

Psychological Therapies: Annual Report on the use of IAPT services

England, 2014/15

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

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Executive Summary

This report provides a picture of activity in Improving Access to Psychological Therapies (IAPT) services and of the people that used them in 2014/15.

Key findings

Between 1st April 2014 and 31st March 2015:

1,267,193 referrals were received;

of which **495,721 (39.1%) were self-referrals.**

815,665 referrals entered treatment;

for which **32.0 days was the average (mean) waiting time between the referral and the first treatment appointment.**

1,123,002 referrals ended;

of which **468,881 (41.8%) finished a course of treatment;**

for which **6.3 was the average (mean) number of attended treatment appointments;**

and of which **285,060 (60.8%) showed reliable improvement;**

and **421,744 (89.9%) started treatment at caseness¹;**

of which **189,152 (44.8%) moved to recovery;**

and **180,300 (42.8%) showed reliable recovery.**

This year's report includes more detailed analysis presenting outcomes at sub-national geographies, for different types of problem, and different groups of patients. For example:

- 57 of 211 CCGs were able to meet or exceed the 50% recovery target²;
- The highest recovery rate was in NHS Cannock Chase CCG (69.4% of 680 referrals);
- The lowest recovery rate was in NHS Heywood, Middleton and Rochdale CCG (18.8% of 1,410 referrals);
- The CCG with the shortest average waiting time from referral to the first treatment appointment was NHS Dudley CCG at 6.7 days;
- The CCG with the longest average waiting time from referral to the first treatment appointment was NHS Blackpool CCG at 124.1 days;
- The majority (39.6%) of referrals that finished a course of treatment in 2014/15 were for people with anxiety and stress related disorders, for whom the recovery rate was 47.8%, compared to an overall recovery rate of 44.8%;
- The recovery rate for people identified as ex-British Armed Forces personnel was 47.1%.

¹ For an explanation of caseness, please see the Glossary at the end of this report.

² *The Mandate: A mandate from the Government to NHS England: April 2015 to March 2016*, p 16-17, available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386221/NHS_England_Mandate.pdf

Introduction

Content of this publication

This is the third annual report produced from the IAPT dataset and is intended to give an overall picture of IAPT services between 1st April 2014 and 31st March 2015, based on key measures of activity and outcomes. This is in addition to the monthly reports on specific measures that have been published throughout the year³.

This release consists of this report, as well as a series of data tables summarising key measures at England and Clinical Commissioning Group (CCG) levels, and is published at <http://www.hscic.gov.uk/pubs/psychther1415>. Descriptions of the methods used in the analysis are included within these data tables.

The IAPT dataset changed from version 1.0 to version 1.5 partway through the 2014/15 financial year⁴, meaning that direct comparisons between equivalent figures in the 2013/14 report⁵ should not be made.

Background to the IAPT programme

IAPT is an NHS programme implemented in England that offers interventions approved by the National Institute for Health and Care Excellence (NICE)⁶ for treating people with depression and anxiety disorders.

The programme was created to offer patients a realistic and routine first line treatment combined, where appropriate, with medication. The programme started in 2008 and was initially mainly focused on people of working age, but in 2010 was opened to adults of all ages.

The second phase of the programme was marked by the publication of 'Talking therapies: a four year plan of action'⁷ in February 2011. This plan was published alongside 'No health without mental health, a cross-government mental health outcomes strategy for people of all ages'⁸ with aims to expand the scope of the programme in future to children and young people, those with long-term physical conditions, those with medically unexplained symptoms, and those with severe mental illness.

The scale of the IAPT programme has expanded each year since 2008. The NHS Mandate⁹ stated that at least 15% of people with depression and/or anxiety disorders in the community should have access to treatment in IAPT services by 31st March 2015.

The IAPT programme is also designed to support the NHS in delivering:

- Access to services and treatments by people experiencing depression and anxiety disorders from all communities within the local population;

³ Please see <http://www.hscic.gov.uk/iaptreports> for a full list of available IAPT publications.

⁴ For detailed information about the changes, see http://www.hscic.gov.uk/media/15415/Methodological-change-2014-Improving-Access-to-Psychological-Therapies-IAPT-Reports/pdf/MethChange20141028_IAPT.pdf

⁵ See <http://www.hscic.gov.uk/pubs/psychther1314>

⁶ <https://www.nice.org.uk/>

⁷ 'Talking therapies: a four year plan of action' available at:

<https://www.gov.uk/government/publications/talking-therapies-a-4-year-plan-of-action>

⁸ 'No health without mental health, a cross-government mental health outcomes strategy for people of all ages' available at: <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

⁹ *The Mandate: A mandate from the Government to NHS England: April 2015 to March 2016*, p 16-17, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386221/NHS_England_Mandate.pdf

- Increased health and wellbeing, with at least 50% of those finishing a course of IAPT treatment moving to recovery and most experiencing a meaningful improvement in their condition;
- Patient choice, and high levels of satisfaction from people using IAPT services and their carers;
- Timely access to services;
- Improved employment, benefit, and social inclusion status; including help for people to retain employment, return to work, improve their vocational situation, and participate in the activities of daily living.

The IAPT dataset

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, including patient-reported outcomes recorded during treatment. The dataset¹⁰ also includes information from independent sector organisations who are providers of NHS-funded IAPT services. These data are received by the Health and Social Care Information Centre (HSCIC)¹¹.

Since quarter 1 of 2012/13, the HSCIC has produced quarterly data on access, activity, and outcomes from the dataset, as well as monthly data quality reports. The HSCIC began reporting access, activity, and outcomes data on a monthly basis from April 2015¹².

A new version of the IAPT reporting database was created as the data source for this report and any future analysis for the year. This reconciles the duplication and inconsistencies that occur across submissions to provide a coherent view of all data submitted for the year. This means there will be slight discrepancies between figures published in this report and figures for the year that might be calculated from published monthly and quarterly figures covering the same period. A more detailed explanation and a description of the method used for creating this annual database asset are included in Appendix 1.

Data Quality

The IAPT data published by the HSCIC are designated as official statistics and are produced to a level of quality that meets users' needs, and which informs users about the quality of statistical outputs. The HSCIC has published a separate Data Quality Statement¹³ that supports all HSCIC produced IAPT statistics including those covered within this report. This document highlights issues that could affect the quality of individual measures within this report.

In addition, as part of the standard monthly publications, two Data Quality reports about the validity, coverage and consistency of data submitted for the specific reporting period are also published. This information is presented at national and provider level, providing monthly measures on key issues. These monthly reports should be treated as the key source for any investigations into the quality of specific measures or breakdowns within this report. In particular, the validity of Generalised Anxiety Disorder (GAD7) scores, Patient Health Questionnaire (PHQ9) score and the recording of Appointment Type will have an impact on recovery and waiting time measurements. To assist readers of this report, a summary of submissions for the year by provider is included in Appendix 5, highlighting possible issues for consideration when interpreting local analysis.

¹⁰ For more information about the IAPT dataset, see Appendix 1 of this report.

¹¹ <http://www.hscic.gov.uk>

¹² For a full list of IAPT reports published by the HSCIC, see <http://www.hscic.gov.uk/iaptreports>.

¹³ <http://www.hscic.gov.uk/media/16923/IAPT-DQ-Month/pdf/IAPT-month-dqs.pdf>

In this annual publication, patients for whom the information submitted would not support the allocation of a reliable pseudo identifier – known as ‘bypass patients’¹⁴ – have been excluded from our analysis. This is because the information would not support the calculation of waiting times and outcomes. Readers should be aware that this will impact any comparisons with published monthly and quarterly counts of Referrals Received in this reporting year. In 2014/15, there were 11,113 referrals received that were ‘bypass’ patients (0.9% of all referrals received).

Feedback

We welcome feedback on the utility of these statistics, as well as any other comments you would like to make. If you wish to provide feedback, you can contact us through enquiries@hscic.gov.uk (please include ‘IAPT’ in the email subject line).

Key measures and concepts

Below is a list of some key concepts in understanding this patient pathway and the wider IAPT programme. Other useful terms are defined in the Glossary, found at the end of this report.

Referrals

In order to access IAPT services, an individual requires a referral. Referrals are often provided by General Practitioners (GPs), but there may be other potential sources of referral, including self-referral by an individual. Once a referral has been received, it should follow the recommended stepped care pathway¹⁵.

One patient can only have one open referral at a provider at any given time, but could have multiple referrals across different providers or multiple referrals in the same provider across the year.

In most cases a count of referrals is used, rather than a count of people, when looking at activity in IAPT services, including recovery.

Treatment appointment

At a treatment appointment, the therapist will deliver a NICE-recommended therapy appropriate to the patient’s problem, and patients will also be asked to complete well-validated¹⁶ questionnaires that assess the severity of their clinical condition¹⁷. The two main questionnaires are:

- Patient Health Questionnaire (PHQ-9), which assesses the severity of depression;
- A questionnaire that assesses the severity of anxiety – either the Generalised Anxiety Disorder scale (GAD7) or another appropriate Anxiety Disorder Specific Measure (ADSM).

The IAPT dataset also records the type of problem, the type of therapy delivered, and the extent to which the problem interferes with everyday functioning (as assessed by the Work & Social Adjustment Scale).

¹⁴ See Glossary for an explanation.

¹⁵ 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>

¹⁶ For further information, see <http://www.iapt.nhs.uk/silo/files/the-iapt-data-handbook.pdf>

¹⁷ A full list of these questionnaires, their scores, and thresholds for assessing caseness for each score can be found in Appendix 3 of this report.

Finished course of treatment

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

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 off¹⁸ on either anxiety, depression, or both, then the referral is classed as a clinical case.

Recovery

A referral is classed as 'recovered' if the patient finished a course of treatment and moved from 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. This is an unusually strict criterion which reflects the IAPT programme's aim to ensure that people show broad recovery, rather than just reduction in one specific clinical state. Referrals that started their course of treatment not at caseness are not included in recovery counts.

Reliable change

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 error¹⁹ of the questionnaire.

Reliable improvement/deterioration

Patients are classed as having shown reliable improvement if they show a reliable decrease in their anxiety or depression score between the first and last measurement, and the other clinical state (depression or anxiety) either also reliably decreases or shows no reliable change.

It is possible for people to show deterioration, as well as improvement, during a course of therapy. Patients are classed as having shown reliable deterioration if they show a reliable increase in anxiety or depression score between the first and last measurement, and the other clinical state (depression or anxiety) either also reliably increases or shows no reliable change.

Reliable recovery

If a patient meets the criteria for both recovery and reliable improvement when they have finished a course of treatment, they are said to have reliably recovered.

¹⁸ Information on the cut off values and how they should be used can be found in the IAPT data handbook: <http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf>

¹⁹ For more information on reliable change, see Jacobsen, N.S. & Truax, P. (1991), 'Clinical Significance: A Statistical Approach to Defining Meaningful Change in Psychotherapy Research', *Journal of Consulting and Clinical Psychology*, 59, p12-19.

Outcome measures in IAPT

This section describes the key measures of outcome in IAPT, which meet the stated aims of the programme in delivering:

- Access to services and treatments by people experiencing depression and anxiety disorders from all communities within the local population;
- Increased health and wellbeing, with at least 50% of those finishing a course of IAPT treatment moving to recovery and most experiencing a meaningful improvement in their condition.

The key measures are recovery, reliable improvement, and reliable recovery, analysed by a range of factors such as the referral's problem descriptor code, the type of therapy given, demographic factors, and by CCG.

Recovery

Key facts about recovery

- The government target for recovery, up to the 31st March 2015, was that 50% of referrals to IAPT services should move to recovery by the end of their course of treatment.
- Nationally, there were 421,744 referrals that finished a course of treatment in the year that started treatment at caseness, and 189,152 referrals that moved to recovery; this gives a recovery rate of 44.8%.
- 57 of 211 CCGs were able to meet or exceed the 50% recovery target.
- The highest recovery rate was in NHS Cannock Chase CCG (69.4% of 680 referrals)
- The lowest recovery rate was in NHS Heywood, Middleton and Rochdale CCG (18.8% of 1,405 referrals).

One of the key outcome measures relating to the IAPT service is the measurement of recovery, calculated from clinician-recorded outcome tools. These are designed to allow therapists to track the progress of patients, but the first and last recorded scores against each measure can also be used to determine whether recovery has been achieved. Higher scores on the questionnaire measures indicate a higher severity of illness.

1,123,002 referrals ended in 2014/15;

of which **468,881** finished a course of treatment (has had at least two attended treatment appointments);

of which **421,744** started treatment at 'caseness' – this means that *either* the first recorded PHQ-9 score *or* the first recorded relevant ADSM score, or both, was above the caseness threshold;

of which **189,152 (44.8%)** recovered. This means that *both* the last recorded PHQ-9 *and* the last recorded relevant ADSM score were below the caseness threshold.

Calculating recovery rates

Number of referrals that finished a course of treatment in the year and moved from caseness at the start of treatment to not caseness at the end of treatment

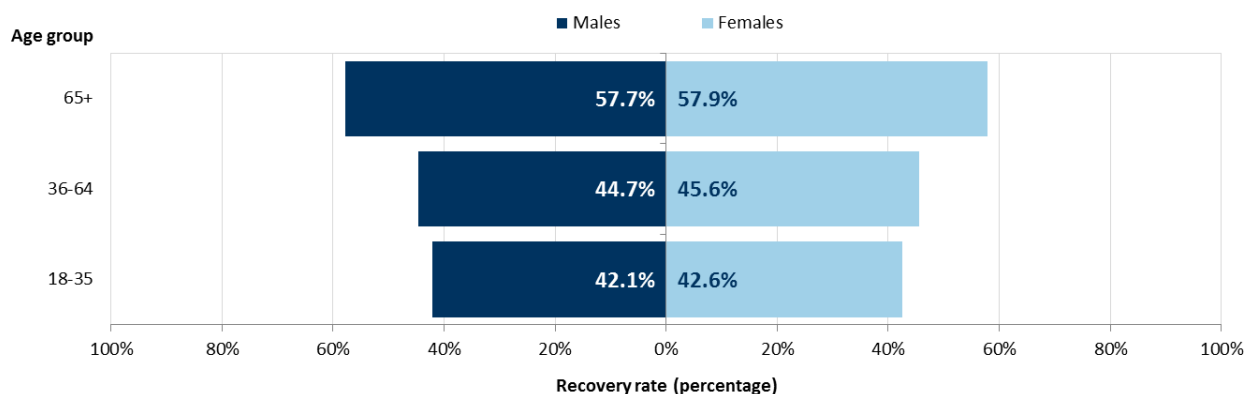
$$\frac{\left(\begin{array}{l} \text{Number of referrals} \\ \text{that finished a course} \\ \text{of treatment in the} \\ \text{year} \end{array} - \begin{array}{l} \text{Number of referrals that} \\ \text{finished a course of treatment} \\ \text{and started treatment not at} \\ \text{caseness} \end{array} \right)}{\text{Number of referrals that finished a course of treatment in the year}} \times 100 = \text{Recovery rate}$$

It is important to note that all referrals that finished a course of treatment are included in the denominator for the recovery rate formula, even if outcome data (i.e. depression and anxiety scores) are missing. By contrast, the numerator only includes people who have outcome data and where that data demonstrates recovery. This ensures that providers are incentivised to have high data completeness for these fields, as poor data quality for referrals finishing a course of treatment will result in a lower recovery rate.

Recovery rates by age and gender

Figure 1 below shows that, broadly, recovery rates are similar between males and females, and are generally higher amongst older patients, peaking at 57.7% for males and 57.9% for females aged 65 and over.

