Nottingham and Nottinghamshire ICS

Depression and Anxiety

Clinical and Community Services Strategy

January 2021

Contents

1. Executive Summary

The Integrated Care System (ICS) ambition across Nottinghamshire is to both increase the duration of people's lives and to improve the quality of those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The aim of the Clinical and Community Services Strategy (CCSS) is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate with a long term view of beyond 5 years.

At any one time between 4 per cent and 10 per cent of people (including children) are experiencing depression serious enough to affect our work, study or personal lives. The experience of depression is very common and the World Health Organization has described depression as the commonest of all health problems. At any one time, over 300 million people around the world are experiencing mood that is so low that they would meet formal criteria for a 'diagnosis of depression'. The wider economic cost of mental health (MH) illness in England have been estimated at £105.2 billion each year. Depression is estimated to make up £7.5 billion of this and anxiety £8.9 billion, including costs in medication, benefits and lost working days (McCrone et al, 2008).

As many as 1 in 10 people receiving help from their general practitioner (GP) for depression may attempt suicide over a five-year period. Nine out of ten adults with MH problems are supported in primary care. The Improving Access to Psychological Therapies (IAPT) programme to treat common MH conditions is world-leading. Mental illness is a leading cause of disability in the UK. Stress, anxiety and depression were the leading cause of lost work days in 2019/20 at 17.9 million work days (HSE.gov). The cost of poor MH to the economy as a whole is far in excess of the NHS MH budget (£12.2 billion in 2018/19). So reducing the impact of common mental illness can also increase our national income and productivity.

The NHS Long Term Plan (LTP) makes strong reference to ensuring improvements are made in the integration of health and social care and in particular access to MH services. This review acknowledges several programmes of work that are underway or been completed and seeks to align to this work, however, within the limitations of this work, the resulting transformation proposals are expected to define further areas of development or of engagement to produce more comprehensive recommendations and implementation plans.

For many people living with long term conditions (LTC) such as diabetes, COPD, sight loss or heart disease, it is crucial to have early and the right timely support to recognise signs of depression and anxiety alongside the physical health condition and better manage their physical and MH and understand the interplay between the two.

This depression and anxiety service review has been undertaken as part of the ICS CCSS work stream. It has been supported by clinical experts and stakeholders in the development of place based service models for the future, to support the long term needs of our existing citizens. The review also focuses on embedding prevention in our population over the next 5-10 years, by shifting our culture from one of illness to one of healthier lifestyles and self-care, but one that recognises the importance to consider MH equally to physical health.

The strategy identifies major stages in the journey of those with depression or anxiety and stresses a need to reorganise the way in which these services are delivered, from prevention through to longer term support for those at highest risk that are living with MH issues. A whole pathway approach in the provision of depression and anxiety services is crucial in order to maximise the clinical and mental wellness outcome for patients, their quality of life and experience of depression and anxiety services.

Fundamental themes have been identified along with key transformational opportunities and potential impacts have been developed which include: prevention strategies to promote mental wellbeing, healthy living and independence; improved access & shared communication about patients' past medical history from secondary care settings to community and primary care; appropriate treatments for adults with depression and anxiety accessible across the ICS; standardise access to services through improved integration between secondary and primary care with a strong focus on both physical and MH care.

A transformational 'Bridge to the Future' highlights current service offers across the ICS and identifies some potential long term next steps that can be taken to achieve the identified opportunities with proposed timelines and the expected outcome for our citizens of Nottinghamshire.

The recommended next steps are vital in keeping the momentum of change in the future offer of improved prevention and better mental wellness for our citizens; providing the right tools for our population to support their wellbeing; providing strong communication links for our staff is vital to enable them to provide the best care for our citizens; the most appropriate models of care in hospital settings, neighbourhood and home need to be provided equitably across the ICS and be provided using best evidence, flexibly and in a patient centred holistic way for them to fulfil their maximum potential throughout their lifetime.

2. Introduction

Background and Purpose	In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable. However, our health and care system faces change and this will impact on our services, for example, the growing prevalence of long-term health conditions places new strains on our system. There is inequality evident in both the location of services and in access to services. In some areas, it is easier to access a GP or than in others, or to find things to do to enable citizens to stay active and fit. The ICS ambition across Nottinghamshire is to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The requirement for a CCSS came from the recognition that to achieve this ambition the system has to change as a whole, rather than just in its individual acute, primary care, community and social care elements. It is recognised that only by working together to describe changes in how care is provided across the system, rather than through individual organisations, will we deliver the scale of change required.
The ICS Clinical and Community Services Strategy	The aim of the CCSS is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention. This should be delivered closer to people's homes or in community locations where this enables better prevention, more supported self-care and earlier intervention to support citizens. The Strategy recognises that achieving this change is a long term programme that will be delivered over the next 5 years and beyond. This is also to enable a necessary long term investment in the health and care buildings and infrastructure in the system. An overall CCSS whole life model framework has been developed to focus on the need to support people through their lives from living healthy, supporting people with illness and urgent and emergency care through to end of life care. Citizens can experience different parts of the system at different stages in their lives. With the development of the overall Strategy framework the next phase of work is to review the 20 areas of service across the ICS that collectively form approximately 80% of the volume of clinical work in the ICS. This will ensure that overall the Strategy is described as a coherent whole and generates a programme of change for the whole ICS. This review of Depression and Anxiety Services provides the opportunity to be such a review and is part of the third phase of work.
NHS Long Term Plan	The NHS LTP is clear that to meet the challenges that face the NHS it will increasingly need to be more joined up and coordinated in its care; More proactive in the services it provides; More differentiated in its support offer to its individuals. The ICS has focused on describing 5 areas of focus for the delivery of the NHS LTP. These requirements are reflected in each of the service reviews that collectively will describe the CCSS **1. Prevention and the wider determinants of health -** More action on and improvements in the upstream prevention of avoidable illness and its exacerbations **2. Proactive care, self management and personalisation -** Improve support to people at risk of and living with single and multiple long term conditions and disabilities through greater proactive care, self-management and personalisation **3. Urgent and emergency care -** Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting **4. Mental health** - Re-shape and transform services and other interventions so they better respond to the MH and care needs of our population **5. Value, resilience and sustainability -** Deliver increased value, resilience and sustainability across the system (including estates)

3. Approach and Scope

Approach	This strategy has been developed through an open and inclusive process which weaves together the expertise of clinicians and care experts with commissioners and citizens in determining the future shape of services across the system. There have been a variety of stakeholder and service user events to develop a clinical and community services model. An extensive system wide piece of work is taking place across a minimum of 20 services. The CCSS Programme Board have reviewed these services against a range of quantitative and qualitative criteria and agreed the third phase of seven service reviews. These include Gastroenterology, Depression and Anxiety, Heart Health, Colorectal, Urological Health, Oncology and End of Life Care. This document discusses the approach, scope, the key issues and potential transformational opportunities within Depression and Anxiety services across the ICS. Health, social care, public health and the voluntary sectors have all been considered through reviewing the current service offer across the ICS. The service review was taken over approximately 14 weeks and there were two workshop held with stakeholders from across the ICS. An evidence review pack was developed which considered national and local best practice to inform the development of potential themes and new models of care where transformational change may take place across the ICS in the future.
Scope	Most of the service reviews that have been considered are fairly focused, allowing the approach to be specific in describing and making recommendations on the key priorities. Depression and anxiety as a service has far more breadth and presents some constraints aligned to the CCSS approach and timelines, which limit the focus achievable. This review therefore considers less specificity, but describes key areas of attention that further work can build upon with the respective engagement. The recommendations, therefore, articulate those areas of focus that were evidenced through the process as areas of significant issue that can be further shaped with the level of detail required. The following focus was agreed in the scope of this review: **In scope:** • Adults services (16+ to include transition and to align to 0-25 years national guidance) • Mild, moderate or severe depression and anxiety • Care and shared care provided or commissioned by health (primary, secondary, tertiary) and social care services • Care and support provided by 3rd sector organisations • Suicidality **Not in scope:** • Specialised commissioned services • Child and Adolescent Mental Health Services (CAMHS)/ Paediatrics
Engagement	The Depression and Anxiety service review has been supported by a tailored Depression and Anxiety Steering Group involving stakeholders and clinical experts from across the ICS. They have provided expert advice, guided, confirmed and challenged assumptions throughout the period of review and connected to other workstreams. This group has formed part of the governance process along with the CCSS Programme Board. Two virtual workshops have been held enabling a wide breadth of stakeholders (Psychiatrists, GPs, Psychologists, mental health nurses, allied health professional (AHP), voluntary groups, Heads of Service, Social Care, Public Health, Commissioners and others) to be proactively involved in re-evaluating current service offers across the ICS, in developing potential themes and agreeing transformational change for the future Clinical and Community Services Strategy. In addition a patient focus group has been attended, organised by ABBA representatives in collaboration between Opportunity Nottingham Beneficiary Ambassadors, Services for Empowerment and Advocacy(SEA), the CDP Service User Involvement Officer. Citizens that attended included those with lived experience of MH issues. Patients with chronic or severe depression also shared their user experiences.

4. Contents

Strategy Development	This Strategy Document consists of five key elements. These have been developed through a process of design and iteration at the workshop and steering group meetings and includes key stakeholders from across the system. The strategy has been developed with reference to the Evidence Review document and the patient focus group that has been held.
Priorities for Change	The work of the Steering Group and the workshop stakeholders identified and confirmed four key areas of focus that need to change in the ICS for depression and anxiety care. These were based on a review of the current issues facing the ICS and the views of the Steering Group and workshop attendees. Some service user experience has also been incorporated into the development of the strategy.
Proposed Future Care System	Following the initial engagement, at subsequent steering group meetings, attendees started to develop the future care system for Depression and Anxiety to address the Priorities for Change. The future care system is described against two dimensions and aligned to the stepped care model: • **Location** split between - Home (usual place of residence) – Hospital (including both acute and MH) with 24/7 medical presence – Neighbourhood representing all community/primary care and ambulatory care settings • **Urgency** split between - **Emergency/Crisis** requiring a service provided 24/7 to avoid crisis or risk to life – **Urgent** requiring a service 7/7 but not 24/7 to meet urgent care needs – **Planned/Scheduled** reflecting any arrangement where an appointment is agreed between a professional and a citizen • **Stepped Care** model which *is used to organise the provision of services and to help people with common MH disorders, their families, carers and healthcare professionals to choose the most effective interventions. (NICE, CG123)* The intention of the system model is to focus future care delivery closer to home and also with greater levels of scheduled care to best use the available resources and reduce demand on urgent and emergency care services. The new system to address the Priorities for Change is presented for each location and then summarised overall for the ICS.
Transformation Proposal	The Transformation proposal describes the key initiatives or programmes that are required to deliver this new mode. As described earlier, for Depression and Anxiety services, some of these programmes need to be developed in more detail. Namely, • **Priority** – What is the priority of the initiative in the view of the steering group and workshop attendees • **Alignment** – At what level of the system should we aim for a consistent approach for each initiative? This was split into two categories: ▪ Alignment to achieve **consistency** - In most instances this is ICS or Integrated Care Provider (ICP) level where with the greater value is perceived to be in an overall consistent approach. ▪ Alignment for **delivery** of the proposal - There are some instances where the recommendation is for delivery to be at ICP level, alternatively, it is at Primary Care Network (PCN) level where differential delivery would benefit the needs of very local populations • **Enabling Requirements** – What is required to enable each Programme to deliver? This includes workforce, technology, estate or service configuration. There are also requirements of culture or finance and commissioning to allow the system to work together differently • **Benefits and Costs** – Where available, the key benefits of the initiative at system level are summarised
Service Vision	The 'Bridge to the Future' was generated at a further virtual steering group meeting. It summarises the current challenges for the depression and anxiety system in the ICS now (Priorities for Change), what the ambition is and the outline steps to get there. Progress with the 'Bridge to the Future' and the partnering vision can be returned to with stakeholders as the work develops to review progress.

