HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Greg Fell
Date:	November 2023
Subject:	Follow up from Mental Health & CYP Workshops
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Summary:

This paper attempts to summarise the main points of learning from two focussed and lengthy discussions at the health and well being board. The board is invited to comment on these reflections from the two sessions set out in section 2. The board may wish to comment more specifically on what members expect to see from the perspective of both content and ways of working from these two workshops going into the next health and well being strategy.

Questions for the Health and Wellbeing Board:

This short paper attempts to summarise the main points of learning from two focussed and lengthy discussions at the health and wellbeing board. The board is invited to comment on these reflections from the two sessions set out in section 2, both on content and process / style of the workshop sessions. Members may have additional perspectives not captured. The board may wish to comment more specifically on what members expect to see from the perspective of both content and ways of working from these two workshops going into the next health and well being strategy.

Who has contributed to this paper?

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Follow up from Mental Health & CYP Workshops

1.0 SUMMARY

1.1 This paper attempts to summarise the main points of learning from two focussed and lengthy discussions at the health and well being board. The board is invited to comment on these reflections from the two sessions set out in section 2, both on content and process / style of the workshop sessions. Members may have additional perspectives not captured. The board may wish to comment more specifically on what members expect to see from the perspective of both content and ways of working from these two workshops going into the next health and well being strategy.

Brief reflections on process and content

2.0 The paper reflects one view, not the only view, other views are appreciated. It summarises main points of reflection on content and on the process of organising what might be termed as a deep dive on two very broad topics – the June board meeting focused on mental health, the September meeting focused on Children and Young People's health and wellbeing.

Design, process, structure & set up of the sessions

2.1 For both sessions a significant amount of effort went into the design, planning, format/structure and organisation of the meeting, to an extent this was an experiment on the merit of this style of focused discussion.

2.2 Attendance at both sessions from board members wasn't optimal.

2.3 Both sessions were hugely informative and the content can and will be used in other spaces, it will stand for some time. There are mixed views from those involved in the planning and delivery of the sessions and also board members of the merit of the effort in organising and running the session versus the benefit to those board members that attended.

2.4 The purpose and intention of the sessions was to provide board members with up to date information relating to the theme and to consider/debate some of the current significant relevant challenges. Those involved aimed to consider what the Health & Wellbeing Board could do to support and address issues raised.

2.5 Arguably there was too much time in the presentation content and insufficient time for board members to discuss and debate what they had heard. This was a difficult balance with so much content to deliver focusing on each themed area.

2.6 The requirement for presentation content was necessary due to the limitations of delivering the sessions within the Council chamber and in planning what was expected to be a session delivered to 20+ board members. Whilst efforts were made in monitoring expected attendance in retrospect given the numbers present a more

informal workshop style session may have been more suitable. This was not possible due to the constraints of the space available and the planning required.

Content of both sessions

2.7 This paper will not replay the content of the presentations or the discussion that followed.

2.8 Both sessions told a strong story on good practice across a wide spectrum of activity, over a long period. Arguably both sessions focused on the positive story and didn't dwell enough on the difficulties and the context. It is widely acknowledged that over the last decade delivery has been difficult and population need has risen, outcomes are static (and beginning to deteriorate in some places). We obviously shouldn't skirt over this. There still are many problems to address. There are also many examples of good practice, both sides of a story need equal airtime.

2.9 It was clear we have a strong culture of partnership across both areas discussed. Obviously something to cherish and nurture. For both areas, there is clearly a strong and coherent approach to programme delivery. How we do what we do matters, that we approach it that way also matters and it is clear we don't always get it right, where we don't we own that and work to put it right as best we can.

2.10 We have the right overall strategy focused on mental health and CYP. Whilst all agree that mental health is everyone's business, arguably the scope of the strategy is too big for a single controlling mind or programme management infrastructure. We know we have a fragmented landscape across many areas of policy and service delivery across multiple sectors.

2.11 In the conversation on mental health we had at the board we spent most time talking about one element of the strategy. The conversation was framed skewed towards the NHS, but strategy is well beyond. We spent our time talking about care for those who needed NHS care – children or adult.

2.12 The determinants of mental health didn't features strongly in the conversation we had, though we know we have plenty of delivery of interventions on the determinants of mental health. We equally know we have cut lots from this resourcing wise – and that has consequence on mental heath outcomes. Often this is not done explicitly in the name of "mental health". It is hard to get this properly documented and programme managed in a way framed and oriented around mental health. For example we didn't talk about child poverty, nor the welfare system and the enormous impact that has on mental health.

2.13 Particularly for mental health in children and young people this is usually not an organic intrinsic disease, but it is a product of the environment. Their physical environment in terms of housing and area they live, their trauma, not just ACE's trauma but living everyday with little food, with cold, with poor clothing, life experience and life expectations AND living with SEND and communication/neurodevelopmental issues - all of that is what drives mental health issues in children, and what drives

attendance/inclusion issues as well. It must therefore be considered preventable, and our city approaches should be preventative.

