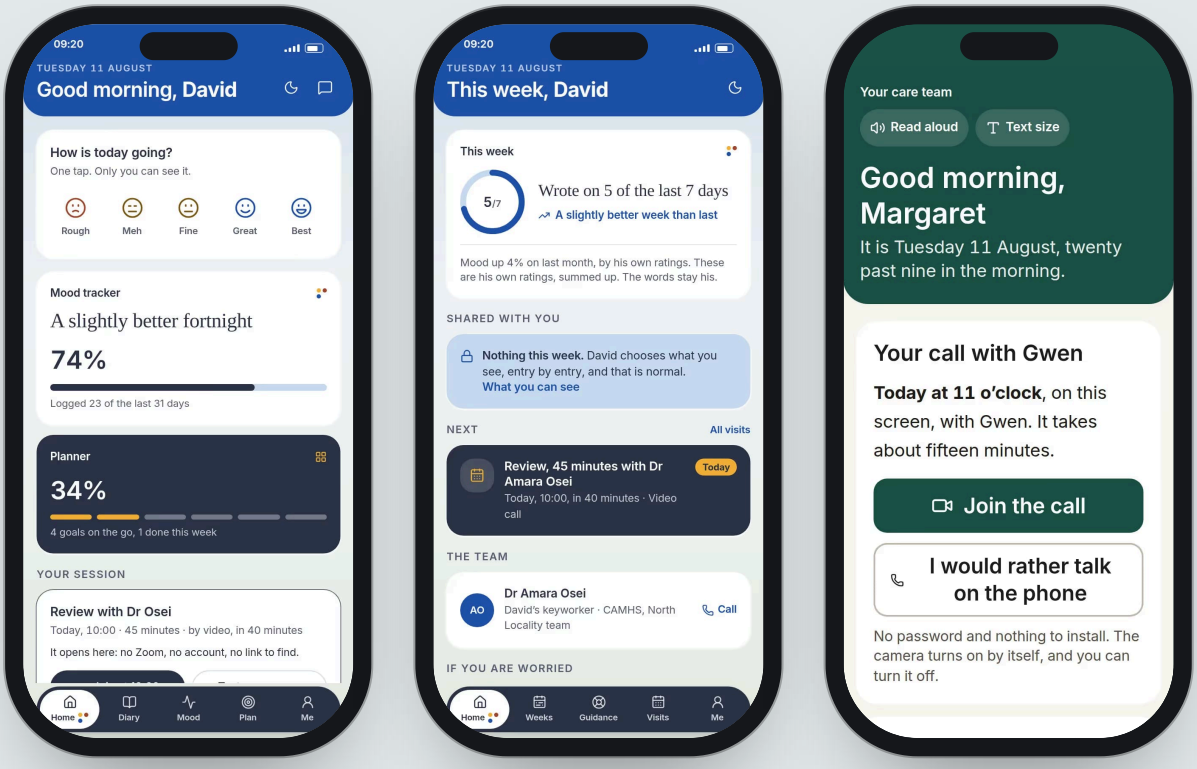
CASE FILE 003 · NHS MENTAL HEALTH TRUST · 2020 · DISCOVERY → LIVE BETA

Safe Space, NHS mental health care when it moved home

WHAT	a private diary for teenagers, a summary for parents, a simple app for older adults, and one clinician tool for calls
FOR	an NHS trust's young people's and older adults' mental health teams
PROBLEM	COVID sent clinicians and patients home, and the notes system was built for a room

In 2020 COVID sent an NHS trust's mental health clinicians home, and the people they cared for were already there. Care that had happened across a desk had to happen through a screen, for the first time, at both ends of the age range. This built the **connection in between**: a diary private enough for a teenager to use, an app simple enough for someone making their first video call, and one clinician tool made for calls rather than rooms.

Safe Space · The three apps



The diary David, 15

Private by default. Every share is his, entry by entry: who, and how much, from his mood alone to the whole entry.

Parents & carers Claire, his mum

That he wrote this week and which way it went. Never the

Your care team Margaret, 78

One button to join a call, a phone call instead, and four questions about her body. Built for a first video call.

Reset Full screen ↗

words, unless he shares them with her.

Reset Full screen ↗

Reset Full screen ↗

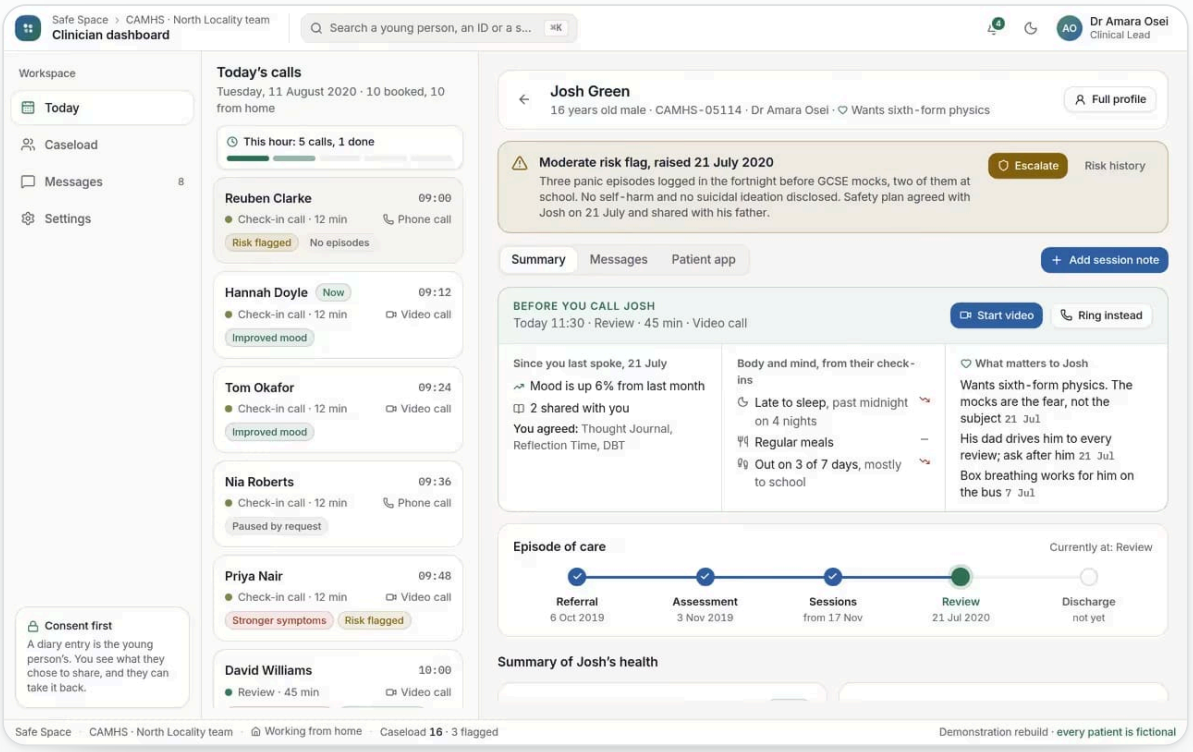
Write an entry on the left and choose who reads it, and how much. In the middle, what his mum sees: that he wrote, which way the week went, never the words. On the right, the other end of the same service: Margaret, 78, reaching her nurse through a screen for the first time.

Safe Space · The clinician dashboard

Accessibility: The clinician tool, the three phone apps and the notes system before all pass axe-core's WCAG 2.1 AA rules at desk and phone, in both settings, and in the 16 states this file links into. Not yet tried with a screen reader. The statement

Weight on a first visit: the clinician dashboard, 349 KB of script and 13 KB of style, compressed, against budgets of 365 and 15 KB; the phone apps, 293 KB of script and 16 KB of style, compressed, against budgets of 310 and 18 KB. The build fails if a product passes its budget.

The states around it, each one a link: a caseload search that finds no one. Each says what is true, names the next step and offers one action.



The clinician tool works on a phone, as it had to once the clinic was a kitchen table: the day's calls as cards and each record in full. Open it full screen for the whole tool.

Open Safe Space ↗

ROLE	CLIENT	DURATION	FRAMEWORK
Product Designer	NHS trust, mental health services (anonymised)	A year · discovery → beta	GDS Service Standard

I OWNED	The discovery research, the privacy model, and the design of the diary, the parents' summary and the clinician tool, through to the beta; and the older adults' app, proposed on the same model
WITH	The CAMHS clinicians, a youth mental-health nurse who co-facilitated the teen interviews, the trust's clinical safety officer, digital governance, and two developer leads
THEIRS	The constraints, set by the trust's clinical safety officer and digital governance in the feasibility session, and the beta, run by the clinic as part of real care
CONSTRAINTS	Care that moved home overnight in 2020, a teenager's privacy under Gillick competence, the GDS Service Standard, the trust's clinical safety and digital governance, and not one minute of added workload for clinicians
FRICTION	Parents wanted to see what their teenagers would not show them, by forty-six points; parents get a summary, never the words

THE OUTCOME

21 people, 3 weeks, 1 real clinic

19 interview sessions with 12 people and 70 surveys in; a live beta out, used as part of real care.

THE PROBLEM

Care moved home overnight

In 2020 clinicians and patients were sent home. The notes system assumed a room, and the clinic lost sight of people between calls.

THE MOVE

Three apps, one clinician tool

A diary private enough for a teenager, an app simple enough for a first video call, and a clinician tool built for calls rather than rooms.

00

WHEN CARE WENT HOME

Two ends of one service, sent home at once

I came to the trust's work through an agency, with access across its projects. The largest was this one. In 2020 COVID moved its mental health care out of clinics and into people's homes, and the software it ran on was built for a room.

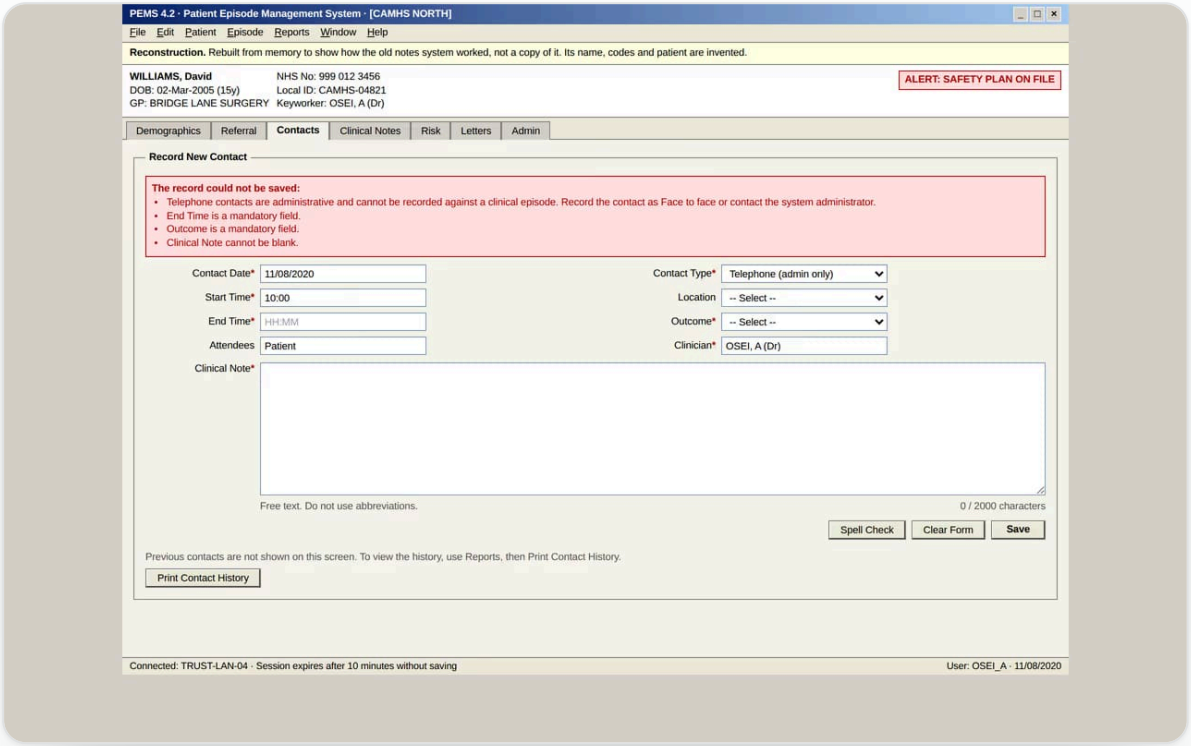
The young people were fluent on their phones, on Instagram and the rest, and guarded about how much of themselves left them. Plenty were not at home on Zoom. They needed somewhere that felt safe enough to write in, like a diary, with full control over how much of it reached a clinician or a parent.

