University of Birmingham and University of York Health Economics Consortium (NCCID)

Development feedback report on piloted indicators

QOF indicator area: Post-natal mental health

Pilot period: 1st October 2016 – 28th February 2017

Potential output: Recommendations for NICE menu

Contents

Summary of recommendations

Indicator

1. The percentage of women who have given birth in the preceding 12 months who have had a post-natal enquiry about their mental health using the Whooley 2 depression questions and the GAD-2 between 4-10 weeks postpartum.

Acceptability recommendation:

Band 4: <50% of practices support inclusion

Implementation recommendation:

Band 2: minor problems identified during piloting or anticipated to arise in wider implementation.

Cost effectiveness recommendation:

See summary report.

Issues to consider:

Issue	Detail	Mitigating activity
Variable approaches to making a postnatal mental health enquiry	Most practices currently make a qualitative postnatal mental health enquiry rather than using measures. That is, they ask patients about how they are feeling rather than use a screening tool. Where measures were used these included the Edinburgh Scale, the PHQ-9 and PHQ-2.	
Sensitivity and specificity of the measures for detecting postnatal mental health issues	The sensitivity and specificity of both measures was questioned.	
Duplication of work completed by health visitors and midwives	Some expressed concerns that this was already completed by midwives and health visitors and viewed it as multidisciplinary care. There were also concerns that women may find it onerous if several health professionals ask these questions.	This indicator could raise the importance of asking about mental health at all post natal contacts.
Low attendance at postnatal health checks	Some practices reported poor attendance at postnatal checks. A small number of practices felt this could be a barrier to indicator achievement.	

Background

As part of the NICE-managed Quality and Outcomes Framework (QOF) process, all clinical and health improvement indicators are piloted, using an agreed methodology, in a representative sample of GP practices across England, Scotland, Wales and Northern Ireland.

The aim of piloting is to test whether indicators work in practice, have any unintended consequences and are fit for purpose.

Practice recruitment

Number of practices recruited:	29
Number of practices dropping out:	2
Number of practices unable to interview:	0
Number of practices interviewed:	27

[26 GPs, 6 practice nurses, 9 practice managers and 1 health care assistant = 42 primary care staff]

All percentages reported have been calculated using the 29 practices recruited to the pilot as the denominator.

Piloted indicators

1. The percentage of women who have given birth in the preceding 12 months who have had a post-natal enquiry about their mental health using the Whooley 2 depression questions and the GAD-2 between 4-10 weeks postpartum.

Assessment of clarity, reliability, feasibility, and acceptability

Clarity

No concerns were identified during piloting or the GP focus group

Reliability and feasibility

We were able to develop business rules to support this indicator.

Issues to be resolved prior to implementation:

Issue	Detail	Mitigating activity
Women with a current diagnosis of anxiety/ depression	Should these women be excluded from this indicator as they should already be receiving treatment?	For the pilot we included these women in the denominator due to known coding issues with depression and anxiety diagnoses, especially when they resolve. The committee may wish to reconsider this if the indicator goes forward to the NICE menu. Excluding women with an inaccurate active diagnosis which has actually resolved risks under-inclusion of women at increased risk of post-natal mental health problems. Including women coded as having a diagnosis of depression/ anxiety risks overinclusion and potentially increases exception reporting.
Defining 'given birth'	Should this include women who have experienced stillbirth and/or other pregnancy loss?	Codes for stillbirth were included in the pilot, but the committee may wish to consider this question if the indicator goes forward to the NICE menu.
Screening for depression/anxiety	Does the indicator need to look for any other more general codes than the Whooley and GAD-2 screening codes? Practices reported using a variety of methods. Including qualitative enquiry rather than screening tools.	The pilot looked only for Whooley and GAD-2 as the screening that counts towards the indicator. The committee may wish to consider if any more general depression/anxiety screening codes should count should the indicator go forward to the NICE menu.
Exceptions for depression and anxiety	Does the indicator need to have the depression/anxiety general exception codes (patient unsuitable, etc.) added?	The pilot did not use these codes although consideration may be needed as to if new exception codes are