Depression and Anxiety Key Themes

Prevention and Self-Care

- Relapse Prevention and Early Intervention
- Adolescents and Transition

Referral and Access Models

- Recognition and Assessment
- Social and Community Care Input
- Inequalities in care and support

Treating Depression and Anxiety

- Psychological Therapies
- Pharmacological Treatments
- Physical Treatments

Whole System Approach

- Organisation and Delivery of Services
- Charity and Voluntary Support
- Integration of Systems

Prevention and Self-Care

Around 1 in 3 GP appointments involves a mental health component
Psychiatry UK

Suicide rate among those with **depression** is approximately **20 times higher** than the rate for the general population
(Harris & Barraclough, 1997)

At least 50% of those who recover from a first episode of depression having one or more additional episodes in their lifetime American Psychiatric Association, 2000; Kupfer, Frank, & Wamhoff, 1996; Post, 1992

Mental illness is a leading cause of disability in the UK. Stress, anxiety and depression were the leading cause of lost work days in 2017/18
NHS Long Term Plan

80% of those with a history of two episodes having another recurrence
American Psychiatric Association, 2000; Kupfer, Frank, & Wamhoff, 1996; Post, 1992

4-10% of the population at anytime are experiencing depression serious enough to affect their work, study or personal lives.

SOCIAL PRESCRIBING

Top comorbidities: Hypertension, Depression & Anxiety

Footprint	Referrals	Referral Declined	COVID Wellness	Average Age	Ethnicity	Supported by Social Care
Mid Notts ICP	2640	270	13455	70	2% BAME	65%
City ICP	645	20	3585	56	19% BAME *	28%
Rushcliffe	360	65	1805	59	10% BAME	19%
South Notts ICP	1210	95	7590	67	5% BAME	49%
Notts ICS	4475	385	24630	67	5% BAME	56%

COVID:
Plausible estimates of the increase in incidence of mental ill health in previous crises range from **5% - 20%**. PHM

Nationally only **4%** of young people received an 'ideal' transition
(TRACK)

Referral and Access Models

40% of older people attending GP surgeries are reported to have 'poor mental health'

(UK Inquiry into Mental Health and Well-being in Later Life 2006).

60% of those living in residential institutions are reported to have 'poor mental health'

(UK Inquiry into Mental Health and Well-being in Later Life 2006).

In England men age 45-49 have the highest suicide risk at 26.1 per 100,000.'

Samaritans

31% of people with depression/ anxiety also suffer with chronic pain.
NHS Long Term Plan

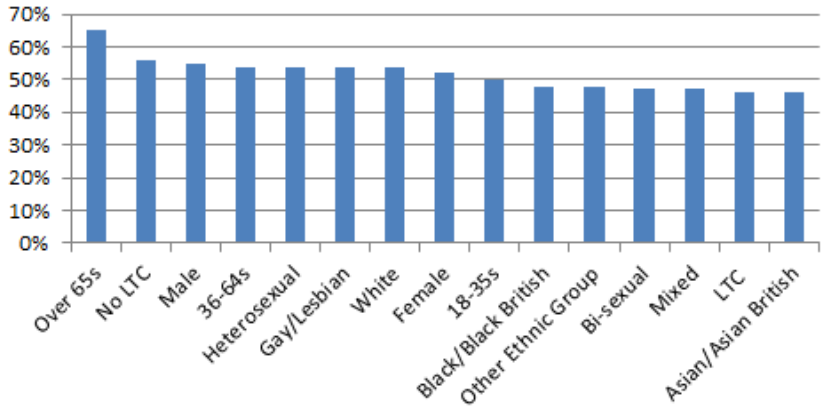
CATCH 22

Vast majority of clinical responses require an individual to address their substance misuse, before mental health treatment can be provided or even a needs assessment carried out. Fulfilling Lives Partnerships

The prevalence of common mental health disorders of those 65+ in Mansfield and Ashfield at 12% is higher than all but Nottingham City. Yet the IAPT referrals at 168 per 100,000 is the lowest. PHE Fingertips

On average 160 patients a month are using liaison psychiatry have depression / anxiety. (This is 1 in 3 of their patients)
Notts Health Care

IAPT recovery rate rates



People with less common sexual orientations more likely to access or tried but been unsuccessful. Pansexual respondents were the most likely to have accessed mental health services (36%) or to have tried but been unsuccessful (13%)

(LGBT survey report 2018)

Treating Depression and Anxiety

Mansfield & Ashfield

- **GREATEST NEED** worst quintiles for depression prevalence (17.8% & 17.3% , vs 15% England).
- **FEWER GET TREATMENT** Significantly lower referrals (774 per 100,000) than England (953)
- **FEWER RECOVER** Lowest quintile of recovery rates 47%.

Nottingham City

- **GREATEST NEED** worst quintiles for depression prevalence in England (18% vs 15% England).
- **BUT MORE GET TREATMENT** Significantly higher referrals (1,158, per 100,000)
- recovery rates are below average at 51%

NEED:

Estimated prevalence of common mental disorders: % of population aged 16 & over 2017 — Percentage point - per 100

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	7,609,582	16.9*	16.2	18.0
NHS Nottingham City CCG	–	55,595	20.8*	19.5	22.7
NHS Mansfield And Ashfield CCG	–	30,971	19.1*	18.1	20.4
NHS Newark & Sherwood CCG	–	15,932	16.0*	15.3	17.2
NHS Nottingham North And East CCG	–	19,877	16.0*	15.2	17.2
NHS Nottingham West CCG	–	13,666	14.6*	13.9	15.8
NHS Rushcliffe CCG	–	11,354	12.0*	11.0	13.5

PHE Fingertips

TREAT: (IAPT)

IAPT referrals: rate (quarterly) per 100,000 population (18+ yrs) 2019/20 Q2 — Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	419,539	953	950	956
North Midlands NHS region	–	-	-	-	-
NHS Nottingham City CCG	↑	3,040	1,158*	1,118	1,200
NHS Nottingham West CCG	↑	900	982*	919	1,048
NHS Rushcliffe CCG	↑	905	970*	908	1,035
NHS Nottingham North And East CCG	→	1,100	902*	850	957
NHS Newark & Sherwood CCG	→	855	879*	821	940
NHS Mansfield And Ashfield CCG	→	1,230	774*	732	819

PHE Fingertips

RECOVER:

IAPT recovery: % of people who have completed IAPT treatment who are "moving to recovery" (18+ yrs) Sep 2019 — Proportion - %

NHS Rushcliffe CCG	→	85	70.0*	-	-
NHS Nottingham North And East CCG	→	75	56.0*	-	-
NHS Nottingham West CCG	→	50	55.0*	-	-
NHS Newark & Sherwood CCG	→	80	55.0*	-	-
NHS Nottingham City CCG	↑	215	51.0*	-	-
NHS Mansfield And Ashfield CCG	→	65	47.0*	-	-

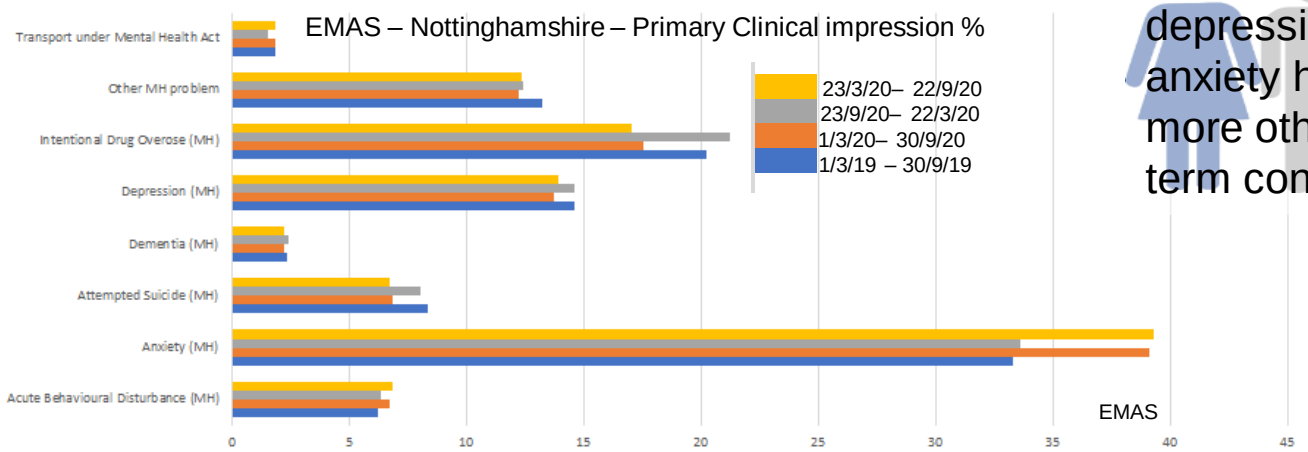
Source: IAPT Quarterly data files and IAPT monthly file https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services

PHE Fingertips

Whole System Approach

In England, 3 in 4 people with depression and/or anxiety have at least one other physical or mental health-related long-term condition

https://www.health.org.uk/publications/long-reads/inequalities-in-health-care-for-people-with-depression-and-anxiety



1 in 3 people with depression and/or anxiety have 3 or more other long-term conditions

By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem.

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

Table J.3: Prevalence Rates for SMD Categories by Local Authority
(all-purpose and county authorities, per 1000 working age population, 2010/11)

Local Authority	H'less only	Offend only	Subst only	Offend + Subst	H'less + Subst	H'less + Offend	SMD3 (SP)	SMD3 (OA)	Total SMD1-3
Nottingham	7.3	6.0	9.1	6.0	2.3	1.6	3.2	2.8	35.3
Nottinghamshire	2.1	3.4	6.3	3.2	1.2	0.8	1.4	1.5	18.4

Fulfilling lives Programme - Nottingham is the 8th highest of multiple disadvantage. Opportunity Nottingham has 100 people on case load. 60 of these have mental health diagnosis recorded and 68% have anxiety and depression

5. Priorities for Change

The review identified 4 key areas of focus highlighting potential areas of change which include:

- Prevention and Self-Care (with emphasis on relapse prevention as recommended by NICE and early intervention; ensuring early recognition is targeted in adolescents and during transition, but also that the capacity to support is available);
- Referral and Access Models (reviewing the referral process to introduce standardised approaches, through improved recognition and assessment, but access to the care that is most appropriate including social and community care provision is accessible, whilst addressing inequalities in care and support are addressed);
- Treating Depression and Anxiety (ensuring the right treatment is available in the right place in a timely manner, with adequate capacity available in psychological therapies, but maintaining focus on pharmacological treatments with reviews in primary care and using physical therapies in a holistic approach to care, this focus should not ignore the chronic and more severely depressed cohort);
- Whole System Approach (endorsing the Stepped Model of Care, whilst ensuring the organisation and delivery of services is consistent through a multi-agency approach that includes 3rd sector organisations and charities supported through local authorities. Well interfaced systems so providers know their patients).