The older adults were the other end of the same spectrum: people who needed to talk to their nurse more often than ever, could not see them, and were asked to use a computer or a phone to do it, often for the first time. They needed the lowest barrier to entry that could be built.

The clinicians were at home too, with four or five people to see an hour. In each call they had to build a connection through a screen, and write down enough of what mattered that the next call, with no waiting room and no corridor to warm it up, could start where this one ended.

And the two were joined. These are services where the body and the mind show up in each other first: a teenager's sleep before their mood, an older adult's meals and pain before theirs. Shut in at home, both got worse together, and the old system recorded neither.

Before · The notes system



The old system is a fixed 1024 pixels wide, as it fitted an office monitor. On a phone it is a picture, which is the point.

What the old system assumed, and what the new one does instead. Each line opens the tool at the place it does it.

THE OLD SYSTEM ASSUMED	THE NEW TOOL DOES
A contact happens in a room, and a room is mandatory	A contact is a call, by video or by phone, and a room is the exception. Book one
One appointment at a time, in a building	Four or five calls an hour, with the hour on screen: how many, how many done, who is next. See the day
The history is a printout	Each call opens on a brief: what has changed since you last spoke, what you agreed, what matters to them. Open Josh's
A note is a free-text box for the record	A note keeps one thing to remember for next time, and the next call opens on it. Open Hannah's
Mood, if anything, typed up afterwards	The body beside the mood, from the person's own check-ins: sleep, meals, getting out, pain. Open Margaret's
One kind of patient, at a desk in an office	One tool for the young people's team and the older adults' team, on a laptop at a kitchen table or on a phone. Switch team

01

THE BLUEPRINT

The system drawn first, then the screens

Before the dashboard: the service as a system, the one gate everything crosses, the four numbers it was built to move, the evidence under each decision, and the spec the rebuilt product is held to on every release.

SERVICE BLUEPRINT

The diary and the clinician dashboard as a service: twelve moments across two people, with the consent gate as the moment the whole service rests on. Pan, zoom, pick a moment, count the clicks to any point, switch the sad paths on.

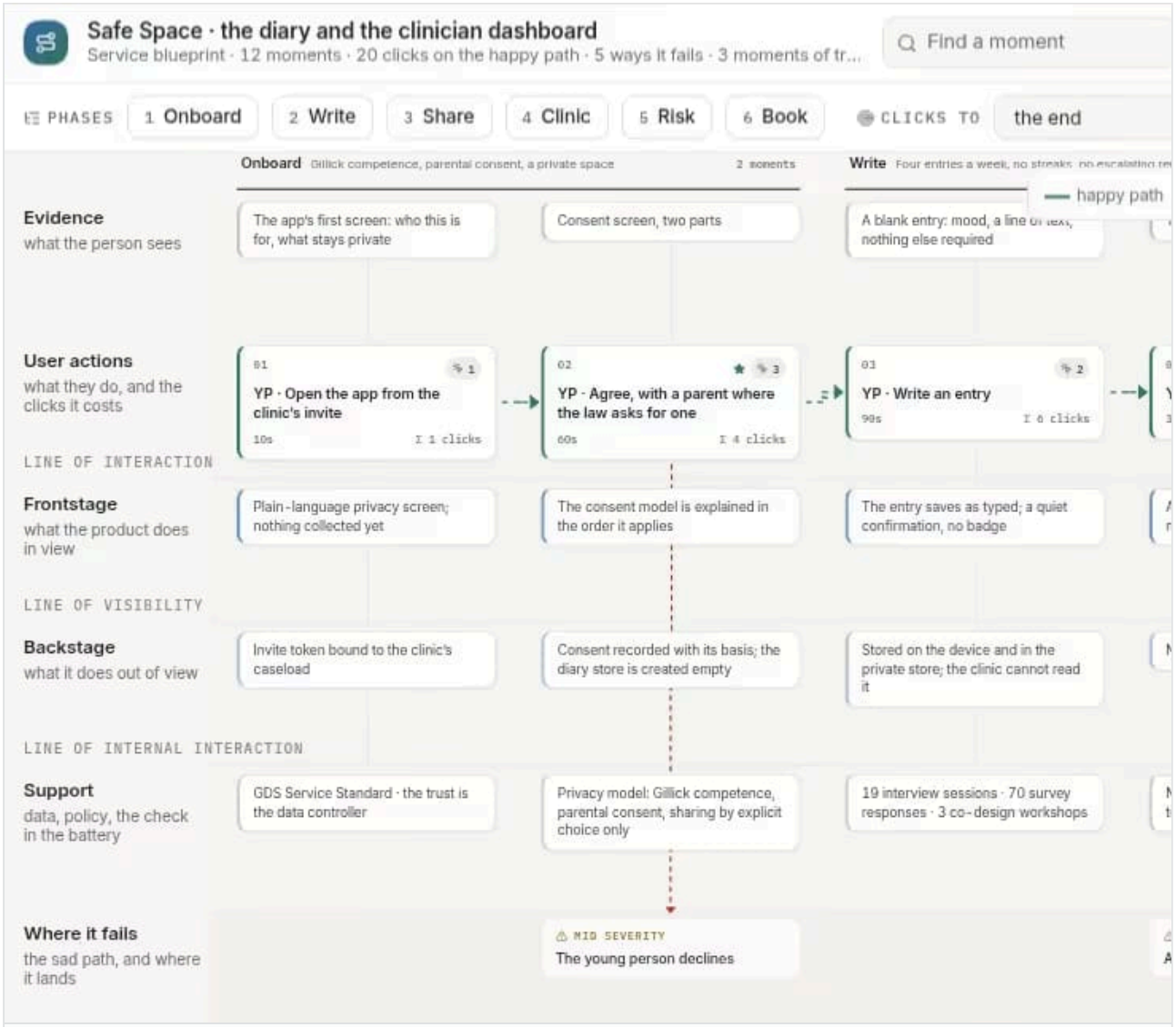
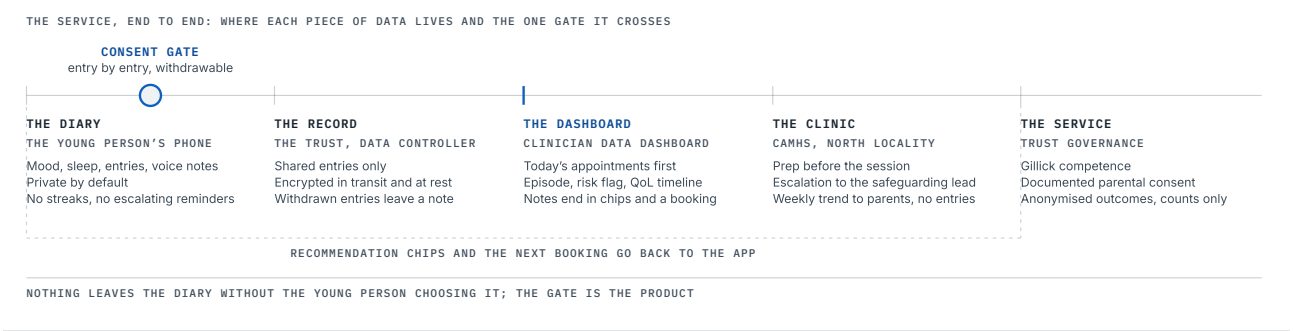


FIG. 001 · THE SYSTEM



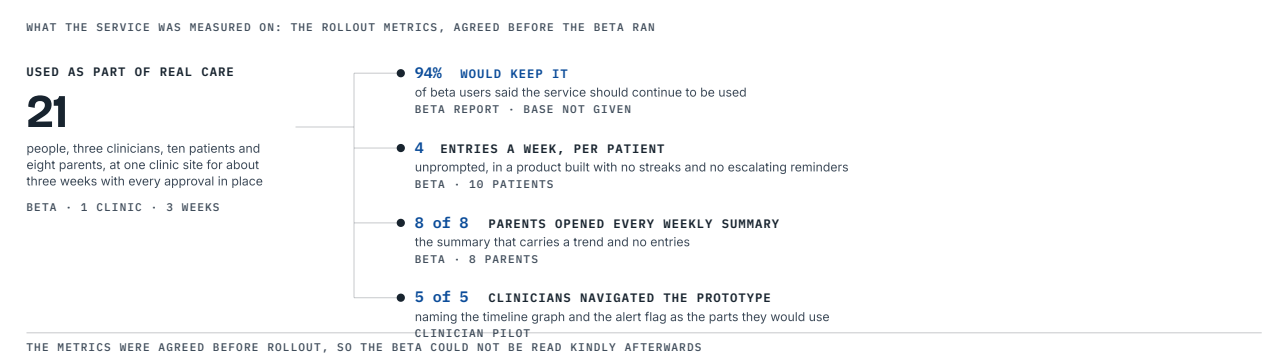
Five places the data can be, and one gate between the first two. Everything the dashboard shows has crossed it; everything it writes back goes round the return leg.

The dashboard is the fourth thing in that drawing, not the first. The diary is private on the phone, the record holds only what crossed the gate, and the clinic reads the record. Draw it in that order and most of the product decisions make themselves: a clinician

cannot see an entry the young person did not share because there is no path on the drawing by which they could.

The return leg is the part the first sketches missed. A session ends in recommendation chips and a booking, and those go back to the app in the same thread as the conversation, which is the only reason the dashboard adds no admin step of its own.

FIG. 002 · THE KPI TREE



One root, four branches, every number from the beta report. The tree was agreed before the beta ran, which is the only way a beta metric means anything afterwards.

FIG. 003 · THE EVIDENCE



Each decision on the right has a finding behind it and a count behind the finding. The research section further down carries the programme in full; this is the part of it that became the product.

The spec below is the part of this that is new. The rebuilt dashboard on this site is held to six statements, each written as an acceptance test before the screen was rebuilt, and each verified by a check that runs before every release of this site. The right-hand column names the check. Spec-driven in the plain sense: the sentence came first, the screen had to satisfy it, and something other than my eye confirms that it still does.

01

THE SPEC

SS-01

No diary entry is visible to a clinician unless the young person shared it.

ACCEPTANCE

Given a record, when the conversation opens, then only entries marked as shared appear, each stamped with who shared it, and the settings page says who can see an entry.

VERIFIED BY

The shared-entry card in every thread, and the consent list under Settings.

THE PRODUCT, EVERY THREAD

02

THE SPEC

SS-02

A risk alert cannot be switched off while a clinician holds a caseload.

ACCEPTANCE

Given Settings, when the clinician reaches the risk-flag preference, then it reads Always on and carries no switch.

VERIFIED BY

The check “the risk alert cannot be switched off”.

THE INTERACTION SUITE, RUN BEFORE EVERY RELEASE OF THIS SITE

03

THE SPEC

SS-03

Escalation is one act, is logged, and notifies the safeguarding lead.

ACCEPTANCE

Given a flagged record, when Escalate is pressed, then the flag rises to High, the risk history gains a dated entry and a notification is raised.

VERIFIED BY

The checks “Escalate raises the flag to High” and “the escalation is confirmed in a toast”.

THE INTERACTION SUITE, RUN BEFORE EVERY RELEASE OF THIS SITE

04

THE SPEC

SS-04

The dashboard opens on the next appointment, not on a menu.

ACCEPTANCE

Given the day loads, when nothing has been clicked, then the first appointment’s record is on screen with its episode and its risk flag.

VERIFIED BY

The check “opens on the first appointment’s record”.

THE INTERACTION SUITE, RUN BEFORE EVERY RELEASE OF THIS SITE

05

THE SPEC

SS-05

A booking reaches the young person’s app.

