Identifying depression in hospital settings to improve patient outcomes
Acknowledgements

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Date of publication

This guide was published in 2010 and will be reviewed in 2012. The latest version will always be available online at www.1000livesplus.wales.nhs.uk

The purpose of this guide

This guide has been produced to enable healthcare organisations and their teams to successfully implement a series of interventions to improve the safety and quality of care that their patients receive.

This ‘How to Guide’ must be read in conjunction with the following:

- Leading the Way to Safety and Quality Improvement
- How to Improve

Further guides are also available to support you in your improvement work:

- How to Use the Extranet
- A Guide to Measuring Mortality
- Improving Clinical Communication using SBAR
- Learning to use Patient Stories
- Using Trigger Tools
- Reducing Patient Identification Errors

These are available from the 1000 Lives Plus office, or online at www.1000livesplus.wales.nhs.uk

We are grateful to The Health Foundation for their support in the production of this guide.
Improving care, delivering quality

The 1000 Lives Campaign has shown what is possible when we are united in the pursuit of a single aim: the avoidance of unnecessary harm for the patients we serve. The enthusiasm, energy and commitment of teams to improve patient safety by following a systematic, evidence-based approach has resulted in many examples of demonstrable safety improvement.

However, as we move forward with 1000 Lives Plus, we know that harm and error continue to be a fact of life and that this applies to health systems across the world. We know that much of this harm is avoidable and that we can make changes that reduce the risk of harm occurring. Safety problems can’t be solved by using the same kind of thinking that created them in the first place. To make the changes we need, we must build on our learning and make the following commitments:

- Acknowledge the scope of the problem and make a clear commitment to change systems.
- Recognise that most harm is caused by bad systems and not bad people.
- Acknowledge that improving patient safety requires everyone on the care team to work in partnership with one another and with patients and families.

The national vision for NHS Wales is to create a world class health service by 2015: one which minimises avoidable death, pain, delays, helplessness and waste. This guide will help you to take a systematic approach and implement practical interventions that can bring that about. The guide is grounded in practical experience and builds on learning from organisations across Wales during the 1000 Lives Campaign and also on the experience of other campaigns and improvement work supported by the Institute for Healthcare Improvement (IHI).
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Depression is a common and disabling condition that affects 1 in 4 people in the UK at some time in their lives.\(^1\) It is also the most common mental health problem globally,\(^2\) and impacts on social and economic mobility. Depression is likely to be second only to cardio-vascular disease in terms of prevalence by 2020.\(^3\)

Depression is best understood as the term used for a range of different mental health problems that tend to impact on one’s ability to feel good about oneself, other people, the future and (when drawing on one’s memories), the past. Depressive conditions can variably affect these emotional responses, as well as resulting in reduced interest or enjoyment in activities.

The condition can manifest as the subjective awareness of unhappiness or physical symptoms such as poor sleep and appetite or weight loss. Depressive conditions are also commonly accompanied by anxiety, and can cause suicidal thoughts or acts.

Depression is also an important co-morbidity in all chronic diseases, increased two to threefold compared to people without chronic physical health conditions.\(^4\)

The most common chronic diseases associated with depression are:

- cancer
- heart disease
- neurological disorders
- respiratory disorders
- diabetes

Depression also occurs within acute physical health presentations such as myocardial infarction (MI). Depression arises in 20% of MI patients hospitalised and persists in most patients up to 4 months afterwards.\(^5\)

Taking these points into consideration, case identification of depression in these high risk groups is a key component to the depression intelligent target.

**Effects of depression on physical health**

There is evidence that quality of life diminishes as severity of depression increases\(^6\) and people who are depressed have shorter life expectancy.\(^4\) A meta-analysis of 25 studies found the overall relative risk of excess mortality in depressed populations was 1.81 when compared to a non-depressed population.\(^7\)

Many treatment outcomes in chronic disease are now being evaluated using tools that refer to quality of life as well as mortality. Treating depression in co-morbid physical conditions reduces depressive symptoms and improves functional outcomes.\(^8\)

Detecting and treating co-morbid depression improves the long-term outcomes for many physical health problems. Conversely, when co-morbid depression is
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present but not detected or treated effectively it results in significantly greater levels of impairment and disability. Evidence suggests that untreated depression post-MI results in higher mortality rates for up to 12 months. Co-morbid depression in diabetic populations has been found to predict functional disability. Suicide risk also increases with co-morbid depression across diabetes, cancer and end stage renal disease. NICE suggests that the economic costs of co-morbid depression are likely to increase significantly in the future providing justification for case identification of depression and appropriate treatment.

Key points:
- Depressive conditions are common and adversely affect quality of life.
- Mortality is increased through elevated suicide risk.
- Mortality is also increased through elevated risk of physical health problems.

Case identification of depression

The cause of depression is complex, involving genetic, psychological, social and biological factors, but nonetheless certain stresses can lead to increased susceptibility. One such important factor in the development of a depressive disorder is having chronic physical illness or disability. The chances of becoming depressed also compound with multiple long term conditions.

Identification of depression is the first step to progress onto treatment. However, the vast majority of depressive disorders go unrecognised and untreated. One study estimated that only 62% of those with depressive disorders would consult their GP, and that of these less than half will have their depressive illness diagnosed.

In an ideal scenario, even if the detection rate by GPs was 100%, over a third of patients with depressive disorders would not be identified as they do not present to GP services. Reasons given for not consulting a GP included not thinking anyone could help and being afraid of the consequences of asking for help.

Using a tool to help identify cases of depression over a wide range of clinical encounters could offer advantages over and above self-presentation. However, it is not feasible to use case identification tools for the entire population in every health encounter, and so closer consideration has been given to patient groups at higher than average risk of developing depressive illness, for example, patients with cancer, respiratory conditions and diabetes.

