Psychological Therapies: Annual report on the use of IAPT services

England, 2015-16

Published 18th October 2016

This report examines activity, waiting times and outcomes in the Improving Access to Psychological Therapies (IAPT) programme from 1st April 2015 to 31st March 2016.

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

Key findings

Between 1st April 2015 and 31st March 2016 there were:

1,399,088
new referrals

953,522
referrals that entered treatment

537,131
referrals that finished a course of treatment

Of which:

81.3% waited less than 6 weeks and

96.2% waited less than 18 weeks to enter treatment

490,395 started their treatment at caseness, with

46.3% moving to recovery

Contents

This is an Official Statistics publication

Government Statistical Service

This document is published by NHS Digital, part of the Government Statistical Service

All official statistics should comply with the UK Statistics Authority's Code of Practice for Official Statistics which promotes the production and dissemination of official statistics that inform decision making.

Find out more about the Code of Practice for Official Statistics at www.statisticsauthority.gov.uk/assessment/code-of-practice

This product may be of interest to the Department of Health (DH), IAPT services, commissioners and members of the public interested in information about activity and outcomes regarding NHS-funded IAPT services for adults in England.

Introduction

Improving Access to Psychological Therapies (IAPT) is an NHS programme in England that offers interventions approved by the National Institute for Health and Care Excellence (NICE)[1] for treating people with depression or anxiety.

The IAPT programme is supported by a regular return of data generated by providers of IAPT services in the course of delivering those services to patients. These data are received by NHS Digital and published in monthly and annual reports[2].

This report summarises activity in the IAPT programme for the annual period 1st April 2015 to 31st March 2016, and is the fourth such report published[3]. It shows key information about activity, patient outcomes and waiting times.

Main findings

Information about the IAPT programme is based broadly on 3 areas:

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

This report is divided into three sections, which discuss each of these areas in turn. There are also additional sections giving further detail about these areas by deprivation, for ex-British Armed Forces personnel, and for those with long-term health conditions.

Activity

1,399,088 new referrals were received in the year.

953,522 referrals entered treatment in the year.

1,299,525 referrals ended (for any reason) in the year.

Outcomes

490,395 referrals finished a course of treatment in the year having started at caseness[4], of which 226,850 (46.3%) moved to recovery.

Waiting times

Of the 537,131 referrals that finished a course of treatment in the year, 81.3% waited less than 6 weeks and 96.2% waited less than 18 weeks to enter treatment.

---

[1] https://www.nice.org.uk/
[2] http://www.digital.nhs.uk/iaptreports
[3] All historical IAPT publications can be found at http://www.digital.nhs.uk/iaptreports.
[4] 'Caseness' is the term used in IAPT to define a clinical case of anxiety or depression. See Appendix 3 of this report for further details.

Outcomes

Outcomes in IAPT are measured in terms of three measures;

- Recovery;
- Reliable improvement;
- Reliable recovery.

For a full explanation of each of these terms, see Appendix 3 of this report.

Recovery

Recovery in IAPT is measured in terms of 'caseness' – a term which means a referral has severe enough symptoms of anxiety or depression to be regarded as a clinical case. A referral has moved to recovery if they were a clinical case at the start of their treatment ('at caseness') and not a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition[5].

The Government target is that 50% of eligible referrals[6] to IAPT services should move to recovery[7].

Recovery

46.3%

of eligible referrals moved to recovery.

A referral has moved to recovery if they were defined as a clinical case at the start of their treatment and not as a clinical case at the end of treatment.

Figure 1: recovery rates over time, England, 2012-13 to 2015-16
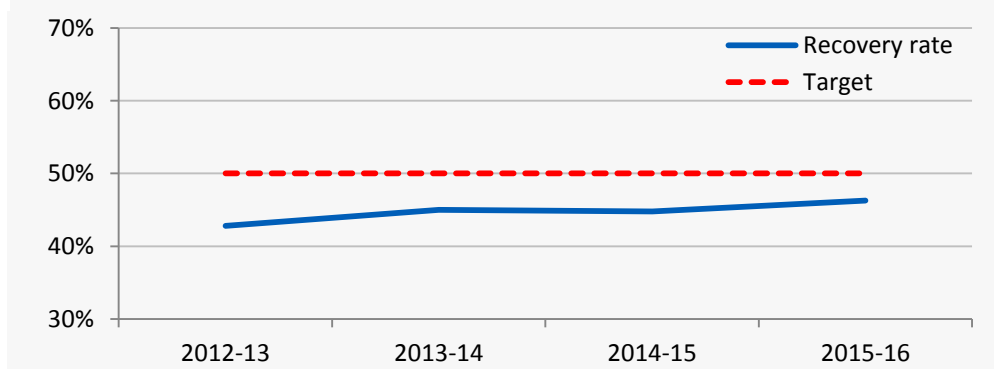
Figure 1 shows that recovery rates have increased gradually year-on-year since the dataset was established in 2012-13[8], reaching 46.3% in 2015/16.

---

[5] Further information about the various questionnaires used to assess caseness, and their caseness thresholds, can be found in Appendix 4 of this report.
[6] Eligible referrals are those that finished a course of treatment in the year having started their treatment at caseness (or initial caseness unknown).
[7] See p16-17 of *The Mandate: A mandate from the Government to NHS England: April 2015 to March 2016*, p 16-17, available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/38622 1/NHS_England_Mandate.pdf
[8] Please note that there were methodological changes to published IAPT data part way through the 2014-15 year as a result of a dataset version change, which may have impacted recovery rates. Full details are published in 'Methodological Change Paper – IAPT version 1.5 reports – November 2014', available from http://www.digital.nhs.uk/iaptmonthly.

Calculating recovery rates

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

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

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

In 2015-16, this calculation is performed as follows:

$$\frac{226{,}850}{\left(537{,}131 - 46{,}736\right)} \times 100 = 46.3\%$$

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

Recovery by problem

NICE recommend that particular therapies are given to treat specific IAPT-relevant problems[9,10] (also known as 'problem descriptors' in the data).

Figures 2a and 2b below show the recovery rates for referrals with each type of problem. Figure 2a shows the primary problem, i.e. the main category in the classification. Figure 2b shows the secondary problems (subcategories) for those with anxiety and stress-related disorders.

---

[9] Problem descriptor codes are based on ICD-10 international standards for the classification of diseases and have been grouped for presentation purposes. For further information, see the 'Constructions' worksheet of the data tables that accompany this report, as well as the IAPT Technical Output Specification, available from http://www.digital.nhs.uk/iapt.

[10] For more information about which therapies are recommended for each problem descriptor, see https://www.nice.org.uk/guidance/published?type=cg; use the search function on the page to find guidance around specific problems.

> Recovery rates by problem at Clinical Commissioning Group level are published in **Table 7c** of the accompanying data tables.

Figure 2a: Recovery rate by primary problem, England 2015-16

Problem	Rate
Depression	46.7%
Anxiety and stress related disorders (Total)	48.8%
Other Mental Health problems	43.3%
Other Recorded Problems	50.7%
Invalid Data Supplied	56.6%
Unspecified	41.1%

Recovery

48.8%

of eligible referrals with anxiety or stress-related disorders moved to recovery, compared to 46.7% of eligible referrals with depression.
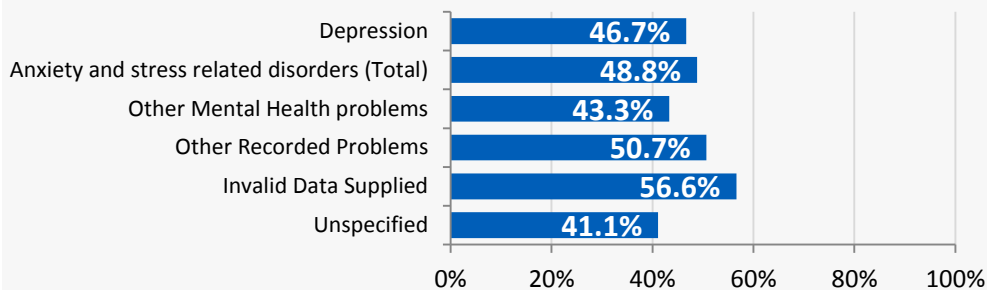
Figure 2a shows that the recovery rate for anxiety and stress-related disorders is slightly higher (48.8%) than that for depression (46.7%); this is comparable to 2014-15[11], when the rates were 47.8% and 44.6% respectively.

Figure 2b: Recovery rate by secondary problem for those with a primary problem of anxiety, England 2015-16

Problem	Rate
Specific (isolated) phobias	64.3%
Generalised anxiety disorder	57.3%
Panic disorder [episodic paroxysmal anxiety]	54.8%
Other anxiety or stress related disorder	53.1%
Obsessive-compulsive disorder	48.5%
Mixed anxiety and depressive disorder	45.2%
Social phobias	44.8%
Post-traumatic stress disorder	37.8%
Agoraphobia	36.9%
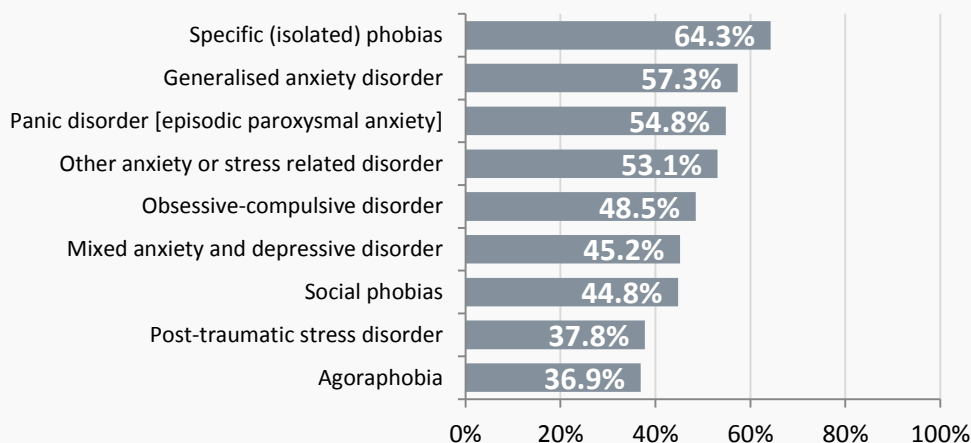
Figure 2b shows recovery rates for specific conditions that fall within the category 'anxiety and stress-related disorders'. 'Specific (isolated) phobias' has the highest recovery rate (64.3%), and 'agoraphobia' has the lowest recovery rate (36.9%). These findings are similar to those in 2014-15[12].

---

[11] See p11 of the 2014-15 annual report, available from http://www.digital.nhs.uk/pubs/psycther1415.
[12] See p11 of the 2014-15 annual report, available from http://www.digital.nhs.uk/pubs/psycther1415.

Recovery by therapy type

NICE's recommendations vary according to the type of problem and its severity[13].

For many mild to moderate cases, NICE recommends a stepped care model[14] - meaning that low intensity therapies[15] are first offered, and those who do not recover as a result of this are 'stepped up' to a high intensity therapy.

Those with more severe symptoms, or those with Social Anxiety Disorder or Post-Traumatic Stress Disorder, would be expected to receive high intensity therapies from the start of their treatment.

A note about reporting by therapy type

Therapy types are recorded at each treatment appointment with a patient, and a patient can have several appointments during the course of a referral. This means that therapy type can change between appointments, and in a single referral two or more therapy types could be recorded.

Subsequently, when categorising patients' recovery by therapy type, a clear method needs to be adopted to choose the therapy type most representative of the treatment the patient has received across their referral. As with last year's report, it has been decided to use the last recorded therapy type. A full description of the methodology can be found in the 'Constructions' tab of the data tables that accompany this report.

The charts below show recovery rates for each therapy type and problem. Figure 3a shows rates for all low intensity therapy types, and Figure 3b shows rates for all high intensity therapy types.

Figure 3a below gives a count of the number of referrals finishing a course of treatment having started at caseness (i.e. the denominator for the recovery rate calculation above), split by low intensity therapy types. It shows that 89,428 referrals, or 19.1% of all referrals where a therapy type has been assigned[16], received 'guided self-help (book)' as their last recorded therapy type. Conversely, just 133 referrals, or 0.03% of all referrals where a therapy type has been assigned, received 'ante/post natal counselling' as their last recorded therapy type. Recovery rates based on those last recorded therapies with small numbers should be interpreted with caution.

---

[13] See https://www.nice.org.uk/guidance/published?type=cg for further details; use the search function on the page to find guidance around specific problems.
[14] See Appendix 5.
[15] A full list of low and high intensity therapies in IAPT can be found in Appendix 5 at the end of this report.
[16] It is possible for an appointment to have no therapy types recorded and still meet the definition of a treatment appointment. Further, only version 1.5 therapy types have been used in this analysis. Where the last recorded therapy type is a version 1.0 code, the referral has not been included in analyses by therapy type. Full details can be found in Appendix 5 at the end of this report.

Figure 3a: Number of referrals finishing a course of treatment having started at caseness, by therapy type (low intensity therapies), England 2015-16

Therapy Type	Number
Guided Self Help (Book)	89,428
Other Low Intensity	53,260
Psychoeducational peer support	23,733
Non-guided Self Help (Book)	13,288
Behavioural Activation (Low Intensity)	9,877
Guided Self Help (Computer)	8,746
Non-Guided Self Help (Computer)	2,356
Structured Physical Activity	374
Employment Support (Low Intensity)	396
Ante/post natal counselling	133

Figure 3b shows recovery rates for each low intensity therapy type and problem. For both depression and for anxiety and stress-related disorders, the highest recovery rate is for 'non-guided self-help (computer)'. The lowest recovery rate for both depression and anxiety and stress-related disorders is 'employment support'.

Figure 3b: Recovery rate by therapy type (low intensity therapies) and problem descriptor, England 2015-16

Therapy Type	Anxiety	Depression
Guided Self Help (Book)	55.2%	49.0%
Other Low Intensity	43.8%	41.3%
Psychoeducational peer support	44.2%	45.6%
Non-guided Self Help (Book)	42.2%	37.0%
Behavioural Activation (Low Intensity)	44.3%	48.1%
Guided Self Help (Computer)	53.6%	51.6%
Non-Guided Self Help (Computer)	60.2%	56.6%
Structured Physical Activity	51.1%	41.7%
Employment Support (Low Intensity)	39.7%	24.1%
Ante/post natal counselling	53.2%	53.8%
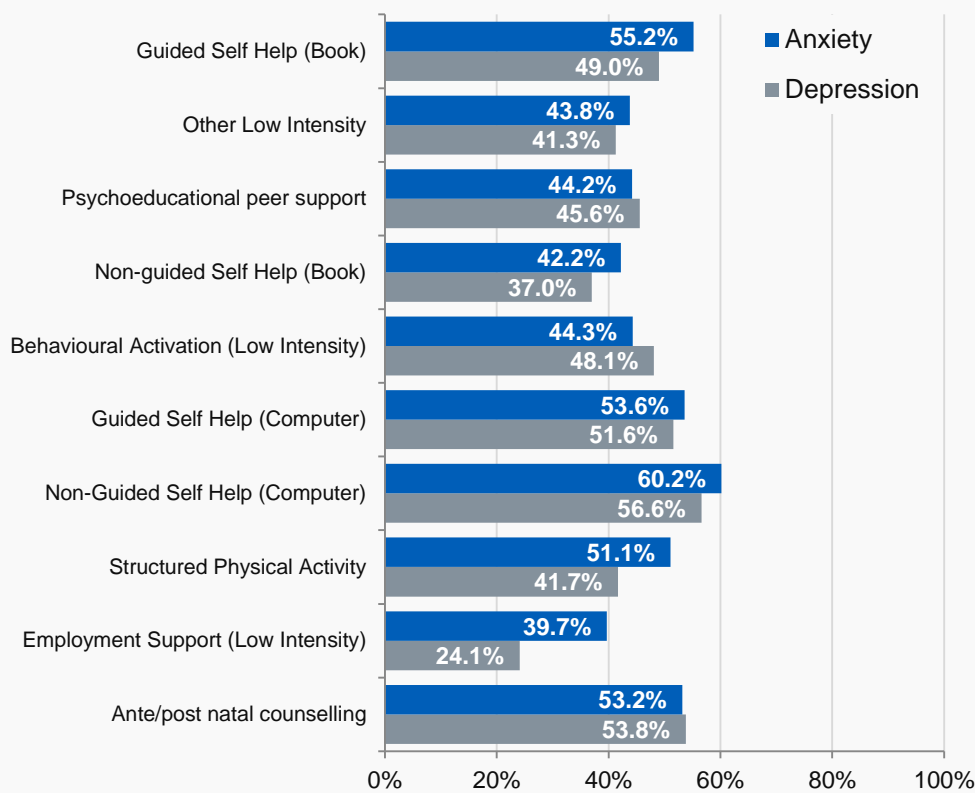
Figure 3c below gives a count of the number of referrals finishing a course of treatment having started at caseness (i.e. the denominator for the recovery rate calculation above), split by high intensity therapy types. It shows that 152,452 referrals, or 32.6% of all referrals where a

therapy type has been assigned[17], received 'Cognitive Behaviour Therapy (CBT)' as their last recorded therapy type. Conversely, just 57 referrals, or 0.01% of all referrals where a therapy type has been assigned, received 'Employment support (high intensity)' as their last recorded therapy type. Recovery rates based on those last recorded therapies with small numbers should be interpreted with caution.

Figure 3c: Number of referrals finishing a course of treatment having started at caseness, by therapy type (high intensity therapies), England 2015-16
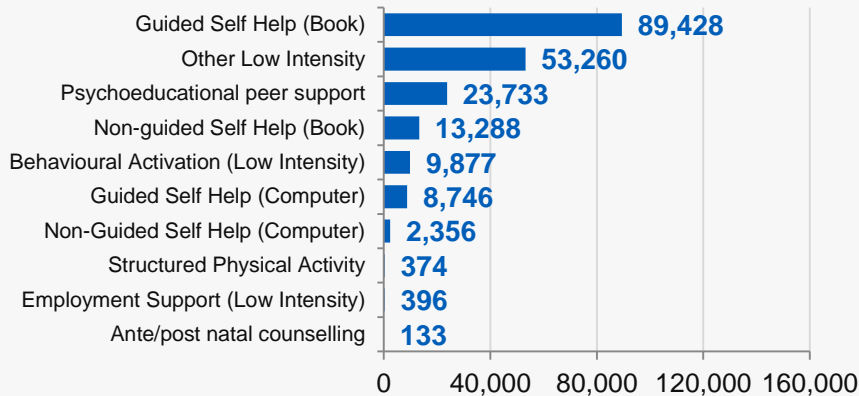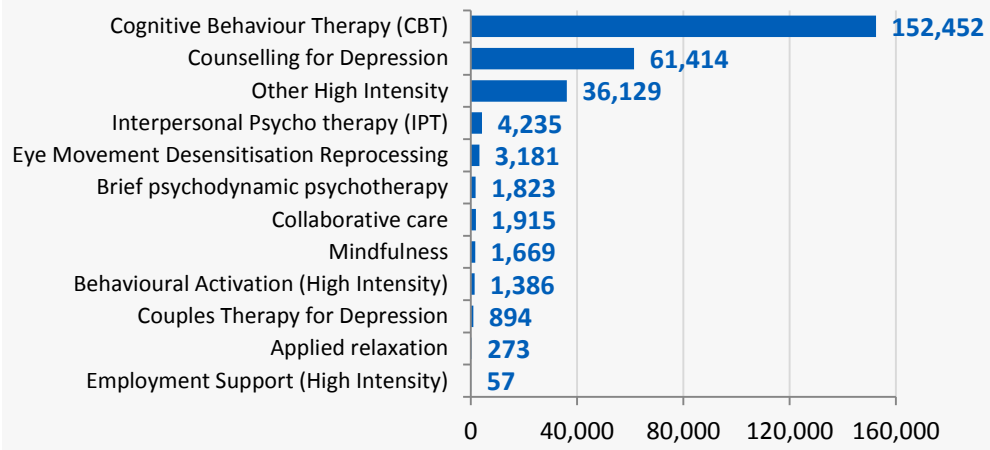

Those with more severe symptoms, or those with social anxiety disorder or Post-Traumatic Stress Disorder, would be expected to receive high intensity therapies from the start of their treatment.