Figure 1: Recovery rates²⁰ by age and gender, 2014/15

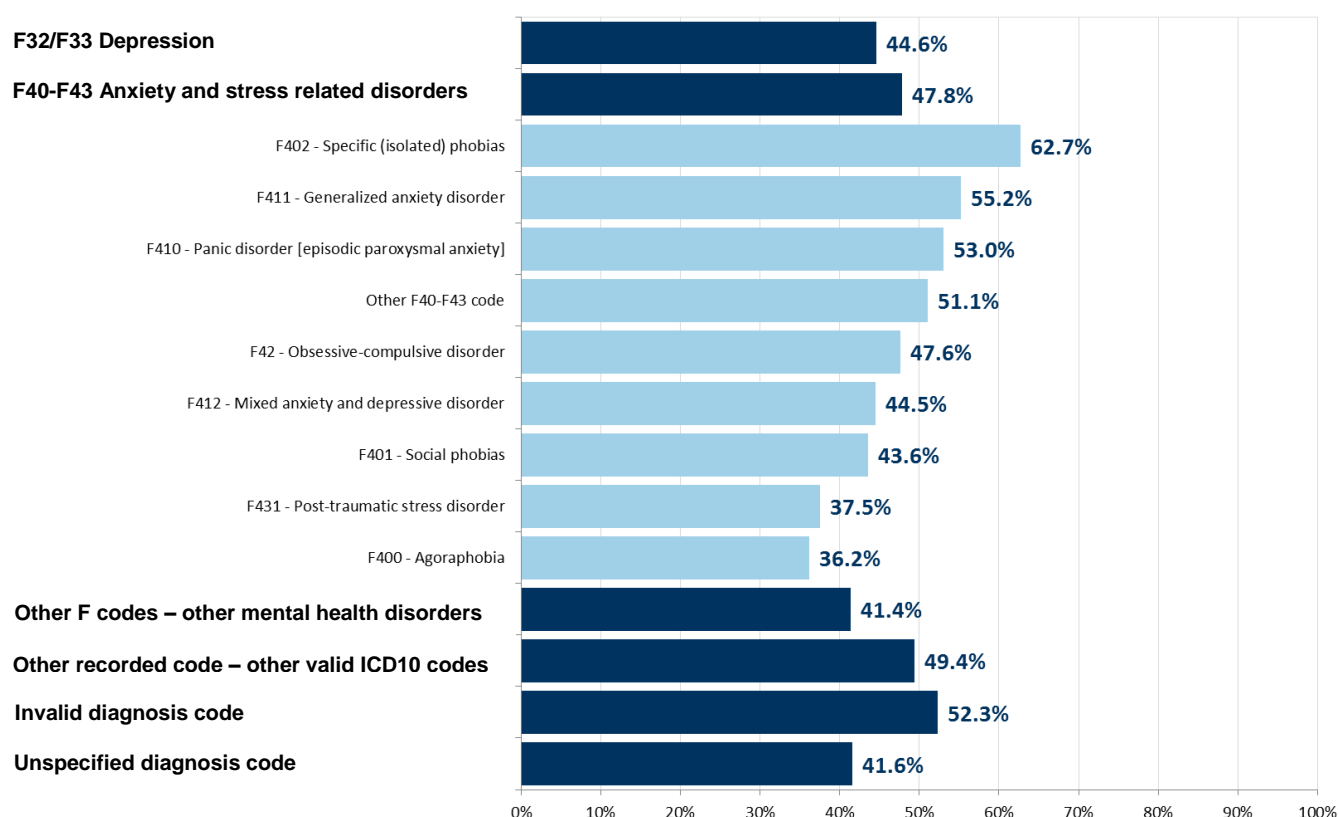


²⁰ Only activity for patients aged 18 and over is shown, but a small number of patients under the age of 18 are recorded as accessing the adult IAPT services covered by this dataset.

Recovery rates by problem descriptor and therapy type

IAPT services aim to implement NICE guidance when providing treatment for different clinical problems. Figure 2 below shows the recovery rate for different problem descriptor codes. It shows that recovery rates are slightly higher amongst referrals with a problem descriptor of anxiety and stress related disorders. Amongst this group, those with a specific problem descriptor of 'specific (isolated) phobias' had the highest rate of recovery (62.7%), and those with a problem descriptor of agoraphobia had the lowest recovery rate (36.2%).

Figure 2: Recovery rates by problem descriptor²¹, 2014/15



NICE's recommendations vary with the severity and type of problem. For many mild to moderate cases NICE recommends a stepped care model with most people being offered a course of a low intensity intervention (such as guided self-help or computerized cognitive-behaviour therapy) first. People who recover with the low intensity intervention are discharged. Those with continuing symptoms should be offered a "step-up" to a high intensity therapy. People with more severe symptoms or with social anxiety disorder or PTSD would normally be expected to go straight to high intensity therapy. NICE recommends a range of high intensity therapies for depression. These include cognitive-behaviour therapy (CBT), interpersonal psychotherapy (IPT), couples therapy, counselling and brief psychodynamic therapy. Currently, NICE only recommends CBT as a high intensity for anxiety disorders.

The 2nd Annual IAPT Report showed recovery rates for different clinical problems. This report goes further by also reporting recovery rates by the last therapy that a person received before finishing their course of treatment in IAPT.

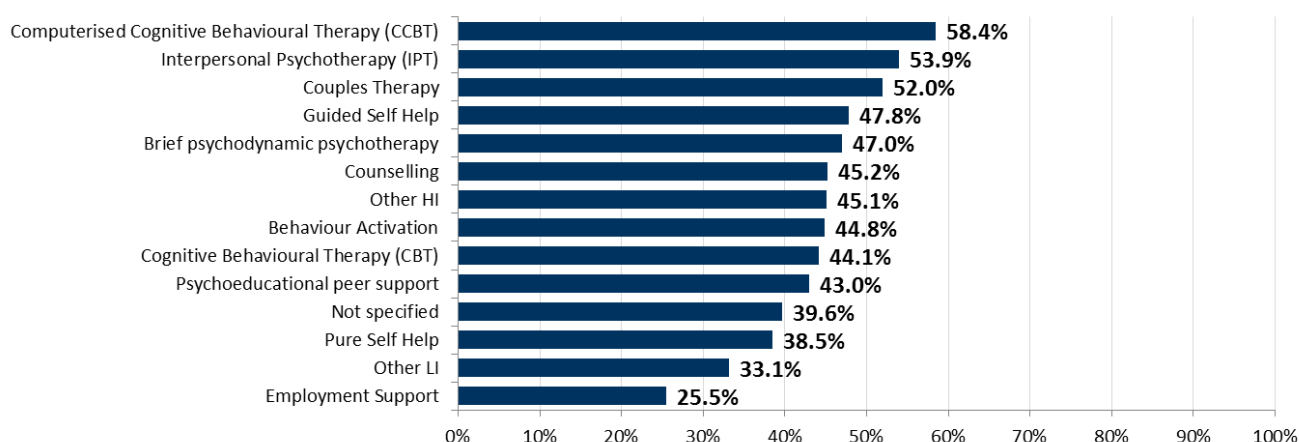
²¹ Problem descriptor codes are based on ICD-10 international standards for the classification of diseases and have been grouped for presentation purposes. For further information, see the 'Constructions' worksheet of the data tables that accompany this report, as well as the IAPT Technical Output Specification, available from <http://www.hscic.gov.uk/iapt>.

Readers should be aware that variation in recovery rates between different last therapy types is likely to be influenced by a range of factors in addition to the effects of the therapies themselves. For example, none of the people who failed to recover at low intensity and were stepped up to high intensity will be included in the calculation of recovery rates for people with a low intensity therapy as their last therapy. Initial symptom severity levels may have differed between therapy types. Some therapies were available in all IAPT services and some were only available in a subset of services. IAPT services should offer patients choice and it is likely that different therapies appeal to different people. Finally, among the high intensity therapies there is variation in the extent to which people had previously had a course of low intensity therapy. Despite this complexity, analysis of rates by last therapy type provides an indication of the extent to which people with different problems recover while receiving different types of therapy.

Figure 3 below shows recovery rates for the various therapy types offered where the problem descriptor was depression; NICE recommends a full range of therapies for this condition, whereas many therapy types are not recommended for anxiety disorders and so the number of people with anxiety disorders who received some therapies will be very small for these groups. Further detail on the numbers and rates of recovery for a wider range of problem descriptor and therapy type combinations can be found in tables 5a and 5b of the data tables that accompany this report²².

Figure 3 also shows that, for referrals with a problem descriptor of depression, Computerised Cognitive Behavioural Therapy (CCBT) has the highest rate of recovery.

Figure 3: Recovery rates by therapy type for referrals with a problem descriptor of depression, 2014/15²³



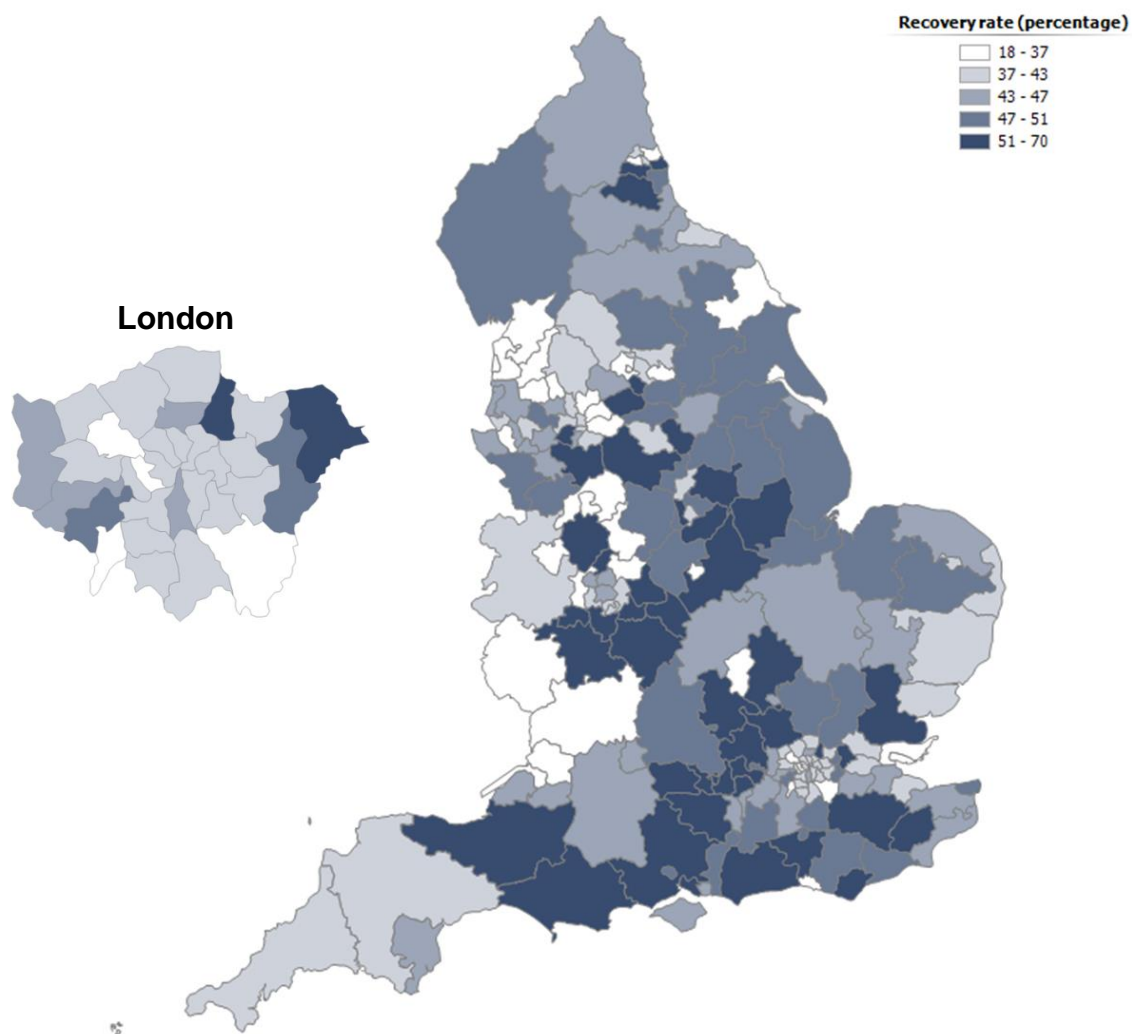
²² <http://www.hscic.gov.uk/pubs/psycther1415>

²³ This chart has been reproduced since its original publication to correct an identified error.

Recovery rates by Clinical Commissioning Group

In 2014/15, 57 of 211 CCGs were able to meet or exceed the 50% recovery rate target. Figure 4 below divides CCGs into five approximately equal sized groupings based on their recovery rates. Broadly, there is a greater number of CCGs with observed higher rates of recovery located in the South compared to the North West, where a greater number of CCGs with observed lower recovery rates are located.

Figure 4: Recovery rates by Clinical Commissioning Group, 2014/15



Reliable improvement

Key facts about reliable improvement

- Nationally, there were 468,881 referrals that finished a course of treatment in the year, and 285,060 referrals that reliably improved; this gives a reliable improvement rate of 60.8%.
- 193 of 211 CCGs had a reliable improvement rate of over 50%.
- The highest reliable improvement rate was in NHS South West Lincolnshire CCG (76.8% of 1,390 referrals)
- The lowest reliable improvement rate was in NHS East Staffordshire CCG (24.8% of 460 referrals).

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.

1,123,002 referrals ended in 2014/15;

of which **468,881** finished a course of treatment (has had at least two attended treatment appointments);

of which **285,060 (60.8%)** have shown a decrease in one or both assessment measure scores that surpasses the measurement error²⁴ of that questionnaire, and neither score has shown 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 for that score, then they are described as having reliably deteriorated. **29,144** referrals reliably deteriorated in 2014/15.

²⁴ This is the amount by which a difference could be attributable to natural variance. For more information on measurement errors for specific questionnaires, the 'IAPT Reporting FAQs', available from: http://www.hscic.gov.uk/media/18182/IAPT-Reporting-FAQs/pdf/Understanding_and_replicating_our_published_reports_July_2015_v1.2.pdf

Calculating reliable improvement rates

Number of referrals that finished a course of treatment in the year, and have shown a decrease beyond the measurement error for at least one assessment score and no increase beyond the measurement error in the other score

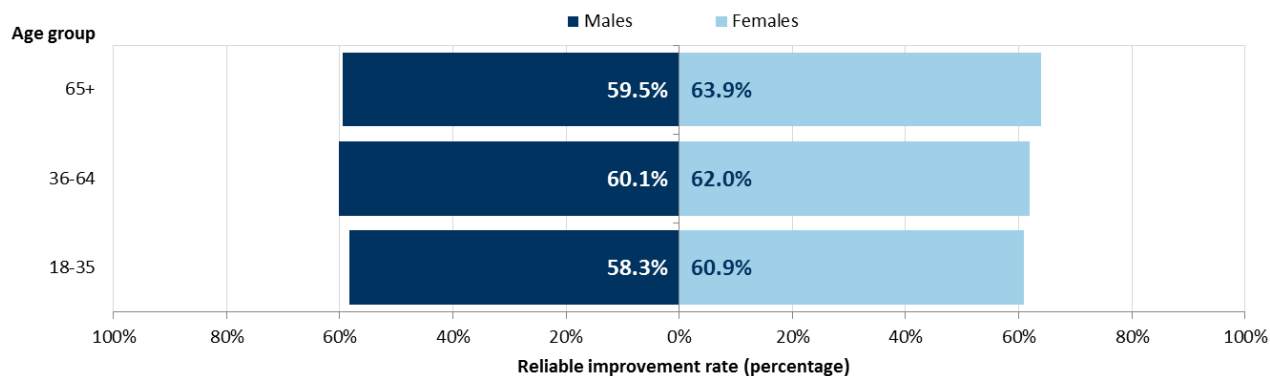
Number of referrals that have finished a course of treatment in the year

$$\frac{\text{Number of referrals that finished a course of treatment in the year, and have shown a decrease beyond the measurement error for at least one assessment score and no increase beyond the measurement error in the other score}}{\text{Number of referrals that have finished a course of treatment in the year}} \times 100 = \text{Reliable improvement rate}$$

Reliable improvement rates by age and gender

Figure 5 below shows that, as with recovery rates, reliable improvement rates are broadly similar between males and females, and increase slightly with age.

