Original Research

Benchmarks for effective primary care-based nursing services for adults with depression: a Delphi study

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Abstract

Title. Benchmarks for effective primary care-based nursing services for adults with depression: a Delphi study.

Aim. This paper is a report of a study conducted to identify and gain consensus on appropriate benchmarks for effective primary care-based nursing services for adults with depression.

Background. Worldwide evidence suggests that between 5% and 16% of the population have a diagnosis of depression. Most of their care and treatment takes place in primary care. In recent years, primary care nurses, including community mental health nurses, have become more involved in the identification and management of patients with depression; however, there are no appropriate benchmarks to guide, develop and support their practice.

Method. In 2006, a three-round electronic Delphi survey was completed by a United Kingdom multi-professional expert panel (n = 67).

Findings. Round 1 generated 1216 statements relating to structures (such as training and protocols), processes (such as access and screening) and outcomes (such as patient satisfaction and treatments). Content analysis was used to collapse statements into 140 benchmarks. Seventy-three benchmarks achieved consensus during subsequent rounds. Of these, 45 (61%) were related to structures, 18 (25%) to processes and 10 (14%) to outcomes.

Conclusion. Multi-professional primary care staff have similar views about the appropriate benchmarks for care of adults with depression. These benchmarks could serve as a foundation for depression improvement initiatives in primary care and ongoing research into depression management by nurses.

Keywords: benchmarks, Delphi, depression, nursing, primary care, survey

Introduction

Depression is a term used to describe many mood disorders with varying severity, symptoms and persistence, including dysthymia, major depressive disorder, bipolar disorder, psychotic depression, postpartum depression and seasonal affective disorder (Armstrong 1998, Wallerstein 2003). According to the World Health Organisation (2006), it is...
one of the leading causes of disability worldwide, affecting around 121 million people. Studies suggest that it affects between 5% and 10% of individuals in the United Kingdom (UK) (Vazquez-Barquero et al. 1999, Singleton et al. 2001) and 10% in the United States of America (American Psychiatric Association, 2004), and a recent report from Australia indicated that 6-6% of the population were likely to have a depressive disorder (Wilhelm et al. 2004). A Department of Health report estimated that a staggering 16% or more of the population in Northern Ireland are likely to suffer from depression at any point in time (Department of Health (DH), Social Services and Public Safety 2003).

Depression is a life-threatening illness, with suicidal thoughts being common (Wallerstein 2003). Major depression, for example, accounts for 60% of suicides and carries as much as a twenty-fold increase in lifetime risk of suicide (Angst et al. 1999, Gaynes et al. 2004). High incidences of depression have also been reported among people with other medical conditions, including cancer (Breitbart et al. 2000, Kadan-Lottick et al. 2003), cardiovascular disorders (Johnston et al. 2000, Berkman et al. 2003), neurological disorders (Leentjens 2004, Nys et al. 2005) and other chronic conditions such as asthma (Mancuso et al. 2000) and diabetes (Anderson et al. 2001). In addition, anxiety disorders often accompany depression, including post-traumatic stress disorder, obsessive compulsive disorder, panic disorder, social phobia and generalized anxiety disorder (Devane et al. 2005).

Most people suffering from depression receive their care solely in primary care settings (Sainsbury Centre for Mental Health 2002, Hague & Cohen 2005). The mental health needs of primary care users are substantial, with up to 50% suffering from a well-defined mental health disorder such as depression (Goldberg 1995, DH 2000, Simon et al. 2004). Although UK studies have indicated that general practitioners are in the best position to undertake early detection of common mental health problems such as depression and anxiety, up to 50% of such problems go undetected and therefore untreated (Katon et al. 1997, Goldberg et al. 1998, Young et al. 2001). Potential reasons proposed for unrecognized depression include lack of knowledge and skill among general practitioners (Coyne et al. 1995, Ratcliffe et al. 2002), excessive workload and competing demands (Mead et al. 1997, Telford et al. 2002), patients attributing symptoms wrongly, presenting instead with physical complaints (Kessler et al. 1999, Walters & Tylee 2005), and a sense of guilt or stigma preventing patients from disclosing their feelings (Casey 1990).

