Version	Date	Summary of changes
Draft	Nov 16	Initial version for feedback at early implementer workshop
v3	Feb 17	Iterated version on Yammer for feedback
v4	March 17	Version agreed at Outcomes & Informatics Committee

Integrated IAPT Data Guide

This IAPT data guide is for anyone working in Integrated IAPT Early Implementer services. This includes clinicians, service managers and commissioners.

What is the purpose of this guide?

The purpose of this guide is to:

- Enable clinicians to use the new measures to reach a shared understanding of a person's difficulties, inform their clinical work and where appropriate, to distinguish between caseness and recovery.
- Enable services to submit the additional data items and routine outcome measures
- To enable local and national evaluation of the Integrated IAPT early implementer services.

Why is data quality important?

In addition to the IAPT Minimum Dataset, Integrated IAPT services will submit additional data and outcomes via their data systems. This information will be used in the national analysis of impact of Integrated IAPT services.

The additional data items and outcome measures cover:

- Mental health and disability
- Perception of the impact of physical health conditions
- Health care utilisation

It is the responsibility of all IAPT workers to enter timely and accurate patient information and scores for each appointment session. Data completeness is critical for:

- Delivery of NICE evidence-based treatment
- Effective clinical governance
- Enhanced patient experience
- Local and national service evaluation

Research (Clark et al 2009) has shown that when services fail to collect outcome data on a significant proportion of treated cases, they overestime their effectiveness. This is because patients with missing data tend to have done less well. For this reason, it is essential that integrated IAPT services achieve the IAPT standard of paired scores for at least 90% of treated cases.

Health care utilisation measures will be essential for Integrated IAPT services in demonstrating the savings and securing investment in an expanded IAPT for people with anxiety and depression in the context of co-morbid long-term physical health conditions and persistent medically unexplained symptoms. Areas should work closely with commissioners to track and evidence activity and savings to ensure there is a viable business case to ensure further investment.

Additional data fields

1. Service type

Field title	Response option	List of options	When to collect
Service Type	Drop down box, select 1	- Core IAPT - Integrated IAPT	- Each appointment

A "service type" field has been added to identify whether activity is in the integrated or core service. Services will need to agree locally how this should be defined, but should consider:

- Whether treatment being provided by an experienced therapist who is booked on/ receiving/ or has received the specific LTC/MUS training
- Whether treatment is co-located with a physical healthcare team
- Whether the clinician is working as part of an integrated team e.g. attending team meetings or attending joint trainings

This should be recorded at every session. This is to enable movement between 'services' within one treatment episode. Everyone treated in the integrated service, should have all of the relevant integrated-IAPT assessment data, as well as the IAPT minimum dataset, completed, even if their initial assessment takes place in the core service.

e.g. it is identified at assessment that someone who self-referred to the core service would benefit from integrated treatment. In this case, he attended an assessment in the core service, and was offered a follow up in the integrated IAPT service, where he and attend a course of 6 treatment appointments.

In this case the initial assessment appointment would be coded as 'core IAPT'. During his first appointment in the integrated service, all of the additional data items (including those which are usually completed at assessment) would need to be recorded. This appointment and each follow up would coded as 'Integrated IAPT'.

Coding this correctly is critical, as it allows us to distinguish between those treated in integrated IAPT and evaluate the impact of integrated services.

2. Long term condition

Field title	Response option	List of options	When to collect
Long Term Condition	Drop down box, can select multiple	- Diabetes - Chronic Obstructive Pulmonary Disease (COPD) - Asthma - Other Respiratory Disease - Heart disease - Cancer - Musculoskeletal Disorder (MSK) - Chronic pain, including fibromyalgia - Epilepsy - Skin condition including Eczema - Digestive tract conditions - Other (tick box)	- Recorded once per episode

Multiple long-term conditions can be selected, which will enable evaluators to look at the impact of co-morbidity.

3. Medically unexplained symptoms

Field title	Response option	List of options	When to collect
Primary Medically unexplained symptoms	Select 1 only	- Irritable Bowel Syndrome - Chronic Fatigue Syndromes/ Myalgic Encephalopathy (ME) - MUS – not otherwise specified - None - Unknown	- Recorded once per episode

		- Not stated	

We are aware that there will be instances where more than one MUS is present. Only the primary medically unexplained symptom can be selected here. This is because the outcome measure associated with each of these conditions can be used in place of the GAD-7 to calculate recovery from the mental health problem (provided the measure is repeated).

4. Additional outcome measures

The additional questionnaires will be collected alongside the existing routine outcome measures.

1. Healthcare Utilisation

Measure	Used at every session and to calculate recovery (where indicated by problem descriptor)?	Data needed for evaluation/nationally	Notes
CSRI for use in integrated IAPT	No – use at first session, last session and at follow up	All responses except those with free text	

2. Long Term Conditions

Long Term Condition	Measure	Used at every session and to calculate recovery (where indicated by problem descriptor)?	Data needed for evaluation/nationally	Notes
Chronic Obstructive Pulmonary Disease (COPD)	COPD Assessment Test (CAT)	No – use at first and last session and at therapists discretion during treatment. Not used to calculate recovery from mental health problem.	Total score	
Diabetes	Diabetes Distress Scale	No – use at first and last session and at therapists discretion during treatment. Not used to calculate recovery from mental health problem.	Total score	
Chronic pain, including fibromyalgia	Brief Pain Inventory	No – use at first and last session and at therapists discretion during treatment. Not used to calculate recovery	Total Score of Pain Interference Subscale	Questions 1, 2, 7 and 8 can be dropped as they don't contribute to either of the sub-scales.

		from mental health problem.		System suppliers required to confirm this will not be made available for commercial use (e.g. clinical trials) and copyright information be displayed.