Figure 3d below shows recovery rates for each high intensity therapy type and problem. For both depression and for anxiety and stress-related disorders, the highest recovery rate is for 'couples' therapy for depression'. The lowest recovery rate for depression is for 'collaborative care', and for anxiety and stress-related disorders the lowest recovery rate is for 'employment support'.

---

[17] It is possible for an appointment to have no therapy types recorded and still meet the definition of a treatment appointment. Further, only version 1.5 therapy types have been used in this analysis. Where the last recorded therapy type is a version 1.0 code, the referral has not been included in analyses by therapy type. Full details can be found in Appendix 5 at the end of this report.

Figure 3d: Recovery rate by therapy type (high intensity therapies) and problem descriptor, England 2015-16

Therapy type	Anxiety	Depression
Cognitive Behaviour Therapy (CBT)	49.0%	45.9%
Counselling for Depression	46.7%	47.6%
Other High Intensity	46.1%	46.9%
Interpersonal Psycho therapy (IPT)	47.0%	54.3%
Eye Movement Desensitisation Reprocessing	50.3%	56.0%
Brief psychodynamic psychotherapy	50.0%	45.9%
Collaborative care	45.2%	25.7%
Mindfulness	50.5%	53.4%
Behavioural Activation (High Intensity)	40.8%	41.1%
Couples Therapy for Depression	61.8%	58.8%
Applied relaxation	48.1%	36.8%
Employment Support (High Intensity)	34.8%	46.7%

Recovery rates by Clinical Commissioning Group

The NHS in England is split into Clinical Commissioning Groups (CCGs), who commission services in their area. In IAPT, it is possible for providers of services to work on behalf of CCGs other than the one in which they operate, for example because of patients who may live near the border of two CCGs. Please note that throughout this report, data presented for CCGs includes 2 Commissioning Hubs – East Commissioning Hub and National Commissioning Hub 1 – that are responsible for specialised commissioning of IAPT services.

Figure 4 below shows recovery rates in the year for each CCG, colour-coded into five groupings with equal distribution[18].

Figure 4: Recovery rates by Clinical Commissioning Group (CCG), 2015-16
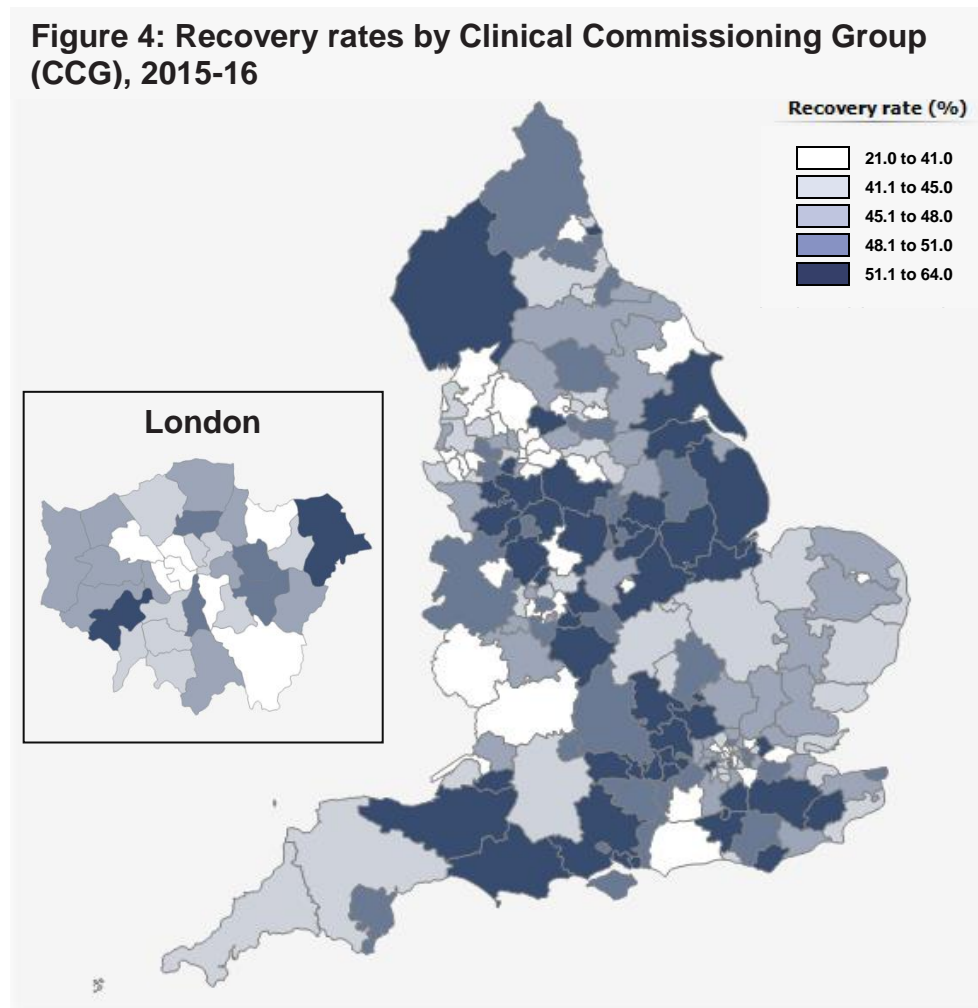
Figure 4 shows that there is considerable variation in recovery rates between CCGs. The lowest recovery rate amongst CCGs was 21.4% (NHS Leicester City CCG) and the highest recovery rate was 63.2% (NHS Bath and North East Somerset CCG).

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

---

[18] Equal distribution means that the CCGs have been split into 5 groups, with approximately the same number of CCGs in each group.

Recovery by patient demographics

The IAPT dataset captures a range of patient demographics, which can be used to assess the variation in outcome for different types of service user. Information about recovery by deprivation, for those with long-term health conditions, and for ex-British Armed Forces personnel and their dependents, are described in a separate section.

Recovery by age and gender

Figure 5: Recovery rates by age[19] and gender, 2015-16

■ Females ■ Males

Age group	Females	Males
65 and over	60.0%	61.4%
36 to 64	47.4%	46.9%
18 to 35	43.3%	43.0%
16 to 17	35.5%	43.3%
Under 16	48.1%	71.4%

100%   50%   0%   50%   100%
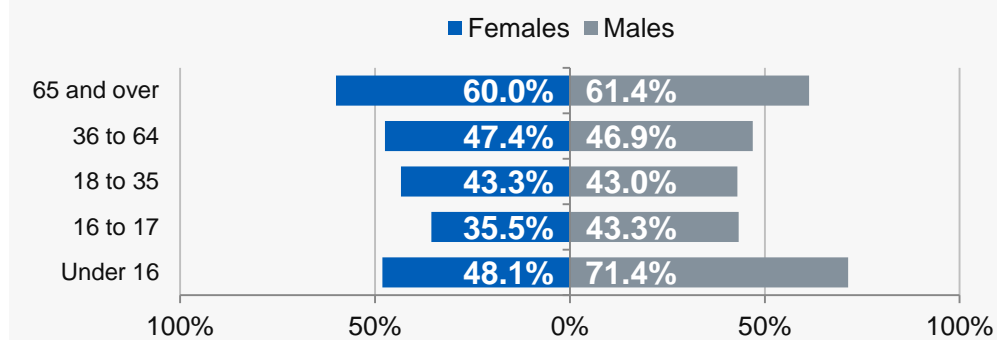
Figure 5[19] shows that recovery rates are similar between males and females, and are generally higher amongst older patients. Please note that rates for under 16s are based on small numbers; this is because this age group is predominantly covered by the Children and Young Persons IAPT data collection (CYP IAPT)[20] and so the figures here will not be a full representation of the activity for this age group.

When analysed solely by age group, 60.4% of those aged 65 and over moved to recovery in 2015-16, compared to 45.4% of referrals for patients of working age (18 to 64).

Recovery rates by age and gender at Clinical Commissioning Group level are published in **Table 8b** of the accompanying data tables.

Recovery

60.4%

of eligible referrals aged 65 and over moved to recovery, compared to 45.4% of eligible referrals aged between 18 and 64.

---

[19] A small number of patients under the age of 16 are recorded as accessing the adult IAPT services covered by this dataset.
[20] See http://www.digital.nhs.uk/mhsds for further information about CYP-IAPT.

Recovery by ethnicity

Figure 6: Recovery rates by ethnicity and gender, 2015-16

■ Females ■ Males

Ethnicity	Females	Males
Asian or Asian British - Bangladeshi	38.8%	34.6%
Asian or Asian British - Indian	43.3%	41.7%
Asian or Asian British - Pakistani	36.0%	33.5%
Asian or Asian British - Any other Asian background	37.5%	34.7%
Black or Black British - African	41.8%	37.0%
Black or Black British - Caribbean	43.4%	41.0%
Black or Black British - Any other Black background	42.0%	37.6%
Mixed - White and Asian	41.2%	44.0%
Mixed - White and Black African	43.3%	40.9%
Mixed - White and Black Caribbean	38.3%	36.4%
Mixed - Any other mixed background	40.5%	39.8%
White - British	47.6%	47.9%
White - Irish	50.5%	45.8%
White - Any other White background	47.2%	45.0%
Other Ethnic Groups - Chinese	46.8%	45.6%
Any other ethnic group	37.4%	34.2%

100% 50% 0% 50% 100%

Figure 6 shows that recovery rates are higher amongst white ethnicities compared to all other ethnicities. White – Irish females had the highest recovery rate (50.5%) and the lowest recovery rate was for Asian or Asian British - Pakistani males (33.5%).

Recovery rates by ethnicity at Clinical Commissioning Group level are published in **Table 9b** of the accompanying data tables.

Recovery by sexual orientation

Figure 7: Recovery rates by sexual orientation, 2015-16

Sexual orientation	Recovery rate
Heterosexual	48.0%
Gay/Lesbian	43.3%
Bi-sexual	36.2%
Person asked and does not know or is not sure	35.5%
Unknown	43.8%
Not stated	44.2%

0% 20% 40% 60% 80% 100%

Figure 7 shows that recovery rates are highest amongst heterosexual patients and lowest amongst bi-sexual patients and those who do not know or are not sure.

Recovery rates by sexual orientation at Clinical Commissioning Group level are published in **Table 10b** of the accompanying data tables.

Recovery by disability

Figure 8: Recovery rates by disability, 2015-16

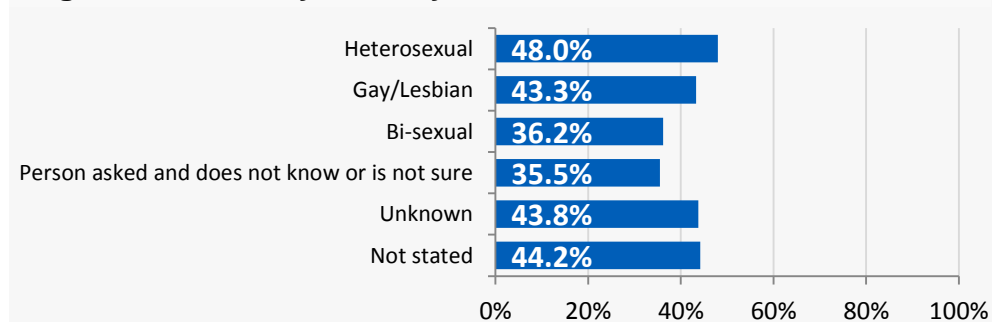| Disability	Recovery rate
No disability	47.8%
Hearing	47.2%
Sight	42.0%
Speech	38.8%
Progressive Conditions and Physical Health	38.7%
Memory or ability to concentrate, learn or understand	36.9%
Other	36.7%
Manual Dexterity	36.2%
Behaviour and Emotional	34.3%
Mobility and Gross Motor	34.2%
Perception of Physical Danger	28.3%
Personal, Self Care and Continence	27.9%
Not Stated	42.3%
Invalid code	29.8%
No code recorded	47.2%

Figure 8 shows that recovery rates where a disability has been recorded are generally lower than the overall national recovery rate. This difference is less pronounced for disabilities such as hearing, which is higher than the overall recovery rate, and sight. It is more pronounced for disabilities such as perception of physical danger and personal, self-care and continence.

It is important to note that multiple disabilities can be recorded for a single referral, and so some referrals will be counted twice or more in the chart above.

Recovery rates by disability at Clinical Commissioning Group level are published in **Table 11b** of the accompanying data tables.

Recovery by religion

Figure 9: Recovery rates by religion, 2015-16

Figure 9 shows that recovery rates are highest amongst Jain, Christian and Jewish patients, and lowest amongst Pagan and Muslim patients.

Recovery rates by religion at Clinical Commissioning Group level are published in **Table 12b** of the accompanying data tables.
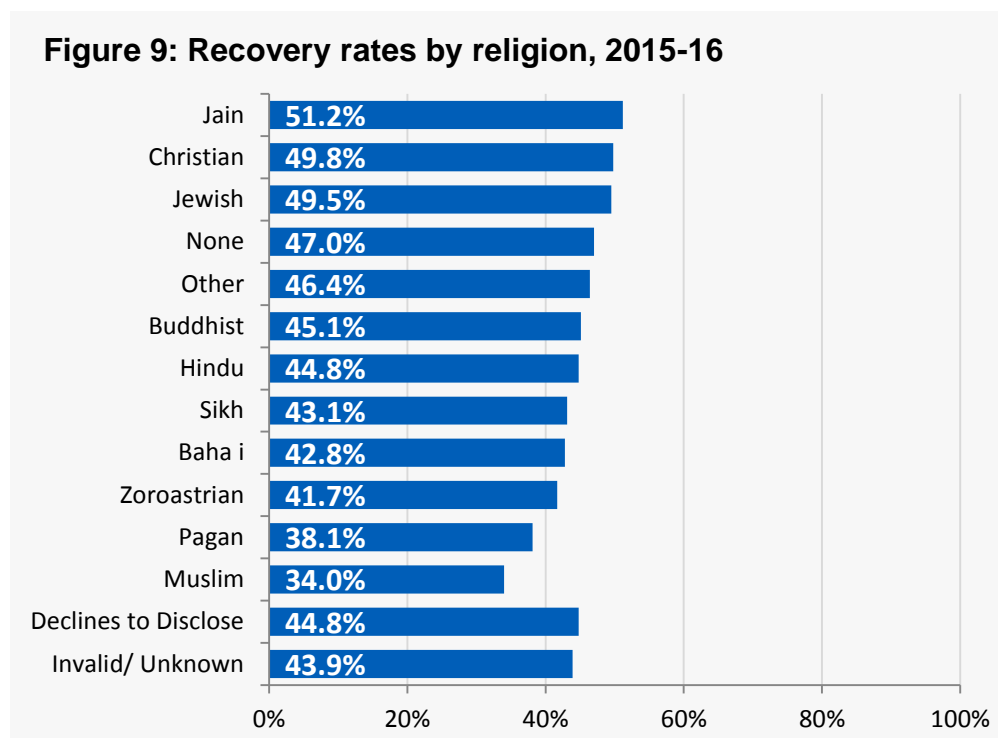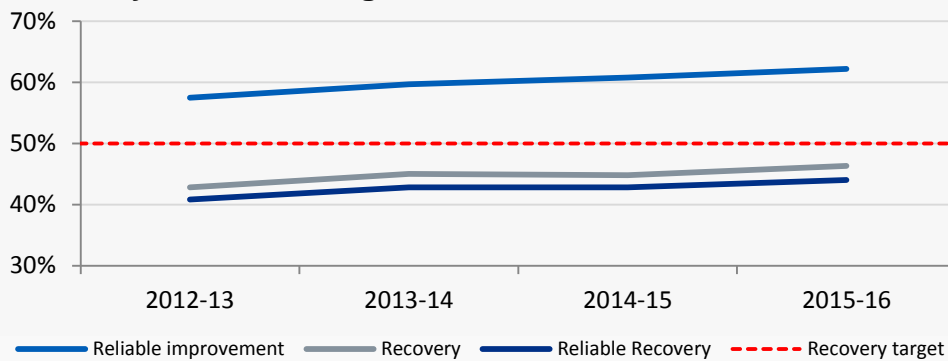
Reliable improvement and reliable recovery

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

A referral has shown reliable improvement if there is a significant improvement in their condition following a course of treatment. This is measured by the difference between their first and last scores on questionnaires tailored to their specific condition.

A referral has reliably recovered if they meet the criteria for both the recovery and reliable improvement measures. That is, they have moved from being a clinical case at the start of treatment to not being a clinical case at the end of treatment, and there has also been a significant improvement in their condition.

Reliable improvement

62.2%

of referrals finishing a course of treatment showed reliable improvement.

Figure 10: Reliable improvement, recovery, and reliable recovery over time, England, 2012-13 to 2015-16

The above chart compares recovery, reliable improvement, and reliable recovery rates year-on-year over the course of the IAPT dataset. Consistently, a higher proportion show reliable improvement than move to recovery; this is because reliable improvement only looks at the scale of change, and not whether the referral has moved below the clinical caseness threshold. Reliable recovery, which requires both recovery and reliable improvement, is the most stringent measure and therefore has the lowest rate.

For further information about these measures, see Appendix 3 to this report.

Calculating reliable improvement rates

$$\frac{\text{Number of referrals that showed reliable improvement}}{\text{Number of referrals that finished a course of treatment}} \times 100$$

In 2015-16, this calculation is performed as follows:

$$\frac{333,962}{537,131} \times 100 = 62.2\%$$

Reliable improvement by Clinical Commissioning Group

Figure 11 below shows reliable improvement rates in the year by CCG.

Figure 11: Reliable improvement rates by Clinical Commissioning Group (CCG), 2015-16

Figure 11 shows that there is considerable variation in reliable improvement rates between CCGs. The lowest reliable improvement rate was 35.4% (NHS Gloucestershire CCG) and the highest was 80.1% (NHS South West Lincolnshire CCG).

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

Rates for various demographic breakdowns, for those with long term health conditions, and for ex-British Armed Forces personnel and their dependents, are also available in the accompanying data tables.

Calculating reliable recovery rates

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

In 2015-16, this calculation is performed as follows:

$$\frac{215,942}{\left(537,131 - 46,736 \right)} \times 100 = 44.0\%$$

Reliable recovery

44.0%

of eligible referrals showed reliable recovery.

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

Reliable recovery by Clinical Commissioning Group

Figure 12 below shows reliable recovery rates in the year by CCG.

