

Improving Access to Psychological Therapies (IAPT) Outcomes Toolkit 2008/9

July 2008

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Executive Summary

The IAPT programme's success has been defined by its participant's ability to collect routine outcomes data. This data demonstrates the benefits for people using evidenced based therapies.

This toolkit builds on the IAPT Implementation Plan and provides guidance on the importance of routine outcome monitoring and outlines collection and reporting mechanisms. The revised recommended IAPT data set and the minimum data set are included. The Toolkit also includes a Checklist for services providing a helpful list of first step actions to implement the IAPT data set.

The Importance of Data Collection

The key characteristic of IAPT services is their ability to ensure routine data collection. The ongoing management of patient outcomes will ensure services are delivering the **right services** to the **right number of people** at **the right time** and with the **right results**.

The primary purpose of outcomes measurement is to improve people's experience and benefits from the service. It also helps service providers improve their services. Additionally, collection of routine outcomes within IAPT services contributes to and helps monitor the delivery of national commitments, including the NHS Vital Signs.

What information should be collected

The Toolkit defines the full, recommended IAPT data set and gives standard inputs and variables, and standard data definitions to support sites to develop a data collection solution. Whilst the collection of the full IAPT data set is recommended, a proportion of the data set is mandatory for IAPT sites in receipt of CSR funding. This is the **IAPT Minimum Data Set (MDS)** and should be routinely collected by all sites to support IAPT Key Performance Indicators. The MDS includes patient data, care pathway data and contact level data. The outcomes measurement tools described in this Toolkit are the most suitable, free to access tools, and are widely used in practice.

How the information will be collected

IAPT sites are able to choose their own method(s) of data collection. The Toolkit includes models of data collection used in IAPT pilots that ensure data quality and provide feedback on efficiency and effectiveness of data collection. Choice of data collection models will depend on the structure of the service, IT equipment availability and IT systems. Regardless of the method(s) chosen for data collection, it is essential that clinicians and users have access to up-to-date clinical progress data at each session of therapy..

The Toolkit offers practical guidance on implementation mechanisms, data collection systems (and what the system should include), dealing with missing data and follow-up data.

How can the data be used

The recommended IAPT data set can be analysed in a number of ways and used by various stakeholder groups including: people receiving care, clinicians, supervisors, commissioners and performance managers. The Toolkit provides guidance on how outcome data may be valuable for these client groups.

The Toolkit also provides information and summarises the use of a small proportion of aggregated non-identifiable patient data that flows externally from PCTs to SHA to support regional and national performance monitoring.

Information Governance and Consent

The use of outcome measuring tools as part of the IAPT data set is primarily for the benefit of the patient and consent can therefore be implied. Data can be used to inform treatment and appropriate care pathways.

The content, rationale, purpose and benefits of routine outcome measurement should be properly conveyed to patients, and for external use of data, information sharing governance should be observed.

Moving Forward

The ability to collect routine outcomes data for at least 90% of patients is the defining feature of IAPT. This document provides the tools which IAPT sites will need to use to achieve this aim. However, we recognise these tools alone will not be enough to ensure success. Consequently, we are working with regional IAPT leads to ensure that training and support are available to all IAPT sites in this critical first year.

1. Introduction

The IAPT programme's success has been defined by its participant's ability to collect routine outcomes data. This data demonstrates the benefits for people using evidenced based therapies in terms of:

- Improved health and wellbeing
- Helping people retain employment
- Supporting people back to work and participating in the activities of daily living
- High levels of satisfaction from people using services and/or their carers
- Increasing choice and accessibility to clinically effective psychological therapy services

This data has also has been essential in helping services deliver the **right service** to the **right numbers** of referrals and people (relevant to the PCT's population), at the **right time**, and are getting the **right results**.

As IAPT services begin to roll out over the next few years, one of the key challenges is replicating these achievements on a much larger scale.

This toolkit supports chapter 7 of the *IAPT Implementation Plan: National guidelines for regional delivery* and chapter 8 of the *IAPT Commissioning Toolkit*. It provides a practical and informative framework for use by IAPT sites in 2008/9 and includes details of:

- Routine outcome monitoring and data collection
- The IAPT Data Set and the Minimum Data Set (MDS)
- Mechanisms to collect and report outcomes data
- Good practice examples in each chapter

This technical document supersedes the *IAPT Outcomes Framework and Data Collection* document of May 2007, which was part of the IAPT Pathfinder initiative. To support IAPT expansion sites in 2009/10, further guidance will be published in due course reflecting ongoing policy and informatics developments, including minor changes to the IAPT Data Set (where necessary).

The checklist below highlights some of the key actions services should be taking now to ensure successful outcome collection.

First steps: A checklist

1. Identify a Data Collection Lead/Information Manager ☐
2. Understand what information should be collected (*Chapter 3*) ☐
3. Conduct a baseline assessment ☐
 - a. What is your current level of data collection
 - b. How does this differ from the IAPT requirement?
 - c. Are you capable of collecting the full requirements, what systems are in place?
 - d. What is your data collection model (i.e. who does what and how?)
 - e. Will your model need to be adapted to meet the requirement?
4. Agree a data collection approach/model (*Chapter 4*) ☐
5. Identify delivery constraints and resource requirements
(including workforce impact and training issues) ☐
6. Develop a local delivery arrangements ☐

2. Importance of collecting routine outcomes data

A key characteristic of IAPT services and their therapists is the ability to demonstrate the health and well-being outcomes delivered.

“Routine outcomes measurement is central to the drive towards improved quality and accountability of services. Routine outcomes measurement offers a means of providing information on health outcomes in an accessible and common format for all stakeholders including service users and carers, the public and health care commissioners”¹

The key principles and benefits of outcomes measurement are set out in [Table 1](#).

Table 1: Principles and Benefits of Outcomes Measurement

Principles	
<ul style="list-style-type: none"> • The primary purpose of outcomes measurement is to improve people’s experience and benefits from the service and is part of ongoing, collaborative service evaluation, with feedback from patients at its heart • Outcomes feedback to clinicians helps improve the quality of their interventions • Outcomes feedback to supervisors supports case reviews, and collaborative treatment planning • Routinely collected outcomes data helps managers monitor and improve overall service performance • Service performance data informs PCT/SHA managers who set national standards to aim for • Intelligent use of aggregate outcomes data by experts aims to define best practice models of service delivery • The requirement for data collection should be proportionate to the treatment being offered, and integrated with clinical priorities. Data is more useful if a complete set of minimum data is obtained for each session 	
Benefits	
<ul style="list-style-type: none"> • People chart their progress towards recovery and see at what point their psychometric score falls within the normal range. For example, if the goal is to reduce or stop medication, this can help decide when would be an appropriate time • People set their own goals for therapy, and give ongoing feedback on whether it is working and which elements are helpful or unhelpful 	

¹ National Institute for Mental Health in England (NIMHE) (2005), Outcomes Measures Implementation: Best Practice Guidance

- If people wish, they can ask their carers (loved ones, family, friends) to help set goals, encourage step-by-step changes, and give additional feedback on progress
- Therapists and supervisors, and the clinical team, can also chart progress, and can adjust treatment plans, if the feedback indicates the current plan is not working. Likewise, clinicians can check performance against their peers, to keep their skills in good shape
- GPs and clinicians doing initial assessments for therapy can engage patients, and work collaboratively. For example, if the patient wishes to get back to work, they will be encouraged to take responsibility for this as part of their therapeutic outcome
- Service managers can use the outcomes framework to manage performance and improve quality, helping commissioners ensure contracts are providing good value for money
- Local, regional and national leads will benefit from having accurate, comprehensive outcomes data being fed in to the policy-making system, helping drive up standards by setting benchmarks and establishing league tables as well as improving whole system care pathways and future resource planning

Further information on the benefits of commissioning for outcomes is in *chapter 8* of the *IAPT Commissioning Toolkit*.

Using patient outcomes to help workforce planning

The original workforce configuration model for the Doncaster IAPT service employed a mix of caseworkers and therapists to deliver high volume, low intensity psychological therapies especially focused on mild to moderate depression. This was to be achieved by the recruitment of 14 caseworkers to deliver low intensity CBT and 3 Cognitive Behavioural Therapists to deliver high intensity CBT. Outcome measures were routinely collected which enabled the service to develop appropriate care pathways. As the service progressed and data outcomes were produced it became evident that many of the people referred had severe or moderately - severe depressive symptoms and / or anxiety. The original workforce configuration for high intensity CBT was therefore increased to ensure patient pathways were seamless and accessible.

The funds allocated to Improving Access to Psychological Therapies (IAPT) for the CSR period 2008-2011 are linked to a specific set of commitments set out by the Secretary of State (SoS) and involve **extending access to NICE-compliant services** by treating 900,000 more people, with half of these who complete treatment moving to recovery, and 25,000 fewer on sick pay and benefits by 2010/11.

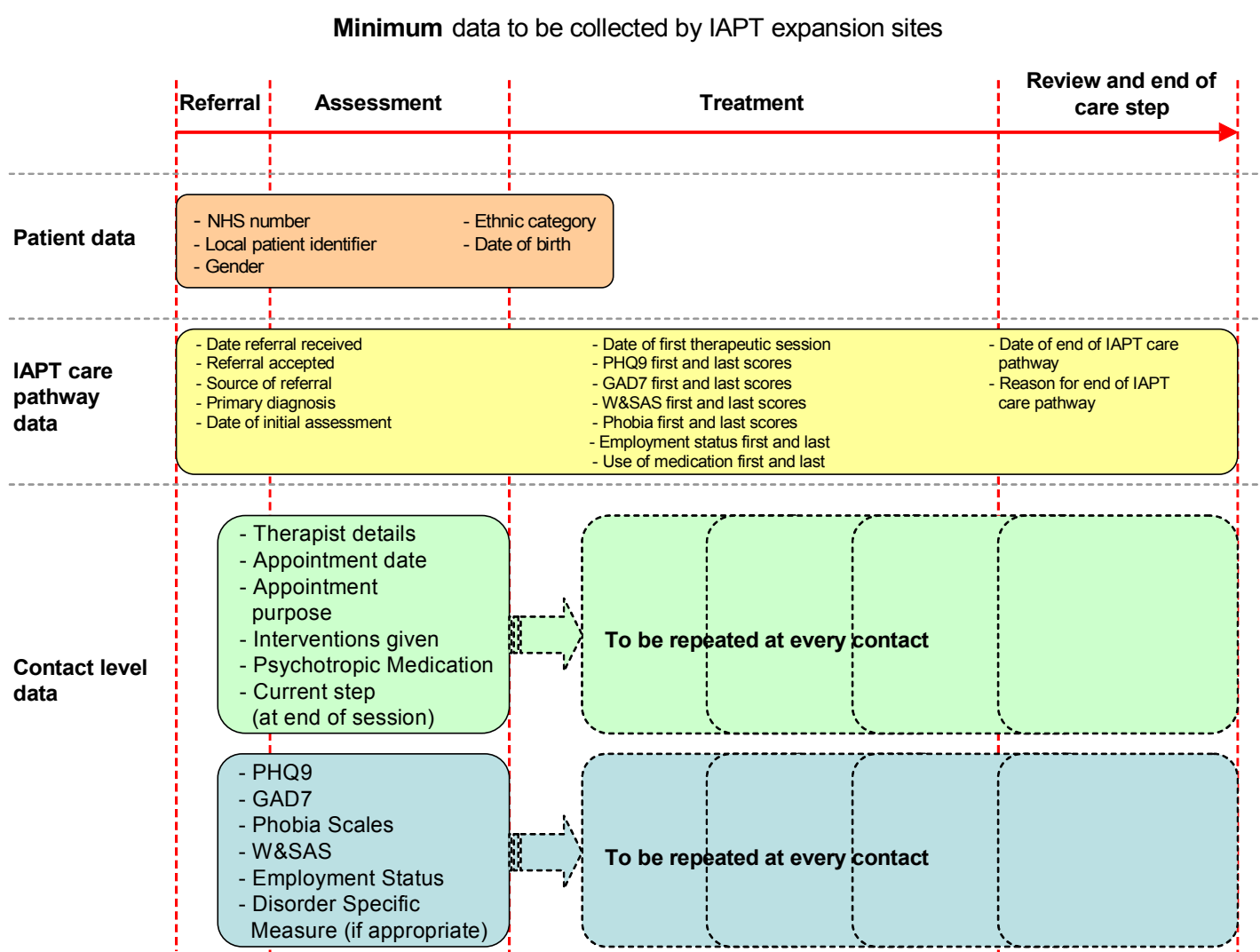
Collection of routine outcomes data using the IAPT Minimum Data Set (MDS) (see [Chapter 3](#)) contributes to and helps monitor the delivery of the national commitments, which form the IAPT Key Performance Indicators (see [Chapter 5](#)). It also provides evidence for the NHS Operating Framework Vital Sign specific to psychological therapies. Further information about Vital Signs can be found at

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082542. The data also helps to formulate benchmark baselines and national averages to assist non-IAPT sites in scoping their state of readiness to join the programme in the future.

3. What information should be collected

The *IAPT Implementation Plan: National guidelines for regional delivery* set out service standards and outcomes to be monitored as part of service level performance indicators. To support sites in monitoring standards and outcomes, [Figure 1](#) below summarises the three types of data that routinely need collecting at certain stages of the care pathway to enable sites to monitor standards and outcomes.

Figure 1. IAPT Data Set Overview



- **Patient data** - Personal or demographic data that relates to the patient, rather than the patient's mental health problem or treatment, should be collected early in the care pathway, ideally prior to initial assessment.

- *IAPT care pathway data* – Summary information about the patient's care pathway including diagnosis, treatment, outcomes and key dates can be used to calculate key performance indicators such as waiting times and recovery rates and should be updated at relevant points along the patient's care pathway. Many of the key fields can be derived from contact level data (see below).
- *Contact level data (appointment data)* - relates to the nature and outcomes of treatment and usage of psychotropic medication. This should be recorded at every contact with the patient, even if the contact is not face to face.

