Integrated IAPT (IAPT-LTC) Frequently Asked Questions

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1. Evidence base

- ***What is the evidence base for this programme?***

  A person's mental and physical health are intrinsically linked. Around one third of people with long-term physical health conditions such as diabetes, cardiovascular disease or respiratory disease, have a coexisting mental health problem. Where a mental health problem coexists with a long-term physical health problem, the potential for harm is greater. This includes poorer health outcomes, reduced quality of life and considerably higher healthcare costs.

  Providing effective care requires integrated mental and physical healthcare which means that people's mental and physical health is assessed and, where needed, treated, wherever they come into contact with healthcare services. This requires staff to be competent in identifying potential mental health and physical health problems and to ensure patients access care in pathways with fully integrated assessment, care and treatment where needed. This includes improving the availability and quality of mental healthcare for people in physical healthcare settings and the quality of physical healthcare provided for people with mental health problems.

  There are a number of different models of integrating mental and physical health staff which may vary with the nature of a person's difficulties and the settings in which care is provided.

  There is good evidence that psychological interventions can save 20% of physical healthcare costs.[1]

  The evidence for physical healthcare savings is strongest in the following areas[2]:

  - *Diabetes.* For instance an IAPT pathfinder site found a net cost reduction of £372 for people with co-morbid diabetes and common mental health problems.

[1] See for instance Chiles, J.A., Lambert, M.J. and Hatch, A.L. (1999), "The impact of psychological interventions on medical cost offset: A meta-analytic review", Clinical Psychology: Science and Practice, 6(2): 204-220.

[2] See Layard, R. and Clark, DM (2015) Thrive: The Power of Psychological Therapy (Chapter 11), Penguin, London, which sets out the evidence in detail.

- *Cardiovascular disease*. For example an intervention in people with angina reduced both admissions by 33% and length of stay in patients the following year, with savings of £1,337 per person in 2007.
- *Respiratory disease, particularly COPD*. For instance in Hillingdon gross savings of £837 per person over 6 months in secondary care costs (fewer A&E presentations and bed days when admitted), and £1,300 in overall healthcare costs over 6 months.

Many people have multiple long term conditions as well as a physical health problem, so distinctions are not as clear in reality. There may also be areas of current good practice which mental and physical health areas want to build services around, for instance medically unexplained symptoms, musculoskeletal disease or cancer with a good prognosis.

Trials evidence suggests savings will outweigh the cost of intervention – meaning that services will become self-funding relatively quickly.

Other useful documents include:

- NHS Confederation (2016) 'Investing in emotional and psychological wellbeing for patients with long-term conditions'
- Naylor et al, The King's Fund (2016) 'Bringing together physical and mental health'
- Naylor et al, The King's Fund (2012) 'Long-term conditions and mental health – The cost of co-morbidities'
- 'Implementing the Five Year Forward View for Mental Health'

2. IAPT-LTC Definition

- ***What is the definition of an IAPT-LTC service?***

IAPT-LTC transformation funding was intended to develop new co-located and IAPT-LTC services: delivering evidence-based psychological therapies for people with anxiety/depression in the context of physical long term conditions and/or medically unexplained symptoms. Therapies will be tailored and focused on the areas where the evidence base for physical healthcare savings is the strongest. This will mean more people with common mental health problems **access treatment,** both their **mental health and management of their physical health improves**, and **savings** are achieved across the physical health system.

Integration not only applies to treating patients with comorbid mental and physical health conditions but also integrating into existing physical health care pathways and into co-located premises. It is more than simply using a room in a GP clinic which is no different from core IAPT service working practices. It could be in a primary or secondary care setting, the important thing is to be working closely with physical health colleagues, learning from each other, supporting practice and providing an integrated approach to patient-centred care. IAPT clinicians will learn to adapt their treatments for patients with comorbid anxiety/depression and LTCs and with persistent distressing symptoms of MUS via the top-up training in LTC/MUS.

The definition of an IAPT-LTC service is as follows:

An IAPT-LTC service will expand access to psychological therapies for people with long term conditions and/or medically unexplained symptoms by providing care genuinely integrated into physical healthcare pathways working as part of a multidisciplinary team, with therapists, who have trained in IAPT LTC/MUS top up training, and provide evidence based treatments collocated with physical health colleagues.

- ***Is there any guidance on how to design an IAPT-LTC service?***

Guidance was circulated as part of the application process, *Annex A – IAPT Expansion useful information*, and is also available on Yammer. In addition, the *interim Implementation Guidance for Integrated Services* from the National Collaborating Centre for Mental Health is

available on Yammer, with the final version due to be published later this year. If you need access to Yammer, please email ENGLAND.MentalHealth@nhs.net

The Royal Colleges of Psychiatrists, General Practitioners, Physicians and the British Psychological Society have published a statement on providing evidence-based psychological therapies to people with long-term conditions and/or medically unexplained symptoms.

This and the evidence for what works in delivering psychological therapies suggest that high performing services will include:

High quality therapies

- NICE-recommended therapies are delivered by appropriately trained practitioners for an appropriate number of sessions.
- Treatment delivered cost-effectively, including stepped-care when appropriate for the person being treated. Appropriate therapy rooms and equipment (computers & recording devices) available.
- Short waiting times: for initial and subsequent treatments, and for moving between interventions in a stepped care model.
- People are offered a choice of therapy where NICE have identified a number of appropriate interventions for the problem descriptor.
- Clinical leaders have the right expertise, support the welfare of staff, and create a collaborative climate in which performance data is seen as a facilitator of service development and innovation.
- Practitioners receive weekly case supervision, and have access to ongoing Continuing Professional Development.