Although general practitioners have traditionally been the first point of contact for people with psychiatric morbidity (Bower 2002), other members of the primary care team have increasingly become involved in identifying and caring for people with depression. These include practice nurses (Crawford et al. 2001, Naji et al. 2004), nurse practitioners (Groh & Hoes 2003, Torrisi & McDanel 2003) and community mental health nurses (Nolan et al. 2004, Gauntlett 2005, McCardle et al. 2007). Similarly, health visitors play an important role in preventing and identifying postnatal depression and treating its milder forms (Elliot et al. 2001, Davies et al. 2003). Nonetheless, little time may be allocated for this and many of these workers are untrained and unsupported (Groh & Hoes 2003, Burman et al. 2005, Brown & Bacigalupo 2006, McCardle et al. 2007).

According to Goldberg and Von Korff (2001), the whole process of care for people with depression needs to be enhanced, involving changes in the organization and function of healthcare teams, such as those already being used to improve outcomes in other chronic diseases. In the UK, the new general practitioner contract (NHS Confederation & BMA 2003) is an ideal vehicle for enhancing the care of people with depression in primary care. It aims to reward quality care and treatment, but also encourages general practitioners to provide extra services (some nurse-led), including mental health care. This offers an opportunity for primary care nurses, including mental health nurses, to contribute to improvements in primary care services for depression. However, there is a lack of benchmarks to develop, guide and support effective primary care-based nursing services for adults with depression. Benchmarking has been defined as ‘the process of continually comparing the performance of an organisation (or part of an organisation) against the performances of others, with the intention of using the outcomes of comparison for the purposes of improvement’ (Yorke 1999, p. 326).


According to the UK Audit Commission (2000) and Public Sector Benchmarking Service (2002), benchmarking can be a
useful method of comparing resources and performance and sharing ideas to deliver better services. Therefore, the development of a list of benchmarks would support primary care nurses in taking a structured approach to sharing and comparing practices, enabling them to identify the best and to develop action plans to remedy poor practice.

The study

Aim

The aim of the study was to identify and gain consensus on benchmarks for an effective primary care-led nursing service for adults (18–64 years) with depression.

Design

Delphi technique

A review of the literature identified a number of different approaches used to develop benchmarks. Irrespective of the variations, they all had one common theme: consultation with a professional group (Ellis & Morris 1997, Northcott & Llewellyn 2005). The Delphi technique was chosen for the present study as it enabled consultation with a larger geographically dispersed and multiprofessional group than could feasibly have been completed using other consensus methods such as the nominal group technique (Carney et al. 1996) or the consensus conference (Jones & Hunter 1995).


In its original form, it is known as the ‘classical Delphi’ (McKenna 1994); however, the literature highlights other versions, including the ‘modified Delphi’ (O’Brien et al. 2002), ‘decision Delphi’ (Burns & Grove 2001), ‘policy Delphi’ (O’Loughlin & Kelly 2004), ‘real-time Delphi’ (Snyder-Halpern et al. 2001) and ‘e-Delphi’ (Avery et al. 2005). However, no matter which definition or type is favoured, it is essential that systematic and rigorous processes are adhered to throughout to ensure validity and reliability of the research (Keeney et al. 2006).

The classical version of the Delphi technique was selected for use in the present study as no consensus currently existed on appropriate benchmarks. An e-Delphi approach was used as all panel members had access to email facilities. The ‘e-Delphi’ involves the administration of the Delphi by email or completion of an online form (Avery et al. 2005).

Participants

The first stage of the Delphi technique involves setting up a panel of participants who, according to Hicks (1999), should be experts in their field. ‘Experts’ have been referred to as ‘specialists’ in their field (Goodman 1987), individuals who are ‘knowledgeable and/or influential’ (White 1991, Lemmer 1998, Green et al. 1999) and as ‘informed individuals’ (McKenna 1994). Potential panel members for this study were identified from an extensive review of the literature and expert databases of organizations, such as the Royal Colleges of Nursing, Psychiatrists and General Practitioners. All experts who participated in the study were willing to make a contribution and met one or more of the criteria outlined in Table 1.

Setting a consensus level

According to Keeney et al. (2006), establishing a consensus level is crucial when undertaking a Delphi survey as the level chosen determines what items are discarded or retained as the rounds unfold. The literature does not offer any standard threshold for consensus (Hasson et al. 2000). Salmond (1994) set the standard of consensus at ‘very high priority’ for items rated as 6 or 7 on a 7-point Likert scale by 70% of participants, or ‘high priority’ for those rated as 5, 6, or 7 by 80% of participants. Alternatively, McDonnell et al. (1996) used a 9-point scale, and deemed participants to be in agreement if nine of the 12 respondents’ scores lay within one of the 3-point