The intelligent target

The purpose of this intelligent target is case finding of co-morbid depression in patients in general hospital settings including those who visit hospitals for clinic appointments or programmes of care. The specificity of this target is to identify possible cases of depression in high risk groups in disease areas.
like cardiovascular disease, chronic respiratory disease (in particular chronic obstructive pulmonary disease), cancer, diabetes and neurological disorders.

The method of implementation is to ask patients to complete a case identification tool as part of routine clinical practice which will then be interpreted by the supervising clinician, and acted upon as necessary according to accompanying guidance.

Case finding tools

There are many case finding tools for depression. NICE has concluded on the evidence and supports the case for general hospital services to pay particular attention to patients with a physical health problem using two set questions developed to identify those at risk of depression.\(^1\) The two questions have a sensitivity of 95% and a specificity of 66% and are simple and quick to administer.

The two questions are:

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

NICE determined that if a patient with a chronic physical health problem answers ‘yes’ to either of the depression identification questions, a practitioner who is competent to perform a mental health assessment should ask three further questions to improve the accuracy of the assessment of depression.\(^4\)

The three further questions are:

- During the last month, have you often been bothered by feelings of worthlessness?
- During the last month, have you often been bothered by poor concentration?
- During the last month, have you often been bothered by thoughts of death?

A practitioner who is competent to perform a mental health assessment then reviews the patient’s mental state and associated functional, interpersonal and social difficulties.

In the absence of sufficient numbers of competent staff to carry out the above assessment (which is the case in the majority areas of hospital practice), NHS Wales has used the Patient Health Questionnaire-9 (PHQ-9), which can be found in Appendix E.

The PHQ-9 has nine items rated from 0 (not at all) to 3 (almost every day) using a Likert scale design.\(^1\) The cut off for severity is if the score exceeds 10 on a scale of 27. NICE has concluded the PHQ-9 had good sensitivity and specificity for determining depression in physically compromised populations whether they be in primary care or in general hospital populations. Sensitivity of the PHQ-9 is 79% with a specificity of 89% in detecting depression in co-morbid medical conditions.\(^4\)
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The PHQ-9 can be used by patients in a self-report format, either electronically or on paper. The tool is widely used in current practice in primary care as it is part of the Quality Outcomes Framework for diabetes and other long term conditions. If patients respond affirmative to either or both of the initial two questions, they are asked to complete the PHQ-9.

Indicative scores on the PHQ-9 are as follows:

- **< 10**  Mild or minimal depressive symptoms
- **10 - 14**  Moderate depressive symptoms
- **15 - 19**  Moderately severe depressive symptoms
- **> 20**  Severe major depression

Patients who score above 10 on the PHQ-9 are then case identified as requiring further assessment.

Targeting patients with chronic physical disease for depression case identification should improve detection rates of depression. It will also improve general health outcomes for those patients through treating the depression which would otherwise have an adverse effect on the outcome of their physical health condition.

We are advocating the use of the PHQ-9 to aid case identification in the absence of fully developed psychiatric liaison services or appropriately trained staff to undertake comprehensive mental health assessment.

Key points:
- Chronic physical ill health predisposes patients to depression.
- Those with depression often do not seek help.
- Using case identification tools for depression can help identify these individuals who may need further assessment.
- Diagnosis and treatment of depression improves general health outcomes.

**Targeted response**

It is important to give patients general information about pathways of treatment which can vary according to the severity of the condition. Evidence suggests that for mild depression, the ‘watchful waiting’ pathway should be adopted but for moderate to severe depression antidepressant medication and or psychological therapies should be introduced.17

Wales Improving Access to Psychological Therapies are developing the pathways for treatment following a positive diagnosis of depression and this work will be incorporated into the depression case identification pathway, where applicable.
There are various types of treatment available to treat depression. Depending on the severity of the illness, some or all of the following may be utilised:

- Medication e.g. antidepressants.
- “Talking therapies” ranging from counselling to more complex forms of psychological intervention such as cognitive-behavioural therapy.
- Social interventions aimed at identifying and remedying dysfunctional aspects of the individual’s life, be it debt, social isolation or perhaps simply lack of day-to-day activity or occupation.
- Electronic self-help forms of therapy such as electronic cognitive behavioural therapy or online outreach.

Very occasionally, depression is so severe and the risk of suicide so acute that in-patient admission to a psychiatric hospital is advisable. This is very much the exception rather than the rule and modern psychiatric services are set up to do everything possible to treat depression outside of the psychiatric ward.

Key points:

- There are a range of effective treatment options for depression that can be started in hospital, in the out-patient clinic or at home.
- Case identification is the first step to receiving the right level of help.
- Psychiatric admission is very much the exception, not the rule.

Satisfaction with care

An important part of the target relates to collecting patient satisfaction data on both the depression recognition tool but also how they have received depression services in the past. NHS Wales can collect and use this local information to tailor specific depression management pathways for particular diagnostic groups.

Development of the depression case identification tool and depression satisfaction feedback form

A depression case identification tool has been developed with consultation and support from a number of service user organisations and Public Health Wales. The tool was presented in a booklet format called ‘how are you feeling’ that provided information to patients about depression, introduced the initial two questions plus the PHQ-9.

Included in this work was a depression satisfaction feedback form to collect data on patient experience in the management of their depression. A number of months were spent consulting and developing the depression case identification tool and the satisfaction form with Vale of Clwyd MIND (VOC MIND), Journeys, BCU Expert Patient Programme and the LOTUS group. VOC MIND carried out two dedicated focus groups on the depression case identification tool and satisfaction feedback form leading to final versions of the tools in Appendix E.
The depression case identification booklet was tested with 327 patients in inpatient and out-patient settings. 81% patients found the booklet quite helpful or extremely helpful to identify their mood.