Information that supports treatment

- IT systems for services support supervision as well as outcome monitoring.
- All patients have their clinical outcomes recorded, and included in national data collections.
- Primary and secondary healthcare utilization data is collected before and after psychological therapy in order to demonstrate any savings.

Integrated care

- Physical and mental healthcare provision is co-located, and psychological therapies services are integrated into existing medical pathways and services. These may be either primary or secondary care services.
- Services promote genuine interactions between professionals, allowing mutual education, support, and the exchange of ideas.

NHS England worked with 13 Pathfinders between 2010 and 2013 who trialled integrated services. The final evaluation is yet to be published; however emerging learning from the sites shows:

- Psychological therapies specifically tailored to long-term conditions achieved better outcomes than generically delivered psychological therapies.
- Services tailored to specific long term conditions (e.g. embedded in the diabetes pathway) performed better than those working on long term conditions / medically unexplained symptoms generally.
- Data collection can be challenging – focus and effort is required from the start of a project to get this right.
- People with Medically Unexplained Symptoms can be hard to engage in psychological treatment, but some methods for enhancing engagement have been identified.

- ***Is there any guidance around referral pathways?***

This will be locally determined because pathways will differ between sites. You will need to identify who sees patients with the physical health condition you are targeting and where. There may be pathway documents detailing this within your local area to see where you might fit in best. Consulting with physical health care colleagues and commissioners can highlight opportunities for developing the pathway to include screening for anxiety/depression and making IAPT treatments available. Your pathway should include opportunities for co-location and integrated working including liaison, mutual training and support and multidisciplinary team working as appropriate in line with the definition of IAPT-LTC.

3. Engaging with the wider health care system

- ***How do we best communicate the benefits of this programme to physical health teams? Are there any examples that can be shared?***

  Some physical health care teams will already be aware that integrating mental and physical health care has many positive benefits. For those who are less sure or not aware of integrated practice then having a summary of key facts and examples of engagement and service user involvement could help promote this. Discussion and sharing ideas can help unify mental and physical health care professionals – both are "expert" in their own field and "together" can work well. Some Early Implementer sites were Pathfinder sites and can be contacted via Yammer. Some have published and could provide practice examples.

  Opportunities to engage with physical health colleagues should be identified at the start of the project. Feedback from our Wave 1 sites has shown that developing engagement and relationships with other parts of the healthcare system can cause significant delays and do take time. Involve physical health colleagues in the development of the pathways to create shared ownership of the transformation.

4. Management and monitoring of IAPT-LTC Early Implementer delivery

- ***What is the national IAPT programme at NHS England doing to assure delivery of the Wave 1 & 2 IAPT-LTC services?***

  As Wave 1 & 2 sites move from 'implementation' to 'delivery' the focus for the national IAPT programme is to ensure that the funded services are delivering in line with their successful bids and the overarching principles including integration, co-location and multi-disciplinary working. We will be monitoring services on the achievement of the commitments made through quarterly monitoring submissions. This includes number of patients seen, number of trainee therapists, co-location of therapists and numbers based in primary care, the integrated delivery of the pathways within physical health and the outcomes achieved by this cohort of patients. All sites will have at least one visit from the national team in addition to delivery telephone conferences halfway through the funding period. If necessary further site visits will be arranged to assure progress is in line with the initial proposal. All sites are also invited to attend the national workshops for Early Implementers, which are organised by the IAPT national programme team.

- ***The focus seems to have shifted from recovery rate targets to savings. Can you clarify how important it is to show savings?***

  Both are important – the focus on savings is needed to secure funding in order to continue delivering IAPT-LTC services – and high quality services are likely to be those that can do both. It is important to continue to achieve recovery rates greater than 50% as well as demonstrate cost savings.

- ***What if I have seen a patient in the IAPT-LTC service for one or two treatment appointments in June 2017 and then transferred the patient to Core IAPT for 5 sessions. In the quarterly monitoring submission to NHS England, do I report this patient as an***

integrated IAPT patient seen in June (the monitoring submission relates to wave 1 and 2 sites only)?

Yes, if the patient has a treatment appointment in the integrated pathway (see definition of IAPT-LTC), and they have not already had a treatment appointment in the integrated pathway in a previous month, this patient would be reported as entering integrated IAPT treatment in June. We have selected this method of monitoring number of patients seen as this is in line with NHS Digital's method of calculating the access rate for core IAPT.