Prevention and Self-Care	Many of the things that cause depression or anxiety are difficult to control, such as your environment, your genes or trauma or some major episode in your life. Evidence suggests that whilst around half the people who become depressed will only have a single episode, half will have multiple episodes or longer periods of depression. Great care needs to be taken to ensure these individuals are not lost in the system and that there is recognition that the pathway needs to provide a route for these patients to access further appropriate support. The risk of relapse and recurrence increases with each prior episode of major depression but decreases as the period of recovery is longer and so many considerations come into play to prevent relapse and these should form important points to discuss with the patient, including their risk of relapse, how to recognise it, how to reduce it, for example with Cognitive Behaviour Therapy (CBT), Mindfulness Based Cognitive Therapy (MBCT), focusing more on the way one thinks; and also medications, the length of time an individual may be on antidepressants as part of their treatment, as findings show this can help reduce the risk of relapse and what the patient should do if relapse happens. Perhaps more can be done to promote awareness and self-care – encouraging people to talk more about MH. The ICS needs to ensure there is enough support on how to cope with stress and improve your self-esteem; promoting general fitness and sleeping well with regular exercise; encouraging people to reach out more to family and friends. There needs to be a balanced approach to ensuring there is enough capacity to meet the demand that awareness will create. Access to early intervention can be paramount in some cases of depression and anxiety. This can be supported by MH social prescribers as described in the stepped care model, where early intervention can highlight early signs of depression and anxiety to GPs or other care professionals. In providing equitable access to services supporting wider determinants of depression and anxiety, such as housing, employment, financial support across the ICS, the escalation of early depression and anxiety to moderate or worse levels, may be avoided. Once again the approach should ensure the service offer is in place before the patients are assured help and support is available and the funding mechanisms for this may already be planned in line with the national targets to offer access to psychological therapies to 25% of need. Several services are already in place to provide early support for the wider determinants such as employment support, housing support, financial and other social factors such as loneliness. Work is currently underway to support this development in community mental health services. The transition from children's services to adult services is at an age where adolescents are more likely to disengage. IAPT services have helped to transform the treatment of adult depression and anxiety disorders in England. IAPT services are available from the age of 16 years and above, including self-help CBT support, physical activity groups for depression or group and individual CBT. Young people of this age group often prefer to seek psychological support and counselling from Youth Information Advocacy and Counselling services or similar. So where the general preparation for adulthood works well with this group from 12 to 16 year olds, the transition element perhaps needs to include introduction to the adult teams and if required with the offer of IAPT. Full support should then be offered by the adult services from 18 to 25 years to ensure the transition is smooth and young adults with a history of MH illness are not lost in the system. This is aligned to the NHS long Term Plan which has outlined that 0-25 year olds will be able to access support via NHS funded services.

Referral and Access Models	Of 130 cases of depression per 1000 people each year, only 80 will consultant their GP, with 50 out of 130 that don't consult their GP. GPs are now much better at recognising more severe depression than in the past and research suggests most patients unrecognised on a single occasion are subsequently recognised and treated. However, there is still a high level of variability across GPs in recognising depressive illnesses and this variability has not improved despite several attempts at trying different approaches, such as training those where communication skills can improve, or using screening or case finding approaches. Of those detected, around 1 in 4 or 5 are referred on for psychological therapy or secondary MH services. Of the 50 that do not seek support from their GPs, some seek help, advice or support from other voluntary, community and social enterprises (VCSE), social care services, care home providers, housing officers, employment advisors and other 3rd sector charitable organisations. These organisations should no be underestimated for the positive impact they have on people's lives and these services should be recognised as pivotal to the supporting those with depression and anxiety. IAPT services have seen an increased number of referrals for treatments, although there is still some variation among individual GPs in their referral rates to MH services. In the Mansfield and Ashfield area of the ICS there is a greater need to support depression (17.5% compared to England average 15%) yet the area has the lowest IAPT referrals and uptake. In-line with national targets for 25% of people with a MH problem to be accessing psychological therapies through IAPT, the objective across the ICS is to improve the number of appointments taken up. Although many of the referrals to IAPT is through the GP, people can self-refer, but locally and particularly through the COVID pandemic, many people have resorted to calling the recently established helpline or crisis line. In the ICS, the all age integrated MH and social care strategy comprehensively details a partnership approach to delivering physical, MH and social care across the ICS. 31% of people with depression or anxiety also suffer from chronic pain and when they are receiving care for the physical health problem, the MH is often not considered. Part of the solution may lie with the health workforce in the widest sense to think about MH in their daily interaction with patients. Through the appropriate education, training and support this can create a powerful team at least able to provide brief interventions. A collaborative, multi-disciplinary, patient-centred team from primary care and home care, through community care to the acute sector and voluntary organisations. With improved partnership working and MH awareness education delivered to HCPs identifying depression and anxiety, a holistic approach to patient care may also allow those with comorbidities, such as diabetes, respiratory disease, obesity or heart disease, to be better treated for their depression and anxiety. This would help address some of the issues where referral rates and access to psychological therapies is low. This model of working between physical and MH care professionals is seen in the Kings Health Partners, where a tripartite agreement between Guy's, St Thomas' and Kings College Hospital Trusts, where all HCPs are supported to recognise and respond to the MH needs of patients with a physical health presentation. The recommendations in the report 'Treat as One – Bridging the gap between mental and physical healthcare in general hospitals' provide detail of how such ways of working could benefit other systems, such as the Nottingham and Nottinghamshire ICS. There are issues with access to psychological support for patients with depression and anxiety that suffer from substance and alcohol misuse as they are unable to access psychological therapy services unless they are free from any misuse for three days. These patients can benefit from timely access to support services without the challenges of having to remain free from using for three plus days. There are many other areas of inequalities in care and support and this is perhaps an area where more can be done to close the gap in the inequalities that exist. There is evidence that shows people from some of these groups that suffer from depression and anxiety, (which include adult men, older people, black, Asian and minority ethnics (BAME), lesbian, gay, bi-sexual, trans, queer or questioning (LGBTQ+), and people with cognitive impairment, asylum seekers), show a higher prevalence of depression and anxiety but show a significant lower level of access to available services. It is important to have focused engagement to work with these groups to fully understand the issues and ask what would be helpful for them. Without this consultation it would remain a challenge to articulate how the gap can be addressed. Needless to say, there is a need to promote inclusiveness and have information in different languages and formats and available from establishments local to various groups.

Treating Depression and Anxiety	The ICS needs to ensure local organisational MH strategies are aligned to the recent improvements made to integrate MH strategies across both social and clinical care models in the ICS. Local strategies within provider organisations may not be aligned to provide a unified approach to supporting mental wellbeing and more specifically, for depression and anxiety, there is a need to improve take up of the appropriate service offers in alignment with national targets. HCPs need a better appreciation of the gap between mental and physical healthcare and this can help collaborate the approach to MH care in all settings from primary care and community care to acute hospital care and MH hospital secondary care. Areas of Mid-Notts (Mansfield and Ashfield) and Nottingham City showed a greater need of support for depression compared to the England average. However, when the numbers being treated (IAPT) were reviewed it is clear that Nottingham City had a significant better take up (1,158 cf. England average of 953 per 100,000), whereas Mid-Notts had significantly less take up (774 per 100,000) for IAPT. The recovery rates of mid-Notts and Nottingham City were also below average at 47% and 51% respectively, compared to Rushcliffe (70%). In order to further improve access to psychological therapies to reach the target of 25% of need (IAPT Manual) and ensure the target for recovery rates are also met, it is important that there is a balanced approach to identification and response. If the perceived gap, particularly in mid-Notts where uptake is low, was identified with referrals to IAPT services made, there may be challenges in meeting demand with current resource levels, which would adversely impact the plan to treat 25% of those identified. However, with many of the calls to the helpline or crisis line now monitored and some logged appropriately against the 25% target, this has helped with the challenges. One way to help meet needs might be through delivery of the some of the psychological therapies (CBT, mindfulness) in groups, (as detailed in the NICE 2018 Update). Other forms of psychological therapies include guided self-help, behavioural activation, interpersonal therapy (IPT), CBT, problem solving therapy, counselling, short-term psychodynamic therapy (STPT) and the delivery of these treatments can depend upon the level of severity of depression and some may be delivered as group treatments. For anxiety, the psychological therapies used for low intensity tend to be guided self-help or psychoeducation, but for high intensity CBT and applied relaxation are used. Locally, there is a gap in psychotherapy provision at steps 4/5 of the Stepped Care model, in secondary and tertiary care for complex anxiety and depression disorders. Patients that can greatly benefit from psychotherapy and clinical psychology at steps 4/5 support are sometimes unable to access these services due to being excluded from primary care IAPTs due to their complex needs and then falling through the net when referred to secondary care as they do not meet the criteria for referral to the more specialist services such as offered by psychotherapy and clinical psychology at step 4/5. This issue was also raised specifically by some patients in the patient group session. Pharmacological treatments include anti-depressants such as SSRIs (selective serotonin re-uptake inhibitors) that should only be used in less severe cases where patients choose not to have psychotherapies, or based on a previous treatment response – for more severe cases an offer of either high intensity individual therapy should be made, such as CBT IPT or behavioural activation or antidepressants (or both). Routine outcome monitoring at 1 week should be undertaken with a switch if there is no response at 4-6 weeks and to reduce relapse there should be 12 month reviews if on maintenance medications. There should be emphasis on follow up and therefore, integrated working with primary care is important. A pilot run in Rushcliffe, supported a Primary Care Depression Advice Clinic with psychiatric outreach expertise reflecting a successful innovative way to promote prevention and self-care with 89% of those seen in the clinic discharged back to the GP with advice on lifestyle, self-care and next step management options (e.g. medication changes/ psychotherapy). Although some deemed this perhaps too early to introduce psychiatry to patients, it brought care closer to home and for the majority of patients found a quicker resolution than just seeing their GP without being referred to secondary care. When progressing further up the stepped care model, physical treatments have been shown to be effective for depression, with a smaller evidence base for its effectiveness for anxiety. Physical treatments include electroconvulsive therapy (ECT), neuromodulation treatments such as Cranial Electrotherapy Stimulation (CES), Transcranial Magnetic Stimulation (TMS) and with ECT featuring in the NICE 2018 Update and TMS in NICE 2015. Evidence shows that both TMS and CES can be effective treatments costing a fraction of most psychological therapies. A nurse led primary care clinic offering CES obtained similar outcomes at much less cost than GP care, a cost minimisation model performed by health economists.