The IAPT Data Set

The **full, recommended IAPT Data Set** can be found at [Appendix A](#) and provides details of standardised formats for collecting these types of data. It can support sites to develop data collection systems by providing standard inputs and variables and standard data definitions (linked to the NHS Data Dictionary). The collection of the full data set is recommended to inform service development, redesign and local/regional performance monitoring.

The Data Set includes minimum data set items that are mandatory for IAPT sites and should be routinely collected by all services to support the IAPT Regional Key Performance Indicators and Service Standards. The table below summarises the **IAPT Minimum Data Set**.

Services should use clinical outcome measures **at each session** to obtain at least 90% pre-/post- treatment outcomes data. Patients sometimes drop out of therapy or terminate at a different time to that which was originally planned. Session by session monitoring ensures that a clinical endpoint (the last session) is always available. Experience in the IAPT pilot sites showed that use of session by session outcome monitoring produced clinical endpoint data on almost everyone, whereas measures intended for administration pre- /post-treatment often fail to achieve complete data in 40% or more cases. This is a particular problem because patients who fail to return measures tend to have a less good outcome.

The IAPT recommended sessional measures are the PHQ9, GAD7, Phobia Scales, the Work and Social Adjustment Scale, the IAPT Employment Status questions, and the use of relevant disorder specific measures. At the penultimate or final therapeutic session, the IAPT Patient

Experience Questionnaire should be used. These all form part of the Minimum Data Set for all IAPT sites to collect.

The outcome measurement tools described in this chapter are the most suitable, free to access tools, and are widely used in practice. Copyright holders have granted permission to the IAPT programme for these measures to form part of the IAPT data set. Copies of all of these measures are in [Appendix B](#).

Table 2. IAPT Minimum Data Set

Data Item No	Data Item	Description	NHS Data Dictionary Title / Reference
P1	NHS number	A number used to identify a patient uniquely within the NHS in England and Wales	NHS NUMBER
P2	Local patient identifier (case number)	A number used to identify a patient uniquely within a local mental health service provider (IAPT service)	LOCAL PATIENT IDENTIFIER
P3	Organisation code (code of provider)	The organisation code of the organisation acting as a Health Care Provider (IAPT service)	ORGANISATION CODE (CODE OF PROVIDER)
P4	Code of GP practice (registered GMP)	This is the code of the practice of the patient's registered GP	CODE OF GP PRACTICE (REGISTERED GMP)
P5	Gender	The patient's gender currently	PERSON GENDER CODE
P6	Date of birth	The date on which the patient was born or is officially deemed to have been born.	PERSON BIRTH DATE
P7	Ethnic category	The ethnicity of the patient, as specified by the patient	ETHNIC CATEGORY
A1	Therapist AFC band (recorded as therapist name - see notes)	The Agenda For Change band of the therapist conducting the appointment	-
A2	Appointment date	The date of the appointment	APPOINTMENT DATE
A3	Appointment purpose	The nature of the appointment	-
A4	Intervention given	The type of therapy provided during the appointment	-
A5	Use of psychotropic medication	Whether or not the patient is currently taking psychotropic medication	-
A6	Current step (at end of session)	The step of care the patient is at following the appointment	-
C1	Date referral received	The date the referral request was received by the health care provider (IAPT service)	To analyse timescales in the provision of services
C2	Referral accepted?	Indicates whether the referral was accepted by the IAPT service	To analyse timescales in the provision of services
C3	Source of referral	The source of referral of a Mental Health Care Spell	To monitor the source of referrals and service provision.
C4	Primary diagnosis	The main condition treated or investigated during the current episode of healthcare. The diagnosis	To analyse prevalence of disorders and ensure appropriate care

		should occur within the IAPT service	
C5	Date of initial assessment	The date of the first assessment attended by the patient	To analyse timescales in the provision of services
C6	Date of first therapeutic session	The date of the first appointment attended by the patient where an intervention is provided	To analyse timescales in the provision of services
C7	Date of end of IAPT care pathway	The date the patient is deemed by the care professional to have completed the current IAPT care pathway	To analyse timescales in the provision of services
C8	Reason for end of IAPT care pathway	The reason for the termination of care spell as determined by the care professional	To analyse timescales and identify completed/dropout rates
C9	PHQ9 first score	The total score from the patients first PHQ9 during the current care spell	To measure change in health and wellbeing
C10	PHQ9 last score	The total score from the patient's last PHQ9 score during the current care spell	To measure change in health and wellbeing
C11	GAD7 first score	The total score from the patients first GAD7 during the current care spell	To measure change in health and wellbeing
C12	GAD7 last score	The total score from the patient's last GAD7 score during the current care spell	To measure change in health and wellbeing
C13	W&SAS first score	The total score from the patients first W&SAS during the current care spell	To measure change in health and wellbeing
C14	W&SAS last score	The total score from the patient's last W&SAS score during the current care spell	To measure change in health and wellbeing
C15	Employment status first	The employment status from the patient's first ESQ during the current care spell	To measure change in employment status
C16	Employment status last	The employment status from the patient's last ESQ during the current care spell	To measure change in employment status
C17	Sick Pay status first	The sick pay status from the patient's first ESQ during the current care spell	To measure change in health and wellbeing
C18	Sick Pay status last	The sick pay status from the patient's last ESQ during the current care spell	To measure change in health and wellbeing
C19	Benefits status first	The benefits status from the patient's first ESQ during the current care spell	To measure change in health and wellbeing
C20	Benefits status last	The benefits status from the patient's last ESQ during the current care spell	To measure change in health and wellbeing
C21	Phobia question 1 first score	Scale rating from the patient's first Phobia question 1 during the current care spell	To measure change in health and wellbeing
C22	Phobia question 1 last score	Scale rating from the patient's last Phobia question 1 during the current	To measure change in health and wellbeing

		care spell	
C23	Phobia question 2 first score	Scale rating from the patient's first Phobia question 2 during the current care spell	To measure change in health and wellbeing
C24	Phobia question 2 last score	Scale rating from the patient's last Phobia question 2 during the current care spell	To measure change in health and wellbeing
C25	Phobia question 3 first score	Scale rating from the patient's first Phobia question 3 during the current care spell	To measure change in health and wellbeing
C26	Phobia question 3 last score	Scale rating from the patient's last Phobia question 3 during the current care spell	To measure change in health and wellbeing
C27	Use of psychotropic medication first	Response to the first psychotropic medication question during the current care spell	To identify patients needing medication support and to analyse relationship between medication, therapy and outcomes
C28	Use of psychotropic medication last	Response to the last psychotropic medication question during the current care spell	To identify patients needing medication support and to analyse relationship between medication, therapy and outcomes
Please refer to IAPT Data Set (Appendix A) for further details and permitted values			

The sections below describe how the IAPT Data Set measures

- improved accessibility
- improved patient choice and access
- improved patient experience
- improved health & wellbeing
- improved employment, benefit and inclusion status
- building a skilled workforce

Improved accessibility

Improving access to psychological therapies is the core aim of the programme. Services will wish to measure their success in meeting this aim in relation to:

- i. *Population coverage* – ensuring services are capable of addressing the needs of the local population, in line with national prevalence data
- ii. *Range of interventions provided across the stepped care model* – demonstrating that people requiring services have access to the full range of NICE-compliant evidence based psychological therapies at different levels of need across the care pathway (in accordance with the Stepped Care System described in the NICE Guidelines). Usage of psychotropic medication should also be recorded
- iii. *Equity of access* – monitoring the service's ability to offer equitable access to the local population based on need, actively demonstrating that services are used in proportion to the local population profile. This will require a local equality impact assessment (EqIA)
- iv. *Waiting times* - services should collect referral information for commissioning, planning and measuring waiting times throughout the care pathway to ensure patients are being seen promptly, and assist with accurate capacity planning. Access information is collated from routine service throughput data

Using Choose and Book to improve access

Choose and Book is now becoming the everyday way for GPs to refer on to specialist services. It is therefore important that providers offering psychological therapies use the system to display their services. If providers have a compliant Patient Administration System they will be able to offer direct booking (i.e. patients can leave the practice with an appointment) or if not, they will be able to offer indirect booking (i.e. patients will call to book their appointment). Either way, patients can be offered a choice of appointment date and time, and referral information can be sent and managed electronically. Providers not yet using the Choose and Book system can find further information on the Choose and Book website at www.chooseandbook.nhs.uk. The Directory of Services pages provide detailed information about setting up services. There is also Implementation Guidance specifically aimed at supporting mental health referrals, which is available at: www.chooseandbook.nhs.uk/staff/implement/guides/index_html#Support

Improved Patient Choice and Access

Measures of **choice** show whether people using the service have been empowered to choose from options of care and treatment available to them. A choice of date, time and venue should be offered, along with information about the service. Patients' overall experiences of how they **access** the service should also be captured.

The IAPT Patient Experience Questionnaire (see [Appendix B](#)) should be used at the end of the step of care, either in the penultimate or the final session. Services that choose to administer the questionnaire after the final session are likely to require significant additional administrative support due to higher non-return rates.

Other mechanisms to monitor choice and access include:

- Service User and Carer focus groups - to determine whether choice of evidence based psychological therapies has been integral to the service users' experience. For further information on enabling and valuing the involvement of people with direct experience of mental health problems and their carers, access Making a Real Difference resources at www.nimhe.csip.org.uk/~mard.html
- Referrer questionnaires such as a questionnaire to GPs to identify what choices referrers have been able to offer people with common mental health problems.

Making a Real Difference

The Making a Real Difference report was commissioned by the National Institute for Mental Health in England (NIMHE) in June 2004, to develop recommendations for improving Service User and Carer involvement throughout the NIMHE programme. As a result, systems, guidelines, policies and procedures were developed in partnership with stakeholders and highlight the benefit of harnessing the expertise of people using mental health services and those caring for them. This helps fulfil the principle of the White Paper, Our Health, Our Care, Our Say - a new direction for community services.

Improved Patient Experience

A measure of patient satisfaction is essential to determine quality, efficiency and effectiveness of services provided. It also enables commissioners and service providers to re-design services appropriately to meet the needs of the local populations. The IAPT Patient Experience Questionnaire should be used to capture this information. This questionnaire focuses on patients' views and experience of the choices they were offered by the service and how satisfied they are with the services received.

Improved Health & Wellbeing

Services should demonstrate their impact on the health and well-being of people using services. To achieve this tools are required for:

- i. *Obtaining caseness* - to ensure that people with, for example, mild to moderate depression and/or anxiety, receive the appropriate level of treatment. To determine caseness, services should use the Patient Health Questionnaire (PHQ9) (for depression) and the Patient Health Questionnaire GAD7 (GAD7) (for anxiety) at intake (see [Appendix B](#)). These two measures are integral to the IAPT minimum data set (MDS) and are used in all aspects of the routine outcome measuring. The PHQ9 and the GAD7 can be used free of charge. The PHQ9 is linked to the GP Quality Outcomes Framework (QoF). It determines the severity of depression and is available in multiple languages. The GAD7 assesses the severity of anxious feelings. However, it is important to note that there may be people who do not reach the caseness cut-off on PHQ9 or GAD7 but nevertheless have a phobia of clinical severity (see *ii below*). Disorder specific measures should also be used where necessary to confirm identification and severity of the disorder (see *iii below*).

Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM)

Another measure widely used to monitor changes in psychological health and well-being is the CORE-OM, a 34-item self-reported generic measure that covers a wider range of client presenting problems than the PHQ-9 and GAD-7 (which are disorder or condition specific measures). Although the CORE-OM is not part of the minimum IAPT data set, sites already using it are encouraged to continue doing so pre- and post-treatment to complement the minimum IAPT requirement, but not as a replacement for any IAPT recommended measures.

Sites that choose to use pre- and post- treatment measures such as the CORE-OM are advised to supplement them with shorter 'tracking' measures, such as the CORE-10, in order to offer outcomes and recovery data for as many patients as possible who have used the service.

Both CORE-OM and CORE-10 are free to photocopy provided they are not changed in any way nor used for financial gain. Creating electronic versions for inclusion in software systems requires written permission from the Trustees of the CORE System Trust. More information on CORE products and permissions as well as further guidance on routine outcome measurement can be found at www.coreims.co.uk

- ii. *Screening for phobia* – The PHQ and GAD mainly assess depressed and anxious affect. Some individuals with phobias may avoid feared situations so successfully that they experience little negative affect, although their everyday functioning is markedly handicapped. Single item scales (see [Appendix B](#)) covering the main clinical phobias (social phobia, panic disorder/agoraphobia, and specific phobias) are therefore included. Severity of the three most common types of phobia (social phobia, panic/agoraphobia, and specific phobia) is assessed on 0-8 scales specifically developed for IAPT. Although these measures are not empirically validated, they provide a good indication of the presence of a phobic condition. Clinicians interested in a more detailed assessment of phobias should consider using the relevant additional disorder specific measures listed in [Table 3](#).
- iii. *Ensuring sensitivity to specific disorders* - The recommended disorder specific measures are presented in [Table 3](#).

Table 3: Disorder specific measures

Disorder	Recommended Measure
Social Phobia	Social Phobia Inventory (SPIN)
Obsessive Compulsive Disorder	Obsessive Compulsive Inventory (OCI)
Post-traumatic Stress Disorder	Impact of Event Scale - revised (IES-R)
Health Anxiety	Health Anxiety Inventory (HAI)
Panic/Agoraphobia	Mobility Inventory
Phobia	Fear Questionnaire
Anger	No free measure identified, use PHQ/GAD in conjunction with general measure of severity, frequency duration and impairment.
Generalised Anxiety Disorder	Penn State Worry

Example:

John presented for treatment because he was feeling low and irritable, had problems sleeping and concentrating, and felt unable to work. At assessment, he mentioned the problems started two years ago after he had been assaulted. The Impact of Events Scale (IES-R) showed that John had severe symptoms of PTSD, and the therapist started a course of trauma-focused CBT for PTSD. Session by session administration of the IES-R showed that imaginal reliving of the trauma memory in therapy had only a modest effect on John's re-experiencing symptoms (flashbacks, intrusive images). Discussion of the IES-R scores revealed that the re-experiencing symptoms related to moments in the trauma that John had not mentioned to the therapist. When these moments were addressed in treatment, John's symptoms declined and he slept much better. However, he was still having trouble concentrating and felt irritable. An IES-R item showed that John felt "watchful and on guard". Treatment then focused on his belief that he could not trust other people after the trauma. As a consequence, his concentration and irritability improved.