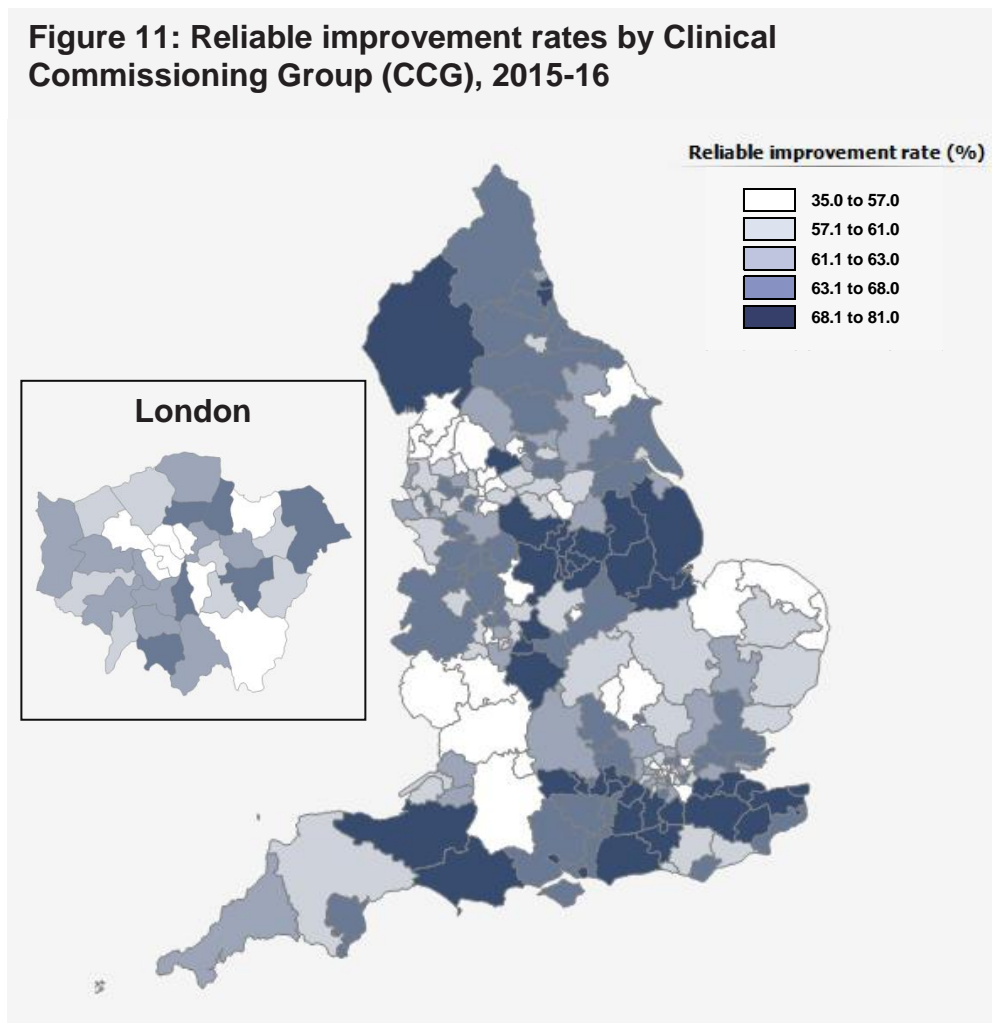**Figure 12: Reliable recovery rates by Clinical Commissioning Group (CCG), 2015-16**
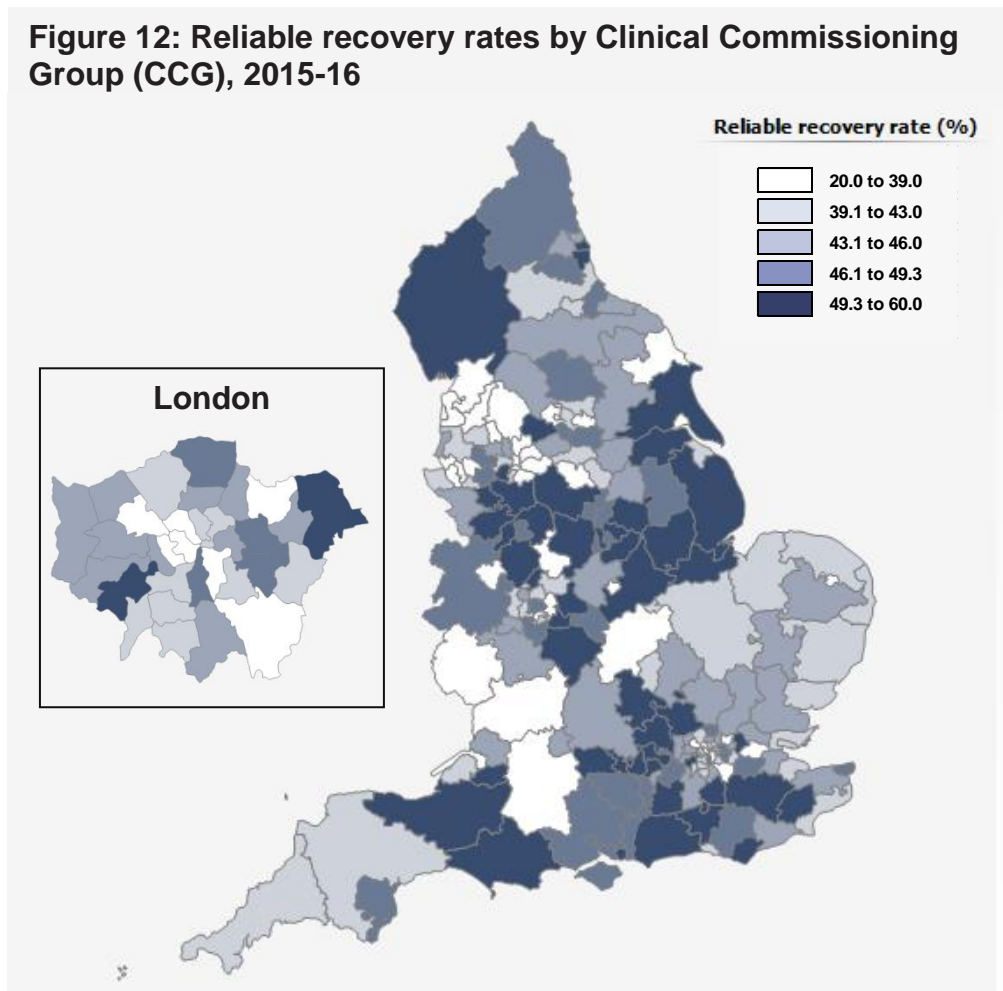
Figure 12 shows that there is considerable variation in reliable recovery rates between CCGs. The lowest reliable recovery rate amongst CCGs was 20.4% (NHS Leicester City CCG) and the highest reliable recovery rate was 58.7% (NHS South West Lincolnshire CCG).

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

Rates for various demographic breakdowns, for those with long term health conditions, and for ex-British Armed Forces personnel and their dependents, are also available in the accompanying data tables.

Waiting times

One of the stated targets of the IAPT programme is that for new referrals, 75% enter treatment within 6 weeks, and 95% within 18 weeks[21]. These are based on the waiting time between the referral date and the first attended treatment appointment, for referrals finishing a course of treatment in the year[22].

In 2015-16, 81.3% of referrals were seen within 6 weeks, and 96.2% were seen within 18 weeks – both above the targets.

Figure 13: Distribution of waiting times between referral and first attended treatment appointment for referrals finishing a course of treatment in 2015-16, England
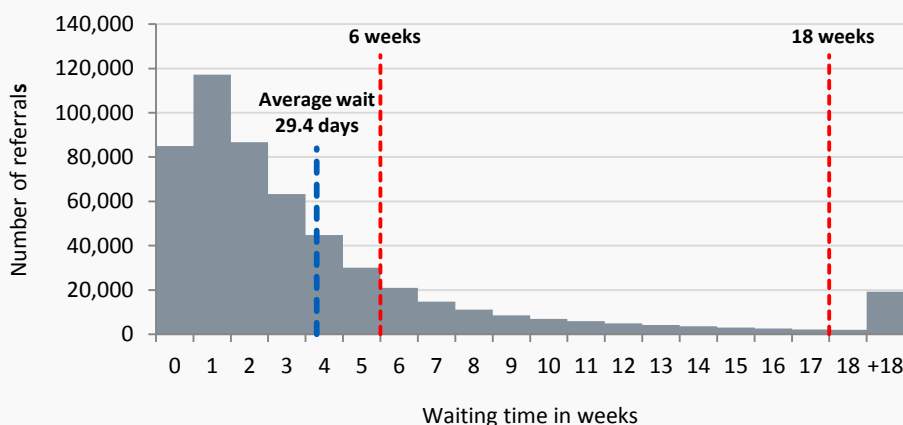
Figure 13 shows that the peak number of referrals entered treatment between 7 and 14 days (117,130 referrals), with only 3.8% (20,347) of referrals waiting over 18 weeks to enter treatment.

The average waiting time to enter treatment was 29.4 days. There is wide variation across CCGs in average waiting times; the shortest average wait was 5.9 days (NHS South Tyneside CCG) and the longest was 139.3 days (NHS Wirral CCG).

Calculating waiting times rates

$$\frac{\text{Number of referrals that finished treatment and waited less than 6 weeks to enter treatment}}{\text{Number of referrals that finished a course of treatment}} \times 100$$

---

[21] See p16-17 of *The Mandate: A mandate from the Government to NHS England: April 2015 to March 2016*, p 16-17, available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386221/NHS_England_Mandate.pdf
[22] Comparisons with previous years waiting times should be made with caution, as these were previously based on referrals entering treatment in the year.

In 2015-16, this calculation is performed as follows (based on 6 week target):

$$\frac{436{,}546}{537{,}131} \times 100 = 81.3\%$$

Further measures about waiting times at Clinical Commissioning Group level are published in **Tables 2a and 2b** of the accompanying data tables.

Waiting times by Clinical Commissioning Group

Figure 14 below shows the rate for referrals entering treatment within 6 weeks by CCG.

Figure 14: Percentage of referrals entering treatment within 6 weeks, by Clinical Commissioning Group (CCG), 2015-16
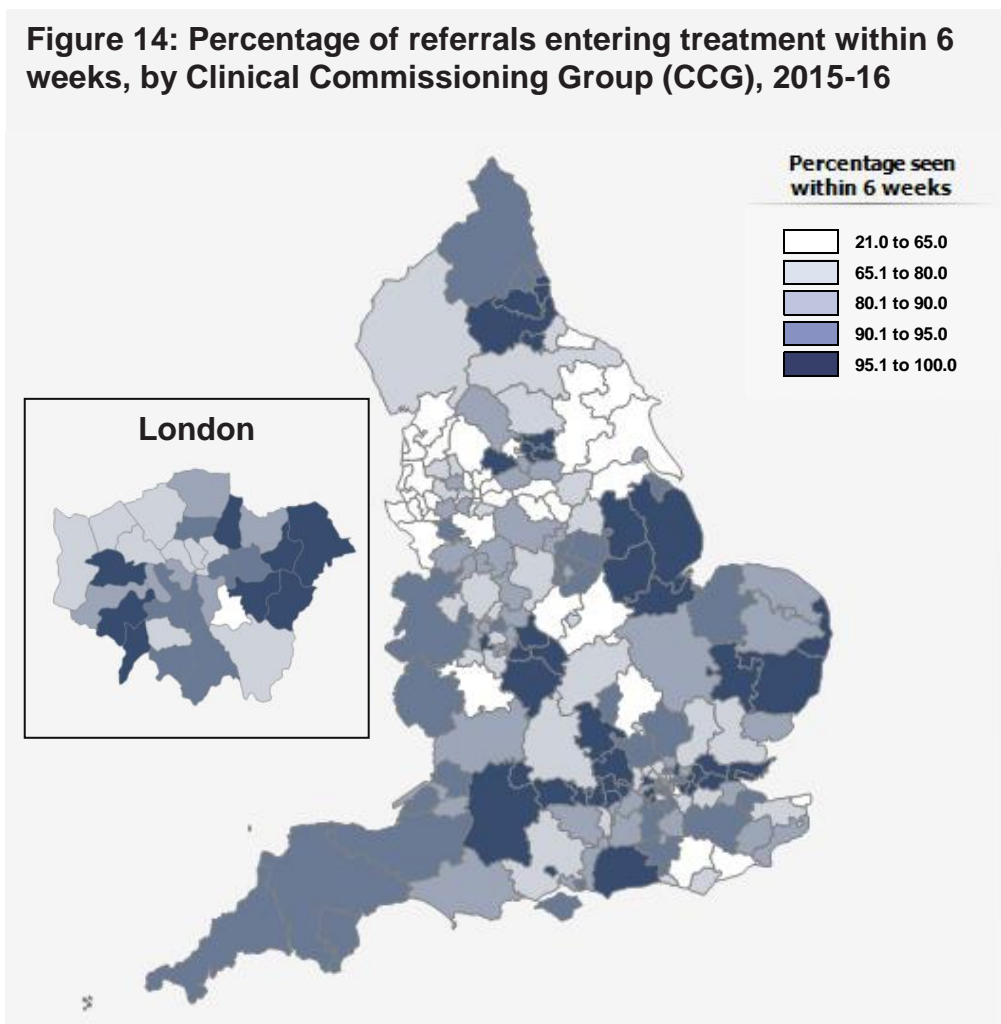
Figure 14 show that there is considerable variation between CCGs in rates of referrals entering treatment within targets.

For referrals entering treatment within 6 weeks, the lowest rate amongst CCGs was 21.2% (NHS Eastern Cheshire CCG) and the highest rate was 99.5% (NHS South Lincolnshire CCG).

For referrals entering treatment within 18 weeks, the lowest rate amongst CCGs was 57.2% (NHS Lancashire North CCG) and the highest rate was 100% (17 CCGs).

Waiting times at Clinical Commissioning Group level are published in **Tables 2a and 2b** of the accompanying data tables.

Waiting times by therapy type

NICE's recommendations vary according to the type of problem and its severity[23].

For many mild to moderate cases, NICE recommends a stepped care model[24] - meaning that low intensity therapies[25] are first offered, and those who do not recover as a result of this are 'stepped up' to a high intensity therapy.

Those with more severe symptoms, or those with Social Anxiety Disorder or Post-Traumatic Stress Disorder, would be expected to receive high intensity therapies from the start of their treatment.

A note about reporting by therapy type

Therapy types are recorded at each treatment appointment with a patient, and a patient can have several appointments during the course of a referral. This means that therapy type can change between appointments, and in a single referral two or more therapy types could be recorded.

Subsequently, when categorising patients' waiting times by therapy type, a clear method needs to be adopted to choose the therapy type most representative of the treatment the patient has received across their referral. It has been decided to use the last recorded therapy type here. A full description of the methodology can be found in the 'Constructions' tab of the data tables that accompany this report.

The charts below show waiting times rates for each therapy type. Figure 15a shows rates for all low intensity therapy types, and Figure 15b shows rates for all high intensity therapy types.

---

[23] See https://www.nice.org.uk/guidance/published?type=cg for further details; use the search function on the page to find guidance around specific problems.
[24] See Appendix 5.
[25] A full list of low and high intensity therapies in IAPT can be found in Appendix 5.

Figure 15a: Waiting times rates by therapy type (low intensity therapies) for referrals finishing a course of treatment in 2015-16, England

Therapy Type	Less than 18 weeks	Less than 6 weeks
Employment Support (Low Intensity)	95.7%	89.4%
Other Low Intensity	97.1%	83.1%
Psychoeducational peer support	99.1%	90.6%
Ante/post natal counselling	94.9%	84.8%
Structured Physical Activity	99.3%	70.9%
Behavioural Activation (Low Intensity)	98.2%	83.2%
Non-Guided Self Help (Computer)	99.1%	91.4%
Guided Self Help (Computer)	97.9%	91.4%
Non-guided Self Help (Book)	98.9%	83.9%
Guided Self Help (Book)	98.6%	85.9%

■ Less than 18 weeks ■ Less than 6 weeks
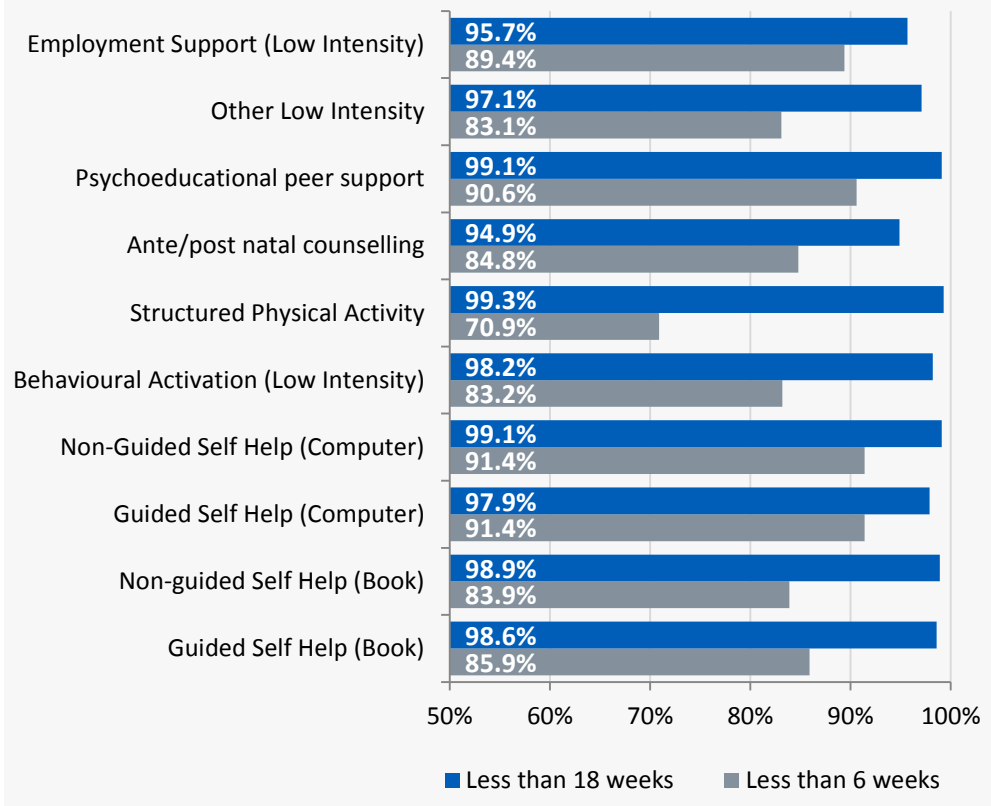
Figure 15a shows waiting times rates for each low intensity therapy type. For the 6-week target, the lowest waiting times rate achieved was for 'Structured Physical Activity' (70.9% seen within 6 weeks), however, this also had the highest waiting time rate achieved against the 18-week target (99.3% seen within 18 weeks).

Across low intensity therapy types, performance against the 6-week target was considerably more variable than performance against the 18-week target.

