

Psychological Therapies: Annual report on the use of IAPT services

England, further analyses on 2016-17

Published 27th February 2018

This report examines activity, waiting times and outcomes in the Improving Access to Psychological Therapies (IAPT) programme from 1st April 2016 to 31st March 2017.

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

Key findings

Between 1st April 2016 and 31st March 2017 there were:



1,385,664
new referrals



965,379
referrals that entered treatment



567,106
referrals that finished
a course of treatment

Of which:

87.5% waited less than 6 weeks and

98.2% waited less than 18 weeks to enter treatment

524,730 started their treatment at caseness, with

49.3% moving to recovery

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This product may be of interest to the Department of Health and Social Care (DHSC), 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 and annual reports².

This report summarises activity in the IAPT programme for the annual period 1st April 2016 to 31st March 2017. It shows key information about activity, patient outcomes and waiting times. It expands upon and supersedes the content of the basic 2016-17 annual publication, released on 30th November 2017.

Main findings³

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

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

Activity

1,385,664 new referrals were received in the year.

965,379 referrals entered treatment in the year.

1,342,809 referrals ended (for any reason) in the year.

Outcomes

524,730 referrals finished a course of treatment in the year having started at caseness⁴, of which 258,888 (49.3%) moved to recovery.

Waiting times

Of the 567,106 referrals that finished a course of treatment in the year, 87.5% waited less than 6 weeks and 98.2% waited less than 18 weeks to enter treatment.

¹ <https://www.nice.org.uk/>

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

³ Note that these figures have been revised since their original publication as part of the basic 2016-17 annual publication released in November 2017.

⁴ 'Caseness' is the term used in IAPT to define a clinical case of anxiety or depression. See Appendix 3 of this report for further details.

Outcomes

Outcomes in IAPT are measured in terms of three measures;

- Recovery;
- Reliable improvement;
- Reliable recovery.

For a full explanation of each of these terms, see Appendix 3 of 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 a clinical case at the start of their treatment ('at caseness') and not a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition⁵.

The Government target is that 50% of eligible referrals⁶ to IAPT services should move to recovery⁷.

Recovery

49.3%

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: recovery rates over time, England, 2012-13 to 2016-17

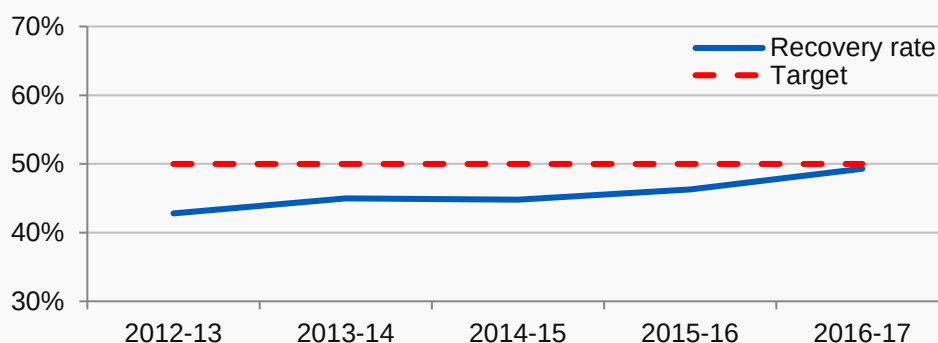


Figure 1 shows that recovery rates have increased gradually year-on-year since the dataset was established in 2012-13⁸, reaching 49.3% in 2016-17.

⁵ Further information about the various questionnaires used to assess caseness, and their caseness thresholds, can be found in Appendix 4 of this report.

⁶ Eligible referrals are those that finished a course of treatment in the year having started their treatment at caseness (or initial caseness unknown).

⁷ See p16-17 of *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

⁸ Please note that there were methodological changes to published IAPT data part way through the 2014-15 year as a result of a dataset version change, which may have impacted recovery rates. Full details are published in 'Methodological Change

Calculating recovery rates

Recovery rates are calculated as a proportion of eligible referrals. A referral is eligible for the assessment of recovery if they have finished a course of treatment and were at caseness at the start of their treatment.

It is important to note that referrals whose initial caseness is not known (because they did not have enough initial scores recorded) are included in the denominator for this calculation. This incentivises the recording of questionnaire scores, since a higher proportion of referrals with unknown caseness will decrease the recovery rate.

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

In 2016-17, this calculation is performed as follows:

$$\frac{258,888}{\left(567,106 - 42,376 \right)} \times 100 = 49.3\%$$

Recovery rates at Clinical Commissioning Group level are published in the accompanying data file.

Recovery rates by Clinical Commissioning Group

The NHS in England is split into Clinical Commissioning Groups (CCGs), who commission services in their area. In IAPT, it is possible for providers of services to work on behalf of CCGs other than the one in which they operate; for example, because of patients who may live near the border of two CCGs. Please note that throughout this report, data presented for CCGs includes three Commissioning Hubs – East Commissioning Hub, London Commissioning Hub and National Commissioning Hub 1 – that are responsible for specialised commissioning of IAPT services.

Recovery rates at Clinical Commissioning Group level are published in **Table 7a** of the accompanying data tables.