Figure 5: Reliable improvement rates by age²⁵ and gender, 2014/15

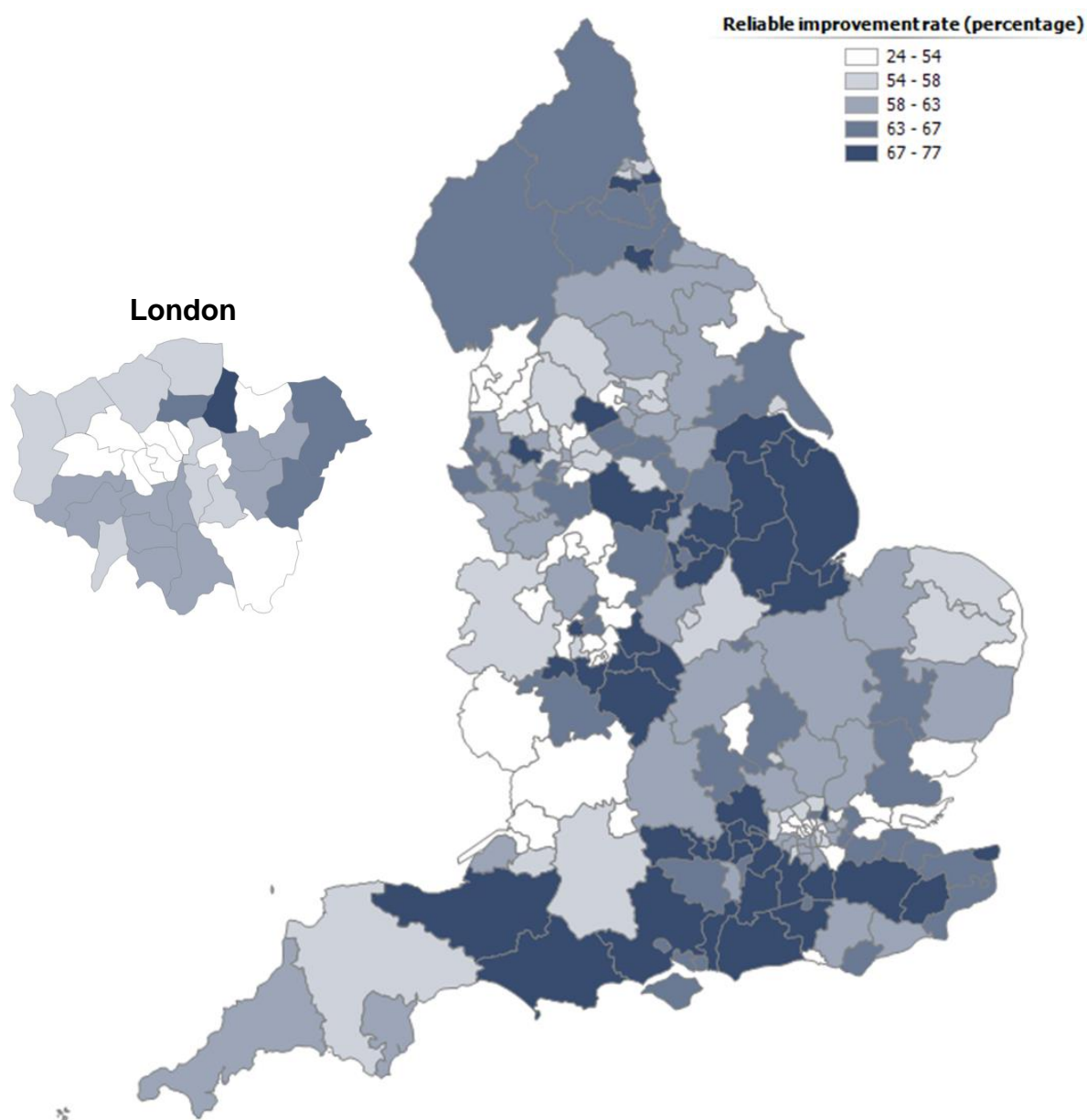


²⁵ Only activity for patients aged 18 and over is shown, but a small number of patients under the age of 18 are recorded as accessing the adult IAPT services covered by this dataset.

Reliable improvement rates by Clinical Commissioning Group

In 2014/15, 193 of 211 CCGs achieved a reliable improvement rate of at least 50%. Figure 6 below divides CCGs into five approximately equal sized groupings based on their reliable improvement rates. Broadly, CCGs located in the south and east midlands tend to have higher rates of reliable improvement, and those located in the north-west and west tend to have lower rates.

Figure 6: Reliable improvement rates by Clinical Commissioning Group, 2014/15



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 reliable improvement, or those which did not show recovery but did show reliable improvement. In some cases it is even possible for an individual to show recovery but also deteriorate when evaluating both the PHQ-9 and ADOS²⁶.

Calculating reliable recovery rates

Number of referrals that finished a course of treatment in the year and moved from caseness at the start of treatment to not caseness at the end of treatment, and have shown a decrease beyond the measurement error for at least one assessment score and no increase beyond the measurement error in the other score

$$\frac{\left(\begin{array}{l} \text{Number of referrals} \\ \text{that finished a course} \\ \text{of treatment in the} \\ \text{year} \end{array} - \begin{array}{l} \text{Number of referrals that} \\ \text{finished a course of treatment} \\ \text{and started treatment not at} \\ \text{caseness} \end{array} \right)}{\times 100} = \text{Reliable recovery rate}$$

Table 1: Summary of referrals moving to recovery²⁷, reliable improvement²⁸ and reliable recovery²⁷ above by NHS Commissioning Region

	Recovery	Reliable Improvement	Reliable Recovery
England	189,152 (44.8%)	285,060 (60.8%)	180,300 (42.8%)
Y54 North of England Commissioning Region	56,235 (43.1%)	86,830 (60.5%)	53,955 (41.4%)
Y55 Midlands and East of England Commissioning Region	51,865 (46.1%)	76,015 (60.8%)	49,490 (44.0%)
Y56 London Commissioning Region	24,385 (41.6%)	37,805 (56.9%)	23,055 (39.3%)
Y57 South of England Commissioning Region	56,350 (47.2%)	83,915 (63.0%)	53,505 (44.8%)
Unknown	315 (38.8%)	490 (52.5%)	295 (36.2%)

Table 1 above shows that in 2014/15 there were 180,300 referrals that showed reliable recovery in the year; 42.8% of the number of referrals that finished a course of treatment and were at caseness at the start of their treatment. This is 2.0% lower than those showing recovery only, which is to be expected since reliable recovery is a more stringent measure. The same pattern is seen across all NHS Commissioning Regions.

²⁶ A full picture of the possible pathways a referral can take can be found in Appendix 2 of this report.

²⁷ The denominator used in recovery and reliable recovery rates is the number of referrals completing a course of treatment in the year minus those who were not at caseness at the start of their treatment.

²⁸ The denominator used to calculate reliable improvement rates is the number of referrals completing a course of treatment in the year, regardless of whether or not they were at caseness at the start of their treatment.

Referrals for ex-British Armed Forces personnel

The IAPT dataset is unique compared to other national mental health datasets in that it contains a flag to identify referrals as relating to ex-British Armed Forces personnel (including dependants)²⁹.

Between 1st April 2014 and 31st March 2015:

18,579 referrals were received for ex-British Armed Forces personnel (including dependants);

14,953 referrals entered treatment for ex-British Armed Forces personnel (including dependants);

9,074 referrals for ex-British Armed Forces personnel (including dependants) finished a course of treatment;

of which **8,111 (89.4%)** started treatment at caseness³⁰;

of which **3,824 (47.1%)** moved to recovery.

Further information at CCG-level is available within the data tables that accompany this report.

²⁹ For more information, see the IAPT Technical Output Specification, available from <http://www.hscic.gov.uk/iapt>.

³⁰ For an explanation of caseness, please see the Glossary at the end of this report.

Waiting times

Key facts about waiting times from referral to first treatment appointment

- Nationally, 815,665 referrals entered treatment in 2014/15, of which:
 - 545,323 (66.9%) waited 28 days or less;
 - 154,868 (19.0%) waited between 29 and 56 days;
 - 57,333 (7.0%) waited between 57 and 90 days, and;
 - 58,141 (7.1%) waited more than 90 days.
- 416,364 ended prior to treatment.
- 32.0 days was the average (mean) waiting time between referral and first treatment appointment.

One of the aims of the IAPT programme is to ensure that patients referred to IAPT services do not wait longer than is necessary to begin their treatment. Government targets for waiting times were first introduced part-way through this financial year³¹ and performance against these targets have been reported by the HSCIC in monthly publications from January 2015³².

The targets are now based on referrals that finished a course of treatment, but this report focuses on the previous method of reporting waiting times for referrals entering treatment in the year, in line with most quarterly reports published in 2014/15. Waiting times are measured from the point a provider receives a referral to the point at which the patient first attends a treatment appointment. The measurement does not take into account patients who fail to attend a first appointment.

To calculate waiting times, a referral must have entered treatment in the year - **815,665** referrals entered treatment in 2014/15.

Calculating waiting times rates

Number of referrals that entered treatment in the year and waited less than X days for their first treatment appointment

Number of referrals that entered treatment in the year

$\times 100$

=

Percentage of referrals entering treatment that waited less than X days for treatment

Figure 7 below shows the distribution of waiting times in England and its constituent NHS Commissioning Regions in 2014/15.

Nationally, 66.9% of referrals entering treatment in the year waited less than 28 days. 73.7% of those entering treatment in South of England Commissioning Region waited 28 days or less, compared to 68.3% of those in London Commissioning Region, 66.0% of those in

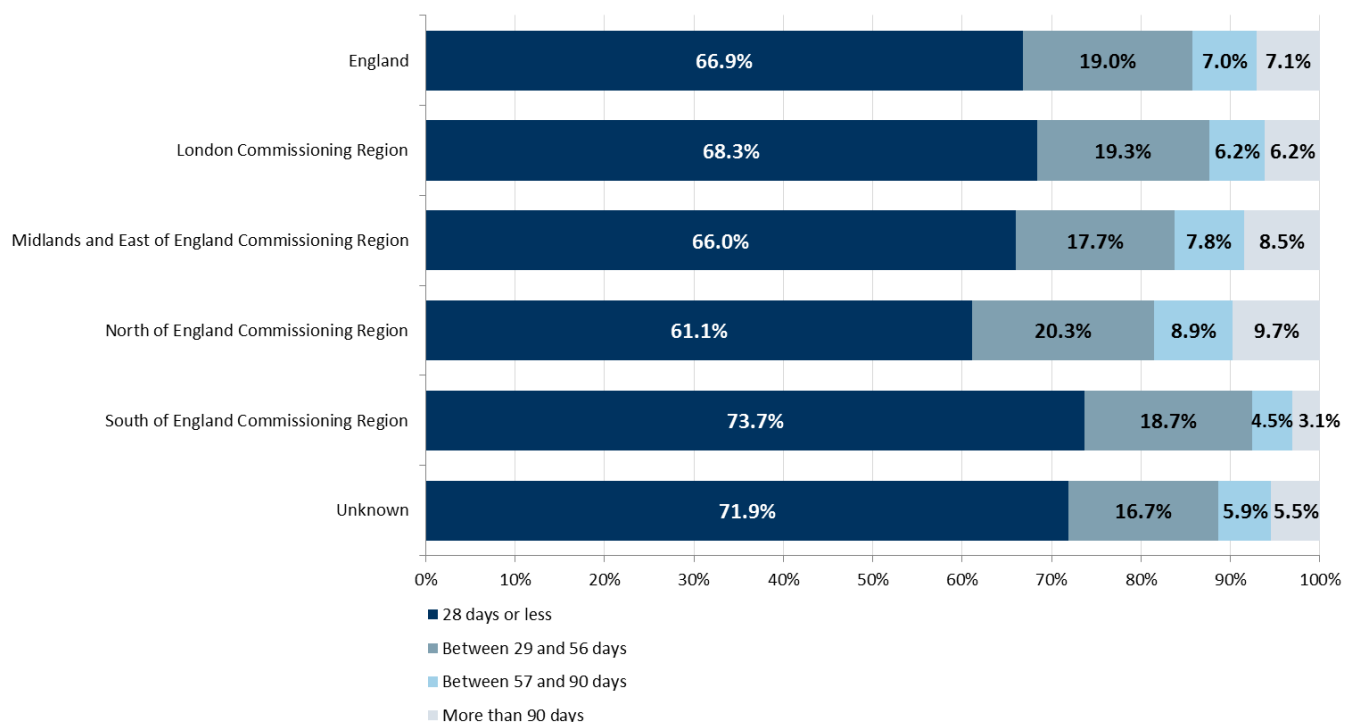
³¹ These targets have been published in 'Achieving Better Access to Mental Health Services by 2020' p17, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf

³² See <http://www.hscic.gov.uk/iaptreports> for a full list of IAPT publications released by the HSCIC.

Midlands and East of England Commissioning Region, and 61.1% of those in North of England Commissioning Region.

Nationally, 7.1% waited longer than 90 days from referral to first treatment appointment. 9.7% of those in North of England Commissioning Region waited longer than 90 days, compared to 8.5% of those in Midlands and East of England Commissioning Region, 6.2% of those in London Commissioning Region, and 3.1% of those in South of England Commissioning Region.

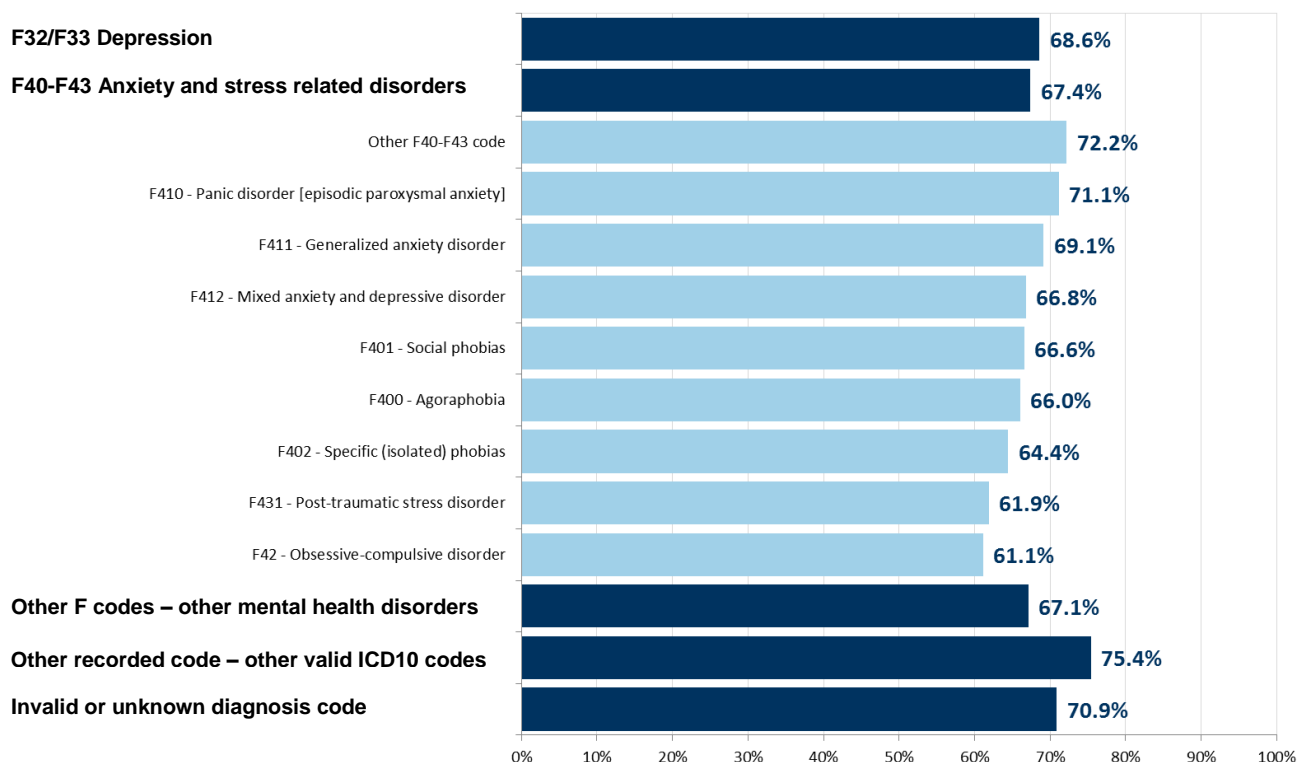
Figure 7: Distribution of waiting times for referrals that entered treatment, 2014/15



Waiting times by problem descriptor

Figure 8 below shows referrals that waited 28 days or less from referral to first treatment appointment as a percentage of all referrals entering treatment, split by problem descriptor. The rates are largely similar between depression and total anxiety and stress related disorders; however, for specific anxiety and stress related disorders there is some variation. Those coded as 'other F40-F43 code' have the highest rate of referrals waiting 28 days or less, and referrals for Obsessive-compulsive disorder show the lowest rate.

