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Improving Access to Psychological Therapies (IAPT) Data Set v2.0 User Guidance

Document Management

Revision History

Version	Date	Summary of Changes
0.1	17/07/2019	Early draft to show DSAS progress of document
0.2	23/08/2019	Updated draft for review
1.0	05/09/2019	First publication of the User Guidance in conjunction with publication of the standard
1.1	13/12/2019	Guidance updated and strengthened in the following sections: <ul style="list-style-type: none"> • Glossary of Terms • IDS01CareContact table • Appendix 1 – Guide for recording assessment tools – reincorporation of IBS-SSS • Important note added to CARE CONTACT PATIENT THERAPY MODE
1.2	30/09/2020	<ul style="list-style-type: none"> • Additional guidance for Organisation Identifier (Code of Commissioner) • Guidance added for Correct Representation of ICD-10 in IAPT • Updated guidance for Peri and Postnatal periods • Updated guidance for Internet Enabled Therapies • Update to Appendix 1.1: List of accepted Assessment Tools for submission within IAPT detailing new questions for IAPT Assessment Patient Experience Questionnaire and IAPT Treatment Patient Experience Questionnaire
1.3	27/10/2020	<ul style="list-style-type: none"> • Addition of SNOMED CT codes following the October 2020 release of SNOMED CT for 'does not misuse alcohol (situation)' and 'not in debt (situation)'. These are detailed within Appendix 2.3 'Specific National Reporting Requirements' • Guidance added relating to an issue with the DATE AND TIME DATA SET CREATED data item within the IDS000 Header table. • Correction of SNOMED code provided for 'does not misuse alcohol (situation)' from 112920100000010 to 1129201000000101.

Reviewers

This document must be reviewed by the following people:

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Gavin Harrison	Business and Operational Delivery Manager, Data Set Development Service, NHS Digital	27/10/2020	1.3
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Glossary of Terms

Term / Abbreviation	What it stands for
CCG	Clinical Commissioning Group
CDS	Commissioning Data Sets
Coded Scored Assessment	Also commonly referred to as Routine Outcome Measure or Assessment Tool.
Data Item	A single component of a data set that holds one type of information and relates to a specific record.
Data Group	A collection of data items that describe a distinct event or episode. This can also be referred to as a table of data.
Data Set	The full collection of data groups. See 'Technical Output Specification'
DCB	The Data Coordination Board (DCB) replaces SCCI and is a sub-group of the Digital Delivery Board (DDB). Empowered by the Health and Social Care Act 2012, the DCB has delegated responsibility for approving information standards for the health and social care system in England. The DCB membership is drawn from a range of organisations operating within health and social care.
DHSC	Department of Health and Social Care
DNA	Did Not Attend
HSCIC	<p>The HSCIC was formed in April 2013 and established as an Executive Non-Departmental Public Body (ENDPB) under the Health and Social Care Act 2012. Through the Act, the HSCIC has a significant statutory duty to support the health and care system with regard to:</p> <ul style="list-style-type: none"> • collecting, storing, analysing and disseminating England's health and care data • providing a trusted safe haven for some of an individual's most sensitive information • building and delivering the technical systems that enable data both to be used to support an individual's care and to deliver better, more effective care for the community as a whole. <p>The HSCIC is also known as NHS Digital.</p>
IAPT	Improving Access to Psychological Therapies
ICD 10	International Classification of Diseases (Revision 10)
IDB	Intermediate Database (a MS Access database used to submit data to the DSP)
ISB	<p>The Information Standards Board (ISB) was a committee with membership drawn from a range of health and social care organisations with responsibility for overseeing the development, assurance and approval of information standards, data collections and data extractions used within the health and social care system.</p> <p>This was succeeded by the Standardisation committee for Care Information (SCCI) and then new national governance arrangements for information standards, data collections and data extractions came into effect on 1 April 2017.</p>

	On 1 April 2017, the Data Coordination Board (DCB) took over responsibility for the approval of standards from SCCI.
ISN	A notice of an Information Standard approved by the Data Coordination Board (DCB). When a health and social care organisation in England receives an ISN, they will ensure that they and their contractors comply with the standard in a reasonable time (such time defined within the ISN). ISNs were previously published by the Standardisation Committee for Care Information (SCCI).
NHS Digital	The preferred name for the HSCIC, with effect from 1 August 2016.
NICE	National Institute for Health and Clinical Excellence
Null	A data item with no value (i.e. blank) and therefore, has no meaning. This is different from a value of 0, since 0 is an actual value.
ODS	Organisation Data Service: The ODS provides a quick and easy search facility for organisation details
PAS	Patient Administration System
PEQ	Patient Experience Questionnaire
RCPsych	Royal College of Psychiatrists
Reporting Period	The period (usually a calendar month) for which a particular data upload refers.
SDCS	Strategic Data Collection Service
TOS	Technical Output Specification

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1 About this Document

1.1 Purpose of the Document

The purpose of this document is to outline the manner by which the national data set should be used and interpreted by users, system suppliers and other stakeholders, for example by providing additional information on data groups and data items, along with supplementing the data set Technical Output Specification with additional guidance regarding the extraction and analysis of the data set.

1.2 Scope of the Document

This document is aimed at:

- Those involved in the collection of data within IAPT services, including service managers, clinical leads and care professionals
- Information management departments within data provider organisations
- IT system suppliers operating on behalf of IAPT services
- Other stakeholders responsible for the submission and analysis of IAPT Data.

The following areas are out of scope of this document:

- Detailed justification for the development of the Information Standard.
- Data submission framework (i.e. how data is submitted by data providers to the central data landing platform. Further information about this is available from the [Strategic Data Collection Service \(SDCS\) Cloud web page](#).
- Restating information already accessible from the IAPT v2.0 Technical Output Specification (TOS).

This document should be read in conjunction with the following documents:

- IAPT v2.0 Standard Specification
- IAPT v2.0 Change Specification
- IAPT v2.0 Technical Output Specification
- IAPT v2.0 Implementation Guidance
- IAPT v2.0 Terminology Requirements
- SDCS Guidance documents – these replace the IAPT Technical Guidance document and can be found on the [SDCS Cloud web page](#)
- NHS Data Model and Dictionary
- [The Improving Access to Psychological Therapies Manual](#)

1.3 Schedule for Updating this Document

Please note this guidance document is considered to be a live document and NHS Digital reserves the right to review and update when necessary, for example in response to stakeholder feedback. Changes to this document will not necessitate further acceptance from the Data Coordination Board (DCB); however this is on the understanding that the changes do not affect the scope of the Information Standard.

1.4 Note re: NHS Data Model and Dictionary

The NHS Data Model and Dictionary publishes data items and code lists relevant to current data flow. Where data items in the IAPT data set are either new to the data set or require an amended code list; the amendments will be published shortly before flow of the new data set, and therefore will not currently be consistent with the published TOS, or advice in guidance documentation.

2 Background Information

The Improving Access to Psychological Therapies (IAPT) Data Set is a patient level, output based, secondary uses data set which aims to deliver robust, comprehensive, nationally consistent, and comparable information for people accessing NHS funded IAPT services located in England.

This national data set has been developed with the IAPT Programme to support service delivery and inform clinical decision-making and encourage improved access to talking therapies for people with common mental health problems such as depression and anxiety disorders.

As a secondary uses data set it re-uses clinical and operational data for purposes other than direct patient care, for example: commissioning, service improvement and service design. It defines the data items, definitions, and associated value sets to be extracted or derived from local information systems. These national definitions allow providers to extract data from their local systems in a consistent manner, which supports national and local reporting to be undertaken.

2.1 Summary of Version 2.0 Changes

An ongoing requirement exists to review the data set to ensure the content remains 'fit for purpose'. The changes included in this Version 2.0 release relate to new government policy initiatives, resolution of issues within the current data collection, and inclusion of other key stakeholder requirements as follows:

1. Structural changes to align with other NHS Digital modular data sets, including the MHSDS, including:
 - Increased use of clinical terminology (including SNOMED CT) to capture clinical activity
 - Improved relational modelling across data tables
2. Alignment of data items with changes to the NHS Data Model & Dictionary, such as with ODS, Gender and Sexual Orientation data items
3. Removal of data items that are no longer required nationally, such as the Opt-In Date
4. Revision of the referral end codes to reflect treatment pathways
5. Changes to support the collection of internet enabled therapies
6. Additional fields to collect information regarding language and use of interpreters
7. Collection of the qualifications held by Care Personnel
8. Incorporation of the Employment Advisors Pilot Data Set and further enhancement of the employment data items
9. Incorporation of items from the Long Term Conditions and Medically Unexplained Symptoms Pilot Data Set
10. Additional data items in the Care Contact table to understand the location of treatment and delivery of group sessions
11. Inclusion of the Overseas Visitor Charging Category (OVCC) fundamental standard (DCB3017)
12. Alignment of the patient consent guidance in line with other NHS Digital data sets, including the MHSDS
13. Clarification of data set scope regarding under 18s accessing adult IAPT services
14. Other minor maintenance changes to respond to issues raised by, for example, the NHS Data Model and Dictionary Service.

These changes are explicitly stated in the *IAPT v2.0 Change Specification* document (available from the [DCB1520 Information Standard](#) webpages) and the *IAPT Technical Output Specification* (available from the [NHS Digital IAPT](#) data set webpage).

2.2 Improving Access to Psychological Therapies (IAPT) Programme

The Adult Improving Access to Psychological Therapies (IAPT) programme began in the NHS in 2008 and has transformed treatment of adult anxiety disorders and depression in England. IAPT services provide evidence-based treatments for people with anxiety and depression.

Further information about the programme can be found on the [NHS England Adult IAPT Programme](#) web pages.

2.3 Integration of clinical terminologies within the IAPT data set

2.3.1 Why are we integrating clinical terminologies within the data set?

The data set can benefit significantly from implementing clinical terminologies within the data model:

- Providers are able to submit care activity information using the appropriate terminology or classification schema, of which, providers can submit what they record over and above specific national information requirements. This enables commissioner information requirements to be better met through the data set.
- Using SNOMED CT to capture outcome measures reduces the need for individual tables for each measure. A single table can capture multiple measures using a common structure.
- The data set can respond more quickly to changes in clinical practice and information requirements. Terminology is updated at regular intervals and the data set automatically can capture the latest terms without the need for changing the data set through the DCB process.

2.3.2 How have we integrated clinical terminologies within the Data Set?

NHS Digital's Data Set Development Service have been working closely with the NHS Digital Terminology and Classifications Service to restructure the data set to further cater for clinical terminology recording.

Within the IAPT data set:

- Presenting complaints can now be submitted using the Schema that is used locally to record the data, whether this is SNOMED CT for recording at the point of care or ICD-10 for retrospective.
- Assessment Tools must now be submitted using SNOMED CT. There are multiple ways to link this data within the data set such as against a specific Referral, Care Contact or anonymously.
- More detailed Care Activity information can now be submitted using the Schema that is used locally to record the data. Procedures, observable entities and findings are all recordable.
- Social and Personal Circumstances can now be submitted using SNOMED CT, which will allow the flow of IDS001MPI data items and personal information in line with published SNOMED CT resets.

