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Improving Access to Psychological Therapies Data Set v1.5 User Guidance

Document Management

Revision History

Version	Date	Summary of Changes
0.1	18/09/2013	First draft for internal review
1.0	25/11/2013	Further amendments following internal review
1.1	19/12/2013	Amendments to guidance and structure
1.2	22/01/2014	Minor amendments for consistency across tables
1.3	07/08/2014	Minor amendments to data item guidance
1.4	21/01/2015	Amendments to guidance including but not limited to: Addition of Appendix A – PEQ submission Postcode updates Empty Appointment table known issue
1.5	24/02/2015	Ammendments to include new guidance on inclusion/submission of Employment Support Data

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version
Nick Bridges	Service Development Manager, HSCIC	19/12/2013	1.1
Nick Bridges	Service Development Manager, HSCIC	22/01/2014	1.2
Nick Bridges	Service Development Manager, HSCIC	07/08/2014	1.3
Nicholas Richman	Service Development Manager, HSCIC	21/01/2015	1.4
Nicholas Richman	Service Development Manager, HSCIC	24/02/2015	1.5

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Netta Hollings		Programme Manager, HSCIC	19/12/2013	1.1
Netta Hollings		Programme Manager, HSCIC	22/01/2014	1.2
Netta Hollings		Programme Manager, HSCIC	07/08/2014	1.3
Netta Hollings		Programme Manager, HSCIC	21/01/2015	1.4
Netta Hollings		Programme Manager, HSCIC	24/02/2015	1.5

Glossary of Acronyms and Terms

Abbreviation	What it stands for
BSP	Bureau Service Portal
CSV	Comma-Separated Values (file format)
DQM	Data Quality Measure
HSCIC	Health and Social Care Information Centre
IAPT	Improving Access to Psychological Therapies
IDB	Intermediate Database
ISB	NHS Information Standards Board for Health and Social Care
ISN	Information Standards Notice
ODS	Organisational Data Services
PAS	Patient Administration System
SSD	Systems and Services Delivery

Term	What it stands for
Data Item	A single component of a data set that holds one type of information and relates to a specific record. Each data item is unique to the data set.
Information Standards Notice (ISN)	Information Standards Notices (ISNs) previously known as Data Set Change Notices (DSCNs) are issued by the Information Standards Board for Health and Social Care to give notice of changes to information requirements and information standards used by the NHS.
NHS Information Standards Board for Health and Social Care (ISB HaSC)	The Information Standards Board (ISB) approves information standards for the NHS and adult social care in England. ISB is one of the advisory boards reporting to the NHS National Programme for IT Board. It is independent in its function and draws its voting members from a broad cross section of stakeholder groups.

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Contents

1. About this Document

1.1 Purpose of the Document

The purpose of this document is to supplement the data set Technical Output Specification with additional guidance regarding the extraction and analysis of the data set. The IAPT data set is intended for secondary uses purposes using data collected by IAPT service providers as a result of direct care of the patient. The data set should be extracted from provider IT systems from the data recorded as part of the care process.

1.2 Scope of the Document

This document is aimed at:

- Managers and clinical leads or organisations providing IAPT services
- Information management departments within data provider organisations
- IT system suppliers operating on behalf of IAPT services
- Other stakeholders responsible for the submission and analysis of IAPT data

1.3 Schedule for Updating this Document

This document will be reviewed and updated when necessary. Changes to this document will not necessitate further approval from the SCCI (formerly ISB); however, this is on the understanding that the changes do not affect the scope of the Information Standard.

2. Background Information

The IAPT Information Standard is the specification of a patient-level data-extraction (output) standard intended for NHS funded IAPT service providers in England. This includes both NHS and Independent Sector providers.

The content of the data set is determined from consultation with a various stakeholder groups. Stakeholders include NHS England, service providers and commissioners. Changes arise for a number of reasons, for example: responding to policy directives; aligning data set requirements with current practice; and commissioner needs. Data collection must remain fit for purpose, which may require inclusion of new data items, amendment of existing items or removal of no longer required items.

This Information Standard amendment has been approved by the ISB and has been assigned Release Number Amd 2/2013 and retaining standard number ISB 1520.

The ISN does not directly place any requirement on system suppliers to accommodate the IAPT data items within their systems. The contractual agreement between data providers and system suppliers will dictate whether system suppliers have to abide by the ISN and at what cost.

The formal Information Standard can be found at:

http://www.isb.nhs.uk/documents/isb-1520

Further information and supporting documents can be found at:

http://www.hscic.gov.uk/iapt.

