers:

- MHSOP Inpatient Team attending Patient and Carer Forums to consult on a Quality Improvement project to embed the use of Kitwood's Enhanced Model of Dementia Care on the organic wards.
- Consulting patients on the adaptation of Decider Skills in weekly patient groups on the MHSOP functional mental health wards, open to all patients.
- Parent practitioner roles within CAMHS Eating Disorders Team and CAMHS Intensive Community Support Team.

Development of consultation meetings and steering groups across services / the wider system, to coordinate care and facilitate access to the most appropriate service:

- The alcohol related brain injury steering group, made up of professionals across multiple teams and organisations (neuropsychology, homelessness, Turning Point, hepatology, dementia services, social care, community neuro) to look at the cognitive impact of alcohol use and improve pathways.
- Regular case review meetings between NHS Talking Therapies (LLR provider of psychological practice beyond LPT) and Medical Psychology, Neuropsychology and LLR Psychological Therapies.
- The Psychological Consulter Model, case discussions in Neighbourhood Teams between community psychology, psychological therapies, and MDT colleagues, to ensure service users access the most appropriate service and psychological intervention.
- The complex case transition meeting between CAMHS and Adult Services, to facilitate the transition into adult mental health services for young people with complex needs and high-risk behaviours.
- Ensuring that psychology and psychological therapies are more firmly embedded within the MDT, from clinical team to directorate management level, working collaboratively with multi-professional colleagues to develop and enhance over-arching patient safety and quality.

Objective 2 - support the culture of psychological safety

There has been considerable investment in staff training in psychological approaches, both for the psychological professions specifically and for wider staff groups, to work towards the goal of enhancing psychological practice within healthcare. There has been a focus on working closely with the MDT colleagues, to support and supervise the implementation of these psychological models in complex clinical situations. Wider attention has been paid to developing psychologically informed cultures of staff support and using research and evaluation to monitor the impact of these developments.

New training for MDT staff in psychological models:

- Decider Skills training for more than 1000 MDT staff, facilitating the consistent application of 'low intensity' psychological skills, informed by Cognitive Behaviour Therapy (CBT) and Dialectical Behaviour Therapy, across services including in the wider healthcare system beyond LPT.
- Open Dialogue training for MDT staff, an integrated social network approach that has increased family intervention and promoted continuity of care across DMH inpatient and community services.
- Neuropsychology Level One Awareness training across the LLR region for staff from UHL and LPT, which has led to requests from other agencies such as social care.
- Training at introductory and intermediate levels in dynamic psychotherapy, which provides a (free) 'grow-our-own' opportunity for career progression for staff through a clinical rather than managerial route.
- Trauma Informed training in inpatient, urgent care and community settings, aligned with the consistent application of the trauma informed, 3 stage model of psychological intervention (Herman) across DMH services.

Increased levels of training for pp and wider staff in psychological approaches:

- Psychological informed interventions aimed primarily as staff groups without a core training as a psychological profession, such as Structured Clinical Management, Mentalisation Based Therapy and Family Intervention.
- Longer courses in psychological therapy such as CBT and Cognitive Analytic Therapy.
- Staff support models, including The Heads and Hearts Model of Reflective Practice, Post Event Team Reflections and Defusion.
- Providing learning opportunities through co-working, for example by increasing the number of family therapy clinics MDT staff can work into.
- Integrating psychological models within existing MDT training programmes, including CAMHS in-house training.

Development of integrated supervision structures for psychological models:

- The establishment and facilitation of supervision groups across services for psychological approaches such as Eye Movement Desensitization and Reprocessing (EMDR) and Family Intervention.
- Embedding psychological consultation sessions for MDT staff teams, to enhance psychological approaches such as 5P formulation in a wide range of settings across the wider healthcare system, including LPT rehabilitation / inpatient / community services, medical teams within UHL, social care staff / foster carers / adoptive parents in Looked After Children services, and with local authority colleagues through the ACES project.

Establishing pathways and frameworks for psychological staff support:

- Development of the Post Incident Pathway for Staff Support (PIPSS) - implementing a co-produced policy, adopting a standard framework for offering Post Event Team Reflections (debriefs) and Defusion (hot debriefs), and providing support to individuals including managers, teams, and the wider system.
- The facilitation of Reflective Practice Groups across clinical services and pathways, and for other teams including The Safeguarding Team and The Freedom to Speak Up Guardians.
- The introduction of LPT Outdoor Working Guidance as part of innovative practice developments during Covid.

Research initiatives:

- The introduction of the Psychological Professions Research Community of Practice and Steering Group, to strengthen the research culture within the group.
- The completion and publication of numerous research, quality improvement and service evaluation projects led by psychological professions – e.g. GUIDE-HD research project, using grant funding to develop an award winning, innovative and novel approach which includes collaborating with colleagues in Europe.

Objective 3 - develop the psychological professions workforce

Significant workforce development has been required within the Psychological Professions, to realise the ambition of strengthening psychological practice and culture. The Psychological Professions Workforce Plan for England defines five areas for workforce enhancement, which are discussed in turn below with regard to recent local developments.

Grow

- The introduction of new roles in LPT to enhance skill-mix and offer various levels of psychological intervention at a wider range of bandings:
  - Clinical Associates in Psychology (CAPs)
  - Education Mental Health Practitioners (EMHPs)
  - Mental Health Wellbeing Practitioners (MHWPs)
  - Children and Young People's Wellbeing Practitioners (CYWPs)
- The introduction of new frameworks or application of existing frameworks, to improve recruitment and retention:
  - Preceptorship Framework for Newly Qualified Psychologists
  - R&R premia for posts that are hard to recruit to
  - Annexe 21, to enable employment of clinicians during last training year.
- The introduction of recruitment events:
  - Annual job fair at the University of Leicester for trainee clinical psychologists
- Increased provision of trainee placements and supervision of trainee service evaluation and research projects, to support the significant expansion of training places for a wide range of roles:
  - Increase in trainee clinical psychologist cohorts from 12 to 29.
- Working with local Higher Education Institutions (HEIs) to offer greater numbers of placement years to local undergraduate psychology students.

Develop

- The introduction of an integrated structure for the psychological professions in DMH and FYPCLDA, and recruitment to Directorate Lead posts.
- The introduction of regular governance and peer support meetings across roles:
  - Monthly Communities of Practice for Assistant Psychologists, CAPs
  - Monthly directorate meetings for Consultants / Leads
  - Quarterly 'Forum' meetings for Practitioner Psychologists
- Expansion of training places for evidence based psychological intervention including 'Grow Our Own', NHSE commissioned, LPT funded and local training courses:
  - Systemic Psychotherapy at Years 1, 2, & MSc Level
  - Dynamic Psychotherapy introductory and intermediate training
- Involvement on local training courses including in course committees, selection and teaching, to promote high standards of practice within training.
- The introduction of welcome / graduation events, to inform about the organisation of and vision for psychological professions in the Trust, and to formally acknowledge training achievements.