- ***What if a patient has an initial assessment appointment in the IAPT-LTC service in July, and is then moved to the core service for the first treatment appointment? Would I report this in the monitoring form as having been seen in an IAPT-LTC service?***
  As this person has not had a treatment appointment in IAPT-LTC, they would not be counted towards the numbers entering treatment in the IAPT-LTC service.
- ***What if a patient is initially assessed and treated in the core service in June, but receives a first treatment appointment in the IAPT-LTC service in July? How do I report this in the monitoring form?***
  As this person has had a first treatment appointment in the IAPT-LTC service in July, they would count as having entered integrated treatment in July.
- ***If a patient, who has a long term physical health condition, is seen by one of our LTC trained therapists but is not in a pathway/does not have a physical health condition we have specified within our IAPT-LTC service can we count them towards the numbers of patients seen in the IAPT-LTC service?***
  We strongly encourage sites to adhere to the commitments they have set out in their bids for the following reasons:
    - The conditions specified in the bids are those where the evidence base is the strongest.
    - It takes a considerable amount of time and resources to develop and set up new pathways.
    - The timescales of this programme limited and national funding is only available until the end of March 2018. For the duration of the Early Implementer programme, we ask sites to focus specifically on the pathways / conditions they have outlined in their bids. We therefore expect the majority of patients seen in an integrated service to be those whose physical health condition matches the ones you have specified in your bid and who are seen in the specific pathway developed for that long term condition by the IAPT-LTC service.

  If sites would like to discuss developing alternative pathways this should be discussed with the IAPT programme team in the first instance.

  In terms of monthly data submissions to NHS Digital, all data received in the additional LTC/MUS data tables will refer to patients seen in an IAPT-LTC service. So for any appointments coded as 'integrated' by sites, will refer to patients seen in an integrated service, and the additional data will flow to NHS Digital in the additional tables and the core data will flow in the core tables.

5. Rollout beyond March 2018

- ***What is required from services that are not part of Wave 1 & 2 for the expansion?***

  There is a national target to achieve 25% access by 2020/2021; this applies to all IAPT services.

  The 2017-19 NHS Operational Planning and Contracting Guidance sets out the following ambition:

From 2018/2019 CCGs will commission IAPT services integrated with physical healthcare and supporting people with physical and mental health problems. This should include increasing the numbers of therapists' co-located in general primary care practice by 3,000 by 2020/21.

CCGs who are part of Wave 1 & 2 have received additional funding for the first two years (2016/17 & 2017/18) to support this objective. From 2018/19 funding will be in CCG baselines to mainstream integrated services, building on the experience of Waves 1 & 2 in the first two years. As CCGs and services develop plans locally they may want to consider the value of local evaluations and data linkage to track savings, determine the impact on other services and ensure sustainability of the service.

CCGs and services who will be starting to develop their own IAPT-LTC service from April 2018 should read the published documentation and engage locally with their physical health colleagues to plan ahead.

- ***I am part of Wave 1 or 2 and understand the results from the national evaluation will not be available before March 2018. What can we do to make the case for continued funding for IAPT-LTC services?***

  During the evaluation process, bids were selected to be funded based on a variety of factors:

  - Commitment to continue funding the services post March 2018 in order to achieve the access targets outlined in the Five Year Forward View for Mental Health.
  - Commitment to complete a local evaluation, which involves linking IAPT data with healthcare utilisation data. Local evaluations are crucial as they allow services to measure and track savings locally, and are able to provide granular and real-time information, with the advantage that this can continue after the lifetime of the national project. It is down to local determination as to what data should be linked and used to evidence savings which will lead to case for continued funding of the service.
  - Commitment to expand the workforce – the numbers of trainees to replace the experienced, qualified staff moving into the IAPT-LTC service.
  - Commitment to provide truly integrated care within physical health pathways.

6. IAPT-LTC Data

- ***What guidance is available on which measures to use and how to record them?***
  Please refer to the *Integrated IAPT Data Handbook* for information about the measures required to use for patients seen in an IAPT-LTC service. The handbook, along with copies of all additional measures, is available on Yammer.

- ***What should we do if there isn't a measure for the LTC our service is working with?***

  Patient self-report measures for heart disease and several other LTCs are not available currently. In these cases, therapists should pay particular attention to the Work and Social Adjustment Scale (WSAS) which assesses patient reported disability in a range of domains. LTC measures are to help inform assessment and clinical decision making. They will not be used to calculate recovery from the primary mental health problem. They should be completed as a minimum at the beginning and end of treatment to support and guide treatment interventions.

- ***Will the LTC and MUS measures be used to calculate recovery?***

  LTC measures are used to inform assessment and clinical decision making, and will not be used to calculate recovery. MUS measures can be used to calculate recovery, provided paired scores are available, the problem descriptor is coded as Somatization Disorder (F45.0) and the relevant MUS is selected in the Medically Unexplained Symptoms field.

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

The measures used to calculate recovery from the mental health problem are listed below:

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 problem descriptor	**PHQ-9**	**GAD-7**	
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.

- ***If somebody has both an anxiety disorder which is associated with an ADSM an MUS, which measure will be used to calculate recovery?***

  The measures used to calculate recovery depends on the problem descriptor selected. If the focus of treatment is an MUS, then Somatization Disorder should be selected as the Problem Descriptor, and the MUS measures can be used along with the PHQ-9 to calculate recovery. If the focus of treatment is an anxiety disorder, then this should be selected as the problem descriptor and the relevant ADSM will be used to calculate recovery.