Reliable improvement and reliable recovery

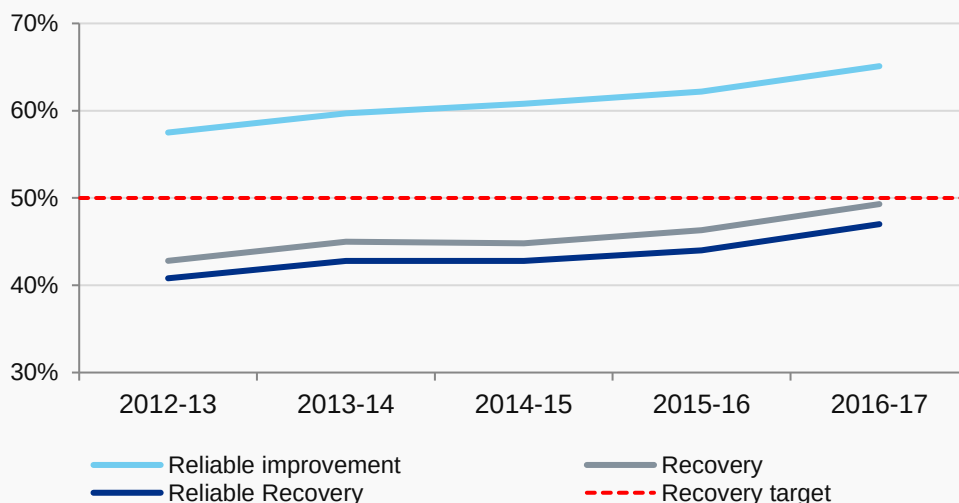
In addition to recovery, there are two other measures of outcome in IAPT: reliable improvement and reliable recovery.

A referral has shown reliable improvement if there is a significant improvement in their condition following a course of treatment. This is 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
65.1%
of referrals finishing a course of treatment showed reliable improvement.

Figure 2: Reliable improvement, recovery and reliable recovery rates over time, England, 2012-13 to 2016-17



The above chart compares recovery, reliable improvement, and reliable recovery rates year-on-year over the course of the IAPT dataset. 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 Appendix 3 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 2016-17, this calculation is performed as follows:

$$\frac{369,254}{567,106} \times 100 = 65.1\%$$

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 2016-17, this calculation is performed as follows:

$$\frac{246,460}{(567,106 - 42,376)} \times 100 = 47.0\%$$

Reliable recovery

47.0%

of eligible referrals showed reliable recovery.

A referral has shown reliable recovery if they have reliably improved and also recovered.

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 year¹⁰.

In 2016-17, 87.5% of referrals were seen within 6 weeks, and 98.2% were seen within 18 weeks – both above the targets.

Waiting times

87.5%

of referrals waited less than 6 weeks for their first treatment appointment.

Figure 3: Distribution of waiting times between referral and first treatment for referrals finishing treatment in 2016-17, England

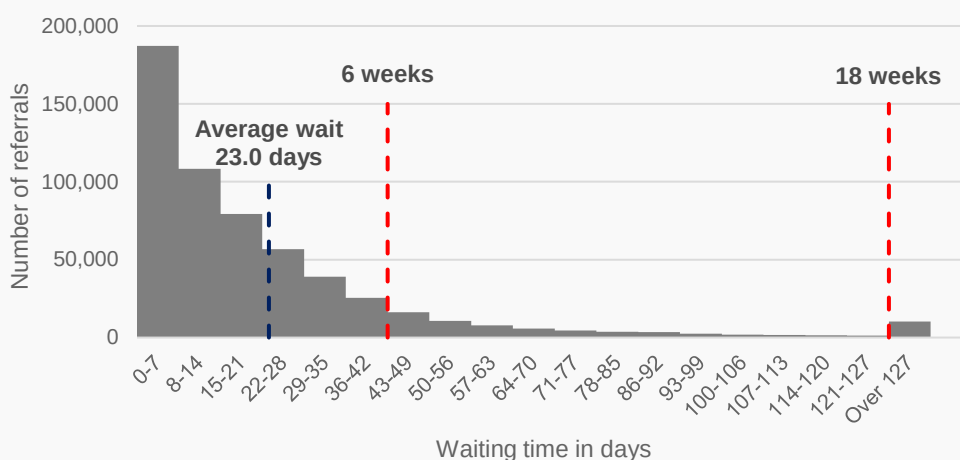


Figure 3 shows that the peak number of referrals entered treatment between 0 and 7 days (187,164 referrals), with only 1.8% (10,214) of referrals waiting over 18 weeks to enter treatment.

The average waiting time to enter treatment was 23.0 days. There is wide variation across CCGs in average waiting times; the shortest average wait was 5.6 days (NHS Waltham Forest CCG) and the longest was 134.5 days (NHS Leicester City CCG).

⁹ See p16-17 of *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

¹⁰ Since July 2014. Comparisons with waiting times in annual data prior to 2015-16 should be made with caution, as these were based on referrals entering treatment in the year.

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 2016-17, this calculation is performed as follows (based on 6-week target):

$$\frac{496,062}{567,106} \times 100 = 87.5\%$$

Waiting times at Clinical Commissioning Group level are published in **Table 2a** of the accompanying data file.

Activity

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

There are four key stages in an IAPT pathway:

- **Referral received:** This is the date on which an IAPT care provider receives a referral for a patient. In 2016-17, there were 1,385,664 new referrals to IAPT care providers.
- **Referral enters treatment:** This is the date of a patient's first attended treatment appointment. In 2016-17, 965,379 referrals entered treatment.
- **Appointments:** Appointments are the way in which patients' contact with IAPT services is recorded. There are a range of appointment types in IAPT, such as assessment, treatment, and review. In 2016-17, there were a total of 4,498,278 attended appointments (of any kind).
- **Referral ends:** A referral most commonly ends having completed a course of IAPT treatment, but there are other reasons a referral may end, such as the patient declining treatment. In 2016-17, 1,342,809 referrals ended, of which 567,106 completed a course of treatment.