Improved employment, benefit and inclusion status

This domain demonstrates how psychological therapy services might help service users to maintain employment, assist them in moving off statutory sick pay and benefits to return to work, or help them engage with local communities and activities of daily living.

- i. *Change in employment status* – the IAPT Employment Status Questions (see [Appendix B](#)) should be administered on a sessional basis to monitor employment status.
- ii. *Change in incapacity benefits* - demonstrates not only a change in the number of people claiming incapacity benefit, but also an improvement in wellbeing outcomes as patients feel better and empowered to make changes to their employment status. The IAPT Employment Status Questions are also used to monitor these changes on a sessional basis. It is important to inform the patients that the responses to this questionnaire will not affect the care or benefits they currently receive.
- iii. *Changes in levels of social inclusion* - measuring changed levels of social inclusion demonstrate whether people feel well enough to engage with their community and social environment as a result of receiving psychological therapy. These changes can be measured by the Work and Social Adjustment Scale (W&SAS) (see [Appendix B](#)) at each therapeutic session.

Measuring the cost effectiveness of psychological therapy interventions

Localities may choose to collect, in addition to the minimum data set, a health related quality of life (HRQoL) such as the SF6-D and EQ5-D. These have become widely used by clinical researchers and may provide a useful tool for policy makers wishing to assess and quantify the cost-effectiveness of interventions. This data can generate Quality Adjusted Life Years (QALYs), which evaluate benefits gained from health interventions.

Building a Skilled Workforce

Each contact with a patient should be linked to the specific worker involved, using a worker code derived from the IAPT Worker Registration Form (see [Appendix C](#)), completed for each worker at the outset. The Worker Registration Form will be developed to include a section for trainees to state which higher education institution they are attending, the date they started and finished the course, including whether it was successfully completed.

This data will help PCTs identify local training requirements, contribute to the national workforce profile (including demographics), and monitor training uptake and attrition to inform the regional/national IAPT Performance Indicator 'Building a skilled workforce'.

Mechanisms to capture Worker Registration Form data should be determined locally/regionally taking account of data protection requirements for collecting/storing personnel data. As ongoing supervision is a core feature of an IAPT service, clinical leads/service managers should also ensure that there is a suitable supervision monitoring system in place.

CSIP Outcomes Compendium

In 2006/2007, the Department of Health's Outcome Steering Group promoted the use of outcomes measures in Mental Health services through workshops hosted by CSIP Regional Development Centres. It soon became clear that services had little information about outcomes tools and their use, so the project commissioned a compendium of such tools with guidance about the wide range available tools and their use in all age mental health services which is due to be published in September 2008. It will provide further useful information about the broader set of outcome measures that can be used in addition to the IAPT Minimum Data Set.

4. How will information be collected

“Collecting outcomes data alone has limited value, it is only when it is interpreted and translated into positive changes in practice that it will yield improvements in the quality of services. Skills in interpreting outcomes data are best evolved locally and require the active involvement and goodwill of all responsible for collecting and interpreting outcomes data...”²

Best practice guidance suggests outcome management is made effective by:

i. Leadership and governance of outcomes measurement and data

- Developing a local outcomes measurement implementation plan to share with stakeholders

ii. Gaining stakeholder support

- Explaining the purposes and potential benefits for all stakeholders (including people who use the services)
- Holding outcomes measurement training/workshops/checklists for all staff, with clear protocols for data collection, specifying who scores, when, and how (e.g. during clinical time, prior to appointments or at home)

iii. Sharing the success

- Reporting outcomes data on a timely basis to those who provide it will provide opportunities to review and check data quality
- Translating raw data into locally relevant intelligence will provide meaningful feedback to various stakeholder groups. See also [Chapter 7](#).

Models of data collection

The IAPT pilot sites showed that there is no right or wrong way to collect data. Choice of data collection method depends on service structure (including geographical spread, number of referrals, workforce (including use of third sector providers), IT equipment availability and IT systems. **Regardless of the method(s) chosen, it is essential that clinicians have access to up-to-date clinical progress data at each of their patients' sessions.** Patient summary

² National Institute for Mental Health in England (NIMHE) (2005), Outcomes Measures Implementation: Best Practice Guidance

sheets (including graphical representation) are often used in services to present this data to the clinician on a regular basis.

Models of data collection collected used in IAPT pilot sites are shown in [Figure 2](#) below and offer various methods of entering data, ensuring its quality and feeding back on the efficiency and effectiveness of its collection. Multiple methods can be used simultaneously i.e. admin-led approach to collecting patient data and therapist-led to collect clinical outcomes. Each method has different levels of efficiency in terms of use of various workforce time used to input data, and process time in terms of time taken for data to be available on the system (backlogs).

All successful data collection models have a nominated IAPT Data Lead with responsibility for managing data collection and development of suitable implementation plans.

Figure 2: Example models of data collection

Who	Service provider	PCT	Various stakeholders
What	Data entry	Quality and validity checks	Learning and sharing
How	Method 1: Patient Led <i>Client is able to enter their own clinical data directly onto IT system prior to each session either via patient interface or computer readable paper-based forms</i>	Data Collection Hub Team may consist of: <i>Assistant Research Psychologist Data Entry Clerks, Project Manager Information Lead/Analysts</i> Functions may include: <i>Offers supportive guidance, provide additional data entry capacity, feedback on data quality issues, facilitate data collection IT system training, analyse, collate and submit reports</i>	Local Steering or Implementation Groups
	Method 2: Therapist Led <i>Therapist schedule time to enter their own patient data directly onto IT system from paper-based forms completed by the client</i>		Data collection meeting/workshops <i>Sharing ideas of efficient and effective data collection</i>
	Method 3: Admin Led <i>Provider level data entry clerks enter patient data onto IT system from paper-based forms completed by the client/therapist</i>		Practice Based Commissioning Groups
	Method 4: PCT Data Hub Led <i>PCT level data entry clerks enter patient data onto IT system from paper-based forms completed by the client/therapist from various providers</i>		Clinical Governance Committees
			Local magazines and newsletters
			Community Consultation Groups
			MH Commissioners Meetings
			Primary Care Steering and Implementation Groups

Example: Learning from the IAPT Demonstration Sites

Newham IAPT initially used a paper-based method to collect outcome data. Each therapist had an outcome folder subdivided into the patients under his or her care, each with a clinical summary sheet. The summary sheet was held at the front of the clinical notes and the therapist updated this after each contact, a copy was then placed in the outcome folder. Due to the complexity of the system, Assistant Therapists then entered the data onto an Excel spreadsheet. The Excel spreadsheet was then collated into SPSS for analysis. This approach was initially inexpensive, quick to set up, and flexible but was slow to process data, the collected information could not be integrated into clinical care and processing/analysing data was resource intensive.

Newham IAPT later commissioned a Case Management and data collection system from an independent IT supplier. The system is securely accessible from any location that has access to the internet. It allows immediate data entry for patient registration, clinical contact, and patient outcome data, and tracks patients as they pass through complex stepped care pathways. It also provides summary reports for individual patients, therapists and service managers. Clinical data (i.e. PHQ9 scores) are inputted onto the system by the patient's therapist on a sessional basis. Initially review questionnaires were entered by the Assistant Therapists, however to improve the integration of review measures into routine clinical care and promote increased quality of data collection therapists are now being encouraged to enter review data themselves as this is now simple and not time consuming. However, this practice is subject to ongoing review to monitor the impact of the model and maintain an appropriate balance between clinical responsibilities and administrative work.

Data Collection Systems

IAPT pilot sites found it helpful to use a computerised records system to collect outcomes data. This can be done either via adaptation of an existing system, or commissioning a private software solution. Choice of a suitable data collection solution will vary depending on local need, existing IT systems/structures and financial and technical resources. To assist sites with data planning an outline technical specification is presented at [Table 5](#) which includes key functions and features sites should consider when commissioning/developing a system. Used in conjunction with the IAPT Data Set (which includes coding for recording the recommended IAPT data set on a computerised records system), will promote standardisation of data collection methods across IAPT sites.

A data collection solution should:

- Allow capture and storage of all routine data items specified in the IAPT Data Set (*Appendix A*)
- Be clear, functional and simple and easy to use
- Enable all data to be downloaded to an Excel spreadsheet for analysis and reporting
- Allow all providers (including voluntary and non-NHS providers) to enter data locally and PCTs to view progression regionally.
- Provide a high level of security to protect patient data
- Be interoperable with a local/national Electronic Patient Record (EPR) systems (where possible) to avoid duplication of entry

Further recommendations are provided in *Table 4* below. Please note: this list is not exhaustive and should be considered in light of local requirements.

Table 4. Technical specification for IAPT data collection system

Functionality	Criteria
Data Collection	<ul style="list-style-type: none"> Ability to collect quantitative data as per the IAPT Minimum Data Set <i>Recommended</i> - Ability to collect quantitative data from all of the IAPT Data Set measures (see Appendix A for suggested input formats) <i>Recommended</i> - Patient interface to allow patients to enter and view only their own data. Or ability to deal with computer readable paper-based records
Reporting/Exporting	<ul style="list-style-type: none"> Ability to export data as (Microsoft Excel) spreadsheets for simple analysis, or for importing into statistical packages such as SPSS (Statistical Package for the Social Sciences) Ability to provide other site-specific report functionality to allow data to be populated on a regular basis for various stakeholder groups (see Chapter 7)
Training and User Support	<ul style="list-style-type: none"> Ability to design and provide a suitable training package for system administrators Capacity to provide telephone and on-line technical support for a number of users The availability of a demonstration version of the system for training purposes
Reporting/ Clinical Feedback	<ul style="list-style-type: none"> Ability to provide functions for tracking patient improvement and recovery by using graphical and numerical displays for health and wellbeing outcome measures (PHQ9, GAD7, and disorder specific measure where applicable and W&SAS).
Quality monitoring	<ul style="list-style-type: none"> Ability to include mandatory fields for completion and other tools for flagging missing data items to ensure 90% completed outcomes data
Access	<ul style="list-style-type: none"> NHS net, N3 Remote Working (does not require N3 connectivity – sponsorship can be obtained through the PCT) or RSA key fob compatible <i>Recommended</i> - Capability to be interoperable with local Patient Administration Systems (PAS) , Electronic Patient Records (EPR) or Patient Demographic Service (PDS)
Standard Security	<ul style="list-style-type: none"> Can provide a highly secure application and data servers with optional SSL Role-based access control - Ability to have multiple user access levels i.e. data entry level, supervisor level and super supervisor level
NHS Operating environment	<ul style="list-style-type: none"> Connecting for Health approved VPN secure network with 2-factor authentication
Capacity	<ul style="list-style-type: none"> Ability to handle a large amount of data in a structured and flexible format and is able to handle a large number of registered and simultaneous users, with fast response times and quick page loads
Flexibility	<ul style="list-style-type: none"> Is responsive to IAPT policy developments and changes in the IAPT Data Set without cost penalties or compromising historic data

Using existing LSP software to collect IAPT data_

The aims of the East Riding IAPT Project were to:

- a) Assess whether or not a locally used information management system was able to provide the same or equivalent functions as a commercial software application, including collection of the IAPT Minimum Data Set and provision of an allocation and supervision function.
- b) Configure the local system unit to deliver equivalent or superior functionality to a commercial software application and to identify required training
- c) Assess whether or not this software solution could be used to enable third sector partners to participate effectively in the IAPT Care Pathway
- d) Rollout to services and organisations within the IAPT partnership

The aims were largely achieved:

- a) The local system unit meets the national data collection requirement present in a commercial software application and in addition has the traditional PAS/management functionality.
- b) The local system unit supports the 6 current MDS Measures, Caseload Allocation and Supervision, Stepped Care support with Milestone date/time stamps and is consistent with NICE recommendations for supporting the delivery of psychological therapies. The Unit also includes all the service management functionality associated with a traditional PAS and used to report on general levels of MDS activity.
- c) The project used RSA N3 VPN secure tokens at Relate to create a portal to access NPfIT systems in the short term. Considerable progress was made in defining the relevant information governance issues vis-à-vis the PCT and Commercial Third Parties and future contracts will reflect this.
- d) The roll out was limited in scale only. No other development work needs to be done on the local system unit to make it accessible to larger numbers of clinicians. Where additional clinical staff are identified to input into the Unit the following preparation will be required;
Local system IAPT Unit training, RA02 amendment, Add IAPT to User profile, RA01 & RA02 for Commercial Third Parties or 3rd Sector clinicians.

Dealing with missing data

Missing data can be caused by a number of factors including patient distress or objection, language or reading barriers, perceived administrative burden, and lack of understanding of the importance of collecting it. In order to meet at least 90% complete patient outcomes data, sites should closely monitor levels of missing data and address any issues that arise. Gaining stakeholder support by communicating the benefits of collecting data (see [Table 1](#)) helps minimise missing data. Patient outcomes data form part of the care process for all individuals and is often part of therapeutic process, good levels of complete data provide an accurate picture of service performance enabling service evaluation.

Data reliability – dealing with missing outcomes measure questions

- *PHQ9/GAD7* - Research suggests that if one or two values are missing from the PHQ9 or GAD7 then total scores can be prorated from non-missing items. Questionnaires with more than two missing values should be excluded from analysis.
- *W&SAS* - When completing the Work and Social Adjustment Scale, if patient has selected 'non-applicable' for question 1, or if one value is missing, then total scores can be prorated from non-missing items. Questionnaires with more than one missing value should be excluded from analysis.