Whole System Approach	In most of the developments over the last 20 years or so, changes in MH care policies have influenced many of the approaches to delivery of services, but the one that remains an exception with a strong evidence base is Collaborative Care, which has grown over the last 20 years and evidenced by some large scale trials and economic evaluations of collaborative care in the UK. One of the more widely adopted models of service delivery for Depression and Anxiety services is the Stepped Care Model. Stepped care is based on matching the severity of presentation with the type of treatment. 'Enhanced Care' is the term adopted in the guidelines that refers to all models of service delivery, including a number of interventions that often have some overlap. To ensure health and care partners are providing appropriate care equitably, a multi-disciplinary approach to working across providers should be adopted. As it stands the Stepped Care model is a health model and current only describes health interventions, not reflecting the roles of community groups, debt advice, reablement, OT, substance misuse services, etc. Without adaption, it risks limiting the 'Whole System Approach'. Going forward, a whole system approach should bring agencies more closely together to achieve a more joined up and collaborative place-based model for mental health support. It is vital that 3rd sector voluntary services and charities are accessible to all patients and therefore the workforce should play an active part in understanding which charities can support a patient's needs. This is particularly important once the treatment and care from health and social care colleagues has ended, as quite often the support needs for the patient will continue and may be well supported through local groups. Furthermore, charities can often play a vital role in supporting patients through crisis, in a manner that provider services may not be able to, patients may obtain help to understand their options or get emotional support to help them cope. This is a stage where it can often be a challenge if the patient is not signposted nor do they know of appropriate charities that may be able to support their specific needs. There is a risk the patient may become more anxious or depressed with the uncertainty of what lies ahead. Again demonstrating why the workforce should maintain close links to both local and national charities. The problem when considering charity and voluntary organisations, is knowing what is out there - charities, volunteer organisations, groups etc. and how to access the support they provide. If HCPs are unable to signpost to these, then the task to navigate 3rd sector support for the public will be even more challenging. Charitable and voluntary organisations can often provide a safe-haven for patients when services cannot be accessed The Depression and Anxiety professional community should be aware of what support is available. Organisations across all care settings need to think innovatively about how partnership working can improve access for patients. An example where this has worked successfully, is the Primary Care Depression Advice Clinic briefly described above, where an outreach model of MH specialist support of a GP medical centre has shown positive outcomes with local delivery. Perhaps with COVID learning, this model can be replicated in other areas of the ICS to share the successes it brings with the added onset of virtual working – although for some people with depression or anxiety, this would not be the preferred way of contact and the preference to maintain face-to-face (F2F) contact i. Systems need better aligning to provide a true integrated approach to providing seamless services for Depression and Anxiety and with various providers using different systems this needs to be considered to ensure patient data is readily accessible when appropriately needed. Finally, for wider system considerations of depression and anxiety, ***Psychologically Informed Environments (PIE) and Trauma Informed Care*** (TIC) can enable much improved collaborative working against shared principles. This presentation includes a summary of how adopting PIE and TIC can really improve provision of MH care for our population.

6. Proposed future care system

Home

Planned/Scheduled

Prevention & Self-Care – Relapse Prevention and Early Intervention, Adolescents and Transition

- 10 key to happier living to implement at population level
- Need to promote living well , easy access to support for wider determinants
- Public MH – collaboration for better MH – 5 steps Education of the public - resilience and when and how to reach out. What does it look and feel like and normative behaviours
- Education for primary care services – early diagnosis and knowledge of all services and keeping updated – Live DoS
- Social prescribers – link workers from April 2021 – referral criteria in development – need to balance demand with offer
- Trusted Apps to support wellbeing
- Consideration of waiting times – bridging gap with information and advice – self-care. Workforce requirements for IAPT therapists to support access
- No wrong door to access advice and support
- Better promotion of general wellbeing – links between MH and physical health
- In order to prevent deterioration or need for urgent/ crisis care, failed support from IAPTs needs to be followed up

Sustainable by:

- Improved support and understanding of risks allows earlier understanding and prevention
- Promotes awareness to support self-care and independence

Referral and Access Models - Recognition and Assessment, Social and Community Care Input

- Helpline providing home support and advice available
- Care providers - education and training, ensure screening and education available to all e.g. including care homes, link to above with prevention
- Primary care MH teams – linking with LTC/IAPT/secondary care
- Develop self-care awareness with Apps to support wellbeing

Sustainable by:

- Awareness and appreciate of the need to offer home support with early contact – prevents deterioration and need for moderate to severe care.

Whole System Approach – Delivery of Services, Charity and Voluntary Support, Integration of Systems

- Link to community transformation work – opportunity to look at this together
- Know what is available 3rd sector and link to social prescribing.
- Collaborative working to help navigate health systems with CVS having a role
- Develop a Live DoS enlisting all linked services – make DoS accessible
- Continue mapping and support for a sustainable voluntary sector.
- Ensure supervision and support for MH link workers in communities of practice e.g. OT providing support. Needs to be across all tiers, support may be over and above other link workers.

Sustainable by:

- Provides home support and promotes self-care and awareness for prevention but also enables people to live more independently, reduces care packages
- Reduced hospital and social care appointments

Urgent – 24 hours

Prevention & Self-Care

- Easy transition between tiers, e.g. step down to Social Prescribing as secondary prevention with direct access back if required
- Access to live DoS listing all available services and education for primary care to promote early diagnosis – understanding available capacity

Sustainable by:

- Provides quick response enables earlier intervention and support to avoid crisis services

Emergency/Crisis – 4 hours

Prevention & Self-Care

- Crisis teams – home treatment support and facilitates discharge – all ages
- Crisis helpline – Notts HC and Turning Point
- All age out of hours team for transition
- MH OP – intensive older teams, link with crisis and rapid response psychiatry
- Access to information 24/7 e.g. RIO across all platforms
- Suicidality – prevention training and clear access and navigation across the system

Sustainable by:

- Allows emergency support to be made swiftly, prevents delayed response, reduce suicide

Colour KEY to information source: Steering Group/ Workshop 1 Evidence Document/ Guideline Patient Focus Groups

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6. Proposed future care system

Planned/Scheduled	Urgent – 24 hours	Neighbourhood	Emergency/Crisis – 4 hours
Prevention & Self-Care – Relapse Prevention and Early Intervention, Adolescents and Transition • Access to allow seeing people with MH needs early to provide the ability to self-care and self-manage better, services need to be accessible though. • Employment sustainability is clearly important and again enabling people to understand how to cope with depression or anxiety issues in this situation. Finding the right job to prevent the inhibitions • Access to exercise therapies for those in physical pain and in danger of this impacting their MH • Long waits to access IAPTs need to be addressed. • IAPT providers need to better understand individual needs and consider tailoring psychological support to these needs. • Reablement workers supporting skills and daily living – also Framework picking up issues on housing or money issues, health and social care – signposting. • Improve wider access to CES in primary care – learn from Cripps pilot • Education of children in school – balance of activities e.g. exercise – MH workers in school/college – educate teachers to eradicate bullying Sustainable by: • Patients seen earlier reducing risk of deterioration requiring more intense support	**Prevention & Self-Care** • Create more primary care clinics across the ICS where MH nurse holds an emergency same day clinics, offering signposting to services like IAPTs – allows people to be seen quite early and in urgent cases – learning from Cripps pilot can be applied to other areas where primary care MH services can work well • This approach prevent crisis management needs. This does prevent patients deteriorating into crisis management Sustainable by: • Provides primary care system for response enables earlier intervention and support to avoid crisis services		
Referral and Access Models - Recognition and Assessment, Social and Community Care Input • Need to address inequity in access to support organisations (e.g. Self Help UK) – need to work more with local groups like this to promote self-help, Connect • Patients reportedly facing further episodes of depression found it difficult to access support as the questions asked for IAPTs only considered the previous two weeks, where their episodes and support needs may have been more irregular. • Knowing who and where our lonely population are and providing support and awareness of groups to help. Physical health – consider for people with chronic pain and LTC – identification and brief interventions or referral - MECC principle. Opportunity to develop skills/joint pathways e.g. Let's Talk Wellbeing Oncology/Pain Sustainable by: • Encourages early detection • Early intervention and support from social care – reduces avoidable admissions due to falls, depression, etc.	**Referral and Access Models** • Need access to urgent support for people that are about to lose their home, have an employment situation, social connection, housing, debts – these can be the triggers that tip people over the edge if not supported in time Sustainable by: • Provides quick response enables earlier intervention and support to avoid crisis services		
Treating Depression and Anxiety - Psychological Therapies, Pharmacological Treatments, Physical Treatments • Standardisation of approaches, but adherence to population needs should be considered – this should be considered by HCPs dealing with physical health issues – "Treat as One" • Improve access to exercise therapies for those in physical pain and in danger of this impacting their MH Sustainable by: • Prevents admissions, speeds up home support as appropriate			
Whole System Approach – Delivery of Services, Charity and Voluntary Support, Integration of Systems • Improve links with VCSEs, including housing, police, employment, 3rd sector in all ICPs (mid-Notts currently has strong links) • Define plans to ensure strong integration is developed with all PCNs to aid a collaborative approach to providing support for depression and anxiety. Sustainable by: • Collaboration with 3rd sector helps sustain support during waits for treatment/ therapy			

Colour KEY to information source: Steering Group/ Workshop 1 Evidence Document/ Guideline Patient Focus Groups

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6. Proposed future care system

Acute or MH Hospital

Planned/Scheduled	Urgent – 24 hours	Emergency/Crisis – 4 hours
<u>Prevention & Self-Care – Relapse Prevention and Early Intervention, Adolescents and Transition</u> • Recognising that most people that have a secondary care MH episode will relapse and have a subsequent episode, so planning for this before it happens – advanced statements, decisions. Provision of mindfulness and CBT. • ICS workforce to be trained and educated to bridge the gap between mental and physical health needs and identify MH presentation in physical health settings • Patients don't realise they have depression. Education to help them make sense – helplessness leads to hopelessness. • Ensure liaison psychiatry is accessible and that HCPs understand when support is required (include education for HCPs). Sustainable by: • Improves secondary prevention, planning for relapse • Understanding and supporting MH alongside physical health needs	<u>Prevention & Self-Care</u> • Ability to admit people to hospital setting. Need provision of sufficient beds in MH hospitals. Need to be in a safe setting, especially if suicidality is out of control. • Crisis response – just seen as overdosing and suicidal – it's a consequence of relapse of depression. Need safer environment through admission. Sustainable by: • Early support provided when relapse is recognised - prevents crisis response	<u>Prevention & Self-Care</u> • Need ability to perform an appropriate and thorough MH assessment quickly in the acute hospital setting Sustainable by: • Allows emergency contact to be made swiftly, prevents delayed response
<u>Referral and Access Models - Recognition and Assessment, Social and Community Care Input</u> • Seamless pathway – primary – secondary – tertiary care service - better collaborative working across all the areas. • There is a need to accurately determine the right level of care patients require • Better communication across all the areas involved, this is where we fall down. • Need to ensure treatment started on MH Ward is seamlessly transferred to community care when patient is discharged. • Acute trusts not always helpful when they see a repeat attender in ED – need to treat each episode separately. Sustainable by: • Patients seen in right setting with closer working between settings	<u>Referral and Access Models</u> • Identify and access social care needs of young person as mood and anxiety problems may stem from home environment Sustainable by: • Reduces hospital visits, whilst improving safeguarding	
<u>Treating Depression and Anxiety - Psychological Therapies, Pharmacological Treatments, Physical Treatments</u> • There is a need for access to therapies in older adult wards in the acute setting - access to psychology is limited, but clear requirement in NICE draft with continuity at discharge – need to consider how this is resourced. • Use light touch intervention at every contact. Social prescribing and peer support offered in hospital Sustainable by: • Improves recognition and support of depression and anxiety in elderly	<u>Treating Depression and Anxiety - Psychological Therapies, Pharmacological Treatments, Physical Treatments</u> • Use of innovative treatments - e.g. Electro convulsive therapies (ECT) Esketamine – going through technology appraisal now. Phase 2 – proof of concept to reduce depression within 4 hours – nasal spray for those that are suicidal. Sustainable by: • Enable quick response to urgent intervention need .	<u>Treating Depression and Anxiety - Psychological Therapies, Pharmacological Treatments, Physical Treatments</u> • ECT, new one Esketamine – going through technology appraisal now. Phase 2 – proof of concept to reduce depression within 4 hours • Risk of suicide to be assessed. Sustainable by: • May prevent acute admission
<u>Whole System Approach – Delivery of Services, Charity and Voluntary Support, Integration of Systems</u> • Transition into community, recovery college – improve care planning. • Planned access to services from hospital needs to be holistic so that OT, social care, housing and other needs are met as part of discharge process. People should also be supported to access advocacy services from Pohwer. • Video consultations – access people more effectively preventing long distance travel – on patient terms • 'Passporting' IG to allow conversations with partner agencies – promotes collaborative working Sustainable by: • Effective service provision and follow up from discharge	<u>Whole System Approach</u> • Crisis housing availability Sustainable by: • Supports urgent response for those not admitted, but in need of support away from home	<u>Whole System Approach</u> • Review documents – advanced decision / advanced directives. Should be visible to all clinicians involved in the care. s/b logged in psychiatry notes. Relative or patient may have them if permitted. Need to see if they exist to prevent patients getting treatments they explicitly said they don't want. Sustainable by: • Patient history accessible for all care providers