Section 4 of this document will address guidance issues related to the above developments at a table and data item level.

2.3.3 SNOMED CT

2.3.3.1 What is SNOMED CT?

SNOMED CT is the standard clinical terminology for the NHS to support recording of clinical information, in a way that supports data management and analysis to support patient care, while enabling data extraction and data exchange.

SNOMED CT provides a comprehensive set of clinical phrases or terms, this is called a terminology. SNOMED CT is much more than just a set of clinical phrases, for example it also includes groups with relationships between terms. It is the most comprehensive international terminology currently available and can be used across all care settings and all clinical domains.

SNOMED CT is managed and maintained internationally by [SNOMED International](#) and in the UK by the [UK National Release Centre \(part of NHS Digital\)](#).

SNOMED CT is specified as the single terminology to be used across the health system in '[Personalised Health and Care 2020: A Framework for Action](#)'.

2.3.3.2 What are the benefits of using SNOMED CT?

As the NHS moves to paperless, and the aspiration to exchange data electronically across the NHS, it is critical that all systems share the same clinical vocabulary. If every system uses its own vocabulary then interoperability is reduced to simply moving readable documents around the system and clinicians having to repeatedly transcribe data they need to be within their system, thus introducing errors.

The use of an international terminology enables system suppliers to design their system to a common terminology that can be implemented with less country specialisation across a number of countries. The last few years has seen a shift by suppliers from developing country specific solutions to global solutions with local configuration.

2.3.3.3 Further Resources for SNOMED CT

More information about SNOMED CT can be found on the [NHS Digital SNOMED CT pages](#), including information about:

- **Licensing**

- The UK is a SNOMED International member country. Use of SNOMED CT in the UK is free, however the use of SNOMED CT does require a license. All SNOMED CT licensing enquiries can be sent to information.standards@nhs.net

- **Training**

- NHS Digital offer a range of ways for individuals to learn more about SNOMED CT and its uses. For those who feel they need more understanding of SNOMED CT, NHS Digital provide a number of [training and education resources](#). For an overview of SNOMED CT, the two live webinars provide a good introduction; you will also find case studies, brochures and technical guidance detailed on this web page. For system suppliers, you may also be interested in the more technical guidance provided through our [recorded webinar on the release files](#).

- **SNOMED CT in Mental Health**

- A range of resources are available via the [NHS Digital SNOMED CT in mental health webpage](#). They include live webinars (providing an overview of SNOMED CT) as well as training materials, guidance and a forum where members can contribute to discussions.

2.4 Correct representation of ICD10 in IAPT

The Technology Reference date Update Distribution (TRUD) platform is the official source of NHS ICD-10 5th Edition data files for download for NHS IT system and software suppliers who build/update software to support NHS business functions. The following guidance has been extracted from the ICD-10 5th Edition Codes and Titles and Metadata File Specification document and the ICD-10 5th Edition Codes and Titles and Metadata XML file. Full information is available in the subpack.

IAPT v2.0 allows the submission of ICD-10 codes in the IDS202 Care Activity, IDS602 Long Term Physical Health Condition & IDS603 Presenting Complaints tables.

Correct representation of ICD-10 codes

The structure of ICD-10 codes consists of:

- 1st char A-Z
- 2nd & 3rd chars numeric = represent 1st two numeric characters
- Followed (optionally) by a decimal point
- 4th char numeric = represents 4th character
- 4th char X = filler for 3-character Undivided code
- 5th char numeric = represents 5th character where it exists

The decimal point must not be considered a 'character' in terms of length. The addition of a decimal point following the two digits is optional.

Most 3-character categories are divided into 4-character subcategories and provide more detail at the lower level. Clinical coding is completed to 4-character level or greater granularity where the classification permits.

Example:

- F42 Obsessive-compulsive disorder
- F42.0 or F420 - Predominantly obsessional thoughts or ruminations
- F42.1 or F421 - Predominantly compulsive acts [obsessional rituals]
- F42.2 or F422 - Mixed obsessional thoughts and acts
- F42.8 or F428 - Other obsessive-compulsive disorders
- F42.9 or F429 - Obsessive-compulsive disorder, unspecified

The 3-character code is called a category. These are included for completeness and to give essential context to 4/5-character codes where this is absent in the lower level code.

Undivided 3-character codes utilise a filler X and therefore qualify as 4-character codes in terms of length but retain the classification characteristics of a 3-character category.

Where a 3-character category is divided into a 4-character subcategory (e.g. F42), the use of the filler X is not permitted. There are two residual categories: .8 is used for 'other' conditions belonging to the 3-character category but not included in any of the 0-7 4-character codes. The .9 is usually reserved for conditions not described sufficiently to permit assignment of a more specific code.

Submitting the value of F42 in isolation would result in a record rejection by the SDCS Cloud for IAPT v2.0. Providers should ensure that when they are submitting ICD-10 codes that these are in the appropriate format.

2.5 Access and Waiting Times Standards

Alongside other national partners, including the Department of Health and Social Care (DHSC), NHS England are introducing access and waiting time standards for mental health services. IAPT was the first standard to be implemented in 2015/16.

Existing guidance for IAPT services can be found on the Access and Waiting Times page of the NHS England website: <https://www.england.nhs.uk/mental-health/resources/access-waiting-time/>

For any further queries on access and waiting time standards please contact NHS England at: england.improvingmhaccess@nhs.net.

3 Configuration of local systems

The IAPT v2.0 Technical Output Specification fully defines the data items within the national data set. The Technical Output Specification splits the data set into a number of tables, each containing related data items.

IAPT is an output data set. An output data set is a description of the data that needs to be extracted or derived from an existing patient administration system (PAS) or clinical system and does not directly support patient care. In many cases, the output data item will be identical to the input definition. However, the two may differ both in terms of the format of the data item and the range of values presented. In addition, the output data set may include items that are derived from the inputs, most commonly, this will include 'Age at' fields and patient demographics.

The data collection system may represent the data in a different manner or in more granularity; however, providing the input data items can be mapped to the output data set, the input source will not require any modification.

This can be illustrated in the following table:

Provider System (Input system)		National Data Set	
Data item name	Format/Values	Data item name	Format/values
Date of birth	dd/mm/yy	Date of birth	ccyy-mm-dd
Appointment Date and Time	YYYY-MM-DDThh:mm:ss dd/mm/yy	Appointment Date	CCYY-MM-DD
		Appointment Time	hh:mm:ss ccyy-mm-dd

The IAPT data set is not a specification for the standardisation of a patient care record. Service Providers have the flexibility to adopt any local data collection processes and system as long as the local data collection frameworks can output and submit data, as per the data set specification, to the central data landing platform. The data set is not a patient care record but is based on clinical and operational information. Providers should therefore look to re-use their clinical and operational systems to extract IAPT data.

4 Constructing submission files

4.1 Key points relating to mandatory fields and validation

The IAPT v2.0 Technical Output Specification fully defines the data items within the output data set and splits the data set into a number of tables, each containing related data items.

Mandatory tables

The following tables are mandatory and MUST be submitted, as a minimum, for each patient:

- IDS001 - Master Patient Index (MPI)
- IDS002 – GP Practice Registration
- IDS101 - Service or Team Referral

In addition, the following table MUST contain a single record for each submission:

- IDS000 - Header

All other tables are denoted as Required and require a record to be present where this table is applicable to the patient. These tables are not Mandatory because the data may not be applicable for some patients. For example, not all service users will have a recorded long term condition and therefore the IDS602LongTermCondition table can be left blank in these cases. If a patient does have a recorded long term condition, then the record MUST be submitted.

Mandatory data items

The requirements for each data item are outlined in the original levels of mandation as described to DCB (as outlined in the mandatory/required/optional/pilot column in the Technical Output Specification).

Please note these requirements only apply when a record is entered in the table. I.e. a mandatory data item doesn't imply the table itself is mandatory.

Mandatory: These data items MUST be reported without exception. Failure to submit these items will result in the rejection of the record.

Required: These data items MUST be reported where they apply. It is a legal and contractual requirement to submit these data items where the service has been provided to a patient. Failure to submit these items will not result in the rejection of the record but may affect the derivation of national indicators or national analysis. Please note that the purpose of the data set is not to change clinical practice.

Optional: These data items MAY be submitted on an optional basis at the submitters' discretion.

Pilot: These data items have been included within the specification for piloting purposes only to support future implementation. These data items have not been approved and/or mandated and SHOULD NOT be submitted unless specifically requested by NHS Digital.

Derived: These data items are derived during pre and/or post deadline processing for inclusion in the extracts made available for download. Please note that these are not for submission to the Submission Portal and are not included in the submission file.

Whilst a particular table itself may not be mandatory, if a record is entered in this table then all of the table's mandatory fields must be completed.

Validation of records

The three phases of validation correspond to these mandation levels. So for instance, if a data item is mandatory, it is likely to have data item level rejections for a null or invalid entry.

Upon submission of the data to the central data warehouse, three phases of validation are undertaken:

1. File level

Leading to rejection or issuing of warning messages. A rejection would be of the entire submission against the selected reporting period, requiring identified issue(s) to be rectified and a resubmission made. Warning messages should be addressed and required actions undertaken.

Where these can be found: File-Level Rejects tab

Example: IREJ003 - Failed Content Check. MPI Table is empty

2. Table level

These compare records within or across multiple tables, leading to rejection of multiple records or a warning message displayed. For example, they could be to check referential integrity between tables or for duplicated records within a table. Rejected records would not progress to post deadline processing. Records with warnings would progress, but data quality would not be as required.

Where these can be found: Individual table tab.

Example: I00147 - Records rejected - More than one IDS001 provided for this NHS Number.

3. Record level

These can be against a single data item or across multiple data items within a single record, leading to either the rejection of the record or a warning displayed. Rejected records would not progress to post deadline processing. Records with warnings would progress, but data quality would not be as required.

Where these can be found: Individual table tabs

Example: I004901 - Record rejected - Local Patient Identifier (Extended) is blank

Each data item within the data set specification may have any of the above types of validation.

Please see the validations and warnings in the Technical Output Specification to understand the submission requirements for each table.

4.2 Inclusion rules

The IAPT Data Set is referral driven. Each monthly submission should include all open/active referrals within that reporting period, which includes:

- referrals that were opened in the reporting period
- referrals that closed in the reporting period
- referrals that were open throughout the reporting period, even if no activity took place
- referrals that were closed in previous reporting periods but have follow-up appointments in the reporting period.

All episode tables (those with start and end dates) within the data set follow a similar inclusion concept.

The rest of the tables have their own inclusion rules which specify when they should be included for a reporting period. For example, Care Contacts would be included only in the Reporting Period they took place, but other tables such as Employment Status allow the “most recent” details to flow.

You can find out the rules by looking at the validations in the latest Technical Output Specification. The column “Additional Validation Rules” outlines the date restrictions. Please also see section 5 of this User Guidance which contains a description of each table.

If a large amount of data is submitted, outside of the required range, then numerous rejection messages will be generated back to the provider. This may hinder the provider’s ability to identify 'real' rejection messages that require corrections to be made to “included” data. Users are advised to place greater emphasis on checking the date validation rules, prior to submission, to identify and submit data that is relevant to the reporting period only.