- ***What can I do to ensure I collect and record high quality data?***
  - Continue completing all IAPT MDS fields, for all patients
  - For patients seen in the IAPT-LTC service, collect the additional measures alongside the existing routine outcome measures
  - Follow routine protocols for collecting, recording, and flowing data
  - Monitor data quality for both MDS and additional IAPT-LTC data
  - Refer to the *Integrated IAPT Data Handbook* hosted on Yammer

- Check that the service type (Core IAPT / Integrated IAPT) is recorded correctly at each appointment – This allows you to distinguish between those treated in Integrated IAPT and those treated in core IAPT and filter data appropriately for submission to NHS Digital
- Check that the measures are completed correctly – copies of the measures are hosted on Yammer
- Check that all additional fields and measures are available on IAPT data systems, so data can flow to NHS Digital (only total scores will flow, plus 5 data fields from the CSRI)
- You can select multiple LTCs but only one MUS as this can be used to calculate recovery
- MUS: Use the additional outcome measures at each appointment
- LTC: Measures are to help inform assessment and clinical decision making. They will not be used to calculate recovery from the primary mental health problem. They should be completed as a minimum at the beginning and end of treatment to support and guide treatment interventions
- Where patients present with more than one LTC, clinical decisions should be made regarding which LTC measures would be most suitable to use.
- Where no specific measures for LTC are available, particular attention should be paid to the WSAS which assess patient reported disability in a range of domains.
- Measures should align with the problem descriptor used

- ***What can I do to ensure the IAPT-LTC data submission is successful?***
  - Use the correct IDB v1.5.4, which allows flowing both core data and additional IAPT-LTC measures in one submission
  - Continue to submit the 7 mandatory tables for all referrals and appointments (both core and integrated)
  - Submit 4 additional tables which only include data associated with patients seen in the IAPT-LTC service
  - Each integrated appointment record should have a corresponding appointment record in the mandatory tables, because the additional measures flow in the additional 4 tables and the core measures flow in the 7 mandatory tables
  - Submit data as early as possible, so any error messages can be resolved before the submission window closes (Link to submission dates and further information: http://content.digital.nhs.uk/iapt)
  - Check for data completeness before submitting the data, especially service ID and local ID so core IAPT and integrated data can be linked
  - Check that NHS numbers are included for each patient, so their data can be linked with other datasets, when approvals are in place
  - Ensure you submit the LTCAPPOINTMENT information for all appointments in the IAPT-LTC service
  - If you receive any warning messages when submitting integrated data, review the messages and if necessary correct and resubmit your data before the submission window closes.
  - Routinely check that local and nationally published data are aligned and any significant variances are investigated and fully understood.

- ***Which additional data should be submitted to NHS Digital as part of the additional data tables? Are there any filters to consider?***

  The additional data fields and measures (as detailed in the *Integrated IAPT data handbook*) should only be submitted for patients seen in the integrated service. The Service Type field does not flow to NHS Digital, but should be used to filter the data so that only data associated with integrated appointments is submitted in the additional data tables.

Therefore all of the data received in the additional data tables will refer to patients seen in an IAPT-LTC service. This is how NHS Digital will know which patients have been seen in an IAPT-LTC service. The core / routine IAPT measures (e.g. PHQ/GAD) taken at integrated appointments will flow in the corresponding mandatory tables. This is why each integrated appointment should have a corresponding appointment in the mandatory tables.

When you filter the additional data in preparation for submitting it to NHS Digital, please include all additional data specified in the IDB (v1.5.4) for patients who have been seen in an IAPT-LTC service.

Data in the additional tables will therefore:

- Include all data required, including the additional data fields, (as per the IDB v1.5.4) for appointments where the service type is coded as 'Integrated'
- Will NOT include data for appointments where the service type data field is coded as 'Core'
- Include all required data fields (as per the IDB) which are recorded at a referral level (i.e. LTC, MUS, CSRI) for any patient with an appointment coded as integrated in the service type field

As a reminder, providers need to submit the 7 mandated tables for **all** referrals and appointments. This is to ensure that all routine IAPT measures flow for both core and integrated appointments.

7. Local Evaluations

- ***Why do we require both national and local evaluations? What is the value in also carrying out local evaluations?***

  The national evaluation has a defined scope and will report the impact of all Wave 1 IAPT Early Implementers on acute healthcare utilisation. The national evaluation will not include assessment of the impact on primary care and will not examine in detail whether each local service has been successful. The local evaluation can also be used as evidence for local commissioners to continue to fund the service beyond the end of the Early Implementers programme as it will show the impact and financial savings that have been delivered locally by the IAPT-LTC service. In addition, due to how the data flows to NHS Digital and the time lag in processing and publishing the data, it is likely that the results of the local evaluations will be available much sooner than the results of the national evaluation.

  There are currently no plans for Wave 2 sites to be included in the national evaluation.

- ***Whose responsibility is it to carry out the evaluations and show savings? Commissioners or services?***

  This is a shared responsibility; both services and commissioners have submitted a bid and signed an agreement. Commissioner support is key in this undertaking because they will be able to request access to healthcare utilisation data and will be able to advise on the type of information required to inform commissioning.

- ***Do we have to do a local evaluation? What is the minimum we can do locally? Could we use the CSRI data in the interim to show savings?***

  Yes, there is a requirement for Early Implementers to undertake a local quantitative evaluation but the scope of this should be determined locally. The aim is to show if your service has had an impact on appropriate healthcare utilisation metrics over the course of the programme. This will help NHS England to understand variation between the different approaches and on different LTC/MUS conditions as well as providing the evidence for local commissioners to provide ongoing funding for the service.

