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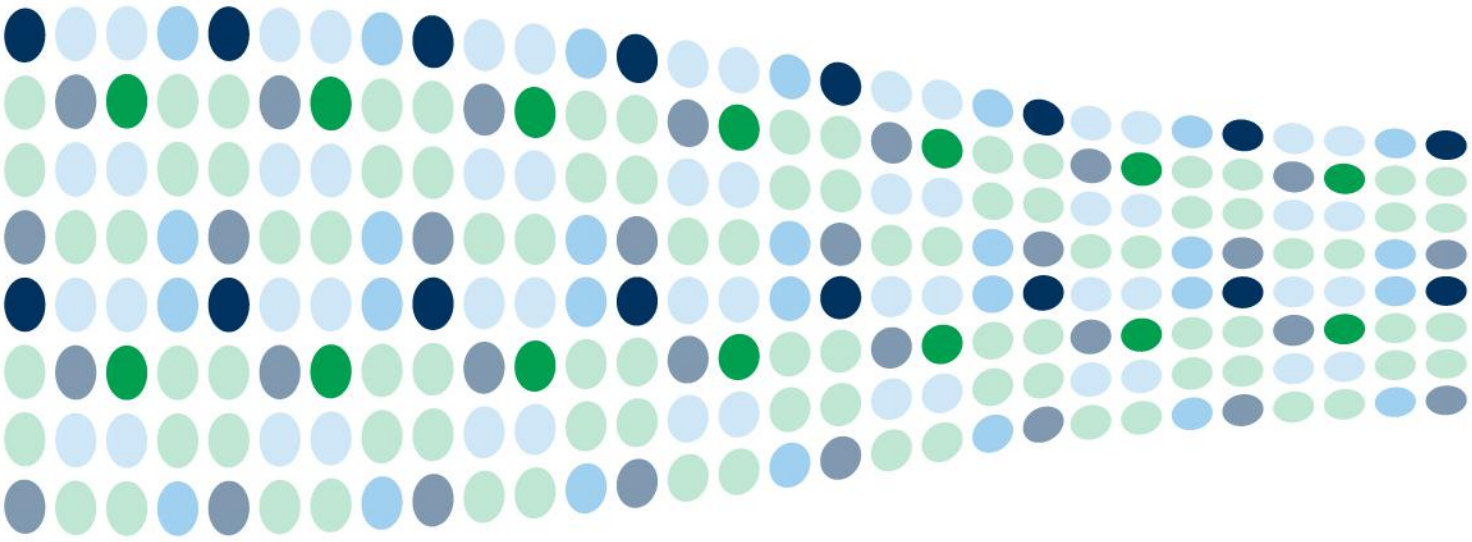
Announcement of methodological change:

Improving Access to Psychological Therapies (IAPT) Reports



Published 28th October 2014

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Version:	**V1.0**
Date of publication:	**October 2014**

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Introduction

This paper announces and describes changes to IAPT reports as a result of an update to a new version of the dataset. We currently report from the first version of the dataset, but from July 2014 data has been recorded under version 1.5. Although most content has remained the same, the addition of new fields, and changes to some validation rules and acceptable values, requires an underlying change in the methodology used to produce a number of key measures in our published reports.

Background

The IAPT dataset is a regular return of data generated by providers of IAPT services in the course of delivering these services to patients. The data also includes information from Independent Sector Organisations who are providers of NHS funded IAPT services.

The IAPT dataset is received by the Health and Social Care Information Centre (HSCIC) as record level data from clinical systems. From Quarter 1 2012/13 the HSCIC has published monthly data quality reports and quarterly data covering access, activity and outcomes in the service.

A new version of the IAPT dataset was mandated in July 2014. The new IAPT dataset version 1.5 specification can be found on the Information Standards Board (ISB) website here:

http://www.isb.nhs.uk/documents/isb-1520/amd-02-2013/index_html

The main changes in the dataset are as follows:

- New permissible values – existing fields such as ‘Therapy type’ or ‘End reason’ have had the permissible values changed in order to collect more useful information that better reflects the service. For example the list of allowable end reasons now includes a distinction between those referrals that were assessed only and those that were assessed and treated. These new values also allow the identification of when a referral has been stepped up or down to another provider.
- New fields – A number of new fields have been introduced to increase the utility of the dataset, such as the introduction of ‘Appointment time’ to facilitate correct ordering of appointments that occur on the same day.
- Increased validations – some new validations have been added to improve data quality in the dataset. For example, ‘Appointment purpose’ has become a mandatory field, meaning that if this field is not present or is invalid for any appointments in a submission, the entire submission will be rejected
- New tables – Three new tables have been added in version 1.5. One includes waiting time pauses which can be used in waiting time calculations, and the other two provide details of patient experience questionnaires to help with the Currencies and Pricing framework.