Figure 4: Referrals received, entered treatment, ended, and finished treatment in 2016-17, England¹¹

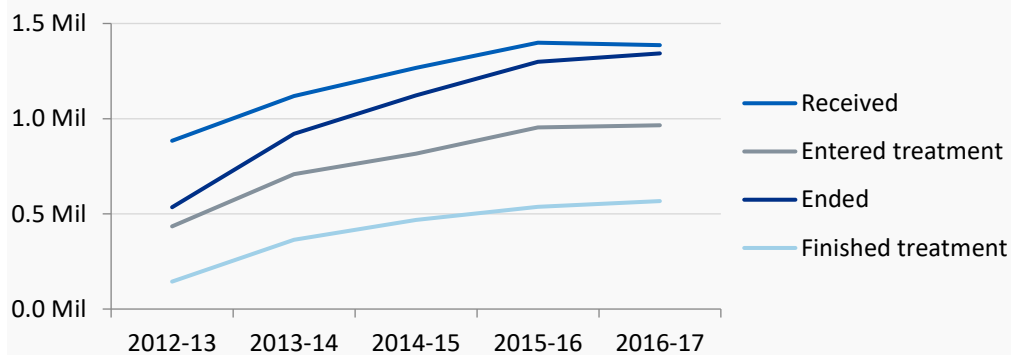


Figure 4 shows that activity of all types has continued to increase over time, though the rate of increase continues to reduce year on year.

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 2016-17 did not necessarily enter treatment¹¹ or end in the year. Likewise, referrals that ended in 2016-17 may have been received or entered treatment before 2016-17.

¹¹ Please note that the definition of a treatment appointment changed with the implementation of v1.5 of the IAPT dataset in July 2014. For full details, see the 'Methodological Change Paper – IAPT version 1.5 reports – November 2014', published at <http://www.digital.nhs.uk/iaptmonthly>.

The number of referrals that finished a course of treatment is a subset of all referrals that ended in the year. In 2016-17, 42% of referrals that ended had finished a course of IAPT treatment. Referrals can end having had different levels of contact with the service; further information can be found in the section “Referrals ending”, found on page 13.

Counts of referrals received, entering treatment, and ending at Clinical Commissioning Group level are published in **Table 1a** of the accompanying data file.

Referrals received

A referral is generated when a person is referred to IAPT services. 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 2016-17 there were:

- 1,385,664 new referrals to IAPT care providers, and
- 1,198,952 people¹² referred to IAPT care providers.

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 provider¹³.

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 having entered treatment in 2016-17, a referral must have attended a first treatment appointment¹⁴ in the year.

¹² This is a count of unique person identifiers with an associated referral received in 2016-17 and does not include bypass patients. For further details, see the Glossary.

¹³ 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.

¹⁴ A treatment appointment in v1.5 of the IAPT dataset is one that is recorded as having an appointment type of ‘treatment’, ‘assessment and treatment’, or ‘review’.

In 2016-17, 965,379 referrals entered treatment.

Not all referrals enter treatment, as a patient may be discharged or otherwise choose not to continue in the service. In 2016-17, 417,939 (31.1% of referrals ending in the year) ended before entering treatment, of which 388,727 (93.0%) did not attend any type of appointment.

Some referrals that entered treatment in 2016-17 will have been received in 2015-16. Similarly, some referrals that were received in 2016-17 will enter treatment in 2017-18.

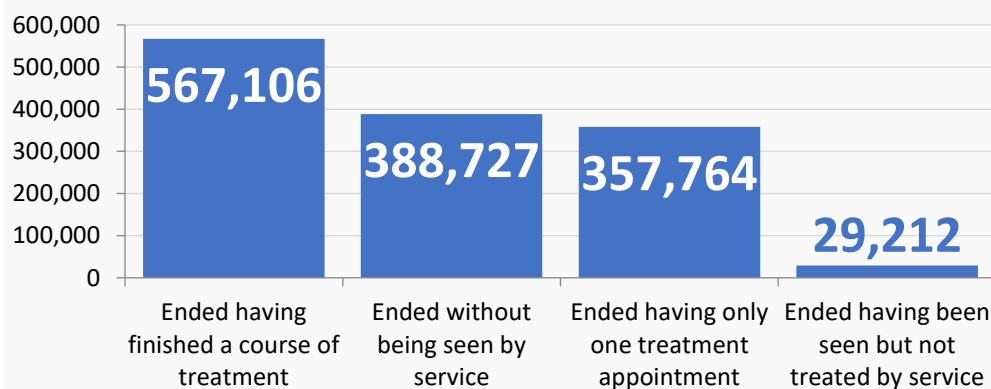
Referrals ending

A referral ends when an end date is received. A referral may end for several reasons, such as having been stepped up to another IAPT service, or the patient being referred elsewhere.

There are also different levels of contact with the service that an ended referral may have. The most common level of contact is the completion of a course of IAPT treatment. 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 2016-17, a total of 1,342,809 referrals ended. Figure 5 describes the different levels of contact an ended referral may have.

Figure 5: Number of referrals that ended, by level of contact with the service, 2016-17, England



567,106, or 42.2% of all referrals ending in 2016-17, finished a course of treatment. Only referrals having finished a course of treatment are assessed against measures of waiting times and outcomes such as recovery, reliable improvement, and reliable recovery.

and treatment'. This is different from previous years, which used the v1.0 definition, where a treatment appointment is one that has at least one valid treatment recorded. For full details, see the 'Methodological Change Paper – IAPT version 1.5 reports – November 2014', published at <http://www.digital.nhs.uk/iaptmonthly>.

57.8% of referrals that ended in 2016-17 did not complete a course of IAPT treatment. There are many reasons why a patient may be referred to an IAPT care provider but not finish a course of treatment. For example, the patient may decline to attend an initial appointment offered, an initial assessment may determine that the patient is not suitable for IAPT services, or a patient may start a course of treatment but then decide not to continue.

Numbers of referrals ending in the year by end reason and level of contact are published in **Table 4a** of the accompanying data file.

Appendix 1: Data source and considerations

A single authoritative national database of IAPT data was created to be the source data for this report. This section explains some of the features of the data flow and how we manage the data asset for 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 (or ending in the month) every month, in accordance with the IAPT data standard¹⁵.