  The approach should be pragmatic based on local availability and capacity to undertake the analysis required, so do consult with your commissioners and develop an approach that

works in your local context and is feasible. It is possible to use the CSRI as an interim metric, however, commissioners tend to place more weight on findings based on healthcare utilisation metrics captured in routine data systems rather than self-report. Linking IAPT data to healthcare utilisation data and assuring the data quality within both datasets should provide a more robust approach. It will also allow you to assess the impact on more focused healthcare utilisation metrics that are appropriate to the long term condition or medically unexplained symptoms conditions for your service. There is lots of support on offer, so do get in touch if you need any help.

- ***Which methods might be appropriate for evaluating the impact of IAPT-LTC services locally? Is there any support available to help design local evaluations?***

  Mike Woodall has developed a *Local Evaluation Support Guide* (available on Yammer), which includes information around evaluation design, information governance, data linkage and outcome metrics. Sites can also contact him for 1:1 support: m.woodall@nhs.net. This support offer is available to Wave 1 and Wave 2 sites.

  In addition, NHS England has commissioned support for Wave 1 sites from Professor David Stuckler at Oxford University to provide support to early implementers on evaluation design. This can be accessed by e-mailing Ineke Wolsey at ineke.wolsey-anxietydepression-IAPT@oxfordahsn.org.

8. Consent / IG

- ***What is the legal basis for flowing data nationally?***
  The legal basis for flowing IAPT data to NHS Digital is a commencement order, which is a type of Direction, issued by the Department of Health. It allows for IAPT MDS data to be collected by IAPT services and to flow to NHS Digital for analysis and reporting. The additional LTC/MUS data are covered by the Data Services for Commissioners Directions 2015.

- ***Do we need additional consent for flowing LTC/MUS data nationally?***
  No additional consent is required for flowing additional LTC/MUS data to NHS Digital. LTC/MUS data flows alongside routine IAPT data to NHS Digital, so local routine protocols need to be followed for flowing data to NHS Digital, who are the national safe haven able to process and de-identify patient data for secondary use purposes, where it is required to ensure that the requesting organisation can meet its statutory duties. The supporting legal basis is the Data Services for Commissioners Directions 2015.

- ***Do we need additional consent for data linkage carried out as part of the national evaluation?***
  No additional consent for data linkage is required for the purpose of the national evaluation of the IAPT- LTC programme. A data sharing agreement is in place between NHS England and NHS Digital, which sets out the legal basis for the sharing of IAPT data and healthcare utilisation (SUS) data, and analysis of linked data. A data processing agreement is in place between NHS England and the evaluators, which allows the processing of IAPT and SUS data for the analysis required for the evaluation and the linking of the two datasets.

- ***Will the data be anonymised, and stored and processed securely?***
  Data will be held on secure platforms, which can only be accessed by a small number of authorised individuals. Strict protocols are in place to ensure the secure transfer and processing of data. Data analysed by the evaluators is pseudonymised to an agreed specification which meets the ICO Anonymisation Code of Practice. The data will not include names, DOB, addresses, or other information which would enable the analysts to re-identify patients. Any reports generated from the analysis will be reported in aggregate form only, following NHS Digital's disclosure rules, with numbers smaller than 5 being suppressed.

- ***Why might I need to ask for consent for local evaluations?***

  Consent is required when there is no other legal basis available to share data. When consent is required, it needs to be explicit and must be fully informed and freely given. It does not always have to be written consent as long as has been recorded in case the consent is challenged. Consent can be removed or withheld by the patient at any time.

  Consent will be required if you wish to link the IAPT data to primary care data as there is no current legal basis covering the flow of this data from a DSCRO for the purpose of evaluating the IAPT programme. Consent may also be required if the local arrangements you put in place for sharing data are not covered by a legal basis to share (e.g. the DSCRO are unable to use the Section 251 to share data with the organisation undertaking the analysis). These issues will need to be addressed when undertaking your Privacy Impact Assessment (PIA).

- ***How do we add specific consent to the data systems? How do we distinguish between routine consent and local consent on a practical level?***

  There might already be a specific additional consent item on your data system, for example, for research purposes, which you can use locally to record participation in your evaluation. It is important that when you flow data to NHS Digital, you use the routine consent items, the same way as you would usually flow your core IAPT MDS data nationally.

9. Local data linkage

- ***What is a DSCRO and how might it help with data linkage?***

  A Data Services for Commissioners Regional Office (DSCRO) is a part of NHS Digital and they are generally housed within Commissioning Support Units (although some may be housed with CCGs). They are covered by the same legislation as NHS Digital that allows them to process patient confidential data. This allows them to link patient data and make this available for analysis. The sharing of data from the DSCRO with other organisations is not covered by the same regulations and therefore requires a different legal basis for sharing. There is a Section 251 currently in place that covers the sharing of specific pseudonymised datasets between DSCROs and Accredited Safe Havens (ASHs) that would allow the sharing of IAPT and SUS acute datasets with commissioners but does not cover primary care data (**A003/CAG 2-03 -**http://www.hra.nhs.uk/documents/2017/04/cag-non-research-register-march-2017.xls).

  The likely process for Early Implementers would be to submit a local IAPT dataset to the DSCRO (this can be based on the national data specification), the DSCRO would then pseudonymise this data using the same key as the acute data and share the pseudonymised IAPT dataset along with the pseudonymised acute that has been requested. This data can then be linked as it contains a common key but does not hold data that would allow individuals to be identified. The same process can be used for primary care data but explicit consent would need to be sought for this data as it is not covered by a section 251 approval.