		required should the indicator go forward to the NICE menu.
Potential 'cross-year' issues	Does the indicator need to cater for patients who give birth at the end of the QOF year?	In the pilot the Business Rules excepted patients who had given birth at the end of the QOF year where their 'delivery'' was more than 4 weeks but less than 10 weeks before the end of the year and who had not been screened for depression/anxiety. Consideration will need to be given to if, in such instances, these patients need to be checked at the end of the following year (when the 4-10 postpartum period has elapsed) to see if they were screened or not? This was not built into the pilot Business Rules.

Acceptability

All practices considered this to be good quality care and stated that this was standard practice, either by making an individualised mental health enquiry or by using a structured tool. Eight practices (27.6%) were supportive of this indicator being considered for QOF in its current wording. A further practice (3.4%) felt that this indicator could be included if it was reworded to "using a structured tool" or if the Edinburgh postnatal mental health scale was included as an option in addition to the specified tools.

"I think it's probably something that's actually a good one to have as a quality because I think it's something that we're all pushing...But I think having a quality measurement … it brings it to the forefront of people's minds and ensures it does happen regardless of whether the person is at risk or not." (GP, Practice ID01)

"Will be a step up for those who don't use anything now. I think really you ought to give the option of the three rather than just two or some structure…I think Edinburgh is certainly better than these." (GP, Practice ID04)

Across the whole sample, approximately two thirds of practices currently made an individualised postnatal mental health enquiry rather than using a structured tool. This involved asking how the patient was feeling, how they were coping, and using clinical skills to identify any other cues that may indicate postnatal depression. A small number of practices made a general enquiry then used a measure if there were concerns.

"So we do make a general enquiry about their mood, how they're getting on, how are they bonding with the baby and obviously pick up any verbal or non-verbal cues from there and then treat the depression if they are low in mood". (GP, Practice ID07)

"We try to avoid using measures but what we will do is we will code specific symptoms so if they hit the major symptoms of low mood, low energy, lack of hope, so the three major symptoms of depression then we would attempt to code that and if they get any of the minor symptoms like the appetite symptoms or the sleep symptoms they get in the winter time we've got a template which we use for that and that's far more useful." (GP, Practice ID16)

Some practices already used structured tools such as the Edinburgh Postnatal Depression Scale, the PHQ-2 or the PHQ-9.These measures were described as more useful than a general enquiry to objectively measure anxiety and depression and practices would be able to see whether patients were improving. Some practices felt postnatal depression may go undetected if structured measures were not used. It would also be impossible to tell if a general enquiry was completed in a useful way through an extraction from the medical record.

"I think, overall, tools are quite a good thing, an objective. They can be fairly blunt instruments. To be viewed with a certain amount of common sense and initiative...They have advantages. In particular, you can tell whether people are getting better or worse." (GP, Practice ID32)

"I suppose it will standardise and make people think about asking the question, it might be easy to overlook if you're not particularly aware of post-natal depression." (GP, Practice ID23)

"As part of our postnatal check we used to screen for postnatal depression I think maybe using an Edinburgh screen." (GP, Practice ID12)

"We do do it in the practice. Only doing it informally and I think basically most practices, where there's a formal framework for post-natal assessments they will actually ask questions but, it's just in best practice so I suppose to have it formalised, there is merit in that because it means it's standardising it rather than asking some general questions which you might think are appropriate" (GP, Practice ID20)

A further two practices (6.8%) were unsure as to whether this was suitable for inclusion in QOF. One practice felt that this was duplicating work completed by the midwives and health visitors. They were concerned that women may find it onerous to be asked questions by other health professionals and questioned whether this duplication of work was necessary. The other practice was concerned about the evidence base for this indicator.