Submissions to NHS Digital are validated and pseudonymised by the Open Exeter Bureau Service provided by the Service Delivery Team and received by the Community and Mental Health team as a monthly pseudonymised XML extract. As 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 that allows the same instance of each referral to be 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 the future and we need to ensure that consistent figures will be produced in the 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 for a given referral was first recorded as 'generalised anxiety disorder' and updated later in the year to 'obsessive-compulsive disorder (OCD)' then the problem descriptor associated with this referral in the annual database will be 'OCD'.

Additionally, we have excluded any referrals that started prior to the IAPT dataset version change on 1st July 2014. Alongside the implementation of IAPT v1.5, a large amount of key definitions and methodologies changed (including, but not limited to, definitions of therapy types and the identification of treatment appointments)¹⁶. In the annual data view, applying previous methodologies and definitions to referrals that are submitted across both versions of the dataset is resource-intensive and of little value. An assessment of v1.0 activity found that 5,831 referrals that started prior to July 2014 had activity during 2016-17, which is 0.33% of all referrals with activity in 2016-17. Therefore, these referrals have been excluded and v1.5 definitions used exclusively.

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 the 'IAPT Reporting FAQs' document available on the NHS Digital website¹⁷.

¹⁵ See <http://www.digital.nhs.uk/iapt>

¹⁶ For full details, see the 'Methodological Change Paper – IAPT version 1.5 reports – November 2014', published at <http://www.digital.nhs.uk/iaptmonthly>.

¹⁷ See <http://www.digital.nhs.uk/iaptmonthly>

Appendix 2: Data Quality Statement

This section provides details and data quality information for the data used in this publication. It aims to provide users with an evidence-based assessment of the quality of the statistical output by reporting against those of the European Statistical System (ESS) quality¹⁸ and related dimensions and principles appropriate to this output¹⁹.

In doing so, this meets the NHS Digital obligation to comply with the UK Statistics Authority (UKSA) Code of Practice for Official Statistics²⁰, particularly Principle 4, Practice 2 which states: “Ensure that official statistics are produced to a level of quality that meets users’ needs, and that users are informed about the quality of statistical outputs, including estimates of the main sources of bias and other errors, and other aspects of the European Statistical System definition of quality”.

Accuracy and Reliability

Accuracy and reliability relates to the proximity between an estimate and the unknown true value.

This report is supported by a Data Quality summary report in an Excel spreadsheet format. The purpose of the DQ summary is to report known issues with providers’ data submissions within the annual period, as well as to present users with information about the validity, completeness and accuracy of records that have been used in this annual analysis.

In addition, every month an overview of Data Quality (DQ) in the IAPT dataset is published. The report includes the VODIM (Valid, Other, Default, Invalid, Missing) tables showing metrics as counts and percentages, both nationally and by provider, for the reporting month and for key data items. The monthly data quality reports include measures related to dataset coverage, data consistency and data integrity.

Monthly data quality reports are available on the NHS Digital website:

<http://digital.nhs.uk/iaptreports>

There is a known issue with the processing of Assessment Patient Experience Questionnaires. An automated process was erroneously transforming NULL (i.e. missing) data values into a value of 0, which is a score of ‘Not at all satisfied’. This artificially inflated the number of questionnaires with a score of ‘Not at all satisfied’ in the dataset.

This issue was corrected from the January 2017 Refresh submission, in March 2017. However, this means that for any Assessment PEQ data submitted to NHS Digital before March 2017, it is not possible to know whether a score of 0 in the dataset is a score of ‘Not at all satisfied’ or a NULL (missing) value.

¹⁸ ESS Quality Framework <http://ec.europa.eu/eurostat/web/quality>

¹⁹ The original quality dimensions are: relevance, accuracy and reliability, timeliness and punctuality, accessibility and clarity, and coherence and comparability; these are set out in Eurostat Statistical Law. However more recent quality guidance from Eurostat includes some additional quality principles on: output quality trade-offs, user needs and perceptions, performance cost and respondent burden, and confidentiality, transparency and security.

²⁰ UKSA Code of Practice for Statistics: <http://www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html>

There have been no issues with processing PEQ scores of: 'Completely satisfied', 'Mostly satisfied', 'Neither satisfied nor dissatisfied' or 'Not satisfied'.

For data in the 2016-17 publication, we have a partial year of data following the correction. Given this, NHS Digital has endeavoured to maximise the utility of the published data and so 2016-17 data is split into quarters based on the date of the referral's last assessment appointment, these data are presented in Table 5c.

Further details of the methods used to calculate PEQ and the impact of this issue are available in the methodology change notice, available from <https://www.digital.nhs.uk/iaptmonthly>.

Relevance

Relevance is the degree to which the statistical product meets user needs in both coverage and content.

Data in this publication are presented in various ways in order to meet user needs: summary report and key findings (this document), a set of data tables and a data quality report published in Excel and CSV data tables.

Where possible the data is presented at CCG level as well as national level to allow users to access information about the IAPT services in their areas.

Comparability and Coherence

Coherence is the degree to which data are derived from different sources of methods, but refer to the same topic, are similar. Comparability is the degree to which data can be compared over time and domain.

The IAPT publication uses clinical terms and definitions wherever possible.

As described in Appendix 3, a patient is defined as recovered if they were above the caseness threshold for either anxiety or depression or both at the start of treatment and if they are below the caseness threshold for both anxiety and depression at the end of treatment. This 'double' recovery measure is specific to IAPT and will continue to be the measure used in regular reporting as it is the most patient centred method of assessing the outcome of treatment.

In many academic and clinical research studies, anxiety and depression are studied in isolation; rather than together. When considering 'recovery' for anxiety and depression separately, it is anticipated that more patients will have dropped below the caseness threshold on one of the scales, irrespective of whether they are above or below the caseness threshold on the other scale. The table below provides information on the number of patients who moved below the caseness threshold for anxiety and depression separately, alongside the standard IAPT recovery measure.