Figure 8: Waiting times: percentage of referrals waiting 28 days or less by problem descriptor³³, 2014/15



³³ Problem descriptor codes are based on ICD-10 international standards for the classification of diseases and have been grouped for presentation purposes. For further information, see the 'Constructions' worksheet of the data tables that accompany this report, as well as the IAPT Technical Output Specification, available from <http://www.hscic.gov.uk/iapt>.

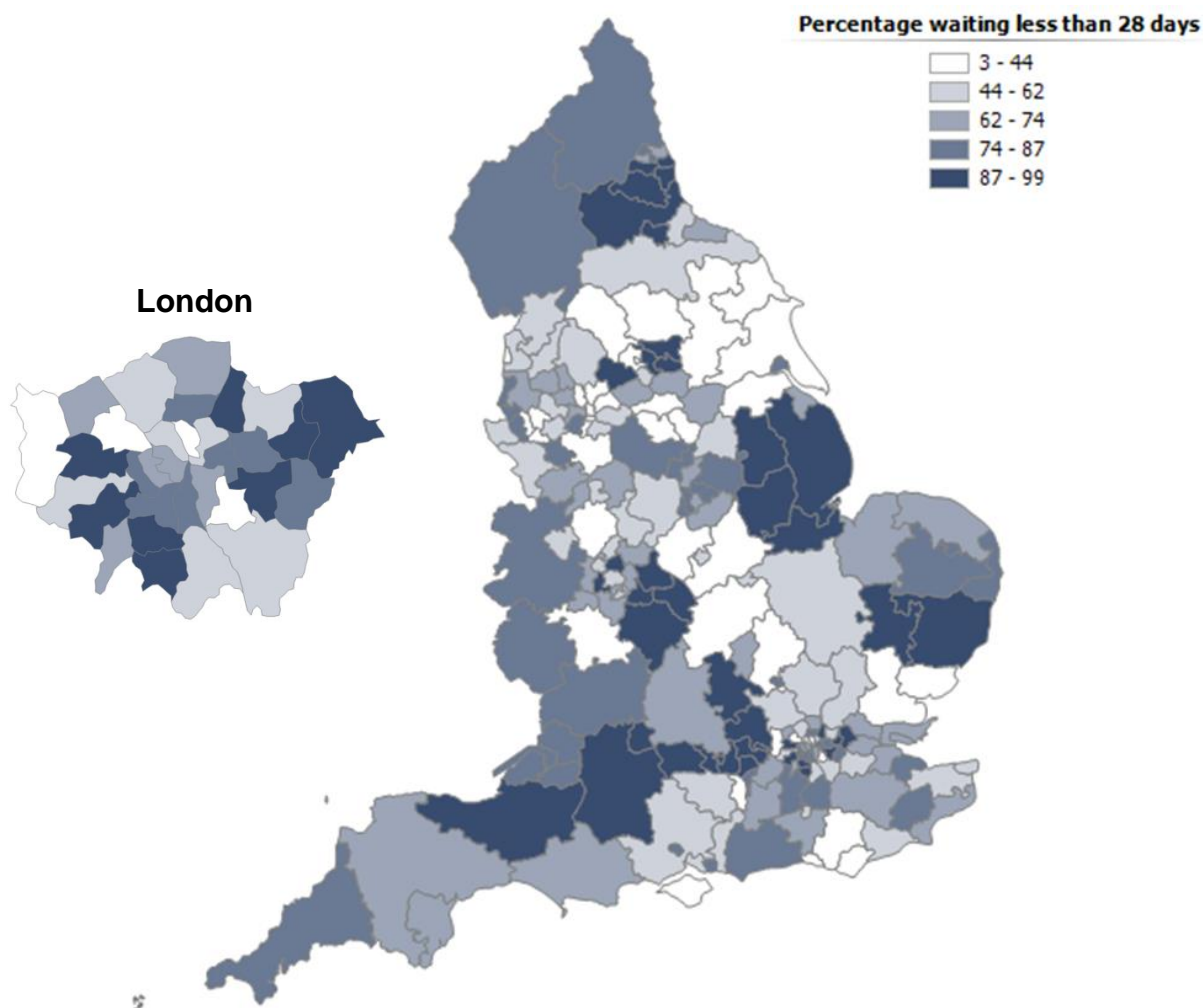
Waiting times by Clinical Commissioning Group

Figure 9 divides CCGs into approximately five equal groups based on referrals that waited 28 days or less from referral to first treatment appointment, as a percentage of all referrals entering treatment.

Broadly, a range of CCGs had a high percentage of referrals waiting less than 28 days. However, a number of CCGs located throughout the North can be seen to have a low percentage of referrals waiting less than 28 days.

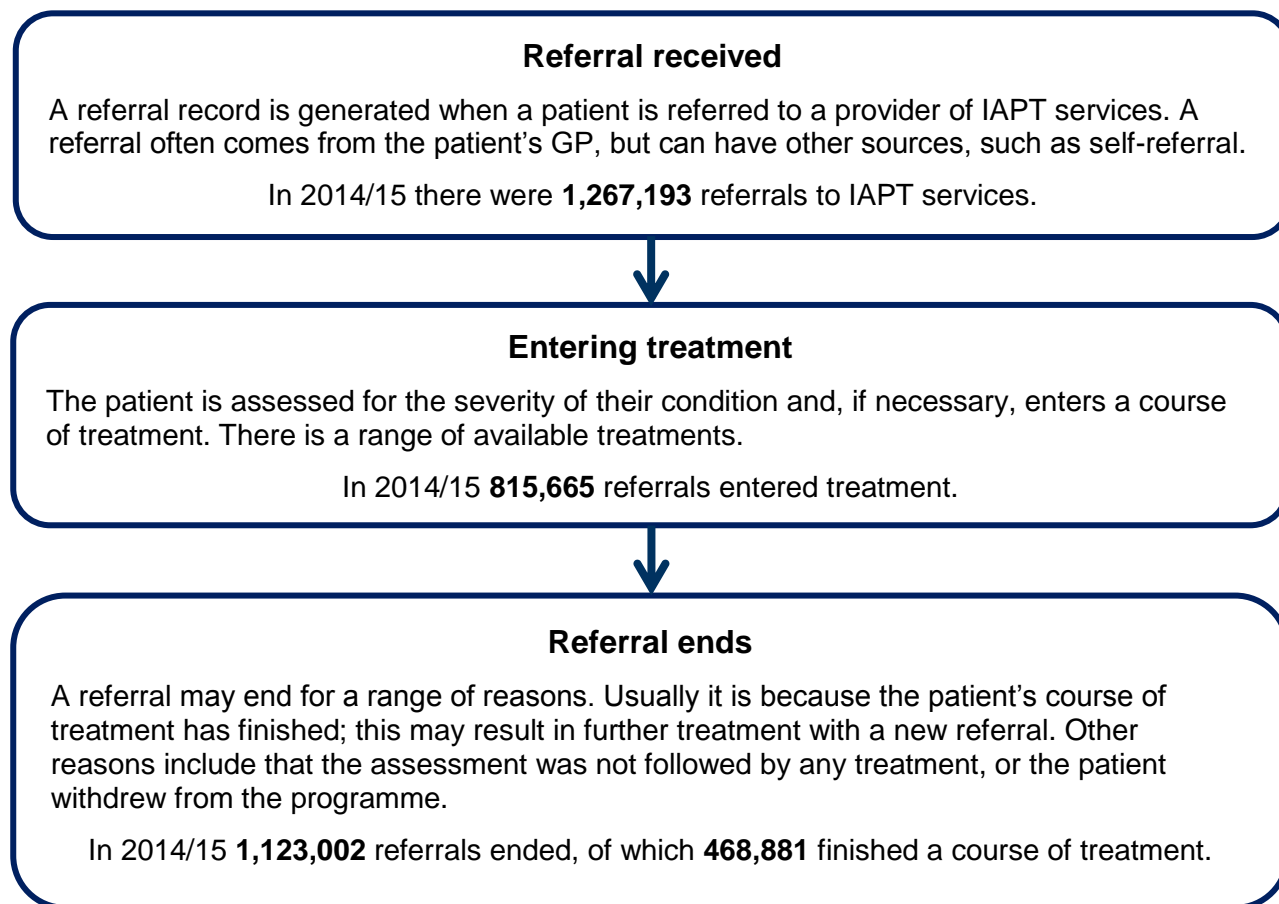
Figure 9: Waiting times by Clinical Commissioning Group, 2014/15

Proportion that waited 28 days or less for treatment



Activity

The following section shows a range of measures for key stages of the patient pathway through IAPT services. The key stages of this pathway are explained below:



Referrals received

A referral is generated when a person is referred to IAPT services for treatment. One individual can only have one referral for a given provider at any one time, but can have multiple referrals across different providers, or could receive more than one referral over the course of the year. A count of referrals, therefore, is not a count of people.

In 2014/15 there were:

- 1,075,999 people referred to IAPT services, and
- 1,267,193 referrals received for IAPT services.

There are several reasons for there being more referrals than people:

- A patient may have finished a referral to IAPT services, but been referred again later in the year;
- A patient may make multiple service requests across different providers;
- A patient may be 'stepped up' to high intensity treatment, or 'stepped down' to low intensity treatment and this may need to be referred to a new provider³⁴.

³⁴ This generates a new referral, despite the step being part of a single spell of care. It is not currently possible to track these individuals across providers within the IAPT dataset and so this is also likely to contribute to the issue of multiple referrals being received in the year for a single service user.

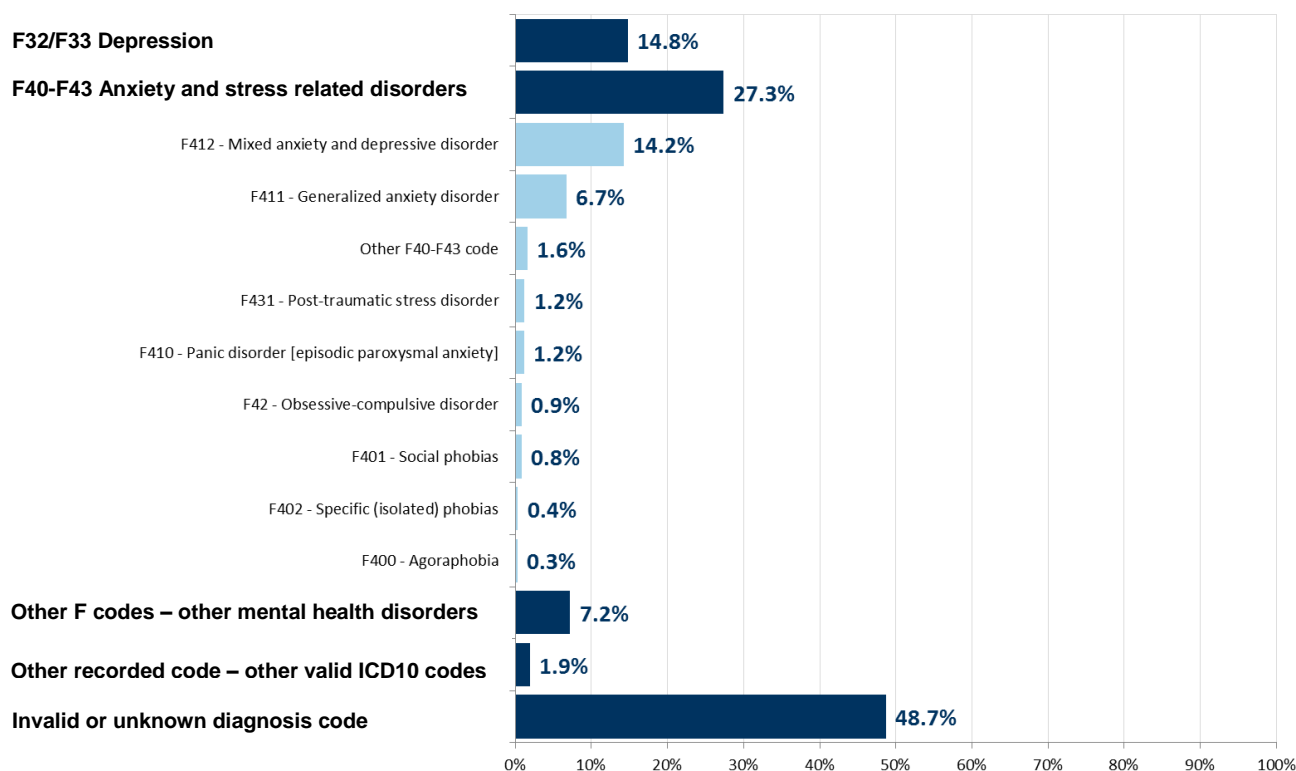
Referrals received by problem descriptor

In 2014/15, problem descriptor³⁵ was recorded for 51.3% (650,132) of new referrals received by IAPT. Most referrals last for several months and information about problem descriptor will probably not be recorded until the patient has been seen and assessed. It is therefore to be expected that not all referrals received in the year (some of which may not have been seen or assessed) will have a problem descriptor recorded.

ICD-10 diagnosis codes³⁶ are presented at three and four character level (e.g. F32, F41.2), to show the breadth of service provision within the IAPT programme. It is important to note that direct comparisons should not be made between three (shown in dark blue in the chart below) and four (shown in light blue) character classifications as four character codes are a subset of three character codes.

Figure 10 below shows that the highest proportion of referrals received are for a problem descriptor of Anxiety or stress related disorders (27.3% or 346,412 referrals). Amongst this type of problem descriptor, Mixed anxiety and depressive disorder has the highest proportion of referrals received (14.2% or 180,395 referrals).