  More information on DSCROs can be found at the link below:
  http://content.digital.nhs.uk/dataservicesforcommissioners

- ***Can NHS Digital send IAPT data to DSCROs for linkage with HES/SUS data?***

  No. The linkage done at a national level uses a different pseudonymisation process than is used within each DSCRO and therefore the nationally processed IAPT will not match locally collected SUS data. The relevant fields from the local IAPT dataset can be shared with the DSCRO who can then pseudonymise this dataset and any other required datasets using the same key which will allow the data to be linked for the evaluation. This data sharing should be underpinned by a sound legal basis and a data sharing agreement signed by all parties. The PIA process will help you define the legal basis and create the content needed for the DSA.

- ***How do I link the IAPT data to the healthcare utilisation data?***

  The NHS Number can be used as the basis for data linkage. This is relatively well collected by most organisations and is unique to an individual. As the data is being linked for analysis, which is a secondary purpose, the NHS Number should be pseudonymised to avoid the unnecessary use of identifiable data. All datasets should be pseudonymised using the same key to ensure that the same person can be matched in each dataset. Data quality checks can be applied to the data to ensure the pseudonymisation process has been applied by consistently checking that the demographics (age and gender) are the same in all datasets (ensure you take into account that the age could have been calculated on different dates within the datasets and therefore allow a year each way when checking the dates). If you have any datasets that do not have a high level of NHS Number coverage the Personal Demographics Service (PDS) from NHS Digital may be able to help with NHS Number tracing. Details of this service can be found at https://digital.nhs.uk/Demographics.

- ***Do we need to undertake a Privacy Impact Assessment (PIA)?***

  Yes. Although PIAs are not currently a legislative requirement they are best practice and mandated in the NHS through the HSCIC Information Governance Toolkit. Undertaking PIAs will become legislative next year with the introduction of General Data Protection Regulation (GDPR) in May 2018. Guidance and an example PIA used by one of the Early Implementers are available on Yammer. If you haven't yet completed your PIA, it is important to start this as soon as possible.

- ***Do we need a Data Sharing Agreement (DSA) in place to flow data?***

  Yes. Data Sharing Agreements will need to be in place to flow the data. The content of these will be supported by the PIA which should include all the data required for the DSA. An example DSA from one of the early implementers is available on Yammer.

- ***Is there any support available to help Early Implementers?***

  Yes. Midlands and Lancashire CSU have been commissioned to provide support to the Wave 1 and 2 Early Implementers on data quality, information governance, data linkage, healthcare utilisation metrics, and evaluation design. This support can be accessed by e-mailing Mike Woodall at m.woodall@nhs.net.

10. Healthcare utilisation outcome metrics

- ***Is there any guidance on how to specify suitable healthcare utilisation outcome metrics? Are there specific metrics for each long term condition?***

  Information on healthcare utilisation outcome metrics is included in the *Local Evaluation Support Guide*, developed by Mike Woodall and available on Yammer, which introduces the range of metrics available, which datasets they are in, and reviews the metrics used in previous studies for the various LTC/MUS. In addition, on Yammer, you can find the *Logic Model* which underpins IAPT-LTC and guidance on how to develop your own logic model.

- ***Have other Early Implementer sites identified suitable healthcare utilisation outcome metrics for specific conditions?***

  Some sites have identified the healthcare utilisation metrics they are going to measure. We encourage sharing via Yammer and through the workshops organised by NHS England and Midlands and Lancashire CSU.

11. National evaluation

- ***Who is undertaking the national evaluation? And which methods will be used?***

Two studies have been commissioned as part of the national evaluation: an implementation study / process evaluation by the National Collaborating Centre for Mental Health and a healthcare utilisation study by Imperial College.

The healthcare utilisation analyses aim to investigate the impact of IAPT-LTC on patient outcomes and secondary healthcare utilisation, including savings, in order to collect evidence to build a strong case for commissioners to support implementation across the NHS. Linked IAPT & inpatients, outpatients and accident and emergency data held by NHS Digital will be used for the analyses, including the additional LTC/MUS measures. Those who were treated in IAPT-LTC services will be compared with matched controls identified in the healthcare utilisation sample, looking at data 3 years prior to implementing IAPT-LTC.

Using mixed methods approaches, the implementation study aims to understand new ways of working and support implementation planning by exploring which aspects of the service implementation contributed to changes in outcomes and to enable learning. It aims to measure 'how' sites introduce the service and 'what' the services look like, providing information to understand what 'good' looks like in an IAPT-LTC service. It will include learning around the issues and challenges encountered by Early Implementers, how these were resolved, and what these mean in the context of policy and commissioning.

- ***What is required from Early Implementer sites to contribute to the national evaluation?***

  The healthcare utilisation analyses rely on local sites to correctly collect and record IAPT MDS data and the additional data specified in the *Integrated IAPT Data Handbook* for patients seen in an integrated service. This data then needs to flow to NHS Digital using routine protocols and using the correct IDB, which allows the additional tables to flow along with the core IAPT data.

  For the implementation study, we ask that local sites participate in the evaluation, which is likely to involve questionnaires, interviews, or participating in focus groups.

  There are currently no plans to include Wave 2 sites in the national evaluation, however, all Early Implementer sites are required to submit data to NHS Digital.

