

Improving Access to Psychological Therapies (IAPT)

Executive Summary (January 2017)

Published 25 April 2017

This statistical release makes available the most recent Improving Access to Psychological Therapies (IAPT) monthly and quarterly data, including activity, waiting times, and outcomes such as recovery.

IAPT is run by the NHS in England and offers NICE-approved therapies for treating people with depression or anxiety.

Key findings

In January 2017 there were:



126,297
new referrals



85,001
referrals entered treatment



45,897
referrals finished
a course of treatment

Of which:

90.2% waited less than 6 weeks and

98.7% waited less than 18 weeks to enter treatment

42,729 started their treatment at caseness, with

50.1% moving to recovery

Contents

Key findings	1
Introduction	4
Main findings	4
Outcomes	5
Recovery	5
Further breakdowns for recovery	6
Reliable improvement and reliable recovery	7
Waiting times	9
Activity	10
Further breakdowns for activity	11
Further information	12
Key resources	12
NHS Digital IAPT webpages	12
Low numbers and suppression	12
Frequently Asked Questions	13
Appendix: Understanding outcome measures	16
Caseness	16
Recovery	16
Reliable improvement	17
Reliable recovery	17
Glossary	18

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This product may be of interest to the Department of Health (DH), IAPT services, commissioners and members of the public interested in information about activity and outcomes regarding NHS-funded IAPT services for adults in England.

Introduction

Improving Access to Psychological Therapies (IAPT) is an NHS programme in England that offers interventions approved by the National Institute for Health and Care Excellence (NICE)¹ for treating people with depression or anxiety.

The IAPT programme is supported by a regular return of data generated by providers of IAPT services in the course of delivering those services to patients. These data are received by NHS Digital and published in monthly reports².

This report summarises activity in the IAPT programme for the period 1 January 2017 to 31 January 2017³. It shows key information about activity, patient outcomes, and waiting times.

Please note that we have updated the methodology used to calculate the following fields in the Monthly Activity Data File CSV: MeanHISessions, MeanCBTSessions, MeanBPDSessions, MeanCounsellingSessions, MeanIPTSessions, MeanCouplesSessions, MeanBehavActSessions, MeanOtherHISessions, MeanLISessions. For full details, please refer to the Methodological Change Paper and the IAPT Metadata Document, both available from <http://www.digital.nhs.uk/iaptmonthly>.

Main findings

Information about the IAPT programme is based broadly on three areas:

- **Activity:** such as how many referrals were received, treated, or ended in the month, or how many appointments took place;
- **Waiting times:** how long referrals waited to be seen or treated by providers of IAPT services;
- **Outcomes:** whether referrals measurably improved as a result of a course of IAPT therapy.

Activity

126,297 new referrals were received in January 2017.

85,001 referrals entered treatment in the month.

110,188 referrals ended (for any reason) in the month.

Waiting times

Of the 45,897 referrals that finished a course of treatment in January 2017, 90.2% waited less than 6 weeks and 98.7% waited less than 18 weeks to enter treatment.

Outcomes

42,729 referrals finished a course of treatment in January 2017 having started at caseness⁴, of which 21,389 (50.1%) moved to recovery.

¹ <https://www.nice.org.uk/>

² <http://www.digital.nhs.uk/iaptmonthly>

³ All historical IAPT publications can be found at <http://www.digital.nhs.uk/iaptreports>.

Outcomes

Outcomes in IAPT are measured in terms of three measures: reliable improvement, recovery, and reliable recovery. For an explanation of these terms, see the Appendix to this report.

Recovery

Recovery in IAPT is measured in terms of ‘caseness’ – a term which means a referral has severe enough symptoms of anxiety or depression to be regarded as a clinical case. A referral has moved to recovery if they were defined as a clinical case at the start of their treatment (‘at caseness’) and not as a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition.

The Government target is that 50% of eligible referrals to IAPT services should move to recovery.^{5,6}

Recovery

50.1%

of eligible referrals moved to recovery.

A referral has moved to recovery if they were defined as a clinical case at the start of their treatment and not as a clinical case at the end of treatment.

Figure 1: Percentage of eligible referrals moving to recovery⁶, February 2016 to January 2017, England and Provider

	February 2016	March 2016	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017
National recovery rate	48.8%	47.9%	49.0%	48.9%	48.8%	48.5%	48.4%	48.4%	49.0%	48.9%	48.5%	50.1%
Variation by Provider												
Lowest recovery rate	-	-	17.9%	22.0%	14.8%	14.5%	20%	21%	25%	24%	19%	23%
Median recovery rate	-	-	49.5%	50.0%	49.4%	50.0%	49%	51%	50%	50%	49%	51%
Highest recovery rate	-	-	83.3%	72.7%	77.2%	70.6%	67%	80%	79%	71%	81%	86%

Source: IAPT Dataset, NHS Digital

¹ Please note from August 2016 final data, sub-national rates have been rounded to the nearest integer.