Diversify

- Increase in the proportion of psychological professions from racialised minorities, from 12% in April 2022 to 19% in January 2025, achieved through greater diversity within cohorts recruited to practitioner, associate and training roles.
- The introduction of mentoring schemes for people from minoritised backgrounds in leadership positions, and graduates aspiring to clinical psychology training.
- Representation at employment fairs organised by local Universities and LPT, to share information about careers with local communities.
- The development of research projects to monitor access to psychological services from ethnic minority communities.
- Leading on the development of, and recruitment to, a new senior post within CAMHS (service development lead for community participation and health equity) to support in building meaningful links with interested parties from the diverse populations of LLR to inform service provision and delivery.

Lead

- The introduction of a lead role for Psychology and Psychological Therapy (Chief Psychological Professions Officer) in LPT and across the LLR Integrated Care System (ICS), and in FYPCLDA
- Development / increase in leadership positions including Consultant posts, enabling psychological professions to provide leadership into more clinical areas, e.g. DMH Inpatient & Urgent Care
- Increased chairing and representation at LPT and University committees and groups (e.g. DMH Clinical Reference Group, MPAC Steering Group)
- Increased representation at LLR committees, collaboratives and partnerships (e.g. LLR ICS Clinical Executive, LLR Mental Health Shadow Collaborative)

Transform

- The collaborative development of passionate and brave spaces where colleagues can engage collectively with one another to support and initiate anti-racist and equity-focused work across LPT (e.g. the CAMHS Race Equity group and the LPT Anti Racist Reading Group, which have both worked hard to combine safe, reflective and solidarity-focus spaces with committed and transformative action projects)
- Embedding meaningful involvement of Experts by Experience and Lived Experience Partners in psychological professions service design and delivery, for example co-chairing groups and committees (e.g. Open Dialogue Steering Group)
- Enacting new roles in the Trust (e.g. Multi-Professional Approved Clinicians)
- Facilitating and leading Trust developments to support the routine collection of patient-reported outcome measures.
- Reviewing options for the re-structuring and extension of psychological practice into other settings:
    - physical healthcare by medical, neuro and paediatric psychology
    - primary care through the initiation of the primary care project for personality difficulties

Appendix 2

The Psychological Professions Strategic Plan 2022/25: examples of innovative practice

The Strategic Plan for Psychological Professions 2022/25 highlighted the breadth of the work of the psychological professions in LPT, to enhance access to psychological practice, to support the culture of psychological safety and to develop the workforce. The examples here provide more detailed illustrations of the key themes and aspects of this work, in each of these areas.

Although these examples focus on the contribution of the psychological professions, we recognise that the work is always enacted in collaboration with MDT colleagues and supporting services, as well as with service users and family members, and should not be separated or viewed in isolation. We appreciate this process of co-production and its multifaceted contributions, and wish to fully acknowledge this at the outset.

A - Principles and commitments

A.1 - Co-production as default

During the COVID-19 pandemic, new partnerships accelerated service development, innovative practice and solution-focused changes across health and social care organisations. Research evaluating the key factors to enable effective changes to systems, cited co-production as the number one recommendation:

> Co-production acknowledges that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions, and to maintain a person-centred perspective. (NHS England, 2022, *Always Events Toolkit*, p5).

The adult acute inpatient psychology team proactively consult with lived experience partners in every new initiative and project, from the ideas stage through to implementation, as illustrated in the following example.

Therapeutic inpatient pathway

During 2024, three co-production events were held to develop work at each stage of the inpatient journey: (i) the first 72 hours: assessment, formulation and collaboratively identifying a formulation-driven admission goal, (ii) stabilisation: planning, delivering and reviewing therapeutic work towards the admission goal as an MDT, (iii) integration: supporting with transition to community.

The sessions were well-attended, attracting good representation across the full range of disciplines working in inpatient service, as well as community organisations, acute services, and experience partners. The framework was presented to generate ideas and agree what should be involved within each stage as a group. We took deliberate action to maximise psychological safety within the sessions, so all voices could be heard and held with equal importance, including:

- being clear that the project was in the early stages - to be shaped, co-produced and owned by the whole service;
- prioritising interactive and experiential exercises over presenting information;
- encouraging polyphony (diversity of simultaneous points of view and voices) in the style of facilitation;
- holding the sessions on non-NHS property;
- instructing the group to not wear NHS ID badges or uniforms;
- avoiding jargon.

A fourth session conducted at the Recovery College to summarise the framework and invite input was open exclusively to experts by experience and carers, to further improve psychological safety for this group and to connect more closely with the experience partner perspective.

Feedback about specific aspects of coproduction was collated:

- *Equality*: My skills, abilities, time, and other qualities were valued as much as other attendees during the session today (98% agreed or strongly agreed).
- *Diversity*: Attendees of the co-production session and issues raised were reflective, inclusive and relevant to the range of people who will be using the service. (100% agreed or strongly agreed).
- *Accessibility*: I had the opportunity to take part fully in an activity that suits me best. I felt able to contribute on an equal basis. (94% agreed or strongly agreed)
- *Reciprocity*: I feel I have received something back for putting something in. This left me feeling my contribution has been valued and needed. (89% agreed or strongly agreed; 11% gave a neutral response).

Summary

This example highlights the role of psychological professions in facilitating collaboration across groups; driving meaningful co-production with experience partners; and sharing and promoting evidence-based psychological approaches. Through connecting with community organisations (e.g. Neighbourhood Leads) in the development of the inpatient pathway project and other initiatives, we have supported joined up working and continuity of care through the transition from inpatient to community services. The inpatient therapeutic pathway project is chaired by a member of psychological professions, which is an example of adopting leadership positions and working as part of multi-professional management teams to support the transformation of mental health services.

Dr Lara Harris, principal clinical psychologist
Dr Claire Hemming, consultant clinical psychologist

A.2 - The individual placement team (IPT) – facilitating timely and safe discharges from alternative hospital placements

Due to limitations in local service provision, people sometimes need to go to a hospital outside Leicestershire to receive specialist interventions that are not available locally. These ‘alternative hospital placements’ (AHP) are usually provided outside of the NHS. In November 2023, the co-ordination of these placements was taken over by Leicestershire Partnership NHS Trust. The Individual Placement Team (IPT) was therefore created as part of our adult rehabilitation service. It was decided that the team would be clinically led by a consultant clinical psychologist, and would use a psychological formulation model to understand the needs of service users, to plan and review interventions, and to support the repatriation of people to the Leicestershire area once they had completed their treatment.

The IPT comprises nurses (case managers), psychology, psychiatry and has support from other disciplines as required. With support from the psychology team the case managers develop a psychological formulation (called a 5P formulation) which looks at what has happened to a person in their past, what are their current difficulties, what maintains those difficulties and what strengths and protective factors they have. This approach helps IPT to understand the person within their context and how they can support the person to return home to be close to their friends and family.