Colour KEY to information source: Steering Group/ Workshop 1 Evidence Document/ Guideline Patient Focus Groups

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Integrated Care System
Nottingham & Nottinghamshire

6. Proposed future care system

www.healthandcarenotts.co.uk @NHSNottingham

Level of Care / Availability	Acute/ MH Hospital	Neighbourhood	Home
4 hours or less / 24/7	• Improved systems interface to ensure records are accessible to enable reviews and advanced decision / advanced directives correctly – particularly for suicidal behaviours – these should be logged in psychiatry notes and be visible to all clinicians involved in the care. Need to prevent patients getting treatments they explicitly said they don't want • Risk of suicide to be assessed early in emergency cases		• Awareness of and access to Crisis Response and Home Service including helplines – Notts HC and Turning Point • HCPs to have access to information 24/7 e.g. Rio across all platforms • Suicidality – clear access and navigation across the system
Urgent Care/ within 24 hours / 7 days	• Need sufficient capacity in MH hospital to provide safe setting, especially when suicidality is out of control • Identify and access social care needs of young person as mood and anxiety problems may stem from home environment • Ensure routine liaison psychiatry assessment including 24hr response. Available from 16 years. • Access to carer support needs to be in place. Teenager / older adult could have profound impact on carer • ECT – Esketamine – going through technology appraisal now. Phase 2 – proof of concept to reduce depression within 4 hours – nasal spray for those that are suicidal • Access to crisis housing	• Adopting working models and sharing best practice e.g. University practice has a MH nurse providing same day emergency clinics but also signposts to services like IAPT - can help prevent need for crisis management - model can be adapted for other areas where primary care MH services can work well • Urgent support for people on verge of triggering due to personal issues (housing, debt, employment, etc.) – urgent support to prevent crisis management and deterioration	• Transition between tiers, e.g. step down to Social Prescribing as secondary prevention with direct access back if required • Access to live DoS listing all available services and education for primary care to promote early diagnosis – understanding available capacity
Scheduled / Appt based	• ICS workforce to be trained and educated to bridge the gap between mental and physical health needs and identify MH presentation in physical health settings • Patients don't realise they have depression. Education to help them make sense – helplessness leads to hopelessness. • Seamless pathway – primary – secondary – tertiary care service - better collaborative working across all the areas. • There is a need to accurately determine the right level of care patients require • There is a need for access to therapies in older adult wards • Access to psychology is limited, but clear requirement in NICE draft with continuity at discharge • Improve access to physical treatments early • Use light touch intervention at every contact. Social prescribing and peer support offered in hospital • Transition into community, recovery college – improve care planning • Video consultations – access people more effectively preventing long distance travel – on patient terms • 'Passporting' IG to allow conversations with partner agencies	• Reablement workers supporting skills and daily living – also Framework picking up issues on housing or money issues, health and social care – signposting • Working towards 2022 target to have MH in schools (LTP), but ensure this stretches to academies – PH involvement • Need to address inequity in access to support organisations (e.g. Self Help UK) – need to work more with local groups like this to promote self-help, Connect – working with older adults to support • Better promotion of general wellbeing – links between MH and physical health • Exercise therapies for those in physical pain and in danger of this impacting their MH • Knowing who and where our lonely population are and providing support and awareness of groups to help • Standardisation of approaches, but adherence to population needs should be considered – this should be considered by HCPs dealing with physical health issues – "Treat as One" and making every contact count (MECC)	• Accessible information on living well – wider determinants including housing, employment, financial management support • Teaching the population to read signs, and understand when and how to reach out • Understanding the MH support requirements when patients present with a physical health • Develop self-care awareness with Apps to support wellbeing • Bridging waiting time gap with information and advice for self-care – ensuring wellness and resilience • No wrong door to access advice and support • Better promotion of general wellbeing – links between MH and physical health • Education and awareness on Depression and Anxiety – recognising signs and talking to friends and family • Knowing what 3rd sector support is available and link to MH social prescribers signposting and referral/ triage

Prevention, education and awareness Lifecycle – different targeted approaches for each stage **Role of Public Health** - LA, LEA, Schools incl. Academies, District Councils, 3rd sector, employers **Medium Priority**	Whilst little evidence is available to show depression and anxiety can be prevented, some of the risks for the onset of depression and anxiety can be mitigated. Adopting structured education programmes in schools from an early age can raise the awareness of MH wellbeing and outline the circumstances in which developing depression or anxiety may be a risk. Providing education and awareness on self-care and coping strategies, would also be beneficial from a young age with strong focus on 'Wellness and Resilience'. Depression and anxiety in some adults stems from childhood experiences, such as physical or psychological bullying at school, or similar abuse at home. Far more needs to be done in schools to deal with this behaviour, but the problem is now systemic, with so much exposure over social media presenting the risk of causing MH issues from a young age. A pilot is already underway with social and MH funding of a schools initiative to have MH support workers in schools. If successful, this could be useful more widely implemented across the ICS. To ensure an all-age approach is taken, education programmes and advice for adults is also essential and this should start from each interaction with the workforce, ensuring we MECC – promoting mental health self-care for all ages. Whilst patients may not have been identified and prevented from having their first episode of depression or anxiety, there remains an opportunity for secondary prevention of relapse. The role of antidepressants, psychotherapies including mindfulness and CBT are amongst the interventions where there is evidence of their effectiveness in reducing relapse. This is also an area in which primary care and GPs can be more effective to help prevent relapse. With at least 50% of patients that suffer from depression likely to have a second episode, capturing early signs of relapse can reduce the onset of more serious or recurring episodes. **Impact & Benefit** • Improve wellness and resilience • Reduced emergency presentation in acute setting – crisis response and home treatment team can see patients at home • Ability to put in place mild-moderate in primary care – addressing with coping strategies early with advice and guidance for them specifically to lower anxiety (esp. students) through these simple coping strategies negating any occupational dysfunction **Alignment –** For prevention, education and awareness the consistency should be aligned at an ICS level, with delivery aligned to each ICP.
Early identification of a mental health presentation **High Priority**	Parity of esteem, or viewing MH equally alongside physical health, helps to ensure those with MH problems benefit from equal access to the most effective and safest care and treatment, equally improving the quality of care. This requires education of the ICS workforce to help identify presentation of early signs of depression or anxiety. The workforce should understand what needs to be done and be able to educate and signpost the population when depression and anxiety is detected and perhaps this can be done through a more formal but brief assessment process. Nearly 40% of people that develop depression or anxiety remain unaware of this and so when this cohort present for a physical health or social care issue, it is important that the process provides an opportunity for the care professional to be mindful of any signs of depression or anxiety and are able to refer onto the appropriate service. It is imperative that MH features on all the LTC pathways and wellness practitioners have a big role to play with LTCs and MH. Although the approach needs to ensure a balance is maintained between the available capacity to provide IAPT support and the emerging additional demand, being mindful of 'no wrong door' is essential to keep in mind a personalised and holistic approach that considers people's circumstances, social needs and personal objectives (what matters to them) might lead to any number of responses that are not IAPT. **Impact & Benefit** • Preventing emergency presentation – also prevents acute admissions • Helping those with LTCs to better manage their conditions, core of depression is lack of motivation and interest so dealing with this in a very direct way can help reduce the level of severity • Many admissions are panic attacks (e.g. not exacerbations for COPD) • Sessions should be included within disease specific areas of LTCs • Preserve the workforce, especially during COVID to deliver these benefits **Alignment –** For consistency in early detection of a MH presentation, alignment should be at ICS level with delivery aligned at PCN level.

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Addressing Inequalities in Depression and Anxiety

High Priority

The prevalence of depression and anxiety in the ICS is higher than the national average. However, some of the more affluent areas show much lower levels of prevalence. In many cases depression and anxiety are related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and the care of oneself. In the UK, the 20% - 25% of people who are obese or continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of depression and anxiety. More detailed work about the demographics of the ICS is underway in the PHM Mental Wellness Review, which will detail areas of inequality and the appropriate approaches that will work best for these populations.

Some of the most deprived areas in the county are also those with higher levels of cultural diversity with high concentration of BAME groups where there is higher prevalence of depression and anxiety. There are also inequalities for depression and anxiety in the over 65 year olds, in LGBTQ+, in middle-aged men (especially black men). In the outreach depression advice clinic conducted in Rushcliffe, the uptake for the trial was predominantly by middle-aged men - a group otherwise difficult to refer onto secondary services for depression and anxiety.

It is important that strategies to address these inequalities are aligned to existing work or learn from successful pilots and ensure these groups are fully engaged in developing initiatives to improve prevention and raise awareness amongst communities and perhaps less in terms of the individual. It is also imperative to maintain links and to work closely with VCSEs, social care colleagues, 3rd sector and voluntary organisations, housing, employment advisors, etc. who already work to support some of these groups. The sustainability of these VCSEs and 3rd sector organisations is paramount as strong relationships have been built with various communities over the years and without these existing foundations, it would prove a much greater challenge to gain the trust of these communities as well.

Understanding the different cultures is paramount in order to explore the issues that cause MH issues so these causes are addressed before raising the awareness that there is an inherent problem of depression and anxiety in some of these groups. A programme of work to improve education and training for carers and care homes would benefit the elderly population.

Public Health England (PHE) have just relaunched the Health Equity Assessment Tool (HEAT), which is a practical framework that enables multiple audiences to systematically embed action on health inequalities and equalities in their work programme and services, and this is a tool that will be adopted to help take the transformation forward.

Impact & Benefit

- Equity of access and addressing the need of the vulnerable groups preventing suicides (prevalence of suicide is highest in middle-aged men)
- Suicide in south Asian groups and African-Caribbean groups disproportionally high and can be reduced
- Improve MH care of elderly through education and training programmes of work with carers and care homes

Alignment – Addressing inequalities in depression and anxiety needs to be approach at localised levels for delivery, but the consistency of approach should be aligned across the ICPs, where an understanding of which PCNs would need to have more in-depth focus

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No wrong door to access support Robust and consistent referral template to access services across the ICS

Medium Priority

The '**no wrong door**' phrase was used at a conference by the National Institute of Drug Abuse (NIDA) when describing how providers of care for people with coexisting MH, substance abuse problems as well as physical health disorders find 'no wrong door' when they seek help. This is a powerful ambition, but one that could bring together care professionals in the ICS from social, mental and physical healthcare providers to support people with getting the right care and treatment for MH problems when they need it. A multi-agency approach to providing robust and consistent access across the ICS is needed, where HCPs and Social Care colleagues are fully supported by the MH professionals. This requires training and education, but also a change of culture of the workforce to encourage conversations where irrespective of whether the patient is attending a physical health episode, they are supported for any recognised MH problem and if required able to refer at that point. A similar model to this, mentioned earlier (King's Health Partners) has shown to be effective in working in this way and providing a 'no wrong door policy' effectively aligned with defined points of access to psychological support. Although there are plans being developed to have an actual access point in each ICP, the ICS workforce culture needs to align to making every contact count (MECC) to improve the patients' experiences in all settings.