Comparison of recovery for anxiety and depression separately and the IAPT definition of recovery, 2016-17

	Number of patients at caseness at the start of treatment	Number of patients below caseness threshold at the end of treatment (recovered)	Recovery rate
Anxiety and depression (IAPT recovery definition)	524,730	258,888	49.3%
Depression only	457,662	244,755	53.5%
Anxiety only	493,903	254,744	51.6%

From January 2017, a subset of IAPT providers are taking part in a pilot programme offering psychological therapy that is integrated with physical healthcare for patients with pre-existing long-term health conditions and/or medically unexplained symptoms²¹. This pilot programme is being supported by the collection of additional data items alongside routine IAPT submissions. An assessment has been made of the impact of this new collection on the data submitted by providers taking part in this pilot that has contributed to this report, which is summarised below.

The additional items collected are appointment-level fields; that is, they are collected during each patient contact for relevant referrals and submitted as an additional data table that is linked to the main appointment table in the IAPT dataset. Where this additional information is not provided, it does not affect the main appointment table, and for referrals where the new information is present, it does not affect the methodologies used in any of the analyses in this annual publication, or routine monthly or quarterly IAPT publications. New data items are analysed and reported in a separate publication product, available alongside monthly publications from March 2017 Final at <http://www.content.digital.nhs.uk/iaptreports>.

The providers submitting integrated data in March 2017 are listed in the table below. The March 2017 Final Data Quality Report²² shows how data completeness, validity and consistency shows no notable differences across key fields for these organisations or compared to non-pilot providers.

²¹ For more information about the integrated services pilot and statistical publications, see monthly IAPT publications from March 2017 Final data onwards, available from <http://www.content.digital.nhs.uk/iaptreports>.

²² See publication: *Psychological Therapies: reports on the use of IAPT services, England, March 2017 final, including reports on the integrated services pilot*, available from <http://www.digital.nhs.uk/catalogue/PUB30006>

Provider Code	Provider Name
AKR01	Blackburn Centre
NCH	Talkplus
NDC03	Insight Healthcare Talking Therapies (Calderdale)
NDC09	Insight Healthcare - Nottinghamshire
NO202	Warrington Psychological Service
R1C	Solent NHS Trust
RDR	Sussex Community NHS Foundation Trust
RHA	Nottinghamshire Healthcare NHS Foundation Trust
RLYD7	Hope Centre
RNUDT	TalkingSpace Plus
RNUDV	Healthy Minds
RT1	Cambridgeshire and Peterborough NHS Foundation Trust
RTF61	Wallsend Health Centre
RV3AR	Mill House
RVNCG	Lift Psychology Swindon
RW5	Lancashire Care NHS Foundation Trust
RWK1G	Richmond Royal Hospital
RWRD7	Waverley Road
RWRRG	West Essex IAPT
RWV	Devon Partnership NHS Trust
RWX	Berkshire Healthcare NHS Foundation Trust
RX3YE	The Briary Unit
RX4	Northumberland, Tyne and Wear NHS Foundation Trust
RXG10	Fieldhead Hospital

Timeliness and Punctuality

Timeliness refers to the time gap between publication and the reference period. Punctuality refers to the gap between planned and actual publication dates.

IAPT data is published monthly, within 3 months of the end of the reporting period. Approximately 122 measures of activity, waiting times and outcomes are released each month.

The initial 2016-17 annual publication was released eight months after the end of the financial year; with this more detailed publication being released 11 months after the end of the financial year.

Accessibility and Clarity

Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and the availability of supporting information. Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice.

This publication includes this report, presenting headline figures and key findings that are aimed at a range of audiences. More detailed information is published in Excel data tables that accompany this report. In addition, all CCG level data tables are also released as CSV files.

This publication may be requested in large print or other formats through the NHS Digital contact centre: enquiries@nhsdigital.nhs.uk.

Assessment of user needs and perceptions

This section describes the processes for finding out about users and their views on the IAPT publication.

In May 2016, we ran a user consultation to help better understand the user requirements for the IAPT publication. Following the consultation, CSV versions of the data tables have been included in this publication. The main findings from the IAPT consultation are available on in the 'related documents' section of this web page: www.nhs.uk/iaptmonthly

Comments on the IAPT publication can be made through various media:

- 'Have your say' on the NHS Digital website
- Email: enquiries@nhsdigital.nhs.uk
- Telephone: 0300 303 5678

Users of this report are also encouraged to complete a short customer satisfaction survey at <http://web.ict.hscic.gov.uk/hscicgovuk-amnje/pages/7f454cb28f9fe711811670106fa55dc1.html>

The IAPT Outcomes and Informatics group consist of a range of stakeholders whose views have been used to continuously develop this publication.

Performance Cost and Respondent Burden

This section describes the effectiveness, efficiency and economy of the statistical output.

Data for this publication is collected by providers of IAPT services in the course of delivering those services to patients.

Information about the administrative sources and their use for statistical purposes is included in the NHS Digital's Statement of Administrative Sources at: <http://digital.nhs.uk/article/1789/Statement-of-administrative-sources>

Confidentiality, Transparency and Security

This section describes the procedures and policy used to ensure sound confidentiality, security and transparent practices.

The data contained in this publication are Official Statistics. The code of practice for official statistics is adhered to from collecting the data to publishing.

<http://www.statisticsauthority.gov.uk/national-statistician/guidance/index.html>

This publication is subject to a standard NHS Digital risk assessment prior to issue. Disclosure control is implemented where this is deemed to be necessary in accordance with the protocols associated with the underlying data sources. Further details of the risk assessment are available in the NHS Digital's Disclosure Control Procedure.

- Link to the NHS Digital's Disclosure Control Procedure: <http://digital.nhs.uk/pubs/calendar>
- Link to the NHS Digital privacy policy: <http://digital.nhs.uk/privacy>
- Freedom of Information Process: <http://digital.nhs.uk/foi>

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. Sub-national rates are rounded to the nearest whole percent to prevent disclosure. National rates are rounded to one decimal place.