ACCEPTANCE

Given Book, when an appointment is saved, then it appears on the week, in notifications, and the confirmation says it was sent to the app.

VERIFIED BY

The checks “Book opens the appointment dialog” and “booking confirms in a toast”.

THE INTERACTION SUITE, RUN BEFORE EVERY RELEASE OF THIS SITE

06

THE SPEC

SS-06

The whole dashboard works on a phone.

ACCEPTANCE

Given a 390-pixel viewport, when any screen opens, then four tabs are on screen, nothing scrolls sideways, and the record reads in full.

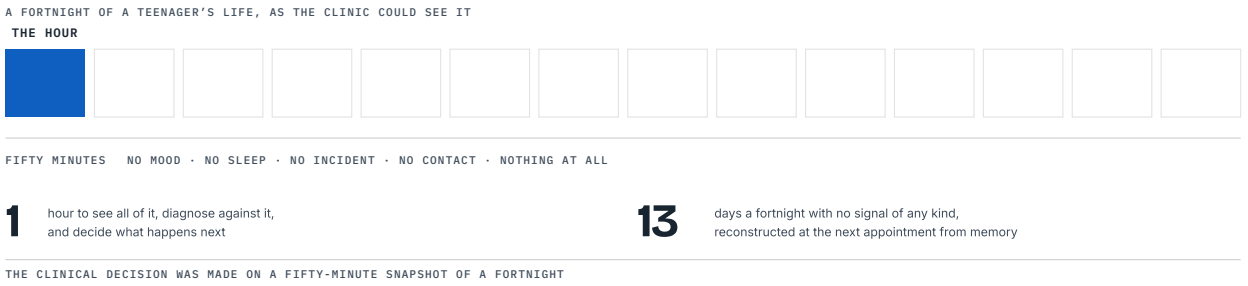
VERIFIED BY

The check “nhs phone: 4 bottom tabs, no sideways scroll, no errors”.

THE INTERACTION SUITE, RUN BEFORE EVERY RELEASE OF THIS SITE

One hour a fortnight, then the teenager disappears

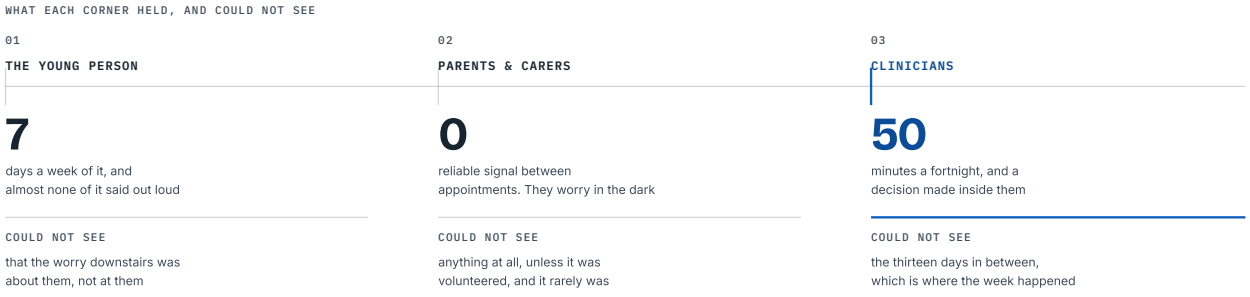
FIG. 004 · ONE HOUR SEEN, THIRTEEN DAYS NOT



One hour the clinic sees, thirteen days it does not. Everything the service does is an attempt to close that gap without taking the teenager's privacy to do it.

The team called it the **Triangle of Care**, and every corner of it was blind.

FIG. 005 · THE TRIANGLE OF CARE



Each corner held information the others needed. The service bridges the triangle without breaking the teenager's privacy.

The answer wasn't one app but two connected ones: a **mood diary** a teenager would actually trust, and a **clinician dashboard** that surfaces what matters before the session, named "Clinician Data Dashboard", in the GDS habit of saying what a thing does.

The older adults' service, sent home in the same weeks, needed the same connection with almost none of the screen: one app, one button to join the call, and a phone call always offered instead.

Four jobs, one per person at the table

Written from the interviews, not quoted from them: what each person was trying to get done when the service went home.

THE YOUNG PERSON

When I have had a hard day and cannot say it out loud, I want to write it down privately, so I can choose later whether my clinician sees it.

THE PARENT OR CARER

When I am worried about my child between appointments, I want to know how their week went without reading their diary, so I can help without breaking their trust.

THE CLINICIAN

When I have five minutes before the next call, I want to see what has changed since we last spoke, so the call starts where the last one ended.

THE OLDER ADULT

When the nurse is due to ring, I want one button that connects me, or a phone call if it will not, so I can talk to my nurse without learning a computer.

RESEARCH · 19
SESSIONS · 70
SURVEYS · 3
WORKSHOPS

03

I asked all three corners before drawing anything

FIG. 006 · NINETY-TWO PEOPLE

19 INTERVIEWS + 70 SURVEYS + 3 WORKSHOPS

19 INTERVIEWS

With 12 people: clinicians, young people and parents

3 WORKSHOPS

The smallest block, and the one that moved the design

Two months of discovery, qualitative first, checked against numbers, then three co-design workshops: a half-day with 12 clinicians, two hours with 8 teens, and a feasibility session with the safety officer, digital governance and two developer leads.

REBUILT FROM THE DECK The discovery programme, three corners of the triangle, then the numbers.

CLINICIANS

8

one-to-one interviews, psychologists, psychiatrists, MH nurses

YOUNG PEOPLE

2 × 4

interview rounds, ages 16–19, co-facilitated by a youth MH nurse

PARENTS

3

parents of current patients

CLINICIAN SURVEY

N = 30

anonymous online form

YOUTH & PARENT SURVEY

N = 40

run with parental consent

RECORDS PASS

1

missed appointments and crisis incidents, for operational grounding: 65% of serious incidents in the past year had warning signs a tracking tool could have caught

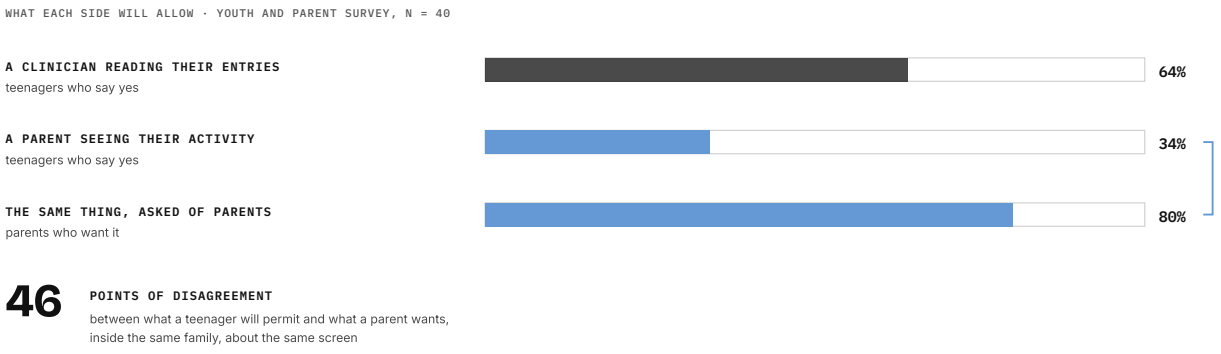
FIG. 007 · THE DISCOVERY PROGRAMME



Qualitative first, then checked against the numbers. The feasibility session is where the constraints were agreed, not discovered late.

The programme above is how the research ran. This is what it found, and it is the reason the product has the shape it has: two of the three relationships in the triangle are uncontested, and one is not.

FIG. 008 · THE CONTESTED EDGE



Two edges agree. One does not, by forty-six points.

Three scripts, not one

The three corners do not share a problem, so they were not asked the same questions: one set would have produced a false consensus. Each interview was semi-structured, forty-five minutes to an hour, and the young people's were co-facilitated by a youth mental-health nurse.

The young people

- How they express what they think and feel
- What is hardest about talking to parents, and to clinicians
- How much privacy matters
- What an ideal support system would look like

Parents and carers

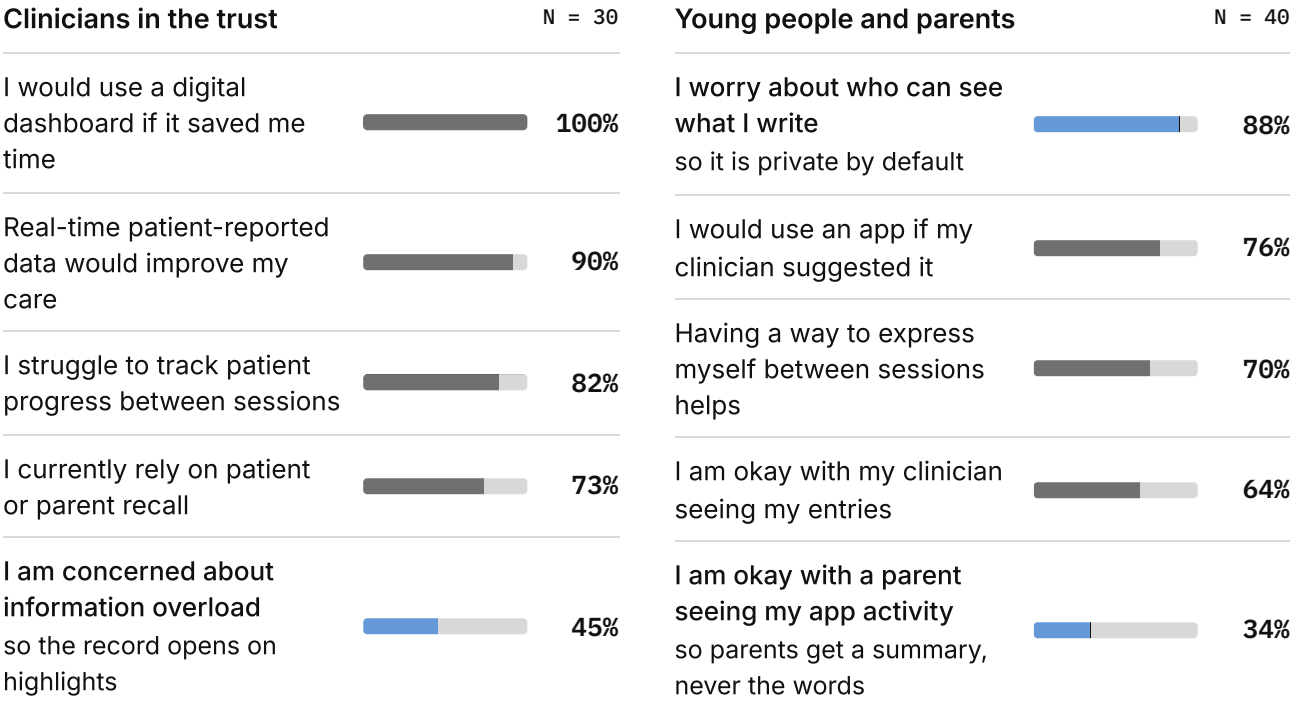
- How they see their child's mental health
- What makes it hard to talk about
- How they balance privacy with wanting to help
- What tools would help

Clinicians

- How they prepare for a session, and what they have or lack
- What gets in the way of a young person's trust
- How they keep confidentiality and keep parents informed
- What a digital tool would need to do

Both surveys, one scale

Run after the interviews, so the questions came from what people had already said. Each bar is the share who agreed. Three rows became the product's shape, and the findings below open the product where each shows.



Six findings, and where each one lives now

The deck's insight cards, grouped by who said it. Each carries its evidence and opens the product at the place it changed.

The young people

Privacy is everything

88% of 40 worry about who can see what they write. “I don’t mind my therapist seeing my mood tracker, but I’d panic if my mum read my actual journal entries”, a 16-year-old.

Sharing per entry and per reader, the mood alone by default

Calm, or they stop

All the young patients said it must not feel like homework or another clinical questionnaire, and that they would stop if it felt cold or like a form.

A diary that opens on today, not on a questionnaire

Easier to write than to say

A 17-year-old said it is sometimes easier to write down what they feel than to say it out loud.