When IPT started in November 2023 there were 35 service users who were in alternative hospital placements. By December 2024, the team had repatriated or discharged 17 people, reducing the cost of alternative hospital placements by over half (58%).

We asked people how they found working with the IPT. Professionals, service users and carers all report high satisfaction, specifically highlighting effective communication, shared accountability and problem solving as clear strengths. We also asked the IPT case managers how they found working within the psychological formulation model:

"It has been my experience that having psychological expertise and support within IPT has been instrumental in providing safe and effective care to our AHP/IPT cohort. This has mostly been a result of collaborative discussions between IPT and the AHP regarding appropriate psychological treatments, therapeutic risk taking and having the opportunity to review a person's case with a new perspective."

"The 5 P formulation is an effective way to ensure a greater understanding of patient needs when they are moved or have a new professional involved in their care. I often have patients express frustration that they have to tell their "story" repeatedly to different professionals, a good 5 P formulation should reduce this frustration for the service user".

This dramatic reduction in AHPs, the positive feedback about IPT from those experiencing the service, and the recognition of the strengths of the psychological formulation model, highlights the value of this initiative to staff, families, and service users.

Dr Kelly Fenton, consultant clinical psychologist

Objective 1 - Enhance psychological practice and access to therapy

1.1 – The development of the ARFID pathway – providing access and intervention to young people previously having to be referred out of area.

Background:
The Leicestershire Partnership NHS Trust (LPT) Avoidant/Restrictive Food Intake Disorder (ARFID) pathway was initially commissioned in Spring 2022 because of the growing recognition of gaps in local service provision for the specific needs of young people with ARFID. Prior to this young people presenting with such needs would have not been accepted by local mental health services, resulting in their needs not being appropriately assessed and diagnosed, often resulting in out of area referrals.

The pathway development and operation has been jointly led by two senior psychological professionals from Child Psychotherapy and Clinical Psychology. Following an initial evaluation / mapping exercise in summer 2022, the ARFID Pathway Pilot was designed in autumn 2022 and was launched in January 2023.

Aim and current remit of service:
The current provision is a mental health pathway for young people who present with moderate to severe risk level of need. The pathway is operating under the umbrella of the existing Eating Disorders team in Child and Adolescent Mental Health Services (CAMHS).

The aim of the service is to provide specialist assessment and intervention to young people who experience moderate / severe risk of ARFID, characterised by significant and persistent nutritional deficiencies and/or energy deficiencies and/or severe psycho-social impact. The level of risk is guided by national frameworks. The pathway is aligned to the access and waiting time standards for eating disorders (2015) and aims to provide timely assessment and clinical formulation, to guide evidence-informed interventions to address physical, psychological, and social aspects associated with the condition.

The pathway is operated by specialist staff with a combination of medical, psychological, and dietetic skills to manage the psychological and physical aspects of ARFID. The current skill mix includes mental health nursing, specialist dietetic, occupational therapy, and assistant psychology. The pathway is clinically led by Child Psychotherapy and Clinical Psychology. Treatment is delivered primarily on an outpatient basis, although where inpatient care is indicated, staff will maintain a link to ensure a smooth transition between levels of service.

In the first year of its implementation, the pathway assessed 50 young people aged 3 -18 years old. Previously, they would either have been referred to tertiary services, not been diagnosed or received a disjointed provision. Treatment outcomes are measured by both the assessment of nutritional and weight / growth improvements, as well as the overall psychosocial functioning. Progress is also evaluated through changes in pre- and post- outcome measures.

The pathway works closely with other agencies and services to ensure those in need of support are identified at the earliest opportunity, including wider partners such as University Hospitals Leicester (UHL) and First Steps Eating Disorder charity. Key professionals from these other services have been identified, which enables liaison with families and young people who might have previously accessed support from one of the earlier intervention services, for example. We

are mindful that service provision is still under development, and are continuing to seek closer collaboration between partners. But we are delighted that young people in the locality presenting with significant risks associated with ARFID now have access to specialist assessment and intervention.

Kyriakos Thomaidis Zades, child and adolescent psychoanalytic psychotherapist

1.2 – Working with families and social networks in acute inpatient mental health services: the introduction of open dialogue

The Open Dialogue approach: Since 2022, LPT have provided foundation level training in Open Dialogue for three cohorts of staff. The approach involves offering network meetings facilitated by two trained professionals, where the person at the centre of concern is invited to bring together the people who are important to them, to discuss the current crisis and find ways forward together. The approach encourages openness and transparency, slowing down and tolerating uncertainty, appreciation of multiple viewpoints, emphasising peoples' own words and stories, and shared responsibility for decision-making. In Western Lapland, the whole mental health system is structured around the Open Dialogue approach, with network meetings being facilitated by the same staff members and continuing until everyone in the network feels the crisis has resolved. The one-year foundation level training has allowed LPT practitioners to consider how this approach may be delivered within and alongside current NHS services in LPT.

Acknowledgement: While this piece has been written to describe the contribution of the inpatient psychology team to introduce this approach to inpatient services, it is important to acknowledge that this work is being done alongside professionals from other disciplines across LPT.

Implementation in acute inpatient services: Introducing this approach at BMHU has involved drawing on strong relationships with staff teams across the unit, to promote Open Dialogue as one way we can work with service users and their networks. Discussing Open Dialogue in our weekly meeting of psychology input across the unit, enables us to offer network meetings in a timely, responsive manner. Service users are given complete choice over who is invited to their network meetings, and we have facilitated meetings where networks have evolved over time as the service users' wishes have changed and feelings of safety have increased. Other members of LPT staff have joined meetings as network members at service-users' request, which has helped foster a sense of shared understanding and responsibility and joined-up working. We have found ways to bring Open Dialogue principles into other aspects of our work: increasing transparency in the way we share information in ward rounds, emphasising service-user perspectives and involvement in team formulation sessions, and encouraging polyphony (giving equal space to all voices and different perspectives) to increase psychological safety in MDT forums.

Felt impact: We have yet to formally evaluate the impact of Open Dialogue in inpatient services, but feedback from network members and our own reflections have identified the following impact:

- A sense of relief can be experienced within the wider system with the introduction of this approach, moving away from placing services in an 'expert' position of needing to solve crises, and highlighting the resources within individuals and networks.
- Restoring service users' sense of choice, autonomy, and confidence in their own ability to navigate difficult and distressing times, which can be limited in inpatient services, particularly when detained in hospital or treated against their will.

- As the approach aligns with Trust, and our own personal and professional, values, facilitating network meetings and working in accordance with our values has been a hugely rewarding experience.
- Working in this way has helped to create space for open conversations at times where an impasse has been reached between services, service users, and network members.
- Network meetings have provided a contained space for networks to express when services have not met their needs, and to feel this has been heard.
- Working in this way can allow a person's network to be involved at an earlier stage than usual (i.e., involved throughout the admission, not just when planning for discharge).
- Network members have shared that meetings have helped them to have a better sense of what is going on for their loved one, and their perspective has been heard.
- Network members have valued the continuity in approach, with network meetings following discharge helping with transition and re-integration to the community.
- Facilitators feel the approach has led to increased transparency in communication, flexibility, and responsiveness.