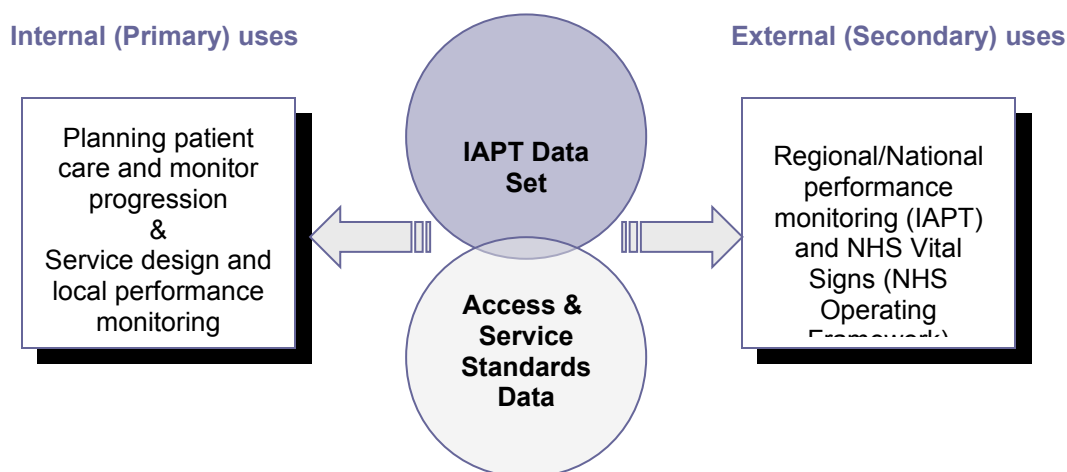
Follow-up data

Depression in particular is a recurring problem. Psychological therapies aim to reduce a patient's vulnerability to relapse. It is important to determine whether this has happened. Therefore, services are recommended to conduct routine 3-6 month follow-ups on all patients using the IAPT MDS sessional measures. Questionnaires could be sent out with stamped addressed envelopes. However, research shows poor return rates with this approach alone. Contact by telephone or in person should therefore also be considered. For individuals who show a partial return of symptoms, services should consider offering a small number of booster/top-up sessions to prevent full relapse and the associated additional costs for both the individual and the service.

5. How can the data be used: Data flows and reporting

The recommended IAPT data set ([Appendix A](#)) can be analysed in a number of ways and used by various client groups. A large proportion of the data set is routinely used *internally* to plan patient care, monitor progression, assist with service design, and contribute to local performance monitoring. Smaller proportions of aggregated non-identifiable patient data (taken from the IAPT Minimum Data Set) flows *externally* from PCTs to SHAs on a quarterly basis to support regional and national performance monitoring. These uses are summarised in [Figure 3](#) below.

Figure 3. Uses and types of IAPT data



	Patient data/records identifiable	Non patient data/record identifiable
Primary use	<ul style="list-style-type: none"> • Direct care of individuals • Screening surveillance and • Caseload management 	<ul style="list-style-type: none"> • Commissioning • Service planning • Performance management
Secondary uses	<ul style="list-style-type: none"> • Clinical Governance 	<ul style="list-style-type: none"> • Clinical audit • Research • Public health • Central Government Research • Local Government Research • Central Returns

		<ul style="list-style-type: none"> • HES • Public Enquiries
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Internal (primary) uses

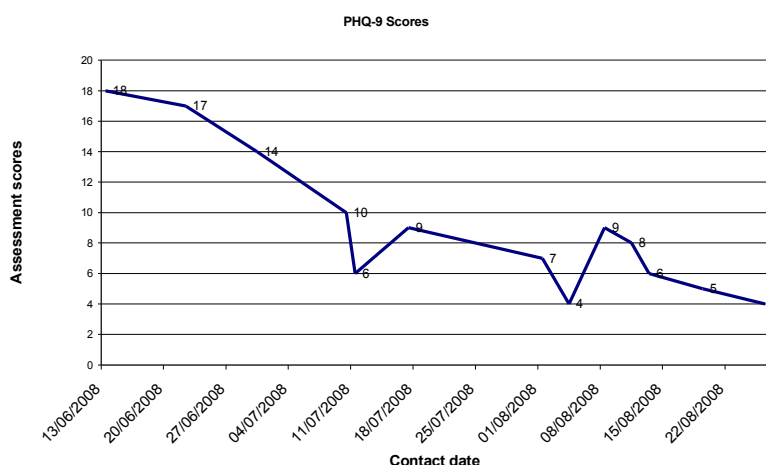
There are a number of different stakeholders who may wish to see various data reports on a regular basis including:

- People receiving care in the IAPT service
- Clinicians delivering care within IAPT
- Supervisors of clinicians delivering care
- Commissioners of services
- Performance managers of the service at PCT and SHA level.

People receiving care - There is value in the patient seeing the scores from their completed questionnaires, and seeing how the scores change over time. Scores helps the patient understand more about their condition and can help support and develop the therapeutic relationship. GPs and IAPT pilot sites found this approach to be positively therapeutic. In the same way, seeing how the outcome score changes over time is also very helpful, both for those who are improving and for those not responding to treatment who may need to consider alternative interventions.

Data that can be useful to report to the patient include: individual scores, sequential outcome scores over time, and the recovery pattern (changing outcome scores over time) expressed as an average score over time for all the patients attending the service.

Figure 4: Example patient progression chart



Clinicians - The treating clinician needs similar data to the person receiving care, especially outcome scores for individuals and expressed as an average for all the people that the clinician has treated. In this way, the characteristics of the clinician's workload can be understood, and compared with others, as can the effectiveness of the interventions offered.

Sharing patient achievements

Stan* (22) had low mood, poor sleep, poor appetite and thoughts of self harm, in the context of a seven-year history of depression that included a suicide attempt. He lived in the same house as his parents but was not close to them. He had a job in a warehouse but drinking two or three large bottles of cola and smoking up to 40 cigarettes a day.

He scored 'severe' on the assessment questionnaires for both depression and anxiety disorder, thought about killing himself and was engaged in self harm. He hated himself for feeling so angry and depressed and hated other people, sometimes lashing out at them. He wanted to stop smoking, be able to socialise more easily, get a new job and get back into education.

Stan's low intensity intervention lasted seven sessions and centred around communication and assertiveness techniques, behavioural activation, improving sleep and cognitive restructuring. When it ended, his scores showed he was in remission. At work, he was able to control his temper and discuss issues assertively, rather than aggressively. Socially, he was seeing friends and playing snooker and football. At every session, his low intensity mental health worker showed him the charts recording his questionnaire results and showing his progress. Stan says he doesn't remember the person he was when it began because he is so much better now. He took all the graphs away with him as evidence of what he had achieved.

** Name has been changed in this true story from Hertfordshire Partnership Foundation Trust*

Supervisors - Supervisors need to know about the cases of the clinicians they are supervising in terms of caseload, average length of treatment sessions, patient outcomes (in particular, patients identified to be at risk), and levels of incomplete/missing data.

Commissioners - The commissioner needs to know about the service quality including how many people are being treated, attendance and drop out rates, patient outcomes, and how this data compares with other providers. They may also need to know about the characteristics of the people referred, in relation to the population demography, ethnicity, and work status for example.

The commissioner may also find it useful to know if patients with physical health problems have changed their use of other health resources, and if this can be used to resource further

investment. Hence, there should be links to both Secondary Uses Service (SUS) and Primary Care databases.

SHA/PCT Performance Managers – Managers generally need a smaller amount of aggregated data relating to both quality and quantity of care provided, with comparisons to other centres and to the national trajectory over the next three years, to assist with regional/national performance monitoring.

External data flows and reporting

Some data collected by the service provider will be used by PCTs to complete the IAPT Key Performance Indicators (KPIs). An overview of external data flows can be found at [Figure 5](#). The KPIs are the agreed mechanism for demonstrating regional and national progress against the Secretary of State for Health's public commitments on IAPT. They include:

- **Vital Signs Indicators** – more people accessing treatment
- **Extending Access to NICE-compliant Services** – half of those who leave treatment moving to recovery
- **Helping People Back to Work** – fewer people on sick pay and benefits
- **Building a Skilled Workforce** – newly trained high and low intensity workers

The KPIs will be used to show progress towards the following national commitments:

- 900,000 more people treated by 2010/11 (half of these moving towards recovery)
- 3,600 newly trained therapists by 2010/11
- 25,000 fewer people on sick pay and benefits by 2010/11

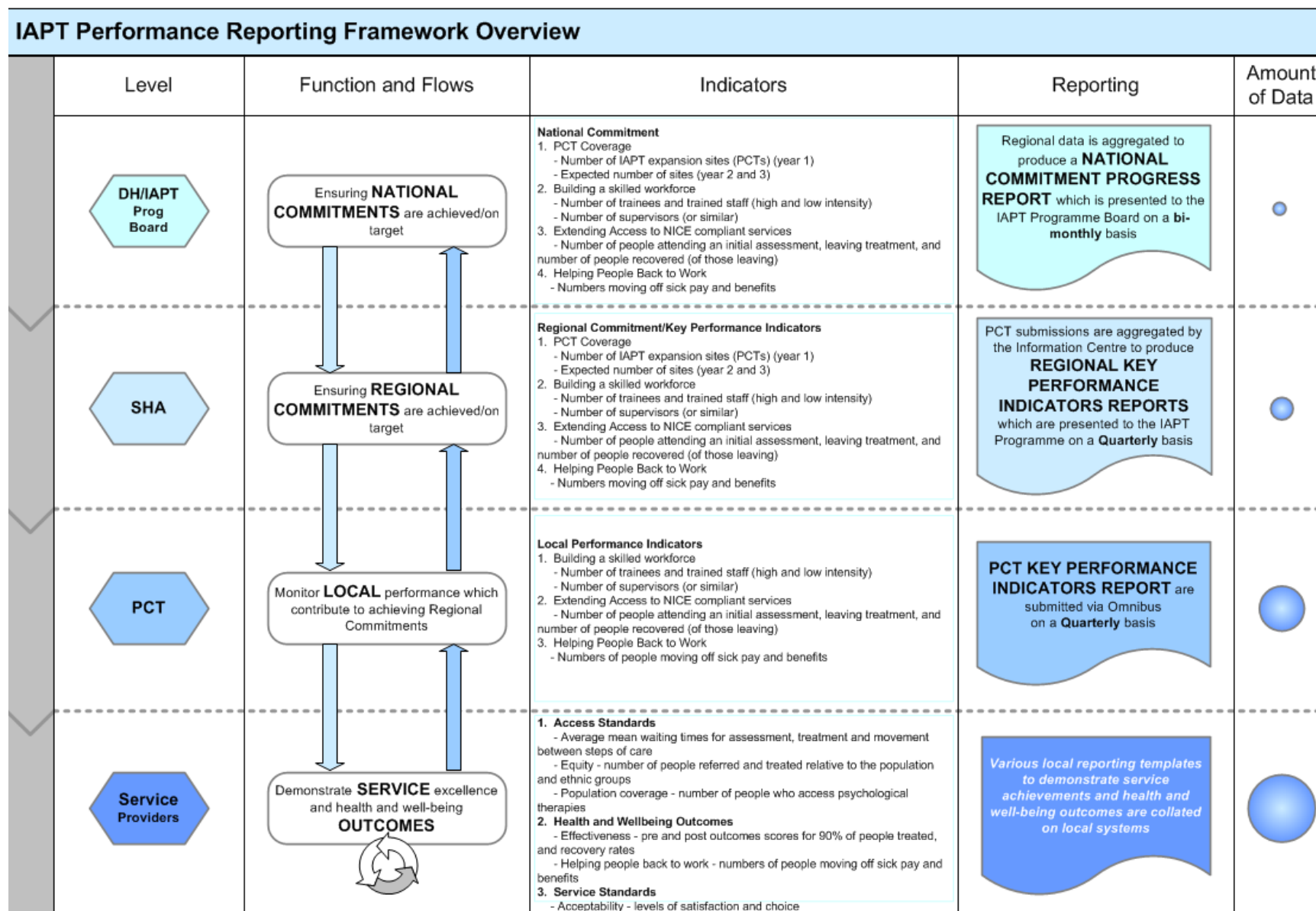
Collection will be via the Information Centre's web-based system, **Omnibus**, which is already used by the NHS. The Omnibus system allows real-time access to the data via a web portal. Data will be collected from PCTs on a quarterly basis, with the first return at the end of December 2008. This data will be available to Strategic Health Authorities (SHAs) and the Department of Health (DH), and will form the basis of reports to the IAPT National Programme Board.

Technical Guidance to support PCTs in collecting the KPIs will be available in Summer 2008.

Data collection rates

Data collection rates should be monitored on a regular basis to help ensure that sites are achieving at least 90% complete outcomes. This percentage can be calculated for the number of people who have had two or more therapeutic sessions (this may include assessment), and who have complete first and last session data for clinical outcome measures, including as a minimum PHQ9 and GAD7.

Figure 5: IAPT Performance Reporting Framework Overview



6. Information governance and Consent

Internal use of data

When a service user provides or contributes confidential information to a service and has been made aware of who may need to see the information about them, their consent to this use of their information can be *implied*.

Use of outcome measuring tools as part of the IAPT data set is part of clinical practice, primarily for the benefit of the patient, to inform treatment and appropriate care pathways. Therefore, the notion of implied consent applies. However, sites should adopt a 'no secrets' approach informing patients of the content and rationale of routine outcome measurement so that the purpose and benefits to the patient are properly conveyed. An example of a patient information leaflet can be found at [Appendix D](#)

However, generally, service users retain the right to restrict the disclosure of their confidential personal information, explicitly declining to allow information to be shared so that no one can decide to share this information on their behalf except for parents or legal guardians, or people with powers under mental health law.