Patients' ratings of the booklet were not affected by them having a previous history of depression (p=0.813), whether they answered positive on the two questions (p=0.777) or scored above threshold on the PHQ-9 (p=0.832).  

References

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18 The pilot report can be accessed at www.1000livesplus.wales.nhs.uk

Additional reading


Depression Case Identification in the General Hospital Setting

**Content Area**

To improve the case identification of depression, ensure consistent measurement and appropriate treatment intervention for individuals who receive care in or from a general hospital setting.

**Drivers**

- Trigger point of contact - case identification and symptom recognition

**Interventions**

- **Target one**
  - Use two questions for target high risk groups in general hospital settings
  - High risk groups are those with co-existing cancer, heart disease, respiratory disorders, neurological disorders and diabetes

- **Target two**
  - Administer the PHQ-9 for patients who score 'yes' to the two questions
  - Refer patient for further assessment if they score above threshold on PHQ-9

- **Target three A**
  - Watchful waiting for 2 weeks
  - Use of ‘Info prescription’ - available treatments & sources of support
  - Bibliotherapy, self-help groups, internet support
  - Psychological treatment for 6-8 sessions over 10-12 weeks, e.g. problem-solving therapy; brief CBT; counselling

- **Target three B**
  - Referral to psychiatric liaison service
  - Referral to primary care
  - Referral to CMHT
  - Treat in general hospital with medication
Getting Started

Have you set up your team?

You need to consider three different dimensions:

- Organisational level leadership
- Clinical or technical expertise
- Frontline leadership and team membership

*See the ‘Leading the Way to Safety and Quality Improvement’ How to Guide; and Appendix C for further information.*

Do you know how you will process measures?

The case identification of depression is predominantly a process target. It is assumed also that case identification of a possible depressive illness will lead to referral for further assessment and possibly one of a number of possible treatment options including ‘watchful waiting’, psychotropic treatment and or ‘talking therapies’.

For this content area, you should use the following process measures:

- Compliance in using the ‘how are you feeling’ booklet in each of the specific disease areas.
- Compliance in referring those patients who score above threshold on the PHQ-9.

Do you and your team understand how to apply the Model for Improvement?

The Model for Improvement is a fundamental building block for change and you need to understand how to use it to test, implement and spread the interventions in this guide.

*See the ‘How to Improve’ Tools for Improvement guide and Appendix D for further information.*

How are you going to measure process reliability?

In order to improve outcomes for your patients you need to demonstrate you are using these interventions reliably. This means that all the elements of the interventions are performed correctly on 95% or more of the occasions when they are appropriate. You need to do this by using the process measures in this guide.

*See the ‘How to Improve’ Tools for Improvement guide and Appendix B for a summary of all process measures.*

How will you share your learning?

Contact 1000 Lives Plus for details of mini-collaboratives and other ways to share your learning and to learn about the progress of other teams.
Drivers and Interventions

This section details the interventions highlighted in the driver diagram which evidence has shown to be effective in this content area. You should use the Model for Improvement to test, implement and spread the intervention, using the listed process to monitor progress.

Please note that tools suggested for use will, where possible, be linked directly from this document using hyperlinks. They will also be available, in addition to tools developed locally by frontline teams, on the WHAIP website www.wales.nhs.uk/WHAIP

Driver: Case identification of depression in general hospital settings

Intervention: Case identification

To apply the Model for Improvement in this area, it will be helpful to review your staff’s:

- knowledge of depression,
- understanding of its importance in chronic disease
- recognition of depression
- compliance with its identification

You may want to contact your psychiatric liaison team to help you introduce information sheets on depression or to support specific training on depression for your staff groups.

Where changes in practice are required to improve compliance with the application of the depression case identification tool, small tests of change using the Plan, Do, Study, Act (PDSA) cycle can be used to determine if the proposed change is practical in your setting. Monitoring of the change can be done by repeating the Rapid Improvement tool periodically.
Based on our experiences to date, we envisage five trigger points to use the depression case identification tool:

**YOUR FIVE OPPORTUNITIES (‘TRIGGER POINTS’) FOR CASE IDENTIFICATION**

1. On hospital admission
2. During hospital admission
3. At the point of hospital discharge
4. When a patient attends a clinic
5. When patient is at home

**Hospital admissions**

Some District General Hospitals or smaller rehabilitation hospitals may decide to use the depression case identification tool at the start of the hospital admission episode. It is important for you to consider the level of variability in the hospital admission process so that the depression case identification tool is applied consistently. ‘Admissions’ could include patient visits to day hospitals or day surgical units where the procedure(s) are carried out on the same day.

For other hospital clinical settings, it may be more appropriate to use the case identification tool midway through the hospital admission or at the point of discharge. Pilot studies on a surgical ward for cancer showed optimal use of the depression case identification tool was at the point of discharge. This enabled the nursing team to have greater control over the consistency of application.

The depression case identification tool could be used midway through a multiple day hospital episode that offers treatment to patients over a period of time.

Each Health Board will need to work through the merits of when to use the case identification tool based on the clinical benefits it would offer. This early work needs to start with clinical environments where the patient pathway is easier to access and incorporate the depression case identification tool.
Out-patient clinics

There are many opportunities to use out-patient clinics as a setting for using the depression case identification tool. Clinics have a wide range of models of delivery but supported by hospital receptionists, plus health care support workers, out-patient nursing staff and in some instances, specialist nurses / allied health professionals that support the physician or surgeon to review cases.