2.1 Summary of Changes

The IAPT Data Set v1.5 introduces changes to the previous v1.0 standard to support the requirements of the national data set. These changes are explicitly stated in the *IAPT v1.5 Change Request document (*available from the ISB website) and *the IAPT Technical Output Specification (*available from the HSCIC website).

3. Configuration of local systems

The IAPT v1.5 Technical Output Specification fully defines the data items within the national data set. The Technical Output Specification splits the data set into a number of tables, each containing related data items.

IAPT is an output data set. An output data set is a description of the data that needs to be extracted or derived from an existing patient administration system (PAS) or clinical system and does not directly support patient care. In many cases, the output data item will be identical to the input definition. However the two may differ both in terms of the format of the data item and the range of values presented. In addition, the output data set may include items that are derived from the inputs, most commonly, this will include 'Age at' fields and patient demographics.

The data collection system may represent the data in a different manner or in more granularity; however, providing the input data items can be mapped to the output data set, the input source will not require any modification.

This can be illustrated in the following table:

<table>
<tr><th colspan="2">Trust System (Input system)</th><th colspan="2">National Data Set</th></tr>
<tr><td>Data item name</td><td>Format/Values</td><td>Data item name</td><td>Format/values</td></tr>
<tr><td>Date of birth</td><td>dd/mm/yy</td><td>Date of birth</td><td>ccyy-mm-dd</td></tr>
<tr><td rowspan="2">Appointment Date and Time</td><td rowspan="2">YYYY-MM-DDThh:mm:ss</td><td>Appointment Date</td><td>CCYY-MM-DD</td></tr>
<tr><td>Appointment Time</td><td>hh:mm:ss</td></tr>
</table>

The IAPT data set is not a specification for the standardisation of a patient care record. Service Providers have the flexibility to adopt any local data collection processes and system as long as the local data collection frameworks can output and submit data, as per the data set specification, to the Bureau Service Portal (BSP). The data set is not a patient care record but is based on clinical and operational information. Providers should therefore look to re-use their clinical and operational systems to extract IAPT data.

4. Data Item Guidance

This section provides further clarity regarding the data items included within the Technical Output Specification. This includes fully explaining how tables may or may not repeat and extending description and explanation of data items where space does not permit within the Technical Output Specification.

4.1 Breakdown of Data Items by Table

Data items are detailed in the following tables with appropriate NHS Data Dictionary definitions and descriptions. Where the data item name in this data set does not match the data dictionary name, both names have been listed. The electronic copy of this document includes hyperlinks to the corresponding entries in the Data Dictionary provided they are currently defined. Links to new data items will not be available immediately following ISN publication. Please refer to the Data Dictionary for more description, attributes and details of where the data items are used.

Please note: data items are only included in this section where there is additional information provided that is not in the Technical Output Specification. If no additional information is included then the data item will not be included below.

4.1.1 Linkage Data Items

Linkage data items appear in more than one table and allow the relationship between records within different tables to be identified. Where additional information is available linkage tables are detailed below, but not further duplicated in individual tables.

Data Item Name	Additional Notes
NHS NUMBER	The NHS Number is the only National Unique Patient Identifier, used to help healthcare staff and service providers match a patient to their health records. Everyone registered with the NHS in England and Wales has their own NHS Number. Where the NHS Number is not known, this should be left blank. The NHS NUMBER is 10 numeric digits in length. The tenth digit is a check digit used to confirm its validity. The check digit is validated using the Modulus 11 algorithm and the use of this algorithm is mandatory. A combination of NHS number (If available), LPTID, Date OF Birth and Postcode is used to uniquely identify a patient's care pathway. When an NHS number is provided it must pass the modulaus 11 check. When an NHS number is provided it should have a corresponding status indicator cade.

LOCAL PATIENT IDENTIFIER (EXTENDED)	This may be different from that used in any of the source systems. The IAPT Local Patient Identifier is used to identify a patient uniquely within a local IAPT service provider. It enables health care providers to create a complete record of care provided by the IAPT service for a patient where patient data is recorded in two or more operational systems that use different Local Patient Identifiers. This data item is a mandatory field in ALL the IAPT tables and if any records are submitted in this table or any other table then the record MUST contain a valid IAPT Local Patient Identifier. Where a common IAPT Local Patient Identifier is used across all local IAPT services, this should be adopted. A combination of NHS number (If available), LPTID, Date OF Birth and Postcode is used to uniquely identify a patient's care pathway. To avoid the incorrect linkage of records the IAPT Local Patient Identifier must not be reused i.e. it should only ever relate to one patient. This ensures that the patient's identifiable data does not appear against more than one patient identifier.