Figure 10: Referrals received by problem descriptor, 2014/15



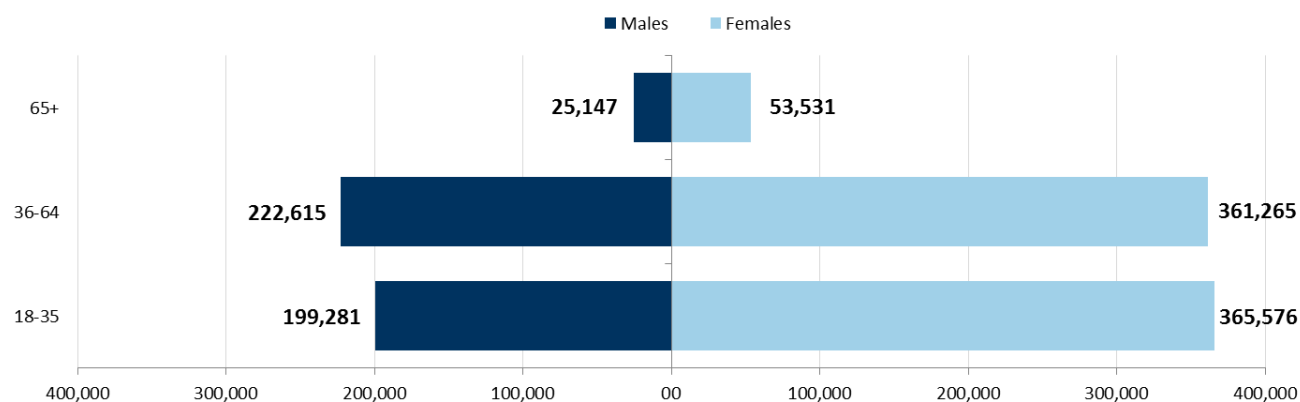
³⁵ Problem descriptor is recorded as an ICD-10 code. Diagnosis codes are presented at three and four character level, to show the breadth of service provision within the IAPT programme. It is important to note that direct comparisons should not be made between three and four character classifications as four character codes are a subset of three character codes. More information about ICD-10 codes is available at: <http://www.who.int/classifications/icd/en/>

³⁶ More information about ICD-10 codes is available at: <http://www.who.int/classifications/icd/en/>

Referrals received by age and gender

Figure 11 below shows that, in 2014/15, women received more referrals than men. There were also differences between the distribution across age groups for males and females.

Figure 11: Referrals received by age group³⁷ and gender, 2014/15

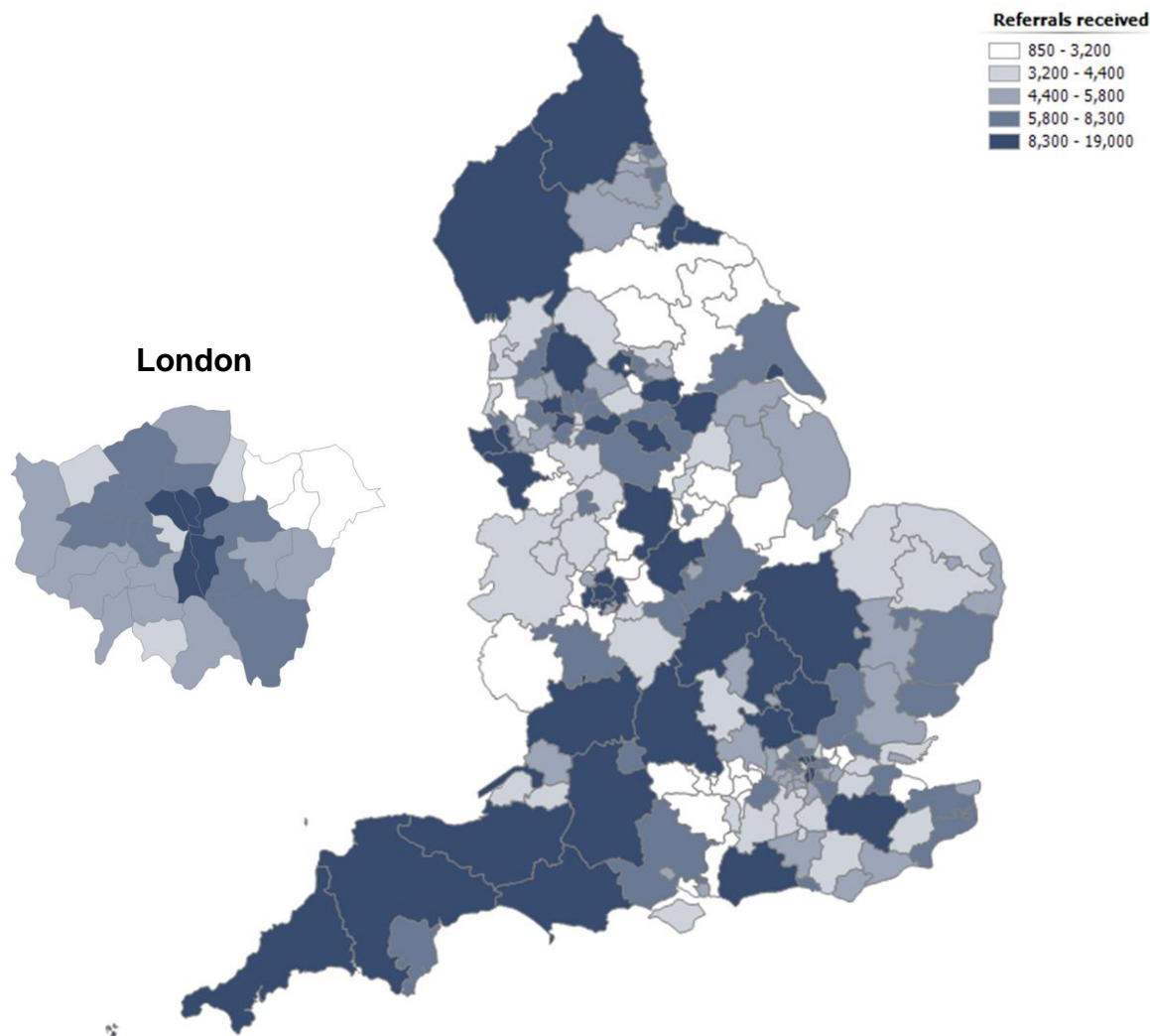


³⁷ Only activity for patients aged 18 and over is shown, but a small number of patients under the age of 18 are recorded as accessing the adult IAPT services covered by this dataset.

Referrals received by Clinical Commissioning Group

Figure 12 below divides the number of referrals received in each CCG into five approximately equal sized groups. Broadly, CCGs with the higher numbers of referrals in 2014/15 are found in the South West and far North of England.

Figure 12: Referrals received by Clinical Commissioning Group, 2014/15



Referrals entering treatment

Once an individual has been referred to IAPT services, they should be assessed and, if appropriate, enter treatment.

In order to be classed as 'entering treatment', a referral must have attended at least one treatment appointment in the year. A treatment appointment is one where at least one therapy type is recorded as having been delivered.

In 2014/15, 815,665 referrals entered treatment.

Not all referrals enter treatment, as a patient may be discharged or otherwise choose not to continue in the service.

In 2014/15:

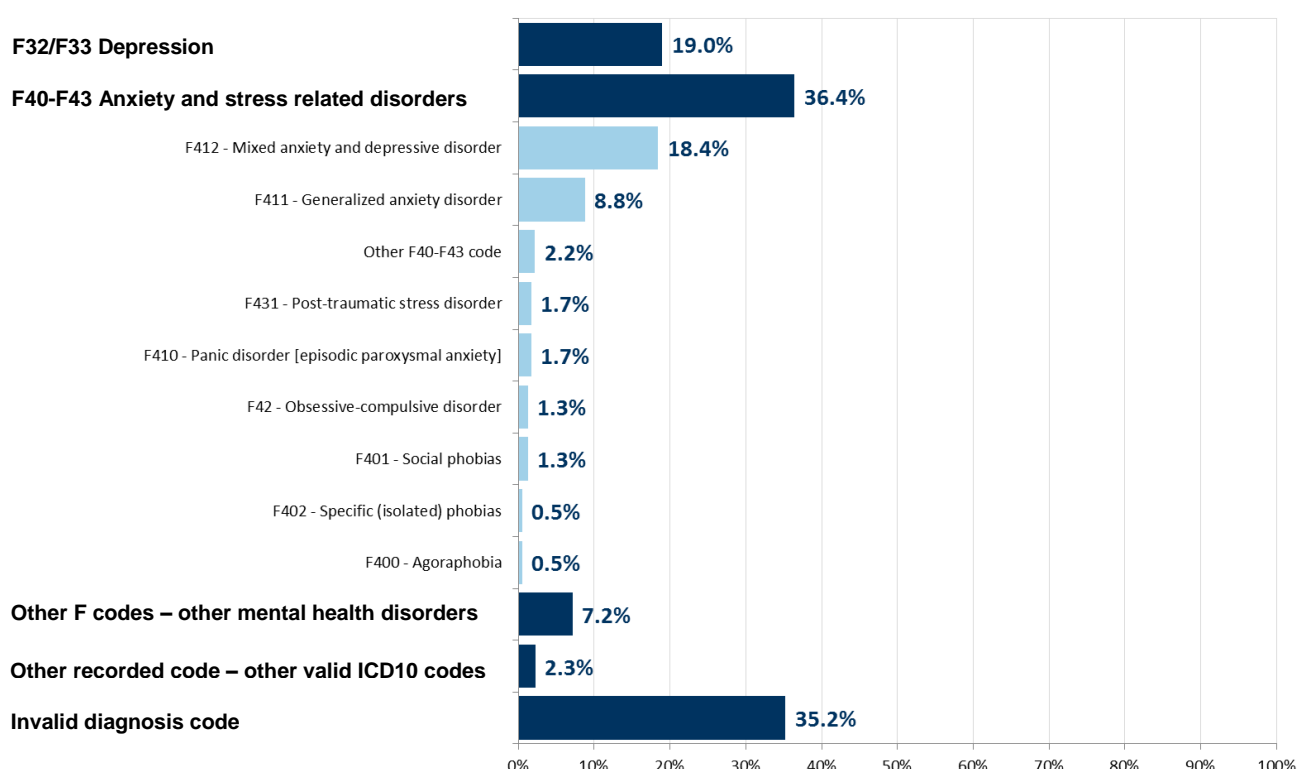
416,364 (37.1% of referrals ending in the year) ended before entering treatment
of which **371,882 (89.3%) did not attend any type of appointment.**

Some referrals that entered treatment in 2014/15 will have been received in 2013/14. Similarly, some referrals that were received in 2014/15 will enter treatment in 2015/16.

Problem descriptor was recorded for 64.8% (528,838) of the referrals entering treatment in 2014/15, showing higher data completeness than for new referrals received.

Figure 13 below shows the number of referrals entering treatment for each problem descriptor code, as a percentage of all referrals entering treatment in 2014/15. The number of referrals with anxiety and stress related disorders is larger in relation to those for depression when compared to the volumes for referrals received.

Figure 13: Referrals entering treatment in the year by problem descriptor³⁸, as a proportion of all referrals entering treatment in 2014/15

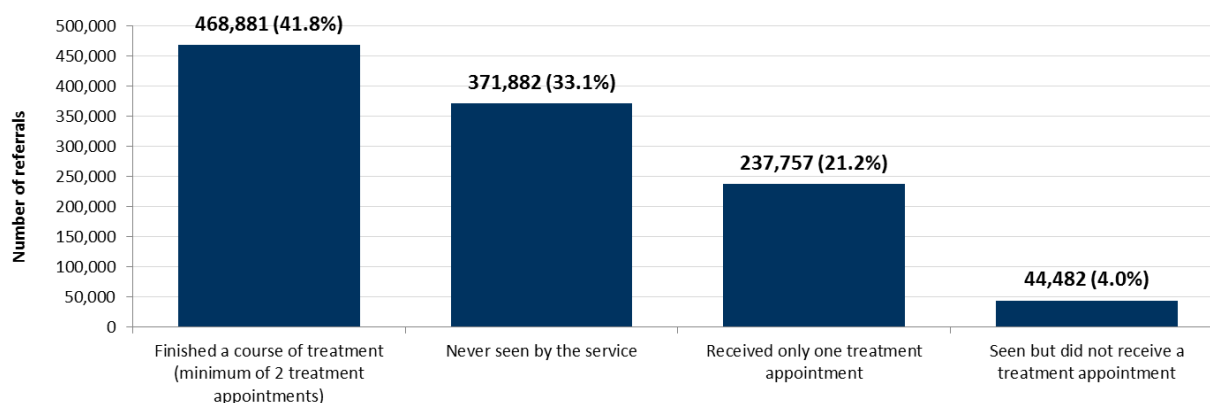


Referrals ending in the year

A referral ends when a provider enters an end date. A referral may end for several reasons. The most common reason for a referral ending is that a course of treatment had finished. Many referrals also end without having been seen by the service; i.e. there were no attended appointments during the course of the referral.

In 2014/15, 1,123,002 referrals ended. Figure 14 describes the different reasons a referral may end. 416,364 referrals to IAPT received no treatment, of which 371,882 (33.1% of all referrals ending in 2014/15) were never seen by the service.

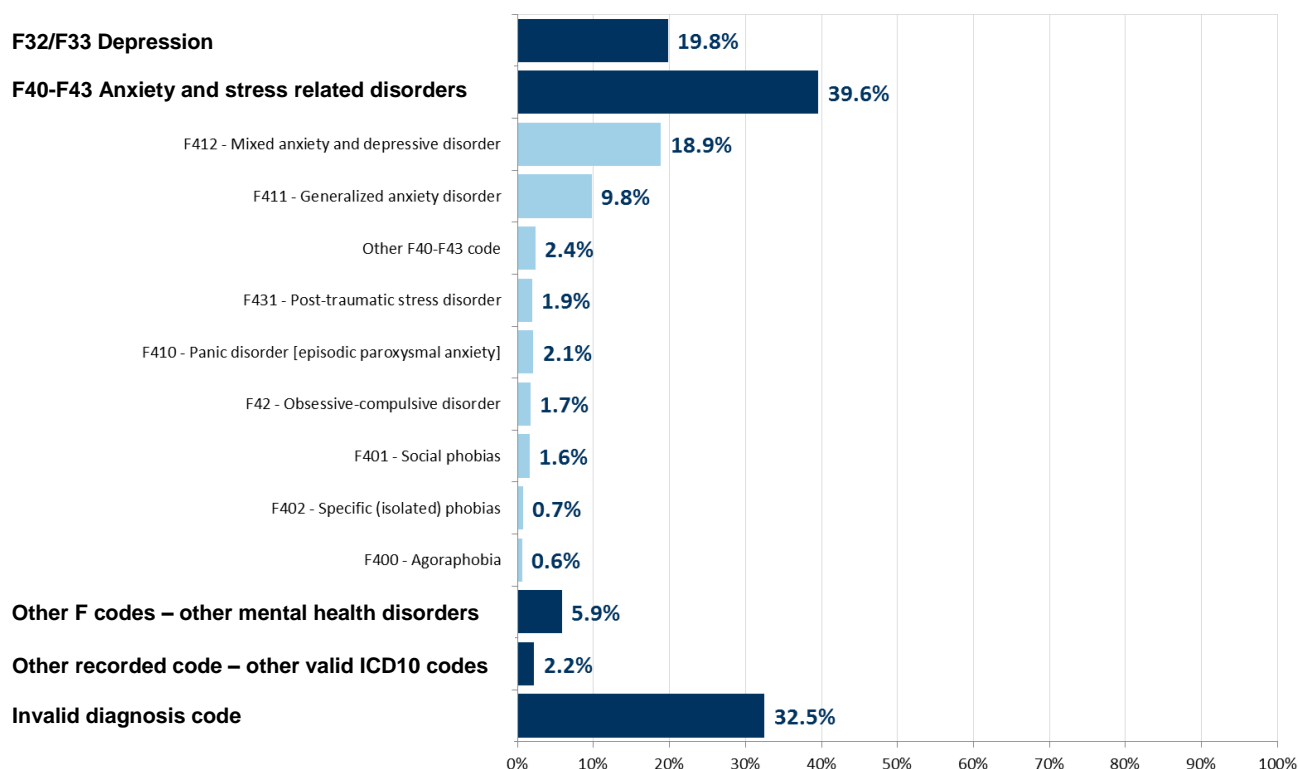
³⁸ Problem descriptor codes are based on ICD-10 international standards for the classification of diseases and have been grouped for presentation purposes. For further information, see the 'Constructions' worksheet of the data tables that accompany this report, as well as the IAPT Technical Output Specification, available from <http://www.hscic.gov.uk/iapt>.

Figure 14: Reasons for a referral ending as a proportion of all referrals ending in the year, 2014/15

Referrals finishing a course of treatment

A referral is classed as having finished a course of treatment if it has at least two treatment appointments. A referral must have finished a course of treatment in order to be assessed for recovery and other outcomes measures. In 2014/15, 468,881 referrals finished a course of treatment.