The adoption of Open Dialogue within the acute inpatient service is a good example of psychological professions attending to service-user need in a responsive, timely and attuned manner.

Acute Inpatient Psychology team

1.3 – Online support and intervention for child anxiety: the introduction of a parent-led intervention

The MHST (Mental Health Support in Schools team) were introduced to improve early intervention and access to mental health support for children and young people in schools and colleges following the publication of the Green Paper for Transforming children and young people's mental health (2017). In addition, the MHST offers Whole School Approach interventions which include working with school staff and within schools. The psychological professions comprise a significant proportion of the MHST. This includes education mental health practitioners, children's wellbeing practitioners, and a newly appointed clinical psychologist to support with the oversight of clinical interventions that are recommended by NICE and are consistent with evidence-based practice.

Within the MHST offer, parent-led interventions have been introduced for children with generalised anxiety related difficulties. The Online Support and Intervention for Child Anxiety (OSI) is an online, parent-led and therapist-supported resource designed to help children overcome problems with fears, worries, and anxiety. It also comes with an optional game app that can help motivate children and offer strategies to try with their parent/carer.

The OSI programme is based on the latest evidence on how to help children aged 5-12 years old overcome issues with fears, worries, and anxiety, and was developed in collaboration with parents, carers, children, NHS professionals, researchers, a technology company, and others with relevant personal experience.

Due to the success of OSI locally and nationally, with outcomes indicating positive psychological change, a small team within the MHST have also opted to participate in the delivery of an adapted version of this parent-led intervention for anxiety; the OSI-A. The aim is to support parents with children who have a confirmed or unconfirmed diagnosis of Autism Spectrum Disorder and is highly relevant within Leicester, Leicestershire and Rutland. It is designed to be more accessible to parents and more time efficient for practitioners. Treatment takes place via telephone over six sessions and one follow-up. Parents access module content within the OSI and OSI-A platform before discussing the information with their assigned practitioner, who will tailor the support to their child. Education mental health practitioners and children's wellbeing practitioners are included within the delivery of the intervention.

The OSI and OSI-A interventions are evidence based along with being tailored to the needs of parents who cannot always attend clinic appointments. Therefore they are taking the service to the families and increasing the accessibility aspect of the intervention. The OSI and OSI-A also contribute to current research which is essential given the ever-changing landscape of mental health for children and young people. The impact of the intervention continues to result in good outcomes for parents and families.

Dr Matthew Daniel, consultant clinical psychologist

1.4 – Addressing the gap between primary and secondary care for anxiety and depression: the introduction of LLR psychological therapies

NHS Talking Therapies (NHS TT), heralded nationally as a phenomenally successful landmark psychological therapy service, has enabled millions of people to access psychological treatments for depression and anxiety under NHS primary care since its inception in 2008. However, a significant gap has emerged between primary (Step 3) and secondary care (Step 4) psychological services. In 2024, the British Medical Association raised concerns that GPs were increasingly holding a cohort of patients who were identified as too complex for the services provided by NHS TT, but did not meet the thresholds required to access services under secondary care. These patients have been described as “the missing middle”, the casualties of NHS commissioning models in mental health provision who are effectively systemically excluded from accessing the appropriate psychological treatment.

Local NHS TT and secondary mental health care providers in Leicester, Leicestershire, and Rutland (LLR) identified that a substantial number of patients, estimated to be over 800, were falling into this gap. A business case for a “Step 3.5” service for LLR was developed, approved and a new service was commissioned by the Integrated Care Board (ICB). By January 2024, the LLR Psychological Therapies (LLR PT) service was fully operational with a small team of BABCP-accredited cognitive behavioural psychotherapists and mental health wellbeing practitioners (MHWP).

Without existing data, the team’s first task was to establish who was falling into this gap. By working closely with the local NHS TT provider, a cohort of patients was identified. They experienced a range of mood and anxiety disorders suitable for Cognitive Behavioural Therapy (CBT), but did not meet thresholds for secondary care services, and were not experiencing meaningful change in primary care due to challenges associated with neurodivergence, severity, complexity, and/or co-morbidity.

A weekly triage meeting between LLR PT and NHS TT was established to ensure every patient considered for the team would be discussed. This meeting quickly emerged as a mutually rewarding forum, successfully identifying suitable referrals for LLR PT, and serving as a formulation driven discussion regarding onward referral or signposting for patients who were not suitable for LLR PT or NHS TT. Our local NHS TT have reported this process as highly informative and beneficial for patients.

The service works to maximise engagement from the outset and to support the patient with overcoming treatment barriers through providing service information leaflets, sending text reminders for appointments, and offering video or face-to-face sessions. Patients are actively supported to access community organisations and settings to improve wellbeing, social functioning and reduce dependency on formal mental health services in the future. Emphasis is placed upon ensuring a person-centred and collaborative approach throughout all phases of contact.

Patient Experience Questionnaires (PEQs) have been completed by almost 100% of patients, with 81 % very satisfied and 19 % satisfied with their experience of the service. Many patients report appreciation of video and face-to-face sessions, with previous treatment often via phone calls. They commend the quick access to assessment and treatment, which for most is just a few weeks, as compared with local wait times in primary and secondary care of 12-18 months. Many report feeling fully involved in decision-making, unrushed in treatment and their difficulties understood for the first time. Patient-reported outcome measures recommended by NHS England have been

routinely used, including Goal-Based Outcomes (GBOs). GBOs have utility in contributing to the process of identifying goals with the patient from the outset and collaboratively monitoring progress towards these goals throughout the course of treatment, with 93% of patients demonstrating meaningful change at end of treatment via GBO scores.

The service is now into its second year. It continues to be highly rewarding working alongside individuals whose unmet needs emerged as an unintended consequence of parameters of mental health services. Through facilitating a collaborative understanding of personal challenges, recognising strengths and promoting agency, and providing suitable adaptations and methods of treatment delivery, the service has achieved high levels of patient satisfaction and of meaningful change in psychological wellbeing, for patients who have previously fallen into the gap.

Tara Cousins and Rachel Shelborne, cognitive behavioural psychotherapists

1.5 Improving transitions between CAMHS and adult services: complex transitions meeting

Two senior psychological professionals within CAMHS and DMH, alongside a senior nursing colleague, have established a complex transitions meeting for young people with complex needs and high-risk behaviours that helps bridge the gap between children's and adult mental health services.

This meeting was set up following the tragic death of a young person to suicide during their transition to adult services several years ago, and the commissioning of the CAMHS Intensive Community Support team (ICST). ICST work with young people in the community at elevated risk of self-harm and suicide.