Out-patient clinics also span the five disease areas identified in this ‘how to guide’ with many clinics having a pathway linked with the ward environment.

You will need to carry out site-specific PDSA cycles to find out your best ways to introduce the depression case identification tool.

Community settings

Many patients are cared for and treated successfully at home with occasional visits to hospital when required. There are several models where community nursing teams support people with COPD and cardiac conditions.

Health Boards could use the depression case identification tool when patients receive domiciliary care from community team as part of an early hospital discharge process. It may be more appropriate to use the depression case identification tool at the patient’s home rather than the in-patient setting.

Five opportunities for five disease areas

Each Health Board must use the depression case identification for the five specific disease areas of cancer, heart disease, respiratory disorders, neurological disorders and diabetes. These five disease areas are listed as highly prevalent disorders in the NICE guideline (2009).

Health Boards will determine at which point to use the case identification tool depending on local needs and circumstances. For example, the Health Board may choose to focus on Parkinson’s disease in a community hospital and COPD in an out-patient clinic operating in a District General Hospital.

Other Health Boards may focus on COPD or stroke in a rehabilitation or community hospital. Case identification for any of the disease areas can take place in more than one ‘opportunity’ if the Health Board deems this appropriate.
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The five disease areas to apply the depression case identification

- Diabetes
- Respiratory Conditions
- Coronary Conditions
- "How are you feeling?"
- Cancer
- Neurological Conditions

Key points

- Choose where and when you will use the depression case identification tool for each of the five disease areas.
- Areas may be District General Hospitals, community hospitals, local health centres, specialist in-patient facilities, mobile health centres, patients’ homes.

Pathway of action

Depending on the trigger moment for each one of the five disease areas, the patient will be given the patient-specific ‘how are you feeling’ booklet. The patient will be asked to read the ‘how are you feeling’ booklet in their own time.

The booklet is self-explanatory, but some patients may need assistance from a health care professional (in the widest sense - including receptionists, health care support workers, doctors and possibly voluntary staff).

In the ‘how are you feeling’ booklet, the patient will be introduced to concepts of depression and asked firstly the following two questions:

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

If patients answer yes to either question, they are asked to continue to complete the PHQ-9 questionnaire.

Receptionists, health care support workers, ward nurses or out-patient doctors will collect the booklet from the patient and go to the section containing the two questions and the PHQ-9. Reading the score on the PHQ-9 will determine the course of action.
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For a score of:

<10  Mild or minimal depressive symptoms - refer to GP.
10-14  Moderate depressive symptoms - ask the patient if they have any suicidal thoughts and if the patient says yes, discuss the case with psychiatric liaison team; otherwise refer to GP.
15-19  Moderately severe depressive symptoms - ask the patient if they have any suicidal thoughts and if the patient says yes, discuss the case with psychiatric liaison team; otherwise refer to GP.
>20  Severe major depression - refer to psychiatric liaison if any suicidal thoughts: otherwise refer to area-appropriate CMHT.

Key points:

- Patients complete the ‘how are you feeling’ booklet with assistance if necessary, but for the large part unaided.
- Nurses and doctors examine the patient’s response and act as directed.

**Process measure:**

For this intervention, use the following process measures:

- Compliance in using the ‘how are you feeling’ booklet in each of the specific disease areas.
- Compliance in referring those patients who score above threshold on the PHQ-9.

**Applying the Model for Improvement - Out-patient clinics**

**Aim:** For out-patient clinics to use the depression case identification tool as the patient waits to see the doctor for clinical review and any cases that reach threshold to be identified and referred to the GP.

For this, you will need to choose the disease area, for example COPD and choose the setting, for example, a District General Hospital.

**Improvement monitoring:** Through prospective or retrospective audit (one method must be used).

**Change required:** For out-patient clinics to set up a system where patients are given a ‘how are you feeling’ booklet as they wait to see the nurse specialist or physician.
On arrival at an out-patient clinic, the patient will be given the booklet by the clinic receptionist or health care support worker. The patient is asked to read and score the booklet while waiting to be seen by their doctor.

For this, you will need to decide who will give the case identification booklet to the patient, who will collect the booklet from them and who will flag up above threshold scores to the specialist nurse or doctor.

The specialist nurse or doctor will then decide to carry out a further assessment or to refer the patient to their GP indicating a need for further assessment to confirm depression.

PDSA cycles should be undertaken at single patient / healthcare worker level to assess if the proposed changes work in that particular environment. Once reliability has been achieved, the depression case identification tool should be spread across the organisation for the specific disease out-patient clinic areas.

**Assessment tools**

For detecting possible depression, NHS Wales can use the purposefully designed ‘how are you feeling’ booklet.

You will need to decide how you will register the information in the clinical notes for those who score above threshold. One way is for the specialist nurse or doctor to write to the GP as part of the usual clinic letter or hospital discharge letter. Pre-printed stickers for use in the notes have been used in pilot sites.

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**Case example: Betsi Cadwaladr University Health Board**

BCU carried out a 4-week pilot to implement the ‘how are you feeling’ booklet across 10 medical and surgical wards and community settings. When 151 patients scored positive on either of the two questions and completed the PHQ-9, 41% scored above threshold on the PHQ-9. This represents over a third of medical and surgical patients who may not otherwise have been identified for a possible depressive episode.

![Percentage of patients scoring 10 or more when PHQ carried out](chart)

Area 6 was a mental health group and has not been included in this example.
**Patient Engagement**

A key part of the depression case identification initiative has been to engage patients in the design of the ‘how are you feeling’ booklet. To support implementation of the depression recognition in high risk groups, NHS Wales should consider engaging their local Expert Patient Programme to support acceptance of the depression case identification tool by specific patient groups. It may be possible that some user organisations may assist some clinic areas in administering the booklets.