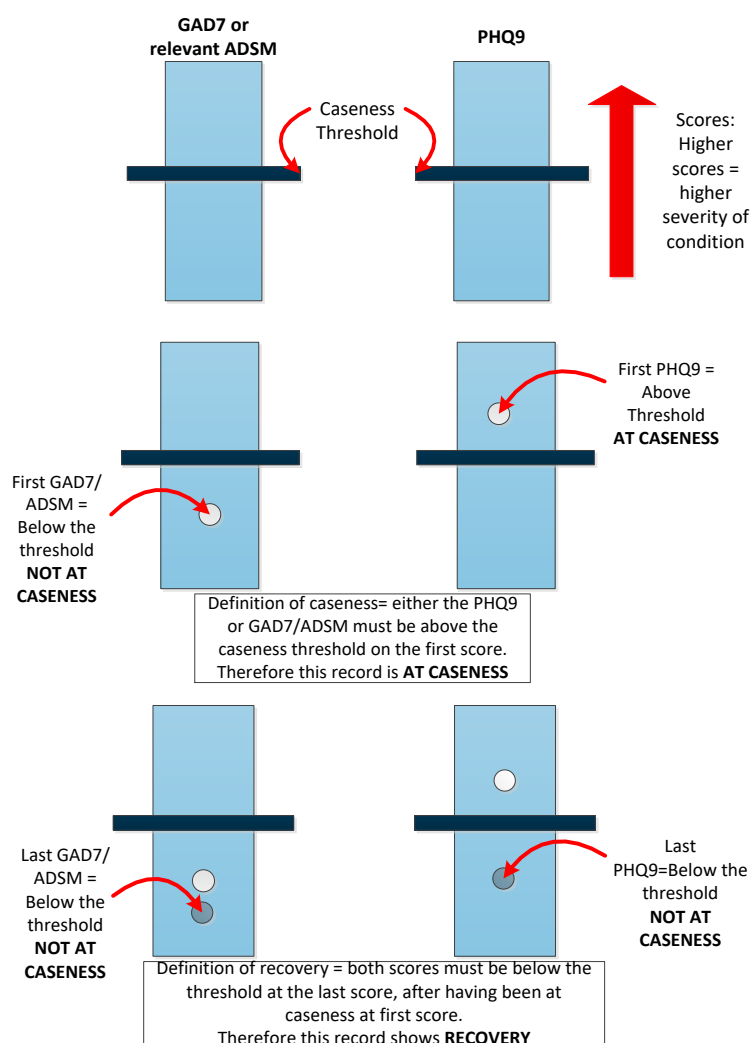
Appendix 3: Caseness, Recovery, and Reliable Improvement

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 off²³ 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.

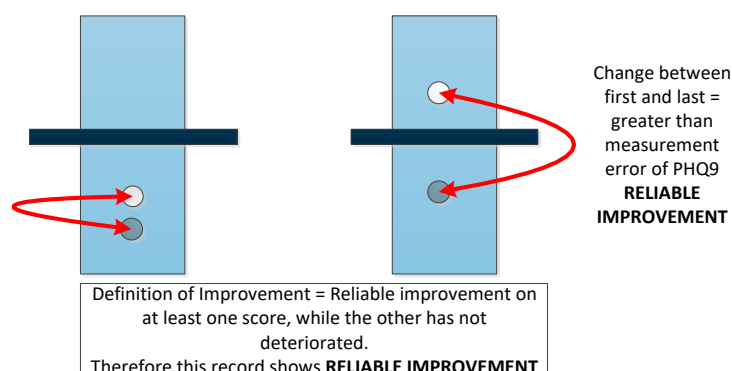
A referral has recovered at the end of a course of treatment if *both* the last recorded PHQ-9 score *and* the last recorded relevant ADSM score are **below** the caseness threshold.

²³ Information on the cut off values and how they should be used can be found in Appendix 4 of this report. For further details, see 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 error²⁴ 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.