Over time, the national recovery rate has remained largely stable, just below the government target of 50%. However, for January 2017 the national recovery rate has surpassed this government target at 50.1%.

⁴ ‘Caseness’ is the term used in IAPT to define a clinical case of anxiety or depression. See the ‘IAPT Metadata Document’ published at <http://www.digital.nhs.uk/iaptmonthly> for details.

⁵ See p16-17 of *The Mandate: A mandate from the Government to NHS England: April 2015 to March 2016*, available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386221/NHS_England_Mandate.pdf

⁶ Sub-national recovery rates first published in April 2016. Please note from August 2016 final data, sub-national rates have been rounded to the nearest integer.

Calculating recovery rates

$$\frac{\text{Number of referrals that moved to recovery}}{\left(\begin{array}{l} \text{Number of referrals that} \\ \text{finished a course} \\ \text{of treatment} \end{array} - \begin{array}{l} \text{Number of referrals that} \\ \text{finished a course of} \\ \text{treatment and started} \\ \text{treatment not at caseness} \end{array} \right)} \times 100$$

In January 2017, this calculation is performed as follows:

$$\frac{21,389}{\left(45,897 - 3,168 \right)} \times 100 = 50.1\%$$

Sub-national recovery rates are published in the Monthly Activity Data File as column 'RecoveryRate'.

Further breakdowns for recovery

Each quarter, more detailed data are published about recovery. The most recent quarterly data, Quarter 3 2016-17, shows the following.

Recovery rates for those who finished a course of treatment:

Sex

48.7%
female

49.3%
male.

Working Age and older people⁷

47.6%
aged 18 to 64

64.7%
aged 65 and over.

White British and BME⁸

45.7%
of BME ethnicities

49.5%
of White British.

Further breakdowns and measures can be found at <http://www.digital.nhs.uk/pubs/iaptjan17>.

⁷ As of Quarter 2 2016-17 this is now based on variable 'Working Age' found in the Quarterly Activity Data File.

⁸ As of Quarter 2 2016-17 this is now based on variable 'BME Group' found in the Quarterly Activity Data File.

Reliable improvement and reliable recovery

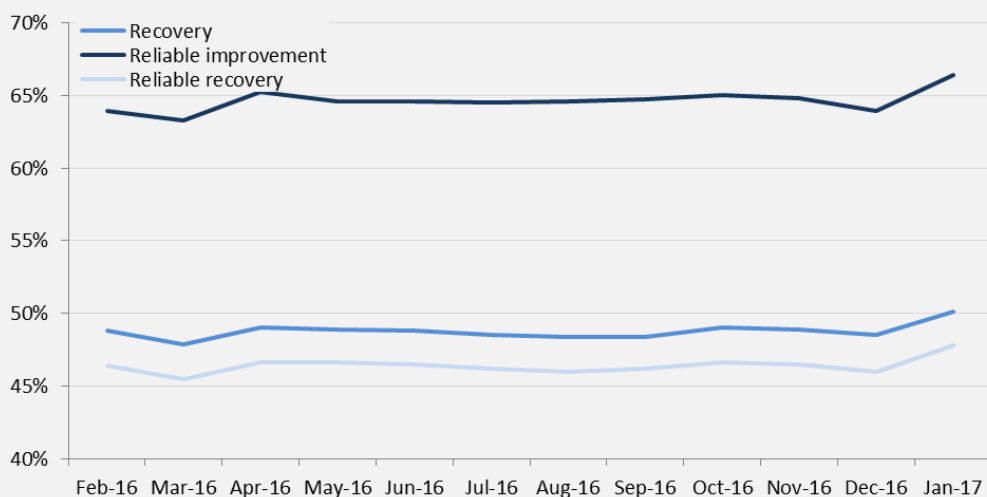
In addition to recovery, there are two other measures of outcome in IAPT; reliable improvement and reliable recovery.

A referral has shown reliable improvement if there is a significant improvement in their condition following a course of treatment, measured by the difference between their first and last scores on questionnaires tailored to their specific condition.

A referral has reliably recovered if they meet the criteria for both the recovery and reliable improvement measures. That is, they have moved from being a clinical case at the start of treatment to not being a clinical case at the end of treatment, and there has also been a significant improvement in their condition.

Reliable improvement
66.4%
of referrals finishing a course of treatment showed reliable improvement.

Figure 2: Percentage of eligible referrals having recovered, reliably improved, and reliably recovered, February 2016 to January 2017, England



Source: IAPT Dataset, NHS Digital

The above chart compares recovery, reliable improvement, and reliable recovery rates. Consistently, a higher proportion show reliable improvement than move to recovery; this is because reliable improvement only looks at the *scale* of change, and not whether the referral has moved below the clinical caseness threshold. Reliable recovery, which requires both recovery and reliable improvement, is the most stringent measure and therefore has the lowest rate.

For further information about these measures, see the Appendix to this report.