**Key Learning Points and Tips**

1. Engagement of all healthcare staff in understanding the importance of recognising depression in co-morbid conditions.
2. Training staff to detect depression should be used with simple descriptions of terms and rationale in the use of the ‘how are you feeling’ booklet.
3. Clinical champions be identified and tasked to lead on identifying test bed areas for implementation.
4. If available, psychiatric liaison teams should be engaged to support acute and rehabilitation medicine to implement training and development of pathways for those patients who score above threshold.
5. Some patients may have difficulty in reading the depression case identification tool or others may require assistance to complete it. Have contingencies in place for when this occurs.
6. Be prepared to audit and collect information on:
   - diagnosis
   - use of a depression case identification tool
   - referral for primary or secondary care for a suspected depressive episode
7. Some staff may be anxious about precipitating self-harm in this potentially depressed population. The clinical reality is that asking patients specific questions in this case identification tool does not increase the risk of suicide.

**Applying the Model for Improvement**

**Patient satisfaction feedback form**

**Aim:** For patients to be asked to complete the depression satisfaction feedback form when they leave hospital after completing the depression case identification form.
Improvement: Through prospective or retrospective audit

Change required: For general hospital services to set up systems where patient satisfaction feedback information is collected following the depression case identification tool.

PDSA cycles should be undertaken at single patient / healthcare worker level to assess if the changes proposed work in that particular environment. Once reliability has been achieved, the satisfaction feedback form should be used across other specific disease areas.

Systems need to be set up that record this depression satisfaction information so that it can be collectable and reviewed for each locality.

Assessment tools

For collecting information about the depression case identification tool, NHS Wales can use the purposefully designed ‘depression satisfaction feedback form’.

Case example: Betsi Cadwaladr University Health Board

It is important to ask patients if they value the process of enquiring about their mood. BCU carried out a large pilot of the depression ‘how are you feeling’ booklet across 10 clinical areas including medical and surgical wards, outpatient clinics and day hospitals.

BCU was interested to find out how acceptable the patient population found this booklet to help identify their mood symptoms. 22% of patients found it to be extremely helpful and the larger majority of 59% to be quite helpful. By contrast 14% found it to be unhelpful.

How much has this ‘how are you feeling’ booklet helped you become more aware about the way you are feeling at the moment? - Excludes mental health groups

![Bar chart showing responses to the question](chart.png)
Further suggestions

You only need to collect depression satisfaction feedback information at annual interval points, but you may want to do this more frequently if indicated through your PDSA cycle.

You may decide to attach the depression satisfaction feedback form to the depression case identification tool. When you come to analyse your results you will be able to see how many patients complete the tool and the satisfaction forms as a unit of analysis for particular disease areas. You may also find trends emerging for experiences of depression services.


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Appendix A - Case identification for depression - Frequently Asked Questions

**Q. Who should carry out the audits and collection of data?**
A. Ownership of the data should be the responsibility of the frontline staff, implementing improvement is the responsibility of all multi-disciplinary staff. If the work is carried out by a single person it is very difficult to sustain the work over a long period of time.

**Q. Who can help me with analysing the information and measurement?**
A. Within your organisation there will be individuals who have been trained in improvement methodologies through the Safer Patient Initiative and 1000 Lives Plus.

**Q. How many audits should be carried out to improve compliance with the depression case identification tool?**
A. The recommendation is for implementation sites to implement the case identification tool for monthly intervals and to then audit the results as part of a PDSA cycle. You may find prospective data collection provides greater clinical utility and control over the care process.

**Q. Is the depression case identification tool the responsibility of the psychiatric liaison team?**
A. Psychiatric liaison teams can facilitate the introduction of the depression case identification into clinical practice. Practical implementation of the depression case identification tool, completion of PDSA cycles rests with the medical departments in each of the Health Boards.

**Q. Will talking about how bad someone feels make them feel worse?**
A. It is common for all of us when we first encounter those with mental illness to feel out of our depth. When dealing with those with depression, common worries are about the reaction that talking to them might elicit, as though the very act of talking about intense negative feelings will make those feelings worse.

This is simply not the case. Some patients may prefer to avoid talking about their feelings, and will doubtless make this clear at an early opportunity. Many more patients will be relieved to have the chance to talk to someone.

**Q. Why ask about depression at all when they are in for a different condition?**
A. Detection and treatment of depression in certain disease groups will improve the quality of life and possibly prognosis of the primary medical condition. Additionally, certain disease groups predispose to depression, so case identification tools will generate a higher ‘yield’ and will be more resource-efficient.
Q. What shall I do if they say that they do feel like ending their life?

A. Thoughts of self-harm and suicide are common amongst those with depression. They do not automatically mean that they will act upon them, and asking further whether they do have any plans to end their life or any intent to go through with it will help decide how much risk there is.

There is more risk if there are plans and intent. If there are suicidal ideas it may be wise to speak to a mental health professional, either from the psychiatric liaison team within the hospital or the area-appropriate community mental health team outside the hospital.

The psychiatric liaison team can carry out assessments on the wards so referral directly to them would be appropriate if concerns are high.

Q. In cancer services, patients can be terminally ill and bound to feel low. Should we bother using the case identification tool?

A. Terminal illness can trigger depressive illness. This can cause significant distress to the patient over and above that which they may be undergoing because of their terminal illness. This distress, if caused by depression, may be treatable.

If a patient does not wish to be asked the questions that is their right, but assuming that there is no role for case identification of depression just because someone is dealing with end of life issues is wrong. They can benefit as well as any other patient from detection and treatment of any depressive illness.

