Health, Care, and Life Sciences Research Group

Curia

Parliamentary Roundtable Summary Report:

From Crisis Management to Recovery: Delivering the Next Phase of Mental Health Reform

Date: 25th November 2025

Host: Cat Eccles MP, Member of the All Party Parliamentary Group on Mental Health, Chair of the All Party Parliamentary Group for Healthcare Workers, and MP for Stourbridge

Chair: Rt Hon Andrew Stephenson CBE, Chair of Curia's Health, Care and Life Sciences Research Group and former Minister of State for Health

Title	First Name	Surname	Job Title	Organisation
	Cat	Eccles MP (Host)	Chair	APPG Healthcare Workers
Rt Hon	Andrew	Stephenson CBE (Chair)	Chair	Curia, Health, Care, and Life Sciences Research Group
	Amanda	Delaney	EA	Patient Advocate
	Arden	Tomison	Founder & CEO	Thalamos
Cllr	Craig	Smith	County Councillor	Leicestershire County Council
	David	Bremner	Group Medical Director	Turning Point
	Faraz	Farooqi	CEO	Cavenham Solutions
	Gemma	Byrne	Policy and Influencing Manager	Mind
	Heema	Sharma	Dental Professional	Dental Practice
Dr	Jon	Van Niekerk	Group Medical Director	Cygnet Health Care
	Koyin	Fuwa	Public Affairs & Media Advisor	Royal College of Psychiatrists
	Lucy	Scarborough	Director of Communications and Marketing	Cygnet
	Luke	Pratsides	Head of Clinical Governance	Numan
	Marcus	Jones	County Councillor	Nottinghamshire County Council
Dr	Melinda	Rees	Chief Executive	Psyomics
	Nafisa	Abdullahi	Founder	The Ejura Foundation
	Paul	Wright	CEO	Alliance 4 Children
	Paul	Scott	Chief Executive	Essex Partnership University NHS Foundation Trust
	Penny	Bee	Professor of Applied Mental Health Research	The University of Manchester
	Sanya	Rajpal	CEO	AdagioVR
	Steve	Gilbert OBE	Co-Chair Mental Health Working Group	NHS Race & Health Observatory

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	Tamunoboma	Briggs	CEO	Changing Lives Foundation Charity UK
	Tony	Reeves	Board Member	EIHA
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Dr	Zoe	Seager	Chief Client Officer	Thalamos

Key points discussed and actions

1) Shared diagnosis: a system stuck between crisis management and recovery
Key points

Participants described a mental health system under sustained pressure, where patients experience care as bottlenecks rather than a joined-up pathway – struggling to access inpatient support when unwell, and then struggling to leave hospital once clinically ready. The group stressed an "implementation gap" between national ambition (long-term plans, reform commitments and the Mental Health Bill) and day-to-day experience on wards and in communities.

Actions

- Define and publish a shared local definition of "crisis", "intermediate support" and "recovery led care" to align commissioning, delivery and performance reporting.
- Map the end-to-end patient journey locally, identifying the main pinch points between lower-level support, crisis care, and step down provision.

2) Delayed discharge and lack of supported housing are amplifying bed pressure
Key points

Speakers argued that a significant share of inpatient bed occupancy is driven by social factors rather than clinical need – particularly delays in accessing supported accommodation, care packages and community step down options. This was framed as part of a wider NHS challenge, intensified in mental health by risk concerns, fragmented decision making and shortages of appropriate provision.

Actions

- Make supported mental health housing a joint priority in local housing and health strategies, with named senior leads.
- Establish integrated discharge "huddles" that include housing providers and local authority decision makers as standard.
- Create or expand transitional recovery units (using existing estate where feasible) linked formally to housing providers to reduce "unsafe discharge" and revolving door admissions.
- Implement an integrated care board level delayed discharge dashboard with categories for housing, social care and clinical causes, reviewed routinely with agreed escalation routes.

3) Integration must include the independent and voluntary sectors

Key points

Participants rejected framing this as NHS versus independent or voluntary provision. The argument was that independent and voluntary providers are already integral to the pathway, and the priority is aligning all providers around shared recovery outcomes, consistent standards, and transparent data.

Actions

- Agree a single set of local recovery outcomes and quality expectations across NHS, independent and voluntary providers.
- Introduce shared outcome dashboards and data sharing agreements across commissioned pathways.
- Reduce duplication and fragmentation by consolidating contracts where appropriate and simplifying interfaces between providers.