5 Data Item Guidance

This section provides additional guidance with regard to data items included within the Technical Output Specification. Frequently asked questions and areas that need further clarification are addressed in this section.

5.1 Intended Age Group

The IAPT data set is intended to capture data relating to people accessing NHS commissioned adult IAPT services for depression and anxiety in England.

As part of the IAPT v2.0 update, the scope has been clarified to include activity relating to people under the age of 18 accessing NHS commissioned adult IAPT services.

5.2 Breakdown of Data Items by Table

Data items are listed in the following tables using the NHS Data Model and Dictionary data element names. The electronic copy of this document includes hyperlinks to the corresponding entries in the NHS Data Model and Dictionary where formal definition of the data item can be found and relationships with other data elements and attributes are defined.

Users should be aware that links to new data items will not be available immediately following ISN publication.

IMPORTANT NOTE: data items are only included in this section where there is additional information provided that is not in the Technical Output Specification. If no additional information is available then the data item will not be included below.

This document is continually under review. Where data items do not have additional guidance, we will amend if suitable guidance becomes available.

5.2.1 Repeating data items

5.2.1.1 Linkage Data Items

Linkage data items appear in more than one table and allow the relationship between records within different tables to be identified.

The below linkage data items are fully described within the *Technical Output Specification*. In order to understand the linkage between tables in IAPT, the following information should be referenced in conjunction with the *Data Model*, available on the [NHS Digital IAPT](#) web page.

Data Item Name	Additional Notes
LOCAL PATIENT IDENTIFIER (EXTENDED)	<p>The Local Patient Identifier (Extended) is used to uniquely identify a patient within the Health Care Provider.</p> <p>This item is a primary key in the IDS001MPI table and must be unique to this table, within submission.</p> <p>No patient can have more than one Local Patient Identifier (Extended). This can be checked by looking at data items such as NHS number, postcode and date of birth.</p> <p>The Local Patient Identifier (Extended) provides a link between records in the IDS001 Master Patient Index table, associated referrals, and all non-referral based data associated with the patient.</p> <p>To avoid the incorrect linkage of records the Local Patient Identifier (Extended) must not be reused i.e. it should only ever relate to one patient. This ensures that data relating to more than one patient does not get incorrectly identified as belonging to a single patient in the data set</p>
SERVICE REQUEST IDENTIFIER	<p>The Service Request Identifier is used to uniquely identify the referral.</p> <p>This item is a primary key in the IDS101 Referral table and must be unique to this table, within submission.</p> <p>The Service Request Identifier provides a means for linking each Referral with additional data associated directly with that referral.</p> <p>Where multiple systems are used the submitted extract may include a prefix to the Service Request Identifier, which relates to the system. The prefix ensures each Service Request Identifier remains unique within submission.</p> <p>When updating systems to allow version 2.0 data to flow, please ensure that the same service request identifiers are used for any open referrals. Failure to do this will result in a break in pathway matching and will effect our analyses.</p>

<p><u>CARE CONTACT IDENTIFIER</u></p>	<p>The Care Contact Identifier is used to uniquely identify the care contact.</p> <p>This item is a primary key in the IDS201 Care Contact table and must be unique to this table.</p> <p>The Care Contact Identifier provides a link between records in the IDS201 Care Contact table and associated Care Activity carried out during a care contact.</p> <p>We would like to remind providers of the importance of ensuring that the Care Contact Identifier is truly a unique data item, both within the same submission file and across multiple submission files. The Care Contact Identifier is a primary key for its respective table and is based upon the <u>Activity Identifier</u> data attribute which is defined as “A unique number or set of characters that is applicable to only one ACTIVITY for a PATIENT within an Organisation”. This reiterates that these identifiers should be unique across submissions.</p> <p>These identifiers will typically be auto generated by the system in use, so will prevent duplicates when using the same system. Where multiple systems are used it is acceptable to include a prefix to the Care Contact Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation.</p>
<p><u>CARE ACTIVITY IDENTIFIER</u></p>	<p>The Care Activity Identifier is used to uniquely identify the care activity.</p> <p>This item is a primary key in the IDS202 Care Activity table and must be unique to this table.</p> <p>The Care Activity Identifier provides a link between records in the IDS202 Care Activity table and associated Coded Scored Assessments carried out during a care contact.</p> <p>We would like to remind providers of the importance of ensuring that the Care Activity Identifier is truly a unique data item, both within the same submission file and across multiple submission files. The Care Activity Identifier is a primary key for its respective table and is based upon the <u>Activity Identifier</u> data attribute which is defined as “A unique number or set of characters that is applicable to only one ACTIVITY for a PATIENT within an Organisation”. This reiterates that these identifiers should be unique across submissions.</p> <p>These identifiers will typically be auto generated by the system in use, so will prevent duplicates when using the same system. Where multiple systems are used it is acceptable to include a prefix to the Care Activity Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation.</p>
<p><u>CARE PERSONNEL LOCAL IDENTIFIER</u></p>	<p>A unique local CARE PERSONNEL IDENTIFIER within a Health Care Provider that may be assigned automatically by the computer system.</p> <p>This data item appears in the IDS202 Care Activity, IDS205 Internet Enabled Therapy Activity Log and IDS902 Care Personnel Qualification tables.</p> <p>The item will enable linkage between the qualifications of the CARE PERSONNEL and the activity they have delivered.</p>

5.2.2 IDS000 Header

IDS000 Header	
Description	
<p>Header: To contain metadata relating to the submission file.</p> <p>One occurrence of this group is required.</p> <p><u>General table guidance</u></p> <p>Data providers should note that IDS000 Header is a mandatory table and must be submitted, containing a single record only.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)	This field will normally contain the same Identifier as ORGANISATION Identifier (CODE OF PROVIDER). It may be appropriate for the codes to differ, where one organisation is appropriately flowing data on behalf of another organisation. However, both provider and submitter should ensure that sufficient governance is in place for the flow of patient identifiable data between the two organisations. Further information can be found on the Information Governance pages of the NHS Digital website .
PRIMARY DATA COLLECTION SYSTEM IN USE	<p>This is a free text field.</p> <p>Where multiple systems are in use, please indicate the primary system in use, from which the highest number of records is extracted.</p>
DATE AND TIME DATA SET CREATED	<p>There is an issue with the Technical Output Specification and the DateTimeDataSetCreate field which specifies a format of an19 CCYY-MM-DDTHH:MM:SS. If this format is used in the IDB submitted to SDCS Cloud, the file is rejected.</p> <p>To work around this, providers are advised to submit data with the 'T' element omitted, with a space between the date and time components (i.e. in the format of an19 CCYY-MM-DD HH:MM:SS).</p> <p>NHS Digital will look to implement a more permanent solution the next time the IAPT data set is updated beyond IAPT v2.0.</p>

5.2.3 IDS001 Master Patient Index

IDS001 Master Patient Index
Description
<p>To carry the personal details of the person.</p> <p>One occurrence of this Group is required for each person.</p> <p><u>General table guidance</u></p> <p>This table contains information on patient identifiers, demographic information and organisational data. The collection of these data items can be used to analyse outcomes across different ethnic groups, age groups and geographic location.</p>

This table should include a record for each patient receiving care within Improving Access to Psychological Therapy (IAPT) services. This may include patients that are under the age of 18 but are accessing IAPT services.

Please ensure that this table contains a record for all patients for whom activity is recorded within any of the other tables.

Providers should supply IDS001 data as it was at the end of the reporting period.

Providers must populate all known data items within this group even if they are unchanged since the last submission. Do not just provide data for all "changed" data items.

Local practices may vary but much of the data within this table will be obtained from the patient (or proxy) on first registration and then checked with the patient at appropriate intervals.

Additional Notes on Data Items

Data Item Name	Additional Notes
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	<p>This identifies the Local Patient Identifier issuing organisation, for example: where organisations have gone through a merger or split.</p> <ul style="list-style-type: none"> - If Local Patient Identifiers are not modified during the merger or split, then the issuing Organisation Identifier of the Local Patient Identifier (even if now discontinued) should be sent in this field; - If the Local Patient Identifier has been modified since the organisation change i.e. by prefix etc., then the new organisation identifier should be used.
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	<p>This field can routinely be left blank. However, if populated, it should contain the organisation identifier of the commissioner with which the patient is resident.</p> <p>The organisation identifier should be current at the end of the reporting period.</p> <p>This item is derived by NHS Digital based on postcode of usual address, using a lookup file which assigns the patient to an organisation.</p> <p>This derivation only applies when the ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is blank upon submission. Providers are able to override this derivation (for instance, if they are aware that a particular CCG has residence responsibility for a patient) by manually entering an organisation identifier in this field.</p>
NHS NUMBER	<p>Where the NHS Number is not known, this should be left blank.</p> <p>Duplicate NHS Numbers within this group will cause the entire file to be rejected.</p> <p>When an NHS number is provided it must pass the modulus 11 check.</p> <p>When an NHS number is provided it should have a corresponding status indicator code.</p> <p>NHS number is the primary source of identification for patients in England and Wales and should be submitted; however it is accepted that occasionally a patient will not yet have an NHS number, therefore this data item is 'Required' and not 'Mandatory' in IAPT, which ensures that data for the patient can still flow. Although it is not a mandated field, data quality reports will be produced with regard to completeness of this field.</p> <p>Further guidance about NHS Numbers can be found here:</p>

	https://digital.nhs.uk/services/nhs-number
NHS NUMBER STATUS INDICATOR CODE	<p>This data item is 'Required' however it should always be completed, irrespective of whether an NHS number is present.</p> <p>In cases where a patient's NHS number is unavailable (which may be because the patient does not possess one) data providers should submit a null NHS number and [07] Number not present and trace not required in NHS Number Status Indicator Code.</p> <p>In most cases, this data item will be flowed with value [01] - <i>Number present and verified</i>. The [01] will indicate that the data provider has validated the number against the central Patient Demographics Service (PDS), and therefore facilitates reliable data linkage.</p> <p>Data providers may flow data for patients with an NHS number status indicator code other than [01] and they will be accepted, however, reports that need reliable linkage may exclude these records (unless reliable linkage is available via LOCAL PATIENT IDENTIFIER)</p>
PERSON BIRTH DATE	<p>Every effort should be made to identify the patient's correct date of birth, or date that the patient has estimated to be their date of birth. However, where the patient's DOB cannot be determined precisely, estimation should be provided.</p> <p>If it is not possible/appropriate to estimate then the data item should be left blank (Null).</p> <p>Estimates should not change once they have been made. Once the actual DOB is identified, it should be recorded and submitted correctly.</p> <p>When estimating a patient's DOB a consistent approach should be used, for example: use 1st July if only the year is known, 15th of the month if only the month is known, 1st January for beginning of the year, 31st December for end of the year, 25th December for Christmas etc.</p>
POSTCODE OF USUAL ADDRESS	<p>Please see the 'Technical Glossary' tab within the <i>Technical Output Specification</i> for further details regarding acceptable postcode formats and validations applied at the submission portal.</p> <p>Where the person has no fixed abode this should be recorded as ZZ99 3VZ.</p> <p>If the postcode is unknown ZZ99 3WZ should be used.</p> <p>For overseas residents, please use the pseudo country postcode found in the 'Country names and pseudo country postcodes in pseudo country postcode order' file on the NHS Digital web page: Data supplied by the Office of National Statistics. The postcode will be recorded in the format ZZ99 xxZ, where xx denotes the country pseudo postcode.</p>
PERSON STATED GENDER CODE	<p>'Person Stated Gender Code' replaces 'Person Stated Gender Code Current' to align with the most recently approved version of the data item in the Data Dictionary.</p> <p>National Code X 'Not Known' means that the sex of a PERSON has not been recorded</p> <p>National Code 9 'Not Specified' means indeterminate, i.e. unable to be classified as either male or female.</p>
ETHNIC CATEGORY	<p>The information recorded about the patient's ETHNIC CATEGORY must be obtained by asking the PATIENT.</p>