2.14 There is plenty of good practice from both policy through to service delivery. Getting the balance of accentuating positives whilst not shying away from difficult issues is hard.

2.15 We probably also focused too much on what is working well and avoided attention being given to some aspects of mental health (care or public mental health) that are fundamentally broken. For example CAHMS under resourcing, welfare policy that many say creates poverty.

2.16 It is easy to be focused on individual provider perspectives rather than whole population perspectives. Obviously, the challenge is to make the conversation about people and communities, not providers, (nor what individual agencies are "commissioned" to do). Some suggested there was some disconnect from user experience then what service providers said. There was an observed apparent lack of join up across system – each organisation saying what they were doing. In the conversation that followed it wasn't obvious at some points how as a system we are coming together – who acted as integrator.

2.17 Everyone accepts it is hard to shift focus of investment to prevention and tackling causes, also avoiding the danger of medicalising social ills. We say shift from medical to social model, and the concept of parity of esteem. On all these we don't make the progress we hope to. We broadly know the reasons, not the least of which is significant under funding of some pretty primary level services.

2.18 The C&YP's session attempted to follow the 0-25 years life course approach. It was unrealistic to attempt to cover such a wide age range in the session. The presentation referenced the many different strategies in existence that attempt to address C&YP's health and wellbeing, as well as describe some of the governance structures that attempt to co-ordinate and oversee their delivery.

2.19 The key priority of Start for Life was shared and board members shared their views of how the best start in life is essential to ensure the best outcomes. Development of a city wide, approach to early identification of need and early help. Ensuring how we link maternity to Best Start in Life, early identification of need and our early help system and services. A focus on children and young people 'belonging'. Views from board members reflected on how our early help system of services and support needs to fully integrate so all our families with needs are identified and receive joined up help and support. All aligned with the priority of identifying those most vulnerable and prioritising areas of the city with greatest need. The themed session used 'real life' annoymised case studies to describe children, young people's and families experiences. Real life examples of navigating services, health needs and the challenges of the system. The case studies were an example of describing lived experience and provided by the VCF sector demonstrating their involvement in the planning and delivery of the session.

2.20 A consistent theme across C&YP session was the correct identification of communication issues whatever the diagnosis and the impact this has on a child/young persons ability to learn and thrive, school behaviour and the wider attainment of the child. There are complexities like the correct diagnosis of DLD, parent/carer expectations of diagnosis, potential over medicalisation of some issues, huge pressure regarding assessment for neuro diversity across the system and the impact on education sufficiency and schools.

2.21 Ultimately unlike perhaps treating an infection or a fracture or a cancer, the NHS' role in most CYP's lives is supportive. It's facilitative of their development, of their education, of their growth (in every sense) - some of our interventions will be from health services but our significant outcomes are actually in the main education outcomes. If we reduce health waiting lists but no more children are in education and learning and getting qualifications then that isn't success. The session emphasised the challenges for the education sector, of regular school attendance and presented the board with some key questions to consider.

3.0 The next health and well being strategy.

Both themed sessions should help shape the development of the next Health and Wellbeing Strategy. As the design and development of this is considered:

3.1 It is expected that quick wins are going to be difficult.

3.2 The broad themes from these two sessions and the board discussion that was prompted from the themes will therefore become integral to the strategies development.

3.3 The strategy should set an expectation of leftward shift of resource (both focus of intervention and age wise), and making progress on parity of esteem.

3.4 It is expected the board may wish to see a strong push on equity of funding for all resource areas that contribute to health and well being (the concept of proportionate universalism)

4.0 QUESTIONS FOR THE BOARD AND RECOMMENDATIONS

4.1 The board is invited to comment on these reflections from the two sessions set out in section 2, both on content and process / style of the workshop sessions. Members may have additional perspectives not captured.

4.2 The board may wish to comment more specifically on what members expect to see from the perspective of both content and ways of working from these two workshops going into the next health and well being strategy.

4.3 Reflection from those facilitating and planning the sessions confirmed it was useful to have 'time' to discuss and present to board members. Overall the constraints of the

Council chamber and limitations this posed were key learning points. For future workshop sessions a different venue and workshop style model may be preferable.

4.4 What other themes should be considered for workshop sessions in the future? Feedback from the C&YP session suggested further discussion on key challenges such as attendance, C&YP MH, neurodiversity, 0-19 Healthy Child Programme Services as individual themes which the board could consider in future.

4.5 The most obvious and final consideration is how we incorporate the main points into the the development of the HWB strategy going forward. Whilst all are agreed the HWBB must reflect on the “right thing to do” at a strategy level (as has been discussed and articulated many times), a wide set of constraints – financial, externally imposed “must do” issues - may make this difficult. Thus board members may reflect on how insistent we are on holding to a strategy and approach that will most reduce the gap in health over a long period and openly discuss trade offs. A key role for the board and the strategy of the board is to set an environment where the “right” things health inequalities wise are more likely to be executed.