Calculating reliable improvement rates

$$\frac{\text{Number of referrals that showed reliable improvement}}{\text{Number of referrals that finished a course of treatment}} \times 100$$

In January 2017, this calculation is performed as follows:

$$\frac{30,462}{45,897} \times 100 = 66.4\%$$

Sub-national reliable improvement rates are published in the Monthly Activity Data File as column 'ImprovementRate'.

Calculating reliable recovery rates

$$\frac{\text{Number of referrals that both moved to recovery and showed reliable improvement}}{\left(\text{Number of referrals that finished a course of treatment} - \text{Number of referrals that finished a course of treatment and started not at caseness} \right)} \times 100$$

In January 2017, this calculation is performed as follows:

$$\frac{20,417}{\left(45,897 - 3,168 \right)} \times 100 = 47.8\%$$

Sub-national reliable recovery rates are published in the Monthly Activity Data File as column 'ReliableRecoveryRate'.

Further breakdowns for reliable improvement & reliable recovery

Each quarter, more detailed data are published about reliable improvement and reliable recovery. The most recent quarterly data, Quarter 3 2016-17, can be found at

<http://www.digital.nhs.uk/pubs/iaptjan17>.

Waiting times

One of the stated targets of the IAPT programme is that for new referrals, 75% enter treatment within 6 weeks, and 95% within 18 weeks⁹. These are based on the waiting time between the referral date and the first attended treatment appointment, for referrals finishing a course of treatment in the month.

Waiting times
90.2%

of referrals waited less than 6 weeks to enter treatment

Based on referrals ending in January 2017.

Figure 3: Percentage of referrals entering treatment within 6 and 18 weeks, February 2016 to January 2017, England

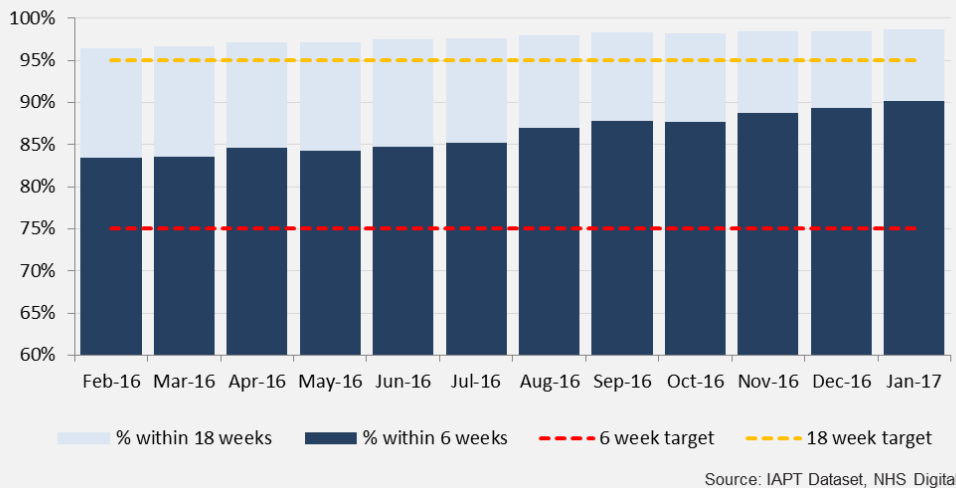


Figure 3 above shows that, nationally, waiting times measures have consistently been above the target, particularly the proportion seen within 6 weeks.

Calculating waiting times rates

$$\frac{\text{Number of referrals that finished treatment and waited less than 6 weeks to enter treatment}}{\text{Number of referrals that finished a course of treatment}} \times 100$$

In January 2017, this calculation is performed as follows:

$$\frac{41,403}{45,897} \times 100 = 90.2\%$$

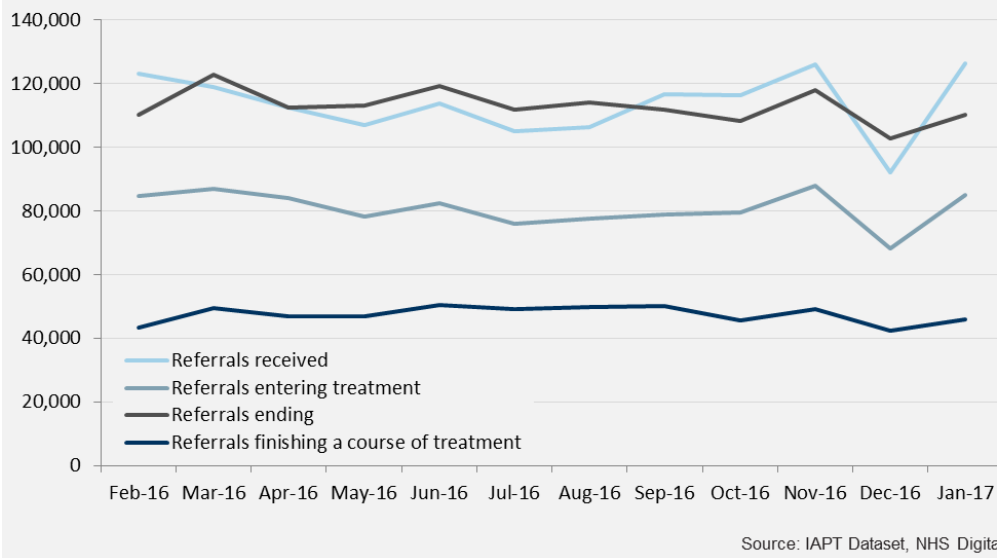
Sub-national waiting times rates are published in the Monthly Activity Data File as columns 'FirstTreatment6WeeksFinishedCourseRate' and 'FirstTreatment18WeeksFinishedCourseRate'.