	<p>Capture and submission of Ethnic Category within the IAPT is required for ALL patients, in order to support ethnic monitoring as required of public bodies under the Race Relations Amendment Act 2000.</p> <p>Codes [Z] – Not Stated, and [99] - Not Known should be applied as follows:</p> <p>The [Z] 'Not Stated' national code should only be used where the patient had been asked and had declined either because of refusal or genuine inability to choose.</p> <p>The [99] 'Not known' national default code should be used where the patient had not been asked or the patient was not in a condition to be asked. E.g. unconscious.</p>
LANGUAGE CODE (PREFERRED)	<p>In order to populate this data item please select either: The two character code found in the ISO 639-1 Code column from the ISO 639.2 Codes for the Representation of Names of Languages (CRNL); code list; or one of the five communication method extensions detailed in the Technical Output Specification and NHS Data Model & Dictionary.</p> <p>Please note: the format for this data item is an2. Only the ISO 639-1 Code column should be referenced. Please do not attempt to submit codes that appear in the ISO 639-2 Code column by truncating to two characters. In some cases a valid code would be derived, however the valid code may link to a language that is unconnected to the intended language for submission. On submission validations would not be able to detect this therefore any reporting would include incorrect calculations related to preferred language.</p>

5.2.4 IDSS002 GP Practice Registration

IDS002 GP Practice Registration	
Description	
<p>To carry details of the GP Practice Registration of the person.</p> <p>One occurrence of this Group is required for each change of GP Practice Registration.</p> <p><u>General Table Guidance</u></p> <p>Data providers should note that IDS002 is a mandatory group that must be included whenever any other groups are transmitted that refer to this person.</p> <p>The group includes start and end dates for when the patient was registered with the practice.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	<p>The following default ODS codes apply:</p> <p>GP Practice Code not applicable - V81998</p> <p>GP Practice Code not known - V81999</p> <p>No Registered GP Practice - V81997</p> <p>Please see GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) for information on the use of the above codes.</p> <p>For more general information on default codes, please visit Organisation Data Service Default Codes.</p>
START DATE (GMP PATIENT REGISTRATION)	<p>This field is primarily to track changes to the GP and their commissioner during the referral.</p> <p>This field should only be populated if the actual start date is known. If this is not known then it is acceptable to leave this field blank.</p> <p>If the patient changes General Medical Practice whilst under the care of the service provider, then a new GP Practice Registration record should be submitted and the start date of the patient's new General Medical Practice registration populated.</p>
END DATE (GMP PATIENT REGISTRATION)	<p>This field is primarily to track changes to the GP and their commissioner during the referral.</p> <p>If this field is left blank the General Medical Practice Code recorded in this table will be assumed to be current.</p> <p>If the patient changes General Medical Practice whilst under the care of the service provider, then it is expected that the end date of the previous General Medical Practice should be populated in the GP Practice Registration record, and new record submitted containing details of the new GMP Registration.</p>
ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)	<p>This field can routinely be left blank. However, if populated, it should contain the organisation identifier of the commissioner that is associated with the patient's current registered GP Practice. This field is used to overwrite the commissioner associated with a GP's registered population, which is derived from the General Medical Practice Code Patient Registration by NHS Digital.</p>

5.2.5 IDS004 Employment Status

IDS004 Employment Status
Description

The current employment status of a person.

One occurrence of this Group is permitted, containing the most recently recorded employment details.

General Table Guidance

This information should be submitted in line with usual local clinical practice.

Further guidance for submitting data to this table is available in the Employment advisers in IAPT data handbook.

Please note that the Employment advisers in IAPT data handbook is published on the IAPT Future collaboration platform within the IAPT v2.0 Guidance section, please visit <https://future.nhs.uk/IAPT/view?objectID=21852976>.

If you do not have a Future NHS collaboration platform account, please visit <https://future.nhs.uk/system/home> and follow the registration process.

Additional Notes on Data Items

Data Item Name	Additional Notes
EMPLOYMENT STATUS	<p>[01] Employed: Employed refers to those who are employed by a company and have their National Insurance paid for directly from their wages.</p> <p>It also includes those who are self-employed (i.e. those who work for themselves and generally pay their National Insurance themselves); those who are in supported employment; and those who are in permitted work (i.e. those who are in paid work and who are also receiving Incapacity Benefit). It should also include those who are unpaid family workers (i.e. those who do unpaid work for a business they own or work for a business a relative owns).</p> <p>[02] Unemployed and actively Seeking Work: Unemployed refers to those who are not in paid work but are actively seeking work and are available to start, or are waiting to start a paid job they have already obtained.</p> <p>Other Employment Status codes (03, 04, 05, 06, 07, 08) represent those who are economically inactive, that is, those who are not in paid work and who are not actively seeking work, or they are not available to start.</p>
EMPLOYMENT STATUS RECORDED DATE	<p>This is the date on which the assessment was done.</p> <p>This date should change with each review, even if the Employment Status remains the same.</p>
SELF EMPLOYED INDICATOR	<p>This data item is only applicable where the patient's EMPLOYMENT STATUS has been recorded as '01 – Employed'.</p>
SICKNESS ABSENCE INDICATOR	<p>This data item is only applicable where the patient's EMPLOYMENT STATUS has been recorded as '01 – Employed'.</p>
BENEFIT RECEIPT INDICATOR (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)	<p>This data item informs the following data items. If the answer is 'N' there is no requirement to flow data for the remaining benefits questions.</p> <p>New benefit status questions will provide greater granularity on patient outcomes. The questions will also provide context to inform the delivery of therapeutic treatment and employment support.</p>

5.2.6 IDS007 Disability Type

IDS007 Disability Type	
Description	
<p>To carry the details of the type of disability affecting a person, based on their perception or the perception of a patient proxy.</p> <p>One occurrence of this Group is permitted for each disability identified.</p> <p><u>General Table Guidance</u></p> <p>Under the Equality Act 2010, a disabled person is defined as "someone who has a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities. For further information, see the gov.uk website.</p> <p>The main focus of this table is to provide information about disabilities where they are present, however providers can choose to submit records for NN or ZZ should they record this locally. Records submitted against either of these codes will be classed as 'Other' for the Data Quality Measures.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes

<p><u>DISABILITY CODE</u></p>	<p>[01] Behaviour and Emotional should be used where the patient has times when they lack control over their feelings or actions.</p> <p>[02] Hearing should be used where the patient has difficulty hearing, or need hearing aids, or need to lip-read what people say.</p> <p>[03] Manual Dexterity should be used where the patient experiences difficulty performing tasks with their hands.</p> <p>[04] Memory or ability to concentrate, learn or understand (Learning Disability) should be used where the patient has difficulty with memory or ability to concentrate, learn or understand which began before the age of 18.</p> <p>[05] Mobility and Gross Motor should be used where the patient has difficulty getting around physically without assistance or needs aids like wheelchairs or walking frames; or where the patient has difficulty controlling how their arms, legs or head move.</p> <p>[06] Perception of Physical Danger should be used where the patient has difficulty understanding that some things, places or situations can be dangerous and could lead to a risk of injury or harm.</p> <p>[07] Personal, Self Care and Continence should be used where the patient has difficulty keeping clean and dressing the way they would like to.</p> <p>[08] Progressive Conditions and Physical Health (such as HIV, cancer, multiple sclerosis, fits etc.) should be used where the patient has any illness which affects what they can do, or which is making them more ill, which is getting worse, and which is going to continue getting worse.</p> <p>[09] Sight should be used where the patient has difficulty seeing signs or things printed on paper, or seeing things at a distance.</p> <p>[10] Speech should be used where the patient has difficulty speaking or using language to communicate or make their needs known.</p> <p>[XX] Other should be used where the patient has any other important health issue including dementia or autism.</p> <p>[NN] No Disability</p> <p>[ZZ] Not Stated person asked but declined to provide a response</p>
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5.2.7 IDS011 Social and Personal Circumstances

IDS0011 Social and Personal Circumstances	
Description	
<p>To carry details of Social and Personal Circumstances of a person.</p> <p>One occurrence of this Group is permitted for each Social and Personal Circumstance recorded.</p> <p>Scope</p> <p>Services are required to submit the following circumstances as a minimum, where data is collected locally:</p> <p style="padding-left: 40px;">Required - RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE or RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE</p> <p style="padding-left: 40px;">Required - PERSON STATED SEXUAL ORIENTATION CODE Please see the NHS Data Model and Dictionary links above for further information regarding the definitions and code lists for these data elements.</p> <p>Further national reporting requirements to flow in this table can be found in Appendix 2.3: Specific national reporting requirements.</p> <p>General Table Guidance</p> <p>Please note that submission must be made using the specified SNOMED CT subsets for each data element, which can be found via the SNOMED CT Term Browser.</p> <p>The SNOMED CT subsets for both data elements are aligned 1:1 with the NHS Data Model and Dictionary National Codes.</p> <p>Further information and guidance please see the SNOMED CT page on the NHS Digital website.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes

<p>SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)</p>	<p>RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION</p> <p>This link provides the full list of Religious or other belief system affiliation group SNOMED codes.</p> <p>DD4C Subset Metadata: Religious or other belief system affiliation groups (DD4C)</p> <p>NHS Data Model and Dictionary Service mapping: RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE</p> <p>Notes:</p> <p>Please note the following mapping between the National Codes and SNOMED CT Subset:</p> <p>“62458008 Has religious belief (finding)” aligns with “K – Other”</p> <p>“312865007 Religion not given – patient refused (finding)” aligns with “M – Declines to Disclose”</p> <p>“160552003 Not religious (finding)” aligns with “L – None”</p> <p>Please note the addition of “Agnostic (person)” within the SNOMED CT terms, which is currently not aligned with the NHS Data Model and Dictionary.</p> <p>RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE</p> <p>NHS Data Model and Dictionary Service mapping: RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE</p> <p>PERSON STATED SEXUAL ORIENTATION CODE</p> <p>This link provides the full list of Sexual orientation SNOMED codes</p> <p>DD4C Subset Metadata: Sexual orientation findings (DD4C)</p> <p>NHS Data Model and Dictionary Service mapping: PERSON STATED SEXUAL ORIENTATION</p> <p>Notes:</p> <p>Please see the DCB2094 Sexual Orientation Monitoring webpage for further details regarding this separate information Standard.</p>
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5.2.8 IDS012 Overseas Visitor Charging Category