Chat instead of talking, offered before every session

Parents and carers

Help without intruding

Most would accept a summary rather than the entries, and pushing for detail is what ends the conversation. 34% of young people would let a parent see their activity; 80% of parents want to.

A weekly summary, never the words

Clinicians

In the dark between sessions

82% of 30 struggle to track progress between sessions; 73% rely on what the patient or a parent remembers.

The record opens on what changed since you last spoke

Five to ten minutes to prepare

That is all the time clinicians said they had, and 45% of 30 feared information overload.

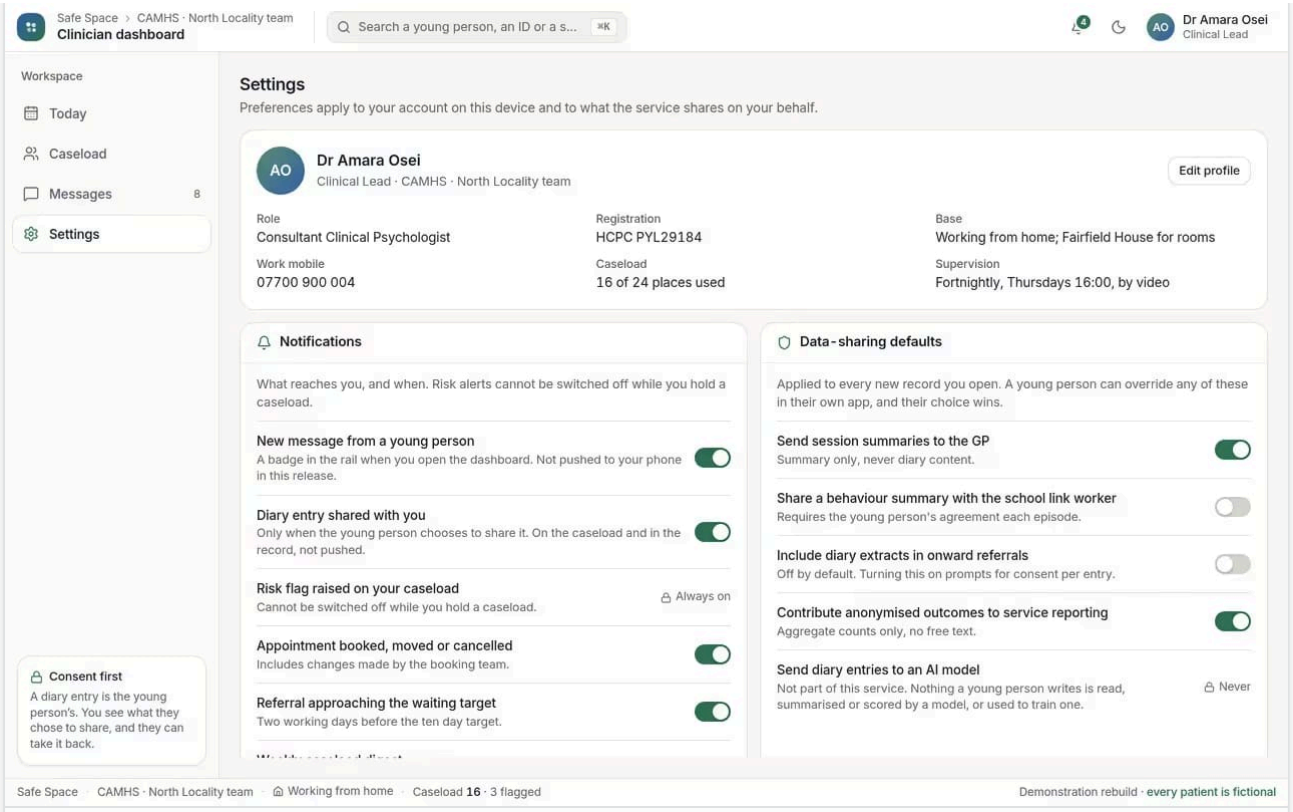
Highlights first, one chart, the rest folded

04

DECISIONS

The teens rejected the feature adults assumed they'd love

Everything from the workshops went through a value-versus-complexity matrix, with point 2 of the GDS Service Standard, do less, as the tie-breaker. Peer-to-peer messaging died in the bottom-right quadrant: the teens themselves killed it, on privacy grounds.



Notifications and data-sharing defaults, with the one that cannot be switched off marked as such.

REBUILT FROM THE DECK

The prioritisation matrix, user impact against technical complexity. Point 2 of the GDS Service Standard ("do less") broke the ties.

HIGH IMPACT · LOW COMPLEXITY, KEPT

Journal entry with optional prompt
High emotional value; technically just text input and storage.

Clinician dashboard, patient list with mood status
Saves prep time; straightforward with NHS UI components.

HIGH IMPACT · HIGH COMPLEXITY, DEFERRED

Real-time clinician notifications
Needs polling or sockets; flagged for a later release.

Patient-to-clinician messaging
Clinical boundaries and safeguarding complexities.

LOW IMPACT · LOW COMPLEXITY, PARKED

Mood input via emoji stickers
The standard slider already works.

Motivational quotes of the day
Low engagement impact.

LOW IMPACT · HIGH COMPLEXITY, REJECTED

Peer-to-peer messaging between patients
The teens themselves rejected it on privacy grounds.

Custom dashboard widgets per clinician
Too much variation; not worth the build.

← USER IMPACT · TECHNICAL COMPLEXITY →

Privacy wasn't a checklist at the end; it shaped the product:

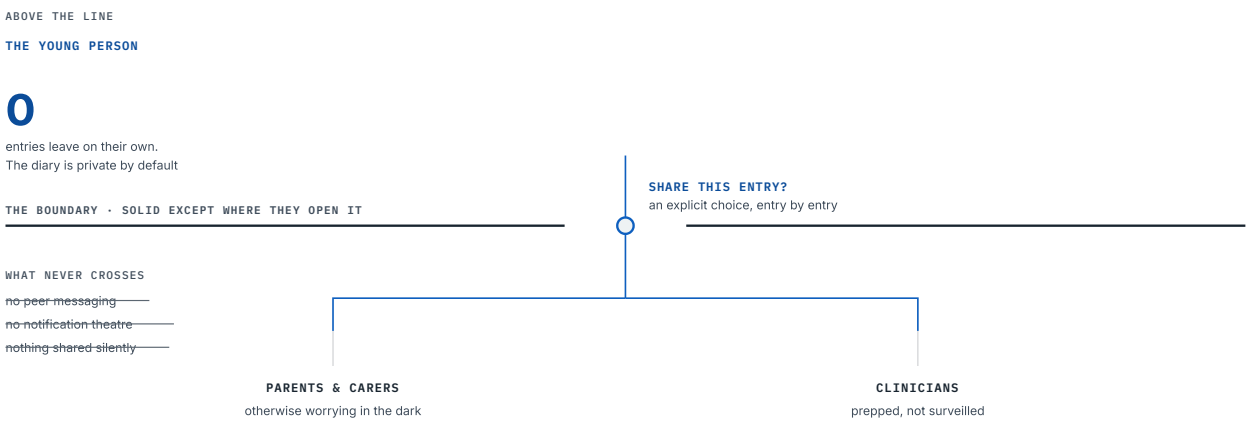
REBUILT FROM THE DECK — The privacy model, designed with the trust's clinical safety officer and digital governance.

- ✓ **Trust as data controller** — defined before a pixel was drawn
- ✓ **Parental consent** — for younger users, documented in session
- ✓ **Gillick competence** — teenagers deciding for themselves
- ✓ **Encryption** — in transit and at rest
- ✓ **Email + PIN login** — aligned with NHS identity standards for the pilot
- ✓ **Adoption by conversation** — a clinician introduces the app and records agreement

"My Mind Diary, your private space to share, only if you want."

THE WAITING-ROOM POSTER LINE, PRIVACY AS THE PITCH, NOT THE FOOTNOTE

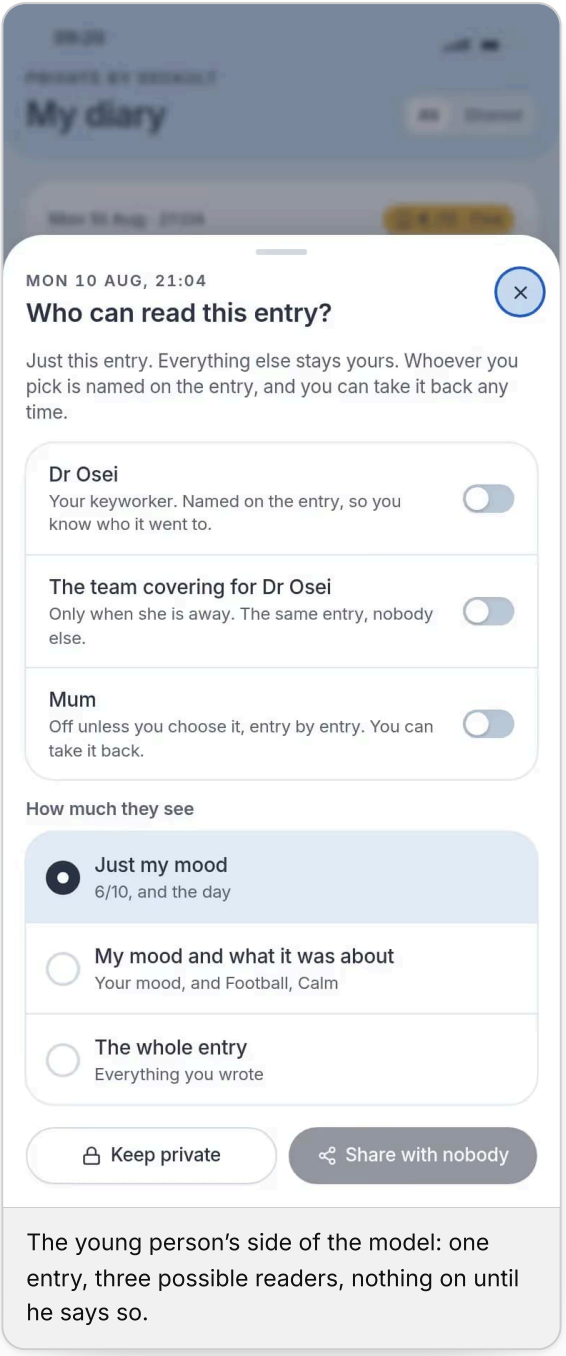
FIG. 009 · THE PRIVACY BOUNDARY



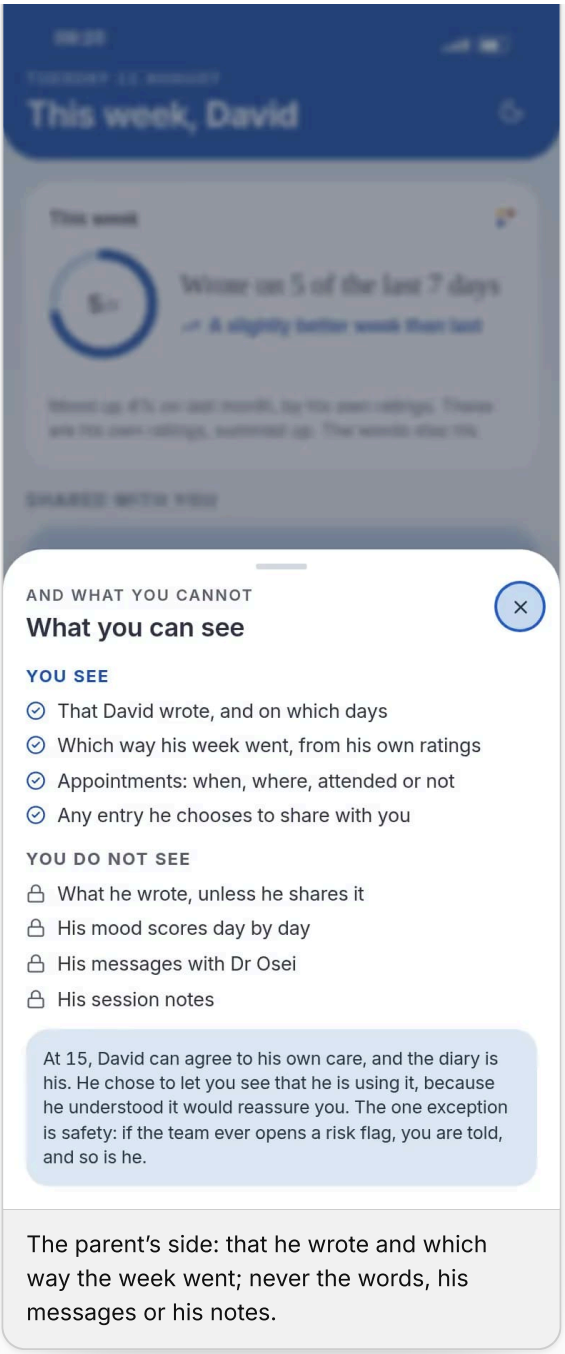
The product decisions that mattered most were refusals. Trust was the feature.