Table 1 Criteria for Delphi study expert panel membership

<table>
<thead>
<tr>
<th>Has managed primary care-based adult depression services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has published papers about primary care-based adult depression services</td>
</tr>
<tr>
<td>Has conducted research or a practice development initiative into primary care-based adult depression services</td>
</tr>
<tr>
<td>Is or has been a senior practitioner specialising in the area of primary care-based adult depression services (Practice nurse/nurse practitioner, community psychiatric nurse, health visitor, general practitioner or psychiatrist who has been practising for 2 years or more)</td>
</tr>
</tbody>
</table>

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categories (1–3, 4–6 and 7–9). For the purpose of our study, consensus on each item was defined as at least 70% agreement; this level has been suggested as a strong cut-off point by Sumison (1998) and McKenna et al. (2002). Therefore, items rated below this level by panel members would be discarded as the rounds progressed.

Data collection

Instrument design
The round 1 questionnaire had three sections. The first was an open-ended question. This allowed respondents the freedom to identify as many benchmarks as they thought were important. It was suggested that they might wish to consider their responses in terms of three categories (structures, processes and outcomes) based on Donabedian’s (1980) model for assessment of quality of care. The second section asked for demographic information, including employment and correspondence details, and the third section required participants to highlight which of the inclusion criteria they met.

Pilot study
To ensure content and face validity, the round 1 questionnaire was pilot-tested with 10 professionals from outside the research setting. A 100% response rate was achieved. In general, respondents considered that the questionnaire was well laid out, clear and concise. They also thought that using Donabedian’s (1980) three categories assisted them to focus their responses while not constraining them. On the basis of feedback obtained from the pilot test, minor wording and layout changes to the instrument were made.

Round 1
The round 1 questionnaire was both emailed and posted to the 67 expert panel members during 2006. The question for round 1 was ‘What are the benchmarks for an effective primary care-based nursing service for adults (18–64 years) with depression?’ Panel members were given a 3-week deadline to return the completed questionnaire, and a reminder was emailed and posted 1 week before the cut-off date. In addition, another reminder was sent to those who had still not responded 1 week after the deadline. This follow-up strategy for non-responders was also used in the subsequent two rounds.

Round 2
Responses from round 1 were used to design a second questionnaire, which was emailed and posted to panel members who had participated in the first round. This was a series of benchmark statements from round 1, and respondents were asked to score the importance of each on a 5-point Likert scale (1, strongly agree; 2, agree; 3, neither agree nor disagree; 4, disagree; and 5, strongly disagree). As well as the same follow-up strategy for non-responders, a telephone call was also made to 10 panel members 2 weeks after the last reminder had been sent. This was to discuss any problems in completing the instrument and to agree an appropriate return date to help ensure their continued participation in the study.

Round 3
Benchmarks that did not achieve a consensus level of 70% or above were included in a third round questionnaire. Panel members who responded during round 2 were asked to re-rate the items in the light of the overall group response, using the same Likert scale from the previous round. In this round, eight panel members received a telephone call 2 weeks after the last reminder had been sent, encouraging their continued participation in the study.

Ethical considerations
The study was approved by the appropriate ethics committee. The autonomy of participants was central to the study and expert panel members were informed of their right to decline to provide specific information or to terminate participation at any stage of the study without detriment. Panel members also received a confidentiality pledge to reassure them that all necessary procedures were in place to protect their privacy and identity during and after completion of the research. However, as the researcher knew the origin of individual responses, it was not possible to maintain total anonymity during the study. Nonetheless, quasi-anonymity, as described by McKenna (1994), was assured.

Data analysis
Data from the round 1 questionnaire were content analysed using Newall and Burnard’s (2006). The researcher’s experience in using this approach guided the analysis process. The statements identified were collapsed to reduce duplication and overlap. This resulted in 140 benchmark statements. These were grouped under the three concepts (structures, processes and outcomes) of Donabedian’s (1980) framework for the assessment of quality of care. The results were then integrated into a list of benchmark statements in preparation for round 2.

Rounds 2 and 3 involved the analysis of quantitative data with the ultimate aim of identifying how much the panel agreed/disagreed with each of the benchmark statements. Measures of central tendency (median and mean) and levels
of dispersion (standard deviation) were calculated for each statement using the Statistical Package for the Social Sciences (SPSS) Version 11.0. The median was used to summarize agreement for each statement and to give feedback to panellists. As the mean provides more differentiation between statements, this was used to rank order the statements once consensus of 70% or greater on each benchmark statement had been reached.