Figure 15b: waiting times rates by therapy type (high intensity therapies) for referrals finishing a course of treatment in 2015-16, England
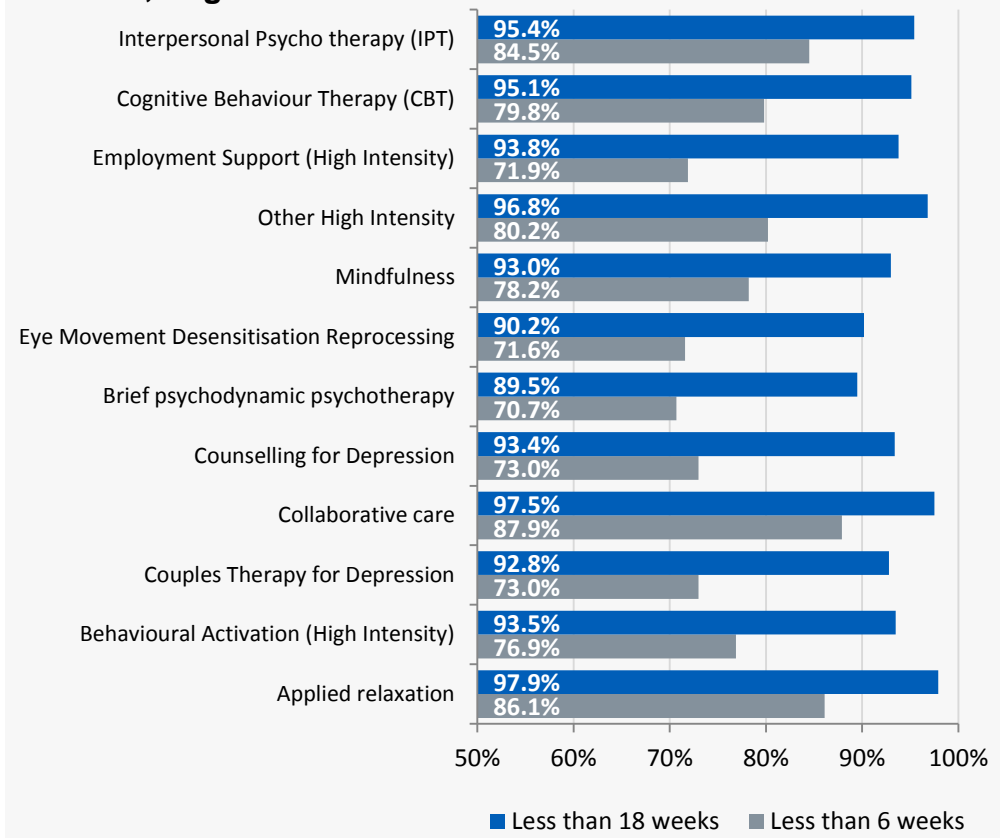
Figure 15b shows waiting times for each high intensity therapy type. The lowest waiting times rates achieved against both the 6-week and 18-week targets are for 'Brief psychodynamic psychotherapy' (70.7% seen within 6-weeks and 89.5% seen within 18 weeks). The highest waiting times rate achieved against the 6-week target is for 'Collaborative care' (87.9% seen within 6 weeks) and the highest rate achieved against the 18-week target is for 'Applied relaxation' (97.9% seen within 18 weeks).

Across low intensity therapy types, performance against the 6-week target is considerably more variable than performance against the 18-week target, and high intensity therapies generally have more varied performance against waiting times targets than low intensity therapies.

Waiting times by therapy type at Clinical Commissioning Group level are published in **Table 2c** of the accompanying data tables.

Waiting times between first and second treatment appointments

As well as monitoring waiting times between referral received date and first treatment appointment, it is also informative to monitor waiting times between first treatment appointment and second treatment appointment. This is important for monitoring abnormal waiting times once a course of treatment has begun, to ensure that referrals experience a continuity of service in their treatment.

Figure 16: Distribution of waiting times between first and second attended treatment appointments for referrals finishing a course of treatment in 2015-16, England
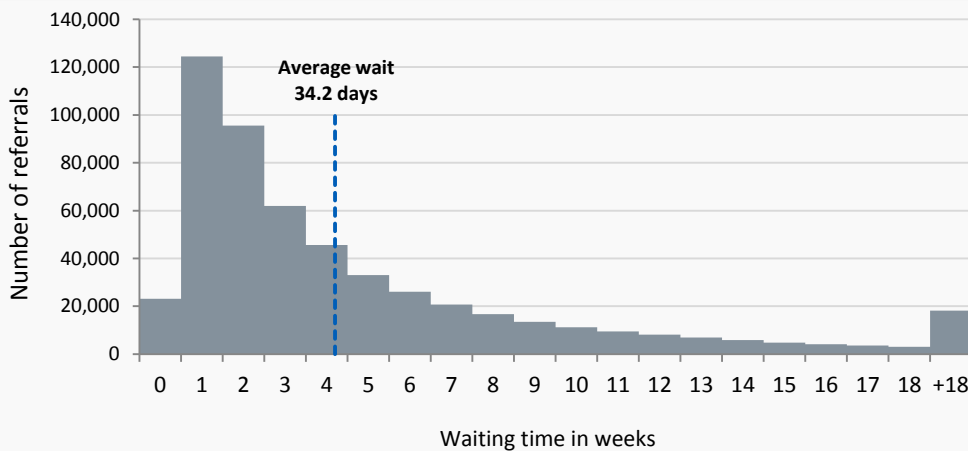
Figure 16 shows that the peak number of referrals had a second treatment appointment between 7 and 14 days (124,442 referrals). In total, 305,057 referrals that finished a course of treatment in 2015-16 waited less than 4 weeks to have a second treatment appointment, 56.9% of all referrals finishing a course of treatment in 2015-16.

The average waiting time between first and second treatment appointment was 34.2 days. There is wide variation across CCGs in average waiting times to second treatment appointment; the shortest average wait was 11.6 days (NHS Thanet CCG) and the longest was 97.3 days (NHS Crawley CCG).

Waiting times between first and second treatment appointments at Clinical Commissioning Group level are published in **Tables 2a and 2b** of the accompanying data tables.

Activity

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

There are four key stages in an IAPT pathway:

- **Referral received:** This is the date on which an IAPT care provider receives a referral for a patient. In 2015-16, there were 1,399,088 new referrals to IAPT care providers.
- **Referral enters treatment:** This is the date of a patient's first attended treatment appointment. In 2015-16, 953,522 referrals entered treatment.
- **Appointments:** Appointments are the way in which patients' contact with IAPT services is recorded. There are a range of appointment types in IAPT, such as assessment, treatment, and review. In 2015-16, there were a total of 4,262,848 attended appointments (of any kind).
- **Referral ends:** A referral most commonly ends having completed a course of IAPT treatment, but there are other reasons a referral may end, such as the patient declining treatment. In 2015-16, 1,299,525 referrals ended, of which 537,131 completed a course of treatment.

Figure 17: Referrals received, entered treatment, ended, and finished treatment in 2015-16, England[26]
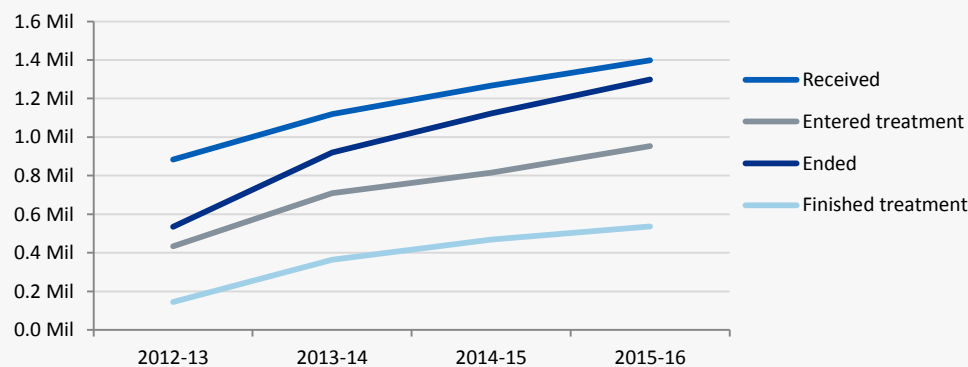
Figure 17 shows that activity of all types has continued to increase over time.

It is important to note that these numbers are not based on the same group of referrals as each other. A referral that was received in 2015-16 did not necessarily enter treatment[26] in this year, and is less likely again to have ended in the year. Likewise, referrals that ended in 2015-16 may have been received or entered treatment before 2015-16.

---

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

The number of referrals that finished a course of treatment is a subset of all referrals that ended in the year. In 2015-16, 41.3% of referrals that ended had finished a course of IAPT treatment. Referrals can end having had different levels of contact with the service; further information can be found in the section "Referrals ending", found on page 41.

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

Referrals received

A referral is generated when a person is referred to IAPT services. One individual can only have one referral for a given provider at any one time, but can have multiple referrals across different providers, or could receive more than one referral over the course of the year. A count of referrals, therefore, is not a count of people.

In 2015-16 there were:

- 1,399,088 new referrals to IAPT care providers, and
- 1,383,085 people[27] referred to IAPT care providers.

There are several reasons for there being more referrals than people:

- A patient may have finished a referral to IAPT services, but been referred again later in the year;
- A patient may make multiple service requests across different providers;
- A patient may be 'stepped up' to high intensity treatment, or 'stepped down' to low intensity treatment and this may need to be referred to a new provider[28].

---

[27] This is a count of unique person identifiers with an associated referral received in in 2015/16 and does not include bypass patients. For further details, see Appendix 2.
[28] This generates a new referral, despite the step being part of a single spell of care. It is not currently possible to track these individuals across providers within the IAPT dataset and so this is also likely to contribute to the issue of multiple referrals being received in the year for a single service user.

Referrals received by age and gender

Figure 18: Referrals received by age group[29] and gender, England, 2015-16
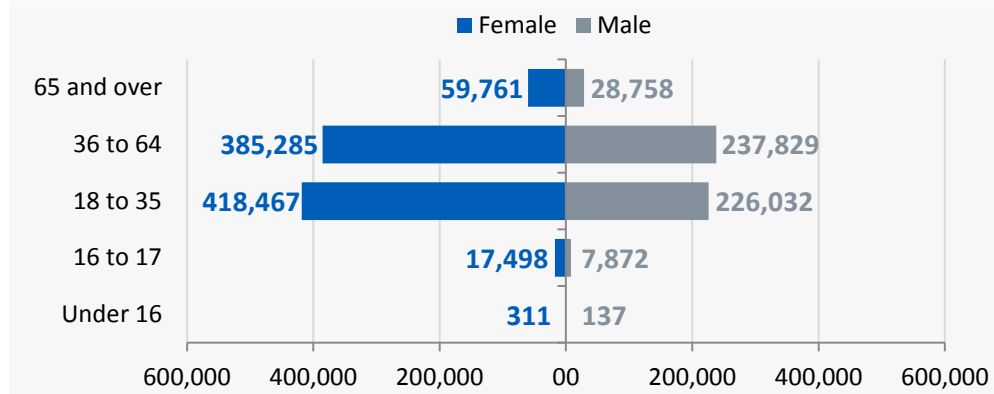
Figure 18[29] shows that users of IAPT services are predominantly female, and of these, the majority are aged 18 to 35. For both male and female referrals, the majority are of working age. Please note that counts for under 16s are small because this age group is predominantly covered by the Children and Young Persons IAPT data collection (CYP IAPT)[30] and so the figures here will not be a full representation of the activity for this age group.

Counts of referrals received by a range of patient demographics at Clinical Commissioning Group level are published in **Table 8a, 9a, 10a, 11a, 12a, and 13a** of the accompanying data tables.

Referrals received by problem

NICE recommend that particular therapies are given to treat specific IAPT-relevant problems[31,32] (also known as 'problem descriptor' in the data).

Figures 19a and 19b below show the number of referrals received by each type of problem. Figure 19a shows the primary problem, i.e. the main category in the classification. Figure 19b shows the secondary problems (subcategories) for those with anxiety and stress-related disorders.

---

[29] A small number of patients under the age of 16 are recorded as accessing the adult IAPT services covered by this dataset.
[30] See http://www.digital.nhs.uk/mhsds for further information about CYP-IAPT.
[31] Problem descriptor codes are based on ICD-10 international standards for the classification of diseases and have been grouped for presentation purposes. For further information, see the 'Constructions' worksheet of the data tables that accompany this report, as well as the IAPT Technical Output Specification, available from http://www.digital.nhs.uk/iapt.
[32] For more information about which therapies are recommended for each problem descriptor, see https://www.nice.org.uk/guidance/published?type=cg for further details; use the search function on the page to find guidance around specific problems.

Figure 19a: Referrals received by primary problem, England, 2015-16

Primary problem	Count
Depression	224,794
Anxiety and stress related disorders (Total)	429,620
Other Mental Health Problems	90,331
Other Recorded Problems	24,813
Invalid Data Supplied	2,568
Unspecified	626,962
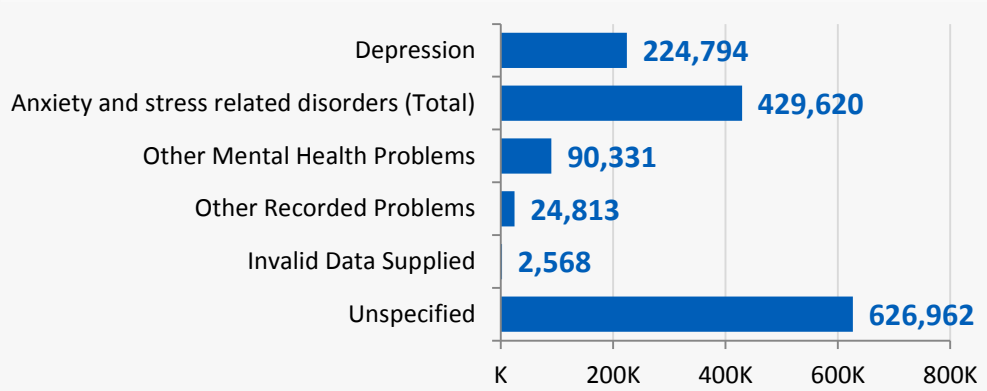
Figure 19a shows that 44.8% of recorded problems for referrals received in 2015-16 were unspecified. Most referrals last for several months and information about the problem to be treated may not be recorded until the patient has been seen and assessed. It is therefore to be expected that not all referrals received in the year (some of which may not have been seen or assessed) will have a problem descriptor recorded. Problem can be recorded in every monthly submission until the referral ends.

Figure 19b: Referrals received by secondary problem for those with a primary problem of anxiety, England, 2015-16

Secondary problem	Count
Mixed anxiety and depressive disorder	222,258
Generalised Anxiety Disorder	105,451
Other anxiety or stress related disorder	24,777
Post-traumatic stress disorder	21,883
Panic disorder [episodic paroxysmal anxiety]	17,902
Social phobias	14,333
Obsessive-compulsive disorder	13,123
Specific (isolated) phobias	5,484
Agoraphobia	4,409
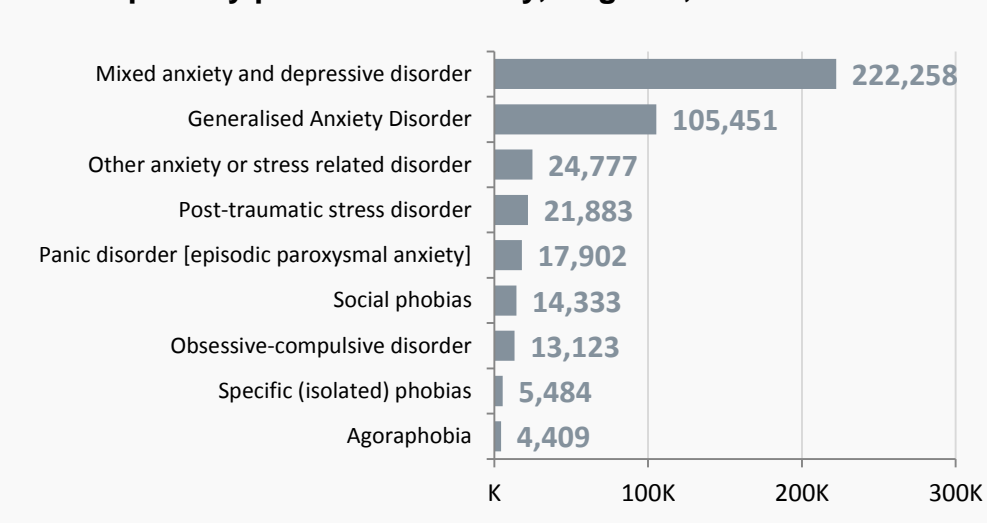
Figure 19b shows that 51.7% of secondary problems (where the primary problem was anxiety) were for 'Mixed anxiety and depressive disorder'.

Counts of referrals received by problem at Clinical Commissioning Group level are published in **Table 1b** of the accompanying data tables.

Referrals received by Clinical Commissioning Group

Figure 20 below shows number of referrals received in the year by CCG.

Figure 20: Number of referrals received by Clinical Commissioning Group, 2015-16
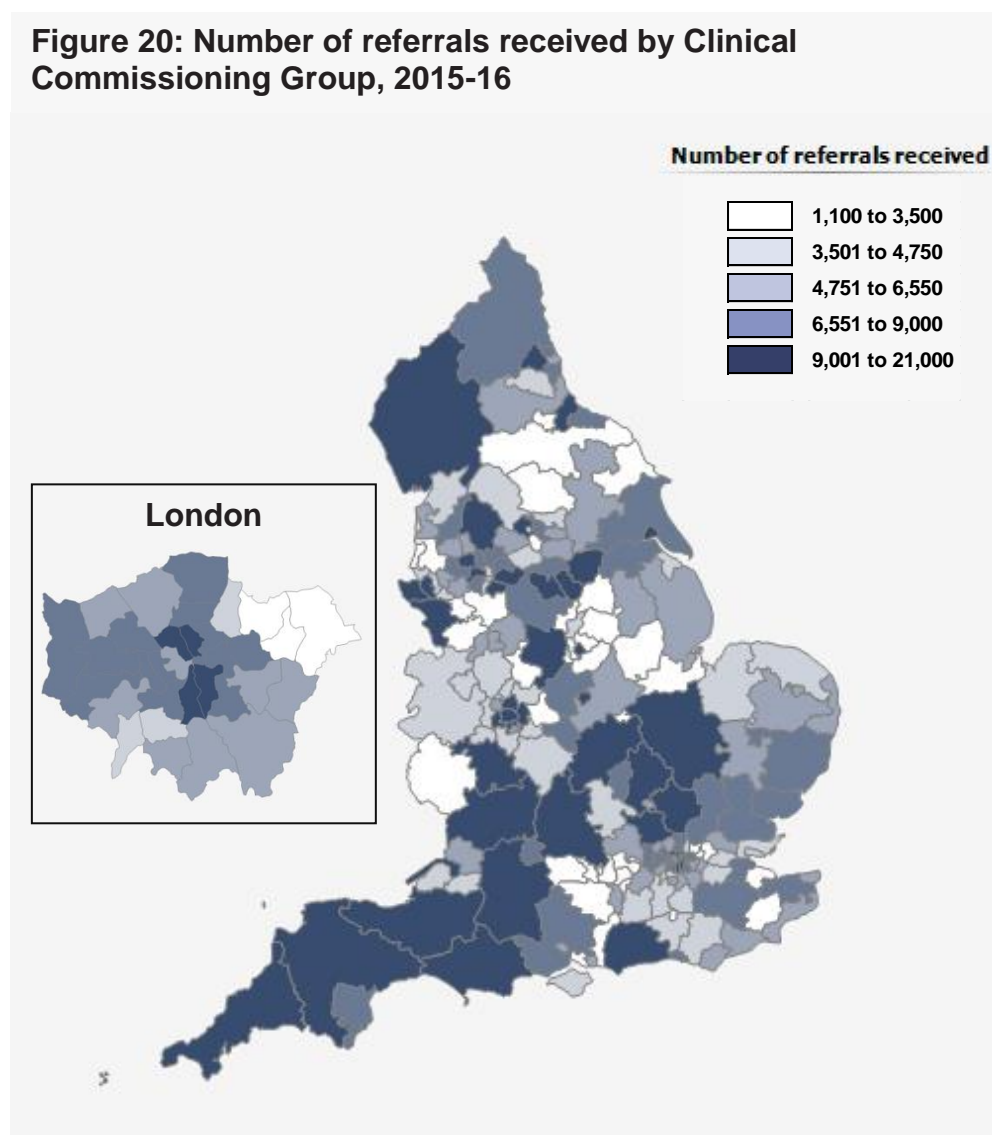
Figure 20 shows that there is considerable variation in volumes of referrals received between CCGs. The smallest number of referrals received was in NHS Surrey Heath CCG (1,150 referrals) and the largest number in NHS Sheffield CCG (20,320 referrals).