Private by default, shared only by choice

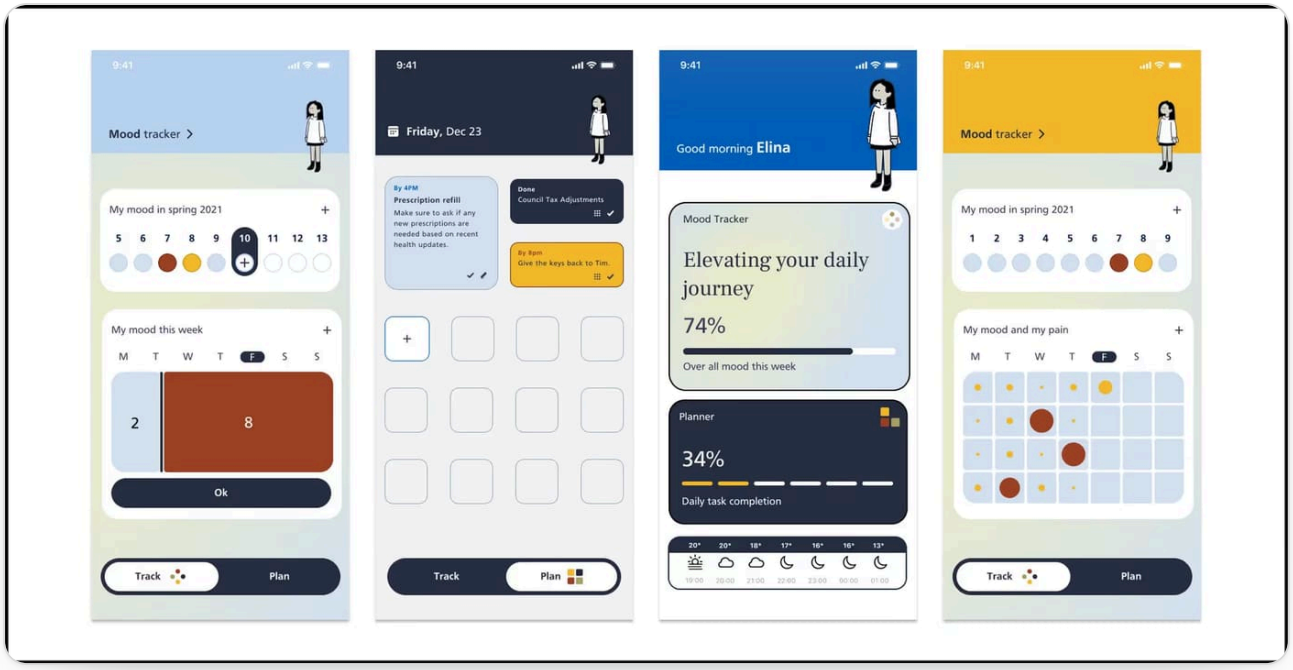
Try the shipped privacy model below, log a week, then decide, entry by entry, what your clinician sees.



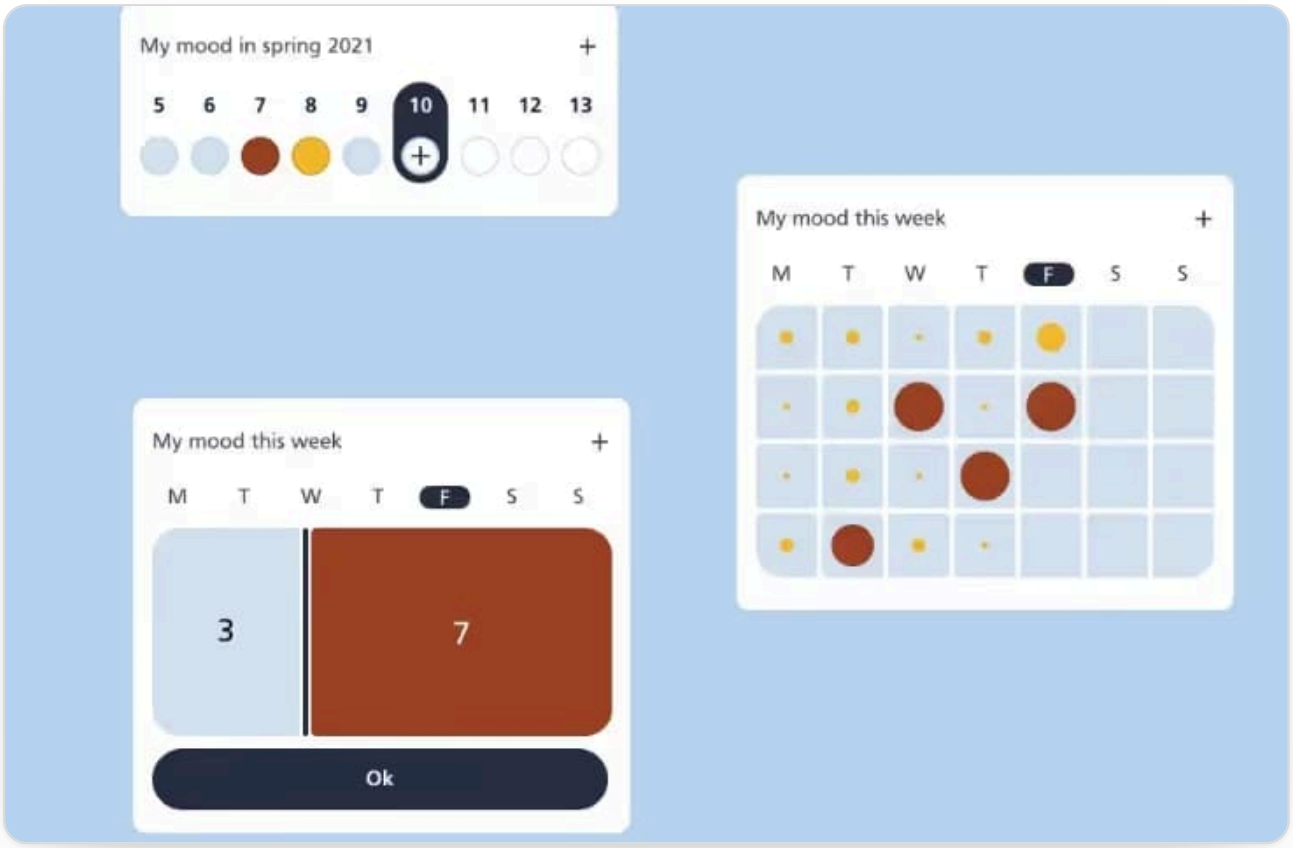
The young person's side of the model: one entry, three possible readers, nothing on until he says so.



The parent's side: that he wrote and which way the week went; never the words, his messages or his notes.

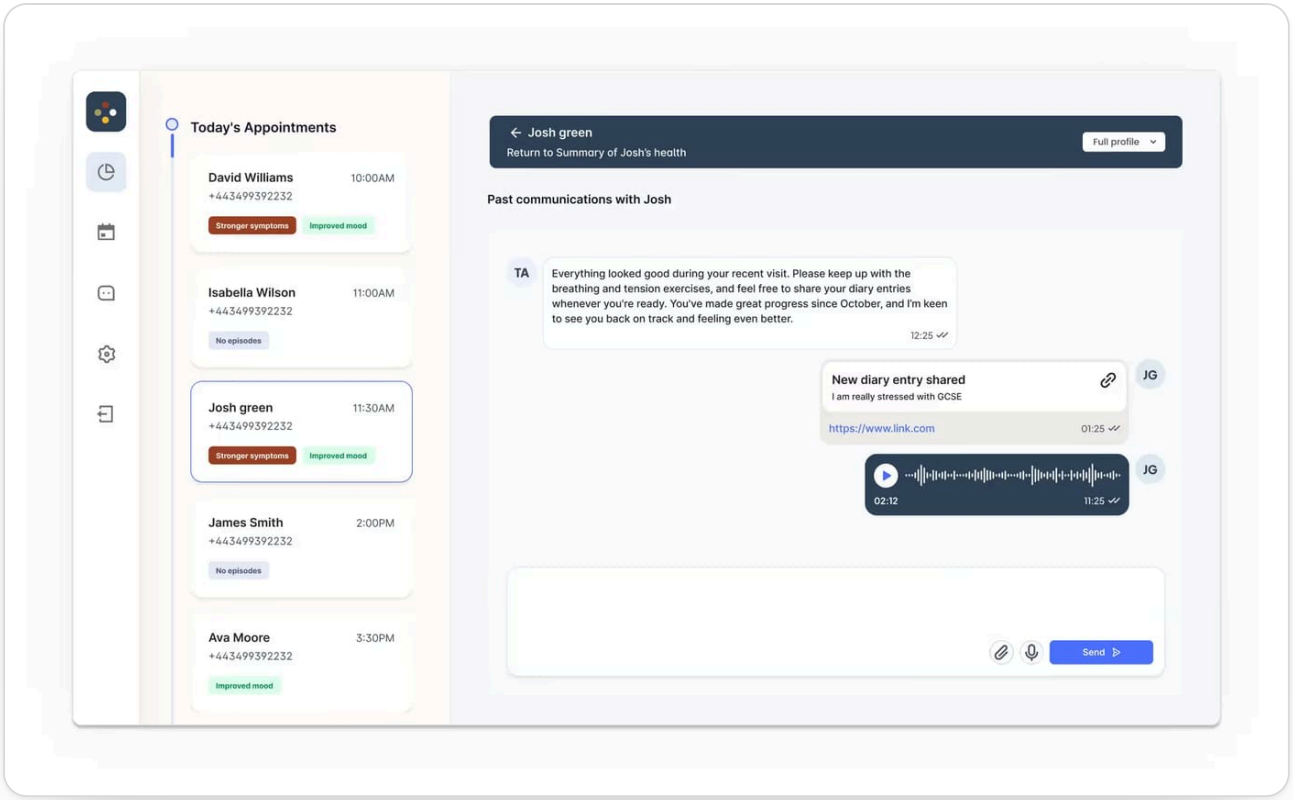


The shipped design: mood calendar, weekly view, planner. Private by default.