Q. Can the case identification tool diagnose depression?

A. No, the case identification tool simply identifies a patient may be depressed and further assessment will be required to confirm the patient is depressed. This further assessment could be carried out by the patients GP or an appropriately trained health professional.
Appendix B - Measures and Operational Definitions

Tools have been hyperlinked to this document where possible. Otherwise please go to the WHAIP website www.wales.nhs.uk/WHAIP for all the improvement tools listed within this document.

Reporting

<table>
<thead>
<tr>
<th>Measure</th>
<th>Operational Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>% compliance with ‘how are you feeling’ booklet</td>
<td>The percentages of time that staff provide patients with the leaflet as a total proportion of patients who enter the ward, out-patient clinic or domiciliary setting.</td>
</tr>
<tr>
<td>% compliance in identifying patients who score above threshold</td>
<td>The percentage of patients who were identified as being above threshold and identified as such in the clinical record and referred to the GP or psychiatric liaison services.</td>
</tr>
<tr>
<td>on the PHQ-9 and onward referral</td>
<td></td>
</tr>
<tr>
<td>% compliance with depression satisfaction feedback form</td>
<td>The percentages of time that staff provide patients with the depression satisfaction feedback form as a total proportion of patients who enter the ward, out-patient clinic or domiciliary setting.</td>
</tr>
<tr>
<td>Intervals between applying the depression case identification tool</td>
<td>Not more frequent than 6-monthly intervals unless a change in risk factors, for example, development of other medical conditions, adverse change in social or personal circumstances.</td>
</tr>
<tr>
<td>Intervals between applying the depression satisfaction feedback form</td>
<td>Not more frequent than at annual intervals unless PDSA cycles suggest a more frequent advantage to do so.</td>
</tr>
</tbody>
</table>
Appendix C - Setting up your Team

Achieving improvements that reduce harm, waste and variation at a whole-organisation level needs a team approach: one person working alone, or groups of individuals working in an unco-ordinated way will not achieve it and this applies equally at all organisational levels.

Whether your improvement priorities relate to 1000 Lives Plus content areas, national intelligent targets or other local priorities, you need to consider three different dimensions in putting your team together:

- Organisation level leadership.
- Clinical or technical expertise.
- Frontline leadership.

There may be one or more individuals on the team working in each dimension, and one individual may fill more than one role, but each component should be represented in order to achieve sustainable improvement.

**Organisation level leadership**

An Executive, or equivalent level Director, should always be given delegated accountability from the Chief Executive for a specific content area; and all staff working on the changes should know who this is. This individual needs sufficient influence and authority to allocate the time and resources necessary for the work to be undertaken.

It is likely that accountability will be further delegated to Divisions, Clinical Programme Groups or Directorates and this can help to build ownership and engagement at a more local level. However, it is essential that the leader has full authority over the areas involved in achieving the improvement aim. As changes spread more widely, crossing organisational boundaries, appropriate levels of delegation will need to be reviewed.

When working with frontline teams, it is essential for organisational level leaders to have an understanding of the improvement methodology and to base conversations around the interpretation of improvement data. Reporting of progress to higher organisational levels should also use a consistent data format so that the Executive level leader can report to the Board on progress.

**Clinical/Technical Expertise**

A clinical or technical expert is someone who has a full professional understanding of the processes in the content area. It is critical to have at least one such champion on the team who is intimately familiar with the roles, functions, and operations of the content area. This person should have a good working relationship with colleagues and with the frontline leaders, and be interested in driving change in the system. It is important to look for clinicians or technical professionals who are opinion leaders in the organisation (individuals sought out for advice who are not afraid to try changes).
Patients can provide expert advice to the improvement team, based on their experience of the system and the needs and wishes of patients. A patient with an interest in the improvement of the system can be a useful member of the team. Additional technical expertise may be provided by an expert on improvement methodology, who can help the team to determine what to measure, assist in the design of simple, effective measurement tools, and provide guidance on the design of tests.

**Frontline leadership**

Frontline leaders will be the critical driving component of the team, assuring that changes are tested and overseeing data collection. It is important that this person understands not only the details of the system, but also the various effects of making changes in the system. They should have skills in improvement methods. This individual must also work effectively with the technical experts and system leader. They will be seen as a bridge between the organisation leadership and the day-to-day work.

Frontline leaders are likely to devote a significant amount of their time to the improvement work, ensuring accurate and timely data collection for process and outcome measures related to the frontline team.

**Characteristics of a good team member**

In selecting team members, you should always consider those who want to work on the project rather than trying to convince those that do not. Some useful questions to consider are the following:

- Is the person respected for their judgment by a range of staff?
- Do they enjoy a reputation as a team player?
- What is the person’s area of skill or technical proficiency?
- Are they an excellent listener?
- Is this person a good verbal communicator within, and in front of, groups?
- Is this person a problem-solver?
- Is this person disappointed with the current system and processes and do they passionately want to improve things?
- Is this person creative, innovative, and enthusiastic?
- Are they excited about change and new technology?
Appendix D - The Model for Improvement

Successful improvement initiatives don’t just happen - they need careful planning and execution. There are many things to consider and techniques to employ, which are captured in the driver diagram on page 30. The rest of this section explains the primary drivers and where to get more help in using them.

In any improvement initiative you need to succeed in three areas. You need to generate the Will to pursue the changes, despite difficulties and competing demands on time and resources. You need the good Ideas that will transform your service. Finally you need to Execute those ideas effectively to get the change required.