Counts of referrals received by Clinical Commissioning Group level are published in **Table 1a** of the accompanying data tables.

Referrals entering treatment

Once an individual has been referred to IAPT services, they should be assessed and, if appropriate, enter treatment.

In order to be classed as having entered treatment in 2015-16, a referral must have attended at least one treatment appointment[33] in the year.

In 2015-16, 953,522 referrals entered treatment.

Not all referrals enter treatment, as a patient may be discharged or otherwise choose not to continue in the service. In 2015-16, 440,629 (33.9% of referrals ending in the year) ended before entering treatment, of which 405,974 (92.1%) did not attend any type of appointment.

Some referrals that entered treatment in 2015-16 will have been received in 2014-15. Similarly, some referrals that were received in 2015-16 will enter treatment in 2016-17.

Referrals entering treatment by age and gender

Figure 21: Referrals entering treatment by age and gender, England, 2015-16
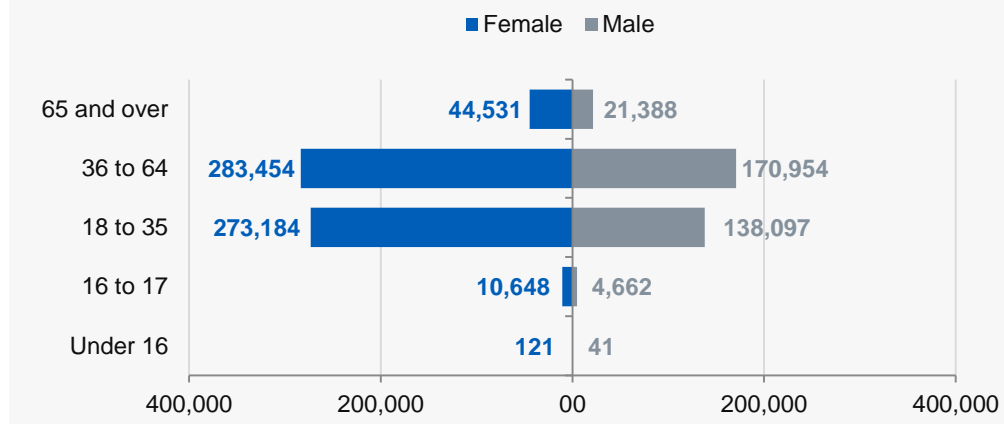
Figure 21[34] shows that the majority of referrals entering treatment are for females, those of working age in particular. Please note that counts for under 16s are small because this age group is predominantly covered by the Children and Young Persons IAPT data collection (CYP IAPT)[35] and so the figures here will not be a full representation of the activity for this age group.

---

[33] A treatment appointment in v1.5 of the IAPT dataset is one that is recorded as having an appointment type of 'treatment', 'assessment and treatment', or 'review and treatment'. This is different from previous years, which used the v1.0 definition, where a treatment appointment is one that has at least one valid treatment recorded. For full details, see the 'Methodological Change Paper – IAPT version 1.5 reports – November 2014', published at http://www.digital.nhs.uk/iaptmonthly.

[34] A small number of patients under the age of 16 are recorded as accessing the adult IAPT services covered by this dataset.

[35] See http://www.digital.nhs.uk/mhsds for further information about CYP-IAPT.

Counts of referrals received by a range of patient demographics at Clinical Commissioning Group level are published in **Table 8a, 9a, 10a, 11a, 12a, and 13a** of the accompanying data tables.

Referrals entering treatment by problem

NICE recommend that particular therapies are given to treat specific IAPT-relevant problems[36],[37] (also known as 'problem descriptor' in the data).

Figures 22a and 22b below show the count of referrals entering treatment with each type of problem. Figure 22a shows the primary problem, i.e. the main category in the classification. Figure 22b shows the secondary problems (subcategories) for those with anxiety and stress-related disorders.

A valid problem was recorded for 71.8% (684,307) of the referrals entering treatment in 2015-16, showing higher data completeness than for new referrals received.

Figure 22a: Referrals entering treatment by primary problem, England, 2015-16
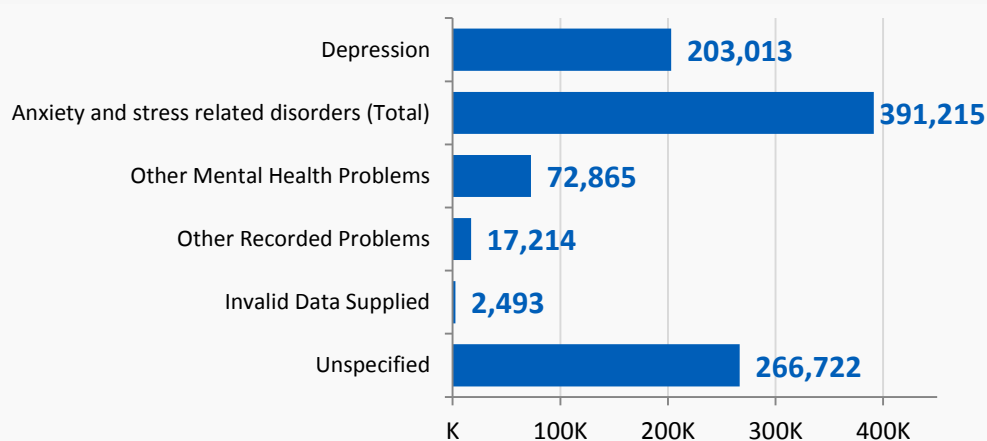
Figure 22a shows that the number of referrals entering treatment with anxiety and stress-related disorders is nearly double (391,215) that for depression (203,013); this is comparable to 2014-15, when the numbers were 296,665 and 154,627 respectively.

---

[36] Problem descriptor codes are based on ICD-10 international standards for the classification of diseases and have been grouped for presentation purposes. For further information, see the 'Constructions' worksheet of the data tables that accompany this report, as well as the IAPT Technical Output Specification, available from http://www.digital.nhs.uk/iapt.
[37] For more information about which therapies are recommended for each problem descriptor, see https://www.nice.org.uk/guidance/published?type=cg for further details; use the search function on the page to find guidance around specific problems.

Figure 22b: Referrals entering treatment by secondary problem for those with a primary problem of anxiety, England, 2015-16

Condition	Referrals
Mixed anxiety and depressive disorder	197,316
Generalised Anxiety Disorder	96,282
Other anxiety or stress related disorder	22,972
Post-traumatic stress disorder	20,966
Panic disorder [episodic paroxysmal anxiety]	17,265
Social phobias	13,992
Obsessive-compulsive disorder	12,745
Specific (isolated) phobias	5,365
Agoraphobia	4,312
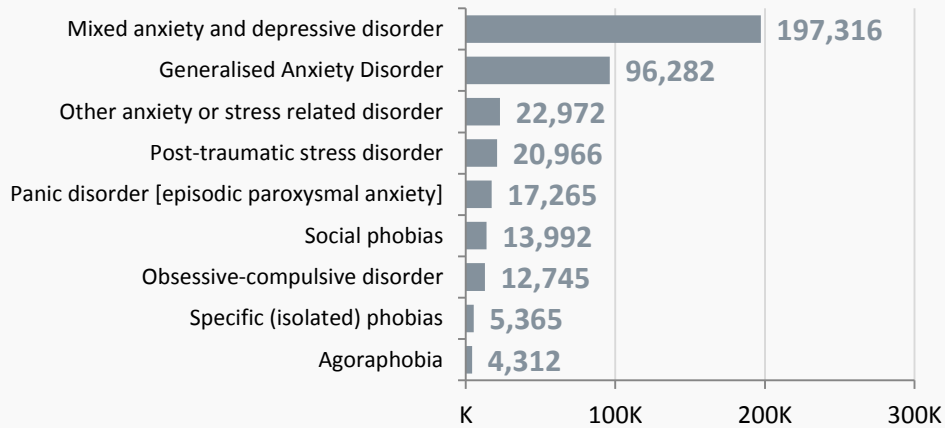
Figure 22b shows the number of referrals entering treatment with specific conditions that fall within the category 'anxiety and stress-related disorders'. 'Mixed anxiety and depressive disorder' has the highest number of referrals (197,316); this may be indicative of a general diagnosis made at the point of entering treatment, pending a more specific diagnosis is made as treatment progresses. This is further evidenced by 'Generalised Anxiety Disorder' and 'Other anxiety or stress related disorder' being common diagnoses at this stage.

'Agoraphobia' has the lowest number of referrals entering treatment (4,312). Overall, these findings are similar to those in 2014-15.

Counts of referrals entering treatment by a range of patient demographics at Clinical Commissioning Group level are published in **Table 8a, 9a, 10a, 11a, 12a, and 13a** of the accompanying data tables.

Referrals entering treatment by Clinical Commissioning Group

Figure 23 below shows the number of referrals entering treatment in the year by CCG.

Figure 23: Referrals entering treatment by Clinical Commissioning Group (CCG), 2015-16
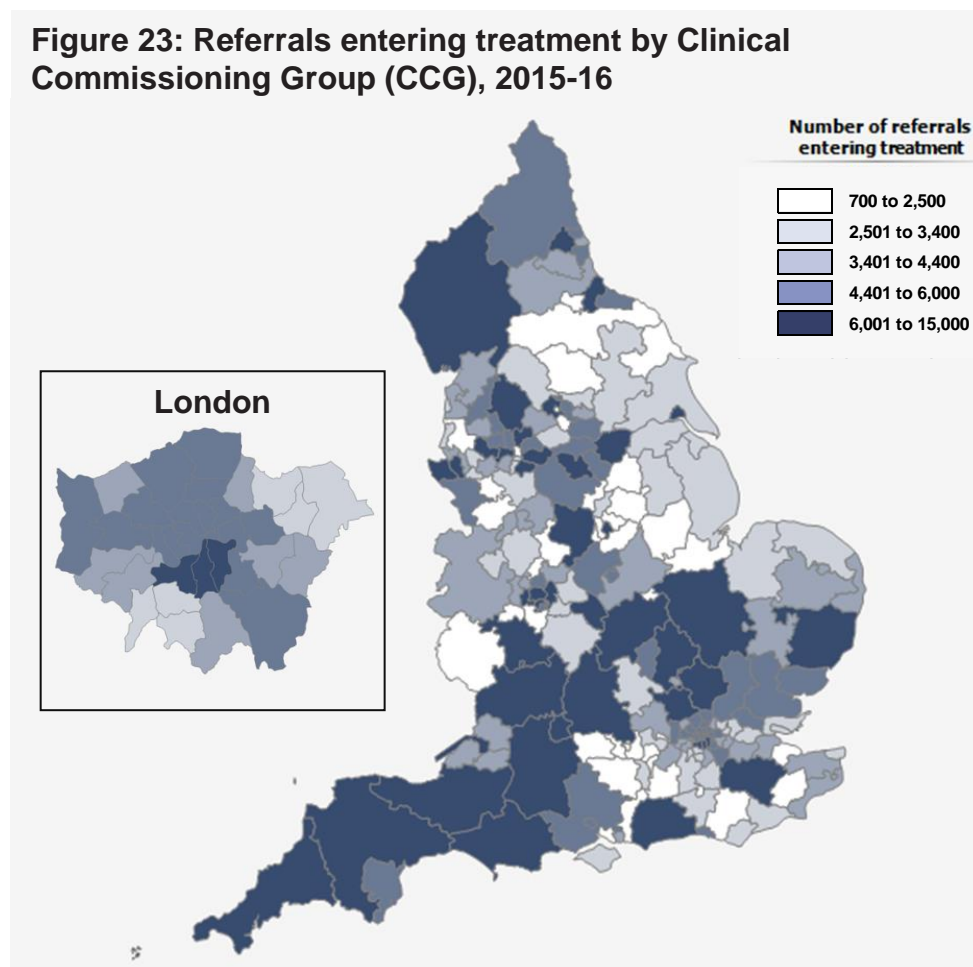
Figure 23 shows that there is considerable variation in volumes of referrals entering treatment between CCGs. The smallest number of referrals entering treatment was in NHS Surrey Heath CCG (760 referrals) and the largest number in NHS Cambridgeshire and Peterborough CCG (14,455 referrals).

Appointments

Each patient contact with an IAPT service is recorded as an appointment. There are several types of appointment in IAPT, including initial assessment, treatment, and review following treatment. The types of therapy given, the patient's attendance, and the consultation method (e.g. face to face, telephone) are also recorded.

Treatment appointments by therapy type and problem

Figures 24a and 24b below show the average number of treatment appointments with each type of therapy for referrals finishing a course of treatment in 2015-16. Figure 24a shows averages for patients with a primary problem of depression, and Figure 24b shows averages for patients with a primary problem of anxiety and stress related disorders.

Figure 24a: Average number of treatment appointments per finished course of treatment for those with depression, by therapy type, 2015-16

Low intensity therapies

Therapy	Value
Psychoeducational peer support	4.8
Structured Physical Activity	4.6
Non-Guided Self Help (Computer)	4.0
Ante/post natal counselling	3.9
Guided Self Help (Book)	3.9
Guided Self Help (Computer)	3.8
Behavioural Activation (Low Intensity)	3.7
Employment Support (Low Intensity)	3.5
Other Low Intensity	3.4
Non-guided Self Help (Book)	2.8

High intensity therapies

Therapy	Value
Interpersonal Psycho therapy (IPT)	8.9
Couples Therapy for Depression	7.8
Brief psychodynamic psychotherapy	7.3
Cognitive Behaviour Therapy (CBT)	7.1
Eye Movement Desensitisation Reprocessing	6.5
Counselling for Depression	5.9
Other High Intensity (not specified above)	5.3
Mindfulness	4.7
Collaborative care	4.5
Behavioural Activation (High Intensity)	4.5
Applied relaxation	2.7
Employment Support (High Intensity)	2.7

Figure 24a shows that, on average, patients with depression in receipt of high intensity therapies receive more appointments than those receiving low intensity therapies. For patients with depression, the highest average number of treatments per finished course is for 'Interpersonal Psycho Therapy (IPT)' and the lowest for 'Applied Relaxation' and 'Employment Support (High Intensity)'.

Figure 24b: Number of treatment appointments per finished course of treatment for those with anxiety and stress related disorders (total), by therapy type, 2015-16

Low intensity therapies

Therapy	Value
Structured Physical Activity	5.3
Ante/post natal counselling	5.1
Psychoeducational peer support	4.6
Guided Self Help (Computer)	4.3
Guided Self Help (Book)	4.1
Non-Guided Self Help (Computer)	4.1
Behavioural Activation (Low Intensity)	3.9
Employment Support (Low Intensity)	3.8
Other Low Intensity	3.6
Non-guided Self Help (Book)	3.0

High intensity therapies

Therapy	Value
Interpersonal Psycho therapy (IPT)	8.6
Brief psychodynamic psychotherapy	7.6
Couples Therapy for Depression	7.6
Cognitive Behaviour Therapy (CBT)	7.4
Eye Movement Desensitisation Reprocessing	7
Counselling for Depression	5.9
Other High Intensity (not specified above)	5.2
Mindfulness	4.6
Behavioural Activation (High Intensity)	4.2
Collaborative care	3.4
Applied relaxation	2.8
Employment Support (High Intensity)	2.8

Figure 24b shows that, on average, patients with anxiety and stress related disorders in receipt of high intensity therapies receive more appointments than those receiving low intensity therapies. For patients with anxiety and stress related disorders, the highest average number of treatments per finished course is for 'Interpersonal Psycho Therapy (IPT)' and the lowest for 'Applied Relaxation' and 'Employment Support (High Intensity)'.

Treatment appointments by therapist role and problem

Figures 25a and 25b below show the average number of treatment appointments for each type of therapist role for referrals finishing a course of treatment in 2015-16. Figure 25a shows averages for patients with a primary problem of depression, and Figure 25b shows averages for patients with a primary problem of anxiety and stress related disorders.

Figure 25a: Average number of treatment appointments per finished course of treatment for those with depression, by therapist role, 2015-16

Trainee roles

Role	Value
High Intensity Couple Therapist for Depression	5.7
High Intensity Interpersonal Therapist	5.3
High Intensity Counselling for Depression	5.1
High Intensity Cognitive Behavioural Therapist	4.9
High Intensity Brief Dynamic Interpersonal Psychotherapist	4.6
Eye Movement Desensitisation Reprocessing	4.4
Psychological Well-being Practitioner (PWP)	2.8
Mindfulness based Cognitive Therapist	

Qualified roles

Role	Value
High Intensity Brief Dynamic Interpersonal Psychotherapist	6.0
High Intensity Cognitive Behavioural Therapist	5.8
High Intensity Interpersonal Therapist	5.7
High Intensity Counselling for Depression	5.2
Other High Intensity Therapist	4.9
Eye Movement Desensitisation Reprocessing	4.6
Mindfulness based Cognitive Therapist	4.5
High Intensity Couple Therapist for Depression	4.3
Psychological Well-being Practitioner (PWP)	3.2
Other low intensity Therapist	2.4
Employment support worker	2.4

Figure 25a shows that the highest average number of appointments for patients with a primary problem of depression is with Qualified High Intensity Brief Dynamic Interpersonal Psychotherapists (6.0) and Qualified High Intensity Cognitive Behavioural Therapists (5.8). The lowest average number of appointments for patients with a primary problem of depression is with Qualified Other Low Intensity Therapists (2.4) and Qualified Employment Support Workers (2.4). Note that there were no appointments with Trainee Mindfulness Based Cognitive Therapists for patients with depression.