The meeting takes place whenever there is a CAMHS service user open to ICST requiring transition to adult services, and works hard to ensure effective handover of information, thoughtfulness around what would constitute appropriate 'wrap around support', as well as an attachment-informed and trauma-informed transition. Young people requiring complex transitions often present to services with complex trauma, intense emotional dysregulation, attachment difficulties, and associated high-risk behaviours. The meeting builds on the challenging work conducted over recent years to support transitions and sits alongside these existing transitions processes.

This forum works hard to think 'outside the box' and ensure a safe transition of care despite very real service capacity issues. The meeting is supported by the directorate lead for psychological professions within DMH to help identify the most appropriate psychological therapy for these young people. As a result, young people avoid being 'bounced' between services, are transitioned with a clear handover that values their journey with CAMHS and are provided with greater clarity around next steps at what can feel like a precarious time.

The meeting is a good example of the role of psychological professions (working alongside valued MDT colleagues) in identifying gaps in service provision, bringing people together to work collaboratively to address issues, establishing robust processes that increase patient safety, and chairing complex meetings involving ethical dilemmas to facilitate meaningful working across directorates.

Dr Andy Brackett, consultant clinical psychologist

1.6 – Integrating mental and physical health paradigms: service examples from medical psychology

There are numerous psychological professions working across the wide range of services in LPT that address the psychological distress arising from or contributing to physical health problems. As service users are typically patients within the University Hospitals of Leicester NHS Trust (UHL), there can be several challenges to effectively integrating physical and mental healthcare. These include LPT and UHL having different digital and electronic systems, for patient records and service evaluation for example; limited opportunity to consider complex clinical needs across Trusts; limited evidence-based pathways and practice-based evidence for dual diagnosis.

Where integration works well, mental and physical health teams work closely together with a mutual understanding of each other's work. Without this, interventions can be poorly received and unintentionally reinforce the dichotomy between mental and physical health. Here are some examples of teams working at the interface of LPT and UHL to effectively integrate mental and physical health paradigms.

The type 1 diabetes and disordered eating team (T1DE) is one of five national sites across the UK providing integrated care for this presentation. The aim is for psychological, dietetic, and medical support to be managed in one appointment and held within one team, rather than patient going between teams, to reduce the incidence of severe health complications. The psychology role in the team involves:

- working directly into the diabetes MDT to provide psychological triage of patients;
- supporting psychologically-informed practice through joint clinics and monthly supervision to MDT colleagues;
- facilitating wider team formulation meetings to generate care plans for complex patients;
- holding a caseload of active patients;
- building relationships between teams through liaison and training.

Patient and carer involvement is sought to help shape and evaluate the dual diagnostic pathway. Outcomes are encouraging for this patient group that typically 'fall between the cracks' of existing services, including:

- reduced admissions to the Emergency Department;
- increased confidence of patients to build a life around the complex difficulties they are living with;
- greater confidence from UHL staff to work in a psychologically informed way.

Psychological input into a Tier 3 weight management pilot has been set up to oversee prescribing of new weight loss medications for overweight patients meeting key criteria. The service was developed to provide a more comprehensive approach, supporting lifestyle changes, and addressing key psychological factors such as emotional eating and behaviour change, alongside medication. Psychological input includes conducting individual psychological assessments, contributing to MDT discussions, supervising a counsellor providing one-to-one psychological support and co-developing and delivering a weight management group with a dietitian. The group takes a values-based approach, integrating self-compassion, motivation, and psychological strategies to support sustainable change.

It is well recognised that haematological conditions can affect the whole person and the family. Having psychology as part of the MDT can result in better quality care, and help patients and families adjust and cope better with haematological conditions. As part of our role in the haematology service at the University Hospital of Leicester we cover three primary areas: haemophilia, Thrombotic Thrombocytopenia Purpura (TTP) and bone marrow transplant. We have

recently been part of setting up a new pilot programme in the bone marrow transplant team, known as prehabilitation (prehab). Prehab is an important part of preparing patients for stem cell transplant. Many professionals are involved, including dietitians, physiotherapists and psychologists. Psychology's aim in being part of this prehab programme is to not only provide preparation but also to give benefits to patients for during and after treatment. We provide indirect and direct support to staff and patients in a timely manner and ensure the patient sees psychological care as a vital integrated part of their treatment pathway.

The severe asthma psychology service has made links to the national asthma psychology network and worked to align outcome measures and share good practice on care for asthma patients. This is particularly important as severe asthma is a new and very small specialism, with psychology being underrepresented in the field despite patients often having significant psychological needs. We collaborated and contributed to a benchmarking exercise and are part of a working group developing guidelines for the role of clinical psychology in severe asthma. The local triage process has been refined, due to previously high number of inappropriate referrals, and alternatives to direct input, such as formulation meetings, have been offered.

Dr Natalie Salimi, Dr Keith Aherne, Dr Esther Hardy, clinical psychologists and Dr Kiran Chima, counselling psychologist

1.7 CAMHS Paediatric Psychology liaison service: establishment of a multidisciplinary pathway for the management of persistent functional symptoms including Functional Neurological Disorder (FND)

The Functional Symptoms Pathway is a rehabilitation-oriented service for young people with persistent physical symptoms who do not have a definite medical explanation, or whose symptoms are beyond those expected for their physical health diagnosis. The goal of the pathway is to improve physical functioning and participation, and to help young people and their families to recover and/or live well with their symptoms.

The heterogeneous, complex, and bio-psycho-social nature of FND requires a wide range of interventions and multidisciplinary formulation to inform care planning. Following funding from the Mental Health Investment Fund (MHIF) in 2023, a small multidisciplinary team has been established including nursing, OT, family therapy, psychology, and psychiatry.

FND is a common cause of neurological disability and occurs across all ages, with peak incidence in childhood at age 11 to 13. The process of obtaining a diagnosis can create significant trauma due to multiple medical investigations and not feeling believed by professionals in the face of significant disability and loss of function. Functional symptoms impact significantly on children's development including social, emotional, and academic functioning, and is associated with increased care burden on the family system. Early detection and positive adjustment are predictive of positive outcomes.

Over the last year we have been working on a range of service development initiatives to establish the Functional Symptoms Pathway. The initiatives described below are examples of psychological professionals collaborating with medical colleagues in the acute hospital trust, to improve the quality of multidisciplinary care and integration of services across physical and mental health.

