Mental Health & Wellbeing Impacts of COVID-19

Findings from analysis of Third Strategic Roundtable with Strategic Leaders 2020:

C19 National Foresight Group

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NOTTINGHAM TRENT UNIVERSITY

Mental Health & Wellbeing Impacts of Covid-19
Third Strategic Roundtable

Contents

EXECUTIVE SUMMARY

The main findings of the roundtable were analysed and cover the challenges of planning for the projected increasing mental health and how to forecast that demand. Seven findings include: Sharing the NHS England (NHSE) mental health plan, a summary of the plan, achieving a strategic and integrated delivery local to national, mental health surveillance, scoping emerging need and planning, prediction of changes to demand profile of mental health needs, social and health inequalities, approaches of other LRFs to understanding the mental health of their communities, moving to new ways of working, networks to access and share practice. A series of suggested solutions are made for each finding.

A roundtable of 12 strategic local decision-makers was convened on the Thursday 11 June 2020 to discuss the challenges of the mental health and wellbeing within the recovery in relation to COVID-19 and to share practice around long-term recovery activities and local management of community mental health. This document sets out the findings of an analysis of those discussions.

Mental Health and Wellbeing Impacts of Covid-19

This briefing summarises a roundtable discussion on mental health and wellbeing impacts of Covid-19 hosted on the 11/06/2020. Reflections from the roundtable have been summarised and themed using thematic analysis. Seven main findings were identified.

Findings and Suggested Actions

One: Share the NHSE mental health plan with all relevant partners immediately

NHSE should share the plan with all relevant partners, including those outside of health, with immediate effect. LRFs and recovery cells should request this plan from their local leads. Ensure that the national plan is articulated to the local level. With planning in response to the local context, demographics and needs. The local articulations should also be shared.

Two: Mental health data, surveillance, scoping emerging need and planning should be shared

For PHE/NHSE to share data on the predicted growth and nature of mental health impacts of COVID-19. Local mental health leads to share up to date sources of additional support with partners. For NHSE, DHSC and PHE to cascade findings of national modelling to local areas to inform real time local planning and longer-term forward look.

Three: Prediction of changes to demand profile of mental health needs

Local partnerships should ensure agencies have knowledge and a tracking system to mitigate deteriorating mental health of younger people. Plans need to be actioned between now and September to remediate the full effect. That local partnerships consider the impact on key worker staff within their areas and put systems in place to manage and remediate this predicted need.

Four: Social and health inequalities

As national thought leadership develops in this area, there is a need to replicate the impacts and planning assumptions at a local level. Local partnerships should undertake a gap analysis to identify what resources and assets there are to address the risks to BAME members of the public and workers.

Five: Approaches of other LRFs to understanding the mental health of their communities:

LRF structures should complete a mental health needs analysis as well as a humanitarian impact assessment. The output of these should then be used to complete a gap analysis with resources across partnerships. The structures and partnerships delivering the plans to respond to the mental health need should have appropriate governance over them, as the structures are likely to be in existence for years. This governance should include holding NHSE accountable for the additional spend at a local level. Where need is likely to exceed sources of support, community solidarity and action should be leveraged through local partnerships to provide additional support.

Six: Moving to new ways of working

Retain, at the local level, the opportunities for multi-agency working that are enabled by digital connections and remote working. Look to ways that organisations and partnerships can work to deliver services in the reality of reduced funding available.

Seven: Networks to access and share practice

For local partnerships, requiring a briefing from members who are on these networks should be requested. Nationally, the leads for mental health should work with wider partner agencies to find a way to share learning from intelligence and data quickly, effectively and fully.

Priorities of the NHSE Plan

Additional 345,000 (double) children and young people seen.

Focus on the 270,000 people with serious mental illness.

Bespoke mental health crisis line.

Additional 380,000 people accessing talking therapies such as IAPT.

Focus on those experiencing health and social inequalities.

Planned expansion to suicide reduction services.

Priority of key worker support.

METHOD/ANALYSIS

The roundtable followed a series of questions facilitated by a chairperson. Questions clustered in to seven main areas; Local Resilience Forum subsidiarity, Sub-National Recovery Structures, Community Impacts, Forward Look and a view of the required need of the Vision 20:20 Platform. Example questions from these main areas included:

- Could you describe how Mental Health recovery links to your ongoing response structures?
- How are you managing mental health recovery at different levels, (eg LRF led versus work led by councils or others)?
- What methods or approaches do you plan to use to scope the latent impacts of COVID-19 on your communities?
- What legal, ethical, logistical and equality issues do you anticipate for your multi-agency containment of a local mental health need? (e.g. S136 demand/enforcement challenge)?
- What kind of intelligence do you want to see?