Figure 25b: Average number of treatment appointments per finished course of treatment for those with anxiety and stress related disorders, by therapist role, 2015-16

Trainee roles

Role	Value
High Intensity Brief Dynamic Interpersonal Psychotherapist	5.9
High Intensity Cognitive Behavioural Therapist	5.5
High Intensity Couple Therapist for Depression	5.2
High Intensity Counselling for Depression	4.4
Eye Movement Desensitisation Reprocessing	2.9
Psychological Well-being Practitioner (PWP)	2.9
High Intensity Interpersonal Therapist	2.8
Mindfulness based Cognitive Therapist	1.0

Qualified roles

Role	Value
High Intensity Cognitive Behavioural Therapist	6.2
High Intensity Brief Dynamic Interpersonal Psychotherapist	5.6
Eye Movement Desensitisation Reprocessing	5.3
High Intensity Counselling for Depression	5.0
Mindfulness based Cognitive Therapist	4.8
High Intensity Interpersonal Therapist	4.5
Other High Intensity Therapist	4.4
High Intensity Couple Therapist for Depression	3.8
Psychological Well-being Practitioner (PWP)	3.4
Other low intensity Therapist	3.0
Employment support worker	2.9

Figure 25b shows that the highest average number of appointments for patients with a primary problem of anxiety and stress related disorders are with Qualified High Intensity Cognitive Behavioural Therapists (6.2) and Trainee High Intensity Brief Dynamic Interpersonal Psychotherapists (5.9). The lowest average number of appointments for patients with a primary problem of anxiety and stress related disorders are with Trainee High Intensity Interpersonal Therapists (2.8) and Trainee Mindfulness Based Cognitive Therapists (1.0).

Further information about treatment appointments by problem descriptor, therapy type and therapist role are published in **Tables 3a and 3b** of the accompanying data tables.

Referrals ending

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

There are also different levels of contact with the service that an ended referral may have. The most common level of contact is the completion of a course of IAPT treatment. Many referrals also end without having been seen by the service; i.e. there were no attended appointments during the course of the referral.

In 2015-16, a total of 1,299,525 referrals ended. Figure 26 describes the different levels of contact an ended referral may have.

Figure 26: Number of referrals that ended, by level of contact with the service, 2015-16, England
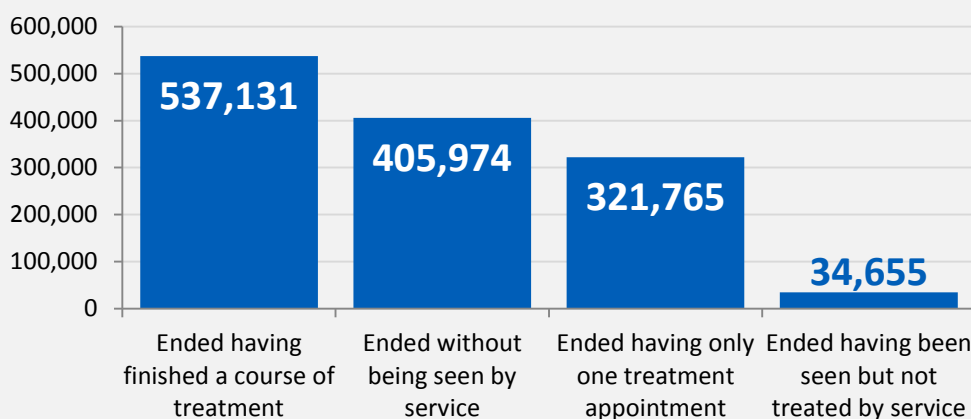
537,131, or 41.3% of all referrals ending in 2015-16, finished a course of treatment. Only referrals having finished a course of treatment are assessed against measures of waiting times and outcomes such as recovery, reliable improvement, and reliable recovery.

58.7% of referrals that ended in 2015-16 did not complete a course of IAPT treatment. There are many reasons why a patient may be referred to an IAPT care provider but not finish a course of treatment. For example, the patient may decline to attend an initial appointment offered, an initial assessment may determine that the patient is not suitable for IAPT services, or a patient may start a course of treatment but then decide not to continue.

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

Deprivation

The Department of Communities and Local Government (DCLG) publish Official Statistics that analyse a range of factors that, when combined, give an overall measure of the relative levels of deprivation across small areas in England. This is known as the Index of Multiple Deprivation (IMD)[38]. This 2015-16 report is the first time we have assessed the impact of deprivation on the access to and outcomes of the IAPT programme.

An IMD score is calculated for each neighbourhood across England. These scores are then split into 10 equal groups (deciles) that represent the least deprived 10% up to the most deprived 10%. These deciles are matched to patients' postcodes in IAPT in order to assign each referral to a deprivation decile.

Deprivation
200,427
referrals were received from the 10% most deprived areas compared to 91,960 in the least deprived areas.

Activity and deprivation

Figure 27 below gives counts of the number of referrals received, entering treatment, and finishing a course of treatment in the year split by IMD decile.

Figure 27: Referrals received, entered treatment and finished a course of treatment by deprivation decile, 2015-16
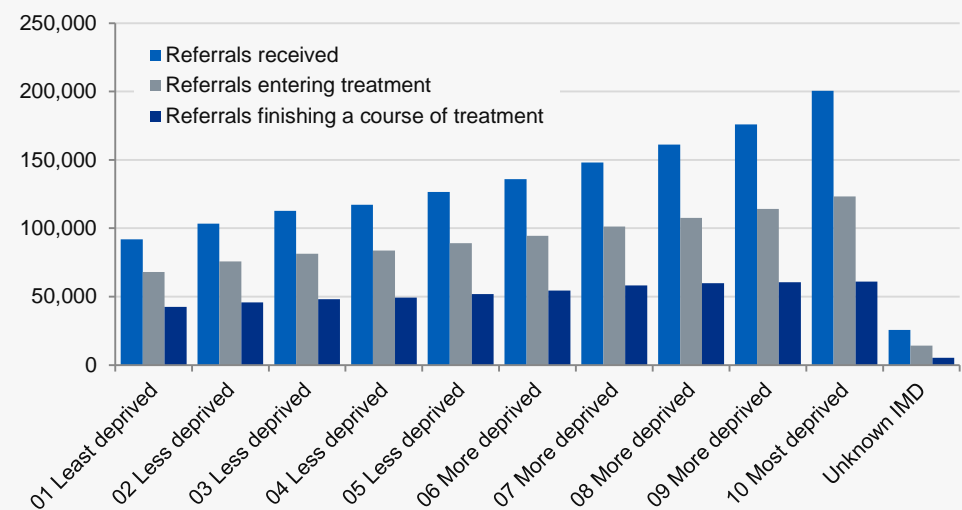
Figure 27 shows that there is a strong relationship between deprivation and the volume of referrals received (that is, referrals increase as deprivation increases). However, the relationship between deprivation and referrals finishing a course of treatment is less pronounced. This suggests that patients living in the most deprived areas are less likely to finish a course of treatment than those living in the least deprived areas.

It is important to note that these numbers are not based on the same group of referrals as each other. A referral that was received in 2015-

---

[38] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

16 did not necessarily enter treatment[39] in this year, and is less likely again to have ended in the year. Likewise, referrals that ended in 2015-16 may have been received or entered treatment before 2015-16.

Deprivation and recovery

Figure 28 below shows recovery rates for referrals finishing a course of treatment in 2015-16, split by the deprivation decile of the patient.

Figure 28: Recovery rates by deprivation decile, England, 2015-16

Decile	Recovery rate
01 Least deprived	55.0%
02 Less deprived	53.5%
03 Less deprived	52.1%
04 Less deprived	51.1%
05 Less deprived	48.5%
06 More deprived	47.7%
07 More deprived	45.2%
08 More deprived	42.8%
09 More deprived	39.8%
10 Most deprived	35.0%
Unknown IMD	46.7%
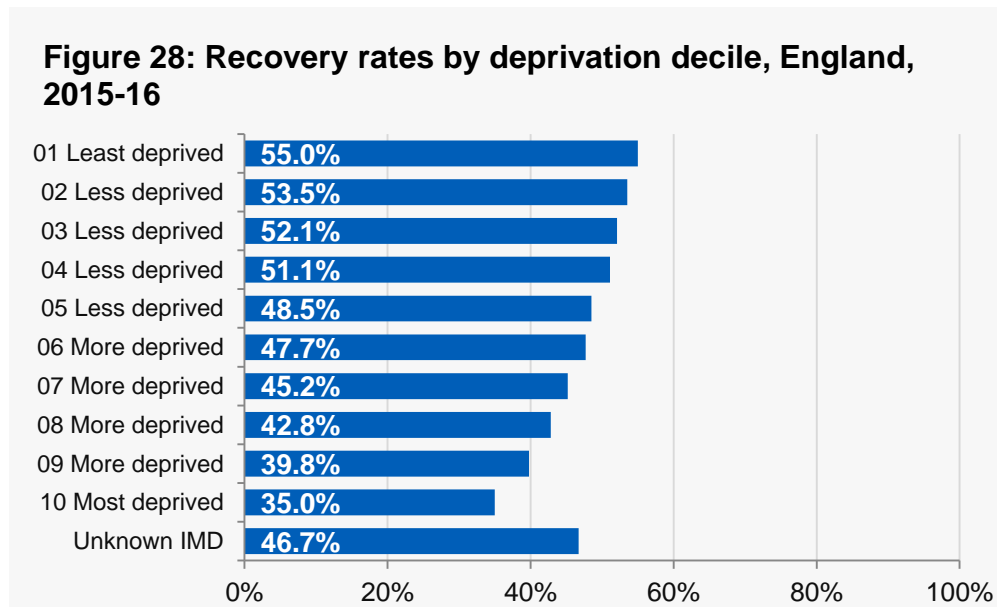
Recovery

35.0%

of eligible referrals in the most deprived 10% of areas moved to recovery, compared to 55.0% of eligible referrals in the least deprived 10% of areas.

Figure 28 shows that recovery rates are linked to IMD and that those people living in the most deprived areas are less likely to recover than those people living in the least deprived areas of England.

Recovery rates and activity data by Index of Multiple Deprivation decile at Clinical Commissioning Group level are published in **Tables 13a and 13b** of the accompanying data tables.

---

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

Patients with long-term health conditions

The IAPT dataset records whether each patient has a long-term physical health condition when they are referred to an IAPT service. Capturing this information allows the NHS to monitor recovery amongst people who have a comorbidity of depression or anxiety alongside physical health conditions, as effectively treating their mental health condition may result in improvement in their physical health and a potential reduction in their use of other NHS services[40].

Recovery

43.0%

of eligible referrals with long-term health conditions moved to recovery, compared to 46.3% of eligible referrals overall.

Figure 29: Outcomes for patients with long-term health conditions, 2015-16
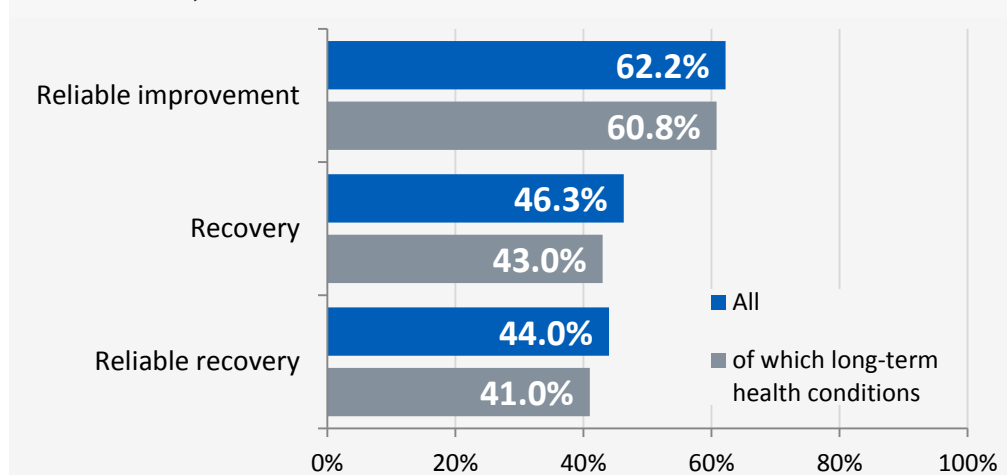
Figure 29 shows that the national recovery rate for patients who reported that they had a long-term physical health condition was 43.0%; slightly lower than the overall national recovery rate of 46.3%.

Amongst CCGs there was wide variation in recovery rates for those who reported that they had long-term physical health conditions; the lowest recovery rate was 16.8% (NHS Brighton and Hove CCG) and the highest 61.1% (NHS Barnsley CCG).

Recovery rates at Clinical Commissioning Group level for patients who reported that they had a long term physical health condition are published in **Table 14** of the accompanying data tables.

---

[40] http://www.iapt.nhs.uk/silo/files/longterm-conditions-positive-practice-guide.pdf

Ex-British Armed Forces personnel and dependents

The IAPT dataset is unique compared to other national mental health datasets in that it contains a flag to identify referrals as being for patients who are ex-British Armed Forces personnel, or dependents of these.

Activity for ex-British Armed Forces personnel and dependents

Figure 30: Number of referrals received, entered treatment and finished a course of treatment for ex-British Armed Forces personnel and dependents, 2015-16
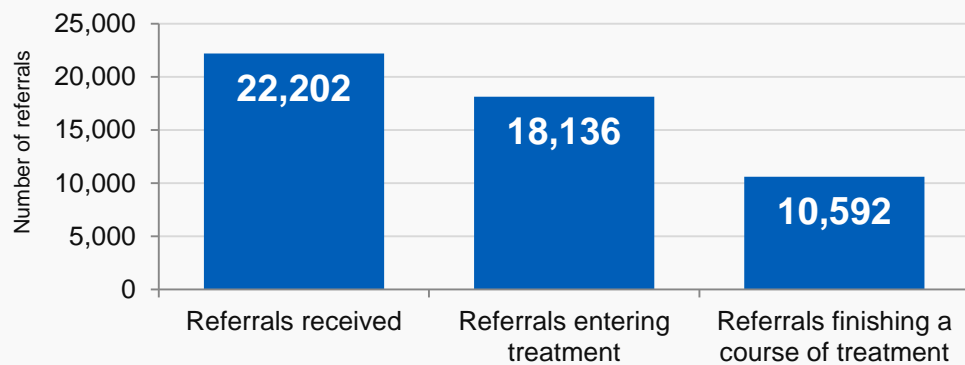
Figure 30 above shows the number of referrals received, entering treatment, and finishing a course of treatment in 2015-16 for ex-British Armed Forces personnel or their dependents. It is important to note that these numbers are not based on the same group of referrals as each other. A referral that was received in 2015-16 did not necessarily enter treatment in the year, and is less likely again to have ended in the year.

Waiting times for ex-British Armed Forces personnel and dependents

Figure 31: Percentage of referrals entering treatment within 6 weeks and 18 weeks for ex-British Armed Forces personnel and dependents, 2015-16
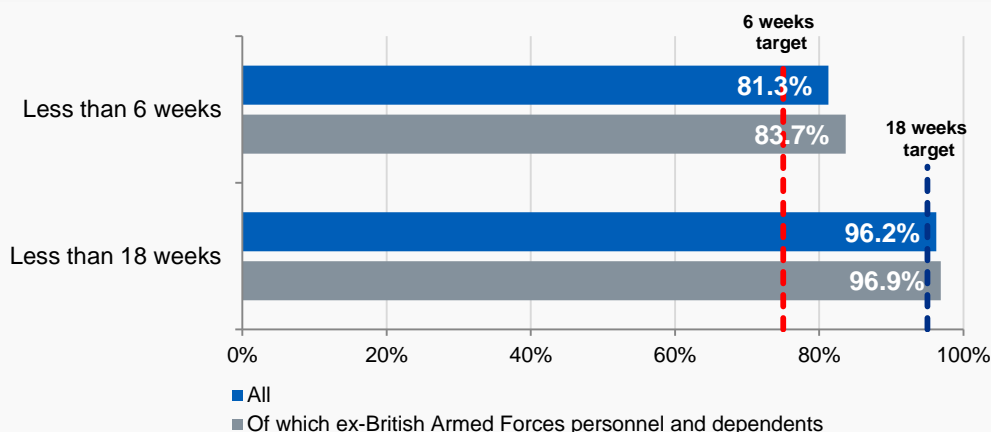
The percentage of referrals for British Armed Forces personnel and dependents waiting less than 6 weeks to enter treatment (based on those who finished their treatment in the year) was 83.7%; higher than the national rate of 81.3%. 96.9% of referrals for ex-British Armed Forces and dependents waited less than 18 weeks to enter treatment; similar to the national rate of 96.2%.

Outcomes for ex-British Armed forces personnel and dependents

Figure 32: Reliable improvement, recovery, and reliable recovery for ex-British Armed Forces personnel and dependents, 2015-16
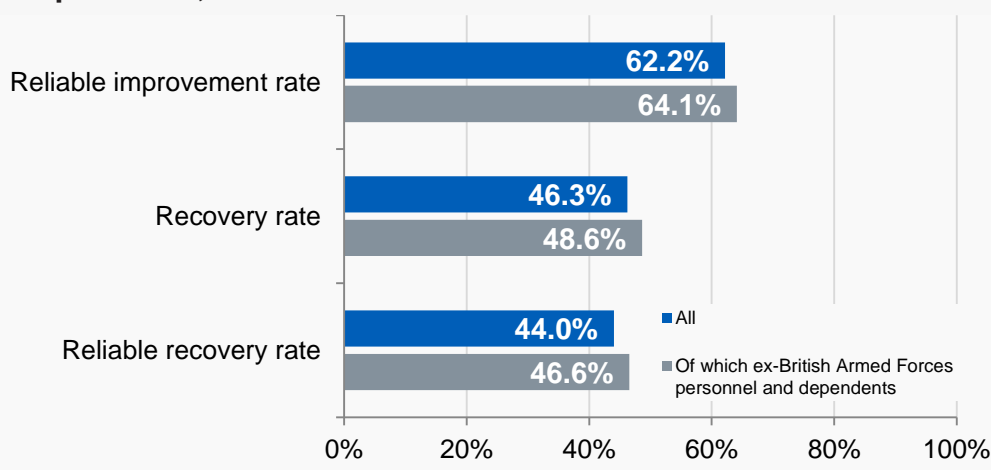
Recovery

48.6%

of eligible referrals for ex-British Armed Forces personnel or dependents moved to recovery, higher than the overall national recovery rate of 46.3%.

Figure 32 shows that, in 2015-16, the recovery rate for patients who reported that they were ex-British Armed Forces personnel or their dependents was 48.6%. This is slightly higher than the equivalent rate reported in 2014-15[41] (47.1%) and higher than the overall national recovery rate in 2015-16 (46.3%).

Amongst CCGs there is wide variation in recovery rates for ex-British Armed Forces personnel and dependents of these; the lowest rate was 32.6% (NHS Wirral CCG) and the highest was 81.3% (NHS Bath and North East Somerset CCG).

Recovery rates at Clinical Commissioning Group level for patients who reported that they were ex-British Armed Forces personnel or dependents of these are published in **Table 15** of the accompanying data tables.

---

[41] See http://www.digital.nhs.uk/pubs/psycther1415, table 18.

Appendix 1: Data source and considerations

A single authoritative national database of IAPT data was created to be the source data for this report. This section explains some of the features of the data flow and how we manage the data asset for monthly reports. It also explains why and how we created a separate database as the source for this annual report.

Providers of adult IAPT services are required to submit data for patients with open referrals (or ending in the month) every month, in accordance with the IAPT data standard[42].

Submissions to NHS Digital are validated and pseudonymised by the Open Exeter Bureau Service provided by the Service Delivery Team and received by the Community and Mental Health team as a monthly pseudonymised XML extract. As most courses of IAPT treatment last for more than a single month, information about the same referrals is included in successive submissions. However, the details of these referrals changes across submissions and this could lead to inconsistencies in our published reports.