IDS012 Overseas Visitor Charging Category	
Description	
<p>To carry details of the Overseas Visitor Charging Category of the patient.</p> <p>Multiple occurrences of this group are permitted, one for each Overseas Visitor Charging Category recorded for the patient.</p> <p>General Table Guidance</p> <p>Please see the Overseas Visitor Charging Category (OVCC) fundamental standard for more information on the recording of the Overseas Visitor Charging Category.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
OVERSEAS VISITOR CHARGING CATEGORY	<p>This is the charging category relating to an OVERSEAS VISITOR STATUS and should be recorded using the appropriate national codes.</p> <p>Each category is recorded with a date parameter enabling the correct status to be tied to the correct episode, using the OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE DATE data item.</p> <p>There are 8 distinct categories.</p> <p>Category A (Standard NHS-funded PATIENT) applies when a patient has been resident here and has permission to be here for over 12 months. Therefore all patients (except illegal immigrants), on reaching the anniversary of their arrival, become eligible for NHS treatment.</p> <p>You would determine when a patient's status changes from overseas visitor to a permanent resident via both the 'OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE DATE' data item and also by any previous code submitted and which then changes.</p> <p>If a PATIENT had always been resident in this country then similarly, code A Standard NHS-funded PATIENT would be recorded. There would be no end date.</p>
OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE DATE	<p>The date when the patient's OVERSEAS VISITOR CHARGING CATEGORY was applicable from. If the applicable date was not available, this should be the date the OVERSEAS VISITOR CHARGING CATEGORY was recorded.</p>

5.2.9 IDS101 Service or Team Referral

IDS101 Referral	
Description	
<p>Service or Team Referral: To carry details of the referral that the patient is subject to.</p> <p>One occurrence of this group is required for each referral.</p> <p>General Table Guidance</p> <p>A referral is a request for care to be provided for a patient, including self-referrals.</p> <p>Both external and internal referrals should be reported.</p> <p>The table includes referrals that were received but subsequently rejected by the provider.</p> <p>A patient may have multiple referrals within a reporting period.</p> <p>All referrals starting, ending or open/active within the reporting period should be flowed with every submission for each period. In addition, referrals that have started and finished in a previous reporting period, and have follow up appointments or PEQs with an ASSESSMENT TOOL COMPLETION DATE in the current reporting period should also flow.</p> <p>All open referrals should be provided in each reporting period they remain open, even if there has been no activity during that reporting period.</p> <p>Data providers should note that IDS001, IDS002 and IDS101 are mandatory groups that must be included whenever any other groups are transmitted that refer to this patient. If the IDS101 Referral table is not included, with all mandatory data items submitted (as a minimum), no other data can flow for that patient.</p> <p>If this table is blank within a submission file, the whole file will be rejected.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	<p>This is the organisation identifier of the organisation that initiated the provision of care bound by the IDS101 Service or Team Referral record.</p> <p>This data item is now a mandatory field within the IDS101 table and MUST be populated for all included referrals. Please see the NHS Data Model and Dictionary webpage for further guidance on populating this item.</p> <p>The DHSC document Who pays? Establishing the Responsible Commissioner¹ sets out a framework for establishing responsibility for commissioning an individual's care within the NHS (i.e. determining who pays for a PATIENT's care).</p>
REFERRAL REQUEST RECEIVED DATE	<p>For both electronic and written referral requests the date that the request was received should be used and NOT the date that the referral was read, processed, or actioned i.e. the date stamped as the date of receipt and not the date entered onto a system. For referral requests received by telephone use the date of the follow up letter if received, otherwise the date of the phone call.</p> <p>For further guidance on what constitutes the REFERRAL REQUEST RECEIVED DATE please see the NHS Data Model and Dictionary.</p> <p>The REFERRAL REQUEST RECEIVED DATE typically forms a key part of IAPT waiting times calculations.</p>

SOURCE OF REFERRAL FOR MENTAL HEALTH	<p>For further guidance with regard to SOURCE OF REFERRAL FOR MENTAL HEALTH please see the NHS Data Model and dictionary.</p> <p>Where a data provider has a more extensive list of referral sources, then they should be mapped to an appropriate value stated in the output data item list.</p> <p>Where it is not possible to map a value against those stated in the output data item list then this should be mapped to the code '[M6] Other Service or Agency.'</p> <p>Please note: codes J1-J4, K1-K5, L1-L2 are no longer valid for use in the IAPT data set.</p> <p>[P1] Internal Referral should be used to record internal referrals.</p>
DISCHARGE FROM IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES SERVICE REASON	<p>The list of end codes have been amended in version 2.0 to facilitate:</p> <ol style="list-style-type: none"> 1) Improved understanding of whether patients, who have not completed a full course of treatment, have had their needs addressed. 2) Distinction between patients that are: <ul style="list-style-type: none"> ○ Referred but not seen ○ Seen but not taken on for a course of treatment, where this is defined as having less than 2 care contacts coded as “assessed and treated” and/or “treated” ○ Taken on for a course of treatment, which is defined as having 2 or more care contacts coded as “assessed and treated” and/or “treated”
SERVICE DISCHARGE DATE	<p>The date entered should reflect the date that the clinical decision was made by the service to discharge the patient from care responsibility. This should NOT be the date that the referral closure is physically administered on the system (if this is a later date).</p>

5.2.10 IDS105 Onward Referral

IDS105 Onward Referral	
Description	
<p>To carry details of any onward referral of the person which has taken place.</p> <p>One occurrence of this Group is permitted for each onward referral.</p> <p>General Table Guidance</p> <p>This table is to record and flow the details of the onward referral, where the patient is being referred/transferred within the services under the current organisation or to another external service/organisation.</p> <p>This table is where providers will need to evidence that they have stepped a patient up/down to a different service. This replaces the 'ORGANISATION CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED TO PROVIDER)' in IAPT v1.5.</p> <p>In these cases, it is essential to record the ORGANISATION IDENTIFIER (RECEIVING) and ONWARD REFERRAL REASON items to aid identification of the stepped care pathway for the patient, even if the patient is being referred to a service within the same organisation.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes

ONWARD REFERRAL REASON	<p>The reason why the person was referred to another service, which may be in the same or a different organisation.</p> <p>Two new codes have been authored specifically for IAPT, to identify stepping up/down on the IAPT care pathway:</p> <p>05 - Stepped up from low intensity Improving Access to Psychological Therapies Service</p> <p>06 - Stepped down from high intensity Improving Access to Psychological Therapies Service</p>
ORGANISATION IDENTIFIER (RECEIVING)	<p>The ODS registered Organisational Identifier of the organisation where the patient was onward referred to. This should be populated if it is known/collected and can be left blank if not.</p>

5.2.11 IDS108 Waiting Time Pauses

IDS108 Waiting Time Pauses	
Description	
<p>To carry details of the Waiting Time Pauses.</p> <p>One occurrence is permitted for each Waiting Time Pause.</p> <p>General table guidance</p> <p>For the latest Waiting Times guidance, please see the following web page: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION IDENTIFIER	<p>The activity suspension identifier should be unique to the Local Patient Identifier (Extended), Service Request Identifier and activity suspension period. In order for waiting times to be calculated accurately, this should be the case for the whole period of the referral, not just within the current reporting period.</p>
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION REASON	<p>Clocks/Activity may be paused for social reasons and when initiated by the patient.</p> <p>There is no facility for pausing clocks due to clinical delays, where there is a clinical reason why a patient cannot be assessed/treated. Where there are any clinical/service related delays, the patient's waiting time clock would keep ticking until start of treatment.</p>

5.2.12 IDS201 Care Contact

IDS201 Care Contact	
Description	
<p>To carry details of any Care Contacts with a patient which have taken place as part of a referral.</p> <p>One occurrence of this group is permitted for each Care Contact.</p> <p>General Table Guidance</p> <p>This table should reflect Care Contacts from a patient perspective. For example, where multiple Care Professionals are involved in a single Care Contact, this will still represent a single Care Contact record, rather than creating multiple records linked to each involved Care Professional.</p> <p>Care contacts that were cancelled by either the provider or the patient or where the patient Did Not Attend (DNA) should also be included.</p> <p>Care Contacts that were related to the patient, but that the patient was not personally involved in (such as appointments with parents, etc), should not be recorded. Non face-to-face contacts should only be included where there is an opportunity for discussion between patient and healthcare professional. For instance, a telephone call to explain the ramifications of test results to a patient would be included, but texting (SMS) or emailing results would not. Non face-to-face telephone contacts solely to inform patients of results are excluded.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
PLANNED CARE CONTACT INDICATOR	An indication as to whether a Care Contact is a result of a Planned Appointment.

<p>ATTENDED OR DID NOT ATTEND CODE</p>	<p>The ATTENDED OR DID NOT ATTEND CODE data item should be submitted irrespective of CONSULTATION MEDIUM USED. I.e. the data item is still applicable even if the contact is not face to face.</p> <p>Please note that the field only applies to planned appointments and can therefore be left blank if it refers to a contact that was not a result of a planned appointment. The PLANNED CARE CONTACT INDICATOR should be populated accordingly to reflect this.</p> <p>[2] Appointment cancelled by, or on behalf of the patient: An appointment is classified as being 'cancelled by, on or behalf of the patient' where it is cancelled at any point in time prior to the start of the appointment.</p> <p>[3] Did not attend, no advance warning given: An appointment is classified as being a DNA if the patient does not attend for the entire duration of the appointment slot, or they do attend but there is insufficient time remaining to conduct the planned activity and therefore the appointment is not usable.</p> <p>In the case of telephone contacts, duration should be recorded as 0 and marked as DNA only if the contact was a planned telephone contact and the patient did not answer the phone.</p> <p>[4] Appointment cancelled or postponed by the health care provider: An appointment is classified as being 'cancelled or postponed by the healthcare provider' where it is cancelled at any point in time prior to the start of the appointment.</p> <p>When an appointment is cancelled (by, or on behalf of the patient, or by the health care provider) the appointment cancelled date should also be recorded. This will identify instances where the appointment was cancelled on the day it was intended to take place.</p> <p>When an appointment is re-arranged this is effectively classed as a cancelled appointment. When it is re-arranged the original appointment is cancelled and a new one is created. Dependant on who cancelled (re-arranged) the appointment, the national code [2] or [4] should be used.</p>
<p>APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR</p>	<p>The precise definition of 'short notice' should be determined locally.</p> <p>The APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR is only relevant where the submitted code for the Attendance data item is 2 - Appointment cancelled by, or on behalf of, the patient.</p> <p>However, the APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR must be submitted on each occasion where 2 - Appointment cancelled by, or on behalf of, the patient is the submitted code for the Attendance data item.</p> <p>Please record this data item as 'Y – Appointment slot could be reallocated' where the appointment slot was cancelled at short notice but where the slot could be made available to be reallocated, irrespective of whether the slot was eventually reallocated or not. It is not necessary within the data set to track whether a new appointment has been allocated to the slot vacated.</p>
<p>CLINICAL CONTACT DURATION OF CARE CONTACT</p>	<p>The duration of the clinical contact should be recorded and accounted for, regardless of the type of contact (i.e. Telephone calls).</p> <p>The duration field should only be left blank if the Care Professional was unable to get through to the patient/the patient did not answer the phone. In which case it should also be recorded as a DNA.</p>