"Part of me sort of wonders if the patients themselves might get a bit fed up of being asked as well because if the midwives are hot on it all the way through pregnancy, aren't they? (PN, Practice ID30)

"Would it improve – that's the question because if it's already being done by the midwife and it's already being done by the health visitor, does it add anything else? Or are you doing something that's already being done? (PN, Practice ID30)

Fourteen practices (48.3%) felt that this indicator was not suitable for inclusion in QOF. Of these, three felt it could be included if it was focused on a general mental health enquiry rather than using specific tools. There were three key reasons for not wishing to see this indicator considered for QOF. Firstly, practices disagreed with the use of the structured measures to assess postnatal mental health and preferred to make a more nuanced and individualised enquiry. Secondly, there were concerns about duplication of effort where this care was already being addressed by health professionals outside of general practice. Thirdly, two practices stated the poor attendance at postnatal health checks as a concern.

"Not in the format it is with the questionnaires in that I think if we're going to ask it ought to be, a bit less fixed" (GP, Practice ID18)

"How do you feel? Do you feel alright? Now, I didn't do formalised GAD 2 scores and all the rest of it, and again, I really question whether that's really what you want. Again, good primary care, in my opinion, I know the ladies. So, I can tell what their mood's like; I can tell how they are. I can tell what's going on because I know them before." (GP, Practice ID22)

"When they come for their six-week check you'll ask what they would like, how they're feeling. 'Are you feeling happy? Are you feeling sad?'...You fit it in and modify it depending on the patient." (GP, Practice ID05)

Most practices who chose not to include the indicator made a more individualised postnatal mental health enquiry and favoured this approach. Compared to making a more general enquiry the measures were regarded as artificial, time consuming and could potentially become a tick box exercise. These practices felt that the measures would not pick up on the subtleties of mental health issues and clinical judgement was usually a better approach, particularly when they knew their patients well. Appropriateness of using the tools may also vary between patients.

"We don't tend to find the measures particularly useful because if you are sad and you're unhappy then you score very high on it and if you're depressed you also score very highly so it's not very specific". (GP, Practice ID16)

"If you make a good general enquiry about their mood, anxiety and depression, I think you get the answer in most cases." (GP, Practice ID07)

"I think it's a bit time consuming and excessive to pick up. I think simple questions and just asking about how they're feeling can only be helpful." (GP, Practice ID26)

Some practices compared the Whooley and GAD-2 measures to other measures they were currently using such as Edinburgh Postnatal Depression Scale, the PHQ-2 or the PHQ-9. Due to the small number of questions it was felt that they may lack the sensitivity to detect depression or anxiety. The Edinburgh Postnatal Depression Scale and the PHQ-9 were described as more comprehensive. Also, some practices felt patients may be identified as being depressed or anxious using the measures when they are actually suffering from normal levels of stress after having a baby.

"I wouldn't put my faith this would be able to pick up the serious cases of postnatal depression there might be in my patients at the moment." (GP, Practice ID11)

"If I had a woman who said that she was feeling a bit stressed or anxious then I would do a more formal test, but I would not necessarily use that. I might use PHQ-9 or the Edinburgh Postnatal Depression Score." (GP, Practice ID24)

All practices stated that other health professionals outside of general practice, usually health visitors and midwives, made a postnatal mental health enquiry. Some practices reported close communication with the health visitors where they would meet monthly to discuss patients with potential postnatal mental health issues. Some practices commented that the health visitors were best placed to make postnatal mental health enquiries due to their increased contact with women. However, most saw the value in the GP making a postnatal mental health enquiry in addition to other clinical staff. Some practices chose not to include the indicator on the basis that health visitors and midwives were best placed to address this and considered it a duplication of work. One practice regarded it as multidisciplinary care and not appropriate for QOF, whilst another was concerned that women may become frustrated by being asked about their mental health by several different groups. A more general comment was made by a small number of practices that patients prefer to discuss these issues with female clinicians; however this was not viewed as a barrier to inclusion.