In order to ensure a stable view of the data for each of our monthly reports, we have to apply a set of business rules to our analysis, to ensure that the same instance of each referral is used for each individual period's reporting. We also derive a nationally unique identifier for each referral to ensure that all the related information about the referral can be linked across submissions.

For the annual report there are additional requirements for an authoritative source of data for the year, because this will be used for historical and time series analysis in the future and we need to ensure that consistent figures will be produced in the future.

We therefore created a view of the data for the whole year, including a single instance of each referral with the most up to date information provided during the year for that referral. For example, if the problem descriptor was first recorded as 'generalised anxiety disorder' and updated later in the year to 'obsessive-compulsive disorder (OCD)' then the problem descriptor associated with this referral in the annual database will be 'OCD'.

Additionally, we have created a view of the data that enables us to identify the dates of treatment appointments according to the methodology at the time of the appointment.

Further details about the construction of the annual dataset are available on request and the details of the logic we apply in calculating key measures are described in the 'IAPT Reporting FAQs' document available on the NHS Digital website[43].

---

[42] See http://wwwdigital.nhs.uk/iapt
[43] See http://www.digital.nhs.uk/iaptmonthly

Appendix 2: Data Quality Statement

This section provides details and data quality information for the data used in this publication. It aims to provide users with an evidence based assessment of the quality of the statistical output by reporting against those of the European Statistical System (ESS) quality[44] and related dimensions and principles appropriate to this output[45].

In doing so, this meets the NHS Digital obligation to comply with the UK Statistics Authority (UKSA) Code of Practice for Official Statistics[46], particularly Principle 4, Practice 2 which states: "Ensure that official statistics are produced to a level of quality that meets users' needs, and that users are informed about the quality of statistical outputs, including estimates of the main sources of bias and other errors, and other aspects of the European Statistical System definition of quality".

Accuracy and Reliability

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

Every month an overview of Data Quality (DQ) in the IAPT dataset is published. The report includes the VODIM (Valid, Other, Default, Invalid, Missing) tables showing metrics as counts and percentages, both nationally and by provider, for the reporting month and for key data items. It also includes the previously produced tables showing percentage of valid records, by data item and provider, for the reporting month and previous 12 months.

The monthly data quality reports include measures related to dataset coverage, data consistency and data integrity.

Data quality reports are available on the NHS Digital website: http://digital.nhs.uk/iaptreports

Relevance

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

Data in this publication is presented in a number of ways to meet user needs: summary report and key findings (this document), detailed data tables published in Excel and CSV table tables.

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

---

[44] ESS Quality Framework http://ec.europa.eu/eurostat/web/quality
[45] The original quality dimensions are: relevance, accuracy and reliability, timeliness and punctuality, accessibility and clarity, and coherence and comparability; these are set out in Eurostat Statistical Law. However more recent quality guidance from Eurostat includes some additional quality principles on: output quality trade-offs, user needs and perceptions, performance cost and respondent burden, and confidentiality, transparency and security.
[46] UKSA Code of Practice for Statistics: http://www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html

Comparability and Coherence

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

The IAPT publication uses clinical terms and definitions wherever possible.

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

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

Comparison of recovery for anxiety and depression separately and the IAPT definition of recovery

	Number of patients at caseness at the start of treatment	Number of patients below caseness threshold at the end of treatment (recovered)	Recovery Rate
Anxiety and Depression (IAPT recovery definition)	490,395	226,850	46.3%
Depression only	428,878	216,543	50.5%
Anxiety only	461,152	224,160	48.6%

Timeliness and Punctuality

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

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

This annual publication is released six months after the end of the financial year. The additional production time is required to create the annual data asset and produce the more detailed analyses and output tables presented here.

Accessibility and Clarity

Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and availability of supporting information.

Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice.

This publication includes this report, presenting headline figures and key findings that are aimed at a range of audiences. More detailed information is published in a CSV file accompanying this publication.

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

Assessment of user needs and perceptions

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

In May 2016, we ran a user consultation to help better understand the user requirements for the IAPT publication. Following the consultation, CSV versions of the data tables have been included in this publication.

The main findings from the IAPT consultation are available on in the 'related documents' section of this web page:

www.nhs.uk/iaptmonthly

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

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

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

Performance Cost and Respondent Burden

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

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

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

Confidentiality, Transparency and Security

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

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

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

This publication is subject to a standard NHS Digital risk assessment prior to issue. Disclosure control is implemented where this is deemed to be necessary in

accordance with the protocols associated with the underlying data sources. Further details of the risk assessment are available in the NHS Digital's Disclosure Control Procedure.

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

Appendix 3: Caseness, Recovery, and Reliable Improvement

Caseness

Caseness is the term used to describe a referral that scores highly enough on measures of depression and anxiety to be classed as a clinical case. It is measured by using the assessment scores that are collected at IAPT appointments; if a patient's score is above the clinical/ non-clinical cut off[47] on either anxiety, depression, or both, then the referral is classed as a clinical case.

Recovery

A referral is classed as 'recovered' if the patient finished a course of treatment and moved from caseness to not being at caseness by the end of the referral. To be considered as recovered, a patient needs to score below the caseness threshold on *both* anxiety and depression measures at the end of their treatment, to ensure that recovery is measured by looking at the welfare of the individual rather than one specific symptom. Referrals that started their course of treatment not at caseness are not included in recovery counts.
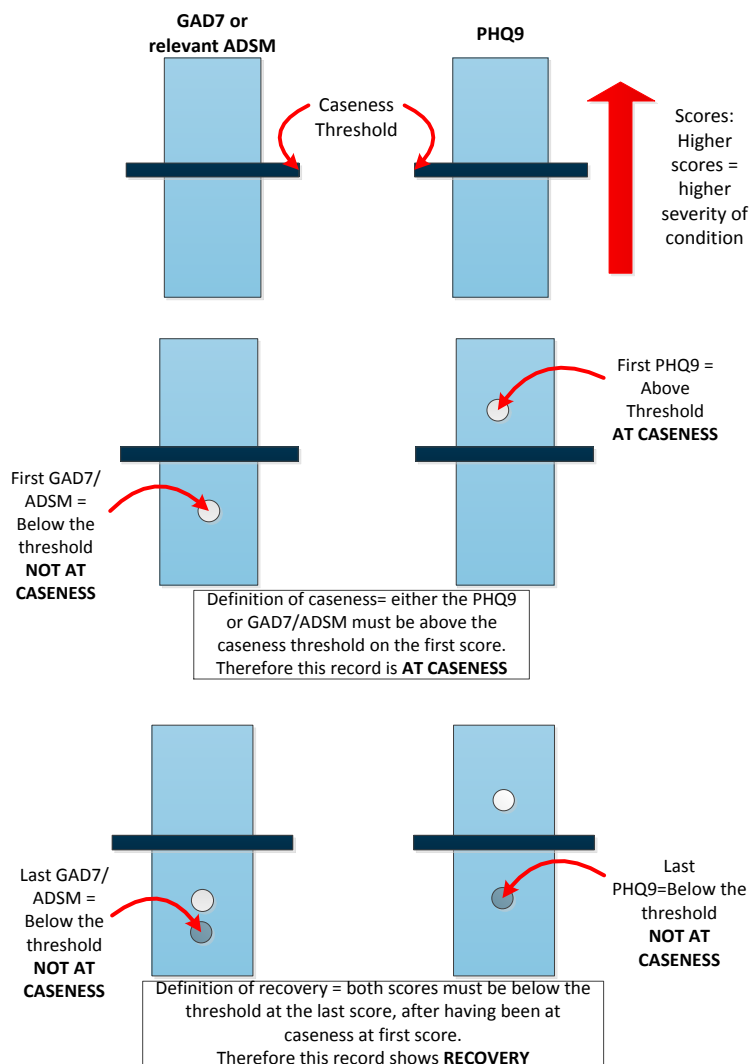
The higher a referral scores on the measures of anxiety and depression, the higher the severity of their clinical condition.

A referral is at 'caseness' at the start of treatment if *either* the first recorded PHQ-9 score *or* the first recorded relevant ADSM score, or both, are **above** the caseness threshold.

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

---

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

Reliable improvement

The assessment of recovery by examining simply whether a referral moves below the caseness threshold has a number of drawbacks. For example, there may be cases which do not move below the caseness threshold but still show a large improvement across their treatment. Conversely, referrals which were not above the caseness threshold at their first treatment may still have shown an improvement that is not reflected when looking solely at caseness. Further, scores for referrals that were 'border line', i.e. just over the caseness threshold on entering treatment, may only decrease by a small amount but still be counted as having recovered.

In order to account for these issues, we have also looked at the number of referrals that have shown *reliable improvement*, regardless of whether or not they were above the caseness threshold at the start of treatment. A referral is deemed to have shown reliable improvement if it shows a decrease in one or both assessment measure scores that surpasses the measurement error[48] of that questionnaire. In addition, neither measure can show an increase beyond the measurement error. Equally, if a referral shows an increase in one or both scores that is more than the measurement error, they can be described as having reliably deteriorated.

Change between first and last = greater than measurement error of PHQ9
RELIABLE IMPROVEMENT

Definition of Improvement = Reliable improvement on at least one score, while the other has not deteriorated.
Therefore this record shows **RELIABLE IMPROVEMENT**
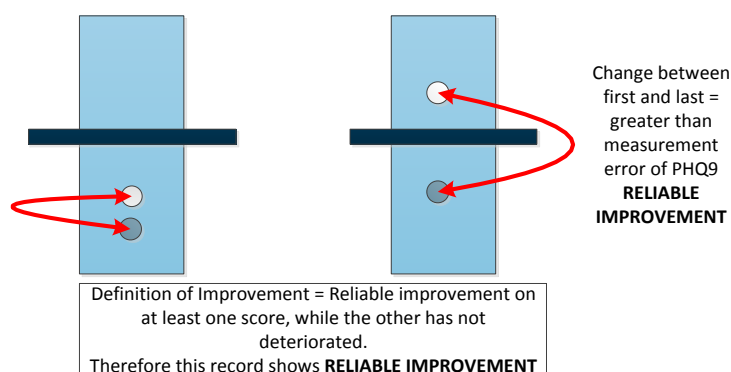
Reliable recovery

Reliable improvement and recovery can be combined to create an overall measure of reliable recovery – a count of those referrals who show **both** a change from caseness to not being caseness during the course of the referral and which also show a reliable improvement in their score(s).

Combining the two measures also allows examination of the outcomes for 'border line' referrals, such as those which showed recovery with no improvement, or those which did not show recovery but did show improvement. In some cases it is even possible for an individual to show recovery but also deteriorate when evaluating both the PHQ-9 and ADSM. A full understanding of the possible pathways a referral can take is described below:

---

[48] This is the amount by which a difference could be attributable to natural variance. For more information on measurement errors for specific questionnaires, see Appendix 4 of this report.

Flowchart of the potential output pathway of a completed referral[49]

---
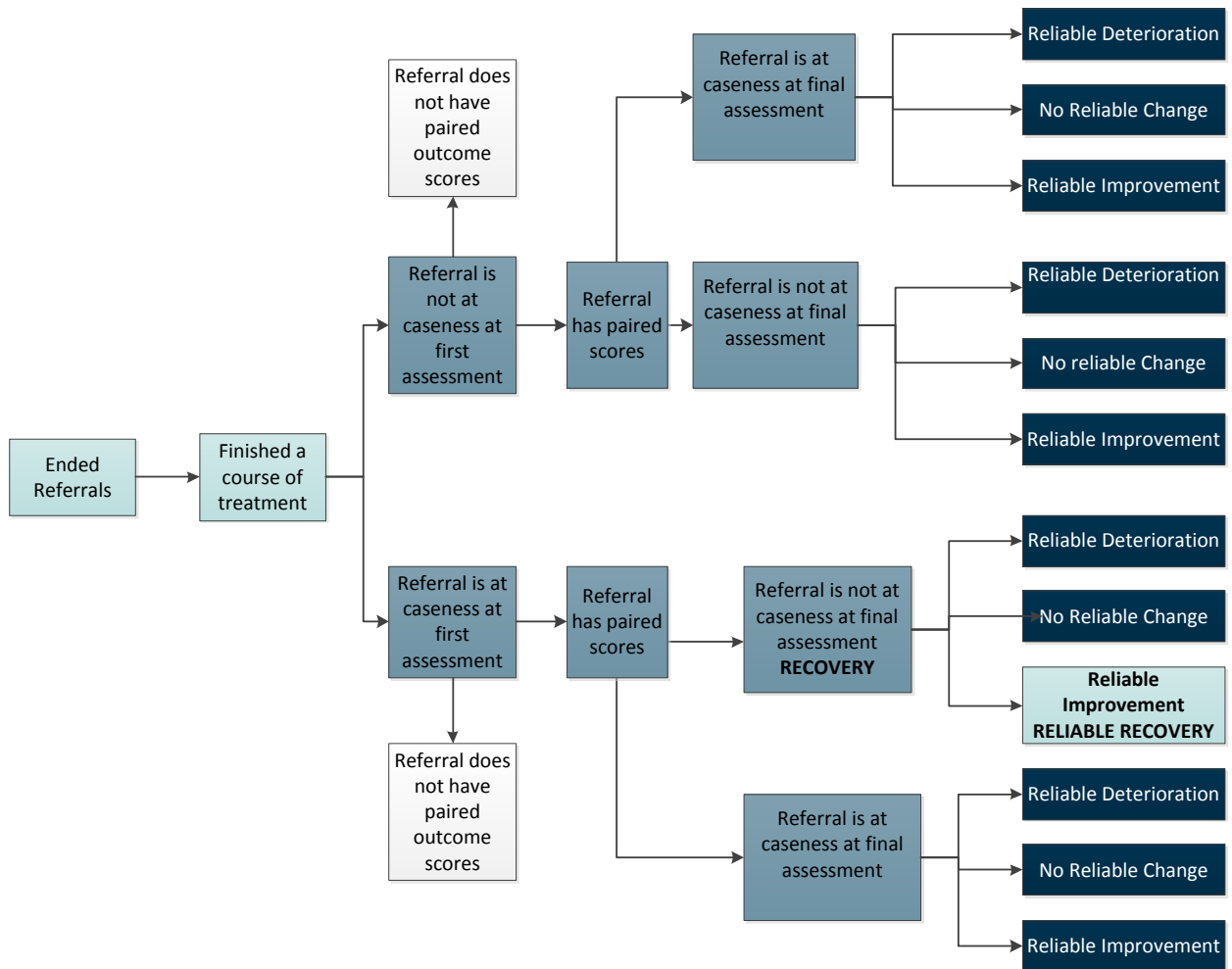
[49] Although unlikely, it is possible for referrals to show recovery and also deterioration, or to move from not being at caseness and still show improvement. This generally occurs when looking at 'borderline' cases, which may show a small change on one measure that passes the caseness threshold while showing a larger change in another measure which does not pass the caseness threshold. This is not expected to occur in many cases but the possibility is included in this diagram for completeness.

54

Appendix 4: ADSMs appropriate to problem descriptors and caseness thresholds

The table below provides a list of Anxiety Disorder Specific Measures appropriate to each problem descriptor, as well as the corresponding caseness threshold and measurement error. At each treatment appointment, patients are asked to complete the Patient Health Questionnaire (PHQ-9), which is an assessment of the severity of depression, and the ADSM from the below table that is appropriate for their problem descriptor. The first and last recorded scores for each of these measures are used in the calculations of caseness, recovery, improvement, reliable change, and reliable recovery.

Measure	Caseness threshold	Measurement error
PHQ-9	10	6

ICD-10 code	Problem descriptor	Appropriate ADSM	Caseness threshold	Measurement error
F10	Mental and behavioural disorders due to use of alcohol	GAD7	8	4
F31	Bipolar affective disorder	GAD7	8	4
F32-F39	Depressive episode	GAD7	8	4
F33	Recurrent depressive disorder	GAD7	8	4
F40.2	Specific (isolated) phobias	GAD7	8	4
F41.1	Generalised Anxiety Disorder	GAD7	8	4
F41.2	Mixed anxiety and depressive disorder	GAD7	8	4
F50	Eating disorders	GAD7	8	4
F99	Mental disorder not otherwise specified	GAD7	8	4
Z63.4	Disappearance or death of a family member	GAD7	8	4
F40.0[50]	Agoraphobia	Agoraphobia Mobility Inventory	60 (v1.0) 2.3 (v1.5)	19 (v1.0) 0.73 (v1.5)
F40.1	Social phobias	Social Phobia Inventory	19	10
F41.0[51]	Panic Disorder	Panic Disorder Severity Scale	-	-
F42	Obsessive Compulsive Disorder	Obsessive Compulsive Inventory	40	32
F43.1	Post-Traumatic Stress Disorder	Impact of Events Scale	33	9
F45.2	Somatoform Disorder	Health Anxiety Inventory (Short Week)	18	4

---

[50] There was a format change between dataset versions for this measure. For further information, see http://www.digital.nhs.uk/media/15415/Methodological-change-2014-Improving-Access-to-Psychological-Therapies-IAPT-Reports/pdf/MethChange20141028_IAPT.pdf, p12.

[51] As there is currently no provided reliable change value for the Panic Disorder Severity Scale, GAD7 is currently used instead as the ADSM for this problem descriptor.

Appendix 5: Distinct therapy types in IAPT

Partway through the 2014/15 financial year the IAPT dataset changed from version 1.0 to version 1.5, and changes to the coding of therapy types were instigated as part of this[52]. In 2015/16, version 1.5 codes were used, which can be grouped by high and low intensity therapies.

