iapt
Improving Access to Psychological Therapies

NHS England

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Data set v1.5: Summary of Changes

June 2014

Version 2

Document Version Control

Version	Date	Author	Key Changes
1.0	01/06/14	Margaret Oates	First release
2.0	25/06/14	Margaret Oates	Changes made to Waiting times appendix 1 - Example 2 page 14

Introduction

The IAPT Minimum Data Set (MDS) was developed to support consistent data collection and reporting across NHS commissioned IAPT services. The MDS was mandated for central return via the Bureau Service Portal (BSP) from April 2012. This has allowed us to develop national reporting based on patient record level data and we no longer rely on aggregated commissioner returns. The MDS is now the source of data used to answer NHS mandate commitment. In the future this will allow us to build a comprehensive picture of patient demographics, treatments provided and outcomes.

Following wide consultation data items contained in the MDS have been updated to better reflect how services are delivered. Changes are detailed in version 1.5 released in December 2013. These changes are expected to be implemented from 1st July 2014. The Health and Social Care Information Centre (HSCIC) has developed a detail change specification, this has been shared with system suppliers and IT leads. This supplementary document is aimed at clinicians, service managers and commissioners and provides high level information on the important changes to data collection requirements that will need your attention from July 2014. It is not intended to replace the technical specification and other documents issued by the Health and Social Care Information Centre (HSCIC) available from http://www.hscic.gov.uk/iapt/

Changes to the data flow process

Central data return will continue via the Bureau Service Portal (BSP). The process will not change, however a new version of the Intermediate Database (IDB) is required to support changes and submit data. To request the latest IDB email enquiries@hscic.gov.uk and title your request "IAPT v1.5 IDB".

In order to ensure accurate reporting it is essential that Commissioner and Provider ODS codes are recorded. The IAPT return is a Provider submission, the BSP will only accept one Provider code per submission. Large organisations may wish to make multiple submissions separating activity by discrete IAPT service, this can be done by allocating a 5 digit ODS code for each service.

Additionally, in order to allow time to implement technical changes there will not be a central submission of July 2014 primary data. The first version 1.5 submission will be July refresh and August primary, submitted in September 2014.

Mandated items

Two data items already included in the MDS will become mandatory from July 2014. These are:

- Appointment - Appointment Purpose
- Referral - Date Referral Received

This means that these fields MUST be populated for every appointment included in your monthly submission otherwise the whole submission will fail and your activity will not be included in national reporting. In the case of referral date it is likely that this is only entered on your IT system at the start of treatment and this is managed in the routine data extraction process. If you are in any doubt please contact your system supplier for confirmation.

Additionally amongst the various data items included in the new MDS are three new mandatory data items that need to be completed when a waiting times clock pause occurs (further details below):

- Appointment - Appointment time
- Waiting time pauses – Pause identifier
- Waiting time pauses – Pause start date

Your Information Management Department has access to monthly processed data extracts, submission summaries and detailed validation reports. If you suspect national reports do not reflect local activity you should contact your Information Management Department who will be able to work through any anomalies and highlight any data quality issues.

Data Set Changes
Changes have been made to reflect local service delivery and include items to capture movement across the care pathway, allow accurate measurement of waiting times and support Payment and Pricing development (formerly PbR). Full detail of changes can be found in the technical specification (HSCIC web site). The following section provides a summary of the most important changes.

1. **Service Delivery**

IAPT services follow a stepped care approach as advocated by NICE. The following changes have been made to capture movement across the care pathway.

New Item! IAPT Stepped Care Intensity
Most services already collect (on local systems) data regarding the IAPT step of care delivered, this will now be included in the central return.

Item change! Source of referral code
This will change to allow recording of internal referral between IAPT services i.e. stepped up/down within a single episode of treatment.

The HSCIC will run background processes that will track a person across the care pathway so it is important that these fields are completed. Tracking will require 'joining up' a number of additional data items to make up a patient unique identifier these items are; NHS Number, date of birth, local patient identifier and postcode, if any of these items are missing linkage is weakened.

The following items have been modified in order to improve consistency of recording.