"I meet the Health Visitor once a month to discuss any post-natal issues and also any child, call it child protection concerns and so that is a kind of disciplined meeting time where we make sure we've met and talked about everyone on the list." (GP, Practice ID23)

"There's a bit of a multi disciplinary approach to mental health in this area. I'm not necessarily convinced that we in general practice are the people best placed to deliver this kind of thing, I think you already have, healthcare professionals in the form of midwives and health visitors who are quite intensely involved with this group of patients and as GPs were are a bit peripheral to that." (GP, Practice ID25)

"I think the health visitors are much better placed because they are actually seeing post-natal women in their own homes. It's perhaps in a more relaxed setting and so they can pick up on signs of depression perhaps better than we maybe can in a one off visit in the surgery." (GP, Practice ID14)

All practices carried out their postnatal mental health assessment at the six week postnatal check. Some commented on the poor attendance at this check, however some practices commented that

they combined the postnatal check with the eight week baby check to improve attendance. Two practices gave attendance as a key reason for not including this indicator in QOF, with one commenting that attendance was only 30-40%. They were concerned about achievement of the indicator.

"They tell them to come back at six weeks and we never see them, so the opportunity to actually assess them at that time is not always there." (GP, Practice ID14)

Assessment of implementation

Assessment of piloting achievement

	Baseline	Final
Number of practices uploading	14	14
Practice population (from NHAIS)	118,341	119,968
Register	1,295	1,271
Excluded		
Rule 2: screening completed prior to 4 weeks post delivery	0	4
Rule 3: patients > 4 weeks but less than 10 weeks post delivery	157	118
Exception reported		
Rule 4: depression screening declined	0	2
Rule 5: recent registration	21	28
Total exceptions	**178**	**152**
Exceptions as a % of eligible population	**13.75**	**11.96**
Denominator	1,117	1,119
Numerator	0	25
Numerator as a percentage of denominator	**0.00**	**2.23**
Prevalence	**1.09**	**1.06**

There are two potential explanations for the low rate of achievement during piloting. Firstly, practices may not have changed their recording habits so the tools were used but not coded. Secondly, practices did not change their practice during the pilot. Given the low level of acceptability of this indicator it is probably that practice did not change during the pilot.

Changes in practice organisation

Most practices did not use a structured tool to make a postnatal mental health enquiry so there would need to be changes in the way this care was organised.

Resource utilisation and costs

Some practices commented on the time required to use these structured tools with patients compared to making a general postnatal mental health enquiry. A concern highlighted by some was the potential duplication of work by health visitors and midwives who are making similar enquiries

Barriers to implementation

A key barrier to implementation was criticism by some practices of the potential ability of these measures to detect postnatal mental health issues. Concerns were expressed that they may detect cases where the woman is actually experiencing a normal level of stress after having a baby. Conversely, they may lack the sensitivity to identify women who are depressed or anxious.

Some practices also commented that there was a low attendance rate at postnatal health checks which could affect indicator achievement.

Assessment of exception reporting

During the pilot, exception reporting was primarily due to the exclusion of women who had not reached 10 weeks post delivery and therefore were still eligible for the care described in the indicator. However, exception reporting is likely to increase on widespread implementation as we were unable to account for discretionary exception reporting such as non-attendance after 3 invitations, other unsuitability etc.

We decided against excluding women with a pre-existing diagnosis of anxiety and/or depression due primarily to the known coding issues around depression diagnosis and resolution and these women being at increased risk of post natal mental health problems.

Assessment of potential unintended consequences

Practices expressed concerns that this could become a tick-box' exercise.

Assessment of overlap with and/or impact on existing QOF indicators

None.

Suggested amendments to indicator wording

None.