<p><u>CONSULTATION MEDIUM USED</u></p>	<p>[02] – Telephone: The telephone or <u>TELEMEDICINE</u> consultation should directly support diagnosis and care planning and must replace a face to face Out-Patient Attendance Consultant, Clinic Attendance Nurse or Clinic Attendance Midwife, types of CARE ACTIVITY. A record of the telephone or telemedicine consultation must be retained in the PATIENT's records.</p> <p>Telephone contacts solely for informing PATIENTS of results are excluded.</p> <p>[08] – Online messaging: This is a new code for version 2.0 to support internet enabled therapies. As for all care contacts, this code should only be used where there has been opportunity for discussion between the patient and care professional.</p> <p>Care providers are not expected to capture Internet Enabled Therapy (IET) in the 'Consultation Medium Used' in the IDS201 Care Contact table as this can be assumed if IDS205 Internet Enabled Therapy Care Professional Activity Log table is completed.</p>
<p><u>INTERNET ENABLED THERAPY PROGRAMME</u></p>	<p>The name of the Internet Enabled Therapy Programme given to a PATIENT.</p> <p>This is a free text field.</p> <p>A list of free text strings for commonly used programmes is available in the <u>IAPT data set guidance for submitting internet enabled therapy data</u> available from the <u>IAPT V2.0 webpage</u>.</p> <p>This should not be completed if the IDS205 Internet Enabled Therapy Care Professional Activity Log table is completed.</p>
<p><u>CARE CONTACT PATIENT THERAPY MODE</u></p>	<p>This data item has been renamed from FACE TO FACE COMMUNICATION MODE (as in v1.5) to reflect the need for this information for non-F2F care contacts.</p> <p>Please note that the value list for this item differs from that which was submitted in v1.5 and is as follows:</p> <ul style="list-style-type: none"> 1 Individual patient 2 Couple 3 Group Therapy <p>In particular, please note options 2 and 3 are now the opposite way round in the new data element.</p>

<p>ACTIVITY LOCATION TYPE CODE</p>	<p>For non-F2F contacts, the ACTIVITY LOCATION TYPE of the patient should be used; not the location of the clinician.</p> <p>[J01] Resource Centre premises: A Resource Centre is the focus for the provision of services to a specific area of the community. It acts as the base of a multi-professional team whose core purpose is to provide community-based care for clients of all ages. The care usually comprises assessment, treatment and rehabilitation via domiciliary, consultant and other HCP outpatient, day hospital and outreach services, delivered at the centre, in the client's home and other suitable venues.</p> <p>[B01] / [B02] Health Centre premises: A health centre is a facility which is used for the provision of primary care services and a range of community health services. It provides a standard of amenity which it is not easy to provide in a traditional consulting room. Services provided include General Medical services and nursing services and may in addition include AHP services, other primary care services and specialist services.</p> <p>[H01] Day Centre premises: Daytime care for the needs of people who cannot be fully independent: such as children or the elderly. Day care centres can offer the person you care for an opportunity to take on new hobbies and arrange days out, and they can also provide you with a break from caring. Day care centres are run by social services departments, or voluntary organisations, such as charities</p> <p>[D01] / [D02] / [D03] Walk In Centres, Out of Hours Premises and Emergency Community Dental Services: NHS Walk-in Centres are predominantly nurse-led primary care facilities dealing with illnesses and injuries – including infections and rashes, fractures and lacerations, emergency contraception and advice, stomach upsets, cuts and bruises, or minor burns and strains – without the need to register or make an appointment. They are not designed for treating long-term conditions or immediately life-threatening problems.</p>
<p>LANGUAGE CODE (TREATMENT)</p>	<p>This is the language used for the delivery of treatment to the Patient.</p> <p>If digital translation is used, the language code would be populated with the language in which the patient received the care.</p> <p>In order to populate this data item please select either: The two character code found in the ISO 639-1 Code column from the ISO 639.2 Codes for the Representation of Names of Languages (CRNL); code list; or one of the five communication method extensions detailed in the Technical Output Specification and NHS Data Model & Dictionary.</p> <p>Please note: the format for this data item is an2. Only the ISO 639-1 Code column should be referenced. Please do not attempt to submit codes that appear in the ISO 639-2 Code column by truncating to two characters. In some cases a valid code would be derived, however the valid code may link to a language that is unconnected to the intended language for submission. On submission validations would not be able to detect this therefore any reporting would include incorrect calculations related to preferred language.</p>

INTERPRETER PRESENT AT CARE CONTACT INDICATION CODE	<p>An indication of whether an interpreter was present at a Care Contact for the purposes of communication, including Sign Language, between a CARE PROFESSIONAL and a Patient and if so the type of interpreter.</p> <p>This item is only for human translators. If digital translation is used, the language item would be populated with the language in which the patient received the care.</p>
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5.2.13 IDS202 Care Activity

IDS202 Care Activity	
Description	
<p>To carry details of any care activity undertaken at a Care Contact.</p> <p>One occurrence of this Group is permitted for each Care Activity.</p> <p>General Table Guidance</p> <p>This table should contain a record for each separate element of assessment, treatment or review that was undertaken within a Care Contact. However, there is no necessity to duplicate closely linked care activity. For example: if several Coded Scored Assessment (Contact) records are submitted, they can be linked to one appropriate care activity (as a result of local decision).</p> <p>This table should reflect Care Activity from a patient perspective. For example, where multiple Care Professionals are involved in a single Care Activity, a single record should flow for the 'lead' Care Professional, rather than creating multiple records linked to each involved Care Professional.</p> <p>Where the ATTENDED OR DID NOT ATTEND CODE submitted in the Care Contact table is [7] <i>Patient arrived late and could not be seen</i>; [2] <i>Appointment cancelled by, or on behalf of the patient</i>; [3] <i>Did not attend, no advance warning given</i>; or [4] <i>Appointment cancelled or postponed by the health care provider</i> a Care Activity record should not be submitted.</p> <p>Each Care Activity can have any combination of Procedures/Findings/Observations flowed to this table and it is not mandatory for all fields to be completed. E.g. a procedure may not have an observation the observation field can be left blank.</p> <p>NHS Digital will not be restricting the input of Coded Procedures/Findings/Observations through validation. Providers can opt to flow any activities and related information that are naturally recorded against the Care Contact. Therapy types should also flow from this table.</p> <p>Additional guidance on procedures, findings, observations, observation values and units of measurement can be found within Appendix 2 – Care and Indirect Activity Guidance, including details of specific national reporting requirements related to the use of these data items.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
CLINICAL CONTACT DURATION OF CARE ACTIVITY	<p>The total summed duration of Care Activities linked to a Care Contact should not exceed the Clinical Contact Duration of the Care Contact.</p> <p>I.e. Duration should be reported from a patient perspective and not duplicated for reporting purposes, such as against multiple Care Professionals involved in a single Care Activity.</p>

<p>CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)</p>	<p>This item can be used to record the specific activity that was undertaken within the Care Contact, through the submission of a SNOMED CT Expression.</p> <p>Procedure: “represents activities performed in the provision of health care. This includes not only invasive procedures but also administration of medicines, imaging, education, therapies and administrative procedures” – SNOMED CT Starter Guide - Section 6 (page 21 onwards).</p> <p>Please see Appendix 2.3 for details of specific national reporting requirements related to the use of this data item.</p> <p>For further information on SNOMED CT Expressions, see the SNOMED CT Glossary at: Expression.</p> <p><u>Examples</u></p> <p>Post-coordinated expression (procedure + qualifier)</p> <p>To flow a procedure and qualifier, three pieces of information are required:</p> <ul style="list-style-type: none"> • The procedure code (for example: 304891004 Cognitive behaviour therapy) • The qualifier code (for example: 410527000 Offered) • A code that links the procedure and the qualifier (in this case: 408730004 Procedure context) <p>The three codes are concatenated for submission as follows: 304891004:408730004=410527000 (Cognitive behaviour therapy: Procedure context=Offered)</p> <p>Precoordinated expression (procedure only)</p> <p>Procedure only flows as a single code: 304891004 (Cognitive behaviour therapy)</p>
<p>FINDING SCHEME IN USE</p>	<p>Please note, this data item should not be submitted if data is not being submitted in the CODED FINDING (CODED CLINICAL ENTRY) field. This will cause the record to be rejected.</p>
<p>CODED FINDING (CODED CLINICAL ENTRY)</p>	<p>This data item should be used to report any Findings captured during the Care Activity.</p> <p>Finding: “represents the result of a clinical observation, assessment or judgment and includes normal and abnormal clinical states” – SNOMED CT Starter Guide - Section 6 (page 21 onwards)</p> <p>Please see Appendix 2 – Care and Indirect Activity Guidance for details of specific national reporting requirements related to the use of this data item</p>

CODED OBSERVATION (SNOMED CT)	<p>This data item should be used to report any Observations captured during the Care Activity.</p> <p>Observation: “represents a question or assessment which can produce an answer or result” – SNOMED CT Starter Guide - Section 6 (page 21 onwards)</p> <p>Please see Appendix 2 – Care and Indirect Activity Guidance for details of specific national reporting requirements related to the use of this data item.</p> <p>NB. This field <u>MUST</u> not be used to flow scored assessments such as PHQ-9, GAD etc. These must be flowed in tables IDS606 and IDS607. Please refer to table guidance for IDS606 and IDS607</p>
OBSERVATION VALUE	Observation Value: represents the value of the observation
UCUM UNIT OF MEASUREMENT	<p>Unit of Measure: represents the unit of measure of the observation value</p> <p>See http://unitsofmeasure.org/trac/.</p>

5.2.14 IDS205 Internet Enabled Therapy Care Professional Activity Log

IDS205 Internet Enabled Therapy Care Professional Activity Log	
Description	
<p>Internet Enabled Therapy Care Professional Activity Log: To carry details of the summarised activity during a specified time period for the Care Professional supporting Internet Enabled Therapy for a patient.</p> <p>One occurrence of this group is permitted for each activity log.</p> <p>General Table Guidance</p> <p>The submitted activity logs should cover the whole period of time in which internet enabled therapy is being completed.</p> <p>IAPT data set guidance for submitting internet enabled therapy data is available on the IAPT v2.0 web page.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
START DATE (INTERNET ENABLED THERAPY ACTIVITY LOG)	The START DATE of the period for which the Internet Enabled Therapy Care Professional Activity Log relates to.
END DATE (INTERNET ENABLED THERAPY ACTIVITY LOG)	The END DATE of the period for which the Internet Enabled Therapy Care Professional Activity Log relates to.
INTERNET ENABLED THERAPY PROGRAMME	<p>The name of the Internet Enabled Therapy Programme given to a PATIENT.</p> <p>This is a free text field.</p> <p>A list of free text strings for commonly used programmes is available in the IAPT data set guidance for submitting internet enabled therapy data available from the IAPT v2.0 web page.</p>