Item change! Care Spell End Code
This will include a more comprehensive list of reasons for the discharge and will also allow differentiation between people who were only assessed and those that entered treatment**.**

Q: Some people receive treatment but are only seen once i.e. 'assessment with treatment session'. Should we use 'assessment only' or 'assessed and treated' end code be used when closing these cases?
A: If a person is seen once and the session was coded as assessed only, then use relevant assessed only code. If a person's receives one session coded as 'assessed and treated', consider whether the termination was planned (i.e. therapist only intended to give one session and that was agreed with the patient). If so, select 'completed scheduled treatment'. If termination was not planned (i.e. therapist intended to give further treatment sessions but patient didn't attend) choose relevant code from the other options.

Item change! Care Profession role:

This item has been modified to separate trainees from qualified staff and the modalities of treatments IAPT staff are trained to deliver.

Q: The values are not in-line with the NHS Electronic Staff Record (ESR) why is this?
A: This item relates directly to the therapy that is being administered at a particular session and should be recorded at each appointment. The ESR records profession or job title, we do not use this as the capacity in which staff are acting may differ depending on who they are seeing e.g. the therapist may be a Mental Health Nurse by Profession but administer CBT to one person and Mindfulness training to an another. Therefore you should record the capacity they are acting in for that particular appointment. If more than one clinician is present you should record the role of the 'lead clinician' at that particular session.

Item change! Therapy Type
This will separate values for high and low intensity therapy.

Q: Not all the treatment we deliver are in the list, how should these be recorded?
A: IAPT services were developed to deliver NICE approved therapies for people with Depression or Anxiety disorders. All these therapies are included in the list of values, however if the treatment you are delivering is not listed then you should record under 'other' and specify if this was a low or high intensity treatment.

New Item! Face-to-face communication mode
This has been added to differentiate between individual, couple and group sessions and will allow reports to be adapted for different modes of delivery.

There are also minor changes to the religion and sexual orientation permissible values. Religion will be recorded using high level groupings and homosexual will be changed to gay/lesbian in line with the NHS data dictionary.

Q: Is it necessary to re-code patients using new permissible values retrospectively?
A: No, the HSCIC will map to current items when reporting where necessary.

2. Patient waits

IAPT updated waiting times guidance in 2012/13, this has now been revised further (Appendix 1) but is subject to change in light of on-going discussions between NHS England and DH regarding the potential introduction of an IAPT access standard. In the meantime a new table has been created in version 1.5 of the data set to support current guidance.

New Items! Activity suspension start date, Activity suspension end date and Activity suspension reason
Collectively these items will allow us to record and report clock pauses. Rules for clock pauses can been found in updated guidance (appendix 1). It is important that these field are completed in order to accurately reporting the time a patient waits from referral to assessment/ treatment, if not populated it is assumed that there is no pause.

New Items! Opt in date
Many IAPT services implement an 'Opt-in' model where on receipt of a referral (other than from the patient) the patient is contacted and asked to confirm they would like to be considered for treatment. The IAPT Programme accepts that where this model has been clearly specified and

agreed with the commissioner then this is acceptable. This new item is optional and will allow recording of the date a person opted into treatment where appropriate.

3. Questionnaires

New Item! Patient Experience Questionnaire (PEQ)

Version 1.5 includes the existing suite of IAPT Outcome Measures tools and for the first time includes a national standard PEQ. This has been tested out in the Payment and Pricing Pilot. There are two questionnaires, the first should be completed at the end of assessment and the second at the end of treatment. Questionnaire can be downloaded from
http://www.iapt.nhs.uk/pbr/currency-model-description/patient-experience/
Explicit consent is required from the patient to flow PEQ data centrally

Q: When should PEQ questionnaires be administered?
A: Each PEQ should be administered only once. The Assessment PEQ should be given at or after the end of the last assessment contact (some services use multiple contacts, e.g. an initial phone call followed by a face to face assessment and some more complex patients may require more than one face to face assessment session). The treatment questionnaire should be given after or at the end of the last planned treatment appointment. NB a follow-up after treatment end is not a treatment session and thus the Treatment PEQ should not be delayed until this takes place.

Q: Which Patients Receive the End of Assessment Questionnaire?
A: At the end of assessment a decision is made to treat or not, all people offered treatment should complete the assessment questionnaire as this will be used in the Payments and Pricing model. As the three choice questions relate to choice of treatment they are not applicable to people who do not enter treatment. However, it is good practice to ask the satisfaction question and return the end of assessment questionnaire for all patients as it is important to get their view on how the assessment went even if they do not go on to treatment .