In addition there are a number of smaller changes such as changes to acceptable formats of tables, and the naming of fields, designed to help with the utility of the dataset and to bring it in line with Data Dictionary[1] definitions.

For a full breakdown of all changes to the dataset contained in the new version of the report please consult the "Summary of Changes" tab of the Technical Output Specification which can be found here: http://www.hscic.gov.uk/iapt

Changes

As a result of these changes to the dataset we will be making a number of alterations to existing reports. These changes will not represent any new content, such as the incorporation of waiting time pauses, as this is a subject for further development in future reporting. This paper deals only with necessary underlying changes to the methodology needed to continue existing publications. These changes are as follows:

- All Reports – New definition of a treatment and assessment appointment
- All Reports - New derivation of CCG
- All Reports – New Pathway derivation
- Monthly Reports – New data quality measures
- Quarterly Reports - Reporting by End Reason
- Quarterly Reports – Reporting by provisional diagnosis
- Quarterly Reports – Changes to First and Last Scores

All Reports: New Definition of treatment and assessment appointments

Due to data quality issues, in the first version of the dataset, the 'Appointment purpose' field could not be used to determine whether or not an appointment was a treatment or assessment appointment (for the purposes of calculating those entering treatment, or finishing a course of treatment). Instead a treatment appointment was defined as any appointment where at least one therapy type field was not null, whilst an assessment appointment was defined as any appointment where assessment scores of anxiety or depression had been recorded (such as the Patient Health Questionnaire (PHQ9) or Generalised Anxiety Disorder Questionnaire (GAD7)). This methodology has been applied up until now to all calculations in the reports that look at the type of treatment appointment.

Version 1.5 makes the 'Appointment purpose' field mandatory, which allows providers to record whether the appointment was a treatment, assessment, or review. From version 1.5 we will use this field to identify the type of appointment, with treatment appointments being those coded as '02' (Treatment), '03' (Assessment and treatment) or '05' (review and treatment), and assessment appointments being all those with an appointment purpose of '01' (Assessment) or '03' (Assessment and Treatment). This change to methodology will affect all measures in quarterly and monthly reports that look at the type of appointment. A full list of measures affected are as follows:

- Monthly:
    - Referrals entering treatment

[1] http://www.datadictionary.nhs.uk/

    - Referrals finishing a course of treatment
- Quarterly:
    - Line 2 - Number of new referrals that began in the quarter for service users who have waited more than 28 days for first or second treatment
    - Line 4 - Number of days from referral received to first assessment where the first assessment occurred within the reporting period
    - Line 5 - Number of days from referral received to first treatment where the first treatment occurred within the reporting period
    - Line 8 - Number of referrals that ended in the quarter having finished a course of treatment (having had at least two treatment appointments)
    - Line 9 - PHQ9 and Anxiety Disorder Specific Measure (ADSM) data completeness for referrals that ended in the quarter having finished a course of treatment
    - Line 10 - Psychotropic medication data completeness for referrals that ended in the quarter having finished a course of treatment
    - Line 11- Number of referrals that ended in the quarter having finished a course of treatment, where the service user had moved off sick pay
    - Line 12 - Duration of treatment for those referrals ending in the quarter that had at least one treatment
    - Line 14a-e - Number of referrals that ended in the quarter having finished a course of treatment, broken down by age bands, gender, ethnicity, disability and provisional diagnosis
    - Line 15 - Number of referrals that ended in the quarter having finished a course of treatment, where the service user has moved to recovery
    - Line 16 - Number of referrals that ended in the quarter having finished a course of treatment, where the service user was not at caseness at initial assessment
    - Line 17 - Number of referrals that ended in the quarter having finished a course of treatment, with reliable improvement, reliable deterioration or no change in both PHQ9 and GAD7 (or other relevant ADSM)
    - Line 18 - Number of referrals that ended in the quarter having finished a course of treatment, where the service user has move to reliable recovery

All Reports: New derivation of Clinical Commissioning Group (CCG)

Currently CCG is presented in two ways in standard reports. In the IAPT Quarterly reports data is presented by Organisation Code of Commissioner, as recorded by the provider. Data quality issues have been common with this field since the restructure of the NHS in April 2013, as a number of records continued to flow with old invalid Primary Care Trust (PCT) codes, rather than CCG codes.