⁹ See p16-17 of *The Mandate: A mandate from the Government to NHS England: April 2015 to March 2016*, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386221/NHS_England_Mandate.pdf

Activity

As well as outcomes and waiting times, NHS Digital also publishes a wide range of information about activity in the IAPT programme within the month.

Figure 4: Number of referrals received, entered treatment, ended, and finished a course of treatment, February 2016 to January 2017, England



Activity in IAPT
41.7%
of all referrals that ended completed a course of treatment.

Other reasons for referrals ending are described in Figure 5.

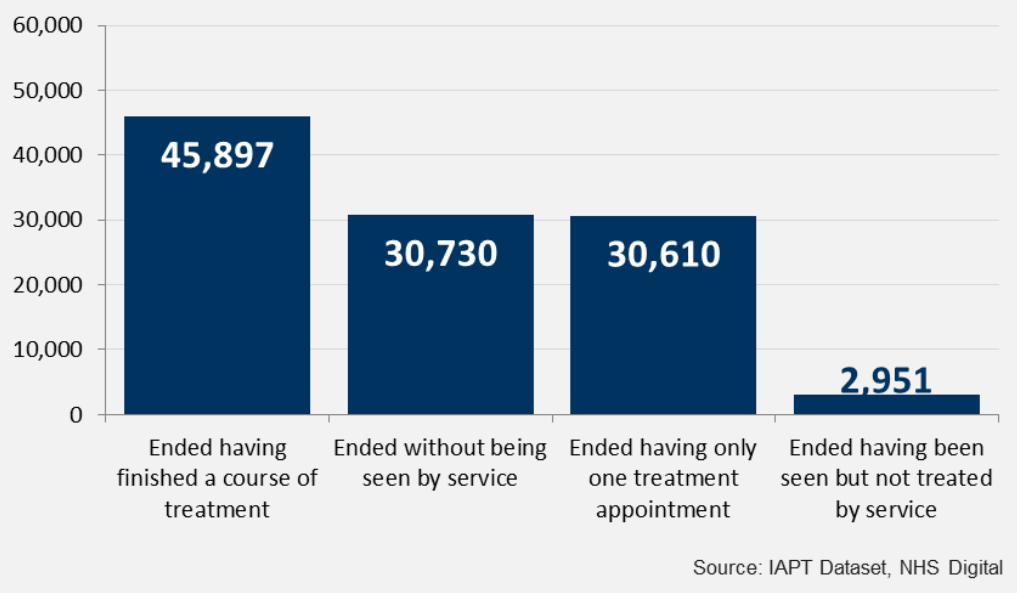
Figure 4 shows the relative volumes of referrals that were received, entered treatment, ended, and finished a course of treatment in each month.

There is a degree of seasonality in these volumes, with slightly less activity around December.

It is important to note that these numbers are not based on the same group of referrals as each other. A referral that was received in January 2017 did not necessarily enter treatment in this month, and is less likely again to have ended in the month.

The number of referrals that finished a course of treatment is a subset of all referrals that ended in the month. In January 2017, 41.7% of referrals that ended had finished a course of IAPT treatment. Referrals can end having had different levels of contact with the service; these are shown in figure 5 below.

Figure 5: Number of referrals that ended in January 2017 by level of contact with the service, England



Further breakdowns for activity

Each quarter, more detailed data are published about activity. The most recent quarterly data, Quarter 3 2016-17, shows the following :-

Of those who finished a course of treatment¹⁰:

Sex

64.9%
female

34.1%
male.

Working Age and older people¹¹

91.4%
aged 18 to 64

7.5%
aged 65 and over.

White British and BME¹²

14.8%
of BME ethnicities

78.6%
of White British.

Further breakdowns and measures can be found at <http://www.digital.nhs.uk/pubs/iaptjan17>.

¹⁰ Percentages for each variable will not sum to 100% as a subgroup was either not recorded or was recorded using an invalid code for some records.

¹¹ As of Quarter 2 2016-17 this is now based on variable 'Working Age' found in the Quarterly Activity Data File.

¹² As of Quarter 2 2016-17 this is now based on variable 'BME Group' found in the Quarterly Activity Data File.

Further information

Key resources

For an explanation of all measures in the Monthly & Quarterly Activity Data File CSVs, see the [IAPT Metadata Document](#).