Q: Should people who turn down treatment complete the end of assessment questionnaire?
A: Yes as dissatisfaction with the assessment or lack of choice may be the reason they turned down treatment.

Q: Which Patients Receive the End of Treatment Questionnaire?
A: All people that enter treatment should complete the end of treatment questionnaire. If treatment ends prematurely then the questionnaire should be given or posted out at this stage.

Q: We use a local PEQ, can we still use these?
A: Services should consider adopting the standard questionnaires from 1st July in order that consistent comparisons can be made and in particular to support potential implementation of a national currency for IAPT services. However if additional information is required to support local requirements then services should review and consider the best way of asking patients minimising burden to both patients and staff.

Q: We currently use an anonymous system why is this system patient identifiable?
A: The data will flow in an identifiable format so that we can link to an individual and ensure only one response per patient. This also allows linkage to other details such as treatment provided, associate outcomes and is also needed to support payment and pricing development. However we are currently looking at other ways that this might be managed. It is important to note that all identifiable data is removed and replaced with a pseudonymised identifier during processing.

Item change! Work and Social Adjustment Scale (W&SAS)

From July you will be required to submit individual scores for each of the 5 items that make up the tool. This is primarily to support the Payment and Pricing methodology. Total scores will be calculated by the HSCIC in reporting.

Q: Is it necessary to answer every question in the W&SAS?

A: In-line with tool makers guidance if one item is missing, invalid or N/A a total may be pro-rated. However, if two or more are missing, invalid or N/A the questionnaire is excluded from analysis. NB: question 1 relates to work and therefore may not apply to all people e.g. a retired person, if this is the case it should be recorded as '9 – not applicable'

Item change! Agoraphobia Mobility Inventory score

The Agoraphobia Mobility Inventory is the recommended ADSM where the provisional diagnosis is Agoraphobia. Due to an error made when originally defining this item the field did not allow decimal places to be recorded. This has now been rectified and allows scores to be recorded in-line with tool makers guidance. The average score (when alone) should be returned centrally. NB Item 27 ('Other') may be used for clinical purposes but should not be included in the pro-rated score.

4. Payment and Pricing

IAPT started modelling and piloting a Payment and Pricing methodology in 2011. This is an outcomes based model, full details can be found at http://www.iapt.nhs.uk/pbr/payments-by-results/. The currency model incorporates existing data items but also requires patient satisfaction data and MH clustering data in order to develop a pricing mechanisms.

New Items! Mental Health Care Cluster Code (Final)

This item is the same as used in Mental Health Secondary Care services and is recorded in the Mental Health Minimum Data Set (MHMDS). All patients entering treatment should be clustered as soon as staff have been trained but no later than April 2015 as it is expected that from this time reference costs for IAPT services will be cluster based. It is acknowledged that it will take time to implement this process and report clusters for all patients. Services are advised to agree a local implementation plan to meet this timeframe which may incorporate phased implementation. Services are not expected to cluster retrospectively but all people entering treatment from the April 2015 are expected to be allocated to a MH cluster.

Q: Who pays for training?

A: Services need to plan, organise and pay for the training of their staff. It normally takes one day to train a trainer, which is the most cost effective approach. Training can be provided by any organisation that already trains trainers; this will include some NHS MH Trusts. We are currently looking at options to arrange training regionally on behalf of providers to reduce costs wherever possible and will publish further guidance.

Q: When should we cluster patients?

A: IAPT services should cluster as they enter treatment, this is used to determine the price paid as it is an indicator of the intensity of treatment that will be required and the number of sessions. Thus, unlike secondary care MH clustering there is no cluster review period and no re-clustering. This includes not clustering again when a patient is stepped up (or down), unless the payment episode is ended by being stepped to another provider, who should then cluster them as entering.

Q: What if after a couple of treatment session the cluster is identifies as being wrong?
A: The cluster assigned may be changed if it is discovered it was wrong. It is important that it is changed in a timely fashion. It needs to be before or during the data set submission period that contains the 'care spell end code' to ensure the new MH Cluster is captured (part of the referral record). Any change to cluster should reflect the true cluster the patient was in as they entered treatment. Clusters must not be changed to reflect treatment effects as this could mean a lower cluster, which does not adequately reflect the cost of treating the patient.