The data was recorded with permission from delegates and analysed by an academic from Nottingham Trent University. The audio recording will be destroyed once the report is finalised, in accordance with GDPR and data protection regulations. The analytical method used was thematic analysis, which involved reviewing the audio recording several times, coding the content and then clustering that coding into the thematic areas.

Mental Health Definition

According to the World Health Organization (WHO), mental health is: “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”.

Wellbeing Definition

Wellbeing is a much broader concept and is linked inextricably with health, encapsulating the physical health, mental health, social and emotional wellbeing of an individual. An individual therefore an individual’s mental health and wellbeing can be different as the two are not predicated on the same things.

SUMMARY OF FINDINGS

Every individual has mental health, it is part of being human. It varies between each individual about what is right for them and where they are in their lives and challenges. Sometimes that can be mental ill health, sometimes mental health can change over time within an individual, sometimes their mental health is better than at other times in their life.

The NHSE published in July 2019 their Longer Term Plan which set out the mental health strategy and timelines in England. The discussion demonstrated that Covid-19 has had a potentially significant impact on the mental health of the UK and how services have adapted and changed to meet those needs, and how they will continue to be updated as the physical distancing and increased participation in online services continues to shape services.
Through the discussions in the roundtable it was clear that the delivery of the plan had been altered and changed to ensure a rapid and supportive response to the challenges of Covid-
19. This is crucial information for relevant partner agencies to know and align their plans and activities to. In this way the nature of the activities and thinking that NHSE and PHE have done between the original July 2019 plan and the current state of play through the catalyst of Covid-19, offers some valuable and insightful knowledge and updated implementation of the plan, which needs to be shared with partners and this update to The Longer Term plan is referred to throughout this document.

The delegates agreed there has been under investment in mental health in this country and there is an unmet gap which is likely to grow as we transition through the different phases of COVID-19. There were some representation that the thresholds for assessing services have been incredibly high, which limited the amount of help available.

As the impacts of COVID-19 are considered by Recovery Coordination Groups, Multi-SCG Response Co-ordinating Groups (ResCGs), Local Resilience Forums (LRFs) and other recovery structures, the premise of investing in early intervention partnership work means that members of the public are not medicalised or medicated unnecessarily and that their overall health would be protected more effectively.

With this starting point, eight findings represent the discussion from this round table. They are:

- Sharing the NHSE mental health plan
- An overview summary of the plan
- How a strategic and integrated delivery of the plan can be implemented local to national
- How mental health surveillance is scoping emerging need and planning
- Predictions of changes to the demand profile of mental health needs
- Social and health inequalities and their link to mental health needs
- The approaches of other LRFs to understanding the mental health of their communities
- An overview of how mental health of the public could move to new ways of working
- Networks to access and use to share practice

The findings are summarised in to these eight key areas.

FINDING ONE: SHARE THE NHSE MENTAL HEALTH PLAN WITH ALL RELEVANT PARTNERS IMMEDIATELY

In order to enact the plan, there is a need to ensure all relevant partners have had sight of the plan, including those outside of the health community. The recovery planning has

a collapsing timeframe to it and so this needs to be done immediately in order to ensure that the plan can be implemented from national to local across all local partners. This should bridge discipline, meeting and sector memberships. Comments from partners in the roundtable inferred that they had not seen the plan before. If this is the case, this needs to be shared across partners from the national to the local immediately so that shared activity and planning assumptions can be developed at pace with and integrated to the local wider recovery activities.

SUMMARY OF THE NHSE PLAN:

Delegates agreed that crucial to the plan is the ability to respond with a partnership approach. Before COVID-19 came to England, there was a treatment gap in mental health provision. Not enough people could access treatment who should have access and there were unacceptably long waiting lists. Mental health services will receive 2.3 billion (rising to approximately 3.4 billion) of extra funding by 2023/24, which would enable an additional two million people a year to access services as part of a long-term plan from NHSE. The second year of that plan has deliverables which will be measured, but in order to succeed it needs to be implemented at the local level.

The priorities of the national plan to spend the extra funding include:

- An additional 345,000 (double) children and young people seen. With additional activity of CAMHS taking place with schools and college-based teams. Through partnership working with schools and other local agencies, early identification of childhood issues can be addressed to avoid escalation.