<p>DURATION OF INTERNET ENABLED THERAPY IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE PROFESSIONAL CLINICAL TIME</p>	<p>The duration of clinical time spent by the Care Professional supporting Internet Enabled Therapy for the patient within the specified time period.</p> <p>If no clinical time has been spent by the IAPT Care Professional within the specified time period, 0 minutes should be submitted.</p>
<p>INTERNET ENABLED THERAPY INTEGRATED SOFTWARE ENGINE USED INDICATOR</p>	<p>An indication of whether an Integrated Software Engine was used as part of Internet Enabled Therapy.</p> <p>An Integrated Software Engine is software that enables information, such as progress notes and outcomes, to be shared electronically between an Internet Enabled Therapy Programme and a patient's clinical record.</p> <p>The use of this software reduces the burden and associated risk of duplicate data input and can provide real time feedback regarding the efficiency of Internet Enabled Therapy for the patient.</p>

5.2.15 IDS602 Long Term Physical Health Condition

IDS602 Long Term Physical Health Condition	
<p>Description</p>	
<p>To carry details of any Long Term Physical Health Conditions for a patient, which are stated by the patient or recorded in medical notes. These do not necessarily have to have been diagnosed by the organisation submitting the data.</p> <p>One occurrence of this group is permitted for each Long Term Physical Health Condition.</p> <p>General Table Guidance</p> <p>Please see the definition of a Long Term Physical Health Condition in the NHS Data Model and Dictionary.</p>	
<p>Additional Notes on Data Items</p>	
Data Item Name	Additional Notes
<p>DIAGNOSIS SCHEME IN USE</p>	<p>The type of CODED CLINICAL ENTRY used for the PATIENT DIAGNOSIS.</p>
<p>LONG TERM PHYSICAL HEALTH CONDITION (CODED CLINICAL ENTRY)</p>	<p>For mapping guidance to effectively flow the list of Long Term Condition data items that were in the IAPT Long Term Conditions/ Medically Unexplained Symptoms (LTC/MUS) Pilot, please see the IAPT v2.0 SNOMED CT Mapping document which can be found on the Submitting IAPT v2.0 data web page.</p> <p>Please note that the mapping provided in the document represents a 'minimum' to enable the existing national codes to flow. Providers may record additional granularity or conditions locally, which SHOULD be provided to the data set.</p> <p>The data set does not specify for these additional codes to be mapped to the original list for submission purposes.</p>

5.2.16 IDS603 Presenting Complaints

IDS603 Presenting Complaints	
Description	
<p>To carry details of the primary and any secondary presenting complaints recorded for a patient, made by the service that the patient was referred or admitted to.</p> <p>One occurrence of this group is permitted for each presenting complaint.</p> <p>General Table Guidance</p> <p>This table replaces the Provisional Diagnosis data item that was previously in the core Referral table and the Medically Unexplained Symptoms item in the LTC/MUS pilot collection. This new table also allows the service to provide 'secondary' presenting complaints alongside the 'primary'.</p> <p>This table references the terminology 'resenting complaint' throughout. IAPT services may be familiar with the term 'problem descriptor' for this definition. Both terminologies are defined equivalently, however 'presenting complaint' is the terminology to be used across the NHS Data Model & Dictionary for other care settings. IAPT services may refer to this table locally using 'problem descriptor' terminology and submit data in this table on that basis.</p> <p>Access to comprehensive information around presenting complaints is fundamental to successful IAPT outcome reporting and service planning. The IAPT Manual provides a coding framework for the range of conditions suitable for treatment within IAPT services, including relevant ICD-10 coding.</p> <p>The Provisional Diagnoses from v1.5 can continue to flow in the usual manner using ICD10 codes within this new table, there is no change to coding required, however, data providers are now able to flow conditions in SNOMED CT, depending on the schema used locally to record this data.</p> <p>On determination of an anxiety disorder problem descriptor by the IAPT Care Professional at initial assessment, the appropriate measurement tools can be applied from the range of relevant anxiety disorder specific measures (ADSMs).</p> <p>Presenting complaints records patterns of symptoms and do not replace in any way the patient-centred assessment required to personalise treatment plans.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
PRESENTING COMPLAINT (CODED CLINICAL ENTRY)	This data item allows the use of terminologies such as ICD-10 and SNOMED CT for the recording of problem descriptors and medically unexplained symptoms. For further details and the Terminology Mapping Guidance document available from the IAPT webpage .
PRESENTING COMPLAINT CODING SIGNIFICANCE	<p>Version 2.0 allows the ability for services to provide any 'secondary' complaints alongside the 'primary' complaint.</p> <p>Despite the data item not being mandatory, it is important that this item is populated to gain a comprehensive and accurate view of primary and secondary complaints.</p> <p>For open referrals spanning 1 September 2020 with a Provisional Diagnosis previously recorded, this field would be populated as 'Primary'. For any new/amended complaints, this field should be populated as 'Primary' or 'Secondary' as appropriate.</p>

5.2.17 IDS606 Coded Scored Assessment (Referral)

IDS606 Coded Scored Assessment (Referral)
Description
<p>To carry details of scored assessments that are issued and completed as part of a service or team referral, but that do not take place at a specific contact. E.g. assessment completed at home and returned or completed during internet enabled therapy</p> <p>One occurrence of this Group is permitted for each coded scored assessment question or dimension captured outside of a Care Contact.</p> <p><u>General Table Guidance</u></p> <p>A list of the scored assessments that can be accepted in this table at the submission portal can be found in Appendix 1 – Guide for recording Assessment Tools. A more detailed table including which ratings/scores are required, SNOMED CT mappings and expected values can be found in the Technical Output Specification. Please see the “ROM¹ Mapping” tab.</p>
Additional Notes on Data Items - There are currently no additional notes

¹ Routine Outcome Measure

5.2.18 IDS607 Coded Scored Assessment (Activity)

IDS607 Coded Scored Assessment (Activity)	
Description	
<p>To carry details of scored assessments that are issued and completed as part of a specific Care Activity.</p> <p>Where scored assessments cannot be appropriately linked to a specific care activity, these can now flow in the IDS606 table via linkage to the referral.</p> <p>One occurrence of this Group is permitted for each coded scored assessment question or dimension captured as part of a specific Care Activity.</p> <p><u>General Table Guidance</u></p> <p>Where assessment tool details are recorded during a Care Contact, the Care Activity table should be populated with the mandatory fields to allow linkage between Care Contact and Care Activity. The Assessment tool and score details can be recorded in IDS607 Coded Scored Assessment (Care Activity).</p> <p>A list of the scored assessments that can be accepted in this table at the Data Services Platform can be found in Appendix 1 – Guide for recording Assessment Tools. A more detailed table including which ratings/scores are required, SNOMED CT mappings and expected values can be found in the Technical Output Specification. Please see the 'ROM² Mapping' tab.</p> <p>There is no validation relating to which specific IDS202 Care Activities should be linked to a IDS607 Coded Scored Assessment (Care Activity) record, however generic activities such as reviews or assessments would be acceptable.</p>	
There are currently no additional notes	

5.2.19 IDS803 Care Cluster

IDS803 Care Cluster	
Description	
<p>To carry details of the Care Cluster Assignment Periods for the patient.</p> <p>One occurrence of this group is permitted for each period of time that a patient was allocated to a Care Cluster.</p> <p><u>General Table Guidance</u></p> <p>Further information regarding Mental Health Care Clusters can be found in the NHS England IAPT Manual and the NHS Improvement National tariff payment system 2019/20, in particular Appendix E.</p>	
Additional Notes on Data Items	
ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Please note, the following code is not valid for Adult Mental Health Clustering: [09] Cluster Under Review

² Routine Outcome Measure

5.2.20 IDS902 Care Personnel Qualification

IDS902 Care Personnel Qualification	
Description	
<p>To carry details of each qualification attained, or planned to be attained by the Care Personnel.</p> <p>One occurrence of this group is permitted for each qualification.</p> <p><u>General Table Guidance</u></p> <p>This table is for IAPT Care Professionals and Employment Advisers.</p> <p>Please be aware the Employment Advisers training is not currently live, but will be introduced in future. This table therefore should not be populated for Employment Advisers until specifically requested by NHS Digital.</p> <p>Only one date field is permitted for this table per record (i.e. either EMPLOYEE QUALIFICATION DATE' or EMPLOYEE QUALIFICATION PLANNED COMPLETION DATE).</p> <p>If the Care Professional has, or is working towards more than one qualification, then at least two records would be submitted in this table for that Care Professional. E.g. Care Professional 12345 has two qualifications for X and Y. Two records would therefore be submitted in this table.</p> <p>12345 + X + relevant date</p> <p>12345 + Y+ relevant date</p> <p>Records with a Qualification Awarded Date prior to 1 January 2005 will not be accepted and will cause the record to be rejected. The QUALIFICATION ATTAINMENT LEVEL (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) specifies a specific set of recognised IAPT qualifications. Any qualification awarded date prior to 1 January 2005 would not be one of these recognised qualifications.</p> <p>IAPT Professional qualification courses do not normally exceed 18 months. Therefore, records with a Employee Planned Qualification Completion Date exceeding 18 months from entry will be rejected.</p>	
Additional Notes on Data Items	
<p>QUALIFICATION ATTAINMENT LEVEL (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)</p>	<p>The following codes are not currently valid:</p> <p>30 - Curriculum for Employment Advisers</p> <p>31 - Curriculum for Senior Employment Advisers</p>

Appendix 1 – Guide for recording Assessment Tools

Routine outcomes and experience measurement is central to improving service quality and accountability.

It ensures the patient receiving treatment and the care professional providing it have up-to-date information on an individual's progress, which is of value in itself.

At an overview level, where individual patients are anonymised, service providers and commissioners can see a performance pattern for the service.

The assessment tools within scope of the IAPT Data Set should only be included in submissions if they are currently in use and appropriate for the service. If any of the below tools are not used by the service, they should not be included in the submission.

Appendix 1.1 List of accepted Assessment Tools for submission within IAPT

Please note: This list will remain under development and assessment tools may be added as and when identified as a requirement for submission through the IAPT Data Set.

Table 3.1

No	Tool	Collection Start Date	Guidance
1	Body Image Questionnaire (BIQ)	01/04/2020	New questionnaire in IAPT v2.0
2	Brief Pain Inventory (BPI)	01/03/2017	
3	COPD Assessment Test (CAT)	01/03/2017	For further information please see the COPD Assessment Test (CAT) website.
4	Diabetes Distress Scale (DDS)	01/03/2017	For further information please see the Diabetes Distress website.
5	Generalised Anxiety Disorder 7 (GAD-7)	01/04/2012	For further information please see the NHS England IAPT Manual: Appendices and helpful resources document.
6	Health Anxiety Inventory (HAI) - Week	01/04/2012	For further information please see the Kings College London Health Anxiety Questionnaires web page.
7	IAPT Treatment Patient Experience Questionnaire	01/07/2014	For further information please see the NHS England IAPT Manual: Appendices and helpful resources document. New question added to PEQ for IAPT v2.0: Q6 - Did you receive the employment help that you required?
8	IAPT Assessment Patient Experience Questionnaire	01/07/2014	For further information please see the NHS England IAPT Manual: Appendices and helpful resources document. New question added to PEQ for IAPT v2.0: Q4 - Did your assessment cover your employment needs?
9	iMTA Productivity Cost Questionnaire (iPCQ)	01/04/2020	For further information please see the Kings College London Health Anxiety Questionnaires web page. This is also known as the presenteeism questions and only relate to those that are in work and working.
10	Irritable Bowel Syndrome - Symptom	01/03/2017	For further information please see the NHS England IAPT Manual: Appendices and helpful resources document.