Figure 15 below shows the number of referrals by their problem descriptor code as a percentage of all referrals finishing a course of treatment in 2014/15. The number of referrals with anxiety and stress related disorders is larger in relation to those for depression when compared to the volumes for referrals received and referrals entering treatment.

Figure 15: Proportion of referrals that finished a course of treatment in the year by problem descriptor³⁹, 2014/15

³⁹ Problem descriptor codes are based on ICD-10 international standards for the classification of diseases and have been grouped for presentation purposes. For further information, see the 'Constructions' worksheet of the data tables that accompany this report, as well as the IAPT Technical Output Specification, available from <http://www.hscic.gov.uk/iapt>.

Employment for referrals finishing a course of treatment

One of the main aims of the IAPT programme is improved employment, benefit, and social inclusion status, including help for people to retain employment, return to work, improve their vocational situation, and participate in the activities of daily living. Employment status should be recorded at every applicable appointment and this information can then be used to look at the employment status at the start and end of a course of treatment.

Table 2 below groups the various employment status codes⁴⁰ into two broad categories. It shows that of the 468,881 referrals finishing a course of treatment in 2014/15, 98,313 (21.0%) started 'unemployed and seeking work; or long term sick or disabled, or in receipt of benefit payments'. Of these, 22.1% (21,775) were 'employed or not actively seeking work by the end of their course of treatment.

336,604 (71.8%) of referrals finishing a course of treatment in 2014/15 were 'employed or not actively seeking work' at the start of their treatment. Of these, 88.0% (296,189) were still in this category at the end of their course of treatment.

Table 2: Referrals with a finished course of treatment by employment status at start and end of treatment, 2014/15

England		Numbers		
Status at start of treatment	Total at start of treatment	Status at end of treatment		
		Unemployed and seeking work; or Long term sick or disabled, or in receipt of benefit payments ^a	Employed or not actively seeking work ^b	Invalid or not stated
Unemployed and seeking work; or Long term sick or disabled, or in receipt of benefit payments ^a	98,313	68,849	21,775	7,689
Employed or not actively seeking work ^b	336,604	21,176	296,189	19,239
Invalid or not stated	33,964	2,506	4,516	26,942
Total at end of treatment	468,881	92,531	322,480	53,870

(a) Referrals for people who are receiving Incapacity Benefit, Income Support, or both; or Employment and Support Allowance.

(b) Amalgamated data field consisting of the following employment status codes: Employed; Students who are not working or actively seeking work; Home maker who is not working or actively seeking work; Not receiving benefits and not working or actively seeking work; Unpaid voluntary work and not working or actively seeking work; Retired.

Psychotropic medication status for referrals finishing a course of treatment

At each appointment the psychotropic medication status should be recorded; this describes whether a person has been prescribed and is currently taking medication.

Table 3 below shows the psychotropic medication status of referrals that finished a course of treatment in 2014/15 before and after treatment. Of the 468,881 referrals finishing a course of treatment in 2014/15, 49.6% (232,421) were being prescribed medication at the point of their first treatment session. Of these, 14.3% were *not* being prescribed medication at the end of their treatment.

⁴⁰ For more information about employment status codes, see the IAPT Technical Output Specification document, which describes the data submitted to the HSCIC. This can be found at <http://www.hscic.gov.uk/iapt>.

Of the 35.7% (167,202) referrals that were not being prescribed medication at the start of their treatment, 68.9% (115,211) were still not being prescribed medication at the end of their treatment.

Table 3: Referrals with a finished course of treatment by psychotropic medication status at start and end of treatment, 2014/15

England		Numbers		
Status at start of treatment	Total at start of treatment	Status at end of treatment		
		Prescribed at last session	Not prescribed at last session	Unknown at last session
Prescribed at first session	232,421	171,623	33,332	27,466
Not prescribed at first session	167,202	30,066	115,211	21,925
Unknown at first session	69,258	8,529	6,852	53,877
Total at end of treatment	468,881	210,218	155,395	103,268

Attended appointments

3,822,121 appointments were attended in 2014/15; these may be for a range of purposes such as assessment, treatment, or review. The main methods of contact for these appointments were face to face and telephone.

Appointments by therapy type

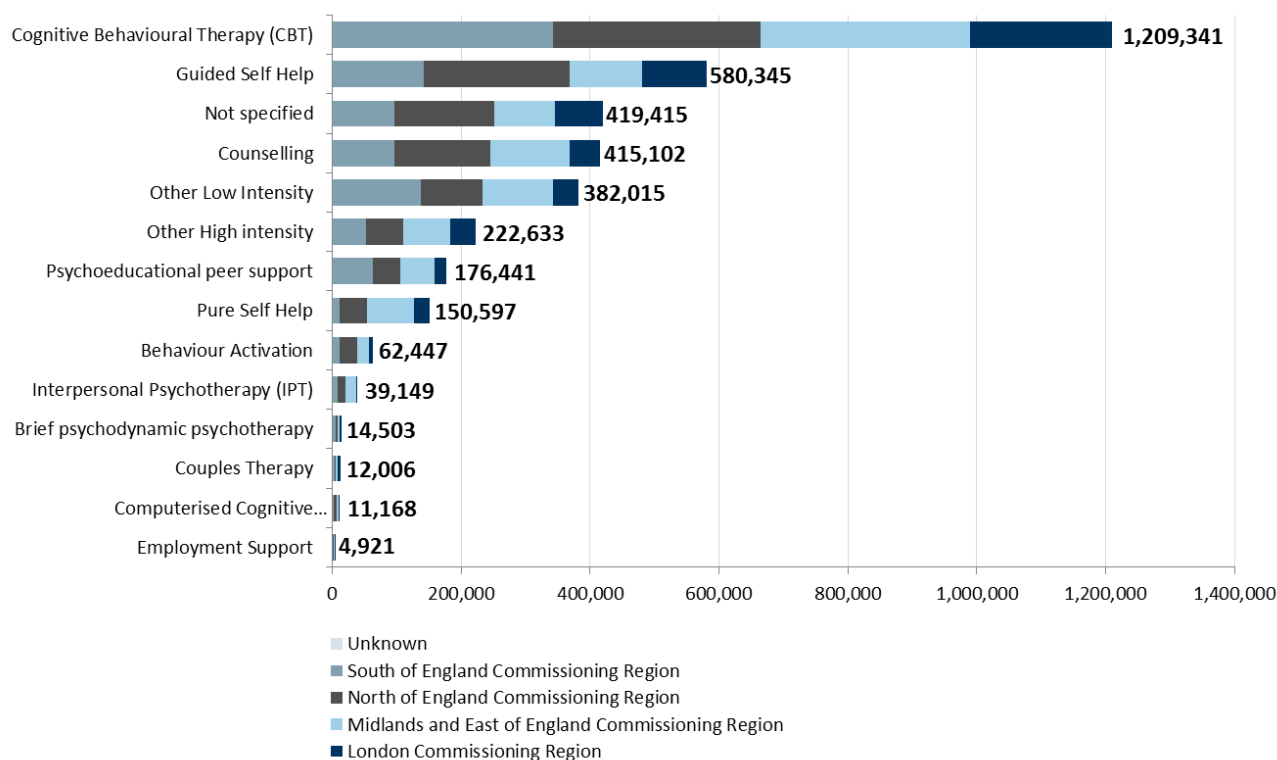
There were 3,576,565 treatment appointments in 2014/15. Figure 16 below shows the number of treatment appointments by therapy type⁴¹ given. The total number of attended treatment appointments does not equal the sum of attended appointments of the different therapy types. This is because multiple therapy types can be offered in one treatment appointment (the dataset allows for up to 4 therapy types to be recorded at one appointment). A treatment is any appointment with a therapy type recorded.

There were 1,209,341 treatment appointments for Cognitive Behavioural Therapy (CBT), making it the most common therapy type in IAPT. Employment Support is the least common with 4,921 treatment appointments.

26.8% (324,464) of CBT appointments were in Midlands and East of England Commissioning Region, compared to 28.2% in South of England Commissioning Region, 26.7% in North of England Commissioning Region, and 18.2% in London Commissioning Region.

⁴¹ A full list of distinct therapy types given in 2014/15 is available in Appendix 4 of this report.

Figure 16: Number of appointments by therapy type in the year, 2014/15



Treatment appointments

In order for a psychological treatment to be as effective as possible, it must be given in the appropriate dose. NICE issues recommendations about the number of treatment sessions that should be offered for different clinical conditions and their severity.

The average (mean) number of treatment appointments for referrals finishing a course of treatment in 2014/15 was 6.3. Figure 17 below shows the average (mean) number of treatment appointments for referrals finishing a course of treatment in 2014/15, split by problem descriptor code. There is little variation between the mean number of sessions delivered for depression (6.5) and anxiety and stress related disorders (6.6); however, for specific anxiety and stress related disorder codes, Obsessive-compulsive disorder has the highest average number of treatment appointments (9.4) and 'mixed anxiety and depressive disorder' and 'other anxiety and stress related disorders' have the lowest (6.2).

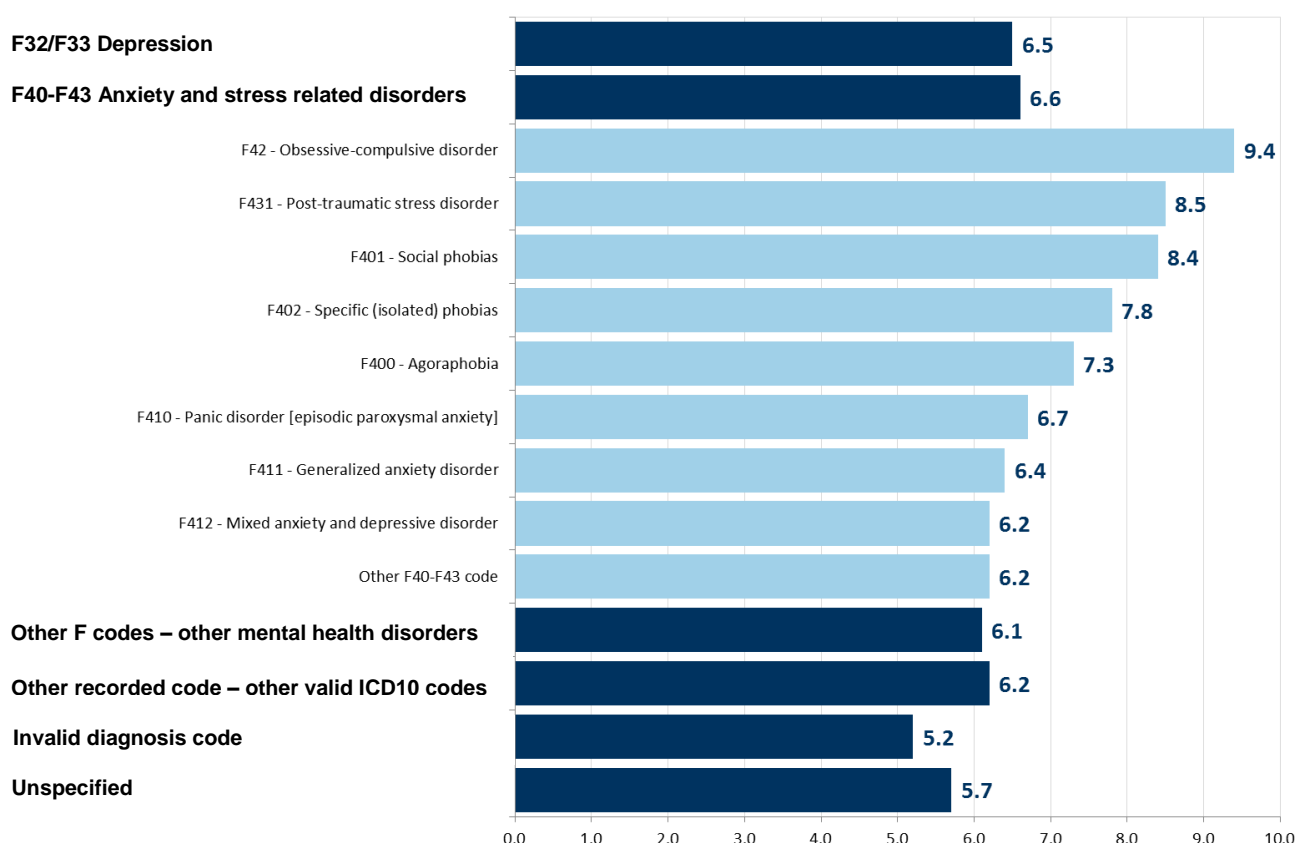
Figure 17: Mean number of appointments in a finished course of treatment by problem descriptor⁴², 2014/15

Figure 18 below shows the average (mean) number of treatment appointments for finished courses of treatment where the problem descriptor code was depression. Interpersonal Psychotherapy (IPT) has the highest mean number of treatment appointments (7.4) and Employment Support the lowest (1.5).

When analysed alongside recovery rates, Interpersonal Psychotherapy also has the second highest recovery rate for referrals where depression is the recorded problem descriptor, and Employment Support the lowest.

⁴² Problem descriptor codes are based on ICD-10 international standards for the classification of diseases and have been grouped for presentation purposes. For further information, see the 'Constructions' worksheet of the data tables that accompany this report, as well as the IAPT Technical Output Specification, available from <http://www.hscic.gov.uk/iapt>.

Figure 18: Mean number of treatment appointments in a finished course of treatment by therapy type for referrals with a problem descriptor of depression, 2014/15

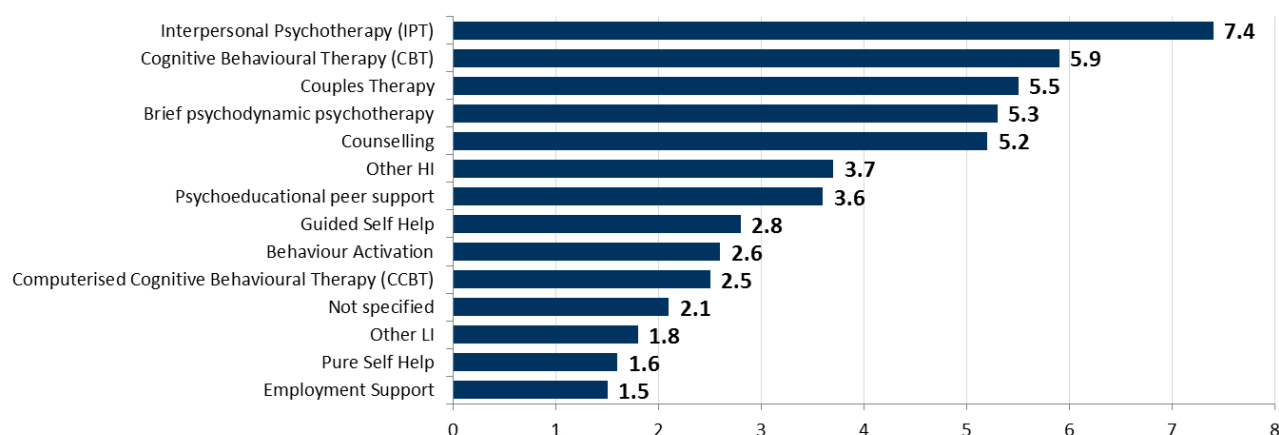
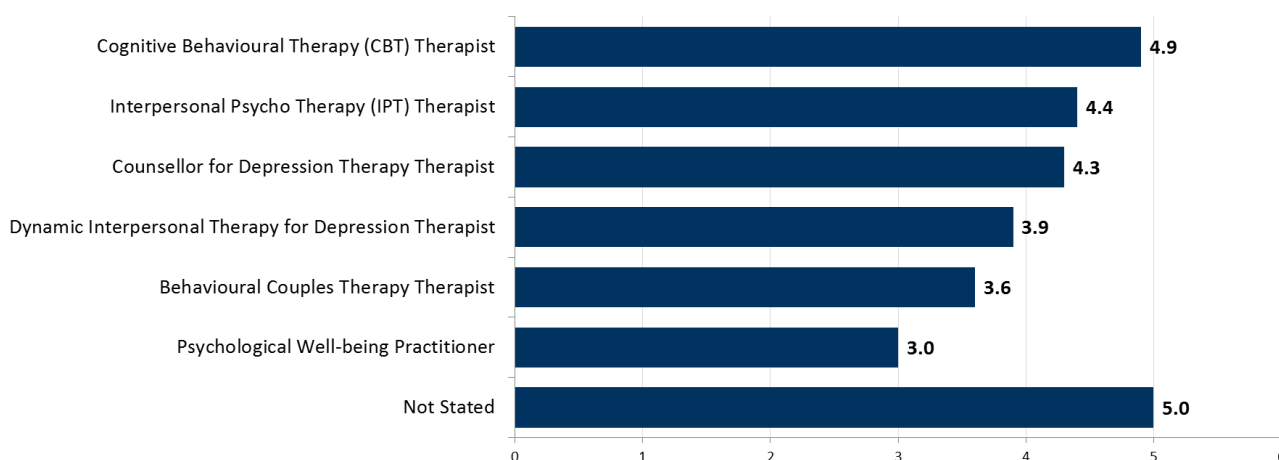


Figure 19 below shows the average (mean) number of treatment appointments by the type of therapist attending the appointment. Where therapist role has been stated, the highest average number of treatment appointments was for Cognitive Behavioural Therapy (CBT) Therapists (4.9), and the lowest Psychological Wellbeing Practitioners (3.0).