- A focus on the 270,000 people with serious mental illness. Those who have been caught between policy changes in recent years such as changes to benefits, housing and other policies means they have not received an integrated approach. Anyone experiencing a mental health crisis across England will be able to call a bespoke mental health crisis line which will be a 24/7 NHS led crisis line. As of Saturday 4 April 2020, 50% of the country has this in place.

- An additional 380,000 people accessing talking therapies such as IAPT to address increased demand for anxiety, depression and traumatic reactions. There is current ongoing training for IAPT services to calibrate the focus to some of the impacts of COVID-19. With particular focus on those experiencing health and social inequalities, homelessness, rough sleeping, problem gambling. There is also a planned expansion to suicide reduction services.

These are the main priorities concluded after a process of engagement from statutory bodies. Whilst the additional two million people in need are being seen in the health service, they all live in local systems and are members of wider society. Partnership working with other agencies is the most effective way to see better mental health and wellbeing outcomes across communities. Therefore, a national plan has to be enacted locally by such bodies as Health and Wellbeing Boards, Local Transformation Partnerships and other forums. This requires the local partners to understand who is vulnerable in their area and identify what the issues are, to be able to adapt the plan to the local area to facilitate a quick partnership response.

Delegates agreed that learning from events such as the Grenfell Tower fire suggests it

is good practice to plan for a high demand/what is likely to come. The delegates agreed that caution or hesitance in planning a response to the projected mental health needs (such as traumatic reactions) should be considered now, so that support can be scaled up with the projected incremental increase in demand over the next 15 years. There might be a proportion of people who come forward in the next weeks or months, but most will come forward over a longer time frame such as months and years, the demand increase goes well beyond days and weeks. In the context of COVID-19, working with local communities and other agencies is advised as there will be a significant impact on mental health which needs to be planned for across the short, medium and long term. Another priority is key workers, most people reading this briefing are included in this group, including strategic leaders.
NHSE, DHSC and others are putting together guidance and support for all key workers.

There is particular concern within this broader group of key workers for care home colleagues and others working in the emergency services, social care as well as health settings. NHSE are working towards a very clear offer for staff.

Suggested action: NHSE should share the plan with all relevant partners, including those outside of health, with immediate effect.

Suggested action: LRFs and recovery cells should request this plan from their local leads.

Suggested action: Ensure that the national plan is articulated to the local level. With planning in response to the local context, demographics and needs. The local articulations should also be shared.

FINDING TWO: MENTAL HEALTH DATA, SURVEILLANCE, SCOPING EMERGING NEED AND PLANNING SHOULD BE SHARED

A requested was directed to the health sector, to share data on the growth and nature of demand of mental health problems. This was also supplemented with a request to address the need to understand in granular detail the forecasted 30% increase in mental health demand, as well as the strategic modelling. This is because it impacts so directly on other services such as policing.

Once the plan, data and modelling is shared, there is a direct request to share the messaging of the sources of additional support such as relevant apps and helpline services with other partner agencies. Those partner agencies are then responsible for ensuring frontline staff are aware of these to direct those members of the public in need of that help to those sources.

As COVID-19 arrived in the UK, NHSE and PHE established a reporting and data collection plan such that real time data as well as administrative data are received on a weekly basis. All survey data and helplines data is collated in to a weekly surveillance tracker which has been influencing ministerial action. However, the ambition is to get a local facing version of that tracker so information can be cascaded to local level. This should be delivered within a couple of weeks from the date of the focus group. There are approximately 20 pilot schemes that collate near real time data relating to suicide. These pilot schemes are viewed as a priority at this time, as the impact on suicide from COVID-19 is unknown, but it is critical that information to highlight any associations are not

delayed through a 3-6 month time lag. Currently some modelling of the main assumed psychological risk factors is being completed. This includes unemployment, poverty and debt, which are being modelled alongside the best available evidence. This modelling is on a timescale of the medium and longer term. Attempts will also try to be made to cascade that modelling output to local areas to inform that real time planning and inform longer-term forward looks. This modelling also includes the effect of protective factors such as community, resilience, volunteering and civic participation. The output of this could inform how those gains could be built on.