4.1.2 Table 1 - Person Details Table

Table 1 - Person Details Table	
Description	
This table will contain personal demographic data that relates to individual patient differences such as age, faith, gender, ethnicity, employment status, and sexuality. The patient is someone in receipt of services for depression or anxiety. Patient details should be captured at the time of registration. **General table guidance** On a patient's first referral and each subsequent referral, the following data items should be updated/recorded: NHS number (if known), Date of birth, Postcode, Code of GP Practice (Registered GMP) (if known), all other relevant demographic information where possible. These should be reviewed at each new referral to ensure they are accurate and up to date. Only one record per patient is required when submitting patient details and this should contain the patient's most up–to-date details as at the time of data extraction. Data items within this table must be recorded for every patient and updated at each new referral if required. Any items marked as 'Mandatory' must be present within the table. Any items marked as 'Required' should be reported if collected. Failure to comply with validations outlined in the table may result in a failure of the submission. Should this occur the identified data quality issues should be rectified and the data set re-submitted. **Submission Requirements** At patient level, data can only be included where the following data items are present for each patient: Local Patient Identifier; Organisation Code of Provider; Date of Birth and Postcode **Submission Validations** Submission will be rejected if: - this table is empty - this table is missing from the submission file - this table is missing any specified columns or the structure has been altered	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

NHS NUMBER STATUS INDICATOR CODE	Where an NHS number is provided it should have a corresponding status indicator code. In most cases, this data item will be flowed with value [01] - Number present and verified. The [01] will indicate that the data provider has validated the number against the central Patient Demographics Service (PDS), and therefore facilitates reliable data linkage. Data providers may flow data for patients with a NHS number status indicator code other than [01] and they will be accepted, however, reports that need reliable linkage between tables will exclude these records(unless reliable linkage is available via LOCAL PATIENT IDENTIFIER (EXTENDED) data items). Please note this item should be submitted as an2 as per the national code list specified in the Technical Output Specification. Any record submitted with this item as an1 will be classed as invalid for the Data Quality Measure DQM20. Please see the IAPT Data Set v1.5 DQ Measure Rules document for further information.
Organisation Code of Provider ORGANISATION CODE (CODE OF PROVIDER)	This is the Organisation Code of the organisation acting as the IAPT Heath Care Provider. A valid Organisation code (Code of Provider) must be provided (as defined by ODS). ODS Default Codes: 89997 - Non-UK provider where no ORGANISATION CODE has been issued 89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued The Organisation Data Service is provided by the Health and Social Care Information Centre (HSCIC). It is responsible for the publication of all ORGANISATION and practitioner codes and for the national policy and standards with regard to the majority of ORGANISATION CODES.
Date of Birth PERSON BIRTH DATE	A valid date of birth must be provided for each Local Identifier (Extended) included in the submission. If a valid DOB is not recorded the record will be rejected. Where a patient is unable or unwilling to supply an accurate date of birth, and date of birth cannot be determined through other means (i.e. NHS Tracing Service) decision regarding an appropriate default date should be made locally.
Gender PERSON GENDER CODE CURRENT	This data item relates to PATIENT STATED gender. The national code value [9] should only be used where the patient does not classify themselves as either male or female. National code [0] should only be used where gender has not been recorded.

Postcode POSTCODE OF USUAL ADDRESS	If a PATIENT has no fixed abode this should be recorded with the appropriate code (ZZ99 3VZ). All postcodes are validated against the Gridall file available from the ODS Whilst the format for this data item is max an8 the data item must be submitted with exactly eight characters. The fifth character is always a space, and separates the outward and inward parts of the Postcode. In addition, where there are less than 4 numbers and/or letters in the outward part, this must be space filled to ensure eight characters in total. New postcodes come into use, and redundant postcodes are retired on a continual basis. This necessitates updates to the ODS files that hold a record of all postcodes, and subsequent updates to the reference files that are used during MHLDDS and IAPT processing. The time lag involved means that on some occasions submissions contain valid postcodes that are then reported as invalid in the Portal warnings. If providers are aware that this is/or might be the case, they can contact the Open Exeter team directly at exeter.helpdesk@hscic.gov.uk, who will record details of the new valid postcodes, which are incorrectly generating the warnings, and ensure the reference files are updated accordingly.
Code of GP Practice (Registered GMP) GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	A valid General Medical Practice Code (GMPC) must be provided (as defined by ODS).
ETHNIC CATEGORY	The information recorded about ETHNIC CATEGORIES must be obtained by asking the PATIENT. Trusts are reminded that the capture and submission of Ethnic Category data within IAPT service is already mandated for ALL patients. Explanation of Ethnic Category codes: The '[Z] Not Stated' national code should only be used where the patient has been asked and has declined to provide their ethnic category because of refusal or the inability to choose. The '[99] Not Known' national code should be used where the patient has not been asked or where the patient was not in a suitable condition to be asked.
RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE	The '[K] Other' national code should be used when the patient has been asked for their RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION but they are unsure what it is. The '[N] Patient Religion Unknown' national code should be used when the patient has not been asked for their RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION.
Sexual Orientation SEXUAL ORIENTATION (CURRENT)	For the purposes of the Improving Access to Psychological Therapies Data Set, there is no requirement to report National Code 9 'Unknown'.