Findings

Eighty-nine potential expert panel members were identified. This included five professional groups: mental health nurses, health visitors, practice nurses/nurse practitioners and general practitioners and psychiatrists. Of those contacted 67 (75%), were willing to participate in the study. The levels/grades of individual members varied within each group. This brought a variety of perspectives to the study, for example, practice, education and research. Table 2 describes the Delphi expert panel.

Round 1

The first round questionnaire yielded a 96% response rate. Unfortunately, three general practitioners dropped out of the study during this round because of declared heavy work commitments. Of the 64 questionnaires returned, 34 (53%) were returned by post and 30 (47%) by email.

A total of 1216 diverse benchmark statements were identified from the panel. These ranged from very practical administration statements such as ‘A choice of venue for appointments should be offered to clients with depression’ to more strategic benchmark statements such as ‘The strategic development of primary care-based depression services should be multi-agency based’.

Following analysis and independent judgments from the research team to reduce response overlap, 140 benchmarks were identified under the three categories of structures \( (n = 76, 54\%) \), processes \( (n = 32, 23\%) \) and outcomes \( (n = 32, 23\%) \).

Table 2 Composition of the Delphi panel

<table>
<thead>
<tr>
<th></th>
<th>Mental health nurse</th>
<th>Health visitor</th>
<th>Practice nurse/nurse practitioner</th>
<th>General practitioner</th>
<th>Psychiatrist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (%)</td>
<td>36 (53-7)</td>
<td>9 (13-4)</td>
<td>2 (2-9)</td>
<td>16 (23-8)</td>
<td>4 (5-9)</td>
</tr>
<tr>
<td>Male</td>
<td>19 (52-7)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>12 (75)</td>
<td>4 (100)</td>
</tr>
<tr>
<td>Female</td>
<td>17 (47-3)</td>
<td>9 (100)</td>
<td>2 (100)</td>
<td>4 (25)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Practice</td>
<td>18 (50)</td>
<td>6 (66-7)</td>
<td>2 (100)</td>
<td>11 (68-8)</td>
<td>2 (50)</td>
</tr>
<tr>
<td>Education</td>
<td>12 (33-3)</td>
<td>2 (22-2)</td>
<td>0 (0)</td>
<td>3 (18-7)</td>
<td>1 (25)</td>
</tr>
<tr>
<td>Research</td>
<td>6 (16-7)</td>
<td>1 (11-1)</td>
<td>0 (0)</td>
<td>2 (12-5)</td>
<td>1 (25)</td>
</tr>
</tbody>
</table>

The values presented in parentheses are percentages.

Round 2

A total of 61 questionnaires were returned in round 2, giving a response rate of 95%. During this round, two community mental health nurses and one psychiatrist dropped out of the study, again because of workload demands. A statistically significant increase of 27% was recorded in the number of questionnaires returned by email during round 2, indicating this as the preferred method of response. During round 2, 22 (16%) benchmarks achieved consensus at 70%. Table 3 lists the 15 benchmarks achieving the highest consensus level during this round.

Round 3

A total of 58 questionnaires were returned in round 3, giving a response rate of 95%. During this round, one community mental health nurse, one general practitioner and one psychiatrist dropped out of the study, again because of workload pressures. Of the questionnaires sent out during this round, only six (10%) were returned by post compared with 16 (26%) in the previous round. In contrast, 52 (90%) were returned via email compared with 45 (74%), again representing an increase in the email response as the study progressed.

Of the 118 benchmarks listed in the round 3 questionnaire, 51 (43%) achieved consensus. This represented 35 (69%) in the category of structures, 10 (19%) under processes and six (12%) under outcomes. Table 4 shows the 15 benchmarks with the highest percentage level of consensus achieved during round 3. Benchmarks achieving consensus during rounds 2 and 3 were added to form a total of 73 benchmarks.

Study limitations

Considerable care was taken during the study to select participants based on their expertise. Delphi panel participants during phase 1 represented five professional groups. This brought a variety of perspectives to the study, for example, practice, education and research. Nonetheless, it cannot be said that the participants involved were representative of the population of primary care professionals in the UK, Ireland.
Primary care nurses should have an identified level of depression training and competency
An integrated care pathway for depression should be developed in partnership with key stakeholders
A regularly updated resource directory should be available for primary care staff and clients listing
Primary care nurses should have knowledge of and be competent in a range of depression screening tools
Primary care nurses should be able to carry out a basic assessment to detect depression
Enhanced depression services should be provided by all primary care teams and rewarded within
the Quality Outcomes Framework
There should be a reduction in the number of patients with mild to moderate depression being referred to secondary care
A primary care-based depression service should be adequately financed and resourced
A regularly updated resource directory should be available for primary care staff and clients listing relevant local services (e.g. voluntary, statutory, other agencies and helplines)
An integrated care pathway for depression should be developed in partnership with key stakeholders and in line with national depression guidelines
Integrated pharmacological and psychological treatments should be available to patients with depression in primary care
Primary care nurses should have an identified level of depression training and competency
Clinical profile data should be available (e.g. number of patients presenting with depression, levels/severity of depression, level/length/effectiveness of interventions)
Enhanced depression services should be provided by a dedicated primary care-based team rather than secondary care teams providing outreach services