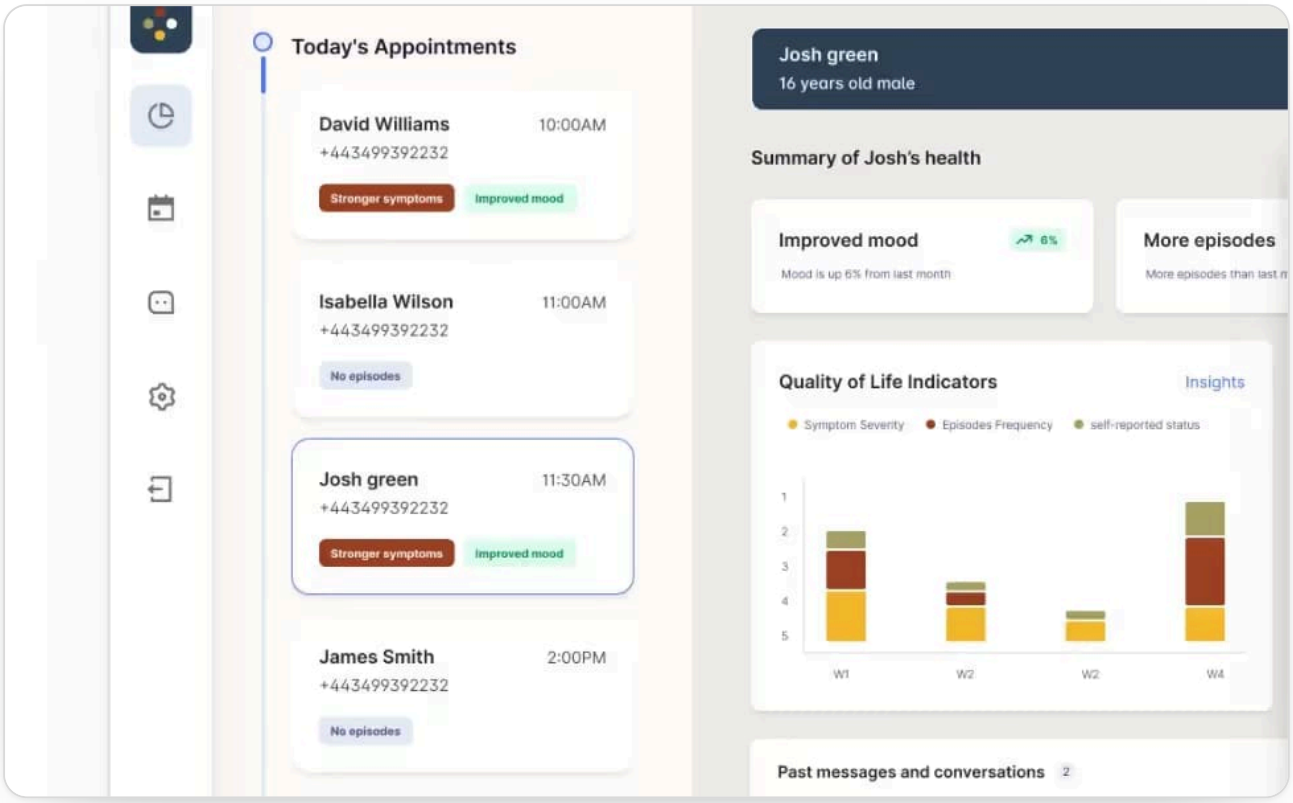


Tracking a spring, one day at a time.

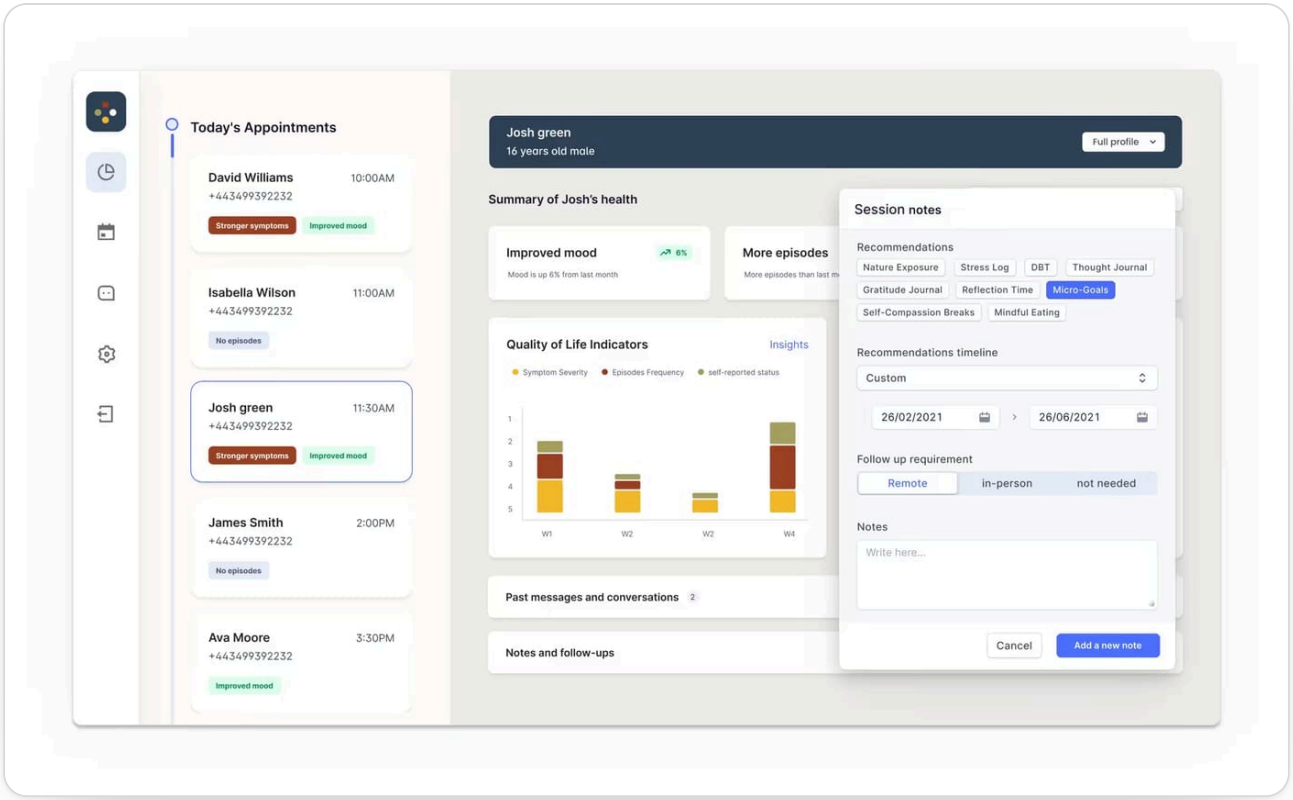
The clinician's side opens on **today**, not on a database: the day's appointments with change chips ("stronger symptoms", "improved mood", "no episodes"), a patient timeline of quality-of-life indicators, and the entries a patient chose to share, right in the communication thread where the conversation happens. Session notes end with recommendation chips (micro-goals, DBT, thought journal) and a follow-up booking, so the admin happens inside the clinical flow.



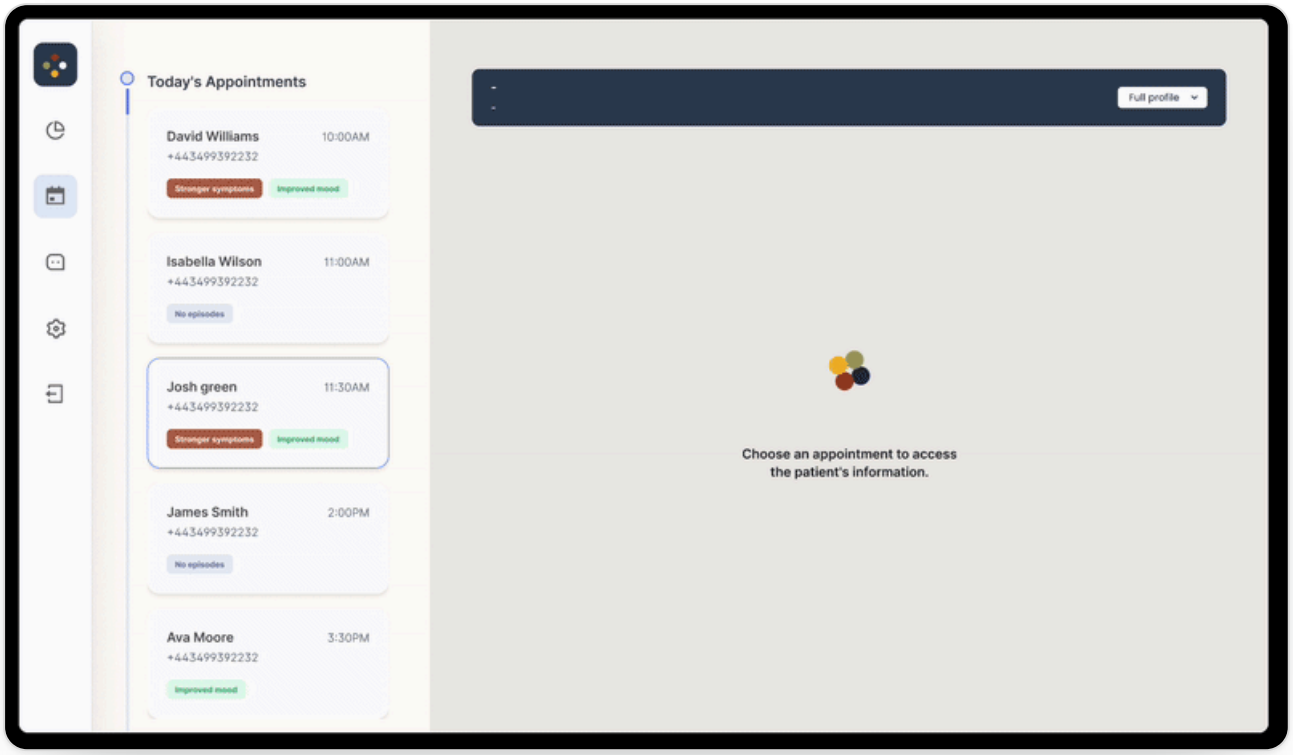
Today's appointments, a shared entry, a voice note, the hour between sessions, visible.



Patient timeline: quality-of-life indicators over time.



Session notes with recommendation chips and follow-up booking.



The interactive prototype in motion.

Where AI does not go

A position rather than a finding: nothing a young person writes is read, summarised or scored by a model, and the products say so where the data is set, in the diary and in the clinician's settings.

WHY NOT	WHAT IT WOULD TAKE

The research's first finding was that privacy is everything to the young people, and 88% of them worried about who could see what they wrote. A model is one more reader, and the one they could not see.

NICE's evidence standards ask a digital health tool for evidence in proportion to what it does, and a tool that shapes care asks for the most. The constraints this beta ran under were set by the trust's clinical safety officer and digital governance; a model reading entries would go back through both before it was built.

WHERE IT MIGHT BELONG

If a model ever helped, the place it would have to earn is the clinician's five minutes before a call, over what the young person has already chosen to share, and it would say it was a model wherever it spoke.

06

TESTING & BETA

Tested mid-build, then run in a real clinic

Scenario-based sessions with **5 clinicians and 5 young patients** changed the build where the evidence said: an entry-tagging system was added; a "your clinician read your entry" notification was postponed. QA ran on real iPhones and Androids.

1 · WIREFLOWS

Every key task in sequence

The dashboard: log in, the patient list, a patient's detail with charts. The app: consent, the daily mood, a journal entry, past entries, the sharing settings.

2 · REVIEW

Too many charts

Reviewed in the team and with a few friendly stakeholders. The dashboard became one main chart and a few key metrics, after a clinician said: "just show me the highlights".

3 · MID-FIDELITY

Clickable, with real-looking data

Figma for the app, a web prototype for the dashboard, the trust's components, and fictional records: Alex's month of moods, a journal line about a rough day at school.

4 · USABILITY

Five clinicians, five young patients

Entries gained tags and a mood scale that says which way it runs; the read notification was postponed.