For general guidance about IAPT publications, see the [IAPT Reporting FAQs](#).

For all historical IAPT publications, see <http://www.digital.nhs.uk/iaptreports>.

For the specification of the IAPT dataset, see the [IAPT v1.5 Technical Output Specification](#).

For the Public Health England Common Mental Health Disorder Profiling Tool ('Fingertips tool'), see <http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders>.

NHS Digital IAPT webpages

For context and resources related to monthly IAPT publications: <http://www.digital.nhs.uk/iaptmonthly>

For links to all historical IAPT publications: <http://www.digital.nhs.uk/iaptreports>

For resources related to the IAPT dataset: <http://www.digital.nhs.uk/iapt>

Low numbers and suppression

In order to protect patient confidentiality in IAPT publications, any figures based on a count of less than 5 referrals is suppressed by replacing the number with an asterisk (*).

In order to prevent suppressed numbers from being calculated through differencing other published numbers from totals, all sub-national counts have been rounded to the nearest 5.

Rates are presented as percentages and are based on unrounded numbers. In publications from November 2016 (August 2016 final data), changes to the suppression methodology were introduced. Sub-national rates are now rounded to the nearest whole percent to prevent disclosure. National rates are rounded to one decimal place.

Frequently Asked Questions

How do we construct our measures?

Definitions of all our measures, including criteria for which referrals are counted and how we have used submitted data fields to construct measures, can be found in the IAPT Metadata Document, available from <http://www.digital.nhs.uk/iaptmonthly>.

I am a provider and my local figures do not match those published - why is this?

There are several potential reasons why local figures do not match published data. The most common reason is due to NHS Digital suppression rules, which mean that published data for all but England totals are rounded to the nearest 5. Another common reason is that local data are on live systems, and a referral's status may have changed since the data were last submitted to NHS Digital.

NHS Digital send providers a Provider Analysis Validation Extract (PAVE) report each month to help them to reconcile local differences with published data. The specification for PAVE reports is available from <http://www.digital.nhs.uk/iaptmonthly>.

Where can I find access rates?

NHS Digital only publishes the numerator for the access rate calculation, which is the number of referrals entering treatment in the month (*FirstTreatment* in the Monthly Activity Data File CSV). The denominator is taken from the Adult Psychiatric Morbidity Survey, 2000. This information is not held at Provider or CCG level by NHS Digital and so is not included in our reports. However, it is available from NHS England at CCG level.

Where can I find KPI data?

The KPI reports ended at the end of 2012/13 and the NHS Digital IAPT reports are now the authoritative source of information. Although many of our published measures are based on the old KPI figures, a number of the constructions and methodologies have been updated over time and so our figures may not exactly replicate the old figures.

Published rates for the organisation I'm looking at don't match when I try to calculate them manually in the data. Why is this?

Published rates (*RecoveryRate*, *ImprovementRate*, *ReliableRecoveryRate*, *FirstTreatment6WeeksFinishedCourseRate*, *FirstTreatment18WeeksFinishedCourseRate*), are based on unrounded numbers, whereas counts are rounded to the nearest 5 in order to protect patient confidentiality. It is therefore not possible to manually calculate the true rates from published data, except at England level.

Where can I find past publications?

All historical IAPT publications are available from <http://www.digital.nhs.uk/iaptreports>.

When will IAPT data next be published?

The NHS Digital Publications Calendar (<http://www.digital.nhs.uk/pubs/calendar>) pre-announces all publication dates, including those for IAPT, at least 3 months in advance.

I can't find the measure I'm looking for in the Activity Data File CSV.

Because of the size and complexity of the IAPT dataset, as well as the level of interest in the IAPT programme, publications now contain a very large number of measures. To find a specific measure you are looking for, you can use the IAPT Metadata Document to search for a plain English description, and then find the corresponding column name in the Monthly or Quarterly Activity Data File CSV.

The IAPT Metadata Document is available from <http://www.digital.nhs.uk/iaptmonthly>.

Where can I find annual reports about IAPT?

All IAPT publications, including annual reports, can be found at <http://www.digital.nhs.uk/iaptreports>.

Where can I find out more about the clinical definitions, e.g. of therapy types used?

NHS Digital is responsible for the collection and publication of IAPT data only. For information about the IAPT programme generally, visit <https://www.england.nhs.uk/mentalhealth/adults/iapt/>.

Where can I learn more about the data quality of publications?

Monthly publications include two comprehensive data quality reports, one for the final data for the current month, and one related to the primary submission of next month's data (provisional data). These can be found within the 'Resources' section of each month's publication page.

In addition to these, a data quality statement, outlining considerations relevant to all IAPT publications, is available at <http://www.digital.nhs.uk/iaptmonthly>.

What do we mean by 'Final' and 'Provisional' data?

IAPT data are submitted to NHS Digital by care providers on a monthly basis, and providers have two opportunities to submit a given month of data – known as 'primary' and 'refresh' submission windows.