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

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

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

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

---

[52] See 'Methodological Change: 2015 Improving Access to Psychological Therapies Reports' published at:
http://www.digital.nhs.uk/media/16289/Improving-Access-to-Psychological-Therapies/pdf/MethChange20150216_MonthlyIAPT.pdf

IAPT Stepped Care Model

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

The stepped care model

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

Step 1: Recognition in primary care and general hospital settings

Step 2: Treatment of mild depression in primary care

Step 3: Treatment of moderate to severe depression in primary care

Step 4: Treatment of depression by mental health specialists

Step 5: Inpatient treatment for depression

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

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

Appendix 6: Submissions by provider

Organisation Code of Provider	Organisation Name of Provider	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016
304	BOLTON METROPOLITAN BOROUGH COUNCIL	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8AC19	RELATE (BRADFORD)	Y	Y	Y	Y								
8GH63	RELATE (HULL)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HL38	OUTLOOK SOUTH WEST LLP	Y	Y	Y									
8HR41	PSYCHOLOGYONLINE.CO.UK LTD	Y	Y										
8HR45	ACTION FOR CHILDREN												Y
8HR97	SIGN HEALTH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HT03	NEWCASTLE TALKING THERAPIES	Y	Y	Y									
8HV57	EAST LANCASHIRE WOMEN'S CENTRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HV88	PML COUNSELLING SERVICE	Y	Y	Y	Y	Y	Y	Y	Y	Y			
8HW71	SELF HELP SERVICES	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HX19	KALEIDOSCOPE PLUS GROUP	Y	Y	Y	Y								
8HX24	MIND IN BEXLEY	Y	Y	Y	Y	Y	Y						
8HX43	SELF HELP SERVICES (PBR)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HX68	TURNING POINT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8HY52	WEST ESSEX MIND	Y	Y	Y	Y	Y							
8HY89	LEA VALE MEDICAL GROUP	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8J293	STARFISH HEALTH AND WELLBEING	Y	Y	Y									
8J495	1POINT (NORTH WEST) LIMITED	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8J555	FREEFLOW COUNSELLING SERVICE												Y
8J615	SURVIVORS MANCHESTER										Y	Y	Y
8J734	THE MAGDALENE PROJECT												Y
8J761	BURTON AND DISTRICT MIND						Y		Y	Y	Y	Y	Y
8J766	DARTFORD, GRAVESHAM AND SWANLEY MIND	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8J784	MIND IN BEXLEY (HEALTHY MIND IN WEST KENT)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
AA5	COMPASS WELLBEING COMMUNITY INTEREST COMPANY	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
AD7	WESTMINSTER MIND	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
AEY01	STARFISH HEALTH AND WELLBEING					Y	Y	Y	Y	Y	Y	Y	Y
AEY04	STARFISH-EWIT					Y	Y	Y	Y	Y	Y	Y	Y
AJA	DOVER COUNSELLING CENTRE HQ	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
ALR01	BIRMINGHAM MENTAL HEALTH CONSORTIUM (HERBERT ROAD)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
AM001	RELATE (BRADFORD HQ)						Y	Y	Y	Y	Y	Y	Y
AM5	OUTLOOK SOUTH WEST LLP			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
AM601	PSYCHOLOGYONLINE.CO.UK			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
AM801	NEWCASTLE TALKING THERAPIES			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
AMD01	THE KALEIDOSCOPE PLUS GROUP						Y	Y	Y	Y	Y	Y	Y
AME01	MIND IN BEXLEY (HQ)							Y	Y	Y	Y	Y	Y
AN2	BROCKLEBANK GROUP PRACTICE (HQ)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
AN4	GRAFTON MEDICAL PARTNERS (HQ)	Y	Y	Y	Y	Y	Y	Y			Y	Y	
AN5	PUTNEYMEAD GROUP MEDICAL PRACTICE (HQ)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
AN901	THE EARLSFIELD PRACTICE (HQ)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
ANA01	HEATHBRIDGE PRACTICE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
ANC	OPEN DOOR SURGERY (HQ)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
ANJ	CENTRAL LONDON PRIMARY CARE COUNSELLORS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
ANV01	CENTRE FOR PSYCHOLOGY											Y	Y
ARY01	THE VILLAGE PRACTICE (THORNTON)									Y	Y	Y	Y
NAF	COUNSELLING TEAM LTD	Y	Y	Y	Y	Y	Y	Y	Y	Y			
NAG01	THINKACTION MENTAL HEALTH AT MEDWAY & SWALE (FORMERLY KNOWN AS KCA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NAG02	THINKACTION MENTAL HEALTH AT ASHFORD (FORMERLY KNOWN AS KCA)	Y	Y	Y	Y	Y	Y	Y	Y				
NAG03	THINKACTION MENTAL HEALTH AT CANTERBURY & COASTAL (FORMERLY KNOWN AS KCA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y
NAG05	THINKACTION MENTAL HEALTH AT THANET (FORMERLY KNOWN AS KCA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NAG07	THINKACTION MENTAL HEALTH AT REIGATE (FORMERLY KNOWN AS KCA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NAG08	THINKACTION MENTAL HEALTH AT WOKING (FORMERLY KNOWN AS KCA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NCH	TALKPLUS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NCM	SIX DEGREES SOCIAL ENTERPRISE CIC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDA	VIRGIN CARE SERVICES LTD	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC01	INSIGHT HEALTHCARE TALKING THERAPIES (NORTHUMBERLAND)	Y	Y	Y	Y	Y							
NDC03	INSIGHT HEALTHCARE TALKING THERAPIES (CALDERDALE)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC04	INSIGHT HEALTHCARE TALKING THERAPIES (WIRRAL)	Y	Y	Y	Y								
NDC05	INSIGHT HEALTHCARE TALKING THERAPIES (PETERBOROUGH)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC06	INSIGHT HEALTHCARE - AQP-PRIMARY CARE PSYCHOLOGICAL THERAPIES (TEES)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC07	INSIGHT HEALTHCARE TALKING THERAPIES (KENT & MEDWAY)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC08	INSIGHT HEALTHCARE - NOTTINGHAM CITY	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC09	INSIGHT HEALTHCARE - NOTTINGHAMSHIRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC10	INSIGHT HEALTHCARE - DERBYSHIRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Organisation Code of Provider	Organisation Name of Provider	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016
NDC11	INSIGHT HEALTHCARE - EAST RIDING OF YORKSHIRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC12	INSIGHT HEALTHCARE - NOTTINGHAM CITY OBESITY PROJECT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NDC13	INSIGHT HEALHTCARE TALKING THERAPIES (BASSETLAW)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NFG	MIND CENTRE	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NFL	HARTLEPOOL AND EAST DURHAM MIND	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NI382	ADDACTION ASHFORD										Y	Y	Y
NI397	ADDACTION MERTON									Y	Y	Y	Y
NIW	FAVERSHAM COUNSELLING SERVICE LTD	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NJG	ALLIANCE PSYCHOLOGY SERVICES LTD	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
NJJ	PSICON LIMITED	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
NKT	UNIVERSITY MEDICAL CENTRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NLS	TRENT PTS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NLY27	LIFT PSYCHOLOGY SWINDON	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NMK	HEALTHSHARE LTD	Y	Y	Y	Y	Y	Y	Y					
NMQ	MAKING SPACE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NNE	DORKING HEALTHCARE LIMITED	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NNF	CITY HEALTH CARE PARTNERSHIP CIC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NO201	TALKING MATTERS TEES	Y	Y	Y	Y	Y							
NO202	WARRINGTON PSYCHOLOGICAL SERVICE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NO203	TALKING MATTERS KENT (MHM)	Y	Y	Y	Y								
NO204	TALKING MATTERS NORTHUMBERLAND						Y	Y	Y	Y	Y	Y	Y
NQL	NAVIGO	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NQV	BROMLEY HEALTHCARE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NR5	LIVEWELL SOUTHWEST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NTYH4	PENINSULA HEALTH LLP	Y	Y	Y		Y	Y						
NWX08	BICS MENTAL HEALTH GATEWAY	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
R1A	WORCESTERSHIRE HEALTH AND CARE NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
R1C	SOLENT NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
R1F	ISLE OF WIGHT NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RAT	NORTH EAST LONDON NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RDR	SUSSEX COMMUNITY NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RDYDL	PSYCHOLOGICAL THERAPIES SOUTHHAMPTON OFFICE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RDYEV	CONIFERS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RDYLK	BOURNEMOUTH AND POOLE PRIMARY CARE MEDICAL TEAM	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RDYLL	EAST DORSET STEPS TO WELLBEING (IAPT)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RGD	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y						
RH5	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RHA	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RJ8	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RKE	THE WHITTINGTON HOSPITAL NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RKL07	EALING IAPT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RKL14	LAKESIDE UNIT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RKL42	GLOUCESTER HOUSE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RLYD7	HOPE CENTRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RMY	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	Y	Y	Y	Y								
RNK02	CITY & HACKNEY PRIMARY CARE PSYCHOTHERAPY CONSULTATION SERVICE (PCPCS)						Y	Y	Y	Y	Y	Y	Y
RNN	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RNUDT	TALKINGSPACE PLUS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RNUDV	HEALTHY MINDS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RP1	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RP7	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RPG	OXLEAS NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RQY12	WANDSWORTH IAPT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RQYPR	SUTTON & MERTON IAPT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RRE	SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RT1	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RT2	PENNINE CARE NHS FOUNDATION TRUST	Y	Y	Y	Y								
RT2HQ	PENNINE CARE NHS TRUST						Y	Y	Y	Y	Y	Y	Y
RT2K2	HUMPHREY HOUSE						Y	Y	Y	Y	Y	Y	Y
RT5	LEICESTERSHIRE PARTNERSHIP NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RTF61	WALLSEND HEALTH CENTRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RTQ	2GETHER NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RTV	5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV332	SOUTH KENSINGTON & CHELSEA MENTAL HEALTH CENTRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

Organisation Code of Provider	Organisation Name of Provider	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016
RV383	NORTHWICK PARK HOSPITAL	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV3AR	MILL HOUSE		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV3CH	ICCS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV3DD	WELLBEING CENTRE	Y											
RV3DG	WESTMINSTER WELLBEING SERVICE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV3H8	K&C PRIMARY CARE MENTAL HEALTH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		
RV3HC	IAPT SERVICES	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV5CG	SOUTHWARK PSYCHOLOGICAL THERAPIES SERVICES (SOUTHWARK IAPT)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV5CH	LEWISHAM PSYCHOLOGICAL THERAPIES SERVICE (LEWISHAM IAPT)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV5CJ	CROYDON PSYCHOLOGICAL THERAPIES SERVICE (CROYDON IAPT)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV5CK	LAMBETH PSYCHOLOGICAL THERAPIES SERVICE (LAMBETH IAPT)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RV9	HUMBER NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RVN	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RW4	MERSEY CARE NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RW5	LANCASHIRE CARE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RWK1G	RICHMOND ROYAL HOSPITAL	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RWK1J	LUTON WELLBEING SERVICE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RWK3A	WREST ENTERPRISE CENTRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RWK3F	VIVIENNE COHEN HOUSE[1]											Y	Y
RWK79	NEWHAM IAPT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RWN	SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RWR	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	Y	Y	Y									
RWRD7	WAVERLEY ROAD		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RWRG3	HERTFORDSHIRE PARTNERSHIP FOUNDATION TRUST (TEKHNICON HOUSE)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RWRG7	HERTFORDSHIRE PARTNERSHIP FOUNDATION TRUST (LEXDEN HOSPITAL)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RWRRG	WEST ESSEX IAPT		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RWV	DEVON PARTNERSHIP NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RWX	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RX2	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RX301	TEES, ESK, WEAR VALLEY NHS TRUST (DURHAM)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RX302	TEES, ESK WEAR VALLEY NHS TRUST (TEES)	Y	Y	Y	Y	Y	Y						
RX34F	BOOTHAM PARK HOSPITAL - ADMIN							Y	Y	Y	Y	Y	Y
RX3YE	THE BRIARY UNIT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RX4	NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXA29	DENTON HOUSE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXA52	1829 BUILDING	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXAWV	ACCESS SEFTON - BOOTLE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXE	ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXG10	FIELDHEAD HOSPITAL	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXG82	KENDRAY HOSPITAL	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXM	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXT	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXV	GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXX1Y	SURREY IAPT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXXY1	BARNET IAPT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RXY	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RY2	BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RY6	LEEDS COMMUNITY HEALTHCARE NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RYG	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RYK	DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RYK14	BLAKENALL VILLAGE CENTRE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RYX	CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
TAD	BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
TAE	MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
TAF87	ISLINGTON IAPT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
TAF88	CAMDEN IAPT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
TAF90	KINGSTON DRUG & ALCOHOL SERVICE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
TAH	SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
TAJ	BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

[1] Please note that organisation with code RWK3F changed their reporting name from 'Vivienne Cohen House' to 'City & Hackney Specialist Psychotherapy Service' after the reporting period and is currently reported under the latter name.

Appendix 7: Calculating *Cohen's d* effect size in IAPT

In the IAPT annual publication 2014-15, the mean and standard deviation were published for the GAD-7 and PHQ-9 scores at the start and end of treatment.

Where the mean is the average score for patients at the start and end of treatment and the standard deviation gives a measure of the dispersion in the data values. When the standard deviation is small, there is a small amount of variation in the data values and the data points tend to be close to the mean. When the standard deviation is large there tends to be large variation in the data values they tend to have a wide variation in values, many being further away from the mean.

For this report, we have also introduced Cohen's d effect size[53] for the WSAS, PHQ-9 and GAD-7 scores. The Cohen's d effect size measures the magnitude of the effect size. In this report it is being used to assess the change in average scores between the start and the end of treatment. Unlike tests for statistical significance, this test is independent of sample size and will produce a standardised difference between them means at the start and end of treatment

To calculate Cohen's d effect size:

$$d = \frac{\text{Mgroup1} - \text{Mgroup2}}{\text{SD}}$$

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

For this IAPT publication we have used the following:

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

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

Cohen defined effect size into 3 broad categories:
- d=0.2 small effect
- d=0.5 medium effect size
- d=0.8 large effect size

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

---

[53] Cohen, J. (1977). *Statistical power analysis for the behavioural sciences.* Routledge.

Glossary

Access

A government target for IAPT is that 15% of those with anxiety or depression should be treated through the IAPT programme[54]. NHS Digital calculates the numerator for access rates – which is the number of referrals entering treatment in a given period – but the denominator (the prevalence of depression and anxiety in the England population) has been determined by NHS England. This is based on figures from the Adult Psychiatric Morbidity Survey, 2000[55].

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

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

Anxiety Disorder Specific Measure (ADSM)

Anxiety Disorder Specific Measures are questionnaires that are sensitive measures of the severity of particular anxiety disorders. The IAPT Data Handbook[56] recommends relevant ADSMs for Obsessive-Compulsive Disorder, Generalised Anxiety Disorder, social phobia, health anxiety, agoraphobia, panic disorder, and Post-Traumatic Stress Disorder. If a patient receives a problem descriptor of one of these conditions, the relevant ADSM should be used to measure change in anxiety during treatment. If the relevant ADSM has not been given at least twice during a course of treatment, the GAD7 (IAPT's generic anxiety measure) is used to assess change in anxiety.

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

Data tables that use ADSM scores:

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

Assessment appointment

All IAPT appointments should be classified by their purpose. An assessment appointment is an attended appointment where the recorded appointment type is either 'assessment' or 'assessment and treatment'.

Data tables based on assessment appointments:

Table 4a.

---

[54] For more information about this, see our 'IAPT Reporting FAQs' document (page 17): http://www.digital.nhs.uk/media/21150/IAPT-Reporting-FAQs/pdf/Understanding_and_replicating_our_published_reports_-July_2015___v1.3.pdf

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

[56] http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf

Bypass patients

When providers' IAPT data submissions to the Bureau Service Portal are processed, each record is assigned a pseudonymised patient identifier based on the NHS number, postcode, birthdate and provider-assigned 'local patient ID'. Where key elements of this information are missing, the pseudo ID generated is flagged up as a 'bypass patient', indicating that poor data quality means we cannot match the record to future submissions[57].

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

Caseness

Caseness is the term used to describe a referral that scores highly enough on measures of depression and anxiety to be classed as a clinical case. It is measured by using the scores that are collected at IAPT appointments; if a patient's score is above the clinical/ non-clinical cut off[58] on either their anxiety score or their depression score, or both, then the referral is classed as a clinical case.

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

Data tables that assess caseness:

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

Completed course of treatment

See 'Finished course of treatment' below.

Entered treatment

In order to enter treatment, a referral must have a first treatment appointment recorded in the period. Some measures based on the first treatment appointment (for example, waiting times) look at a cohort of referrals that ended in the year, as this group represents referrals that have undergone the full IAPT pathway.

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

Table 1a, Table1b, Table 2a, Table 2b, Table 2c, Table 8a, Table 9a, Table 10a, Table 11a, Table 12a, Table 13a, Table 15.

---

[57] See IAPT Data Quality Statement for further information:
http://www.digital.nhs.uk/media/16923/IAPT-DQ-Month/pdf/IAPT-month-dqs.pdf
[58] Information on the cut off values and how they should be used can be found in Appendix 4 of this report. For further information, see the IAPT data handbook: http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf

Finished course of treatment

A referral that has finished a course of treatment is one that has ended having had at least two attended treatment appointments during the referral. Follow-up appointments do not count, since by definition these should take place after the end of a course of treatment. All patients who have finished a course of treatment are eligible for assessment of outcome (recovery, reliable improvement, no reliable change, or reliable deterioration).

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

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

GAD7

The Generalised Anxiety Disorder-7 questionnaire is IAPT's default questionnaire for assessing the severity of anxiety. It was originally developed as a measure of Generalised Anxiety Disorder and can be used as an Anxiety Disorder Specific Measure (ADSM) for this clinical condition. However, it can also pick up changes in other anxiety disorders and is therefore used to measure change in anxiety where the relevant ADSM has not been given at least twice. The GAD7 should be recorded at every appointment.

Data tables that use GAD7 scores:

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

National Institute for Health and Clinical Excellence (NICE)[59]

NICE's role is to improve outcomes for people using the NHS and other public health and social care services. NICE approve and oversee therapy types used in the IAPT programme.

PHQ-9 questionnaire

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

Data tables that use PHQ-9 scores:

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

---

[59] http://www.nice.org.uk

Problem descriptor

This describes the specific problem being assessed by the IAPT service for a given referral (for example, Obsessive Compulsive Disorder). The terminology was changed from 'provisional diagnosis' as it was felt that a formal diagnosis cannot always be made at initial contact with a patient and that this sometimes only becomes apparent over the course of several appointments. For this reason, the problem descriptor can be updated in each submission. In the analysis of outcomes, the problem descriptor used is the last recorded one.

Data tables that use problem descriptor:

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

Recovery (moving to recovery)

Recovery is one of the key outcome measures in IAPT, and services are monitored in terms of the proportion of eligible patients who recover (known as the 'recovery rate' or 'moved to recovery rate').

To be eligible for the assessment of recovery, a patient must have completed a course of IAPT treatment (see definition 'Finished course of treatment') having started their course of treatment at 'caseness' (see definition 'Caseness'). A patient has then moved to recovery if they are no longer at caseness at the end of their treatment.

Data tables that assess recovery:

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

Referral

In order to access IAPT services, an individual requires a referral. Referrals are often provided by General Practitioners (GPs), but there are many other sources of referral, including self-referral by the individual requiring the service. Once a referral has been received by a service provider, it should follow the recommended stepped care pathway[60].

One patient can only have one open referral at a given provider at any one time, but could have multiple referrals across different providers or multiple referrals with the same provider across time. For this reason, a count of referrals is used, rather than a count of people, in IAPT publications.

There are three key stages for referrals in IAPT publications; referral received date, first treatment appointment date, and referral end date.

---

[60] For further information, see 'Talking therapies: a four year plan of action' available at: https://www.gov.uk/government/publications/talking-therapies-a-4-year-plan-of-action

Data tables that assess referrals received:

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

Reliable change (Reliable Improvement and Reliable Deterioration)

The severity of a patient's condition in IAPT is assessed using tailored questionnaires (ADSM and PHQ-9 scores). All measures of symptoms are subject to error. As a consequence, small changes in questionnaire scores may not indicate a real change in clinical state. A change of scores between the beginning and end of a course of treatment is considered a reliable change if it exceeds the measurement error[61] of the questionnaire.

Conversely, patients have shown no reliable change if they fail to show reliable change on *both* anxiety and depression measures, or if reliable improvement is shown on one whilst reliable deterioration is shown on the other.

---

[61] See Jacobsen, N.S. & Truax, P. (1991), 'Clinical Significance: A Statistical Approach to Defining Meaningful Change in Psychotherapy Research', Journal of Consulting and Clinical Psychology, 59, p12-19.

Information and technology
for better health and care

www.digital.nhs.uk

0300 303 5678

enquiries@nhsdigital.nhs.uk

@nhsdigital

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