4.1.3 Table 2 - Disability Table

Table 2 - Disability Table	
Description	
This table holds details of patient disability. A patient may have multiple disabilities, or they may have none. Co-morbid physical or mental health disability should be collected early in the care pathway, some even prior to initial assessment where this data is available from the referrer. Any disabilities which are present should be recorded within this table. **General table guidance** On a patient's first referral and each subsequent referral the Disability data item should be updated: *A patient should only appear in this table if they have a disability/disabilities. If they do not, then there is no need to record any details for the patient in this table.* Note: a patient can have more than one disability recorded. Data items within this table must be recorded for every patient and updated at each new referral if required. Any items marked as 'Mandatory' must be present within the table. Any items marked as 'Required' should be reported if collected. **Submission Requirements** At patient level, data can only be included where the following data items are present for each patient: Local Patient Identifier only for any patients with a disability, in which case there must be a corresponding entry for the Local Patient Identifier in the Person table, **Submission Validations** Submission will be rejected if: - this table is missing from the submission file (even if to contains no data) - this table is missing any specified columns or the structure has been altered	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
Organisation Code of Provider ORGANISATION CODE (CODE OF PROVIDER)	This is the Organisation Code of the organisation acting as the IAPT Heath Care Provider. A valid Organisation code (Code of Provider) must be provided (as defined by ODS). ODS Default Codes: 89997 - Non-UK provider where no ORGANISATION CODE has been issued 89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued The Organisation Data Service is provided by the Health and Social Care Information Centre (HSCIC). It is responsible for the publication of all ORGANISATION and practitioner codes and for the national policy and standards with regard to the majority of ORGANISATION CODES.

DISABILITY	Under the Equalities Act 2010 a disabled person is defined as 'someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'. This table may contain more than once record for instances where a patient has multiples disabilities. This data item has permissible codes for 'NN – No perceived disability' and 'ZZ – Not stated'. Only records for patients with disabilities should be submitted in this table and records submitted against either of these codes will be classed as 'Other' for the Data Quality Measure DQM31. Please see the IAPT Data Set v1.5 DQ Measure Rules document for further information. If a patient has a disability, then either the NHS number or Local Patient Identifier must appear in the Patient details table.

4.1.4 Table 3 - Referral Table (REFERRAL)

Table 3 - Referral Table (REFERRAL)
Description

A referral is a request for a care service to be provided for a patient. It includes self referrals. Whilst a patient may have multiple referrals which require recording within the table, only one record is required for each referral.

General table guidance

This table will contain summary information including provisional diagnosis and key dates should be updated at relevant points along the patient's care pathway. Date information can be used to calculate waiting times. Provisional diagnosis is included to inform the clinical approach and to ensure patients receive the right treatment.

On a patient's first referral and each subsequent referral the following data items should be updated:

- Disability details if they have changed since a previous referral or are now known (when previously unknown)
- Date the referral request was received
- Source of referral
- If the referral was accepted by the service
- Commissioner details of the referral
- For referrals ended, record the spell end code and the date the spell ended
- For subsequent referrals, these should be recorded as a new referral (rather than a follow on) such as to allow the monitoring of relapse.
- Provisional diagnosis

All referrals open at some point within a reporting period should flow as part of each submission for that reporting period. In addition, referrals that have started and finished in a previous reporting period, and have follow up appointments or PEQs with an ASSESSMENT TOOL COMPLETION DATE in the current reporting period should also flow.