As a result of this issue, monthly IAPT reports and supplementary CCG analysis in the quarterly reports provided data on selected activity measures by CCG of GP practice rather than Organisation Code of Commissioner. Whilst this excludes any invalid codes as a result of legacy PCT codes being submitted, the CCG of the GP Practice for the patient is not always the CCG that commissions their care. The intended purpose of the organisation code of commissioner is to capture cases such as these.

In order to address both of these issues, and to report by the most comprehensive list of valid, accurate CCGs available, all reports by commissioner from November onwards (July Final data) will use a new method to determine the CCG, as follows.

- Where the Organisation Code of Commissioner is a valid CCG this will be used.
- If there is no valid Organisation Code of Commissioner, CCG will be derived from the GP Practice.
- If the GP Practice code is missing or does not map to a valid CCG, CCG of Residence will be used (based on the postcode of the service user).
- If there is no CCG of Residence then the CCG will be null.

This will affect Quarterly commissioner reports, Quarterly CCG supplementary analysis and Monthly activity reports.

All Reports: New pathway derivation

Throughout version 1 of the dataset, the HSCIC has combined referrals submitted each month into a single pathway, to allow the entire course of the referral to be tracked. In order to join the referrals submitted each month to one another a pathway ID has been created for each unique combination of Service ID, Person ID and organisation code. This works well in most cases, however if an organisation changes its code, all pathways in that organisation will be broken as the pathway ID can no longer be assigned. As the organisation code has changed, there is a new unique combination of service ID, Person ID and Organisation code and so each of these referrals is assigned a new pathway ID, which cannot be joined to the old one.

Although this should not occur often, it can cause significant problems in certain circumstances, and will affect all activity measures including access and recovery.

While it is not recommended that an organisation change its code except where absolutely necessary, the construction of the pathway ID in version 1.5 is changing slightly to try and reduce the impact of this issue. From July final data the Pathway ID will be assigned to unique combinations of Person ID and Service ID only, no matter what the organisation code is. This means that if a Referral has both the same person ID and the same service ID (locally unique referral ID), but occurs in multiple organisations it can still be joined. This will mean that where organisations change their organisation code the pathway can be maintained. When this occurs all activity, including outcomes, will be reported under the organisation with the most recent referral date, where the referral is still open.

As the unique combination of patient ID and service ID is still required, the risk of joining two referrals which are not part of the same pathway is minimal. The only case in which this is likely is if a referral is being stepped between organisations. When this occurs the referral should be closed in one organisation, and a new referral opened in the receiving organisation – generating a new service ID. In this case the referrals would not be combined into one pathway, which is correct (joining pathways where a referral has been stepped up or down to another organisation should be possible with this version of the dataset, but will be developed separately to these methodological changes).

In some cases however the referral is not closed and is instead transferred to the receiving organisation with the service ID maintained. If this occurs the pathway would be maintained, which

would mean all activity associated with the pathway would be attributed to the ‘receiving’ organisation, including all outcomes measures, and none would be attributed to the ‘sending’ organisation. In order to avoid this situation organisations are urged to end referrals when they are stepped to another service, and to start a new referral when receiving referrals that are stepped from another service.

Monthly Reports – New data quality measures

Since the IAPT dataset was first mandated the HSCIC has published data quality information on the validity of measures each month. These reports provide the number of valid, other, default, invalid or missing records submitted by each provider for a number of key fields. These are known as VODIM reports. In addition a validity percentage is calculated for each provider to give an indication of the overall validity of their submission.

With the introduction of new fields and on submission validations in the new version of the dataset, the fields monitored in these reports will be updated to ensure that the data quality of key measures can be monitored. The changes to the fields monitored are as follows:

Field	Status	Notes
Appointment Type	Updated	Although this field is now mandatory it has been retained in the VODIM reports to identify how many records are “Other” (07- Other) or “Default” (08-Not Recorded). Invalid or missing codes would cause the entire file to be rejected.
Birth Date	Discontinued	This field has been removed as on submission validation of this mandatory field means that only valid records can be submitted.
Disability	Continued	
Ethnic Category	Continued	
Generalised Anxiety Disorder (GAD7) Score	Continued	
GMPC	Continued	
Long Term Physical Health Condition	Discontinued	This field is removed as it is not currently used in any reports
NHS Number Status Indicator	Discontinued	This field has been discontinued as it does not indicate whether the NHS Number is valid, it indicates the validity of the indicator that identifies if the NHS number has been traced, which is of limited use. Instead a measure has been introduced that looks at the validity of the NHS number itself.
Patient Health Questionnaire (PHQ9) Score	Continued	
Person Gender Current	Continued	
Postcode of Usual Address	Continued	
Provisional Diagnosis	Updated	This measure will be modified to look at the validity of this field only for referrals with at least one attended assessment appointment, as a provisional diagnosis may not be recorded before this point.
Religious or Other Belief Affiliation System	Updated	The number of valid values for this field has been reduced, and so the VODIM has been brought in line with the updated valid code list.
Sexual Orientation	Continued	
Source of Referral	Updated	The list of valid values for this field has been altered, and so the VODIM has been brought in line with the updated valid code list
Therapy Types (1-4)	Continued	
Work and Social Adjustment Scale Scores	Discontinued	This field has been discontinued in favour of recording all 5 elements of the Work and Social Adjustment Scale separately. Therefore this data quality measure is no longer required.

NHS Number	New	NHS Number will now be validated rather than the NHS number status indicator. This should give a better indication of the validity of the NHS numbers submitted.
Organisation Code of Commissioner	New	Due to high levels of invalid records submitted under Organisation Code of Commissioner in 2013/14 Organisation Code of Commissioner will now be included in VODIM reports.
Mental Health Care Cluster	New	This is a new field added as part of the move to version 1.5.
Reason for End of IAPT Care pathway	New	The reason for end of care pathway will be required to identify those referrals that have stepped up or down and is reported on in the quarterly publication.
Organisation Code (IAPT Stepped to provider)	New	This is a new field added as part of the move to version 1.5. It will be needed to help map referrals which are stepped up or down between providers
Stepped Care Intensity Delivered	New	This is a new field added as part of the move to version 1.5.
Employment Status	New	Employment status should be recorded at each appointment, and can be used to look at the change in employment status between the beginning and end of treatment. This is currently reported on in annual IAPT reports.
Use of Psychotropic Medication	New	The use of psychotropic medication field should be recorded at each appointment, and is used to look at the change in use of psychotropic medication between the beginning and end of treatment. This is currently reported on in Quarterly IAPT reports.
Statutory Sick pay Indicator	New	The Statutory Sick pay Indicator should be recorded at each appointment, and is used to look at whether a service user has moved off sick pay and benefits between the beginning and end of treatment. This is currently reported on in Quarterly IAPT reports.
Work and Social Adjustment Scale (WSAS) Work Score	New	This is a new field added as part of the move to version 1.5. It has been added to the VODIM reports along with the other WSAS scores in place of the old WSAS total score.
Work and Social Adjustment Scale (WSAS) Home Management Score	New	This is a new field added as part of the move to version 1.5. It has been added to the VODIM reports along with the other WSAS scores in place of the old WSAS total score.
Work and Social Adjustment Scale (WSAS) Social Leisure Activities Score	New	This is a new field added as part of the move to version 1.5. It has been added to the VODIM reports along with the other WSAS scores in place of the old WSAS total score.
Work and Social Adjustment Scale (WSAS) Private Leisure Activities Score	New	This is a new field added as part of the move to version 1.5. It has been added to the VODIM reports along with the other WSAS scores in place of the old WSAS total score.
Work and Social Adjustment Scale (WSAS) Relationships Score	New	This is a new field added as part of the move to version 1.5. It has been added to the VODIM reports along with the other WSAS scores in place of the old WSAS total score.

Anxiety Disorder Specific Measure Scores	New	Where a provisional diagnosis is recorded, the appropriate ADSM should also be provided and so this is a new measure to monitor the data quality of these measures and whether they are being provided
Activity Suspension Reason	New	This is a new field added as part of the move to version 1.5.

Quarterly Reports - Reporting by End Reason

Since Q1 2012/13 the quarterly reports produced by the HSCIC have included a count of the number of ended referrals in the period by end reason. Originally this was a count of all new referrals that began and ended in the period, but from Quarter 2 2013/14 this became a count of all referrals that ended in the period, no matter when they were first received.

In the latest version of the dataset the list of end reasons has changed entirely as shown in the table below. This has been implemented in order to allow the identification of those referrals that end as they have been stepped up or down to another provider, and also to provide more detail on the reason for the end of referrals, depending on whether the service user has been assessed or assessed and treated.