The 'no wrong door' vision will form part of the work of the community MH transformation programme.

Impact & Benefit

- Closes the gap in support for those with LTCs needing MH support
- Service user experience much improved and to not keep being bounced back

Alignment – The approach to a 'no wrong door' policy should consistent at ICP level with the focus to simplify referral processes delivered at PCN level.

Treatments for adults with depression, including NICE guidance – practice based evidence (e.g. social prescribing, arts, alternative therapies, etc.)

High Priority

In the ICS, the approach to providing treatments for people with depression and anxiety follows the Stepped Care Model from primary care through to acute care (see **Appendix 1**). This allows service-users and therapists to choose the most effective intervention to meet their need. The first three steps of the model detail how the intensity of input increases from PC intervention, where it is believe the MH Social Prescribers will be most effective. The third step moves to high intensity input including therapy from community practitioners using evidence based therapies such as CBT, IPT and acceptance and commitment therapy. Steps 4 and 5 provide specialist and highly specialist treatments with secondary care involvement.

In order to align with NICE recommendations and treatment guidelines, it is proposed the following key areas are considered:

- Treatment choice at all levels from primary care through to psychiatric admission, including adequate provision of psychotherapy through these levels of care. The apparent gap in secondary/ tertiary care access to psychological/psychotherapy interventions at step 4/5 was also an area raised by some patients that struggled to get a referral to these services, even though they are available now with good outcome evidence but are generally under resourced across the pathway. To improve patient outcomes this is an area where more referrals should be considered through review of resourcing. This could further promote the opportunity to link primary care patients with secondary care interventions when most appropriate and avoid the most severe patients having to go out of area for more expensive residential treatment when more resources would reduce the need for this. Local transformation projects are working to reduce these gaps to help consolidate this service offer, but real strengthening of the transition from step 3 to step 4 is needed. Due to the complexity of their presentation, the service only accept referrals from those already under secondary care services, this is so they have continued support from the LMHT duty services and crisis teams. Unfortunately, this does mean that for those not under secondary service, there is no other provision for psychotherapy other than IAPT within the NHS. The amount of sessions that IAPT currently offer are not in line with NICE guidance and so are often inadequate in treating depression and so can better link primary psychotherapy services with secondary/tertiary psychotherapy so that patients have better access to the treatment that they need without having to jump through hoops.

PTO…

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Treatments for adults with depression, including NICE guidance – practice based evidence (e.g. social prescribing, arts, alternative therapies, etc.)

High Priority

Continued…

This is currently part of the community transformation where there is a review of the psychology offer within the Trust that will include step 4 and 5 and looking at future models.

- Pharmacotherapy approaches that includes timely review of antidepressant initiation, dose increase (within 1 -2 weeks) and longer-term maintenance treatment, including an active review at least yearly to prevent people being left on medication they may not need, which happens in both primary and secondary care. This is a key part of the guidelines re-emphasised by NICE in the update, which can lead to poor patient care if not addressed adequately.
- Collaborative Care, including across traditional care boundaries through enabling advice from 'secondary' to 'primary' care clinicians and patients. The pilot carried out in Rushcliffe showed that at a local level, this is both feasible and acceptable (including to some groups for which access can be improved, e.g. men). Although this pilot completed several years ago and is not ongoing work, a decision would be needed as to whether it is an approach that should be developed.
- Specialist assessment of chronic (or persistent) depression that has not responded to treatment by secondary services, (by a service able to consider the full range of treatment alternatives including evidence-based pharmacology, psychotherapy and neuromodulation). A service for this was developed in Nottingham 10 years ago (the Nottingham Specialist Depression Service) and an audit of this service has been running in secondary care and shows its positive impact on NICE approved care. This local initiative can be built on to help educate and transform services.

Through development of this core structure, the ICS is able to build the foundations upon which treatments can be offered, but it would also be beneficial to build in quality improvement and audit cycles to monitor progress in primary care too, including GP surgeries and IAPT.

There are two other new technologies pertinent to the review where there is already a lot of expertise in the MH trust, some in NUH and locally in primary care as well.

Transcranial magnetic stimulation (TMS, approved by NICE in 2015) is used for both depression and treatment resistant depression. TMS is cost saving for early treatment resistant depression and is more effective than alternatives including ECT. It is considerably safer to give than many drug treatments or ECT in people with comorbid physical illness. There are proposals for a neuromodulation hub to safely and efficiently deliver TMS, esketamine and ECT. At the moment it is only available as part of a research study. It would be important to have this capability at Mansfield, not just greater Nottingham.

Cranial electrotherapy stimulation (CES) is a home based treatment for generalised anxiety disorder. It has approval from NICE for its use and is currently undergoing a full NICE Technology Appraisal. It has been shown that CES is cost saving when compared to CBT used in IAPT services in a peer reviewed published study conducted with health economists and this is the case in NICE's own modelling. As detailed earlier, CES has a completed primary care service evaluation carried out at the Cripps Medical Centre. CES is a good option for people alongside medication and psychological treatment.

Impact & Benefit

- Cost saving through uses of technological approaches for treatment resistant depression, TMS cheaper than conventional methods of care
- CES more cost effective and practical, including for primary care delivery

Alignment – Access to all treatments needs to be equitable across the ICS and so alignment for consistency should be at this level. In terms of delivery the offer of treatments should be managed and aligned at an ICP level.

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7. Depression and Anxiety Transformation Proposal

Transformation Proposals	Priority (High/ Med/ Low)	Alignment (ICS/ ICP/ PCN)		Workforce	Technology	Estate/ Configuration	Culture	Finance/ Commissioning	Benefits (*Less than £20,000 per QALY is cost effective)
		Consistency	Delivery						
Prevention, education and awareness **Lifecycle** – different targeted approaches for each stage **Role of Public Health** - LA, LEA, Schools incl. Academies, District Councils, 3rd sector, employers • Align to existing strategic priorities – raising awareness and promoting wellbeing activities • Mental wellness and resilience • Secondary prevention across the age range • Addressing wider determinants • Tackling early triggers, e.g. bullying	Med	ICS	ICP	• Social prescribers to be in place from April 2021 • Five year plan social and MH – funding for schools initiative – MH support workers to work in schools • Employment support advisors embedded in IAPT • Up-scale ACEs training across workforce • PCN MH Practitioners	• Role of social media • Self-care apps – user guide for the benefits of each one • Patient Knows Best • Live DoS including 3rd Sector organisations • Online counselling service – e.g. KOOTH, colleges and schools for young people	• Local hubs – build on one stop shops models already established	• Collaborative approach • ICPs key in delivering 'Collaboration for better MH' (PH) • Partnerships between 3rd sector and organisations to ensure they understand the pathways better and how to refer/ signpost • Cultural change to support prevention – self-care • Workforce to address prevention – everyone's responsibility	• Length of contracts for 3rd sector providers to allow sustainability and impact of the organisations funding streams – building capacity and capability • Establish role of CVS to provide infrastructure • Need to explore the links between LA, District Councils and well as health commissioning	• Improve wellness and resilience • Reduced emergency presentation – crisis response and home treatment team can see patients at home • Ability to put in place mild-moderate in primary care – addressing with coping strategies early with advice and guidance for them specifically to lower anxiety (esp. students) through these simple coping strategies negating any occupational dysfunction
Early identification of a mental health presentation: • Education for the ICS workforce • Identification of problem • What to do if a change is noticed – population and staff level • Understanding the MH support requirements when patients present with a physical health need or in another context job centre, homecare, workplace • Ensuring HCPs both have the opportunity to ask MH wellness questions, but are aware of how to interact and ask these questions • Improve screening • Pain and medically unexplained conditions	High	ICS	PCN	• Parity of Esteem work to better integrate MH into primary care – training practice nurses who normally focus on physical health • 3rd sector often very quickly support people's MH issues • Training for hospital staff so when a patient comes with a physical health issue their MH is screened	• Integration of information – accessible and visible • Data sharing • Technology to support broader workforce • Use technology to highlight pathway and support signposting		• Adopting strengths based, trauma informed, psychologically informed environment approach • Transitioning needs are very different due to trauma	• Invest earlier in young people to treat them. Psycho education – don't understand • Expectations in contracts – explicit mention of MH of physical health contracts so staff know where to signpost patients to. Such as diabetes contract, LTC and common MH	• Preventing emergency response • Helping those with LTCs to better manage their conditions, core of depression is lack of motivation and interest so dealing with this in a very direct way can help reduce the level of severity • Many admissions are panic attacks (e.g. not exacerbations for COPD) – crisis teams can help reduce LoS and admission • Sessions should be included within disease specific areas of LTCs • Preserve the workforce, especially during COVID to deliver these benefits
Addressing Inequalities in Depression and Anxiety: • Men, BAME, > 65years, deprivation, Asylum seekers • Increasing awareness of risks to certain groups - link back to lifecycle approach e.g. young LGBT people, black men and late access to support • Link into already established work and community groups including 3rd sector organisations	High	ICP	PCN	• Partner with community leaders to gain integrity • LGBTQ, trans young people's group and trans training offered by CAHMS to schools, workforce. Lack of understanding of this group. • Education and training programmes of work with carers and care homes	• Making use of media platforms including different languages and formats for all groups. • Cannot assume everyone has technology and can access support this way.	• Asylum seekers may not present at GP. Where can they present? Make use of local community centres/ cultural centres	• Awareness so correct language is used. Remove the stigma • Community groups and voluntary – understand strengths/ structures to reach people	• 3rd Sector organisations appear to be struggling in the current pandemic • Commissioning – cultural competency and important consideration of delivery	• Equity of access and addressing the need of these vulnerable groups preventing suicides (young men prevalence of suicide is highest) • Suicide in south Asian groups and African-Caribbean groups too • Reduce Health inequalities.
No wrong door to access support **Robust and consistent referral template to access services across the ICS:** • Single Point of Access by ICP level – MDT triage and signposting and advice • Link this to training	Med	ICP	PCN	• MH Primary care training for nurses dealing with physical issues • Part of HC trust's community MH transformation plan to have an access point in each ICP	• Primary care training for nurses dealing with physical issues • Part of HC trust's community MH transformation plan to have an access point in each ICP	• Co-location	• PH funded ACES training to help tackle bullying and abuse – upscaling this • Language and having the right key words understood	• Integration between primary and secondary care • ASK Lion – looking at making a single system approach across MH and physical health	• Early recognition can reduce LoS • Service user experience much better to not keep being bounced back.
Treatments for adults with depression, including NICE guidance – practice based evidence (e.g. social prescribing, arts, alternative therapies, etc.) • Treatment choice at all levels from primary care through to psychiatric admission e.g.in primary care access to IAPT before commencing medication, depending on severity – people with previous issue should be treated by GP straight away • Treatment review, including of antidepressant initiation or dose increase (within 1-2 weeks) and longer maintenance treatment (yearly active review) • Secondary MH care e.g. review post commencing medication and Technological approaches for treatment resistant depression: ▪ Transcranial magnetic stimulation (TMS) ▪ Cranial Electrotherapy Stimulation (CES) • Collaborative care, including across traditional boundaries through enabling advice from 'secondary' to 'primary' care clinicians and patients • Quality improvement through periodic audit cycles	High	ICS	ICP	• CES treatment for anxiety delivered by nurse practitioners in primary care – evidence from local pilots show good response, existing expertise in region • LTP work – training around psychological treatments • Support for PC for complex cases - early discussion • Integrated care with adequate consultation • Extension of existing secondary care audits in IAPTs,	• Consider increased use of technological therapies TMS/ CES as a fraction of cost compared to all psychological therapies (except computerised) • Virtual opportunities to support communication	• Would need to consider estate/ where TMS can or should be made available • Co-location to	• 14% patients have depression with 1 in 3 seeking support within a year – capacity to support - balance needs to be observed to prevent system getting swamped or missing cases – advice from GPs needs to be accurate • Joint working to help people in a different way – liaison between professionals to support person-centred	• TMS currently paid privately or need to seek commissioner permission • Need to understand economic case needed to implement this – other areas have begun to deliver this • Flexibility in IAPT to do more than 6 sessions, in NICE the treatments can be longer, but we aren't able to do this.	• Cost saving through uses of technological approaches for treatment resistant depression - TMS cheaper than conventional methods of care • CES more cost effective and practical for primary care delivery (nurse practitioners)