<table>
<thead>
<tr>
<th>Benchmark statement</th>
<th>Mean (SD)</th>
<th>Consensus (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care nurses should view the provision of depression care as part of their role</td>
<td>1.14 (0.350)</td>
<td>86.0</td>
</tr>
<tr>
<td>Alternative service delivery models should be utilized by primary care nurses to support patients with depression</td>
<td>1.16 (0.428)</td>
<td>84.2</td>
</tr>
<tr>
<td>There should be adequate numbers of primary care nurses to assist in the recognition and management of depression</td>
<td>1.18 (0.373)</td>
<td>83.6</td>
</tr>
<tr>
<td>Protected time should be provided to primary care nurses to provide depression care</td>
<td>1.23 (0.424)</td>
<td>77.0</td>
</tr>
<tr>
<td>Primary care nurses should have knowledge of and be competent in a range of depression screening tools</td>
<td>1.25 (0.434)</td>
<td>75.4</td>
</tr>
<tr>
<td>Primary care nurses should be able to carry out a basic assessment to detect depression</td>
<td>1.26 (0.444)</td>
<td>73.8</td>
</tr>
<tr>
<td>Enhanced depression services should be provided by all primary care teams and rewarded within the Quality Outcomes Framework</td>
<td>1.29 (0.459)</td>
<td>70.7</td>
</tr>
<tr>
<td>There should be a reduction in the number of patients with mild to moderate depression being referred to secondary care</td>
<td>1.29 (0.459)</td>
<td>70.7</td>
</tr>
<tr>
<td>A primary care-based depression service should be adequately financed and resourced</td>
<td>1.30 (0.460)</td>
<td>70.5</td>
</tr>
<tr>
<td>A regularly updated resource directory should be available for primary care staff and clients listing relevant local services (e.g. voluntary, statutory, other agencies and helplines)</td>
<td>1.30 (0.460)</td>
<td>70.5</td>
</tr>
<tr>
<td>An integrated care pathway for depression should be developed in partnership with key stakeholders and in line with national depression guidelines</td>
<td>1.30 (0.462)</td>
<td>70.2</td>
</tr>
<tr>
<td>Integrated pharmacological and psychological treatments should be available to patients with depression in primary care</td>
<td>1.30 (0.527)</td>
<td>73.8</td>
</tr>
<tr>
<td>Primary care nurses should have an identified level of depression training and competency</td>
<td>1.31 (0.501)</td>
<td>70.5</td>
</tr>
<tr>
<td>Clinical profile data should be available (e.g. number of patients presenting with depression, levels/severity of depression, level/length/effectiveness of interventions)</td>
<td>1.31 (0.501)</td>
<td>70.5</td>
</tr>
<tr>
<td>Enhanced depression services should be provided by a dedicated primary care-based team rather than secondary care teams providing outreach services</td>
<td>1.33 (0.569)</td>
<td>72.1</td>
</tr>
</tbody>
</table>

and beyond. However, there were remarkably few contradictions amongst the professional groups involved, and strong concurrence in the findings and with the international research and policy literature.

Service users’ expectations of primary care nursing services are important and their perspectives may differ from those of professionals. However, they were excluded from the study because of the fact that it was not feasible to expect patients suffering from the debilitating symptoms of depression to take part in a rigorous three-round survey. We were also aware, as suggested by Cunningham and Slevin (2005), that service users’ participation in decisions about services becomes more difficult when professional roles are unclear. This is the case with the present study, mainly because of the developing nature of primary care mental health services in Northern Ireland.

It is important to note that the benchmarks identified in this study cannot be considered as a comprehensive assessment of depression services or a comprehensive tool-set for measuring the quality of care. Rather, they can be used to raise awareness of important issues of primary care depression services, identify the baseline for depression care provision, act as signposts in defining quality of care and develop local standards of care.