Service users also have the right to change their mind about a disclosure decision at any time before the disclosure is made, and can do so afterwards to prevent further disclosures where an activity requires a regular transfer of their personal information.

External use of data

Consent cannot be implied for other purposes, such as disclosure to outreach teams, the police, government departments (other than the Department of Health), or the courts, for example. In most cases, service users should be asked for their *explicit* consent for information to be shared for non-care purposes.

In certain circumstances, information can be disclosed without seeking explicit consent, or where consent has been sought but refused. This happens when:

- The disclosure is *required* or *permitted by law* – perhaps by court order or under an Act of Parliament. For example, certain confidential information must be disclosed to the Health Protection Agency for monitoring and controlling disease. Disclosures may also be permitted under section 60 of the Health and Social Care Act 2001
- There is a robust *public interest* in disclosure, where failure to do so would put someone else at risk. Senior members of staff such as the Caldicott Guardian decide this taking legal advice where necessary. Ultimately, this issue may rest with the courts.

Summary

Where truly anonymised aggregated data is transmitted and used, and that where the transmission and use of data is necessary for the care of the patient to whom the data relates, consent can be *implied* for that transmission and use from the individual's decision to accept that care. However, the transmission and use of identifiable data for purposes that are not necessary to provide individual patient care requires *explicit* patient consent.

Key guidance documents

- The *NHS Care Record Guarantee* reflects the legislative framework and guidance to the NHS through which patient data is collected, stored and managed. It incorporates statutory and common-law principles of confidentiality.

The Care Record Guarantee - Principles

The use of patient identifiable data for purposes other than direct care is allowed only in certain circumstances, for instance where:

- A statutory requirement or court order allowing access to the data
- There is clinical need to share data between sites for healthcare purposes
- The data use is essential for other medical purposes (including research and commissioning). It must also be appropriate according to Caldicott guidelines, with explicit consent from the patient, or no objection from the patient, where data access is approved under s60 HSCA 2001, or when it is in the Public Interest.

- The need is essential and appropriate for non-medical purposes and the patient has given explicit consent, or it is in the public interest and a condition of Sch.3 DPA 1998 is satisfied.
- In all other cases, patient data must only be used in a non-identifiable form.

Further information about the National Care Record Guarantee can be found at www.connectingforhealth.nhs.uk

- *NHS Code of Practice* - This Department of Health guidance is for those working in or under contract to NHS organisations. It covers the concept of confidentiality, describes what a confidential service should look like, provides a high-level description of the main legal requirements, presents a generic decision support tool for sharing/disclosing information, and lists examples of particular information disclosure scenarios. The Code of Practice is available to download at www.dh.gov.uk
- *Caldicott Guardian Manual* – This guidance takes account of developments in information management in the NHS and in local authorities with social services responsibilities since the publication of the Caldicott report. It sets out the role of the Caldicott Guardian as a part of broader information governance and is available to download at www.dh.gov.uk

Useful websites

- *Department of Health: Section 60 Health & Social Care Act 2001 - Guidance notes* (www.dh.gov.uk)

This is intended for those wishing to obtain identifiable patient information, data controllers who are asked to supply identifiable patient information in circumstances where patient consent has not been obtained, and there is no other reliable basis in law to permit the disclosure and use of identifiable patient information.
- *Information Governance Training Materials*

As a key part of the Information Governance agenda, the Department of Health and the NHS Connecting for Health have produced an online Information Governance Toolkit available at www.connectingforhealth.nhs.uk

The Toolkit has been made available to assist organisations to achieve the aims of Information Governance, including:

- Information Governance Management
- The Confidentiality NHS Code of Practice
- Data Protection Act 1998
- Information Security
- Information Quality
- Records Management
- Freedom of Information Act 2000

Glossary of Terms

Caldicott Guardian – a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Guardian plays a key role in ensuring that the NHS, Councils with Social Services responsibilities and partner organisations satisfy the highest practicable standards for handling patient identifiable information.

Caseness – Individual's score exceeds the accepted case/non-case threshold for a standardized measure of symptoms. For the PHQ 9, this is a score of 10 or above. For the GAD7, this is a score of 8 or above.

Demographics - statistics characterising human populations (or segments of human populations broken down by age or sex or income etc.)

Evidence-based intervention - an intervention that has been shown in rigorous evaluations to have sustained meaningful effects on the outcome you wish to improve

Integrated care pathway - (ICP) is a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes

National Programme for IT (Npfit) – Better, faster and safer patient care is the objective of Npfit. It is designed to provide hugely powerful tools, like a patient's record being instantly available to any clinician at any location; clinical decision support software and electronic appointment booking. Npfit is part of NHS Connecting for Health, which came into operation on 1 April 2005, and is an agency of the Department of Health. NHS Connecting for Health supports the NHS to deliver better, safer care to patients, by bringing in new computer systems and services.

NHS Care Records Service (NCRS) - is designed to begin to provide healthcare staff with quicker access access to reliable information about patients to help with their treatment, including in an emergency. It will also give patients access to their records that covers their care across different organisations, such as the GP practice and the hospital. The purpose of NHS CRS is to allow information about individual

patients to be accessed more quickly, and gradually to phase out paper and film records which can be more difficult to access.

NHS Data Dictionary - The NHS Data Model and Dictionary provides a reference point for assured information standards to support health care activities within the NHS in England. It has been developed for everyone who is actively involved in the collection of data and the management of information in the NHS.

NICE-compliant – The treatment that is offered is consistent with NICE recommendations for the relevant condition(s).

Outcomes measurement – The assessment of changes in clinical and other measures over the course of treatment.

Patient Health Questionnaire (PHQ9) – The Patient Health Questionnaire (PHQ) facilitates the recognition and diagnosis of the most common mental disorders in primary care patients. PHQ materials were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

Patient Health Questionnaire (GAD7) – The GAD7 is primarily a screening and severity measure for anxiety disorders (especially generalized anxiety disorder). This like the PHQ materials above was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. Further guidance and information can be found in 'PHQ9 & GAD7 Guidance Notes' available at www.nhs.uk/iapt

Prevalence – is a frequently used epidemiological measure of how commonly a disease or condition occurs in a population. Prevalence measures how much of some disease or condition there is in a population at a particular point in time.

Stepped care system/model – See page 24 of the IAPT Commissioning Toolkit (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084065)

Secondary Uses Service (SUS) – is part of the National Programme for IT NHS Care Records Service (NHS CRS) contracts managed by NHS Connecting for Health (NHSCFH). It

provides a single source of patient activity data submitted by providers of NHS-commissioned care to help planning and research as well as clinical and non-clinical NHS management. It replaced the NHS-Wide Clearing Service (NWCS) at the end of 2006 and has become the principal source of patient level secondary uses activity data.

Vital Signs – measures of progress against national and local priorities. For more info see (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082542)

Work & Social Adjustment Scale (W&SAS) – The Work and Social Adjustment Scale (WSAS) is a simple 5-item measure of general impairment which grew out of a study of change during psychotherapy. It was adapted as a 4-item scale (work, home, social, and private leisure) to rate disability in psychotherapy studies in phobics. Marks et al adapted it further to measure the outcome of most patients in treatment and later added its fifth item concerning interpersonal relations.

Appendix A – IAPT Data Set

Patient Data

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title / Reference	Notes
P1	NHS number	Y	A number used to identify a patient uniquely within the NHS in England and Wales	n10		To uniquely identify the patient and allow analysis across data sets	NHS NUMBER	
P2	Local patient identifier (case number)	Y	A number used to identify a patient uniquely within a local mental health service provider (IAPT service)	n		To identify a patient in the absence of an NHS number	LOCAL PATIENT IDENTIFIER	May only be unique to a particular service and can be assigned by the computer system. Code should be numeric only
P3	Organisation code (code of provider)	Y	The organisation code of the organisation acting as a Health Care Provider (IAPT service)	an5		To identify the IAPT service providing care	ORGANISATION CODE (CODE OF PROVIDER)	
P4	Code of GP practice (registered GMP)	Y (if applicable)	This is the code of the practice of the patient's registered GP	an6		Allows the GP to be notified about treatment received by the patient. PCT can be derived from this field	CODE OF GP PRACTICE (REGISTERED GMP)	The registered GP may or may not be the same as the referring GP
P5	Gender	Y	The patient's gender currently	n1	0 – Not known 1 – Male 2 – Female 9 – Not specified	To analyse equality of access to services and outcomes across genders.	PERSON GENDER CODE	This classification relates to the patient's identity rather than physiology. "0 Not Known" means that the sex of the patient has not been recorded. "9 Not Specified" means

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title / Reference	Notes
								indeterminate, i.e. unable to be classified as either male or female.
P6	Date of birth	Y	The date on which the patient was born or is officially deemed to have been born.	an10	dd-mm-yyyy	To analyse equality of access to services and outcomes across age groups.	PERSON BIRTH DATE	
P7	Ethnic category	Y	The ethnicity of the patient, as specified by the patient	an2	White A - British B - Irish C - Any other White background <i>Mixed</i> D - White and Black Caribbean E - White and Black African F - White and Asian G - Any other mixed background <i>Asian or Asian British</i> H - Indian J - Pakistani K - Bangladeshi L - Any other Asian background <i>Black or Black British</i> M - Caribbean N - African P - Any other Black background <i>Other Ethnic Groups</i> R - Chinese S - Any other ethnic group Z - Not stated	To analyse equality of access to services and outcomes across ethnic groups.	ETHNIC CATEGORY	The Office of National Statistics has developed further sub-codes, elements of which should be used locally, depending on local circumstance and data collection needs. It is only mandatory to collect the 16 top level categories. However, collection of detailed ethnicity data that is relevant to the local population is recommended. The detailed breakdown can be found here: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_5319277?IdcService=GET_FILE&dID=4305&Renderition=Web

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title / Reference	Notes
Additional recommended items								
P8	Sexual orientation	N	The sexual orientation of the patient, as specified by the patient	n1	1 - Heterosexual 2 - Lesbian or gay 3 - Bisexual 4 - Other 5 - Not stated 6 - Not known	To ensure equality of access to services and outcomes across groups.	-	There are no nationally agreed classifications for sexual orientation. This list may be used locally as an interim measure but may be subject to change when a national list is developed
P9 (i)	Visual disability	N	Identifies whether the patient has a visual disability. This classification is as stated by the patient, not observed	n2	1 - Yes 2 - No 3 - Not stated	To ensure equality of access to services for people with disabilities	-	There are no nationally agreed classifications for disability. This list may be used locally as an interim measure but may be subject to change when a

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title / Reference	Notes
								national list is developed
P9 (ii)	Speech disability	N	Identifies whether the patient has a speech disability. This classification is as stated by the patient, not observed	n1	1 - Yes 2 - No 3 - Not stated	To ensure equality of access to services for people with disabilities	-	There are no nationally agreed classifications for disability. This list may be used locally as an interim measure but may be subject to change when a national list is developed
P9 (iii)	Hearing disability	N	Identifies whether the patient has a hearing disability. This classification is as stated by the patient, not observed	n2	1 - Yes 2 - No 3 - Not stated	To ensure equality of access to services for people with disabilities	-	There are no nationally agreed classifications for disability. This list may be used locally as an interim measure but may be subject to change when a national list is developed
P9 (iv)	Mobility disability	N	Identifies whether the patient has a mobility disability. This classification is as stated by the patient, not observed	n1	1 - Yes 2 - No 3 - Not stated	To ensure equality of access to services for people with disabilities	-	There are no nationally agreed classifications for disability. This list may be used locally as an interim measure but may be subject to change when a national list is developed
P10	Able to communicate in spoken English?	N	Identifies whether an interpreter is required for the purposes of communication between the care professional and	n1	1 - Yes 2 - No 3 - Not stated	To ensure equality of access for patients with additional communication requirements	-	

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title / Reference	Notes
			the patient					
P11	Understand written English?	N	Identifies whether translations of written materials are needed for the purpose of communication with the patient	n1	1 - Yes 2 - No 3 - Not stated	To ensure equality of access for patients with additional communication requirements	-	
P12	Preferred language	N	The patient's preferred language	n3	001 Akan (Ashanti) 002 Albanian 003 Amharic 004 Arabic 005 Bengali & Sylheti 006 Brawa & Somali 007 British Signing Language 008 Cantonese 009 Cantonese and Vietnamese 010 Creole 011 Dutch 012 English 013 Ethiopian 014 Farsi (Persian) 015 Finnish 016 Flemish 017 French 018 French creole 019 Gaelic 020 German 021 Greek 022 Gujarati 023 Hakka 024 Hausa 025 Hebrew 026 Hindi 027 Igbo (Ibo)	To identify a suitable language for communication between the care professional and the patient	LANGUAGE CLASSIFICATION CODE	

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title / Reference	Notes
					028 Italian			
					029 Japanese			
					030 Korean			
					031 Kurdish			
					032 Lingala			
					033 Luganda			
					034 Makaton (sign language)			
					035 Malayalam			
					036 Mandarin			
					037 Norwegian			
					038 Pashto (Pushtoo)			
					039 Patois			
					040 Polish			
					041 Portuguese			
					042 Punjabi			
					043 Russian			
					044 Serbian/Croatian			
					045 Sinhala			
					046 Somali			
					048 Spanish			
					049 Swahili			
					050 Swedish			
					051 Sylheti			
					052 Tagalog (Filipino)			
					053 Tamil			
					054 Thai			
					055 Tigrinya			
					056 Turkish			
					057 Urdu			
					058 Vietnamese			
					059 Welsh			
					060 Yoruba			
					200 Other			

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title / Reference	Notes
P13	National Identity	N	The patient's self-defined association with a particular country.	n1	1 - English 2 - Scottish 3 - Welsh 4 - Irish 5 - British 9 - Other	To analyse equality of access to services and outcomes across ethnic groups.	-	In combination with ethnic category, this field can be used to give a detailed picture of ethnicity. Official guidance on collection of ethnicity data can be found here: http://www.statistics.gov.uk/about/ethnic_group_statistics/downloads/ethnic_group_statistics.pdf