Version 1		Version 1.5	
End Code	Meaning	End Code	Meaning
01	Completed Treatment	10	Not suitable for IAPT service – no action taken or directed back to referrer
02	Deceased	11	Not suitable for IAPT service – signposted elsewhere with mutual agreement of patient
03	Declined Treatment	12	Discharged by mutual agreement following advice and support
04	Dropped out of treatment (unscheduled discontinuation)	13	Referred to another therapy service by mutual agreement
05	Not suitable for service	14	Suitable for IAPT service, but patient declined treatment that was offered
06	Referral to another service	15	Deceased (assessed only)
99	Not Known	97	Not Known (assessed only)
		40	Stepped up from low intensity IAPT service
		41	Stepped down from high intensity IAPT service
		42	Completed scheduled treatment
		43	Dropped out of treatment (unscheduled discontinuation)
		44	Referred to non IAPT service
		45	Deceased (Assessed and treated)
		98	Not Known (Assessed and treated)

As the new codes cannot be mapped to the old codes, reporting by end reason must change to match the new code list. From the first quarterly report using version 1.5 data (Quarter 2 2014/15, due to be published in January 2015) Line 7, which reports on ended referrals by ‘End reason’, will change from using the old end reasons to the new list of values as shown above.

Quarterly Reports – Reporting by Provisional Diagnosis

Currently IAPT Quarterly reports include reporting of referrals received and referrals finishing a course of treatment by Provisional Diagnosis. This has consisted of reporting by a combination of 3 and 4 digit ICD-10 codes, in order to represent the various conditions that are expected to be seen in IAPT services. 4 digit ICD-10 codes are nested under 3 digit codes, with the 4 digit code being a specific subset of the three digit code. For example, codes F41.0 – Panic Disorder, F41.1 Generalised Anxiety disorder and F41.2 Mixed Anxiety and Depressive Disorder are all subsets of the overall code F41 – Other Anxiety Disorders.

It has emerged that some services report by three digit codes only, which means that where quarterly reports show the 4 digit breakdowns, referrals that only have three digit ICD-10 codes are grouped into “other ICD-10 code”. This means that the reports do not give a true indication of how many referrals have a diagnosis of the three digit ICD-10 code. In addition, this makes comparisons between diagnostic conditions difficult as three digit ICD-10 codes should not be compared with 4 digit ICD-10 codes.

In order to rectify this, and to preserve the granularity which already exists in the reports, from Quarter 2 2013/14 activity by provisional diagnosis will be reported at both the three and four digit ICD-10 code level. This will mean that information is not lost where a service provides only three digit ICD-10 codes, and a greater granularity of information will be available for those conditions that are currently only reported on at three digit code level (e.g. F32 – Depressive Episode). This will also increase the ability to compare activity levels between different diagnostic conditions.

Quarterly Reports - Changes to First and Last Scores

The derivation of first and last scores has been altered to incorporate appointment time. In version 1 of the dataset there was no ‘Appointment time’ field, just ‘Appointment date’. In order to select the first and last scores, scores were ordered according to appointment, but where there were two scores recorded at two separate contacts on the same day there was no way to choose between them and one would be selected as the first or last score at random. In version 1.5 of the dataset the ‘Appointment time’ field has been introduced and is now used to order scores in conjunction with appointment day in order to select first and last scores. This means that where scores are recorded twice on the same day the earliest or latest can be consistently chosen as the first or last score, rather than a random decision between the two.

In addition there have been some further alterations to the format of scores. The ‘Agoraphobia Mobility Inventory’ is a score generated from responses to a number of questions. This is then turned into an average score between 1 and 5. In the first version of the dataset the format did not allow decimal places, so data could not be presented in this way. Instead the score was presented as an aggregate of between 0 and 135. In order to calculate recovery and improvement using this, a new caseness threshold and measurement error value was introduced, as agreed with the toolmaker.

In version 1.5 of the dataset the format issue has been rectified, allowing these scores to be submitted as intended (an average of between 1 and 5, presented with decimal places). This will allow the correct caseness and measurement error values to be used. This does lead to

complication in the cases of those referrals which have a first score that has been recorded using the old aggregate measure and a last score recorded using the average. In order to avoid this issue it has been determined that in all cases where Agoraphobia Mobility Inventory would normally be used to calculate recovery and improvement, but the first score dates from before the start of version 1.5 of the dataset (1st July 2014), GAD7 will be used to calculate these measures instead.

Finally, the work and social adjustment scale has been presented in the first version of the dataset as a single score, which is derived from five separate elements, as completed by the service user. In version 1.5 of the dataset all of these elements are recorded, alongside the overall score to provide more detail. These scores will be available in all extracts, but are not currently used in any analysis.

Published by the Health and Social Care Information Centre

Part of the Government Statistical Service

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This publication may be requested in large print or other formats.

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