4) Intermediate care is the missing middle

Key points

MP reflections focused on constituents "bouncing" between low-level support and crisis services, with insufficient intermediate provision. This cycle undermines employment, relationships and wellbeing, and contributes to repeat admissions.

Actions

- Commission specific intermediate mental health support pathways, with clear eligibility and fast access, designed to prevent deterioration and avoid readmission.
- Require discharge plans to include a defined intermediate support offer, not only a handover to primary care or generic community services.
- Track "repeat crisis presentations" and "time to relapse after discharge" as outcome measures.

5) Fear, blame and risk aversion are shaping decisions

Key points

A recurring theme was a culture of fear – fuelled by scrutiny, inquiries and accountability pressures – contributing to risk aversion and longer lengths of stay. Several speakers argued for shifting from "risk ownership" to shared responsibility for recovery, and reframing "risk" as "safety management" through collaborative practice.

Actions

- Adopt a shared "safety management" approach across providers, supported by joint training and consistent language.

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- Embed co-produced risk and safety planning with patients and carers as routine practice.
- Create a cross-system forum to review learning from adverse events in a non-punitive way, focused on improvement and shared accountability.

6) Dignity, autonomy and advanced choice documents must be real in practice

Key points

The group emphasised core principles: choice and autonomy, least restriction, therapeutic benefit, and seeing the person as an individual. Lived experience highlighted how Mental Health Act assessments can strip people of voice, with lasting effects across care journeys. Advanced choice documents were positioned as a practical mechanism for restoring autonomy.

Actions

- Set a local implementation plan for advanced choice documents, including timelines, minimum standards and staff training.
- Ensure advanced choice documents are accessible at the point of crisis across settings (acute, community, crisis teams, approved mental health professional processes).
- Audit dignity and autonomy indicators (including experience of assessments) and publish improvement actions.

7) Digital and data: focus on basic infrastructure that follows the patient

Key points

Speakers stressed that digitisation often reinforces organisational silos. Patients' information can sit across numerous unconnected records, particularly across NHS, third sector, prisons and addictions services. A consistent view was that records and pathways should be patient centred, and that the Mental Health Act process could be used as an anchor for system wide improvement.

Actions

- Prioritise interoperability and patient centred information sharing, starting with Mental Health Act pathway data as a "backbone" dataset.
- Implement role-based access to key documents (including advanced choice documents) across all relevant services.
- Establish a minimum data standard for tracking outcomes across the pathway (admission, discharge readiness, housing status, follow up, relapse, readmission).

8) Workforce pressures and retention remain central

Key points

The discussion highlighted current and emerging workforce strain, including retention challenges at senior levels. Participants argued that sustainable reform requires supporting staff wellbeing, strengthening capability and placing workforce investment where it will reduce pressure across the pathway.

Actions

- Produce a workforce investment plan aligned to pathway gaps (community, intermediate care, inpatient, crisis).
- Implement retention measures for senior clinicians and leaders, informed by existing charters and evidence.
- Measure workforce wellbeing and vacancy rates alongside service outcomes to track system sustainability.

9) Inequalities and culturally sensitive provision

Key points

Participants noted that mental health experiences and outcomes vary by background, with calls for culturally sensitive support, improved accessibility, and attention to racial and ethnic disparities in care and detention experiences.

Actions

- Co-design culturally sensitive support offers with community organisations, with clear referral routes and translated or accessible materials.
- Monitor outcomes and experiences by protected characteristics and act on disparities through targeted improvement plans.

10) Broader prevention and whole person integration, including oral health

Key points

While crisis pressures dominated, contributors also highlighted prevention and reintegration, including the role of existing touchpoints such as dental and primary care. One proposal was to use routine GP and dental contact to support recovery and spot early issues, particularly for young people.

Actions

- Pilot integrated referral pathways via dentistry and primary care for early identification and onward support, especially for children and young people.
- Add physical health checks and oral health support into discharge and recovery plans, with clear follow up responsibilities.
- Evaluate pilots using practical metrics: attendance, referral completion, relapse rates and patient experience.

Suggested outputs from this roundtable

- A short set of cross-sector recommendations structured around: housing and discharge, intermediate care, advanced choice documents and dignity, patient centred digital records, workforce, and accountability culture.
- A draft local "30, 60, 90 day" action plan to demonstrate immediate progress alongside longer term reform.