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title / Reference	Notes
P14	Religion	N	The patient's religion. This may refer to identity with a particular religious community even though the religion may not be practiced	n2	01 - No religious group or secular 02 - Atheist / Agnostic 03 - Church of England 04 - Other protestant 05 - Orthodox Christian 06 - Roman Catholic 07 - Other Christian 08 - Muslim 09 - Shi'ite Muslim 10 - Sunni Muslim 11 - Sikh 12 - Jewish 13 - Orthodox Jewish 14 - Buddhist 15 - Hindu 16 - Jain 17 - Parsi / Zoroastrian 18 - Rastafarian 19 - Any other religion 20 - Not stated	To ensure equality of access across religions	-	This is the list developed for 'count me in', the 2005 census conducted by the Mental Health Act Commission, the National Institute for Mental Health in England and the Healthcare Commission. A nationally approved list is not available, but this list or a more detailed breakdown may be used locally to ensure equality of access and improve patient care
P15	Postcode	N	The code allocated by the Post Office to identify a group of postal delivery points.	an8 (max)		To allow association and analysis by geographic area. Can also be used as an identifier	POSTCODE	

Contact level (appointment) data

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
A1	Therapist AFC band (recorded as therapist name - see notes)	Y	The Agenda For Change band of the therapist conducting the appointment	n2	01 - Band 1 02 - Band 2 03 - Band 3 04 - Band 4 05 - Band 5 06 - Band 6 07 - Band 7 08 - Band 8a 10 - Band 8b 11 - Band 8c 12 - Band 8d	To allow analysis of the grade and skills of professionals in a service	-	This field should be hidden and should not be repeated for each appointment. It should be recorded once under therapist details (using the IAPT worker registration form). Therapist name should be collected at each appointment which can then be used to link to title and banding details. Agenda for Change equivalents should be given for non-NHS providers (salary details can be found at http://www.nhsemployers.org/pay-conditions/pay-conditions-217.cfm)
A2	Appointment date	Y	The date of the appointment	an10	dd-mm-yyyy	To analyse timescales in the provision of services	APPOINTMENT DATE	-
A3	Appointment purpose	Y	The nature of the appointment	n1	1 - Assessment only 2 - Treatment only 3 - Assessment and treatment 4 - Review only 5 - Review and treatment 6 - Follow-up after left treatment 7 - Other		-	-

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
A4	Intervention given	Y	The type of therapy provided during the appointment	n2	01 - cCBT 02 - Pure self-help (e.g. Books on Prescription) 03 - Guided self-help 04 - Behavioural activation 05 - Structured exercise 06 - Psychoeducational groups 07 - CBT 08 - Interpersonal therapy (IPT) 09 - Counselling 10 - Couples therapy 11 - Other		-	
A5	Use of psychotropic medication	Y	Identifies whether the patient is taking psychotropic medication (at any point during the care spell)	n1	1 - Yes 2 - No 3 - Not stated	To identify patients needing medication support and to analyse relationship between medication, therapy and outcomes.	-	
A6	Current step (at end of session)	Y	The step of care the patient is at following the appointment	n1	1 - Step 1 2 - Step 2 3 - Step 3 4 - Step 4		-	
Additional recommended items								
A7	Appointment type	N	The means of communication during the appointment	n1	1 - Face-to-face 2 - Telephone 3 - Email 4 - SMS 5 - Other		-	-

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
A8	Attendance	N	This indicates whether or not the patient attended the appointment. If the appointment was not attended it also indicates whether or not advanced warning was given.	an1	5 - Attended on time or, if late, before the relevant CARE PROFESSIONAL was ready to see the PATIENT 6 - Arrived late, after the relevant CARE PROFESSIONAL was ready to see the PATIENT, but was seen 7 - PATIENT arrived late and could not be seen 2 - Appointment cancelled by, or on behalf of, the PATIENT 3 - Did not attend - no advance warning given 4 - Appointment cancelled or postponed by the Health Care Provider 0 - Not applicable - Appointment occurs in the future	To monitor attendance levels.	ATTENDED OR DID NOT ATTEND	
A9	Contact duration (clinical time)	N	The duration of the appointment (in minutes) excluding any administration time	n3	000-999 minutes		-	-
A10	Therapist occupational group	N	The professional staff group of the therapist/clinician conducting the appointment	n2	01 - Occupational therapy 02 - Physiotherapy 03 - Art/music/drama therapy 04 - Speech and language therapy 05 - Clinical psychology 06 - Psychotherapy 07 - Counselling 08 - Social work 09 - Mental health nursing 10 - General practice 11 - Psychiatry 12 - Other		-	This field should be hidden and should not be repeated for each appointment. It should be recorded once under therapist details. Therapist name should be collected at each appointment which can then be used to link to title and banding details.

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
Outcomes data (required)								
A11	PHQ9 total score	Y	The total score from the PHQ9 depression severity index	n2	00-27	To measure change in health and wellbeing	-	If one or two values are missing then they can be substituted with the average score of the non-missing items. Questionnaires with more than 2 missing values should be disregarded.
A12	GAD7 total score	Y	The total score from the GAD7 anxiety severity index	n2	00-21	To measure change in health and wellbeing	-	If one or two values are missing then they can be substituted with the average score of the non-missing items. Questionnaires with more than 2 missing values should be disregarded.
A13	W&SAS total score	Y	The total score from the Work and Social Adjustment Scale	n2	00-40	To measure change in health and wellbeing	-	If patient has selected 'non-applicable' for question 1, or if 1 value is missing, then these scores can be substituted with the average score of the non-missing items. Questionnaires with more than 1 missing value should be disregarded.

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
A14	Employment status	Y	The patient's current employment status	n1	1 - Employed full-time 2 - Employed part-time 3 - Unemployed 4 - Full-time student 5 - Retired 6 - Full-time homemaker or carer	To measure change in health and wellbeing	-	
A15	Receiving Statutory Sick Pay (SSP)	Y	Indicates whether the patient is currently receiving SSP	n1	1 - Yes 2 - No 3 - Not stated	To measure change in health and wellbeing	-	
A16	Receiving benefits	Y	Indicates whether the patient is currently receiving any benefits including Job Seekers Allowance, Incapacity Benefit and Income Support.	n1	1 - Yes 2 - No 3 - Not stated	To measure change in health and wellbeing	-	
A17	Phobia question 1 score	Y	The patient's current social phobia score	n1	0-8	To measure change in health and wellbeing	-	
A18	Phobia question 2 score	Y	The patient's current agoraphobia score	n1	0-8	To measure change in health and wellbeing	-	
A19	Phobia question 3 score	Y	The patient's current specific phobia score	n1	0-8	To measure change in health and wellbeing	-	

Care pathway data

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
C1	Date referral received	Y	The date the referral request was received by the health care provider (IAPT service)	an10	dd-mm-yyyy	To analyse timescales in the provision of services	REFERRAL REQUEST RECEIVED DATE	Please follow this link for detailed notes
C2	Referral accepted?	Y	Indicates whether the referral was accepted by the IAPT service	n1	1 - Yes 2 - No 3 - Not stated	To analyse timescales in the provision of services	-	-
C3	Source of referral	Y	The source of referral of a Mental Health Care Spell	n2	00 - General Medical Practitioner 01 - Self 02 - Local Authority Social Services 03 - A&E Department 04 - Employer 05 - Education Service 06 - Police 07 - Other clinical specialty 08 - Carer 09 - Courts 10 - Probation Service 13 - Other 14 - Job centre plus 15 - Voluntary sector organisation 16 - Community/practice nurse/health visitor	To monitor the source of referrals and service provision.	SOURCE OF REFERRAL FOR MENTAL HEALTH	

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
C4	Primary diagnosis	Y	The main condition treated or investigated during the current episode of healthcare. The diagnosis should occur within the IAPT service	ann(naa)	F10 - Mental and behavioural disorders due to use of alcohol F31 - Bipolar affective disorder F32 - Depressive episode F33 - Recurrent depressive disorder F41.1 - Generalized anxiety disorder F41.2 - Mixed anxiety and depressive disorder F40.0 - Agoraphobia (with or without history of panic disorder) F40.1 - Social phobias F40.2 - Specific (isolated) phobias F42 - Obsessive-compulsive disorder F43.1 - Post-traumatic stress disorder F45 - Somatoform disorders F50 - Eating disorders Z63.4 - Disappearance and death of family member F99 - Mental disorder, not otherwise specified	To analyse prevalence of disorders and ensure appropriate care	PRIMARY DIAGNOSIS	This list is taken from the World Health Organization's ICD10 'International Statistical Classification of Diseases and Related Health Problems'. If the appropriate condition is not listed, further codes may be used from the ICD10 list: http://www.who.int/classifications/apps/icd/icd10online/
C5	Date of initial assessment	Y	The date of the first assessment attended by the patient	an10	dd-mm-yyyy	To analyse timescales in the provision of services	APPOINTMENT DATE	This field may be derived from contact level data

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
C6	Date of first therapeutic session	Y	The date of the first appointment attended by the patient where an intervention is provided	an10	dd-mm-yyyy	To analyse timescales in the provision of services	APPOINTMENT DATE	This is the date on which the patient first received a therapeutic contact (intervention). This may be during the same appointment as initial assessment. This can also be considered the START DATE (MENTAL HEALTH CARE SPELL). This field may be derived from contact level data
C7	Date of end of IAPT care pathway	Y	The date the patient is deemed by the care professional to have completed the current IAPT care pathway	an10	dd-mm-yyyy	To analyse timescales in the provision of services	END DATE (MENTAL HEALTH CARE SPELL)	-
C8	Reason for end of IAPT care pathway	Y	The reason for the termination of care spell as determined by the care professional	n1	1 - Completed treatment 2 - Deceased 3 - Declined treatment 4 - Dropped out of treatment (unscheduled discontinuation) 5 - Not suitable for service 9 - Unknown	To analyse timescales and identify completed/dropout rates	-	-
C9	PHQ9 first score	Y	The total score from the patients first PHQ9 during the current care spell	n2	00-27	To measure change in health and wellbeing	-	-
C10	PHQ9 last score	Y	The total score from the patient's last PHQ9 score during the current care spell	n2	00-27	To measure change in health and wellbeing	-	If only one PHQ9 score is recorded, this should count as the first score only and the last score should be left blank

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
C11	GAD7 first score	Y	The total score from the patients first GAD7 during the current care spell	n2	00-21	To measure change in health and wellbeing	-	-
C12	GAD7 last score	Y	The total score from the patient's last GAD7 score during the current care spell	n2	00-21	To measure change in health and wellbeing	-	If only one GAD7 score is recorded, this should count as the first score only and the last score should be left blank
C13	W&SAS first score	Y	The total score from the patients first W&SAS during the current care spell	n2	00-40	To measure change in health and wellbeing	-	-
C14	W&SAS last score	Y	The total score from the patient's last W&SAS score during the current care spell	n2	00-40	To measure change in health and wellbeing	-	If only one W&SAS score is recorded, this should count as the first score only and the last score should be left blank
C15	Employment status first	Y	The employment status from the patient's first ESQ during the current care spell	n2	1 - Employed full-time 2 - Employed part-time 3 - Unemployed 4 - Full-time student 5 - Retired 6 - Full-time homemaker or carer	To measure change in employment status	-	-
C16	Employment status last	Y	The employment status from the patient's last ESQ during the current care spell	n2	1 - Employed full-time 2 - Employed part-time 3 - Unemployed 4 - Full-time student 5 - Retired 6 - Full-time homemaker or carer	To measure change in employment status	-	-
C17	Sick Pay status first	Y	The sick pay status from the patient's first ESQ during the current care spell	n1	1 - Yes 2 - No 3 - Not stated	To measure change in health and wellbeing	-	-
C18	Sick Pay status last	Y	The sick pay status from the patient's last ESQ during the current care spell	n1	1 - Yes 2 - No 3 - Not stated	To measure change in health and wellbeing	-	-

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
C19	Benefits status first	Y	The benefits status from the patient's first ESQ during the current care spell	n1	1 - Yes 2 - No 3 - Not stated	To measure change in health and wellbeing	-	-
C20	Benefits status last	Y	The benefits status from the patient's last ESQ during the current care spell	n1	1 - Yes 2 - No 3 - Not stated	To measure change in health and wellbeing	-	-
C21	Phobia question 1 first score	Y	Scale rating from the patient's first Phobia question 1 during the current care spell	n1	0-8	To measure change in health and wellbeing	-	-
C22	Phobia question 1 last score	Y	Scale rating from the patient's last Phobia question 1 during the current care spell	n1	0-8	To measure change in health and wellbeing	-	-
C23	Phobia question 2 first score	Y	Scale rating from the patient's first Phobia question 2 during the current care spell	n1	0-8	To measure change in health and wellbeing	-	-
C24	Phobia question 2 last score	Y	Scale rating from the patient's last Phobia question 2 during the current care spell	n1	0-8	To measure change in health and wellbeing	-	-
C25	Phobia question 3 first score	Y	Scale rating from the patient's first Phobia question 3 during the current care spell	n1	0-8	To measure change in health and wellbeing	-	-
C26	Phobia question 3 last score	Y	Scale rating from the patient's last Phobia question 3 during the current care spell	n1	0-8	To measure change in health and wellbeing	-	-
C27	Use of psychotropic medication first	Y	Response to the first psychotropic medication question during the current care spell	n1	1 - Yes 2 - No 3 - Not stated	To identify patients needing medication support and to analyse relationship between medication, therapy and outcomes	-	-
C28	Use of psychotropic medication last	Y	Response to the last psychotropic medication question during the current care spell	n1	1 - Yes 2 - No 3 - Not stated	To identify patients needing medication support and to analyse relationship between medication, therapy and	-	-