Each month, NHS Digital publish a data quality report for data based on a primary submission only, meaning that at this point providers have a subsequent opportunity to update their data. For this reason, we refer to this as 'provisional' data.

All published data in Monthly and Quarterly Activity Data Files, Executive Summaries, and Interactive Tools are based on refresh data having been received. A provider may choose not to send a refresh submission, in which case we take their primary submission as being correct. For this reason, we refer to these data as 'final' data.

Further information can be found in the IAPT Reporting FAQs Document, available at <http://www.digital.nhs.uk/iaptmonthly>.

Can I compare these data to previous publications?

Data from April 2015 Final onwards use the same methodology and so are comparable, subject to the considerations outlined in the IAPT Data Quality Statement available from <http://www.digital.nhs.uk/iaptmonthly>.

Publications prior to April 2015 Final were released on a quarterly basis and are not comparable with monthly publications for this reason.

Comparisons with data prior to July 2014 are not always possible, due to changes in the IAPT dataset. These changes are outlined in 'Methodological Change Note – IAPT version 1.5 reports' and 'Methodological Change Note – IAPT monthly reports', available from <http://www.digital.nhs.uk/iaptmonthly>.

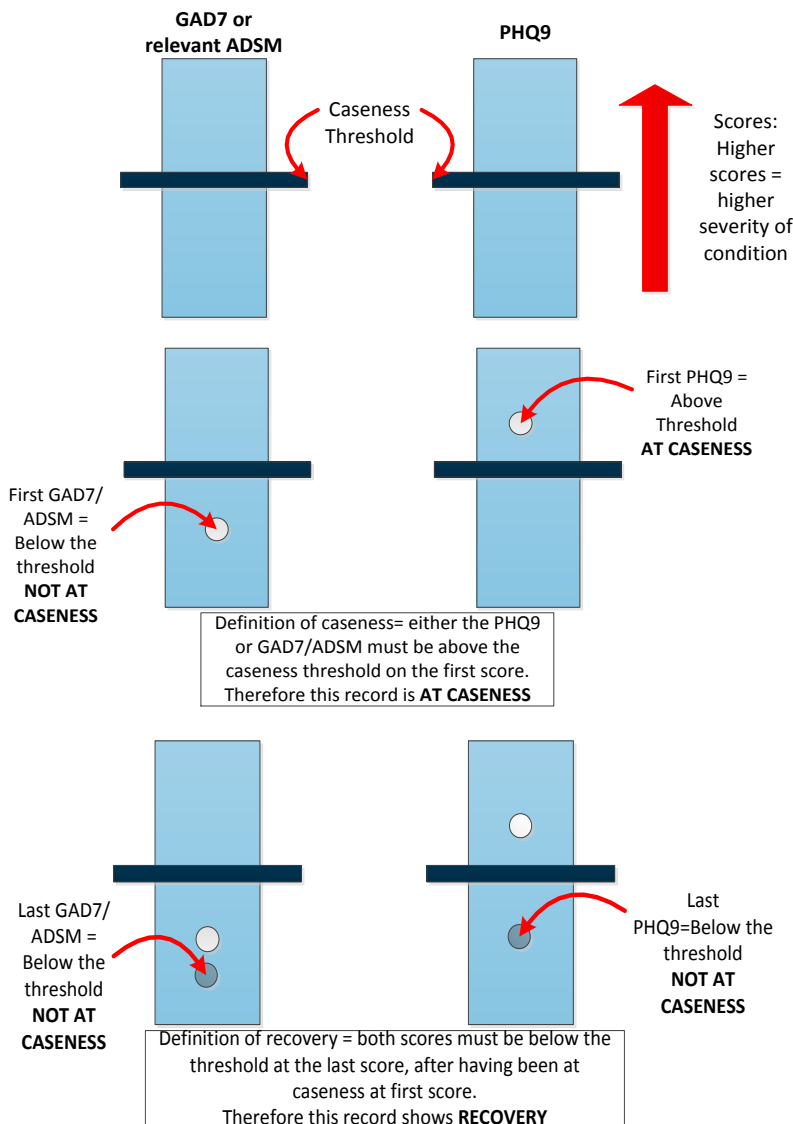
Appendix: Understanding outcome measures

Caseness

'Caseness' is the term used to describe a referral that scores highly enough on measures of depression and anxiety to be classed as a clinical case. It is measured by using the assessment scores that are collected at IAPT appointments; if a patient's score is above the clinical / non-clinical cut off¹³ (also known as the 'caseness threshold') on either anxiety, depression, or both, then the referral is classed as a clinical case ('at caseness').

Recovery

A referral is classed as 'recovered' if the patient finished a course of treatment and moved from being at caseness to not being at caseness by the end of the referral. To be considered as recovered, a patient needs to score below the caseness threshold on *both* anxiety and depression measures at the end of their treatment, to ensure that recovery is measured by looking at the welfare of the individual rather than one specific symptom. Referrals that started their course of treatment not at caseness are not included in recovery counts.