Appendix A: Practice recruitment

We planned to recruit 34 practices in England and 2 in each of the Devolved Administrations. English practices were to be representative in terms of practice list size, deprivation and clinical QOF score. Given the limited variability in clinical QOF score we excluded practices with a score of ≤ 10th centile. Practice list size and IMD scores were divided into tertiles and a 3x3 matrix created with target recruitment numbers for each cell. These are detailed in the table below.

	List size		
IMD Score	Low	Medium	High
Low	3	4	5
Medium	3	4	4
High	4	4	3

As previously presented to the Committee, practice recruitment has been extremely challenging. At the beginning of this pilot we had recruited 28 practices in England and 3 in the Devolved Administrations (2 in Northern Ireland, 1 in Scotland). Practice recruitment by strata is shown in the table below with cells in bold where we failed to meet target numbers. We also over recruited in one strata which is shown by the numbers in the table. Two practices in England withdrew from the pilot prior to it starting reducing the total numbers of pilot practices to 26 in England, 2 in Northern Ireland and 1 in Scotland.

	List size		
IMD Score	Low	Medium	High
Low	**2/3**	**3/4**	**1/5**
Medium	3/3	4/4	**1/4**
High	5/4	4/4	3/3

Appendix B: Indicator development

Following the June 2016 Advisory Committee meeting the NCCID was asked to develop new indicators measuring the assessment of postnatal mental health in general practice.

GP focus group

A focus group to discuss potential indicators was held on 20th July 2016 where all potential indicators were discussed. Focus group attendees were volunteers recruited via our database of GPs who had responded to previous invitations. From the volunteers we purposively selected 15 GPs to attend the focus group to try to ensure a balance of men and women, representation from minority ethnic groups and a range of ages.

Of those invited, 14 attended the meeting. Nine (60%) were male. Approximately one third of the participants described themselves as being of white ethnicity (n=5). Participants were reimbursed £250 for their attendance.

Anneka Patel and Shaun Rowark attended on behalf of NICE. Gemma Ramsey and Ross Ambler attended on behalf of NHS Digital.

One indicator was presented to the group focusing upon depression and anxiety assessment using Whooley depression screening questions and the GAD-2 between 4-10 weeks post-partum. Despite an acknowledgement of the importance of postnatal mental health a number of concerns were noted in relation to this indicator. Namely, the timing of the intervention, the level of GP involvement with postnatal care (which varied between CCGs) and it becoming a tick-box exercise. The implementation of the indicator could also be affected by communication between maternity services and GPs, variation in the professionals responsible for postnatal care, poor coding in relation to previous episodes of depression and the best way to incorporate women who have experienced pregnancy loss.

One indicator was progressed to piloting.

Indicator wording as piloted

1. The percentage of women who have given birth in the preceding 12 months who have had a post-natal enquiry about their mental health using the Whooley 2 depression questions and the GAD-2 between 4-10 weeks postpartum.

Appendix C: Acceptability and Implementation recommendations

Acceptability recommendations

One of the following recommendations is made based upon reported acceptability of the indicator to pilot practices.

Band 1: ≥70% of practices support inclusion

Band 2: 60-69% of practices support inclusion

Band 3: 50-59% of practice support inclusion

Band 4: <50% of practices support inclusion.

Implementation recommendations

One of the following recommendations is made based upon an assessment of issues or barriers to implementation reported during piloting.

Band 1: no problems identified during piloting or anticipated to arise. Indicator terms precisely defined.

Band 2: minor problems identified during piloting or anticipated to arise in wider implementation. Problems resolvable prior to implementation through either 1) an amendment to indicator wording, 2) an amendment to the business rules and/or 3) by giving further clarification of indicator terms in associated guidance.

Band 3: major problems identified during piloting or anticipated in wider implementation. Possibly resolvable through the actions described in band 2 but indicator requires further development work and/or piloting.

Band 4: major problems identified during piloting. Not immediately resolvable. Indicator not recommended for wider implementation.