- There is a weekly MDT meeting for triaging referrals, formulation, case discussion, care planning, peer supervision, CPD and service development.
- With colleagues in the University of Leicester Children's Hospital, we are establishing clear referral criteria for the care pathway, shared language, psychoeducation resources and training. We have regular pathway meetings with the lead paediatric consultant for FND in the Acute Hospital Trust and the lead paediatric consultant for the Children's ED.
- There is a bi-weekly online psycho-social meeting for all paediatric specialties, to discuss children and young people (CYP) across physical health services presenting with functional neurological symptoms including: non-epileptic seizures; atypical limb movements; functional gastrointestinal issues and functional cardiac symptoms. This has led to a substantial reduction in hospital visits following the initial psychology assessment, and significant enhancement of the timeliness of psychological assessments, accelerating intervention when necessary. This has highlighted the importance of consistent communication between medical and psychology teams to improve the evaluation and treatment of patients with functional symptoms.
- Non epileptic seizures (NES) are one of the most common referrals received. By having a timely response to referrals, and supporting families with psychoeducation around the condition, there has been a reduction in ED visits and repeated admissions to hospital. In particular, the mental health nurse specialist has worked on joint care planning with CYP, families and our medical colleagues to create a joint care plan/NES passport template to help contain anxiety and establish a clear management plan for families and schools to support CYP to get back into school and increase their access their education.

Dr Louise Brittenden, clinical psychologist

Objective 2 - Support the culture of psychological safety

2.1 **Psychology culture seminars**

Psychology culture seminars are trainee clinical psychology co-produced online seminars that are open to other clinicians, including those across the Psychological Professions Network and the public, including service users. The seminars provide multiple functions and impact, including:

- Inter-year learning and discussion in pre-seminar reading and discussion groups.
- Discussion of topical subjects not otherwise covered in the curriculum (or to more depth), many of which later become integrated into the main curriculum.
- Project management experience for trainees.
- Learning opportunities for, and promotion to, the wider psychological and public community.

There are three per year, organised by each cohort, often attracting global interest. The format usually entails presentations from key-note speakers, followed by breakout rooms of attendees on set discussion points, before feedback and Q&A. Feedback has been extremely positive.
Below are the recent topics that have been discussed.

2019	Power Threat Meaning Framework Clinical Psychology in the Digital Age	*2020*	Virtual Reality in Mental Health Covid-19 & NHS Nightingale London The Climate Emergency
2021	An Exploration of Outdoor Therapy Racism in Clinical Psychology Religion in Clinical Psychology	*2022*	Lived experience of distress Working Creatively in Psychology Women's Health
2023	The Cost-of-Living Crisis Class in Clinical Psychology Mental Health and the Online World	2024	Introduction to Islamic Psychology Working psychologically with people who have experienced war / conflict. Exploring Gender Diversity in NHSE
2025	Activism for Palestine & the role of Psychology		

Dr Alex Margetts, consultant clinical psychologist

2.2 Delivering trauma informed care training within community mental health services for older people (MHSOP)

It is now well recognised that childhood adversity can have an impact on health behaviours, and physical and mental health comorbidities across the lifespan. Early trauma, rather than fading with age, can continue to impact individuals throughout life, yet older adults may not always spontaneously report trauma, and it can be difficult to identify in assessments. The Mental Health Implementation Guide for community services states that services should be 'trauma-informed', yet many approaches to trauma-informed care have been developed in relation to working age services.

To address this gap, psychologists within MHSOP developed a tailored, trauma-informed care training package for community teams, specifically adapted to better meet the needs of older adults. The full day, in-person training was delivered across six geographical teams and was attended by a range of multidisciplinary colleagues including psychiatry, nursing, occupational therapy, peer support workers, health care support workers and administrative staff.

The morning session focused on psychoeducation, highlighting the prevalence and effects of early trauma, with specific reference to the impact on older adults. The afternoon focussed on applying this to practice, aiming to increase staff confidence in supporting service users in the stabilisation phase of recovery from trauma. The training included how to take a trauma-informed approach to assessment, formulation, and intervention, emphasising the therapeutic relationship and the importance of attending to endings from the outset. Considerations for working with older adults included adaptations for those with sensory impairments and dementia, the concept of post-traumatic growth, and identifying the ways in which mental health services can potentially retraumatise people.

Pre- and post-training measures showed significant increases in staff confidence across seven key areas.

Area of knowledge and skill	Confidence (%)	
	Before	**After**
Prevalence of trauma	49	81
How trauma is stored in the brain and how the threat system is activated	46	80
The longer-term effects of trauma on sense of self, relationships, and coping	60	84
Recognising and assessing trauma in older adults	45	81
Making sense of how trauma has affected an individual	52	84
Intervening to reduce distress around trauma	43	80
Managing endings / relationships with people who have experienced trauma	40	80
Overall Rating	48	81

Prior to the training there was great variability in confidence levels between staff teams, with only two in ten staff feeling above 50% confident in one team, compared to nine out of ten in another. After training, variability reduced to just over 5% between teams, with only one attendee (out of 80) rating their confidence below 50%, although even this person's confidence rating doubled after the training. Staff valued the training highly, with many reporting its practical use in daily work and expressing interest in further training.

Feedback on the day was positive with comments such as:

Based on feedback, the training was refined after the first round and will now be delivered twice a year to accommodate new starters and staff who missed the first round. The training is also being adapted for rollout within Unscheduled Care and Inpatient services, as well as to admin staff across MHSOP. The adaptations include greater co-production of the training, with those who have lived experience of trauma.

MHSOP Psychology team

2.3 – Development and implementation of the post incident pathway for staff support

A pathway for supporting staff after experiencing traumatic incidents in the workplace was developed in 2024, known as the Post Incident Pathway for Staff Support (PIPSS). The pathway was co-created with multi-disciplinary representatives from across LPT via a task and finish group. The process also involved consulting wider staff networks about their experience and expectations of post-incident support, and a comprehensive review of best practice literature.

Implementation of the pathway involves responding to staff-support requests in a structured and coordinated way. In a recent example, a referral was made to PIPPS from Community Hospital Services (CHS) to support the team on a stroke ward at a community hospital. A couple of remarkable events had occurred on the ward that left the staff team in a highly distressed and unsafe state of mind. These incidents involved physical and psychological attacks towards staff, by an unwell patient who died shortly afterwards. These events had traumatised many of the staff team.

There was a request for a psychological debrief, or Post Event Team Reflection (PETR). However, on meeting with relevant managers and operational leads, it became clear that there were several conflicting needs expressed by staff that all needed equal attention for them to develop a renewed sense of safety and confidence at work again.

For this, a needs-led and multi-faceted response was required, which was possible via the PIPPS pathway. The following support offers were provided to the team.

1) A PETR with special focus on bereavement support co-facilitated by the PIPPS lead alongside a counsellor from Amica.

2) Opportunities for one to one support by Amica counsellors.

3) Liaison with the Trust's security manager advisor to activate greater levels of out-of-hours safety measures at a hospital site, and referral to safety interventions training for the team to equip them with disengagement and physical hold skills.

4) Changes to in-house handover processes triggered by management to enable improved communication about high-risk patients. At the end of this process, affected staff members and those involved in the coordination of support, were grateful for the range of support they received and felt that it was effective in promoting recovery within and between the team.

Feedback from some of those involved are outlined below:

Since this incident, the PIPPS model has been presented to several management teams to enable greater awareness of the pathway for senior leadership teams, who have then communicated the information to their teams. There are plans to train senior managers on immediate debrief models ('defusion') so that they can develop their internal post incident support processes, in line with the recommendations within the PIPPS pathway.