The blue bars represent scales, along which scores are recorded. The higher a referral scores on the measures of anxiety and depression, the higher the severity of their clinical condition.

A referral is 'at caseness' at the start of treatment if *either* the first recorded PHQ-9 score *or* the first recorded relevant ADASM score, or both, are **above** the caseness threshold.

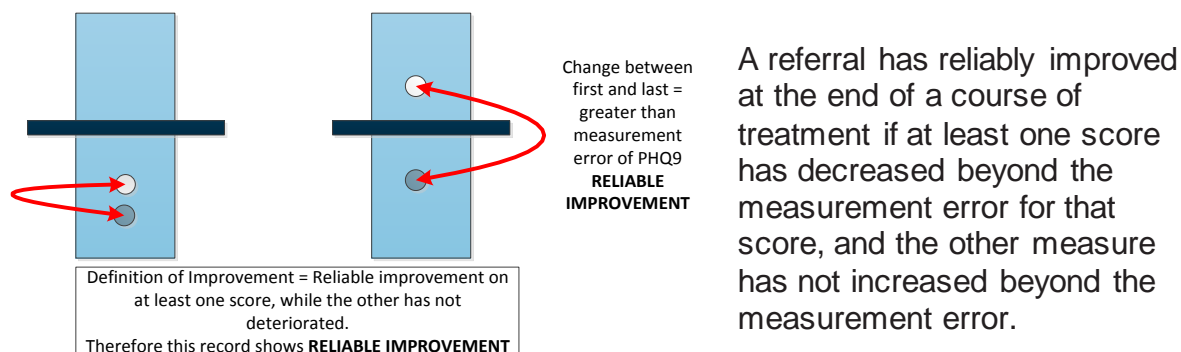
A referral has recovered at the end of a course of treatment if *both* the last recorded PHQ-9 score *and* the last recorded relevant ADASM score are **below** the caseness threshold.

¹³ Information on caseness thresholds can be found in the Glossary tab of the IAPT Metadata Document, available from <http://www.digital.nhs.uk/iaptmonthly>.

Reliable improvement

The assessment of recovery by examining simply whether a referral moves below the caseness threshold has a number of drawbacks. For example, there may be cases which do not move below the caseness threshold but still show a large improvement across their treatment. Conversely, referrals which were not above the caseness threshold at their first treatment may still have shown an improvement that is not reflected when looking solely at caseness. Further, scores for referrals that were 'border line', i.e. just over the caseness threshold on entering treatment, may only decrease by a small amount but still be counted as having recovered.

In order to account for these issues, we have also looked at the number of referrals that have shown reliable improvement, regardless of whether or not they were above the caseness threshold at the start of treatment. A referral is deemed to have shown reliable improvement if it shows a decrease in one or both assessment measure scores that surpasses the measurement error¹⁴ of that questionnaire. In addition, neither measure can show an increase beyond the measurement error. Equally, if a referral shows an increase in one or both scores that is more than the measurement error, they can be described as having reliably deteriorated.



Reliable recovery

Reliable improvement and recovery can be combined to create an overall measure of reliable recovery – a count of those referrals who show both a change from caseness to not being caseness during the course of the referral and which also show a reliable improvement in their score(s).

Combining the two measures also allows examination of the outcomes for 'border line' referrals, such as those which showed recovery with no improvement, or those which did not show recovery but did show improvement. In some cases it is even possible for an individual to show recovery but also deteriorate when evaluating both the PHQ-9 and ADMS.

¹⁴ This is the amount by which a difference could be attributable to natural variance. For more information on measurement errors for specific questionnaires, see the IAPT Metadata Document, available from <http://www.digital.nhs.uk/iaptmonthly>.

Glossary

Access

A government target for IAPT is that 15% of those with anxiety or depression should be treated through the IAPT programme¹⁵. NHS Digital calculates the numerator for access rates – which is the number of referrals entering treatment in a given period – but the denominator (the prevalence of depression and anxiety in the England population) has been determined by NHS England. This is based on figures from the Adult Psychiatric Morbidity Survey, 2000¹⁶.

Anxiety Disorder Specific Measure (ADSM)

Anxiety Disorder Specific Measures are questionnaires¹⁷ that are sensitive measures of the severity of particular anxiety disorders. The IAPT Data Handbook¹⁸ recommends relevant ADSMs for Obsessive-Compulsive Disorder, Generalised Anxiety Disorder, social phobia, health anxiety, agoraphobia, panic disorder, and Post-Traumatic Stress Disorder. If a patient receives a problem descriptor of one of these conditions, the relevant ADSM should be used to measure change in anxiety during treatment. If the relevant ADSM has not been given at least twice during a course of treatment, the GAD7 (IAPT's generic anxiety measure) is used to assess change in anxiety.

Assessment appointment

All IAPT appointments should be classified by their purpose. An assessment appointment is an attended appointment where the recorded appointment type is either 'assessment' or 'assessment and treatment'.