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
						outcomes		
Additional recommended items								
C29	Patient pathway identifier	N	An identifier, which together with the organisation code of the issuer, uniquely identifies a patient pathway	an20		To identify the route that the patient takes through the mental health service	PATIENT PATHWAY IDENTIFIER	Please follow this link for detailed notes
C30	Date referral made	N	The date on which the referral was made, as recorded on the referral request.	an10	dd-mm-yyyy	To analyse timescales in the provision of services	-	-
C31	Referred problem	N	The reason for the patient's referral to the service, as described by the referrer	n1	F10 - Mental and behavioural disorders due to use of alcohol F31 - Bipolar affective disorder F32 - Depressive episode F33 - Recurrent depressive disorder F41.1 - Generalized anxiety disorder F41.2 - Mixed anxiety and depressive disorder F40.0 - Agoraphobia (with or without history of panic disorder) F40.1 - Social phobias F40.2 - Specific (isolated) phobias F42 - Obsessive-compulsive disorder F43.1 - Post-traumatic stress disorder F45 - Somatoform disorders F50 - Eating disorders Z63.4 - Disappearance and death of family member F99 - Mental disorder, not otherwise specified	To analyse reasons for referral across referral sources	-	This list is taken from the World Health Organization's ICD10 'International Statistical Classification of Diseases and Related Health Problems'. If the appropriate condition is not listed, further codes may be used from the ICD10 list: http://www.who.int/classifications/apps/icd/icd10online/

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
C32	Presenting problem	N	The reason for the patient's referral to the service, as described by the patient	an - open box		To involve the patient in the diagnostic and treatment process	-	
C33	Secondary diagnosis	N	Any secondary condition treated or investigated during the current episode of healthcare. The diagnosis should occur within the IAPT service	ann(naa)	F10 - Mental and behavioural disorders due to use of alcohol F31 - Bipolar affective disorder F32 - Depressive episode F33 - Recurrent depressive disorder F41.1 - Generalized anxiety disorder F41.2 - Mixed anxiety and depressive disorder F40.0 - Agoraphobia (with or without history of panic disorder) F40.1 - Social phobias F40.2 - Specific (isolated) phobias F42 - Obsessive-compulsive disorder F43.1 - Post-traumatic stress disorder F45 - Somatoform disorders F50 - Eating disorders Z63.4 - Disappearance and death of family member F99 - Mental disorder, not otherwise specified	To analyse prevalence of disorders and ensure appropriate care	PATIENT DIAGNOSIS	This list is taken from the World Health Organization's ICD10 'International Statistical Classification of Diseases and Related Health Problems'. If the appropriate condition is not listed, further codes may be used from the ICD10 list: http://www.who.int/classifications/apps/icd/icd10online/
C34	Date of onset of current episode	N	The date the current mental health problem (primary) was first experienced by the patient	an10	dd-mm-yyyy	To analyse timescales in the provision of services	-	
C35	Recurrence indicator.	N	Is this a recurrent diagnosis of a previously diagnosed mental health	n1	1 - Yes 2 - No 3 - Not stated		-	

Data Item No	Data Item	Mandatory	Description	Format	Permissible values	Purpose	NHS Data Dictionary Title	Notes
			problem?					
Repeating group for each psychotropic medication								
C36	Psychotropic medication class	N	Identifies the class of psychotropic medication the patient is taking (at any point during the care spell)	n2	01 - No medication 02 - SSRI 03 - Tricyclic 04 - MAOI 05 - Other anti-depressant 06 - Beta blocker 07 - Anti-psychotic 08 - Hypnotic or anxiolytic 09 - Stimulant 10 - Other psychotropic medication 99 - Not stated	To identify patients needing medication support and to analyse relationship between medication, therapy and outcomes.	- DRUG TREATMENT	Includes: any psychotropic medication prescribed to and taken by the patient at any time between initial assessment and end of care spell. Excludes: any non-psychotropic, any medication outside of these dates and any medication prescribed but not taken by the patient
C37	Name of drug	N	The name of the psychotropic medication described above	an (open box)			-	
C38	Dosage	N	The prescribed dosage of the psychotropic medication described above	an (open box)			-	
C39	Medication start date	N (if applicable)	The date that the patient started taking the psychotropic medication described above	an10	dd-mm-yyyy	To identify patients needing medication support and to analyse relationship between medication, therapy and outcomes.	-	
C40	Medication end date	N (if applicable)	The date that the patient stopped taking the psychotropic medication described above	an10	dd-mm-yyyy	To identify patients needing medication support and to analyse relationship between medication, therapy and outcomes.	-	
End of repeating group for each psychotropic medication								

Appendix B – IAPT Paper Based Data Set Questionnaires

Improving Access to Psychological Therapies Programme (IAPT)

Patient information

P1 - NHS number	<input type="text"/>
P2 - Local patient identifier	<input type="text"/>
P3 - Organisation code	<input type="text"/>
P4 – Code of GP Practice	<input type="text"/>

Please check ☒ or tick ☒ your answers.

P5 - Gender

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>
Not specified (indeterminate)	<input type="checkbox"/>

P6 - Date of birth (dd/mm/yyyy)

dd	mm	yyyy
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P7 - Ethnic category

White

British	Irish	Any other White background
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mixed

White and Black Caribbean	White and Black African	White and Asian	Any other Mixed background
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Asian or Asian British

Indian	Pakistani	Bangladeshi	Any other Asian background
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Black or Black British

Caribbean	African	Any other Black background
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Chinese or Other Ethnic Group

Chinese	Any other ethnic group
<input type="checkbox"/>	<input type="checkbox"/>

P2—Local Patient Identifier

Improving Access to Psychological Therapies Programme (IAPT)

IAPT Appointment Data

A1 – Therapist name

A2 – Appointment date

dd	mm	yyyy
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Please check ☒ or tick ☒ your answers.

A3 – Appointment purpose

Assessment only	<input type="checkbox"/>
Treatment only	<input type="checkbox"/>
Assessment and treatment	<input type="checkbox"/>
Review only	<input type="checkbox"/>
Review and treatment	<input type="checkbox"/>
Follow-up (after left treatment)	<input type="checkbox"/>
Other	<input type="checkbox"/>

A4 – Interventions given

cCBT (Computerised Cognitive Behavioural Therapy)	<input type="checkbox"/>
Pure self-help (e.g. Books on Prescription)	<input type="checkbox"/>
Guided self-help	<input type="checkbox"/>
Behavioural activation	<input type="checkbox"/>
Structured exercise	<input type="checkbox"/>
Psycho educational groups	<input type="checkbox"/>
CBT (Cognitive Behavioural Therapy)	<input type="checkbox"/>
IPT (Interpersonal therapy)	<input type="checkbox"/>
Counselling	<input type="checkbox"/>
Couples therapy	<input type="checkbox"/>
Other	<input type="checkbox"/>

A5 – Use of psychotropic medication

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

A6 – Current step (at end of session)

PHQ-9

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

A11 – PHQ9 total score

GAD-7

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge	0	1	2	3
2 Not being able to stop or control worrying	0	1	2	3
3 Worrying too much about different things	0	1	2	3
4 Trouble relaxing	0	1	2	3
5 Being so restless that it is hard to sit still	0	1	2	3
6 Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3

A12 – GAD7 total score

IAPT Phobia Scales

Choose a number from the scale below to show how much you would avoid each of the situations or objects listed below. Then write the number in the box opposite the situation.

0	1	2	3	4	5	6	7	8
Would avoid it	not	Slightly avoid it		Definitely avoid it		Markedly avoid it		Always avoid it
A17	Social situations due to a fear of being embarrassed or making a fool of myself							<input type="text"/>
A18	Certain situations because of a fear of having a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness)							<input type="text"/>

P2 – Local Patient Identifier Certain situations (such as heights, seeing blood, being in confined spaces, driving or flying).

IAPT Employment Status Questions

A14 - Please indicate which of the following options best describes your current status:

Employed full-time (30 hours or more per week)	<input type="checkbox"/>
Employed part-time	<input type="checkbox"/>
Unemployed	<input type="checkbox"/>
Full-time student	<input type="checkbox"/>
Retired	<input type="checkbox"/>
Full-time homemaker or carer	<input type="checkbox"/>

A15 - Are you currently receiving Statutory Sick Pay?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

A16 - Are you currently receiving Job Seekers Allowance, Income support or Incapacity benefit?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

Work and Social Adjustment

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

1. **WORK** - if you are retired or choose not to have a job for reasons unrelated to your problem, please tick N/A (not applicable)

0	1	2	3	4	5	6	7	8	N/A
Not at all		Slightly		Definitely		Markedly		Very severely, I cannot work	<input type="checkbox"/>

2. **HOME MANAGEMENT** – Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

3. **SOCIAL LEISURE ACTIVITIES** - With other people, e.g. parties, pubs, outings, entertaining etc.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

4. **PRIVATE LEISURE ACTIVITIES** – Done alone, e.g. reading, gardening, sewing, hobbies, walking etc.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

5. **FAMILY AND RELATIONSHIPS** – Form and maintain close relationships with others including the people that I live with

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

A13 – W&SAS total score

P2 – Local Patient Identifier

Improving Access to Psychological Therapies Programme (IAPT)

IAPT Care Pathway Data

*Enter code from data set where appropriate***Referral**

C1 – Date referral received

dd	mm	yyyy
----	----	------

C2 – Referral accepted?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

C3 – Source of referral

C4 – Primary diagnosis

Key dates

C5 – Date of initial assessment

--	--	--

C6 – Date of first therapeutic session

--	--	--

C7 – Date of end of IAPT care pathway

--	--	--

C8 – Reason for end of IAPT care pathway

Outcomes

C9 – PHQ9 first score

C10 – PHQ9 last score

C11 – GAD7 first score

C12 – GAD7 last score

C13 – W&SAS first score

C14 – W&SAS last score

C15 – Employment status first

C16 – Employment status last

C17 – Sick Pay status first

C18 – Sick Pay status last

C19 – Benefits status first

C20 – Benefits status last

C21 – Phobia Scale 1 first

C22 – Phobia Scale 1 last

C23 – Phobia Scale 2 first

C24 – Phobia Scale 2 last

C25 – Phobia Scale 3 first

C26 – Phobia Scale 3 last

C27 – Use of psychotropic medication first

C28 – Use of psychotropic medication last

P2 – Local Patient Identifier

Improving Access to Psychological Therapies Programme (IAPT)

Patient Experience Questionnaire

(PEQ - Post-treatment)

Please help us improve our service by answering some questions about the service you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much. We appreciate your help.

Please check ☒ or tick ☒ your answers. Please mark one answer per question.

1. How satisfied are you with the amount of time you had to wait for your first appointment?

Very dissatisfied ☐
Dissatisfied ☐
Neutral/not sure ☐
Satisfied ☐
Very satisfied ☐

2. Were you given the option of more than one form of therapy/treatment from which to choose?

Yes ☐
No ☐

3. How satisfied are you with the type of treatment that you received?

Very dissatisfied ☐
Dissatisfied ☐
Neutral/not sure ☐
Satisfied ☐
Very satisfied ☐

4. Were you offered a choice of worker/therapist?

Yes ☐
No ☐

5. How satisfied are you with the therapist that treated you?

Very dissatisfied ☐
Dissatisfied ☐
Neutral/not sure ☐
Satisfied ☐
Very satisfied ☐

6. Did you receive information from us in relation to other forms of help that may have been available to you?

Yes ☐
No ☐

7. Was there sufficient time to think about what was offered to you before you had to make any important decisions?

Yes ☐
No ☐

Continued overleaf....

8. How **involved** were you with important decisions about your care/treatment?

Decisions were taken:

Against your wishes

☐

*As you wished but
without your
permission*

☐

*Without your full
involvement, but with
your permission*

☐

*With your full
involvement*

☐

9. Did you feel free to change your mind after making a decision about your treatment?

Yes

☐

No

☐

10. How satisfied are you with the overall experience of using this service?

Very dissatisfied

☐

Dissatisfied

☐

Neutral/not sure

☐

Satisfied

☐

Very satisfied

☐

11. Please tell us about anything that you think would improve this psychological therapies service.

IAPT Worker Registration Form

The purpose of this questionnaire is to collect data
regarding staff who are involved in the
Improving Access to Psychological Therapies (IAPT) Programme

THE FORM IS IN 5 PARTS (A-E)

- PART A** Front Sheet for **all staff to complete**
PART B Demographic information for **all staff to complete** Questions 1 - 9
PART C For those who are providing **high intensity interventions** Questions 10 – 21
PART D For those who are providing **low intensity interventions** Questions 22 - 27
PART E For those who are providing **other services** e.g. employment support, administration, business manager IT manager Questions 28 – 34

PART A – ALL staff to complete

Name:

Unique reference code:

Job title:

Name of implementation site:

Name of Current Employer:
(may be the same as above)

What is your current role? Please tick ✓ the appropriate box

High Intensity qualified ☐ High Intensity trainee ☐

Low intensity qualified ☐ Low intensity trainee ☐

Other e.g. Employment Support ☐

If other, please describe your role:

Current banding or salary scale:

If you have taken up this post within the last 12 months:

Date of appointment	Name of previous employer	Previous job title and role

For office use only

High Intensity fully trained	<input type="checkbox"/>	requires minor development	<input type="checkbox"/>	requires training	<input type="checkbox"/>
Low Intensity Fully Trained	<input type="checkbox"/>	requires minor development	<input type="checkbox"/>	requires training	<input type="checkbox"/>
Other Fully Trained	<input type="checkbox"/>	requires minor development	<input type="checkbox"/>	requires training	<input type="checkbox"/>

PART B – ALL staff to complete

Please tick ✓ the appropriate box for the below

1. What is your gender?

Female ☐ Male ☐

2. What is your age?

20- 29 ☐ 30- 39 ☐ 40-49 ☐ 50-59 ☐ 60+ ☐

3. What is your nationality?

English ☐ Scottish ☐ Welsh ☐ Irish ☐ British ☐ Other ☐

If other, please describe your national identity here

4. What is your ethnic group

Choose **ONE** section from A to F, then tick ✓ the appropriate box to indicate your ethnicity;