	Severity Scale (IBS-SSS)		
11	Mobility Inventory (MI) for Agoraphobia		For further information please see the NHS England IAPT Manual: Appendices and helpful resources document.
12	Obsessive Compulsive Inventory (OCI)	01/04/2012	For further information please see the NHS England IAPT Manual: Appendices and helpful resources document.
13	Panic Disorder Severity Scale (PDSS)	01/04/2012	For further information please see the NHS England IAPT Manual: Appendices and helpful resources document.
14	Patient Health Questionnaire-9 (PHQ-9)	01/04/2012	For further information please see the NHS England IAPT Manual: Appendices and helpful resources document.
15	Patient Health Questionnaire-15 (PHQ-15)	01/03/2017	For further information please see the NHS England IAPT Manual: Appendices and helpful resources document.
16	Penn State Worry Questionnaire (PSWQ)	01/04/2012	
17	PTSD (post-traumatic stress disorder) checklist for DSM-5 (Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition) (PCL-5)	01/04/2020	New questionnaire in IAPT to replace Impacts of Events Scale (IES) - Revised.
18	Social Phobia Inventory (SPIN)	01/04/2012	For further information please see the NHS England IAPT Manual: Appendices and helpful resources document.
19	Work and Social Adjustment Scale	01/07/2014	For further information please see the NHS England IAPT Manual: Appendices and helpful resources document.

Appendix 1.1.2. Assessment tools under review IAPT data set

The following national outcome measure tools previously in IAPT v1.5 are currently under review and therefore not included at this stage. Users will be advised accordingly if they are to be re-introduced as part of the data set.

No	Tool	Guidance
1	Chalder Fatigue Scale (CFQ 11)	Currently under review.

Appendix 1.1.3 Assessment tools removed from IAPT data set

The following tools have been removed from the IAPT data set and should no longer be flowed.

No	Tool	Guidance
1	Impacts of Events Scale (IES) - Revised	To be replaced by PTSD (post-traumatic stress disorder) checklist for DSM-5 (Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition) (PCL-5).

Appendix 1.2 Licensing of Assessment Tools for use within systems

Providers and their IT suppliers are reminded of the need to ensure their compliance with Intellectual Property Law in relation to the use of copyright protected assessment tools.

Whilst SNOMED CT values can flow to NHS Digital without any copyright infringement (because SNOMED CT does not reproduce the text of the tools), reproduction of the tool within IT systems (text, values and algorithms etc.) requires suitable permissions to be in place. It is assumed that providers already have appropriate permissions in place for the assessment tools they use in paper form.

NHS England has commissioned NHS Digital to work towards securing permissions for the use of IAPT assessment tools within care provider IT systems. This work is underway and updates on progress will be posted regularly to the following website:

<https://digital.nhs.uk/National-Clinical-Content-Repository>

The website is regularly updated. It contains details on how providers and their suppliers can obtain permission to use assessment tools within their systems and the tools for which we are seeking permissions.

Appendix 1.3 SNOMED CT Mapping

A detailed table including which ratings/scores are required for each assessment tool, SNOMED CT mappings and expected value ranges can be found in the Technical Output Specification. Please see the “ROM³ Mapping” tab.

The codes for all IAPT v2.0 assessment tools are available in SNOMED CT within the reference set: 1323831000000101. Please visit <https://termbrowser.nhs.uk/> to access this reference set.

Maintaining SNOMED CT mapping

Organisations whose local systems are not fully SNOMED CT compliant may rely on Information departments to undertake manual mapping of data to SNOMED CT terms in order to submit the data. This mapping will require review at each SNOMED CT release every 6 months (in April and October), as well as when new assessment tools are introduced to (or retired from) the scope of the IAPT Data Set.

³ Routine Outcome Measure

Appendix 2 – Care and Indirect Activity Guidance

NHS Digital are not placing any restrictions on the activities/interventions that service providers can demonstrate through clinical terminology.

It is likely the case that specific reporting needs for different policies will instigate work on developing comprehensive lists for service activities or intervention types. This approach is going to place emphasis on the development of terminology “refsets” to meet particular clinical and reporting needs (both locally and nationally) by the wider community (such as DHSC, NHS England and NHS Improvement, IAPT Programme, NICE, RCPsych, clinicians, informatics staff..).

NHS Digital will include references to appropriate nationally-relevant refsets within this User Guidance appendix. However, this appendix should not be considered definitive and it is essential service providers keep up to date with both national and local reporting requirements.

Appendix 2.1 Illustration of IDS202 Care Activity fields

The following table provides a high-level illustration and basic example of the purpose and relationship between each data item within the IDS202 Care Activity table:

Hierarchy	Description	Example
Procedure	represents activities performed in the provision of health care. This includes not only invasive procedures but also administration of medicines, imaging, education, therapies and administrative procedures	'Measuring weight'
Finding	represents the result of a clinical observation, assessment or judgment and includes normal and abnormal clinical states	Examples include: <ul style="list-style-type: none"> • 'normal weight' • 'excessive weight loss'
Observation	represents a question or assessment which can produce an answer or result	'Body weight'
Obs Value	represents the value of the observation	90
Unit of Measure	represents the unit of measure of the observation value	kg

Further information with regard to the concept model of SNOMED CT can be found within the [SNOMED CT Starter Guide](#), in particular please see section 6.

Appendix 2.2 Mandatory reporting requirements for continuation of IAPT data flow Therapy Types

Submitters must now be using SNOMED CT to record therapy types as specified in the IDS202 Care Activity table. Mappings to the SNOMED codes are detailed within the Terminology Mapping Guidance document accessible on the [IAPT webpage](#).

Long Term Conditions

The Long Term Conditions from v1.5 can continue to flow in the usual manner within this new table, there is no change to coding required, however, data providers are now able to flow conditions in SNOMED CT, depending on the schema used locally to record this data.

Mappings to the SNOMED codes are detailed within the Terminology Mapping Guidance document accessible on the [IAPT v2.0 webpage](#).

Presenting Complaints

Table IDS603 Presenting Complaints allows the use of terminologies such as ICD-10 and SNOMED CT for the recording of problem descriptors and medically unexplained symptoms. Please see section 5.2.16 Presenting Complaints for further details and the Terminology Mapping Guidance document available from the [IAPT webpage](#).

Appendix 2.3 Specific National Reporting Requirements

Smoking Status

Patient smoking status should be submitted as part of the data set in line with local clinical practice for collecting this information.

NHS Digital have provided mapping to the consistent list used in MHSDS and other data sets, which MAY be used by IAPT services. However, where greater granularity is already recorded, providers can submit that data and it will be aggregated to the higher level during analysis. E.g. if 'Ex-very heavy cigarette smoker (40+/day)' is submitted it would appear in analysis as 'ex-smoker'. This data should flow in the Social and Personal Circumstances table.

SNOMED CT Concept	SNOMED CT Concept ID
smoker (finding)	77176002
ex-smoker (finding)	8517006
current non smoker but past smoking history unknown (finding)	405746006
never smoked tobacco (finding)	266919005

Asylum Status

Information about asylum seeker status should be submitted to the data set where this is naturally recorded as part of clinical practice. The following SNOMED CT codes are available to use and policy guidance in development with the IAPT Programme will be published to support the capture of this information locally.

There are two levels of granularity enabling services to capture information to identify whether the person is an Asylum Seeker or Refugee and to further expand with 5 codes relating to the status of the Asylum Seeker. This data should flow in the Social and Personal Circumstances table.

SNOMED CT Concept Preferred Term	SNOMED CT Concept ID
Asylum seeker (person)	390790000

asylum seeker awaiting decision on refugee status (person)	728611000000100
asylum seeker with application for asylum refused (person)	728621000000106
asylum seeker with discretionary leave to remain (person)	729851000000109
asylum seeker with humanitarian protection status (person)	728631000000108
unaccompanied child asylum seeker (person)	748241000000103

Refugee (person)	446654005
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Contextual Factors

Contextual factors such as alcohol and drug misuse, debt problems, gambling problems and smoking should be submitted to the data set when recorded locally for primary purposes, in the Social and Personal Circumstances table.

The following codes are available in SNOMED CT to support the flow of this information and additional guidance in development with the IAPT Programme will be provided in support of this.

SNOMED CT Concept Preferred Term	SNOMED CT Concept ID
Alcohol	
does not misuse alcohol (situation)	1129201000000101
alcohol abuse (disorder)	15167005
alcohol dependence (disorder)	66590003

Drug Use	
does not misuse drugs (situation)	228367002
drug abuse (disorder)	26416006
drug dependence (disorder)	191816009

Debt	
assessment of financial status (procedure)	710852001
financial problem affecting mental well-being (finding)	1240211000000108
referral to debt counselling service (procedure)	1239851000000103
not in debt (situation)	1239721000000101

Gambling	
compulsive Gambling (disorder)	18085000
no evidence of compulsive gambling disorder (situation)	748071000000101

Peri and postnatal periods

The IAPT Programme have provided guidance for the capture of information in support of the perinatal period. This guidance is available on the [IAPT v2.0 webpage](#). Data for individuals in the Perinatal period should flow in the Social and Personal Circumstances table.

Populating Care Activities for Coded Scored Assessments

A SNOMED CT refset exists containing SNOMED CT procedure codes for each Coded Scored Assessment in scope for IAPT.

For example: "Assessment using PHQ-9 Questionnaire for depression screening (procedure)"

This subset is "Mental health assessment procedures simple reference set" with SCTID 991461000000106.

These procedure codes MAY be used for linking IDS607 Coded Scored Assessment (Care Activity) records to a relevant IDS202 Care Activity record.

Legally unshareable clinical codes

NHS Digital are currently undertaking a review of clinical codes that are defined as sensitive (legally restricted) in order to ensure that its use of provider data is compliant with the Human Fertilisation

and Embryology Act 1990 (as amended by the Human Fertilisation and Embryology Act 2008) and the Gender Recognition Act 2004 (as amended by The Gender Recognition (Disclosure of Information) (England, Wales and Northern Ireland) Order 2005).

As part of this work, NHS Digital sought feedback on a proposed list of legally unsharable clinical codes. The codes that have been identified will continue to be used for secondary purposes, but all related information that could potentially identify an individual would be removed where the codes are used for any other reason apart from direct care.

Until these lists of codes are finalised for use across national data sets, the Data Set Development Service advise services to take extra care when flowing clinical terminology which may fall in the scope of legally unsharable clinical codes. Services should consult with their local Caldicott Guardian in first instance where doubt exists.

ⁱ <https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf>