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Changemakers: Creativity and Value Creation (BMHP5014)

Component 2: Poster and Pitch

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SAFEMIND

AI-supported early emotional support and service navigation for ages 13-25



● THE NEED AND SERVICE GAP

Young people face stigma, long waits and confusing entry points (NHS England, 2023a). Support is fragmented across education, community and clinical services. CAMHS supports children and adolescents, while NHS Talking Therapies mainly serves adults. Around age 18, needs continue but consent, safeguarding and referral routes change.

GAP: no single, age-responsive pathway combines early self-help, pattern recognition and navigation across education, community, CAMHS and adult services.

● WHAT MAKES SAFEMIND DIFFERENT?

HEADSPACE¹

Meditation, sleep and general wellbeing content; not designed as a UK referral bridge.

WYSA²

AI-led self-help and coaching; SafeMind adds local service rules, professional review and a 13-25 transition pathway.

NHS DIGITAL

Information and approved digital therapies exist, but users still navigate separate services and eligibility routes.

SafeMind fills the navigation and continuity gap rather than replacing these services.

● HOW THE AI WORKS

1 INPUT

User-entered mood, sleep, stress, goals, age band, accessibility needs and optional journal themes. No passive monitoring without consent.

2 PERSONALISE

Rule-limited AI matches trends to clinically reviewed CBT-based exercises, coping tools and age-appropriate local pathways.

3 REVIEW

Clinical and safeguarding leads approve content, escalation rules and referral logic; patterns and safety events are audited.

4 CONNECT

Low-risk users receive self-help and signposting. Risk indicators trigger crisis guidance and referral to a professional, not an automated diagnosis.

● ONE APP, TWO AGE PATHWAYS

AGES 13-17

Child-friendly privacy and consent information; safeguarding rules; links to school support, trusted adults, GP and local CAMHS. Escalation follows local child-protection procedures.

AGES 18-25

Adult consent and referral routes; links to GP, university support, community services and NHS Talking Therapies.

TRANSITION

Before age 18, users receive a reviewed transition plan and warm signposting so support is not lost at the service boundary.

● GOVERNANCE AND SAFEGUARDS

- UK GDPR and Data Protection Act 2018: explicit consent, data minimisation, encryption, retention limits and a DPIA.
- Clinical risk management: approved content, human oversight, incident reporting, accuracy and bias audits.
- Safeguarding: age-specific escalation protocols, crisis signposting and named professional accountability.
- Accessibility: WCAG 2.2 AA testing, plain language, multilingual options and staff-assisted or non-digital routes.

● £250,000 PILOT: FUNDING AND DELIVERY

FUNDERS

ICB innovation funding, university partnership and matched grant funding.

DELIVERY

Commissioned digital developer with clinical, safeguarding, information-governance and cybersecurity leads; paid youth co-production panel.

BUDGET

£120k development; £40k clinical/safeguarding input; £30k security and accessibility testing; £35k pilot delivery/staff training; £25k independent evaluation and contingency.

TIMELINE

M1-3
CO-DESIGN

M4-6
BUILD

M7-9
PILOT

M10-12
EVALUATE

M13+
ROLLOUT

● AUDIENCE AND REACH

WHO

Ages 13-25 in education and community settings, including disabled and minoritised users.

VALUE

Earlier, equitable access supports wellbeing, dignity, continuity and the common good.

YOUTH

A paid youth panel shapes AI language, tests accessibility and reviews findings.

REACH

Staff briefings, inductions, NHS/community websites, social media and youth ambassadors.

● ANTICIPATED OUTCOMES AND EVALUATION

Compare baseline, 4- and 12-week results, plus pilot-end findings: wellbeing scores; time to appropriate support; earlier help-seeking; appropriate referrals; engagement; crisis escalations; satisfaction; accessibility and differences between groups. Pilot targets: ≥70% satisfaction, ≥60% 30-day engagement and 20% faster navigation to appropriate support. Targets will be tested, not assumed.

CONCLUSION

SafeMind provides one governed, age-responsive pathway. Personalised early help and safe navigation across the child-adult boundary could improve wellbeing, accelerate help-seeking and make referrals more appropriate.

ICBs, NHS providers and education partners: co-fund and evaluate the pilot.

THE PITCH

Introduction

SafeMind is an AI-supported mobile application providing early emotional support for young people aged 13-25. It combines mood tracking, evidence-based self-help, personalised recommendations and signposting to GPs, CAMHS, NHS Talking Therapies and education wellbeing services. Its purpose is not to diagnose or replace practitioners, but to help users recognise difficulties, take an appropriate first step and reach professional support earlier. Support would be available privately at any time, including when a user is unsure whether their concern is serious enough to discuss. This responds to NHS priorities for prevention, early intervention and digitally enabled care (NHS England, 2019; NICE, 2023).

Background and Market Gap

Young people's mental health remains a major concern in England, while stigma, uncertainty and delays can restrict timely help-seeking (NHS England, 2023a). Existing platforms address parts of this problem. Headspace provides mindfulness, meditation, sleep resources, coaching and AI-supported guidance, while Wysa offers an AI conversation tool, evidence-based exercises and care integration (Headspace, 2026; Wysa, 2026). These are valuable services, so SafeMind's claim is not that AI itself is new. The identified gap is a co-produced UK pathway for ages 13-25 that connects personalised early support with local NHS, CAMHS, GP, school, college and university services across the transition from adolescence to adulthood. AI is preferred to a static content library because it can respond to changing mood patterns, prioritise relevant resources and personalise navigation at scale, while defined clinical rules retain clear boundaries and escalation routes.

Innovation, Creativity and Value Creation

SafeMind represents service and process innovation because it combines functions that are often fragmented: self-monitoring, tailored self-help and navigation into professional care. Rather than producing a completely new technology, it applies existing technologies in a new service configuration. Creativity is demonstrated by reframing the smartphone from a general wellbeing tool into a bridge between young people and existing services. A Design Thinking model will guide development through empathising with users, defining the access problem, generating ideas, prototyping and repeated testing. This iterative model allows unsuccessful features to be changed before costly rollout. It supports entrepreneurship by converting an identified social need into a feasible digital service, securing resources and testing whether commissioners and educational institutions will adopt it. Value is created for users through accessible and personalised support, and for services through earlier, more

appropriate help-seeking and clearer navigation. Its contribution to the common good is improved equity, dignity and access, including for users who may initially avoid formal help because of stigma.

Impact and Measures of Success

Primary beneficiaries are secondary school pupils, students and young adults experiencing stress, anxiety or low mood. SafeMind may also help families, educators and practitioners by encouraging earlier recognition and clearer routes to care. A 12-month pilot will establish baseline data and compare outcomes at four and twelve weeks. Measures will include changes in a validated wellbeing score, help-seeking behaviour, time from first concern to appropriate contact, completed signposts, continued app engagement, user satisfaction and accessibility across demographic groups. Interviews will explore whether users felt understood and whether recommended pathways were useful. It will not claim to shorten NHS waiting lists directly; instead, evaluation will test whether it supports users while waiting and reduces avoidable delay in reaching the correct service. Results will determine whether the application should be changed, expanded or discontinued.

Implementation

SafeMind would be developed by a small digital-health company with software developers, a clinical lead, safeguarding adviser, data-protection specialist and paid youth co-design panel. Initial funding could combine an Integrated Care Board innovation budget, university partnership and health-innovation grant. An indicative 12-month pilot budget is £250,000: £120,000 for development, £40,000 for clinical and safeguarding input, £30,000 for security and accessibility testing, £35,000 for pilot delivery and staff training, and £25,000 for independent evaluation and contingency. This is a planning estimate that would require competitive quotations before approval. The pilot would involve one secondary school, one university and linked primary-care or community partners. Staff would receive training on the app's boundaries, safeguarding escalation, referral routes and digital inclusion before phased rollout. A project board would review safety incidents, usage and evaluation findings monthly.

AI Risks and Safeguards

AI may produce inaccurate or unsuitable responses, miss safeguarding indicators or reproduce bias from incomplete training data. Over-reliance could also delay professional help. Sensitive data creates privacy risks, while limited devices, connectivity, language access or digital skills may exclude some users. SafeMind would therefore use clinician-approved content, restricted response pathways, human safeguarding oversight, crisis

signposting, bias and accuracy audits, data minimisation, transparent consent and a Data Protection Impact Assessment. Users would receive repeated reminders that the tool is not a clinician or emergency service. Non-digital referral information translated content and staff-assisted access would remain available. These controls reflect ICO guidance on fairness throughout the AI lifecycle and NHS guidance that digital care should complement non-digital support (ICO, 2023; NHS England, 2023b).

Co-production and Stakeholder Involvement

Young people would be decision-making partners throughout development rather than consulted once. A diverse paid youth panel would include different ages, backgrounds, disabilities and levels of previous service use. Members would help define needs, select language and functions, review accessibility and safeguarding, test prototypes and interpret pilot findings. They would retain representation on the project board, receive feedback showing how their recommendations were used and approve major changes before rollout. GPs, mental health practitioners, educators and voluntary organisations would validate content and referral pathways. This continuous co-production supports shared decision making and keeps the service relevant to its intended users (NICE, 2021).

Policies, Services and Professional Links

SafeMind would comply with UK GDPR and the Data Protection Act 2018 and support inclusive access under the Equality Act 2010. Its focus on wellbeing and prevention is consistent with the Care Act 2014, while NICE guidance would inform clinically appropriate self-help content. GPs, CAMHS, NHS Talking Therapies, education wellbeing teams, nurses, social workers and voluntary organisations would provide the professional and service network for further assessment and intervention.

Conclusion and Call to Action

SafeMind offers a practical bridge between everyday wellbeing applications and formal services. Healthcare providers, Integrated Care Boards and educational institutions should jointly fund a 12-month pilot and independent evaluation. Adopting SafeMind would not replace existing care; it would give young people a safer, clearer and more personalised first route towards it. The next step is to establish the youth co-design panel and implementation partnership.

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