Implementation of PIPSS creates a framework for debriefs, which allow staff to connect with each other, be heard and have their experience witnessed. It also connects disparate elements of the staff support offer, such as through Amica offering simultaneous one-to-one support as needed, and the Trust security advisor reviewing and changing security arrangements.

Click here to visit https://staffnet.leicspart.nhs.uk/support-services/psychological-professions/celebrations/ to learn more about resources for supporting colleagues.

Dr Bandana Datta, clinical psychologist

2.4 - Leicester psychologically informed environments for people experiencing homelessness

After contributing to the development of national guidelines on Psychologically Informed Environments (PIE) in 2012, Clinical Psychologists from LPT's Homeless Mental Health Service have been supporting the homeless sector in Leicester (including VCS, primary care, and local authority partners) to develop psychologically informed service provision. The guidelines acknowledge that many people who are homeless have trauma in their personal histories. This can influence the way they act in relationships with other people and in their relationships with services.

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News

Putting psychology on streets

By STAFF REPORTER

DOC IN TRAINING VIDEO TO HELP OUTREACH TEAM WITH HOMELESS

INNOVATIVE work that takes psychology on to Leicester streets to support homeless people is being featured in a new national training programme.

Dr Suzanne Elliott, clinical psychologist with Leicestershire Partnership NHS Trust has been filmed with Joseph Murphy, who manages Leicester City Council's street outreach team, for a free UK-wide online training programme focusing on the mental health needs of people who are sleeping rough.

Dr Elliott, part of the trust's homeless mental health service, was invited to take part in the programme because of her involvement in Leicester's street outreach service – which has increased the support already offered by the team – and

her expertise in "psychologically informed environments".

This is an approach that helps to provide services based on a strong understanding of the psychological and social issues behind homelessness.

Dr Elliott and trust homeless service mental health practitioners are going out on to the streets every week with the city council's street outreach team and said psychology on the streets is now earning growing recognition as good practice across clinical psychology for people who are homeless.

The new national programme aims to widen access to best practice training for street outreach workers who support homeless people with complex mental health needs.

Dr Elliott said: "The training film is directed at people who work with rough sleepers and aims to make them more mental health aware.

"I use a narrative approach to psychological wellbeing, which encourages practitioners to see beyond the problems that someone has, and seek to get to know the other stories about the person that are important to them.

"I'm sharing this approach with support workers to build trust and better relationships with rough sleepers.

"As practitioners working with people who are homeless, we take a lead from the expertise in the city council's street outreach team which has decades of experience in this area.

"When it approached us about joint working, we were keen to pilot something different by being a regular presence on the streets.

"We have also listened to people with experience of homelessness who were telling us we needed to be seen and trusted more by rough sleepers."

"Homeless mental health service staff now go out every week with the outreach team raising awareness about mental health and building relationships with people who have lost trust in everything while they are sleeping on the streets.

"There is still a lot of stigma attached to mental health services among rough sleepers and this is part of our work to tackle it."

Joseph Murphy said: "As an outreach service for rough sleepers, our aim has always been to take a personalised proactive approach.

"This is why I approached Dr Elliott to develop a joint working street-based model so we can empower people to take support and ownership on their journey away from rough sleeping.

Councillor Adam Clarke, deputy city mayor for public health, said: "Many rough sleepers have serious mental health issues that need tackling before they can even start to engage with other services.

"By taking a psychologist out to people on the street instead of expecting them to come to us, we are removing a barrier that will hopefully enable many more people to get the support they need to get off the streets for good."

Psychologically informed services for homeless people

Good Practice Guide

February 2012

This document is interactive and has been linked for easy navigation and use. Link through pages using the document map or the colour coded menus on the right.

Click to go to →

Document Map

Introduction

Psychologically Informed Environments (PIE)

Five key areas

Case studies

Appendix

The guidelines advocate that services should be designed with this in mind, and that staff should be aware when responding to people we may find 'difficult to manage'. LPT clinical psychologists support the PIE of agencies working with those experiencing homelessness by offering psychologically informed training, reflective practice groups, clinical psychology consultations, team formulation, the 'psychology on the streets' project and post-event team reflection meetings where appropriate.

Reflective practice groups have been positively received by homelessness services and are provided through an innovative collaboration between LPT and the University of Leicester. Trainee clinical psychologists form the University of Leicester DClinPsy training course facilitate groups alongside, and under the supervision of, an LPT clinical psychologist. Groups are developed according to demand and there are now groups in five different agencies. Services using reflective practice consider them essential to the operation of their service, which means that although staff are not mandated to attend, groups are well attended.

The original 'pilot' reflective practice group is now 12 years old, and a recent evaluation revealed that staff generally felt reflective practice groups were relevant to their work and helped staff to broaden their theoretical understanding of what they encountered at work, which then improved their practice. Staff reported that the groups helped them to better understand their colleagues and feel that they 'had each other's backs', and that reflective practice enabled them to remain focussed on the people who used their service.

Ethical pain at work can negatively impact our wellbeing and job satisfaction. Unsurprisingly then, it is also implicated in staff retention which is known to be a challenge in homelessness services. These reflective practice groups help staff to mitigate the 'ethical pain' they inevitably feel when working in imperfect systems. Our understanding is that this positively influences their experience of job satisfaction and wellbeing, and therefore improves staff retention.

Dr Suzanne Elliott, clinical psychologist

2.5 The impact of psychological research on patient care: an example from the Huntington's disease service

The Huntington's disease (HD) psychology team within LPT's Neuropsychology Department is an excellent example of how psychological professions are leading on a programme of research to improve psychological care for service-users, family carers, and service delivery.

The HD psychology team recently led an innovative, grant-funded, feasibility randomised controlled trial (RCT) designed to reduce anxiety and equip individuals in the earlier stages of HD with skills to manage distress. This was the first trial of its kind globally. The novel intervention, GUIDE-HD, blends principles from cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT) and was co-designed with experts-by-experience. The intervention demonstrated important levels of acceptability among participants. This research is advancing towards a fully powered trial, aiming to further establish its efficacy and expand its reach.

As part of the GUIDE-HD project, 10 colourful, user-friendly workbooks, tailored to the unique needs of people with HD, were produced. Locally, these resources have been integrated into psychological practice, to help enhance therapeutic outcomes.

An evidence-based HD formulation developed by the HD psychology team, published in 2022 and presented at international conferences, is being used to inform new international care guidelines for the behavioural changes in advanced HD. This formulation is used in team-based clinical discussions within LPT and has been adopted by clinical services across different countries, contributing to more consistent, psychologically informed care practices. Locally, this work supports person-centred, multi-disciplinary collaborative care, which has the person's life-story and wishes at its heart.