### Discussion

Although the expert panel in this study consisted of mental health nurses, practice nurses/nurse practitioners, health visitors, general practitioners and psychiatrists, there were remarkably few contradictions among the identified benchmarks. General practitioners and nurses tended to focus more on structures and processes, whereas the main focus for psychiatrists was on outcomes. This may be because of the fact that, as secondary care professionals, psychiatrists have no direct influence over the structures and processes involved in primary care. However, as they are often involved in sharing patients’ care with primary care professionals, they may be particularly interested in outcomes that affect not only their current but also future patients. It is also possible that psychiatrists base their definition of depression on signs and symptoms, and a measure of the success of treatment would be resolution or non-resolution of these in the form of outcomes. However, it is also possible that if there had been more psychiatrists participating, there might have been a greater spread of responses across the structure, process and outcome categories.

Following three rounds of the Delphi, consensus was achieved on 73 benchmarks under the categories of structures, processes and outcomes. Importantly, those achieving
A workplace culture exists that views depression as a problem worth addressing. Effective communication systems (verbal, written and electronic) should exist between primary care, secondary care and other relevant agencies. Quality depression information leaflets/booklets/fact sheets should be provided by primary care nurses. There should be regular continuous professional development (CPD) for primary care nurses. Each practice should have an active case register of patients diagnosed with depression. Collaborative core organizational structures should exist which ensure partnership working between primary care, secondary care and other relevant agencies. Each practice should have an active case register of patients diagnosed with depression. IT systems should support audit/analysis (e.g. extractable data on referral patterns). There should be regular continuous professional development (CPD) for primary care nurses on the recognition and management of depression. Primary care nurses should have knowledge of the causes, symptoms of depression and influences of co-morbidity. Primary care nurses should view the provision of depression care as part of their role. Effective communication systems (verbal, written and electronic) should exist between primary care and key stakeholders (e.g. Trusts, voluntary agencies). A workplace culture exists that views depression as a problem worth addressing. An annual report should be developed to review progress against stated aims of primary care depression services. There should be an increase in early recognition/assessment of depression by primary care nurses using relevant screening tools. Primary care practitioners should lead and assist in the management of depression at primary care level.

<table>
<thead>
<tr>
<th>Benchmark statement</th>
<th>Mean (SD)</th>
<th>Consensus (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients attending primary care depression services should have access to a clean, comfortable, safe environment</td>
<td>1.23 (0.464)</td>
<td>78.9</td>
</tr>
<tr>
<td>Advice and support regarding depression management should be available to primary care nurses from secondary care specialists when necessary</td>
<td>1.23 (0.464)</td>
<td>78.9</td>
</tr>
<tr>
<td>Primary care nurses should have attended at least a 1 day training course on depression</td>
<td>1.23 (0.464)</td>
<td>78.9</td>
</tr>
<tr>
<td>Guidelines for the recognition, treatment, management and referral of patients with depression are utilized by primary care nurses</td>
<td>1.23 (0.464)</td>
<td>78.9</td>
</tr>
<tr>
<td>Primary care nurses should have knowledge of the causes, symptoms of depression and influences of co-morbidity</td>
<td>1.23 (0.464)</td>
<td>78.9</td>
</tr>
<tr>
<td>Collaborative core organizational structures should exist which ensure partnership working between primary care, secondary care and other relevant agencies</td>
<td>1.23 (0.464)</td>
<td>78.9</td>
</tr>
<tr>
<td>Each practice should have an active case register of patients diagnosed with depression</td>
<td>1.23 (0.464)</td>
<td>78.9</td>
</tr>
<tr>
<td>IT systems should support audit/analysis (e.g. extractable data on referral patterns)</td>
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<td>78.9</td>
</tr>
<tr>
<td>There should be regular continuous professional development (CPD) for primary care nurses on the recognition and management of depression</td>
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<td>Quality depression information leaflets/booklets/fact sheets should be provided by primary care nurses</td>
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<td>Effective communication systems (verbal, written and electronic) should exist between primary care and key stakeholders (e.g. Trusts, voluntary agencies)</td>
<td>1.23 (0.464)</td>
<td>78.9</td>
</tr>
<tr>
<td>A workplace culture exists that views depression as a problem worth addressing</td>
<td>1.23 (0.464)</td>
<td>78.9</td>
</tr>
<tr>
<td>An annual report should be developed to review progress against stated aims of primary care depression services</td>
<td>1.23 (0.464)</td>
<td>78.9</td>
</tr>
<tr>
<td>There should be an increase in early recognition/assessment of depression by primary care nurses using relevant screening tools</td>
<td>1.23 (0.464)</td>
<td>78.9</td>
</tr>
<tr>
<td>Primary care practitioners should lead and assist in the management of depression at primary care level</td>
<td>1.23 (0.464)</td>
<td>78.9</td>
</tr>
</tbody>
</table>