Will

The interventions you need to build Will are explained in the ‘Leading the Way to Safety and Quality Improvement’ and ‘How to Improve’ guides. They concentrate on raising the commitment levels for change and then providing the project structure to underpin improvement approaches. Spreading changes to achieve transformative change across the whole health system requires strong leadership. We need to create an environment where there is an unstoppable will for improvement and a commitment to challenge and support teams to remove any obstacles to progress.

Ideas

The interventions in this guide describe ideas which evidence shows to be effective for achieving changes that result in improvements. It gives examples from organisations that have achieved them and also advice based on their experience. Methods and techniques for generating new ideas or innovative ways to implement the evidence can be found in the ‘How to Improve’ guide and other improvement literature.

Execution

However, to bring these ideas into routine practice in your organisation, it is essential that you test the interventions and ensure that you have achieved a reliable change in your processes before attempting to spread the change more widely.

1000 Lives Plus uses the Model for Improvement (MFI) which is a proven methodology as the basis for all its improvement programmes. It requires you to address three key questions and then use Plan-Do-Study-Act (PDSA) cycles to test a change idea. By doing repeated small-scale tests, you will be able to adapt change ideas until they result in the reliable process improvement you require. Only then are you ready to implement and spread the change more widely.
Model for Improvement

Driver Diagram

Aim

Primary drivers

Secondary drivers

Interventions

Create an organisational culture and environment for improvement

Use the relevant content area ‘How to Guide’ to assess the latest evidence of best practice

The Model for Improvement

What are you trying to accomplish?

How will you know that a change is an improvement?

What change can you make that will result in improvement?

Establish reliable process

Use reliability model

Engage senior Leadership

Make links to organisation goals

Form teams

Build skills

Raise awareness

Appoint clinical champions

Consult Faculty members to agree standards to be achieved

Use critical sub sets of key content areas to improve the outcome

Set SMART aims

Communicate aims

Use project charter to provide structure

Understand what to measure

Use 7 step measurement process

Map the process

Use creative thinking

PDSA cycles:
Test - implement - spread - sustain

Will

Ideas
Evidence Base (The what to)

To deliver patient safety and quality initiatives for Health Boards and Trusts

Execution
Improvement Methodology (The how to)
Model for Improvement-PDSA Cycle

For more guidance on using the Model for Improvement, see the 'How to Improve' guide.

Seven Steps to Measurement

1 Decide aim
2 Choose measures
3 Define measures
4 Collect data
5 Analyse & present
6 Review measures
7 Repeat steps 4-6
Identifying depression in hospital settings to improve patient outcomes

One area that bears extra attention is measurement because we have found that this is often the Achilles heel of improvement projects. When measuring your progress, follow the Seven Steps to Measurement shown on page 31 and covered in more detail in the ‘How to Improve’ Guide.

The key is to go round the Collect-Analyse-Review cycle frequently:

Collect your data
Analyse - turn it into something useful like a run chart
Review - meet to decide what your data is telling you and then take action

Successful improvement projects all have clear aims, robust measurement and well-tested ideas. Use the ‘How to Improve’ guide to ensure your projects have all three.

What are we trying to accomplish?

You will need to set an aim that is Specific, Measurable, Achievable, Realistic and Time-bound (SMART). Everyone involved in the change needs to understand what this is and be able to communicate it to others.

How will we know that change is an improvement?

It is essential to identify what data you need to answer this question and how to interpret what the data is telling you. The improvement methodology ‘How to Guide’ provides detailed information on the tools, tips and information you need to achieve this, and includes the following advice:

Plot data over time - Tracking a few key measures over time is the single most powerful tool a team can use.
Seek usefulness, not perfection. Remember, measurement is not the goal; improvement is the goal. In order to move forward to the next step, a team needs just enough data to know whether changes are leading to improvement.
Use sampling. Sampling is a simple, efficient way to help a team understand how a system is performing.
Integrate measurement into the daily routine. Useful data is often easy to obtain without relying on information systems.
Use qualitative and quantitative data. In addition to collecting quantitative data, be sure to collect qualitative data, which is often easier to access and highly informative.
Understand the variation that lives within your data. Don’t over-react to a special cause and don’t think that random movement of your data up and down is a signal of improvement.
What change can we make that will result in improvement?

The interventions in this guide describe a range of change ideas that are known to be effective. However, you need to think about your current local systems and processes and use the guide as a starting point to think creatively about ideas to test. The improvement methodology guide gives more advice to support you in generating ideas.

Spreading changes to achieve transformative change across the whole health system requires strong leadership. We need to create an environment where there is an unstoppable will for improvement and a commitment to challenge and support teams to remove any obstacles to progress. The guide on ‘Leading the Way to Safety and Quality Improvement’ gives detailed information on interventions that will support this. However, the Model for Improvement, PDSA cycles and process measurement lie at the heart of the transformative change we seek.
Appendix E - Depression case identification and depression satisfaction feedback form

Name ______________________
DOB ______________________
Ward / Clinic ______________________

How are you feeling?

Information collected is confidential and placed in the health record
How are you feeling today?

The staff that care for you in hospital, at home or at your doctor’s surgery want to know how you are feeling. We are giving this leaflet out to lots of patients so that we can help people if they want it.

If someone asks how are you feeling today? what will you say?

I’m fine not too bad a bit fed up not too good

Perhaps the way you feel changes from day to day.

Lots of things can affect the way you feel. There is a very close link between your body and mind. One affects the other. If you have a long term physical health problem like arthritis, or if you have been in hospital, you may feel fed up from time to time. Feeling like this is a normal part of life.