Caseness

Caseness is the term used to describe a referral that scores highly enough on measures of depression and anxiety to be classed as a clinical case. It is measured by using the scores that are collected at IAPT appointments; if a patient's score is above the clinical / non-clinical cut off¹⁹ on either their anxiety score, their depression score, or both, then the referral is classed as a clinical case.

Completed course of treatment

See 'Finished course of treatment' below.

¹⁵ For more information about this, see our FAQ document (page 17):

<http://www.digital.nhs.uk/media/21150/IAPT-Reporting-FAQs/pdf/iaptreportingfaqs.pdf>

¹⁶

http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4019414

¹⁷ Copies of each questionnaire can be found in the Appendices to the IAPT Data Handbook, available from <http://webarchive.nationalarchives.gov.uk/20160302154833/http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-appendicies-v2.pdf>

¹⁸ <http://webarchive.nationalarchives.gov.uk/20160302154833/http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf>

¹⁹ Information on the cut off values and how they should be used can be found in the IAPT data handbook:

<http://webarchive.nationalarchives.gov.uk/20160302154833/http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf>

Entered treatment

In order to enter treatment, a referral must have a first treatment appointment recorded in the period. Some measures based on the first treatment appointment (for example, waiting times) look at a cohort of referrals that ended in the year, as this group represents referrals that have undergone the full IAPT pathway.

Finished course of treatment

A referral that has finished a course of treatment is one that has ended having had at least two attended treatment appointments during the referral. Follow-up appointments do not count, since these should take place after the end of a course of treatment. All patients who have finished a course of treatment are eligible for assessment of outcome (recovery, reliable improvement, no reliable change, or reliable deterioration).

GAD7

The Generalised Anxiety Disorder-7²⁰ questionnaire is IAPT's default questionnaire for assessing the severity of anxiety. It was originally developed as a measure of Generalised Anxiety Disorder and can be used as an Anxiety Disorder Specific Measure (ADSM) for this clinical condition. However, it can also pick up changes in other anxiety disorders and is therefore used to measure change in anxiety where the relevant ADSM has not been given at least twice. The GAD7 should be recorded at every appointment.

National Institute for Health and Clinical Excellence (NICE)

NICE's role is to improve outcomes for people using the NHS and other public health and social care services. NICE approve and oversee therapy types used in the IAPT programme.

PHQ-9 questionnaire

The Public Health Questionnaire-9²¹ is IAPT's measure of the severity of depression and should be recorded at each appointment.

Problem descriptor

This describes the specific problem being assessed by the IAPT service for a given referral (for example, Obsessive Compulsive Disorder). The terminology was changed from 'provisional diagnosis' as it was felt that a formal diagnosis cannot always be made at initial contact with a patient, and that this sometimes only becomes apparent over the course of several appointments. For this reason, the problem descriptor can be updated in each submission. In the analysis of outcomes, the problem descriptor used is the last recorded one.

²⁰ A copy of the questionnaire can be found in the Appendices to the IAPT Data Handbook, available from <http://webarchive.nationalarchives.gov.uk/20160302154833/http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-appendicies-v2.pdf>

²¹ A copy of the questionnaire can be found in the Appendices to the IAPT Data Handbook, available from <http://webarchive.nationalarchives.gov.uk/20160302154833/http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-appendicies-v2.pdf>

Recovery (moving to recovery)

Recovery is one of the key outcome measures in IAPT, and services are monitored in terms of the proportion of eligible patients who recover (known as the 'recovery rate' or 'moved to recovery rate').

To be eligible for the assessment of recovery, a patient must have completed a course of IAPT treatment (see definition 'Finished course of treatment') having started their course of treatment at 'caseness' (see definition 'Caseness'). A patient has then moved to recovery if they are no longer at caseness at the end of their treatment.

Referral

In order to access IAPT services, an individual requires a referral. Referrals are often provided by General Practitioners (GPs), but there are many other sources of referral, including self-referral by the individual requiring the service. Once a referral has been received by a service provider, it should follow the recommended stepped care pathway²².

One patient can only have one open referral at a given provider at any one time, but could have multiple referrals across different providers or multiple referrals with the same provider across time. For this reason, a count of referrals is used, rather than a count of people, in IAPT publications.

There are three key stages for referrals in IAPT publications; referral received date, first treatment appointment date, and referral end date.

Reliable change (Reliable Improvement and Reliable Deterioration)

The severity of a patient's condition in IAPT is assessed using tailored questionnaires (ADSM and PHQ-9 scores). All measures of symptoms are subject to error. As a consequence, small changes in questionnaire scores may not indicate a real change in clinical state. A change of scores between the beginning and end of a course of treatment is considered a reliable change if it exceeds the measurement error of the questionnaire.

Conversely, patients have shown no reliable change if they fail to show reliable change on *both* anxiety and depression measures, or if reliable improvement is shown on one whilst reliable deterioration is shown on the other.

²² For further information, see 'Talking therapies: a four year plan of action' available at: <https://www.gov.uk/government/publications/talking-therapies-a-4-year-plan-of-action>

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