Where patients present with more than one long term condition, clinical decisions should be made regarding which LTC measures would be most suitable to use. LTC measures are to help inform assessment and clinical decision making.

3. Medically unexplained symptoms

Medically Unexplained Symptoms	Measure	Used at every session and to calculate recovery (where indicated by problem descriptor)?	Data needed for evaluation/nationally	Caseness
Chronic Fatigue Syndromes/ Myalgic Encephalopathy (ME)	Chalder Fatigue Questionnaire	Yes	Total score	≥19
Irritable Bowel Syndrome (IBS)	Francis IBS Symptom Severity Scale (5 items)	Yes	Total score	≥75
Medically Unexplained Symptom – Not Otherwise Specified	PHQ-15	Yes	Total score	≥10

Patient self-report measures for heart disease, and several other long term conditions are not available. In these cases, therapists should pay particular attention to the WSAS which assess patient reported disability in a range of domains. This emphasises the importance of good data quality in both the IAPT minimum dataset, and the integrated IAPT specific items.

LTC measures (page 4) will not be used to calculate recovery from the primary mental health problem. Best practice suggests these should be completed as a minimum at the beginning and end of treatment to support and guide treatment interventions.

The outcome measures for MUS (page 5) can be used to calculate recovery, and therefore need to be **completed at every session.**

A note about the relationship between the Problem Descriptor (ICD-10) and LTC and MUS and the calculation of recovery:

All of the IAPT minimum dataset, including Problem Descriptor should be completed for all patients in both integrated and core services. For patients who are seen in the integrated service, the LTC or MUS which they have will also be captured in the additional data fields, as per the above.

For those being treated in the integrated service with LTCs, the purpose of treatment is to treat the person's anxiety or depression in the context of their LTC. The problem descriptor (ICD-10 code) which is selected as part of the IAPT minimum dataset would therefore be the primary presenting mental health problem which is being treated. The LTC(s) would then be specified in the additional field (as described above).

As the additional LTC outcome measures are not used to calculate recovery from the mental health problem, this will continue to be calculated as usual (using the PHQ9 and GAD7 or ADSM, depending on what their problem descriptor is).

For those being treated in the integrated service for MUS, Somatization Disorder (ICD-10 code: F45.0) should be selected as the problem descriptor in the IAPT minimum dataset. The relevant MUS would then also be selected in the additional field.

As Somatization Disorder is not associated with an ADSM, patients would complete the routine IAPT measures and the relevant MUS specific outcome measure. The MUS specific outcome measure can be used, in conjunction with the PHQ9 to calculate recovery (provided paired scores are available).

The calculation of recovery in the standard national reports remains unchanged, and all patients should complete all of the routine IAPT measurements at each appointment.

Main Mental Health Problem (primary problem descriptor)	**Depression Measure**	**Other Recommended Symptom Measure (ADSM/MUS)**	**Back-up to "Other Recommended Symptom Measure" for calculating recovery if other recommended measure is missing**
Depression/ Depressive episode	**Patient Health Questionnaire -9 (PHQ-9)**	**Generalised Anxiety Disorder – 7 (GAD-7)**	
Generalised Anxiety Disorder	**PHQ-9**	**GAD-7**	
Mixed anxiety/depression	**PHQ-9**	**GAD-7**	
No problem descriptor/ other	**PHQ-9**	**GAD-7**	

problem descriptor			
Social anxiety/ Social phobias	**PHQ-9**	**Social Phobia Inventory (SPIN)**	GAD-7
Post-Traumatic Stress Disorder	**PHQ-9**	**Impact of Events Scale – Revise (IES-R)**	GAD-7
Agoraphobia	**PHQ-9**	**Mobility Inventory (MI)**	GAD-7
Obsessive Compulsive Disorder	**PHQ-9**	**Obsessive-Compulsive Inventory (OCI)**	GAD-7
Panic Disorder	**PHQ-9**	**Panic Disorder Severity Scale (PDSS)**	GAD-7
Health Anxiety/ Hypochondriasis	**PHQ-9**	**Health Anxiety Inventory**	GAD-7
Irritable bowel syndrome*	**PHQ-9**	**Francis IBS scale**	GAD-7
Chronic fatigue syndrome*	**PHQ-9**	**Chalder Fatigue Questionnaire**	GAD-7
MUS not otherwise specified*	**PHQ-9**	**PHQ-15**	GAD-7

* denotes a mental health problem that is new to the IAPT programme as it is being introduced in the context of integrated IAPT. These are not currently included in the list of IAPT problem descriptors, the appropriate primary problem descriptor would be Somatization Disorder.

The pair of measures shown in bold are those recommended for calculating recovery and reliable improvement. If the "other recommended measure" is missing, then recovery/ reliable improvement has to be calculated using the combination of PHQ-9 & GAD-7.