The HD psychology team is engaged in diverse research collaborations, including with Lancaster University, University of Leicester and the European HD Network's Working Group for Psychological Interventions and Approaches, co-chaired by an LPT psychologist. These projects explore critical areas such as the lived experiences of families affected by HD, the psychological needs often overlooked in HD care, and the development of evidence-based interventions. In addition to intervention development and testing, the HD psychology team have undertaken qualitative studies which have provided rich insights into HD family dynamics, and systematic reviews highlighting gaps in psychological support. These have all reinforced the need for a stronger psychological focus within HD services. The learning from this research has enhanced the proficiency of the HD psychology team and MDT working in understanding the needs of HD families, and therein providing care that is better attuned to their needs.

Recent evidence-based service developments have included projects relating to nature connectedness. This has increased access to nature for inpatients with HD, delivery of a nature connectedness programme, and surveying the perspectives of family carers and staff within the HD service. Furthermore, nature-based psychological practices have also been brought into the HD psychology team's staff support initiatives and positive feedback has been received from staff. Having observed benefits in the wellbeing of our service users with HD through access to nature, these initial findings will be shared at a national conference and in written publications.

The research culture within the HD psychology team has tangible benefits on service delivery such as securing funding for psychology posts, enhancing staff recruitment and retention, and most importantly, ensuring that service-users and carers receive psychologically-informed care tailored to their specific needs.

Dr Maria Dale, clinical psychologist

Objective 3 - Develop the psychological professions workforce

3.1 **Enhancing diversity within the workforce: leading on cultural responsiveness project and recruitment of new role into CAMHS.**

Members of the psychological professions led on developing and coordinating a whole-CAMHS project to assess the cultural responsiveness of the service (i.e. how accessible and able the service is to meet the needs of the diverse populations of LLR) to highlight recommendations for meaningful service development.

The project arose out of a requirement for a staff member to complete a piece of service development work for a leadership qualification, which then became passionately owned by the CAMHS Race Equity Group. Working collaboratively, this collective of colleagues from a broad range of professional backgrounds generously gave their time and served as a vital reference group in the design, implementation, and interpretation of the project. The project involved: analysing existing CAMHS data, conducting semi-structured interviews with all team leads, conducting unstructured interviews with non-substantive staff specifically from racialised backgrounds, and rolling out a whole CAMHS staff survey.

One of the key recommendations highlighted was the need to create a community participation lead role within CAMHS, with both an inward and outward focus. Outward regarding establishing meaningfully collaborative relationships between CAMHS and local communities, and inward in regard to leading on service development within CAMHS to better meet the mental health needs of our diverse communities.

This led to:

- creating a new job specification informed by broad consultation to minimise barriers that might discriminate against those not training through traditional routes;
- advocating fiercely for this to be banded at a more senior role (8a);
- ensuring the job was advertised broadly rather than solely on NHS jobs;
- completing multiple rounds of interviews, with interested parties from local communities on the panel to ensure the right person for the job;
- successfully recruiting into this full-time, permanent post in October 2024.

Alongside this, the project will also supports the Trust's work towards the Patient and Carer Race Equity Framework (PCREF) requirements to meet the mental health needs of young people and their families from racialised communities.

This stands out as a shining example of how the research, service development and leadership skills of psychological professionals can be used to advantageous effect to contribute to understanding the developmental needs of services, facilitating collaborative working groups, collectively designing plans for action, and pushing for innovative roles to effect meaningful change.

Dr Alison Smith, clinical psychologist
Dr Andy Brackett, consultant clinical psychologist

3.2 Leadership and transformation of community services: the introduction of the psychological awareness of unusual and sensory experiences team (PAUSE)

PAUSE is a new service within LPT, operational since 2024. The team is multidisciplinary, but all staff work in a psychologically-informed way. The psychological professions have been instrumental in establishing the team's core philosophy, values, and processes, and leading the team. With an emphasis on normalising and de-stigmatising unusual experiences, PAUSE seeks to help individuals, and their families better understand and manage often distressing experiences. The PAUSE team seeks to move away from the medicalisation of distress, and as such does not provide psychiatric labels or diagnoses. All interventions are formulation driven. GPs manage any prescription of medication.

Collaboration and partnership are central to PAUSE, and significant decisions about the developing service have been coproduced with lived experience partners in the psychosis pathway. The assistant psychologist in the team is leading on developing, delivering, and evaluating a new "Artistic Minds" group within PAUSE. This will focus on the facilitation of creative expression. This will be a joint venture in collaboration with a lived experience partner.

Most of the team are trained in family interventions (Open Dialogue or Behavioural Family Therapy). The team is still in its infancy and developing its family offer, but the intention is for the family/network of everyone referred into PAUSE to be offered support at the point of joining the service and again when discharge planning as a minimum.

A big part of PAUSE's remit is social inclusion and as such we have a member of the Employment Support Team embedded in the team. In partnership working, we have successfully supported many young people into employment. In keeping with the philosophy of place-based care, PAUSE has the capacity to work with individuals in their local communities and can visit those we support in locations to suit them. Our psychologists have successfully engaged in outdoor therapy.

PAUSE has sought to develop links with the three Universities in Leicestershire, to help the wellbeing services at these universities recognise students who might present with an At-Risk Mental State and refer them to PAUSE.

As part of our community working remit, PAUSE has successfully collaborated with local Imams to raise awareness of how to identify individuals who might be at risk of developing psychosis. PAUSE has also benefitted from discussion with Imams about how best to have discussions about unusual experiences in a culturally relevant / meaningful way. In setting up the service, focus groups were held in racially diverse areas of Leicester to collaborate with local community groups and learn from them how best to make the service engaging and accessible, especially to communities that are traditionally underrepresented in mental health services.

Dr Helen Reader, consultant clinical psychologist

3.3 Developing new roles: the introduction of psychologist-approved clinicians

The 2007 amendments to the Mental Health Act 1983 introduced the roles of approved clinician (AC) and responsible clinician (RC), enabling mental health professionals other than psychiatrists to perform duties under the Mental Health Act previously performed by psychiatrists. Practitioner psychologists are one of four professions who may be approved as Multi Professional Approved Clinicians (MPACs). Psychologist ACs take overall responsibility for the care and treatment of the patient, making decisions about all aspects of the patient's care including renewal (or removal) of detention under a section of the Act, while working alongside consultant psychiatrist ACs who are responsible for medication and physical health assessment. By widening these roles beyond what was exclusively a psychiatric function previously, psychologists are able to work as ACs to promote and enhance psycho-social approaches to patient care.

Within LPT, there is a psychologist AC in the inpatient mental health rehabilitation service who acts as RC for patients in the open and high-dependency wards. Placing greater emphasis on psychosocial rehabilitation and engagement with psychological services, and widening the lens from a predominantly medical focus, promotes a range of potential benefits including reduced likelihood of re-admission, improved quality of life and a greater understanding of strengths and difficulties.

Dr Mandi Hodges, consultant clinical psychologist