Q: Should patients who only receive assessment be clustered?
A: No

Q; What about patients who only get a few telephone contacts or are given cCBT and are only seen twice?
A: There will be a price in the Payment & Pricing System for patients treated without a cluster; this will be set at a level to cover the costs of treating these low-cost patients, thus it is acceptable not to cluster these people. All other patients need to be clustered otherwise the service may not be adequately paid for their treatment, this applies especially those with complex needs, such as where it is known that they are more likely to require treatment at step 3 or above.

Q: Is there any link between MH Clustering and Provisional Diagnosis?
A: No. MH Cluster is a measure of the care needs of patients, which can be the same for a number of provisional diagnoses. Diagnosis is used to determine which ADSM scale needs to be used when measuring recovery. The cluster is needed to support Pricing and Payment development and will be used in the future to determine what level of price to apply (low to high)

Summary of changes

New Items

- Waiting time clock pauses:
- Patient experience Questionnaire
- Stepped Care Intensity
- Face-to-face communication mode

Modifications to existing Items

- Work and Social Adjustment Scale
- Source of referral code
- Care Spell End Code
- Care Profession role
- Therapy Type
- Agoraphobia Mobility Inventory score
- Religion or other belief system affiliation
- Sexual Orientation

Next steps
The Information Standard Notice issued in December 2013 instructed local system suppliers to make changes to comply with IAPT MDS Version 1.5 before July 2015, your system supplier will be able to provide a release schedule. In preparation for July you should:

1. Check your IT department has downloaded the latest version of the IDB, without this they will not be able to submit data.
2. Circulate changes to all staff involved with recording of IAPT data.
3. Understand how new mandated fields are managed in your IT system, contact your System Supplier if you are in any doubt.
4. Review change documentation and supporting guidance on the HSCIC website http://www.hscic.gov.uk/iapt/
5. Clarify any issues in the first instance with your IT department if they are unable to help contact the HSCIC directly at enquiries@hscic.gov.uk
6. From September 2014 review local validation and data quality reports in order monitor data quality and compliance.

Appendix: IAPT waiting times Guidance

Introduction

The NHS Mandate[1] has committed DH and NHS England to an examination of current waiting times in mental health services. This will involve working with other stakeholders to develop a range of costed implementation options for a set of clinically informed standards with effect from April 2015 coupled to a phased implementation approach depending on affordability. The need to progress work on waiting times was further emphasised by DH in "Closing the Gap: priorities for essential change in mental health services" (Jan 2014).

The above work is on-going and it is not possible at this stage to determine focus or impact but it may in due course inform an access standard for IAPT. However in the interim, given important revisions to the IAPT MDS with the introduction of v1.5 from 1st July 2014, this refreshed guidance should be followed. During this time we will continue to work with providers and other interested parties to examine existing practice and produce revised rules and guidance for the application of any clock stops by exception to ensure that the access standard, if rolled out, is both robust and deliverable without driving perverse incentives.

Guidance

1. A key priority of the IAPT programme is to reduce the time people wait for treatment. The programme has monitored waiting times since roll-out of its first wave sites in 2008. However it is widely acknowledged that measuring waiting time across all areas of health is not straight-forward and complicated by local processes, IT system capabilities and patient choice. Accurate and consistent returns are essential in order to improve service models, manage performance, and report on standards delivered.

2. The process for central return and reporting of IAPT data changed from an aggregate commissioner submission to a patient level service provider submission in 2013/14. This guidance has been developed to further support the new process, updates for the introduction of v1.5 of the MDS and supersedes previous guidance issued in the IAPT 2012/13 KPI publication.

3. Services should measure and monitor waiting times with the aim of ensuring that no patient waits longer than the locally stipulated maximum that is acceptable to patients. A choice of appointment times, and where possible, venue and the mode of treatment (phone, email, etc.) should be offered to every patient. A patient may only be able to attend an appointment on certain days or times; the service should endeavour to accommodate this. However, if the patient declines two reasonable appointments offers then the waiting time clock should be paused for a period. National publications will show total waits by bandings so that local services will be able to monitor improvement and make comparison with other services. It is the service's responsibility to monitor individual patient waits.