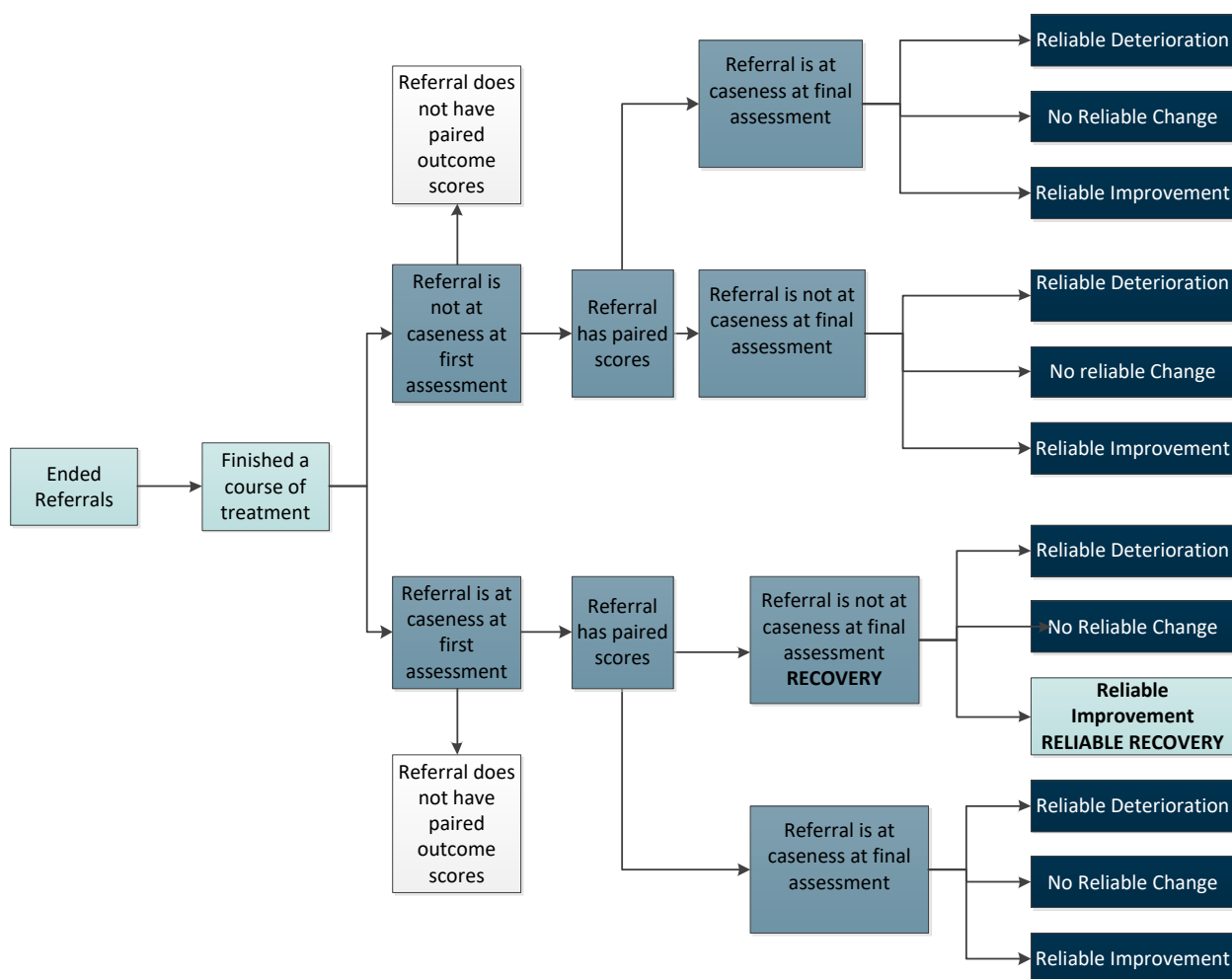
Reliable recovery

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

²⁴ 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 4 of this report.

Flowchart of the potential output pathway of a completed referral²⁵



²⁵ 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 4: ADSMs appropriate to problem descriptors and caseness thresholds

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	Agoraphobia	Agoraphobia Mobility Inventory	>2.3 ²⁶	0.73
F40.1	Social phobias	Social Phobia Inventory	19	10
F41.0 ²⁷	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	Hypochondriacal disorder	Health Anxiety Inventory (Short Week)	18	4

²⁶ Note that this caseness threshold has been updated since the 2015-16 annual report. Please see the accompanying Methodology Change Note, available from <https://www.digital.nhs.uk/iaptmonthly>.

²⁷ 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 5: Distinct therapy types in IAPT

Following an assessment, a decision to offer treatment may be made and a therapy type decided upon. There are cases when this decision is made after further assessments are carried out. Once a therapy type is adopted, it may be later reassessed, as a different therapy type is deemed more appropriate or beneficial to the patient. For this reason, in our reporting we look at the therapy type provided in the last treatment appointment in the assessment of outcomes.

There are two categories of therapy in IAPT - low intensity and high intensity. Each type of therapy has a given code for submission purposes.

A patient's therapy may be 'stepped up' from low intensity therapy to high intensity or in some cases 'stepped down'. For specific severe cases, the guidance is that high intensity treatment is offered from the initial assessment.

Low Intensity therapies		High Intensity therapies	
20	Guided Self Help (Book)	40	Applied relaxation
21	Non-guided Self Help (Book)	41	Behavioural Activation (High Intensity)
22	Guided Self Help (Computer)	42	Couples Therapy for Depression
23	Non-Guided Self Help (Computer)	43	Collaborative care (for people with depression and a chronic physical health condition)
24	Behavioural Activation (Low Intensity)	44	Counselling for Depression
25	Structured Physical Activity	45	Brief psychodynamic psychotherapy
26	Ante/post natal counselling	46	Eye Movement Desensitisation Reprocessing
27	Psychoeducational peer support	47	Mindfulness
28	Other Low Intensity	48	Other High Intensity (not specified above)
29	Employment Support (Low Intensity)	49	Employment Support (High Intensity)
		50	Cognitive Behaviour Therapy (CBT)
		51	Interpersonal Psychotherapy (IPT)

IAPT Stepped Care Model

The mental health stepped care model is described below, within which IAPT therapies sit in step 2 (low intensity therapies) and step 3 (high intensity therapies).

The stepped care model

The recommendations in this guideline are presented within a stepped care framework that aims to match the needs of people with depression to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances. Each step represents increased complexity of intervention, with higher steps assuming interventions in previous steps.

Step 1: Recognition in primary care and general hospital settings		
Step 2: Treatment of mild depression in primary care		
Step 3: Treatment of moderate to severe depression in primary care		
Step 4: Treatment of depression by mental health specialists		
Step 5: Inpatient treatment for depression		
Who is responsible for care?	What is the focus?	What do they do?
Step 5: Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4: Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3: Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2: Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1: GP, practice nurse	Recognition	Assessment

Source: <http://www.iapt.nhs.uk/silo/files/iapt-outline-service-specification.pdf>

Appendix 6: Calculating Cohen's d effect size in IAPT

In previous IAPT annual publications, the mean and standard deviation were published for the GAD-7 and PHQ-9 scores at the start and end of treatment, where the mean is the average score for patients at the start and end of treatment and the standard deviation gives a measure of the dispersion in the data values.

When the standard deviation is small, there is a small amount of variation in the data values and the data points tend to be close to the mean. When the standard deviation is large there tends to be large variation in the data values they tend to have a wide variation in values, many being further away from the mean.