A request was made from the delegates to expand the real time tracking of suicides to include vulnerabilities around missing persons. Discussions took place about the importance of making clear links between suicide and vulnerable missing persons data sets. This was highlighted as good practice and enables alignment which in turn allows joint strategic decision making and action. PHE and partner organisations sharing this with other agencies through appropriate channels such as the PCC network was seen as critical to facilitating the partnership approach highlighted throughout discussions.

Suggested action: For PHE/NHSE to share data on the predicted growth and nature of mental health impacts of COVID-19.

Suggested action: Local mental health leads to share up to date sources of additional support with partners.

Suggested action: For NHSE, DHSC and PHE to cascade findings of national modelling to local areas to inform real time local planning and longer-term forward look.

FINDING THREE: PREDICTION OF CHANGES TO DEMAND PROFILE OF MENTAL HEALTH NEEDS

There is increasing demand from existing and new emergent mental health needs. The emergent needs have been initiated by the impacts of managing COVID-19, such as loneliness and isolation, grief, financial worries, higher rates of depression and anxiety and traumatic reactions. The existing demand is increasing as early, informal intelligence suggests that people with existing mental health issues are relapsing. This is because their support networks (informal support networks, and the support from the health and care system) have changed from face to face to online, or they have been withdrawn due to service prioritisation, and they have felt a reduction in the amount of contact with mental health services. Mental health clinicians are seeing people who have relapsed who they would not normally have expected to relapse, people who have been stable for quite a long period of time who have been impacted by the current circumstances.

There is also an increase in demand forecasted from the workforce. Challenges in the workforce of mental-health services pre-COVID-19 have been documented. Staff levels of wellness have been further impacted due to the change to admissions and other services have been reconfigured to cope with the crisis. This has pulled staff out of services and into different roles and tasks. Services have had to draw on agency staff and staff are feeling very tired. Whilst they have not had the same level of recognition that staff in intensive care units have had they are stretched physically and mentally. So, staff morale, workforce and numbers maybe a concern and a growing area of demand.

Demand will grow due to the psychological impacts of managing COVID-19. As referenced at the start of this report, mental health is inextricably bound with the economy. Depending on the levels of employment and economic prosperity across the country over the next ten years, there is likely to be a correlation between economic fragility and the extent of the mental health need. Together will partners, NHSE and PHE have identified the following as at risk;

- women,
- people with pre-existing mental health conditions,
- children and young people.

Children and young people are at risk from missing school and the support and development they receive through school. Looking at under 18 suicides in the last few months it was concluded that a proportion of these young people at risk were not known to the health service. As a partnership, ensuring there is sight on those at risk is important, and with deteriorating mental health in the young, plans need to be actioned between now and September. This support might include families who have been living with greater complexity and stress, including the parents. As NHSE funding facilitates the crisis lines and expansion of services, the effectiveness is predicated on partnership working. DHSE, PHE are looking at identifying the most vulnerable groups and which agencies need to be identifying and working with.

There are demographical changes in COVID-19 needs include increases in depression and anxiety from economic fragility. International learning for the UK has come from the US, as social welfare is not present in the US so it serves as a forerunner of who the economic impact will affect in quicker time than the UK. Large-scale societal tracking research looks at unemployment rate and it is impacting on young adults. This is very different to the recent financial crisis where it hit older people more who were in secure jobs and could absorb time off with less repercussions. It will also impact those in lower income jobs, which is millions of people in the UK, rather than tens of thousands. The virus and the impacts does not affect everyone equally, it is a discriminator.

Discussions also included the need to consider aspects of recent parenthood during COVID- 19 and lockdown measures, including the pause of healthcare of reproductive health, postnatal care for families whose babies were born in isolation, birth trauma, isolation and sleep deprivation through lack of availability of physical support networks.

Suggested action: Local partnerships should ensure agencies have knowledge and a tracking system to mitigate deteriorating mental health of younger people. Plans need to be actioned between now and September to remediate the full effect.

Suggested action: That local partnerships consider the impact on key worker staff within their areas and put systems in place to manage and remediate this predicted need.

FINDING FOUR: SOCIAL AND HEALTH INEQUALITIES

Places of higher social deprivation are associated with poorer health outcomes, lower academic achievement, poor housing, higher welfare support and increased levels of mental ill health. At the time of this focus group, there is evidence of a significant increase in mental health issues in the patients who are contacting services and access to support

services such as IAPT has been difficult. The C-19 National Foresight Group has published work discussing equity, which delegates endorsed, rather than supporting equality. Delegates were interested in looking at wider impacts of this, through such processes such as adverse childhood experiences. GP practices have started screening for ACEs and predict an increase in the scores of all children, young people and families. This crisis, alongside the financial burden needs to be considered holistically with families.