Figure 19: Mean number of appointments in a finished course of treatment by therapist type, 2014/15



Appendix 1: data source for this report

A single authoritative national database of IAPT data was created to be the source of data for this report. This section explains some of the features of the data flow and how we manage the data asset for our monthly reports. It also explains why and how we created a separate database as the source for this annual report.

Providers of adult IAPT services are required to submit data for patients with open referrals every month, in accordance with the IAPT data standard⁴³.

Submissions to HSCIC are validated and pseudonymised by the Open Exeter Bureau Service provided by the Systems and Service Delivery Team and received by the Community and Mental Health Team as a monthly pseudonymised XML extract. Because most courses of IAPT treatment last for more than a single month, information about the same referrals is included in successive submissions. However, the details of these referrals changes across submissions and this could lead to inconsistencies in our published reports.

In order to ensure a stable view of the data for each of our monthly reports, we have to apply a set of business rules to our analysis, to ensure that the same instance of each referral is used for each individual period's reporting. We also derive a nationally unique identifier for each referral to ensure that all the related information about the referral can be linked across submissions.

For the annual report there are additional requirements for an authoritative source of data for the year, because this will be used for historical and time series analysis in future and we need to ensure that consistent figures will be produced in future.

We therefore created a view of the data for the whole year, including a single instance of each referral with the most up to date information provided during the year for that referral. For example, if the problem descriptor was first recorded as 'anxiety' and later updated to 'Obsessive-compulsive disorder (OCD)' then the problem descriptor associated with this referral in the annual database will be 'OCD'.

Additionally, we have created a view of the data that enables us to identify the dates of treatment appointments according to the methodology prevailing at the time of the appointment. Treatment appointments are crucial in calculating the date of entering treatment and whether referrals complete a course of treatment, but the method for identifying them changed in July 2014 with the introduction of the new version of the dataset (v1.5).

Further details about the construction of the annual dataset are available on request and the details of the logic we apply in calculating key measures are described in our 'IAPT Reporting FAQs' document, available on our website⁴⁴.

⁴³ See <http://www.hscic.gov.uk/iapt>.

⁴⁴ See <http://www.hscic.gov.uk/iaptmonthly>.

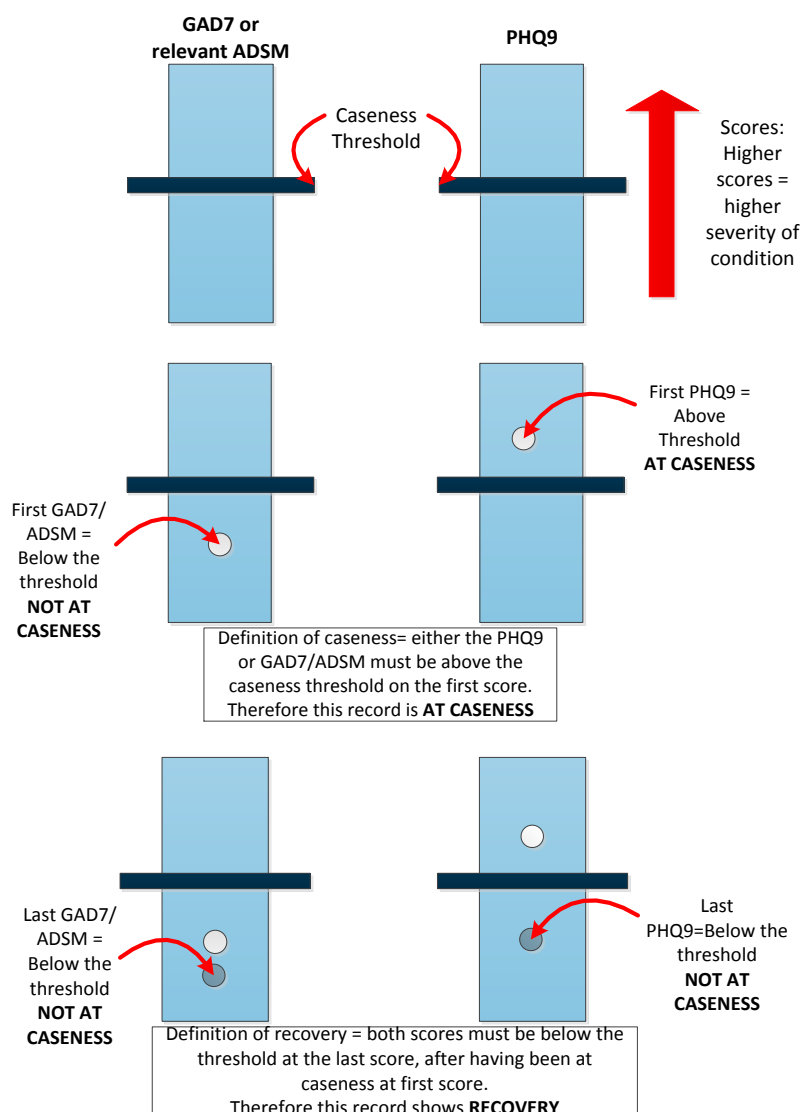
Appendix 2: Caseness, Recovery, and Reliable improvement

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 off⁴⁵ on either anxiety, depression, or both, then the referral is classed as a clinical case.

Recovery

A referral is classed as 'recovered' if the patient finished a course of treatment and moved from 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 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 ADSM score, or both, are **above** the caseness threshold.

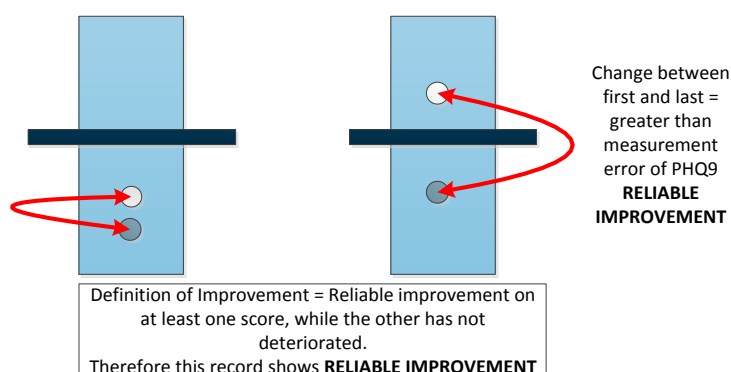
A referral has recovered at the end of a course of treatment if *both* the last recorded PHQ-9 score *and* the last recorded relevant ADSM score are **below** the caseness threshold.

⁴⁵ Information on the cut off values and how they should be used can be found in the IAPT data handbook: <http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf>

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 error⁴⁶ 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.



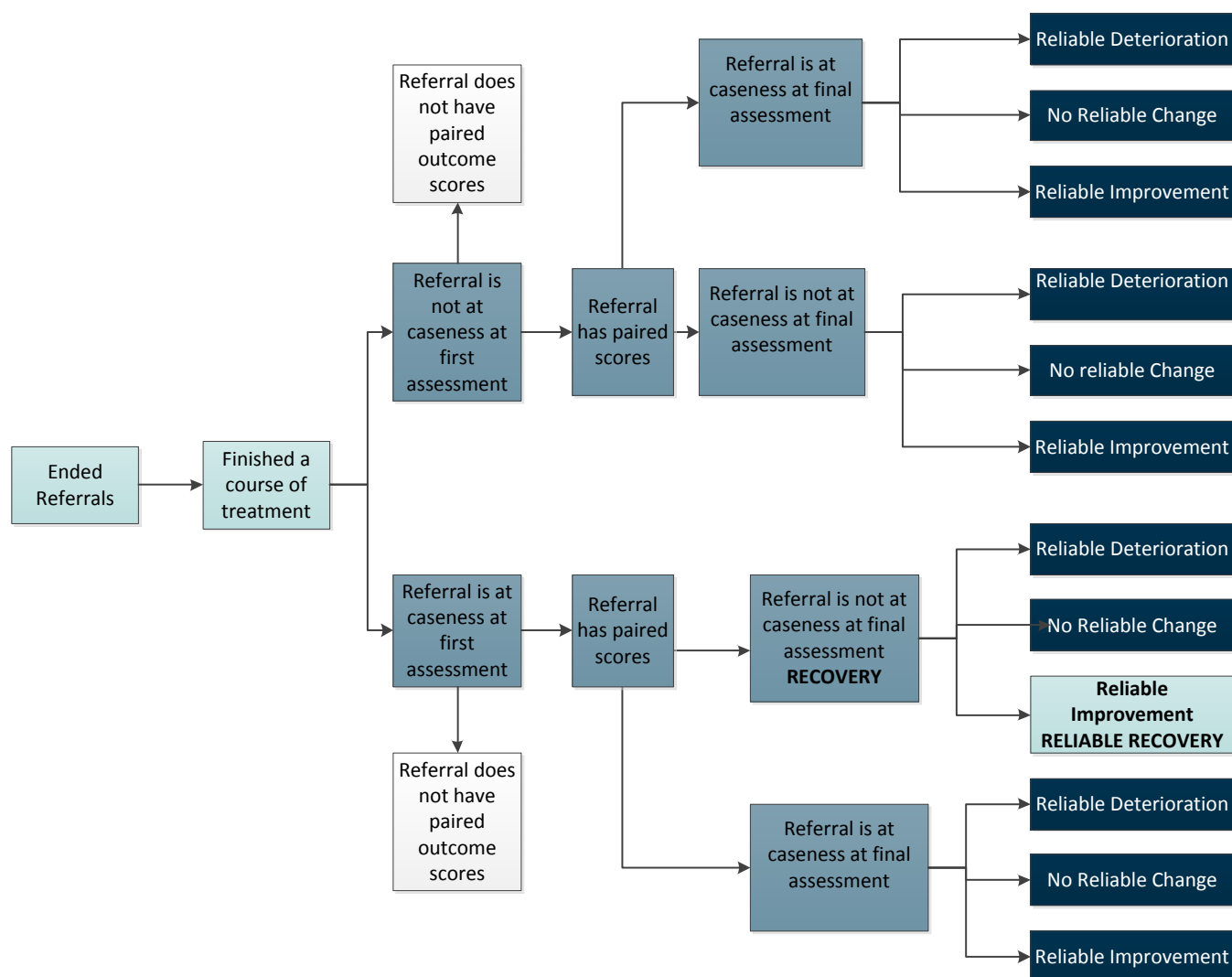
A referral has reliably improved at the end of a course of treatment if at least one score has decreased beyond the measurement error for that score, and the other measure has not increased beyond the measurement error.

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 ADSM. A full understanding of the possible pathways a referral can take is described below:

⁴⁶ This is the amount by which a difference could be attributable to natural variance. For more information on measurement errors for specific questionnaires, see Appendix 3 of this report.

Figure 20: Flowchart of the potential output pathway of a completed referral⁴⁷

⁴⁷ Although unlikely, it is possible for referrals to show recovery and also deterioration, or to move from not being at caseness and still show improvement. This generally occurs when looking at 'borderline' cases, which may show a small change on one measure that passes the caseness threshold while showing a larger change in another measure which does not pass the caseness threshold. This is not expected to occur in many cases but the possibility is included in this diagram for completeness.

Appendix 3: ADSMs appropriate to provisional diagnoses

The table below provides a list of Anxiety Disorder Specific Measures appropriate to each problem descriptor, as well as the corresponding caseness threshold and measurement error. At each treatment appointment, patients are asked to complete the Patient Health Questionnaire (PHQ-9), which is an assessment of the severity of depression, and the ADSM from the below table that is appropriate for their problem descriptor. The first and last recorded scores for each of these measures are used in the calculations of caseness, recovery, improvement, reliable change, and reliable recovery.

Measure	Caseness threshold	Measurement error
PHQ-9	10	6

ICD-10 code	Problem descriptor	Appropriate ADSM	Caseness threshold	Measurement error
F10	Mental and behavioural disorders due to use of alcohol	GAD7	8	4
F31	Bipolar affective disorder	GAD7	8	4
F32-F39	Depressive episode	GAD7	8	4
F33	Recurrent depressive disorder	GAD7	8	4
F40.2	Specific (isolated) phobias	GAD7	8	4
F41.1	Generalised Anxiety Disorder	GAD7	8	4
F41.2	Mixed anxiety and depressive disorder	GAD7	8	4
F50	Eating disorders	GAD7	8	4
F99	Mental disorder not otherwise specified	GAD7	8	4
Z63.4	Disappearance or death of a family member	GAD7	8	4
F40.0 ⁴⁸	Agoraphobia	Agoraphobia Mobility Inventory	60 (v1.0) ⁴⁹ 2.3 (v1.5) ⁴⁹	19 (v1.0) ⁴⁹ 0.73 (v1.5) ⁴⁹
F40.1	Social phobias	Social Phobia Inventory	19	10
F41.0 ⁵⁰	Panic Disorder	Panic Disorder Severity Scale	-	-
F42	Obsessive Compulsive Disorder	Obsessive Compulsive Inventory	40	32
F43.1	Post-Traumatic Stress Disorder	Impact of Events Scale	33	9
F45.2	Somatoform Disorder	Health Anxiety Inventory (Short Week)	18	4

⁴⁸ As the IAPT dataset does not accept decimals, the Agoraphobia measure is evaluated as a cumulative score, rather than the normal average. Normal caseness threshold on this measure is 2.3, and the measurement error is 0.73. For the evaluation of recovery from the dataset, however, the caseness threshold is 60 and the measurement error is 19, as confirmed by the toolmaker.

⁴⁹ There was a format change between dataset versions for this measure. For further information, see http://www.hscic.gov.uk/media/15415/Methodological-change-2014-Improving-Access-to-Psychological-Therapies-IAPT-Reports/pdf/MethChange20141028_IAPT.pdf, p12.

⁵⁰ As there is currently no provided reliable change value for the Panic Disorder Severity Scale, GAD7 is currently used instead as the ADSM for this problem descriptor.

Appendix 4: Distinct therapy types presented in 2014/15

The following table gives a list of distinct therapy types in the IAPT dataset. The IAPT dataset changed from version 1.0 to version 1.5 partway through the 2014/15 financial year, and changes to the coding of therapy types were instigated as part of this⁵¹. Because the therapy types recorded in version 1 of the dataset could not be mapped to individual codes in version 1.5, a compromise set of values for this year's report was agreed with interested parties. In 2015/16, we will be using version 1.5 codes, which can be grouped by high and low intensity therapies.