- ***When will reports be available from the national evaluation?***

  Reports are due in March 2018.

12. Support available for Early Implementers

General implementation support	Come to workshops to network with other areas, hear from the national team and raise queries
Clinical questions, or questions around implementation, outcome measures etc.	Contact IAPT national team & IAPT national clinical advisors via Yammer or via email: ENGLAND.MentalHealth@nhs.net
Questions around recording data on IAPT data systems	Contact IAPT systems suppliers (e.g. IAPTus, PCMIS etc.)
Questions around submitting data to the Bureau Services Portal (Exeter)	Contact the Exeter helpdesk: Tel: 0300 303 4034 Email: exeter.helpdesk@nhs.net FAO IAPT
Any other questions for NHS Digital, e.g. IDB, recovery rates, monthly reporting, data quality etc.	Contact NHS Digital: Tel: 0300 303 5678 Email: enquiries@nhsdigital.nhs.uk FAO IAPT
Questions around local data linkage, IG, outcome metrics, data quality, evaluation design	Contact Mike Woodall (Midlands & Lancashire CSU): Email: m.woodall@nhs.net Tel: 0121 612 3850
Questions around evaluation design (Wave 1 sites only)	Contact Prof David Stuckler, via Ineke Wolsey: ineke.wolsey-anxietydepression-IAPT@oxfordahsn.org

13. Annex: Supporting information

Table 1: Healthcare utilisation benefits table	
Diabetes	Secondary care cost reduction of:[i] ○ £372 a year in the Berkshire West IAPT pathfinder (net cost reduction) ○ £700-1000 for high intensity multidisciplinary treatment (in this case focused on people with severe diabetes) – examples from King's College Hospital and Hillingdon. Primary care cost reductions unquantified in these examples.
COPD	Hillingdon COPD example: a psychological component in a breathlessness clinic: ○ Gross saving of £837 per person over 6 months in secondary care costs (A&E presentations and fewer bed days when admitted),[ii] and £1,300 in overall healthcare costs over 6 months.[iii]
Angina	• A brief intervention reduced both admissions by 33% and length of stay in patients with angina the following year, with savings of £1,337 per person in 2007[iv] - calculated by NHS Confed as £2000 in 2010/11 prices.
Cardiac: implantation of	• A British study[v] found a 50% reduction in unplanned

a defibrillator	admissions in patients having received a home-based cognitive behavioural rehabilitation programme (11% of the intervention group compared to 22% of patients experiencing usual care).
Cancer	• Breast cancer[vi]: A Canadian RCT found non-oncology healthcare costs were 23.5% lower over a 2 year period in the group given CBT – an average of $147 less in 1994-1998 prices. • A range of studies have found collaborative care to be more cost effective than other cancer treatments (e.g. Sharpe et al)
Musculoskeletal disorders	• A Spanish study[vii] found net direct healthcare savings of $251 dollars (2007 prices) for those in a rheumatology programme with relatively high rates of sickness absence treated with CBT. They also found a reduction in the episode length of MSD-related temporary work disability: mean 98 versus 127 days, and relapse episodes were significantly shorter in the intervention group: mean 63 days versus 197 days (follow up period 6-24 months after intervention). • Another Spanish study covering those with lower back pain found patients were absent from work 5.4 days less than the non-intervention group over 6 months.[viii]
Rheumatoid Arthritis	• A 2008 small RCT[ix] in London found reductions in healthcare costs over the five years after a CBT intervention early in the course of rheumatoid arthritis found secondary care savings of $1,701.42 per patient (2008 prices – £1295 in 2014 from Bank of England calculator, meaning £323 a year)
Somatoform disorders (or MUS)	• A German 2003 study[x] found a reduction of EUR382 (24.5%) and EUR1098 (36.7%) for outpatient and inpatient care respectively for a cohort of people accessing CBT. Also found a reduction in days off sick 26.5% reduction. • In primary care, providing psychological therapies for those with medically unexplained symptoms produced a reduction in GP visits of 50%[xi]. • An evaluation of the Hackney psychotherapy consultation service,[xii] which comprises of psychiatric liaison, social care support and psychological therapy for people with MUS, personality disorder, or a chronic mental health problem not being managed in primary care found a reduction in NHS service use of over £460 per patient at the end of a 12-month follow-up – around a third of the cost of intervention (this service covered a more complex cohort of patients than being proposed here). • LSE modelling for DH in 2011[xiii] found a similar magnitude of intervention to healthcare benefit ratio: three years to recoup intervention costs (although the costs they used for CBT were somewhat higher than the IAPT stepped care model). They also found a reduction in sickness absence associated with the intervention.