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8. Enabling Requirements

Workforce	Enhancing the future health and social care for depression and anxiety services, requires the following main considerations for workforce: • Existing plans are in place for the roll out of MH trained social prescribers in April 2021, however, with existing challenges in meeting national targets for the provision of IAPT services, the role they will fulfil to help identify cases of depression and anxiety making up some of the current gap may add to the existing challenges - a balance needs to be maintained in the approach take • Strong involvement from Public Health consultants to lead the prevention agenda, promoting wellness and resilience education in schools from an early age • Widespread training of HCPs to empower them to provide appropriate brief advice and support or signposting/ referring to IAPTs for early identification and response of depression and anxiety • Maximise resource utilisation through greater engagement with HCPs (make every contact count) offering true parity of esteem with structured education and appropriate accreditation
Technology	The main areas in which technology can effect transformation for depression and anxiety include: • Digital interfaces and information sharing between organisation should be a clear part of our ambitions going forward. • App development/ promotion for self-care and signposting locally (e.g. Patient Knows Best). Waiting rooms in various health and social care settings to use screens with rolling information on health and social care advice/ support services available – promote wellness and resilience • Use of virtual appointments to deliver access to psychological therapies only where appropriate for patients • Ensure all MH services, including 3rd sector organisations are accessible through a Live Director of Services (DoS) • Rollout of neuromodulation treatments to bridge gap compared to UK peers, and provide cost reductions
Estate	• Maximise opportunities to utilise general practices, health centres and GP practices to provide access to services closer to home where appropriate • Increase presence and access to IAPT services in areas where inequalities exist • Consider neuromodulation treatments in mid-Notts (Mansfield) as a second hub in addition to Nottingham
Culture	• To drive a culture change we need shared and integrated use of workforce across organisations to enable the sharing of resources as there are limited staff groups and expertise, with the introduction of multi-agency approaches this should improve education across the workforce • All ICS partner organisations to be part of the collaborative providers of depression and anxiety care – parity of esteem • Adopting strengths based, trauma informed, psychologically informed environment approach • Joint working to help people in a different way – liaison between professionals to support person-centred • Partnerships between 3rd sector and organisations to ensure they understand the pathways better and how to refer/ signpost • Cultural change to support prevention – self-care • Workforce to address prevention – everyone's responsibility

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9. Depression and Anxiety Services Future Vision

'Bridge to the Future'

From…		Phase 1 1st year	Phase 2 2-3 years	Phase 3 5 years +	To…
• Limited awareness and support at early school age • Inconsistent training and education for healthcare professions to support both MH and physical health • Inequitable access to early support across the ICS • Poor access to screening	Prevention & Self-Care	• PH to lead development of a base plan of action, consider resources - • Build on existing pilot with schools receiving support and education, including academies – currently via MH support teams (2 years) • Review specific issues (bullying) and opportunities to address these • Prevent recurrence (2° prevention) – adequate pharmacotherapy – with education for GPs in reviews of pharmacotherapy, consider lifestyle • School curriculum – plan in primary schools and so younger intervention of MH wellness • Plan signposting of support services	• Initially raise awareness and focus on training the workforce (to prevent imbalance in capacity and demand) • Review pilot learning and decide rollout of best practice learning to schools across the ICS • PCNs targeted for uptake of education and training to prevent relapse – 'know your patients' • Target basic causes e.g. bullying, to teach and reinforce from primary school age • Improved access to support for housing, employment, finance, etc.	• Routine outcome monitoring • Regular and outcomes focused supervision • PCNs aligned to relapse prevention approaches in partnership with secondary care (GPs to be involved) including medicine reviews • Basic prevention strategies adopted in schools and LEAs across the ICS • Better access to support services ICS-wide	• PH defined clear and consistent prevention strategies across schools, 3rd sector, employers • Early detection and intervention • Improved mental wellness through improved access through primary care • ICS Workforce trained to identify signs of depression and anxiety • Equitable access to services supporting wider determinants of depression and anxiety, such as housing, employment, financial support across the ICS
• Inequalities of care for minority groups affected by depression and anxiety • Low levels of training for social prescribers to support MH, especially in hard to reach groups • Lack of consistency across the ICS in detecting early signs of depression and anxiety • Complex pathways across the ICS	Referral and Access Models	• Consider deprivation, which will be more exaggerated during COVID, where the people in these areas are less likely to get help or be able to seek help. • Develop plan to tackle inequalities in care provision for specific groups - BAME, LGBTQ+, through consultation with these groups • Loneliness – also an area to look into post-COVID – including Frailty (align to existing frailty work)	• Improved integration and support for hard to reach groups – promote mental wellbeing through addressing factors causing depression and anxiety (as opposed to highlighting depression and anxiety) • Further define referral pathways linked to services now also listed on Live DoS including access to 3rd sector support • Access to IAPT aligned to the NHS LTP to provide psychological support therapies to patients with LTCs	• Offer of equitable access to services for ICS population • Clear referral pathways, with increased access for low to moderate needs (stepped care model) • IAPT services integrated with physical health services to routinely offer access to psychological therapies	• Easier access and support for hard to reach groups (BAME, men, >65yrs, asylum seekers) • Simplified referral and access to support across settings and across the ICS • Live DoS listing all providers and capacity and all 3rd sector organisations • Embedded support to psychological therapies for those with LTCs
• Inadequate access to technological therapies in the ICS • Limited support for primary care dealing with complex depression and anxiety cases • Inconsistent uptake of IAPT services across the region • Process driven approaches (not person-centred)	Treating Depression and Anxiety	• Develop TMS implementation plan – start in Nottingham, with plan to expand across the ICS with developed expertise • Explore MH Social Prescribers supporting CES – again develop experience and roll out further across more practices • Ensure core treatment gaps (psychotherapies) are identified – focus on supporting effective treatments, e.g. medication – link to GP education above • Consider GPwER supported by consultants – e.g. augmentation with Lithium and anti-psychotics – secondary advice can support	• Routine access to TMS developed for Nottingham • Increase access to CES across PCNs – delivered through upskilled workforce • Improved provision of core treatments • Viewing treatment in a truly holistic way, psychotherapies, looking at transition from IP to OP • Increased access to person-centred IAPT support across ICS	• Maintain continuous improvement with regular review of outputs • TMS treatment available in multiple locations alongside core treatments • All PCNs providing access to CES • Integrated approach to support pharmacotherapy treatments in primary care	• Early access and support closer to home through integrated approaches between secondary care and primary care/ PCN • Equitable access to technological therapies, (TMS, CES) in appropriate location • Improved training and education for the workforce supporting NICE guidance across care settings • Adopting evidence based practice aligned to NICE guidance
• Some degree of collaboration in care delivery approach • Inconsistent uptake of successful pilots (e.g. Primary Care Advice Clinic) • Reduced awareness and signposting to 3rd sector support groups • Incompatible systems between care settings and providers of depression and anxiety services	Whole System Approach	• Re-establish support after COVID – domestic abuse, housing – real need to bring this together once pandemic/ isolation allows • Voluntary sector and social care services need to re-establish links and plans on how the 'fall-out' will be managed • Multi-agency organisation looking at all wider determinants – housing, loneliness, employment, social care input – needs assessment • Multi-agency infrastructure needs to be established (cf. PHM – MH focus within the ICPs – to ensure it is not just physical health that's focused on) • Making the system more efficient through improved integration with primary care	• Interface systems to ensure patient data is readily accessible • Develop joint working towards integrated pathways of care across all settings (Stepped Care model) • Establish core foundations required to support, with a balance in identified cases and capacity to respond • Increase collaboration and support for 3rd sector groups – include on live DoS	• Integrated pathways between primary and secondary care working to stepped care model • IAPT provision across the ICS matched to demand, across all levels • LA backing for 3rd sector to help collaborate multi-agency support for depression and anxiety • Fully interfaced systems providing timely and appropriate access to patient data	• Stepped Care Model adopted across the ICS for provision of care for depression and anxiety • True partnership working across professionals and organisations (including 3rd sector) to consistently meet the MH needs of the ICS population • Interoperability of systems to allow visibility of information to support shared-decision making

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10. Conclusions and Next Steps

Conclusions	The review of Depression and Anxiety services as part of the development of a Clinical and Community Services Strategy for Nottingham and Nottinghamshire ICS has been undertaken using a co-design model where patients, carers, key stakeholders and voluntary sector groups such as Framework and Opportunity Nottingham, have collaboratively worked together to shape a vision for the future care system. The work has progressed well working remotely and holding virtual meetings. Additional patient engagement will prove beneficial and will be revisited as time allows. The four key themes for improvement identified are: • Prevention and Self-Care (with emphasis on relapse prevention as recommended by NICE and early intervention; ensuring early recognition is targeted in adolescents and during transition, but also that the capacity to support is available); • Referral and Access Models (reviewing the referral process to introduce standardised approaches, through improved recognition and assessment, but access to the care that is most appropriate including social and community care provision is accessible, whilst addressing inequalities in care and support are addressed); • Treating Depression and Anxiety (ensuring the right treatment is available in the right place in a timely manner, with adequate capacity available in psychological therapies, but maintaining focus on pharmacological treatments with reviews in primary care and using physical therapies in a holistic approach to care, this focus should not ignore the chronic and more severely depressed cohort); • Whole System Approach (endorsing the Stepped Model of Care, whilst ensuring the organisation and delivery of services is consistent through a multi-agency approach that includes 3rd sector organisations and charities supported through local authorities. Well interfaced systems so providers know their patients). The review describes a future care system in optimal care settings and with care provided at different levels of urgency and envisages 3 high priority and 2 medium priority programmes to transform care: • **Med** – Prevention, education and awareness • **High** – Early identification of a MH presentation • **High** – Addressing Inequalities in Depression and Anxiety • **Med** – No wrong door to access support, Robust and consistent referral template to access services across the ICS • **High** – Treatments for adults with depression, including NICE guidance – practice based evidence To achieve these there are a range of enabling requirements for the ICS across workforce, technology, estate, culture and financial systems. Collectively these initiatives can help transform and provide long term health improvement and sustainability in the area of depression and anxiety services in the Nottingham and Nottinghamshire ICS.
Next Steps	This strategy sets the future direction of development for depression and anxiety care in the ICS and it is proposed it will shape future work of the ICS in a number of ways: • The identified priorities and programmes should be used to inform commissioning ICS, ICP and PCN activity • The enabling activities require development and inclusion in the relevant ICS workstreams to inform their work programmes • The impact on estate and configuration changes require inclusion in a programme of pre-consultation business case development alongside the service changes recommended from other reviews, although the impact for depression and anxiety is less specific in relation to community hub space • The aggregate impact of the collective suite of service reviews should be used to shape focus of future service provision in acute/ MH and community settings in the ICS