Sometimes people who have long term health problems can feel so bad that they become depressed. This can show itself in different ways such as:

<table>
<thead>
<tr>
<th>Not wanting to do anything</th>
<th>No interest in things</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor sleep</td>
<td>Feeling very low most of the time</td>
</tr>
<tr>
<td>New aches and pain</td>
<td>Not eating properly</td>
</tr>
<tr>
<td>Not looking after yourself properly</td>
<td>Hopeless and negative</td>
</tr>
</tbody>
</table>

If you think you might be feeling depressed then it is important to tell someone.

Depression is very common. About 1 out of every 5 people can be affected by it. With the right help and support most people who have depression get well again quite quickly.
So, how are you feeling?

Try these two questions and tick your answer:

1. During the past month, have you often been bothered by feeling down, depressed or hopeless?

   ![Yes](yes.png) ![No](no.png)

2. During the past month, have you often been bothered by little interest or pleasure in doing things?

   ![Yes](yes.png) ![No](no.png)

What did you say?

**Did you say ‘no’ to both questions?**
Great. We hope that you have found this leaflet useful. **You do not need to complete any more sections.** Please watch out for any changes in the way you feel in the future and ask for help if you need it another time.

**Did you say ‘yes’ to either question?**
If so, you may be depressed. We would like you to answer some more questions on the Patient Health Questionnaire – 9 (overleaf) to help you and us understand more about your responses. A member of staff will help you if you wish. Please ask.
### Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answer.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Trouble falling or staying asleep, or sleeping too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Feeling bad about yourself, or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>Trouble concentrating on things such as reading a newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless or you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Add columns</th>
<th>+</th>
<th>+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th></th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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If you scored 10 or more on the Patient Health Questionnaire we would like to talk to you about the way you are feeling. There could be things that your GP could suggest to help you.

**Why should you get help?**

If you think you might be depressed then getting help is very important. Depression can make it hard for you to get on with your day to day life. If you have been unwell or have a long term health problem then it will be harder for you to look after yourself. Getting treatment for depression could help to make you feel better physically and get well sooner and start enjoying things again.

**Do you want to know more about depression?**

*If so, please have a look at the following*

- Ask your doctor or nurse to tell you more about depression or ask them for a leaflet about it
- Have a look in your local library that may have reading books on depression called bibliotherapy
- Look on the internet at some websites that give you good, correct information such as Journeysonline.org or the Mental Health Foundation
- Contact a local voluntary organisation such as MIND or Hafal
- Telephone CALL Helpline on 0800 132 737
Patient Satisfaction Feedback Form

Please give us your views....

We want to know what you think about the ‘how are you feeling’ booklet. We are also interested to hear what you think about the help or services you may have had for your depression.

Please complete the form as much as you can. All feedback is welcome.

Please circle your answer

1. Are you a patient / carer / relative / friend / other, please say.................... ?

2. Are you in hospital / attending an outpatient clinic / at home / other, please say....................?

3. Do you have a long term physical health problem?

   Yes ☐       No ☐

4. How much has this ‘how are you feeling’ booklet helped you become more aware about the way you are feeling at the moment?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely helpful</td>
<td>Quite helpful</td>
<td>Quite unhelpful</td>
<td>Extremely unhelpful</td>
</tr>
</tbody>
</table>

5. How satisfied are you with the way staff helped you to work through this ‘how are you feeling’ booklet?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely satisfied</td>
<td>Quite satisfied</td>
<td>Quite dissatisfied</td>
<td>Extremely dissatisfied</td>
</tr>
</tbody>
</table>

6. Have you experienced depression in the past?

   Yes ☐       No ☐

If you replied no to this question, thank you for your time and you do not need to answer any further questions.
If you replied yes to this question, please continue to answer the following questions.

7. If you have been treated in the past for your depression by your General Practitioner please tell us when this was

☐ 0 – 1 years ago  ☐ 1 – 2 years ago  ☐ 2 – 3 years ago
☐ 3 – 4 years ago  ☐ 4 – 5 years ago
☐ More than 5 years ago

8. If you have been treated in the past for your depression please tick what treatments you received (you can tick more than one box)

Anti-depressant medication ☐
Counselling ☐
Cognitive behavioural therapy ☐
Books on prescription ☐
Exercise on prescription ☐
Sick certificate ☐
Other (please state) ..................

9. If you have been treated in the past for your depression, please tell us where you got help (you can tick more than one box)

My General Practitioner ☐
Local Library ☐
Internet ☐
Voluntary organisation ☐
Private sector ☐
Admitted to hospital ☐
Social services ☐
Community mental health team ☐
Self help, for example, help lines ☐
Other (please state) ..................

10. Overall, if you have been treated in the past for your depression, how beneficial was the service you received?
Identifying depression in hospital settings to improve patient outcomes

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Extremely beneficial</td>
<td>Quite beneficial</td>
<td>Not really beneficial</td>
<td>Not beneficial at all</td>
</tr>
</tbody>
</table>

11. If you have received help for your depression, which service or services did you find most useful? (you can tick more than one box)

   My General Practitioner  
   Local Library  
   Internet  
   Voluntary organisation  
   Private sector  
   Admitted to hospital  
   Social services  
   Community mental health team  
   Self help, for example help lines  
   Other (please state)  

12. If you have received treatment for depression, how satisfied were you with the range of services offered to you?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely satisfied</td>
<td>Quite satisfied</td>
<td>Quite dissatisfied</td>
<td>Extremely dissatisfied</td>
</tr>
</tbody>
</table>

Do you have any other comments about how services should be offered to help with your depression?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Thank you for your feedback.
Improving care, delivering quality

If we can improve care for one person, then we can do it for ten.

If we can do it for ten, then we can do it for a 100.

If we can do it for a 100, we can do it for a 1000.

And if we can do it for a 1000, we can do it for everyone in Wales.

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