Delegates all agreed that the extra funding should ensure that services are at an operating level where patients are referred to services when they need services and seen without waiting 12-18 months for psychological therapies. This delay means that members of the public are often medicalised or medicated who would not need to be if they were seen earlier.

Delegates agreed that messaging about Non-Pharmaceutical Interventions (NPIs) to those vulnerable in the community is challenging. Understanding messaging about impacts on locality, in the context of local area outbreak plans, will become more complex. The original messaging was very clear in terms of stay at home and wash your hands. As the messaging gets more nuanced, the feedback received from the community is that people are now losing the grasp of the messaging and what it means to them. This is likely to impact on those members of the public who have mental health challenges.

At the time of the focus groups Black Lives Matter demonstrations were taking place and those members of the community who are of BAME origin are twice as likely to die of COVID-19. Delegates considered how this also compounds with the representation of members of the BAME communities in mental health services.

NHSE continue to talk and learn from international colleagues facing similar issues of overrepresentation in services by BAME members. Data and findings have suggested that young black men come forward very late because they are apprehensive that they will be sectioned, so they come forward when they are at an acute stage and consequently a proportionate number are sectioned. Delegates agreed that collaboration with staff and key stakeholders, involving them in solving the problems, rather than solving the problems for them and then telling them this is how the problem will be solved is a mistake. There was a desire to coproduce the solutions.

Communications with BAME members of the public to advise of health or behavioural risks of COVID-19 is a challenge. Directly targeting messaging in a broader sense about health is happening, but when the risks are being learnt about and new information is updating regularly, that makes for a challenging messaging strategy. Delegates were agreed that they would like to include patients in discussing how to improve their care.

Suggested Action: As national thought leadership develops in this area, there is a need to replicate the impacts and planning assumptions at a local level.

Suggested action: Local partnerships should undertake a gap analysis to identify what resources and assets there are to address the risks to BAME members of the public and workers.

FINDING FIVE: APPROACHES OF OTHER LRFS TO UNDERSTANDING THE MENTAL HEALTH OF THEIR COMMUNITIES

Delegates placed importance on the positive relationships with commissioning groups. Structures to facilitate coordination and planning of mental health support includes:

- Vulnerable person's cell set up within response and recovery structures.
- Mental health recovery group looking at both adults and children to reconfigure pathways to mental health services.
- Work has delineated COVID-19 and non-COVID-19 situations for accessing support.
- Shadow recovery has completed modelling of the projected 30% increase.
- Wellbeing hubs have focused on those people disadvantaged through the impact of COVID-19 and people with mental health issues.
- Plans to drive mental health programme forward over the coming years with community and voluntary groups.
- Shadow mental health recovery cell has enabled integration of actions with local authorities and communities.
- An LRF recovery cell to integrate arrangements and plan next steps.

The processes that other LRFs are engaged in to facilitate planning in response to that demand typically include a mental health strategic needs analysis which incorporates route causal or predeterminal factors of mental health. Using data to inform the predicted need of planning. The NHSE national model supports local models and should be implemented by the local strategic level.

In terms of community impacts, delegates reported wide use of a place (town) based approach. With community and volunteer engagement, planning using a gap analysis and incorporating crisis helplines for crisis and wellbeing.

Through the recovery cell structures delegates spoke of taking national learning about community impacts and articulating that to town level. Typically, there is available public health data and data from community mental health teams. This is used to provide a gap analysis to inform what communities might need and how that might be collectively deployed. This is challenging work due to silo and fragmented organisational working.

Delegates widely agreed that although there was learning from partnership organisations, there was a challenge to share intelligence and data. For example, triangulating real time collective population based intelligence to demonstrate the impact of plans and actions.

GOVERNANCE AND STRUCTURES

Delegates discussed the need to have governance structures around mental health plans and partnerships. Having a centre partnerships approach and engaging providers for adult and children mental health services with CCGs could be beneficial to ensure that pathways are there for onward referrals. Using a local/town footprint, all the providers, including GP practices, community resilience and volunteers and others are cross-referencing data sources to identify any spikes and groups who might be at risk.