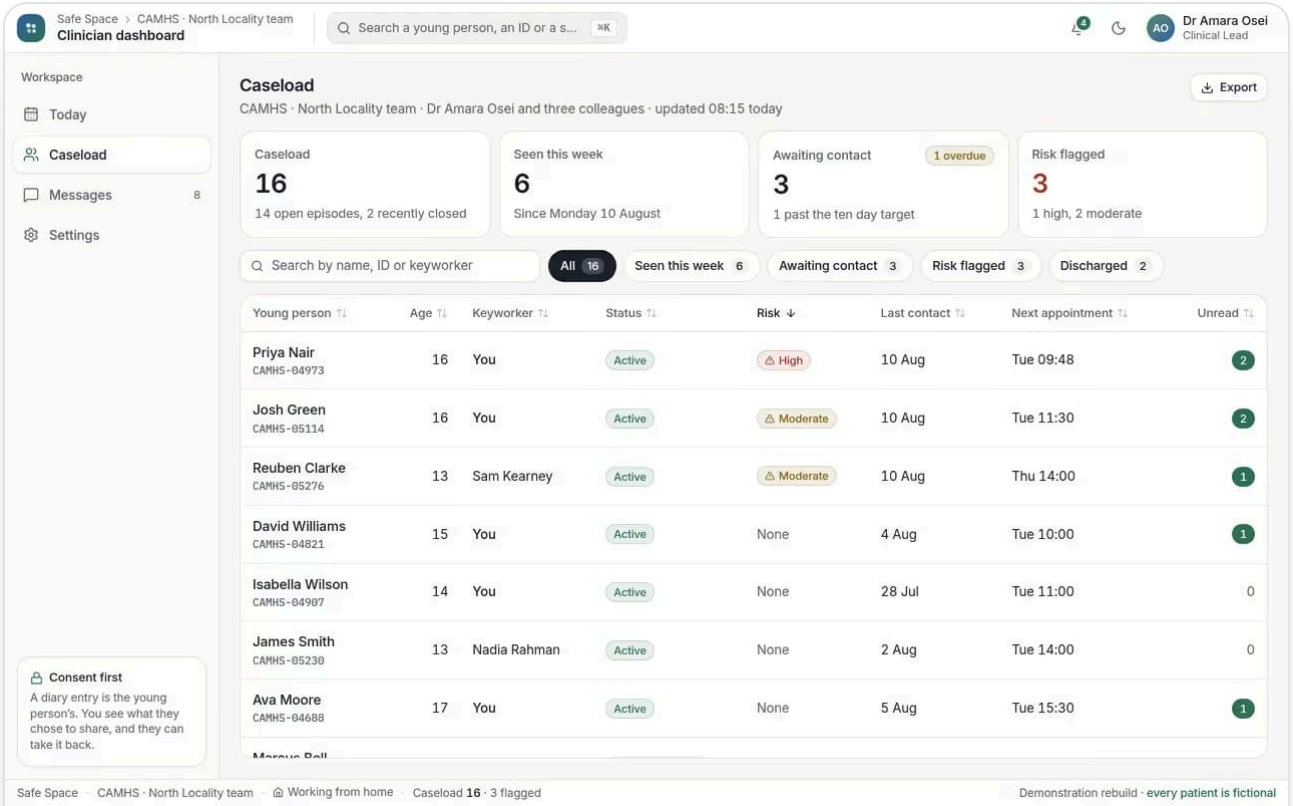
5 · BETA

A live clinic, three weeks

Three clinicians, ten patients and eight parents, on the build the four passes left.

THE USABILITY TASKS, WORD FOR WORD, AND WHAT THEY FOUND

TASK	WITH	WHAT IT FOUND
“Imagine you’re about to see patient Alex. Use the dashboard to get ready and tell us what you gather.”	5 clinicians	5 of 5 got ready from the dashboard and found the data useful 95% interval 51% to 100%
Reading the mood graph, labelled “Wellbeing Score over 4 weeks”	5 clinicians	2 of 5 could not tell whether higher was better 95% interval 12% to 77% Relabelled Mood (1 = low, 10 = high), and the rebuild gives every measure on the record’s chart its direction
“You’ve just had a hard day. Can you log that in the app? Now imagine a week passed, can you see how you were feeling over the week?”	5 young patients	Fed the two changes the sessions made: entries gained tags, and the “your clinician read your entry” notification was postponed



The beta's caseload: three clinicians, ten patients, eight parents, three weeks.

21 people, in real care

The beta put the system into one live clinic for three weeks with 3 clinicians, 10 patients and 8 parents, and the rollout metrics were defined before rollout: clinician usage rate, entries per user per week, qualitative clinical outcomes.

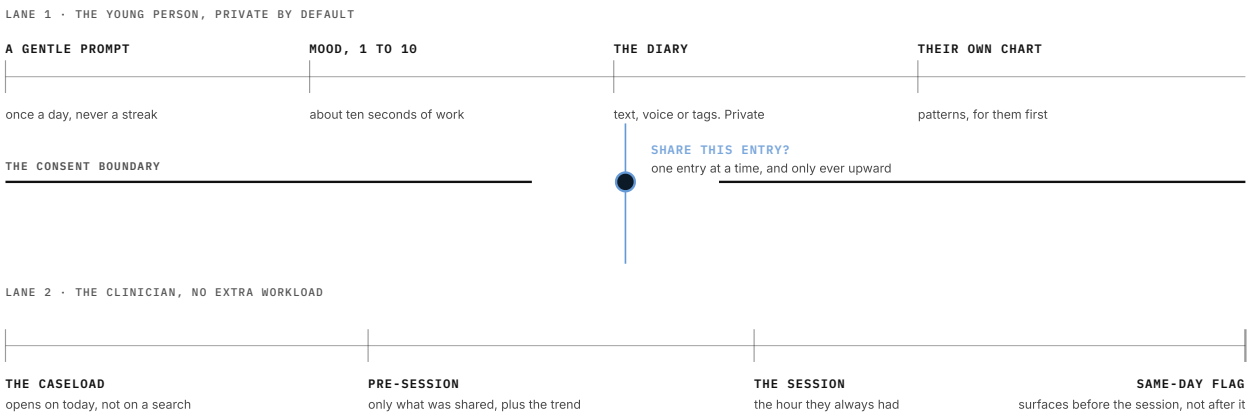
THE FLOW · END TO END

07

Two apps, one lane each, and a gate between them

The young person's week and the clinician's day run as separate lanes, and nothing crosses from one to the other without an explicit choice.

FIG. 010 · TWO LANES, ONE GATE



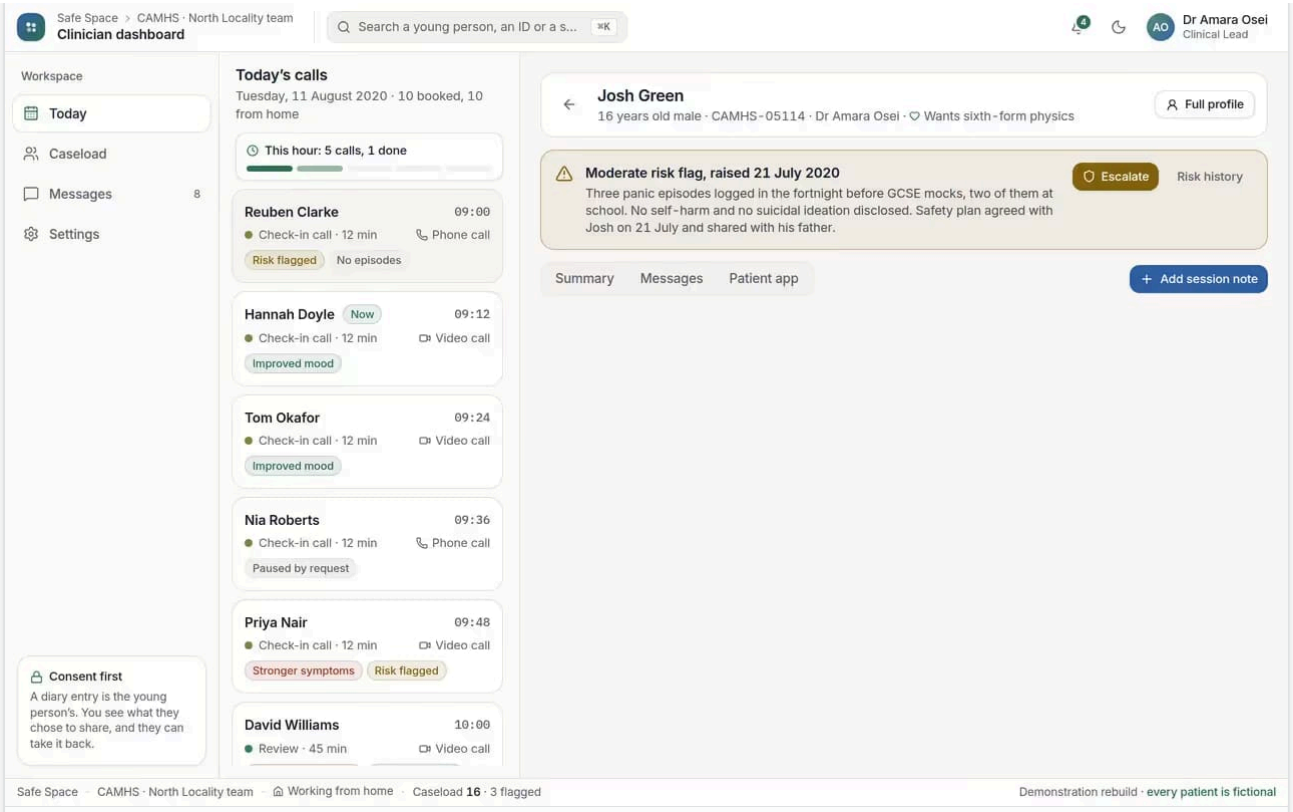
One arrow crosses the boundary, and only because the young person put it there.

WHAT WAS BROKEN · WHAT CHANGED

08

Where the service broke, and what closed it

Six things the discovery work found, the design decision taken on each, and what happened next.



What moved, in the product: the risk history and the one-act escalation.

01

WAS BROKEN

A CAMHS team sees a teenager for one hour, then loses sight of them until the next appointment, so clinical decisions were made on a fifty-minute snapshot of a fortnight.

WHAT I CHANGED

Two connected apps rather than one: a mood diary with an optional prompt, and a dashboard that opens on today's appointments with change chips, a quality-of-life timeline and the entries a patient chose to share.

WHAT IT MOVED

21

people used it as part of real care: 3 clinicians, 10 patients and 8 parents, with the rollout metrics agreed before rollout.

BETA · 1 CLINIC · 3 WEEKS

02

WAS BROKEN

Teenagers will not volunteer how the week really went, and anything that reports on them quietly makes them report less.

WHAT I CHANGED

Private by default, shared entry by entry. Nothing syncs on a schedule and nothing leaves the diary without the young person choosing it; the consent gate is the product, not a setting inside it.

WHAT IT MOVED

Privacy became the pitch rather than the footnote: the waiting-room poster led with “your private space to share, only if you want”.

THE POSTER LINE, VERBATIM

03

WAS BROKEN

The adults in the room assumed teenagers wanted to message each other, and a feature list built on that assumption would have swallowed the budget.

WHAT I CHANGED

Asked all three corners of the triangle first, then ran every workshop idea through a value-versus-complexity matrix with point 2 of the GDS Service Standard ("do less") as the tie-breaker. The teens killed peer-to-peer messaging themselves, on privacy grounds.

WHAT IT MOVED

19 / 70

interviews and survey responses before anything was drawn, and three features refused rather than built.

19 SESSIONS WITH 12 PEOPLE · N=70

04

WAS BROKEN

The mood graph was labelled “Wellbeing Score over 4 weeks”, and two clinicians could not tell whether a higher number meant a better week or a worse one.

WHAT I CHANGED

Renamed it in plain language as “Mood (1 = low, 10 = high)”, in the GDS habit of saying what a thing does, which is also why the dashboard is called the Clinician Data Dashboard.

WHAT IT MOVED

5 of 5

clinicians then navigated the prototype successfully, naming the timeline graph and the alert flag as the parts they would use.

CLINICIAN PILOT

05

WAS BROKEN

Any tool that adds administration to a clinic does not get used, however good the data in it is.

WHAT I CHANGED

Put the admin inside the clinical flow: session notes end in recommendation chips (micro-goals, DBT, thought journal) and a follow-up booking, in the same thread where the conversation happened.

WHAT IT MOVED

The dashboard asks for no separate write-up step, which is the only reason a clinician with a caseload of twenty opens it before a session.

DESIGNED WITH THE CLINICAL TEAM

06

WAS BROKEN

Consent, data controller and identity are usually settled after the screens exist, which is when they start costing rewrites.

WHAT I CHANGED

Wrote the privacy model first with the trust's clinical safety officer and digital governance: trust as data controller, Gillick competence, documented parental consent, encryption in transit and at rest, email and PIN aligned to NHS identity standards, and adoption by conversation.

WHAT IT MOVED

The model was fixed before the first screen, so the beta ran inside a real clinic as part of care rather than as a trial bolted onto it.