4. For some patients more than one course of treatment may be appropriate. The patient should be given enough information to make an informed choice about which treatment best meets their needs. The treatment plan should be mutually agreed between the practitioner and the patient. Local standards should be set for all waits, not just the nationally reported wait from referral to first treatment to ensure the necessary visibility and resolution of any hidden long waits.

[1] The Mandate – A mandate from the government to NHS England; April 2014 to March 2015

5. The Department of Health (DH) has issued best practice guidance for calculating waiting times[2]. This guidance has been reviewed and adapted for IAPT services in order to reflect best practice. Under the IAPT Data Standard, waiting times will be derived from patient level data submitted to the IAPT central reporting system using the 'Date Referral Received' and the 'Appointment Date' fields. The Appointment date used will be the Appointment date for the first treatment appointment in the Referral table. In Version 1.0, an appointment is identified as a treatment appointment through the presence of a Therapy Type for the appointment record. In Version 1.5 of the IAPT data set (implemented in July 2014) this determination will instead be based on the Appointment Type, with Appointment Types 02 – Treatment, 03 - Assessment and Treatment, and 05 - Review and Treatment being used to identify a treatment appointment. Local systems should be able to generate reports using these variables to manage waiting lists.

6. From July 2014 the IAPT central reporting system will have the functionality to capture clock pauses. Clock start, pause and stop should be managed locally. DH guidance sets out the rules and definitions for referral to treatment to ensure that each patient's waiting time clock starts and stops fairly and consistently. It should be noted that this guidance is currently under review but at present these principles should be adopted for IAPT services as follows:

7. Clock Starts – The waiting time clock starts when:

   i) Any care professional (GP or other) or service permitted by an English NHS commissioner to make such referrals, refers to an IAPT service with the intention that the patient be assessed and, if appropriate, treated.

      - The clock will start when the referral letter, complete with all the required information, is received. The commissioner and providers should agree locally what information the referral is expected to contain.
      - Some localities operate a 'single point of access' approach where all referrals for mental health services are processed by a central multi-disciplinary team and referred on to the appropriate service. Previous IAPT guidance stated that the clock should start when the referral is received by the IAPT service. This will now change to bring IAPT in line with wider NHS guidance and the clock will now start when the referral is received by the single point of access. It is the responsibility of the single point of access to ensure that essential information regarding the person is sent to the provider this includes the date the referral was received. It is important that local protocols are put in place to ensure the referral is progressed through the system in a timely manner.

   ii) The patient refers themselves to an IAPT service and the referral is deemed appropriate for the service. The clock will start when the patient first contacts the service and requests to be seen. This should exclude general enquiries. If after assessment the patient is not deemed

[2] We used two documents to inform this paper a) 'Allied Health Professional Referral to Treatment - Revised Guide 2011' available from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131969.pdf and b) 'Referral to treatment consultant-led waiting times – Rules Suite – January 2012' available from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_132484.pdf

suitable for IAPT treatment the referral should be closed. This is coded '10 - Not suitable for IAPT service - no action taken' or directed back to referrer or '11 - Not suitable for IAPT service - signposted elsewhere with mutual agreement of patient' in the IAPT data set

iii) Opt-in and starting the clock

Many IAPT services adopt an 'opt-in' model where on receipt of a referral (other than from the patient), the patient is contacted and asked to confirm if they would like to be considered for treatment. This has been found to be an effective way of managing inappropriate referrals, limits DNAs and utilises staff time more effectively. In effect the patient is referring themselves to the service. The IAPT Programme accepts that where this model has been clearly specified and agreed with the commissioner then this is acceptable. National publications will report both opt-in to treatment and referral to treatment for the services who operate this model. However, local processes must be put in place to ensure that patients are contacted within the timeframe agreed with the commissioner - this should not be more than two weeks. Where this model is adopted, the clock should start when the patient confirms they want to be considered for treatment.

8. Clock Stops (waiting time ends) - A clock stops when:

i. A patient receives their first treatment appointment. In version 1 of the dataset this was the first appointment with a therapy type recorded. In version 1.5. this will be the first appointment with an appointment type of 02-Treatment, 03-Assessed and Treated or 05-Review and Treatment.

ii.