A White

British ☐ European Union ☐ East European (non EU) ☐

If other white, please describe here

B Mixed

White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐
Black and Chinese or SE Asian ☐ White and Chinese or SE Asian ☐

If other mixed, please describe here

C Asian or Asian British

Indian ☐ Pakistani ☐ Bangladeshi ☐ African Asian ☐
Tamil ☐ Kashmiri ☐ Sri Lankan ☐ Caribbean Asian ☐

If other asian, please describe here

D Black or Black British

Caribbean ☐ Somali ☐ Nigerian ☐ Other African ☐

If other black, please describe here

E Chinese or other ethnic group

Chinese ☐ Vietnamese ☐ Japanese ☐ Filipino ☐ Malaysian ☐

If other any other SE Asian or ethnic group, please describe here

F I do not wish to state my ethnic group ☐

5. Please describe your sexual identity

Please tick ✓ the appropriate box for the below

Heterosexual ☐ Lesbian, gay or bisexual ☐ Transgender ☐ I do not wish to state ☐

6. **Are you registered as disabled?**

Yes ☐ No ☐

If yes, please state your disability:

Employment Details

7. **How long** (including years in training) **have you been working with people experiencing problems relating to mental health?**

Years: Months:

8. **Are you currently working:**

Full time ☐ Part Time ☐

If part time, how many hours?:

9. **How long have you been in your current post?**

Years: Months:

If you are employed to provide **High Intensity interventions** please move to **PART C**

If you are employed to provide **Low Intensity interventions** please move to **PART D**

If you are employed to provide **other services** e.g. employment support please move to **PART E**

PART C - To be completed by those who are employed to provide HIGH INTENSITY interventions

10. Which best describes your current profession / occupation?

Please tick ✓ the appropriate box for the below

Art Psychotherapies	<input type="checkbox"/>	Clinical Psychology	<input type="checkbox"/>	Counselling Psychology	<input type="checkbox"/>	Counselling	<input type="checkbox"/>
CBT Therapist	<input type="checkbox"/>	Graduate Mental Health Worker	<input type="checkbox"/>	Medicine	<input type="checkbox"/>	Nursing	<input type="checkbox"/>
Occupational therapy	<input type="checkbox"/>	Psychotherapy	<input type="checkbox"/>	Social Work	<input type="checkbox"/>		

If other, please specify: _____

11. Please provide details on how you obtained your professional training and/or qualifications:

Name of Qualification e.g. Clinical Psychologist /Family Therapist / Nurse	Full Title of Course	Name of Institution	Year Obtained	Duration of Training	Qualification e.g. Doctorate in Clinical Psychology, MSc, BSc

12. Are you an accredited practitioner with a professional body? Yes ☐ No ☐

If yes, please name professional body: _____

Accreditation status: _____

(e.g. member, practitioner, supervisor): _____

13. Please indicate on the grid below how you have already developed your expertise in CBT:

Type of Training (Tick as many as apply)

No formal training – experience acquired through work ☐

Have developed expertise as part of working with supervision ☐

Short workshops – up to 10 days ☐

Courses Lasting more than 10 Days (Give details of all completed)

Full Name of Course	Duration of course e.g. 1 yr course over three terms of 10 weeks	Number of taught course days e.g. 30 days over one yr	Year of Graduation	Name of Institution	Qualification Obtained e.g. Post Grad Cert in CBT, Post Grad Diploma in CBT, Masters in CBT

14. What CBT training if any, are you currently undertaking?

Full Name of Course	Duration of course e.g. 1 yr course over three terms of 10 weeks	Number of taught course days eg 30 days over one yr	Anticipated Date of Graduation	Name of Institution	Qualification Obtained e.g. Post Grad Cert in CBT, Post Grad Diploma in CBT, Masters in CBT

15. Please indicate on the grid below how you have already developed your expertise in any other evidence based therapies:

Type of Training (Tick as many as apply)

Name of Therapy
e.g. Interpersonal
Psychotherapy,
Family Therapy

No formal training – experience acquired through work
Have developed expertise as part of working with supervision
Short workshops – up to 10 days

☐
☐
☐

Courses Lasting more than 10 Days (Give details of all completed)						
Name of Therapy e.g. IP Family Therapy	Full Name of Course	Duration of course e.g. 1 yr course over three terms of 10 weeks	Number of taught course days e.g. 30 days over one yr	Year of Graduation	Name of Institution	Qualification Obtained e.g. Post Grad Cert in family Therapy, Post Grad Diploma in Family Therapy, Masters in Family Therapy

16. What other evidence based psychological training, if any, are you currently undertaking?

Name of Therapy e.g. Interpersonal, Family Therapy	Full Name of Course	Duration of course e.g. 1 yr course over three terms of 10 weeks	Number of taught course days e.g. 30 days over one year	Anticipated Date of Graduation	Name of Institution	Qualification e.g. Post Grad Cert in Family Therapy

17. Please specify the supervision you currently receive:

Please tick as many as apply and indicate average number of hrs per week

		Average no of hrs per wk
Peer Supervision 1 to 1	<input type="checkbox"/>	_____
Peer supervision in a group	<input type="checkbox"/>	_____
Expert supervisor 1to 1	<input type="checkbox"/>	_____
Expert supervisor in a group	<input type="checkbox"/>	_____
Case Management 1 to 1	<input type="checkbox"/>	_____
Case Management in a group	<input type="checkbox"/>	_____
None	<input type="checkbox"/>	_____

18. **Do you provide supervision?** Yes ☐ No ☐

If yes, to how many people	Average no of hrs per wk

19. **Have you had training in relation to the provision of supervision?** Yes ☐No ☐

(continued overleaf)

If yes, please describe using the grid below:

Full Name of Course	Duration of course e.g. 1 yr course over three terms of 10 weeks	Number of taught course days eg 30 days over one yr	Date of completion	Name of Institution	Qualification Obtained e.g. Post Grad Cert in CBT, Post Grad Diploma in CBT, Masters in CBT

20. **Are you an accredited supervisor by a professional body?** Yes ☐ No ☐

If yes, please name professional body: _____

21. **Do you have training in service leadership and management?** Yes ☐ No ☐

If yes please describe using the grid below:

Full Name of Course	Duration of course e.g. 1 yr course over three terms of 10 weeks	Number of taught course days eg 30 days over one yr	Date of completion	Name of Institution	Qualification Obtained e.g. MBA

Signature Date

****This is now the end of the questionnaire for high intensity workers****

Thank you for completing it. Please return your completed form to

PART D - To be completed by those employed to provide LOW INTENSITY Interventions

22. Do you consider yourself as having received any training which equips you in your role as a low intensity practitioner? Yes ☐ No ☐

If yes please indicate on the grid below

Type of Training (Tick as many as apply)

No formal training – experience acquired through work ☐

Have developed expertise as part of working with supervision ☐

Short workshops – up to 10 days ☐

Courses Lasting more than 10 Days (Give details of all completed)					
Full Name of Course	Duration of course e.g. 1 yr course over three terms of 10 weeks	Number of taught course days eg 30 days over one yr	Year of Graduation	Name of Institution	Qualification Obtained e.g. Certificate in Mental Health, Post Grad Cert in Primary Care Mental Health

23. What training, if any, are you currently undertaking to fulfil your role?

Full Name of Course	Duration of course e.g. 1 yr course over three terms of 10 weeks	Number of taught course days e.g. 30 days over one yr	Anticipated Date of Graduation	Name of Institution	Qualification Obtained e.g. Post Grad Cert in Low Intensity Interventions

24. Please specify the supervision you currently receive:

Please tick as many as apply and indicate average number of hrs per week

Peer Supervision 1 to 1	<input type="checkbox"/>	Average no of hrs per wk	_____
Peer supervision in a group	<input type="checkbox"/>		_____
Expert supervisor 1to 1	<input type="checkbox"/>		_____
Expert supervisor in a group	<input type="checkbox"/>		_____
Case Management 1 to 1	<input type="checkbox"/>		_____

Case Management in a group ☐ _____
 None ☐ _____

25. **Do you provide supervision ?** Yes ☐ No ☐

If yes, to how many people	Average no of hrs per wk

26. **Have you had training in relation to the provision of supervision?** Yes ☐

No ☐

(continued overleaf)

If yes, please describe using the grid below

Full Name of Course	Duration of course e.g. 1 yr course over three terms of 10 weeks	Number of taught course days eg 30 days over one yr	Date of completion	Name of Institution	Qualification Obtained e.g. Post Grad Cert in supervision,

27. **Are you an accredited supervisor by a professional body?** Yes ☐ No ☐

If yes, please name professional body: _____

Signature Date

****This is now the end of the questionnaire for low intensity workers****

Thank you for completing it. Please return your completed form to

PART E - To be completed by those employed to provide OTHER SERVICES

28. What is your role in the service? _____

29. Do you consider yourself as having received any training which equips you with this role? Yes ☐ No ☐

If yes please indicate on the grid below

Type of Training (Tick as many as apply)

No formal training – experience acquired through work ☐

Have developed expertise as part of working with supervision ☐

Short workshops – up to 10 days ☐

Courses Lasting more than 10 Days (Give details of all completed)

Full Name of Course	Duration of course e.g. 1 yr course over three terms of 10 weeks	Number of taught course days e.g. 30 days over one yr	Year of Graduation	Name of Institution	Qualification Obtained e.g. Certificate in Management, NVQ level 3

30. What training if any are you currently undertaking to fulfil your role?

Full Name of Course	Duration of course e.g. 1 yr course over three terms of 10 weeks	Number of taught course days e.g. 30 days over one yr	Anticipated Date of Graduation	Name of Institution	Qualification Obtained e.g. Post Grad Cert in Management

31. Please specify the supervision you currently receive:

Please tick as many as apply and indicate average number of hrs per week

Peer Supervision 1 to 1	<input type="checkbox"/>	Average no of hrs per wk
Peer supervision in a group	<input type="checkbox"/>	_____
Expert supervisor 1to 1	<input type="checkbox"/>	_____
Expert supervisor in a group	<input type="checkbox"/>	_____
Case Management 1 to 1	<input type="checkbox"/>	_____
Case Management in a group	<input type="checkbox"/>	_____
None	<input type="checkbox"/>	

32. Do you provide supervision? Yes ☐ No ☐

If yes, to how many people	Average no of hrs per wk
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33. **Have you had training in relation to the provision of supervision?** Yes ☐

No ☐

(continued overleaf)

If yes, please describe using the grid below

Full Name of Course	Duration of course e.g. 1 yr course over three terms of 10 weeks	Number of taught course days eg 30 days over one yr	Date of completion	Name of Institution	Qualification Obtained e.g. Post Grad Cert in Supervision

34. **Are you an accredited supervisor by a professional body?** Yes ☐ No ☐

If yes, please name professional body: _____

Signature Date

****This is now the end of the questionnaire for other services workers****

Thank you for completing it. Please return your completed form to

Appendix D – Example Patient Information Leaflet

Information about storing and sharing your confidential information

This leaflet gives you answers to commonly asked questions about how we store your confidential information, your right to access this information and our usual NHS practice of confidentiality.

If you have questions or concerns you can telephone us on XXX XXXX XXXX during office hours to talk about these. It is important to us that you are happy with the arrangements we have made for your care, so please feel comfortable calling us if you are unsure. If after speaking with us you are still not happy you can contact PALS on 0800 XXXX XXXX who will be able to help you further.

What kind of information do you keep?

We keep contact information for you and others involved in your care, information about your background, assessments, results of tests and questionnaires, our plans for your future care, details of the care we give you and correspondence related to your care. It is important that you tell us within one week if you change your details, telephone numbers or address because we will continue to use the address and telephone numbers you have given us until you tell us they have changed.

How do you store information about my care?

We keep information about your care in paper records, on the trust computer system and on a dedicated specialist computer system.

What are each of these used for?

The paper records contain notes and copies of documents related to your care. Our computer systems contain electronic records of your care. These systems are used by staff to plan and monitor the quality of your care, to continually improve the quality of the services that we offer and plan future services.

Can I see my records?

Yes, we are happy to provide you with a copy of your records and you will need to write to us to request these (there may be a standard copying fee) or if appropriate we can meet with you to read and discuss your notes together.

Who will know about my care?

You have control over who else is involved in your care and this service observes strict NHS standards of confidentiality. The only time we will inform others without your permission is if we are very concerned for your immediate safety, for the safety of someone else, or if an British Court orders the release of your records. We will try to contact you first if this happens and do our best to help you.

We will write to your GP about your care unless you ask us not to: this is usual in the NHS as your GP is the main person who organises your care. If you do not want us to keep your GP informed please make sure you call us to discuss this. We will usually send you copies of any letters we send out about you. We will also write to other people who you tell us need to be involved in your care (e.g. housing or social services) but only tell them what they need to know to help you.

How does the service use the questionnaires and other information to improve my care?

After you have completed the questionnaires we enter your results into our secure computer system. We use the results to plan your care. You can ask for a print out of your results from your therapist to show how much you have improved.

How is the information used to improve the service offered?

After we have removed all your details from the results, we collect together all the results from all the patients. This means that someone who looks at the data cannot tell who gave the replies (the data is anonymous) and it is impossible to identify any individual patient. We use these results to look for ways to improve the service we offer. We also provide this data to organisations that pay for the service we offer and share what we have learned with other health professionals.

How can I help?

Please complete and return the questionnaires as soon as possible after you receive them. These questionnaires are not compulsory. However, they are an important part of your treatment and we use them to tailor your care to your individual needs. In addition, without these results it is more difficult to assess your improvement and we cannot show how we are helping people.

INFORMATION ABOUT STORING AND SHARING YOUR CONFIDENTIAL INFORMATION

This leaflet gives details about the information we need to ensure that we provide you with high quality services. It explains what happens to the information you provide and how you will be involved in sharing it.

If you have further questions please ask to speak with a member of the team.

CONTACT INFORMATION
ADDRESS
TELEPHONE NO