Consensus retained the highest scores during the second and third rounds; although only 22 benchmarks achieved consensus during round 2, this suggest that the results were reliable. For instance, ‘Advice and support regarding depression management should be available to primary care nurses from secondary care specialists when necessary’ was ranked 1st in round 2, with a consensus level of 68.9%, and 2nd in round 3, with a consensus level of 86%. This contradicts critics of the Delphi who, according to Keeney et al. (2006), assert that panel members are inclined to change their minds because of a mistaken belief that the views expressed by the majority must be right.

The highest rated benchmarks focused on the need for a culture that views depression as a problem worth addressing, the use of alternative service delivery models, appropriate training for practitioners, effective treatments and clear guidelines for the screening and management of depression. In particular, panelists strongly supported the benchmark relating to the need for primary care-based nursing services for adults with depression to be adequately resourced. According to the Sainsbury Centre for Mental Health (2002), an increase in the numbers and skills of nurses in primary care is required to maximize their potential and meet the expectations of both government and service users. In the UK, however, this may not always be possible as over 90% of the mental health budget is allocated to secondary care services (Sainsbury Centre for Mental Health 2002). Nonetheless, funding issues should not be an excuse for inactivity.

Panellists strongly supported the benchmark that primary care nurses should view the provision of depression care as part of their role. This may be related to the variation in depression services provided by primary care nurses. For instance, Atkin et al. (1993) found that fewer than half of practice nurses in their study saw the identification of depression as part of their role. Similarly, Crosland and Kai (1998) reported that only a fifth of practice nurses in their study were happy with their existing role. In contrast, studies by Nolan et al. (1999) and Thomas and Corney (1993) showed that 89% and 86% of practice nurses respectively stated that they saw a role for themselves in the care and treatment of patients with a mental health problem. Eve and Gerrish (2001) reported that the work undertaken by individual nurses varies considerably and is largely attributable to the particular interests of their employing general practitioners.

According to ‘Effective Commissioning’ (Light 1998), primary care must be commissioned to achieve coordinated, effective services and good value. In the UK, the new general practitioner contract (NHS Confederation and BMA 2003) offers this opportunity for depression management. Useful
models and templates, including for effective communication and case management systems, exist within the contract for the effective management of other chronic diseases, such as asthma and diabetes. Enhanced depression services are currently categorized as ‘additional services’ under the general practitioner contract, which enables primary care practices to opt out of providing such services. Our results highlight the need for this to change. Panel participants proposed that all primary care practices should provide adequately resourced enhanced depression services, and that these should be provided by a dedicated primary care team rather than secondary teams providing outreach services.

The call for appropriate nurse staffing levels within such a service may be difficult to address. There is currently a dearth of literature on what this means for primary care nursing depression services. Our participants suggested that, rather than focusing on a universal model of staffing levels, the emphasis should be on ensuring protected time for primary care nurses to identify and assist in the management of depression, take on new counselling roles and have access to a counsellor or key worker to support them when dealing with patients with depression. The results also highlight the need for community mental health nurses to be based in or close to local health centres, with easy access to general practitioners. Further work is also recommended to develop a primary care-based nursing model for adults with depression.

Regarding ethos, the most strongly supported benchmark related to ensuring a workplace culture that views depression as a problem worth addressing. According to Carroll and Quijada (2004), professionals in healthcare organizations who seek to enhance safety and quality in an increasingly demanding environment often identify culture as a barrier to change. Primary care nursing depression services face the additional obstacle that no clear cultural model exists currently to emulate. This is because of the variations in the way depression services are managed in primary care across communities and practices. Another barrier is that primary care is not a single culture, but rather a collection of occupational cultures incorporating medicine, nursing and management.

To enable the development of a supportive culture, primary care practices need to give priority to developing team approaches to depression, including practice nurses, health visitors, district nurses and mental health nurses. This view has been underpinned by Government policy outlined in the National Service Framework for Mental Health (DH 1999) and the NHS Plan (DH 2000). The process of developing a culture that supports depression as a problem worth addressing is much more likely to succeed if all primary care professionals responsible for caring for patients with depression and service users themselves are involved in helping to design new ways of providing services. All those involved should have clear roles and responsibilities, which in turn should engage their internal motivation.