Version 1 code	Version 1.5 code	Reporting category
01 Computerised Cognitive Behavioural Therapy (cCBT)		Computerised CBT
02 Pure self-help (e.g. Books on Prescription)	21 Non-guided Self Help (Book) 23 Non-Guided Self Help (Computer)	Pure Self Help
03 Guided Self Help	20 Guided Self Help (Book) 22 Guided Self Help (Computer)	Guided Self Help
06 Psycho educational groups	27 Psycho educational peer support	Psycho educational peer support
41 Employment support	29 Employment Support (Low Intensity) 40 Employment support (high intensity)	Employment support
04 Behaviour activation	24 Behavioural Activation (Low Intensity) 41 Behavioural Activation (High Intensity)	Behaviour activation
07 Cognitive Behaviour Therapy (CBT)	50 Cognitive Behaviour Therapy (CBT)	Cognitive Behaviour Therapy (CBT)
08 Interpersonal Psychotherapy (IPT)	51 Interpersonal Psychotherapy (IPT)	Interpersonal Psychotherapy (IPT)
09 Counselling	44 Counselling for Depression	Counselling
10 Behavioural couples therapy	42 Couples Therapy for Depression	Couples Therapy
13 Dynamic Interpersonal therapy	45 Brief psychodynamic psychotherapy	Brief psychodynamic psychotherapy
12 Collaborative care 05 Structured Exercise	25 Structured Physical Activity 26 Ante/post natal counselling 43 Collaborative care (for people with depression and a chronic physical health condition)	Other LI
	40 Applied relaxation 47 Mindfulness 46 Eye Movement Desensitisation Reprocessing 48 Other HI	Other HI
11 Other Invalid or missing code	Invalid or missing code	Not specified

⁵¹ See 'Methodological Change: 2015 Improving Access to Psychological Therapies Reports' published at: http://www.hscic.gov.uk/media/16289/Improving-Access-to-Psychological-Therapies/pdf/MethChange20150216_MonthlyIAPT.pdf

Appendix 5: Submissions by provider

Organisation Code of Provider	Organisation Name of Provider	April 2014	May 2014	June 2014	July 2014	August 2014	September 2014	October 2014	November 2014	December 2014	January 2015	February 2015	March 2015
304	BOLTON METROPOLITAN BOROUGH COUNCIL	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8AC19	RELATE (BRADFORD)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8ER41	PICKARD JOAN (COUNSELLOR)	Y	Y	Y	Y	Y	Y	Y	Y				
8GH63	RELATE (HULL)										Y	Y	Y
8HL38	OUTLOOK SOUTH WEST LLP	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HR41	PSYCHOLOGYONLINE.CO.UK LTD	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HR97	SIGN HEALTH		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HT03	NEWCASTLE TALKING THERAPIES	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HT29	TRENT CBT SERVICES LTD	Y	Y										
8HV57	EAST LANCASHIRE WOMEN'S CENTRE				Y	Y	Y	Y			Y	Y	Y
8HV88	PML COUNSELLING SERVICE	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y
8HW71	SELF HELP SERVICES	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HX19	KALEIDOSCOPE PLUS GROUP	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HX24	MIND IN BEXLEY	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HX43	SELF HELP SERVICES (PBR)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HX68	TURNING POINT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HY52	WEST ESSEX MIND	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HY89	LEA VALE MEDICAL GROUP	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8J293	STARFISH HEALTH AND WELLBEING	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y
8J495	1POINT (NORTH WEST) LIMITED	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8J603	READY TO TALK CIC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		
8J766	DARTFORD, GRAVESHAM AND SWANLEY MIND							Y	Y	Y	Y	Y	Y
8J784	MIND IN BEXLEY (HEALTHY MIND IN WEST KENT)												Y
AA5	COMPASS WELLBEING COMMUNITY INTEREST COMPANY	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
AD7	WESTMINSTER MIND	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y
AJA	DOVER COUNSELLING CENTRE HQ						Y	Y	Y	Y	Y	Y	Y
ALR01	BIRMINGHAM MENTAL HEALTH CONSORTIUM (HERBERT ROAD)									Y	Y	Y	Y
AN2	BROCKLEBANK GROUP PRACTICE (HQ)										Y	Y	Y
AN4	GRAFTON MEDICAL PARTNERS (HQ)										Y	Y	Y
AN5	PUTNEYMEAD GROUP MEDICAL PRACTICE (HQ)										Y	Y	Y
AN901	THE EARLSFIELD PRACTICE (HQ)										Y	Y	Y
ANA01	HEATHBRIDGE PRACTICE									Y	Y	Y	Y
ANC	OPEN DOOR SURGERY (HQ)										Y	Y	Y
ANJ	CENTRAL LONDON PRIMARY CARE COUNSELLORS											Y	Y
NAF	COUNSELLING TEAM LTD					Y	Y	Y	Y	Y	Y	Y	Y
NAG01	THINKACTION MENTAL HEALTH AT MEDWAY & SWALE (FORMERLY KNOWN AS KCA)					Y	Y	Y	Y	Y	Y	Y	Y
NAG02	THINKACTION MENTAL HEALTH AT ASHFORD (FORMERLY KNOWN AS KCA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NAG03	THINKACTION MENTAL HEALTH AT CANTERBURY & COASTAL (FORMERLY KNOWN AS KCA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NAG04	PTP SWALE	Y	Y	Y									
NAG05	THINKACTION MENTAL HEALTH AT THANET (FORMERLY KNOWN AS KCA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NAG06	PTP MEDWAY	Y	Y	Y									
NAG07	THINKACTION MENTAL HEALTH AT REIGATE (FORMERLY KNOWN AS KCA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NAG08	THINKACTION MENTAL HEALTH AT WOKING (FORMERLY KNOWN AS KCA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NCH	TALKPLUS	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y
NCM	SIX DEGREES SOCIAL ENTERPRISE CIC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDA	VIRGIN CARE SERVICES LTD	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC01	INSIGHT HEALTHCARE TALKING THERAPIES (NORTHUMBERLAND)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC03	INSIGHT HEALTHCARE TALKING THERAPIES (CALDERDALE)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC04	INSIGHT HEALTHCARE TALKING THERAPIES (WIRRAL)					Y	Y	Y	Y	Y	Y	Y	Y
NDC05	INSIGHT HEALTHCARE TALKING THERAPIES (PETERBOROUGH)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC06	INSIGHT HEALTHCARE - AQP-PRIMARY CARE PSYCHOLOGICAL THERAPIES (TEES)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC07	INSIGHT HEALTHCARE TALKING THERAPIES (KENT & MEDWAY)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC08	INSIGHT HEALTHCARE - NOTTINGHAM CITY	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC09	INSIGHT HEALTHCARE - NOTTINGHAMSHIRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC10	INSIGHT HEALTHCARE - DERBYSHIRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC11	INSIGHT HEALTHCARE - EAST RIDING OF YORKSHIRE				Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC12	INSIGHT HEALTHCARE - NOTTINGHAM CITY OBESITY PROJECT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC13	INSIGHT HEALTHCARE TALKING THERAPIES (BASSETLAW)												Y
NFG	MIND CENTRE	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y
NFL	HARTLEPOOL AND EAST DURHAM MIND	Y	Y	Y		Y	Y	Y		Y	Y	Y	Y
NIW	FAVERSHAM COUNSELLING SERVICE LTD						Y			Y	Y	Y	Y
NJG	ALLIANCE PSYCHOLOGY SERVICES LTD		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NJJ	PSICON LIMITED					Y	Y	Y	Y	Y	Y	Y	Y

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Organisation Code of Provider	Organisation Name of Provider	April 2014	May 2014	June 2014	July 2014	August 2014	September 2014	October 2014	November 2014	December 2014	January 2015	February 2015	March 2015
NKT	UNIVERSITY MEDICAL CENTRE					Y	Y	Y	Y	Y	Y	Y	Y
NLS	TRENT PTS		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NMK	HEALTHSHARE LTD						Y	Y	Y	Y	Y	Y	Y
NMQ	MAKING SPACE										Y	Y	Y
NNE	DORKING HEALTHCARE LIMITED	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y
NNF	CITY HEALTH CARE PARTNERSHIP CIC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NO201	TALKING MATTERS TEES	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NO202	WARRINGTON PSYCHOLOGICAL SERVICE	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y
NO203	TALKING MATTERS KENT (MHM)				Y	Y	Y	Y	Y	Y	Y	Y	Y
NQL	NAVIGO	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NQV	BROMLEY HEALTHCARE	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y
NR5	PLYMOUTH COMMUNITY HEALTHCARE (CIC)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NTYH4	PENINSULA HEALTH LLP	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NV802	HORIZON HEALTH CHOICES LTD	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NWX08	BICS MENTAL HEALTH GATEWAY	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y
R1A	WORCESTERSHIRE HEALTH AND CARE NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
R1C	SOLENT NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
R1F	ISLE OF WIGHT NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RAT	NORTH EAST LONDON NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RDR	SUSSEX COMMUNITY NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RDYDL	PSYCHOLOGICAL THERAPIES SOUTHAMPTON OFFICE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RDYEV	CONIFERS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RDYLK	BOURNEMOUTH AND POOLE PRIMARY CARE MEDICAL TEAM	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RDYLL	EAST DORSET STEPS TO WELLBEING (IAPT)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RGD	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RH5	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RHA	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RJ8	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RKE	THE WHITTINGTON HOSPITAL NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RKL07	EALING IAPT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RKL14	LAKESIDE UNIT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RKL42	GLOUCESTER HOUSE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RLYD7	HOPE CENTRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RMV	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RNN	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RNUDT	TALKINGSPACE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RNUDV	HEALTHY MINDS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RP1	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RP7	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RP6	OXLEAS NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RQY12	WANDSWORTH IAPT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RQYPR	SUTTON & MERTON IAPT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RRE	SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RT1	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RT2	PENNINE CARE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RT5	LEICESTERSHIRE PARTNERSHIP NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RTF61	WALLSEND HEALTH CENTRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RTQ	2GETHER NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RTV	5 BOROUGH PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV332	SOUTH KENSINGTON & CHELSEA MENTAL HEALTH CENTRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV383	NORTHWICK PARK HOSPITAL	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV3CH	ICCS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV3DD	WELLBEING CENTRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV3DG	WESTMINSTER WELLBEING SERVICE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV3H8	K&C PRIMARY CARE MENTAL HEALTH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV3HC	IAPT SERVICES	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV5CG	SOUTHWARK PSYCHOLOGICAL THERAPIES SERVICES (SOUTHWARK IAPT)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV5CH	LEWISHAM PSYCHOLOGICAL THERAPIES SERVICE (LEWISHAM IAPT)	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y
RV5CJ	CROYDON PSYCHOLOGICAL THERAPIES SERVICE (CROYDON IAPT)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV5CK	LAMBETH PSYCHOLOGICAL THERAPIES SERVICE (LAMBETH IAPT)	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Glossary

Access

A government target for IAPT is that 15% of those with anxiety or depression should be treated through the IAPT programme⁵². The HSCIC calculates the numerator for access rates – which is the number of referrals entering treatment in a given period – but the denominator has been determined by NHS England. This is based on figures from the Adult Psychiatric Morbidity Survey, 2000⁵³.

Anxiety Disorder Specific Measure (ADSM)

Anxiety Disorder Specific Measures are questionnaires that are sensitive measures of the severity of particular anxiety disorders. The IAPT Data Handbook⁵⁴ 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.

Bypass Patient

When providers' IAPT data submissions to the Open Exeter Portal are processed each record is assigned a pseudonymised patient identifier based on the NHS number, postcode, birthdate and provider-assigned 'local patient ID'. Where key elements of this information are missing the pseudo ID generated is flagged up as a 'Bypass patient', indicating that the quality of the data does not support future matching – this pseudo ID cannot be allocated to a future record and this record cannot be linked to future submissions⁵⁵. Since the patient pathway that supports analysis of access and outcomes is created over multiple submissions over several months, the analysis that depends on a patient pathway across submissions cannot include records for 'Bypass patients'. In order to provide as much consistency in terms of data volumes between data submitted and data reported in our monthly reports, some measures (i.e. Referrals Received in the month) do include records for 'Bypass Patients'. However, analysis of these records is excluded from the annual report to provide a more consistent suite of reports on a clearly defined population of services users' referrals.

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 off⁵⁶ on either anxiety, depression, or both, then the referral is classed as a clinical case.

⁵² For more information about this, see our FAQ document (page 17):

http://www.hscic.gov.uk/media/18182/IAPT-Reporting-FAQs/pdf/Understanding_and_replicating_our_published_reports_-July_2015_v1.2.pdf

⁵³ http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4019414

⁵⁴ <http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf>

⁵⁵ See IAPT Data Quality Statement for further information: <http://www.hscic.gov.uk/media/16923/IAPT-DQ-Month/pdf/IAPT-month-dqs.pdf>

⁵⁶ Information on the cut off values and how they should be used can be found in the IAPT data handbook: <http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf>

Entering treatment

In order to enter treatment, a referral must have a first treatment appointment in the period.

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. 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-7 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.

Initial assessment appointment

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

National Institute for Health and Care 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.

No reliable change

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.

PHQ-9

The Public Health Questionnaire-9 is IAPT's measure of the severity of depression and should be recorded at each appointment.

Recovery

A referral is classed as 'recovered' if the patient finished a course of treatment and moved from 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.

Referrals

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

One patient can only have one open referral at a provider at a given time, but could have multiple referrals across providers or multiple referrals in the same provider across the year.

In most cases a count of referrals is used, rather than a count of people, when looking at activity in IAPT services, including recovery.

Referral ending in the year

A referral is considered to have ended in the year if it has a valid end date recorded that is between 1st April 2014 and 31st March 2015.

Reliable change

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 error⁵⁷ of the questionnaire.

Reliable deterioration

It is possible for people to show deterioration as well as improvement during a course of therapy. Patients are classed as having shown reliable deterioration if they show a reliable increase in their anxiety or depression score between the first and last measurement, and the other measurement either also reliably increases or shows no reliable change.

Reliable improvement

Patients have shown reliable improvement if they show a reliable decrease in their anxiety or depression score between the first and last measurement, and the other clinical state (depression or anxiety) either also reliably decreases or shows no reliable change.

Reliable recovery

If a patient meets the criteria for both recovery and reliable improvement when they have finished a course of treatment, they are said to have reliably recovered.

Therapy type

This is the type of therapy⁵⁸ given to a patient or planned to be given to the patient during an IAPT contact. The national codes are National Institute for Health and Care Excellence (NICE) approved and/ or evidence-based (i.e. employment support is evidence-based). In this report, tabulation of outcomes by therapy type is based on the *last* therapy that a person received during a course of treatment.

Treatment appointment

An attended appointment is considered a treatment appointment if the appointment type is either 'treatment', 'assessment and treatment', or 'review and treatment'. At each treatment appointment, patients will also be asked to complete several well-validated⁵⁹ questionnaires that assess the severity of their clinical condition⁶⁰. The two main questionnaires are:

- Patient Health Questionnaire (PHQ-9), which assesses the severity of depression;
- A questionnaire that assesses severity of anxiety – Generalised Anxiety Disorder scale (GAD7) or another appropriate Anxiety Disorder Specific Measure (ADSM).

⁵⁷ See Jacobsen, N.S. & Truax, P. (1991), 'Clinical Significance: A Statistical Approach to Defining Meaningful Change in Psychotherapy Research', *Journal of Consulting and Clinical Psychology*, 59, p12-19.

⁵⁸ http://www.datadictionary.nhs.uk/data_dictionary/attributes/t/tes/therapy_type_for_improving_access_to_psychological_therapies_de.asp?shownav=1

⁵⁹ For further information, see <http://www.iapt.nhs.uk/silo/files/the-iapt-data-handbook.pdf>

⁶⁰ A full list of these questionnaires, their scores, and thresholds for assessing caseness for each score can be found in Appendix 3 of this report.

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