It is the responsibility of every service to ensure all referrals are followed up and every effort made to understand why patients may disengage with the service. However this information is not captured in the IAPT data standard therefore people who are referred but never seen should be excluded from waiting time calculations.

Example 1 - IAPT clock start/ stop

An IAPT service receives a GP referral on 1st April. The service notices that the referral is incomplete and returns to the GP requesting further information. On 4th April, the service receives a complete referral. On 7th April, the service telephones the patient and offers an appointment on 15th April. This is accepted and the patient attends the appointment where assessment takes place. The patient is then booked in for treatment on 19th April.

Clock start – 4th April
Clock Stops – 19th April
Total waiting time = 16 days

9. Clock Stops (and is nullified) - A clock stops when:

A patient does not attend (DNAs) their first appointment, a new clock for that patient restarts from the DNA date.

10. A clock should not stop when:

i. A patient is referred on to another IAPT service before first treatment commences (for example, when they are 'stepped up').

ii. A patient cancels an appointment. As part of the rebooking process, the patient should be offered alternative dates for treatment. If at the rebooking stage the patient declines two or more reasonable offers, then the clock may be paused. The date the waiting times clock is paused is the date of the earliest reasonable appointment offered.

iii. Previous IAPT guidance stated that the clock did not stop when "A patient has an 'assessment with treatment' session but does not start a full course of treatment within 28 days." This will no longer be enforced, however it is good practice that as part of the assessment process a treatment plan is agreed including frequency of contact and at the first appointment for treatment the date for the next treatment is set. Nationally IAPT will measure time from referral to first treatment, regardless of whether a second appointment has been booked, but will also look at patterns and duration of treatment. It is good practice for local areas to monitor any delays that occur throughout the care pathway in order to understand blockages and minimise.

11. Patient initiated delays and Clock Pauses

When a patient chooses to delay attendance of their first appointment, for example due to work commitments, religious reasons or holidays then this will delay the waiting times clock stop. Beyond a certain point, patient-initiated delay like this makes it unreasonable or impossible for the NHS to provide treatment in a timely manner and will prevent IAPT services meeting a local waiting time target where this exists. However, there are mechanisms available to flag some of these situations.

There are instances in other NHS services when clocks can be paused under specific circumstances to allow for significant patient choice delays. As referenced above, although this is currently acceptable, IAPT will adopt recommendations from the wider DH/NHS England review of waiting times and this guidance will be refreshed accordingly.

In the interim, the clock may be paused or stopped in line with the following rules, and use of an 'opt in' model should have no bearing on application of these rules.

For now a clock may be paused when a referral or self-referral has been made, and the patient has declined at least two reasonable appointments. The clock is paused for the duration of the time between the earliest reasonable offer and the date from which the patient makes themselves available again for treatment.

An appointment offer is considered reasonable where the offer is for a time and date three or more weeks from the time that the offer was made **or** the patient accepts the offer (www/datadictionary.nhs.uk).

Example 2 IAPT clock start/ paused/ stopped

An IAPT service receives a complete referral on 29th May. The service offers the patient an appointment for 29th June. The patient declines this offer and advises that they will be available to attend an appointment from 5th July. An appointment is booked for 10th July.

Clock start – 29th May
Clock paused – 29th June
Clock restarts – 5th July
Clock stops –10th July

Calculation :
29th May to 28th June = 31 days wait
29th June to 4th July = 6 days pause
5th July to 10th July = 6 days wait

Total time waiting = 37 days + 6 days pause

12. Group therapy sessions and stopping the clock

During the early years of IAPT implementation guidance excluded people attending group therapy session from waiting times analysis. This will no longer be the case as mature services should ensure that waits are kept to a minimum for all modes of treatment.

13. Processing data

All patient activity should be recorded routinely on local IT systems. A monthly extract of activity should be submitted to the HSCIC for secondary uses. Full guidance on data requirements and how to submit can be found at http://www.hscic.gov.uk/iapt

i. Displaced activity: Where activity occurs close to the end of the reporting period it may not be possible to process appointments in time to meet data submission requirements. In this case services should use the refresh submission to make corrections otherwise this activity will not be reported in national publications. This is the accepted way of ensuring accurate reporting and is adopted across many NHS data collections.