Concerns have been voiced about the variations in qualifications and professional accountability of primary care professionals and other practice-based mental health workers (Telford et al. 2002). General practitioners vary considerably in their skills, experience and confidence in dealing with depression (Greene & Dowrick 1995), as do primary care nurses (Sainsbury Centre for Mental Health 2002). The need for an identified level of preparation for primary care nurses delivering depression services was another benchmark which was highly rated in our study. Panel members proposed that all primary care nurses providing depression services should have knowledge of relevant policies, guidelines, protocols and procedures and have the competence to carry out a basic assessment using evidence-based screening tools/rating scales. The results also indicated a need for all primary care nurses to attend at least a 1-day training course on depression.

This view is supported by the literature, which demonstrates that although primary care nurses regularly see patients with mental illness (Plummer et al. 2000, Crawford et al. 2001, Davies et al. 2003, Groh & Hoes 2003, Naji et al. 2004), many are unprepared and lack the necessary knowledge and skills (Nolan et al. 1999, Gray et al. 1999, Plummer et al. 2000, Sainsbury Centre for Mental Health 2002, Gauntlett 2005). The need for regular professional development and clinical supervision for primary care nurses providing depression services were also highlighted.

The availability and utilization of evidence-based guidelines for the management of depression in primary care was also strongly supported by panel members. Evidence-based guidelines have the potential to ensure that rigorous clinical standards are maintained, and for directing research to address gaps in the evidence base (Rush 2001). In 2004, the National Institute for Clinical Excellence (National Collaborating Centre for Mental Health 2004) issued guidelines for the NHS on the management of depression in primary and secondary care. However, evidence suggests that guidelines are not always adhered to in primary care (Cabana et al. 1999, Feder et al. 1999, Gillam 2006). Our results highlight the need for a structured approach to ensuring the implementation and evaluation of guidelines at local level.

The agreement among respondents across the three rounds was notable. However, although 73 benchmarks achieved consensus, Keeney et al. (2001) highlighted that the existence of consensus from the Delphi process does not mean that the correct answer has been found; it merely means that participants have agreed on an issue or set of issues.
What is already known about this topic

- Depression is a serious condition with significant mortality if unrecognized or untreated.
- Primary care nurses have become increasingly involved in identifying, assessing and caring for people with depression.
- Patient care can be improved by benchmarking by enabling practitioners, patients and carers to influence and participate in developing best practice that is linked to comparison and sharing.

What this paper adds

- A multi-professional panel of experts had similar views about which benchmarks denote a quality service.
- The top rated benchmarks focused on the need for alternative service delivery models, an identified level of training and competency for nurses, and the availability of advice and support from secondary care specialists when necessary.

Implications for practice and/or policy

- The benchmarks will enable primary care practitioners to identify gaps in their practice against their peers, encourage improvement in the delivery of depression care and establish ‘standards’ of what types of care are feasible.
- The benchmarks may also be used by healthcare employers and commissioners to monitor, evaluate and improve the quality of depression services provided in primary care.
- It is important that these benchmarks are linked with other research initiatives aimed at addressing the quality of primary mental health care as a whole.

Conclusion

The Delphi technique proved helpful in systematically identifying and gaining consensus on a core set of appropriate benchmarks from a multiprofessional panel of experts across the UK. Careful consideration was necessary in relation to understanding the Delphi process, identification of ‘experts’, questionnaire design, agreement on an appropriate level of consensus and the number of rounds to conduct.

The 73 benchmarks on which consensus was gained will enable primary care practitioners to identify gaps in their practice against their peers, encourage improvement in the delivery of depression care and establish ‘standards’ of what types of care are feasible. The benchmarks may also be used by healthcare employers and commissioners to monitor, evaluate and improve the quality of depression services provided in primary care. It is important that these benchmarks are linked with other research initiatives aimed at addressing the quality of primary mental health care as a whole. Although this study is an important step towards routinely measuring the quality of care provided to patients with depression in primary care, it is important that it is incorporated into a process of continuous quality improvement.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

HMcK, CMcl, SK and DMcL were responsible for the study conception and design. CMcl performed the data collection and CMCcl performed the data analysis. CMcl and SK were responsible for the drafting of the manuscript; and provided administrative, technical or material support. SK & HMcK made critical revisions to the paper for important intellectual content. SK provided statistical expertise. HMcK and CMcl obtained funding. HMcK, SK and DMcL supervised the study.

References


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