Since 2015-16, we have also used Cohen's d effect size²⁸ for the WSAS, PHQ-9 and GAD-7 scores. The Cohen's d effect size measures the magnitude of the effect size. In this report it is being used to assess the change in average scores between the start and the end of treatment. Unlike tests for statistical significance, this test is independent of sample size and will produce a standardised difference between them means at the start and end of treatment

To calculate Cohen's d effect size:

$$d = \frac{M_{\text{group1}} - M_{\text{group2}}}{SD}$$

Where d = Cohen's d effect size, M = mean and SD = standard deviation

For this IAPT publication we have used the following:

$$\text{Cohen's } d = \frac{\text{Mean score pretreatment} - \text{Mean score posttreatment}}{\text{standard deviation at pretreatment for England}}$$

By using the standard deviation for England in all effect size calculations, we can assess and compare the difference in scores between CCGs.

Cohen defined effect size into 3 broad categories:

- d=0.2 small effect
- d=0.5 medium effect size
- d=0.8 large effect size

The larger the effect size, the bigger difference there is between the mean scores at the start and end of treatment. In IAPT, when the effect size is large, there is higher probability that a person's score at the end of treatment will be lower than the score for a person at the start of treatment.

When the Cohen's d score is negative, the mean scores at the end of treatment are higher than the scores at the start of treatment for that CCG.

²⁸ Cohen, J. (1977). Statistical power analysis for the behavioural sciences. Routledge.

Glossary

Access

A government target for IAPT is that 15% of those with anxiety or depression should be treated through the IAPT programme²⁹. 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, 2000³⁰.

Data tables that assess referrals entering treatment (access rate numerator):

Table 1a, Table 1b, Table 2a, Table 2b, Table 2c, Table 8a, Table 9a, Table 10a, Table 11a, Table 12a, Table 13a, Table 15.

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 Handbook³¹ 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.

Information about ADSMs relevant to the different problem descriptors can be found in Appendix 4.

Data tables that use ADSM scores:

Table 6b, Table 6c, Table 7a, Table 7b, Table 7c, Table 7d, Table 8b, Table 9b, Table 10b, Table 11b, Table 12b, Table 13b, Table 14, Table 15.

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'.

Data tables based on assessment appointments:

Table 4a.

²⁹ For more information about this, see our 'IAPT Reporting FAQs' document (page 17):

http://www.digital.nhs.uk/media/21150/IAPT-Reporting-FAQs/pdf/Understanding_and_replicating_our_published_reports_July_2015_v1.3.pdf

³⁰

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

³¹ <http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf>

Bypass patients

When providers' IAPT data submissions to the Bureau Service 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 poor data quality means we cannot match the record to future submissions³².

Since the patient pathway is usually created over multiple submissions, records for 'bypass patients' can be duplicated over the course of the year and for this reason this report does not include 'Bypass patients'.

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 off³³ on either their anxiety score or their depression score, or both, then the referral is classed as a clinical case.

A detailed description of caseness and how it is used in assessing outcomes can be found in Appendix 3, and a list of caseness thresholds for the various scores can be found in Appendix 4.

Data tables that assess caseness:

Table 6c, Table 7a, Table 7b, Table 7c, Table 7d, Table 8b, Table 9b, Table 10b, Table 11b, Table 12b, Table 13b, Table 14, Table 15.

Completed course of treatment

See 'Finished course of treatment' below.

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.

Data tables that assess referrals entering treatment (based on first treatment appointment date):

Table 1a, Table 1b, Table 2a, Table 2b, Table 2c, Table 8a, Table 9a, Table 10a, Table 11a, Table 12a, Table 13a, Table 15.

³² See IAPT Data Quality Statement for further information:

<http://www.digital.nhs.uk/media/16923/IAPT-DQ-Month/pdf/IAPT-month-dqs.pdf>

³³ Information on the cut off values and how they should be used can be found in Appendix 4 of this report. For further information, see the IAPT data handbook: <http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf>

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 by definition 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).

Data tables that assess referrals that have finished a course of treatment:

Table 1a, Table 1b, Table 2a, Table 2c, Table 3a, Table 3b, Table 4a, Table 4b, Table 4c, Table 4d, Table 4e, Table 4f, Table 4g, Table 5a, Table 5b, Table 5c, Table 6a, Table 6b, Table 6c, Table 7a, Table 7b, Table 7c, Table 7d, Table 8a, Table 8b, Table 9a, Table 9b, Table 10a, Table 10b, Table 11a, Table 11b, Table 12a, Table 12b, Table 13a, Table 13b, Table 14, Table 15, Table 16.

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.

Data tables that use GAD7 scores:

Table 6c, Table 7a, Table 7b, Table 7c, Table 7d, Table 8b, Table 9b, Table 10b, Table 11b, Table 12b, Table 13b, Table 14, Table 15.

National Institute for Health and Clinical Excellence (NICE)³⁴

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

Data tables that use PHQ-9 scores:

Table 6c, Table 7a, Table 7b, Table 7c, Table 7d, Table 8b, Table 9b, Table 10b, Table 11b, Table 12b, Table 13b, Table 14, Table 15.

³⁴ <http://www.nice.org.uk>

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.

Data tables that use problem descriptor:

Table 1b, Table 3a, Table 3b, Table 4b, Table 6b, Table 6c, Table 7b, Table 7c, Table 7d.

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.

Data tables that assess recovery:

Table 7a, Table 7b, Table 7c, Table 7d, Table 8b, Table 9b, Table 10b, Table 11b, Table 12b, Table 13b, Table 14, Table 15.

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 pathway³⁵.

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.

³⁵ 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>

Data tables that assess referrals received:

Table 1a, Table 1b, Table 8a, Table 9a, Table 10a, Table 11a, Table 12a, Table 13a.

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 error³⁶ 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.

Data tables that assess reliable change:

Table 7a, Table 7b, Table 8b, Table 9b, Table 10b, Table 11b, Table 12b, Table 13b, Table 14

³⁶ 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.

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