Triangulating local data with national reports coming out to build a more complete picture. Some areas are using their MOD planners with modelling skills, within intelligence hubs to help identify early stage action triggers on a range of indicators. This is with the intention of connecting the community with secondary services when appropriate. This is to address that current reported trend of people coming to seek support late in the development of their needs, or the VCS referring too quickly. These are the drivers to balance effective help seeking for individuals and appropriate use of support structures.

NHSE need to be held to account for their investment money being effective on the frontline and for delivery. Delegates shared the need to innovate and to be free of some of the bureaucracy and reporting requirements, staff feel they have had more powers to enable the right thing, to work with the right people. Another challenge was the status of Integrated Care System arrangements and tiers of authorities. COVID-19 has helped to cut through of some red tape which was reported as highly beneficial.

Collaboration with partners, communities and volunteer support

Delegates discussed the support of communities and the strong patterns of neighbourhood need and activities of volunteers. There has been community action, the challenge is how to harness that and work with mental health expertise to enhance it rather than lose the learning and energy. These local partnerships and opportunities that have been developed in response to COVID-19 is a challenge to galvanise going forward.

Work from the Grenfell Tower fire response shows the value of being community focussed because this approach can identify needs and support more effectively and identified that statutory services are not likely to be sufficient to meet this increased demand. Community resources could be accessed currently as COVID-19 has given rise to collective identity, leveraging that to educate people on the mental health effects that are likely to be present in increased numbers. Others in society who are not so affected can be supported to help those effected. There are international lessons from around the world on building community resources. There are ways of working when mental health services are under stress, global mental health strategies are used where the workforce is not as organised or absent. These include enhancing and facilitating communities to provide support to vulnerable people and ways of providing support with a limited workforce.

Suggested Action: LRF structures should complete a mental health needs analysis as well as a humanitarian impact assessment. The output of these should then be used to complete a gap analysis with resources across partnerships.

Suggested action: The structures and partnerships delivering the plans to respond to the mental health need should have appropriate governance over them, as the structures are likely to be in existence for years. This governance should include holding NHSE accountable for the additional spend at a local level.

Suggested action: Where need is likely to exceed sources of support, community solidarity and action should be leveraged through local partnerships to provide additional support.

FINDING SIX: MOVING TO NEW WAYS OF WORKING

The shift to digital channels has required training for therapists on delivering care remotely. The use of digital channels has enabled ongoing support for the public and provided ways of organisational working such as multi-agency reviews, which will be strengths in the future.
Use of an app allowing those in need to see a skilled therapist quickly, or by appointment, has seen a big decrease (20% or more) in people attending A&E and being referred into mental health services. This is predicted to change with emergent and latent demand through restart of NHSE services.

There have been examples where statutory mental health services have been working in new ways with voluntary sector providers. For example, bringing in VSC providers to run crisis lines.

Suggested action: Retain, at the local level, the opportunities for multi-agency working that are enabled by digital connections and remote working.

Suggested action: Look to ways that organisations and partnerships can work to deliver services in the reality of reduced funding available.

FINDING SEVEN: NETWORKS TO ACCESS AND SHARE PRACTICE

Going forward, capturing the learning ahead of and during phases of the crisis, and then cascading them. This seems to be facilitated well within the mental health sector but appears not to include other partners who need to share the same understanding and knowledge.
Current ways in which this happens include:

- Regular regional meetings through Clinical Commissioning Groups at the ICSSP level. These include quarterly deep dives and rapid gathering of intelligence around issues.
- Weekly webinar for Chief Executives of mental health trusts from across the country, every week for an hour.
- Integrated Care Services and CCGs are networked at a regional level, but a parallel fast track for NHS providers has been facilitated. This includes a mix of sharing good practice around bespoke topics, discussion of new guidance coming out, and informing the national agenda.
- Focussing on partnership work there has been a focus on children and young people across health and Trusts are invited to present joint work they have been involved with. Key questions included what partners are you working with? Do you know who your most vulnerable are? Are you discussing them? Have you got a register? Have you got line of sight?
- There is a weekly webinar for broader partnerships particularly LGA, DHSC, Young Minds, Mind, Royal College of Psychiatry.
- There are also plans for a future forum platform where good practice is captured and shared.
- NHSE, DHSC and PHE have shared a lot of data in health, but how this culturally moves outside of the health sector and is shared between agencies is still a challenge.

Suggested action: For local partnerships, requiring a briefing from members who are on these networks should be requested.

Suggested action: Nationally, the leads for mental health should work with wider partner agencies to find a way to share learning from intelligence and data quickly, effectively and fully.

END.

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