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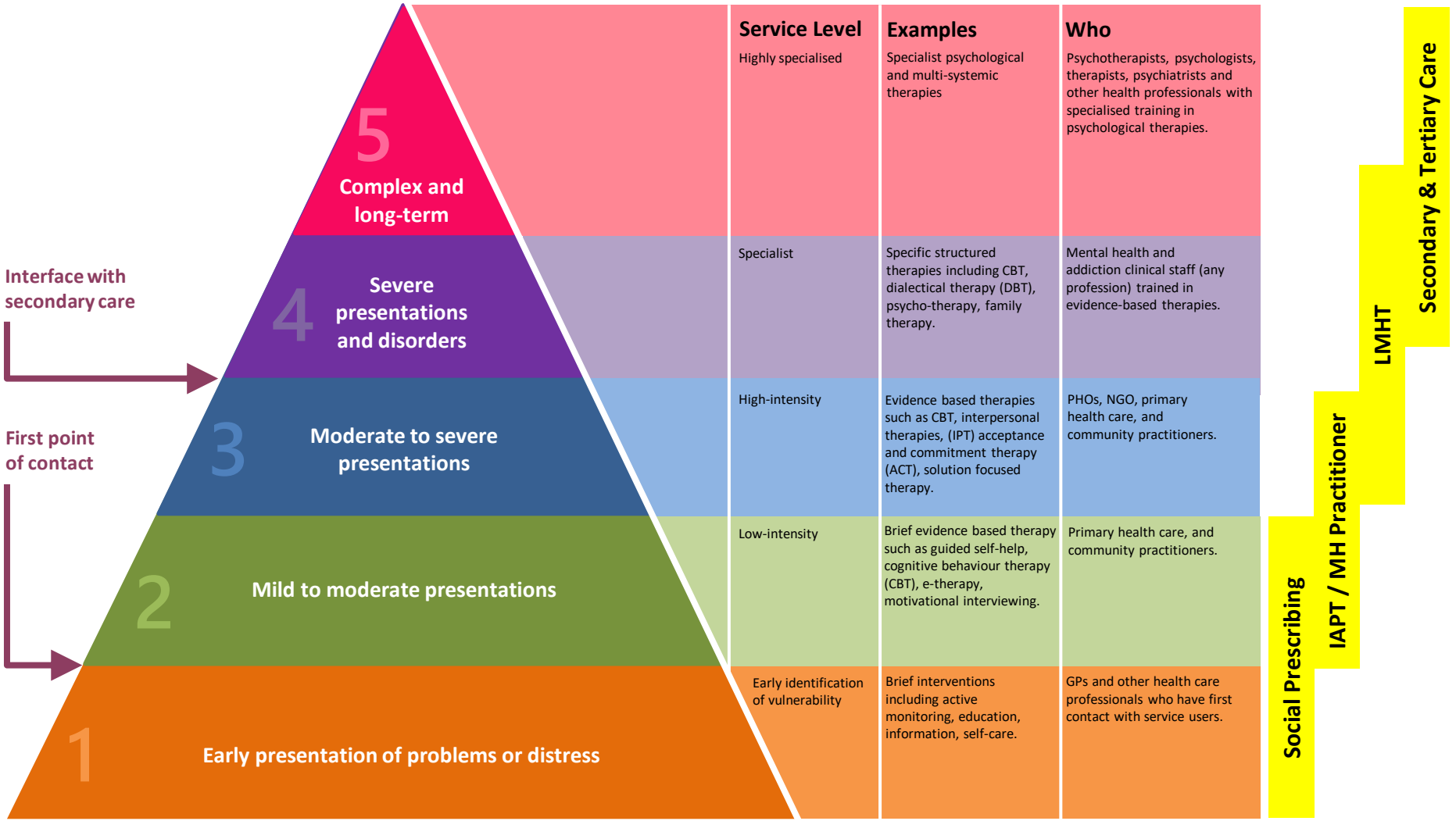
11. List of Common Abbreviations

1°, 2° Care	Primary, Secondary Care	ELBG	Ear Lobe Blood Gas	NICU	Neonatal Intensive Care Unit
A&E	Accident and Emergency	EM ODN	East Midlands Operational Delivery Network	NIDA	National Institute of Drug Abuse
A&G	Advice and Guidance	EMAS	East Midlands Ambulance Service	NNU	Neonatal Unit
ACE	Adverse Childhood Experience	EMRAD	East Midlands Ambulance Radiography	Notts.	Nottinghamshire
ACP	Advanced Care Practitioner	ENCH	Enhanced Health in Care Homes	NRC	National Rehabilitation Centre
ADHD	Attention Deficit Hyperactivity Disorder	EoL	End of Life	NRCP	National Register of Certified Professionals
AF	Atrial Fibrilation	eSCR	Electronic Shared Care Record	NRT	Nicotine Replacement Therapy
AI	Artifical Intelligence	ESD	Early Supportive Discharge	NUH	Nottingham University Hospitals
AK	Actinic Keratosis	ESDT	Early Supportive Discharge Teams	O_2	Oxygen
AMD	Age-related Macular Degeneration	F2F	Face to Face	OCCCF	Ophthalmic Common Clinical Competency Framework
ANP	Advanced Nurse Practitioner	FeNO	Frasntonal Exhaled Nitric Oxide	OCT	Optical Coherence Tomography
App	Application	FT	Foundation Trust	OOH	Out of Hours
APPG	All Party Parliamentary Group	FTE	Full Time Equivalent	OPM	Office of Public Management
ARTP	Association for Respiratory Technology and Physiology	FU	Follow Up	OTC	Over-the-Counter
ASC	Autism Spectrum Conditions	GBD	Global Burden of Disease	PCN	Primary Care Network
AT	Assisitive Technology	GOC	General Optical Council	PCP	Personalised Care Plan
ATAIN	Avoiding Term Admission Into Neonatal units	GOS	General Ophthalmic Service	PCR	Patient Care Record
BAD	British Association of Dermatology	GP	General Practitioner	PH	Public Health
BAME	Black, Asian and Minority Ethnic	GPRCC	General Practice Repository for Clinical Care	PHE	Public Health England
BB	Better Births	GPwER	General Practitioner with an Extended Role	PHM	Population Health Management
BCC	Basal Cell Carcinoma	GRASP-COPD	Guidance on Risk Assessment on Stroke Prevention for COPD	PID	Project Initiation Document
BEH	Behavioural and Emotional Health	H&SC	Health and Social Care	PKB	Patient Knows Best
BF	Breast Feeding	HCP	Healthcare Professional	PN	Practitioner Nurse
BFI	Baby Friendly Initiative	HES	Hospital Episode Statistics	PR	Pulmonary Rehabilitation
BLF	British Lung Foundation	HES	Hospital Eye Service	PSNC	Pharmaceutical Services Negotiating Committee
BMI	Body Mass Index	HV	Health Visitor	PwER	Pharmacist with Extended Role (in skin health)
BMJ	British Medical Journal	IAPT	Improving Access to Psychological Therapies	QALY	Quality Adjusted Life Years
BP	Blood Pressure	ICP	Integrated Care Partnership	QIPP	Quality, Innovation, Productivity and Prevention
BSG	British Society of Geriatrics	ICS	Integrated Care System	QMC	Queen's Medical Centre
BTS	British Thoracic Society	ICT	Information and Communication Technology	RCEM	The Royal College of Emergency Medicine
CAMHS	Child and Adolescent Mental Health Service	IT	Information Technology	RCN	Royal College of Nursing
CAS	Clinical Assessment Service	IUC	Integrated Urgent Care	RCOG	Royal College of Obstetricians and Gynaecologists
CBT	Cognitive Behaviour Therapy	IUT	In-Utero Transfer	RCOphth	Royal College of Ophthalmology
CCG	Clinical Commissioning Group	KMH	Kings Mill Hospital	RNIB	Royal National Institute for the Blind
CCSS	Clinical and Community Services Strategy	LD	Learning Disability	ROI	Return on Investment
CES	Cranial Electrotherapy Stimulation	LMNS	Local Maternity and Neonatal System	RoSPA	Royal Society for the Prevention of Accidents
CFS	Clinical Frailty Scale	LNU	Local Neonatal Unit	ROVI	Rehabilitation Officer for Visually Impaired
CGA	Clinical Geriatric Assessment	LOC	Local Optical Council	RTT	Request To Treatement
CoC T&F	Continuity of Care Task and Finish	LoS	Length of Stay	SALT	Speech and Language Therapy
CoO	College of Optometrists	LTC	Long Term Conditions	SaToD	Smoking at Time of Delivery
COPD	Chronic Obstructive Pulmonary Disease	LTOT	Long Term Oxygen Therapy	SBLCB	Saving Babies Lives Care Bundle
COVID19	Corona Virus Disease 2019	LTP	Long Term Plan	SC	Social Care
CPR	Cardio-Pulmonary Rescucitation	LTV	Long Term Ventilation	SCC	Squamous Cell Carcinoma
CQUIN	Commissioning for Quality and Innovation	LV	Low Vision	SEND	Special Educational Needs and Disabilities
CUES	COVID Urgent Eye-care System	MBCT	Mindfullness Based Cognitive Therapy	SFH	Sherwood Forest Hospitals
CVD	Cardio Vascular Disease	MDT	Multi-Disciplinary Team	SIGN	Scottish Intercollegiate Guidelines Network
CVI	Certification of Vision Impairment	MECC	Make Every Contact Count	SPA	Single Point of Access
CYP	Children and Young People	$MgSO_4$	Magnesium Sulphate	STP	Sustainability and Transformation Partnership
CYPF	Children, Young People and Families	MH	Mental Health	TC	Treatment Centre
DASV	Domestic Abuse and Secual Violence	Mid Notts.	Mansfield & Ashfield, Newark & Sherwood	TIA	Trans-Ischaemic Attack
DNA	Did Not Attend	MMR	Measles, Mumps, Rubella	TTO	To Take Out
DoS	Directory of Service	NCGPA	Nottingham City General Practice Alliance	UC	Urgent Care
ECG	Electrocardiogram	NCH	Nottingham City Hospital	UCC	Urgent Care Centre
ECLO	Eye Clinic Liaison Officer	NHFT	Nottinghamshire Healthcare Foundation Trust	UEC	Urgent and Emergency Care
ECT	Electroconvulsive Therapy	NHS	National Health Service	UECDI	Urgent and Emergency Care Digital Integration
eCVI	Electronic Certfication of Vision Impairment	NHSE	National Health Service England	UTC	Urgent Treatment Centre
ED	Emergency Department	NHSI	National Health Service Improvement	VI	Visual Impairment
EFI	Electronic Frailty Index	NICE	National Institute for Health and Care Excellence	WHO	World Health Organisation

12. Data Sources

Data Sources	British Medical Journal Local Data from NUH, SFH, Social Care, CCGs, GPRCC, eHealthscope Mind.org National Institute for Health and Care Excellence (NICE 2018, Updated Draft), (NICE CG113) NCEPOD Improving the Quality of Healthcare NHS England NHS Health and Social Care Boards NHS Long Term Plan No health without mental health Office of National Statistics Patient Focus Group, 18 Dec 2020 Public Health England World Health Organisation

13. Appendix 1 Stepped Care Model



*LMHT – Local Mental Health Team – Local name for Community Mental Health Service provided by Nottinghamshire Healthcare Trust

*Step 5 – Crisis and inpatient services