FEASIBILITY SESSION · SAFETY OFFICER & GOVERNANCE

09

OUTCOME

The decisions that

mattered were refusals

MEASURED AGAINST THE ROLLOUT METRICS AGREED BEFORE THE BETA RAN

IT WORKED IF	RESULT	STATUS
It is used as part of real care	21 people, three clinicians, ten patients and eight parents, at one clinic for about three weeks, with every approval in place	MET
The people using it want to keep it	94% of beta users said the service should continue; the beta report gives the share, not the number it is a share of	MET
Teenagers write without being nudged	4 entries a week per patient, in a product with no streaks and no escalating reminders	MET
Parents read the summary	8 of 8 parents opened every weekly summary	MET
Clinicians can find what they need	5 of 5 clinicians navigated the prototype	MET

19
interview sessions
WITH 12 PEOPLE, ACROSS THE TRIANGLE

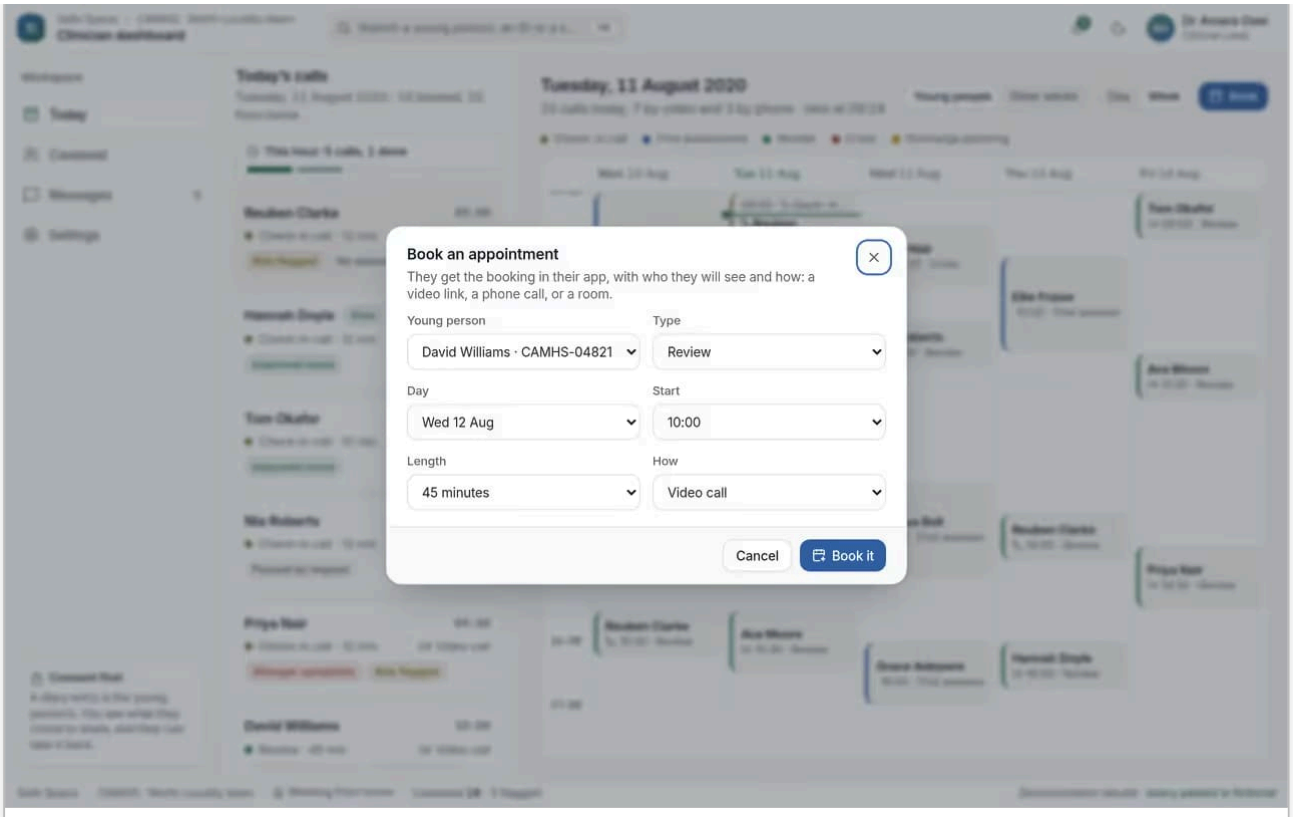
70
survey responses
N=30 CLINICIANS · N=40 YOUTH & PARENTS

3
co-design workshops
CLINICIANS · TEENS · GOVERNANCE

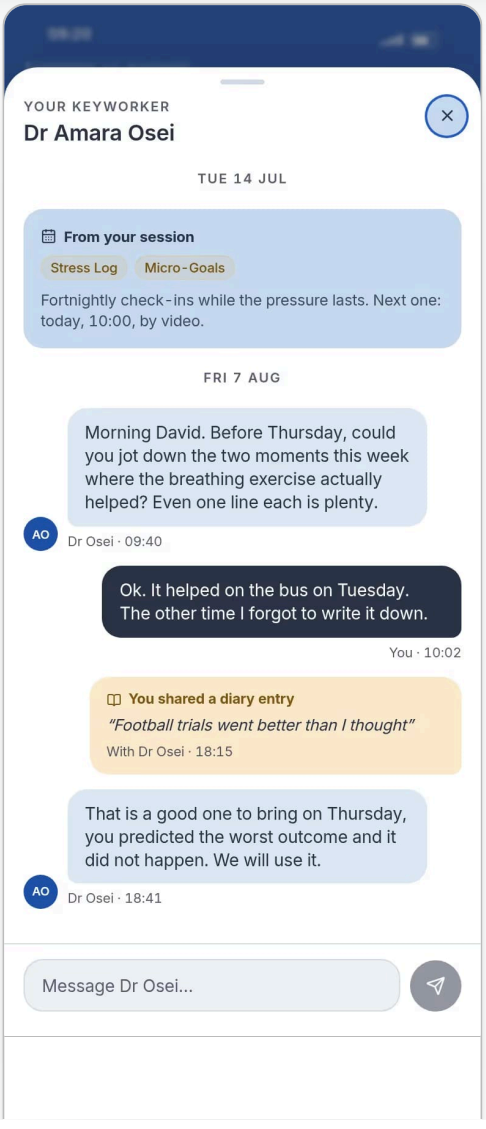
94%
of beta users would keep it
THE BETA REPORT'S SHARE · ITS BASE NOT GIVEN

The beta ran with three clinicians, ten patients and eight parents at one clinic site for about three weeks, with every approval in place. The beta report puts those who said the system should continue to be used at ninety-four per cent; it gives the share, not the number it is a share of. Patients wrote an average of **four journal entries a week each**, unprompted, in a product that was deliberately built with no streaks and no escalating reminders, and all eight parents opened every weekly summary, which is the one that carries a trend and no entries. The deck carries the full beta report.

What I'd tell another designer taking this on: the product decisions that mattered most were **refusals**, no peer messaging, no notification theatre, nothing shared without an explicit choice. Trust was the feature. Everything else was UI.



The outcome, running: a booking that reaches the young person's app.



Where the booking lands: the session's recommendations and the next appointment, in the same thread as the conversation.

What I would do differently

01 **Test the riskiest assumption before it reaches the build.** Peer messaging was in the build when the teenagers killed it. A paper version in front of them would have cost an afternoon.

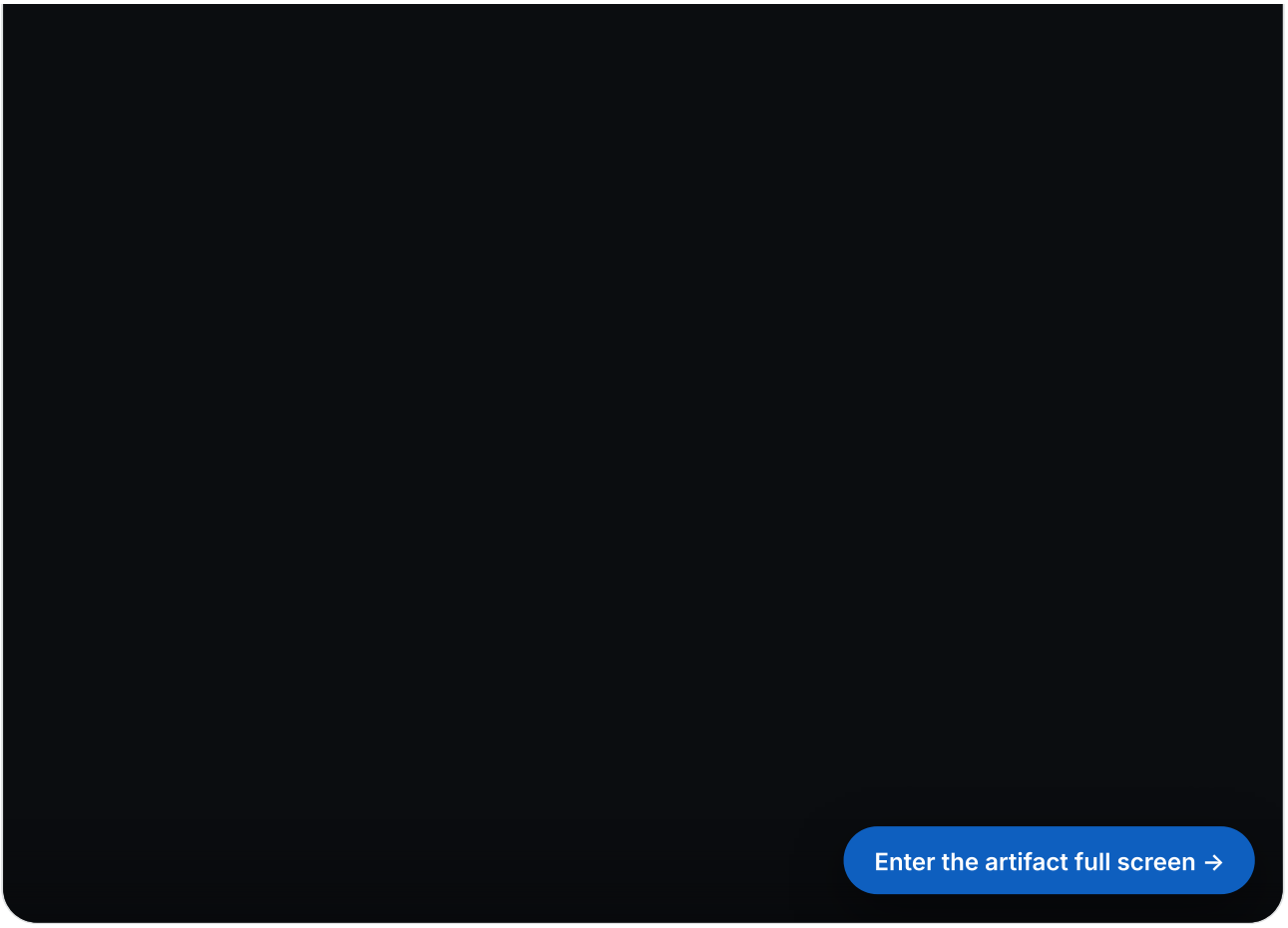
02 **Keep the research records with the work.** The breakdown behind the nineteen interview sessions survives only in this portfolio's own earlier text, which makes it the weakest figure on the site.

SEE ALSO

004 · Novo Nordisk
Another file about trust: a number shown with its basis, as an entry is shown with its reader.

002 · Astrato
Research on tape: moderated sessions and attention heatmaps behind a redesign.

LIVE ARTIFACT The full Safe Space case study: the interactive site, personas and journey included.



SOURCE NOTES

Trust identity, staff and patient details anonymised throughout; personas in the full deck are labelled fictional.

Research figures (interview counts, survey Ns, workshop rosters, beta cohort) are from the project's research plan and rollout deck, shown above.

Full interactive case study: withcontexts.com/artifacts/safe-space

← PREVIOUS
Astrato · three years inside a data platform

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Novo Nordisk · the number that was true twice

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withcontexts.com
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