Chronic fatigue syndrome	• A RCT in the Netherlands[xiv] found a cohort of patients' mean healthcare costs to be EUR88 lower (including the cost of intervention) in months 0-8, and EUR146 lower in months 9-14. They also found a reduction in time off work for those treated with CBT. • Another study found CBT to be more cost-effective than usual care, and produced gross healthcare savings of £300 over 12 months[xv].
Generic IAPT	• One general practice analysed all patients referred to IAPT and looked at change in healthcare utilisation: they found a reduction of £1,050 (for those who recovered?) per year over a two year period.[xvi] • Comparison of service utilisation 6 months before and after referral to IAPT was associated with reduced use of emergency department attendances (mean difference: 0.12 (95% CI 0.06 to 0.19, p<0.001)). They also found a reduction in sickness certification[xvii]
Meta-analysis of psychological interventions in people with LTCs	• A review of 91 studies[xviii] of psychological intervention for those with co-morbid physical and mental health problems showed a mean reduction of healthcare costs of 20%, with over 90% of studies showing a cost saving.
Assumptions used in calculations	• The vast majority of available evidence (both studies and evidence from the IAPT pathfinders) measures secondary care utilisation only. • The interventions measured in the studies vary, as do the follow up periods and benefits (plus the way these are reported and measured). • Gross savings in British studies vary between £300 and £2600 a year. • Take a middle figure of around £1000 saving per year, covering both primary and secondary care costs

Table 2: How long should we assume the benefits of therapy last for?	
Anxiety disorders	1-9 year follow up studies find that on average people with anxiety disorders are as well on follow up as they are when completing treatment, around 20% of people will also have had some booster treatment.[xix] In addition, some studies show further improvement in social anxiety disorder post follow up.[xx]

Depression	Psychological therapies halve the risk of a future episode of depression compared with anti-depressant treatment[xxi] Over 50% of people are still depression free 24 months after treatment after CBT, however in the two years after successful treatment about 40% of people who initially had moderate-severe depression will experience a depressive episode of at least a month.[xxii] Clinical advice: Assume 1/3 of people who recover successfully will need some form of booster treatment.
Chronic fatigue	One study found looks at 5 year follow up for people with chronic fatigue syndrome after CBT: 24% were completely recovered, 71% rated themselves as much better.[xxiii]
Assumption used in calculations	Depression ~ 50% of case mix. 50% see full benefit for 2 years. For others assume benefit on average lasts for 12 months over 2 years (based on X, Y, Z). Anxiety ~ 50% of case mix – conservatively assume 90% retain benefits for 3 years. Benefits to last for (0.5*36 + 0.25*24 + 0.25*12) = 26.5 months

Table 3: What proportion of people benefit from treatment?	
Recovery	• Recovery rates are measured for all those that complete treatment (i.e. have at least two treatment sessions). • The national average recovery rate is 45%, although some CCGs achieve recovery rates of over 60%. Work in 2015 is ongoing to bring all CCGs to at least a 50% recovery rate, and in the future higher rates may be possible through an intensive focus on quality.
Completing treatment	• A simple ratio of those entering and completing treatment in a quarter in generic IAPT services gives a figure of 50-60%. • High quality services will be accessible and welcoming and so achieve a greater retention of people using their services. • LTC services will be co-located with physical healthcare, or delivered at home, meaning we can expect a lower dropout rate. They are also an older cohort, who generally benefit more from IAPT services and are more likely to complete treatment. • Therefore for LTC/MUS services assume 60% of people who enter treatment complete
Assumption used in calculations	Using a recovery rate of 50% and a 'conversion' rate of 60% of people starting treatment completing, gives 30% (0.5*0.6) of people entering treatment recover.

[i] Numbers from BCG case studies
[ii] Howard et al, 2010 The effectiveness of a group cognitive-behavioural breathlessness intervention on health status, mood and hospital admissions in elderly patients with chronic obstructive pulmonary disease
[iii] Ref Thrive p 184
[iv] Moore et al, 2007: A brief cognitive-behavioural intervention reduces admission in refractory angina patients
[v] Lewin, R. J., Coulton, S., Frizelle, D. J., Kaye, G., & Cox, H. (2009). A brief cognitive behavioural preimplantation and rehabilitation programme for patients receiving an implantable cardioverter-defibrillator improves physical health and reduces psychological morbidity and unplanned readmissions. *Heart, 95,* 63-69.
[vi] Simpson, Carlson, and Trew (2001). Effect of group therapy for breast cancer on healthcare utilization. *Cancer Practice. Study in Canada*
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[xi] IAPT PBC business case, 2012
[xii] Parsonage, M., Hard, E. and Rock, B. (2014) *Management of patients with complex needs: evaluation of the City and Hackney Primary Care Psychotherapy Consultation Service.* London: Centre for Mental Health.

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[xv] Adaptive Pacing, Cognitive Behaviour Therapy, Graded Exercise, and Specialist Medical Care for Chronic Fatigue Syndrome: A Cost-Effectiveness Analysis. McCrone et al,PLOS, 2012
[xvi] Thrive, English version
[xvii] Referral to a new psychological therapy service is associated with reduced utilisation of healthcare and sickness absence by people with common mental health problems: a before and after comparison. Simon de Lusignan, Tom Chan, Glenys Parry, Kim Dent-Brown,Tony Kendrick *J Epidemiol Community Health jech.2011.139873Published Online First: 3 October 2011 doi:10.1136/jech.2011.139873*
[xviii] Chiles, J.A., Lambert, M.J. and Hatch, A.L. (1999), "The impact of psychological interventions on medical cost offset: A meta-analytic review", Clinical Psychology: Science and Practice, 6(2): 204-220.
[xix] Thrive, American version.
[xx] Thrive, American version.
[xxi] Thrive, English version
[xxii] Thrive p 122
[xxiii] Deale, Hussain, Chalder & Wessely, Long-term outcome of cognitive behavior therapy versus relaxation therapy for chronic fatigue syndrome: a 5-year follow-up study. Am J Psychiatry 2001.