Please note: The Referral table supports both standard waiting times calculations and the Opt-in model. The Date Referral Received data item is mandatory, and must be submitted in support of standard waiting times calculations. The Opt-in model may be used by Improving Access to Psychological Therapies providers. If this is the case, The Improving Access to Psychological Therapies Opt-in date should be submitted to enable those providers to have access to additional analyses, specifically applicable to the Opt-in model.

For the latest Waiting Times guidance, please see the IAPT Programme website:

http://www.iapt.nhs.uk/data/

Submission Requirements

At patient level, data can only be included where the following data items are present for each patient:

Local Patient Identifier (there must be a corresponding entry for the Local Patient Identifier in the Person table), Organisation Code of Provider, Service Request ID and Referral Request Received Date.

Submission Validations

Include referrals active in current reporting period and referrals associated with follow up appointments in the current reporting period.

Submission will be rejected if:
- this table is empty
- this table is missing from the submission file
- this table is missing any specified columns or the structure has been altered

Additional Notes on Data Items	
Data Item Name	**Additional Notes**
Organisation Code of Provider ORGANISATION CODE (CODE OF PROVIDER)	This is the Organisation Code of the organisation acting as the IAPT Heath Care Provider. A valid Organisation code (Code of Provider) must be provided (as defined by ODS). ODS Default Codes: 89997 - Non-UK provider where no ORGANISATION CODE has been issued 89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued The Organisation Data Service is provided by the Health and Social Care Information Centre (HSCIC). It is responsible for the publication of all ORGANISATION and practitioner codes and for the national policy and standards with regard to the majority of ORGANISATION CODES.
Date Referral Received REFERRAL REQUEST RECEIVED DATE	This data item is a mandatory field in this table and the data will not be processed for patients who do not have a referral. For both electronic and written referral requests the date that the request was received should be used and NOT the date that the referral was read, processed, or actioned i.e. the date stamped as the date of receipt and not the date entered onto a system. For referral requests received by telephone use the date of the follow up letter if received, otherwise the date of the phone call.
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE	Services using Opt in system should ensure that each Referral is screened within 3 days of receipt. The Patient should be contacted to offer an assessment date either through telephones or an opt-in letter. If contact has not been made with the patient within 2 weeks of receipt of Referral, the patient is discharged back to the care of their GP. Should an IDB contain any IAPT Opt-In Dates which are greater than the current reporting period end date, these dates will be excluded from the data extracts produced at both pre deadline and post deadline stages.
Source of Referral SOURCE OF REFERRAL FOR MENTAL HEALTH	Where a data provider has a more extensive list of referral sources, then they should be mapped to an appropriate values stated in the output data item list. Where it is not possible to map a value against those stated in the output data item list then this should be mapped to the code '[M6] Other Service or Agency.'

Org Code of Commissioner ORGANISATION CODE (CODE OF COMMISSIONER)	The commissioner may be determined by the CCG of the patients GP Practice (responsibility) or the CCG of residence (residence responsibility). It may alternatively be that commissioning is subject to another arrangement, including use of collaborative arrangements offered by Specialised Commissioning Groups (SCGs). The latest organisational data including up to date commissioner codes can be downloaded from the Organisation Data Services (ODS) webpage available from the following link: http://systems.hscic.gov.uk/data/ods/datadownloads/othernhs The Department of Health 'Who pays? Establishing the responsible commissioner' guidance provides further information on assigning responsible commissioner and is available from the following link: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078466
Provisional Diagnosis PROVISIONAL DIAGNOSIS (ICD)	Access to comprehensive diagnosis information is fundamental to successful IAPT outcome reporting and service planning; however not all services effectively report diagnosis within the IAPT data set. This is particularly true of the 'Provisional Diagnosis' field. This is due to the fact that staff types who would normally make a diagnosis do not typically form a significant proportion of IAPT staff. Services who under report have indicated a preference for the term 'Problem Descriptor (ICD-10 Code)'. We are unable to change the name of the 'Provisional Diagnosis' field in the IAPT Data Set until the next version, however **National reporting, including all HSCIC reporting, and the NHS England 'Profiles Tool', will cease to use the term 'Provisional Diagnosis' and replace it with 'Problem Descriptor (ICD-10) with immediate effect.** When making your IAPT submissions please treat the data item 'Provisional Diagnosis' as 'Problem Descriptor (ICD-10)' and include ICD-10 data on that basis. The IAPT Data Standard provides a coding framework for the range of diagnoses suitable for treatment within IAPT services, including relevant ICD-10 coding. On determination of an anxiety disorder problem descriptor by the IAPT worker at initial assessment, the appropriate measurement tools can be applied from the range of relevant anxiety disorder specific measures (ADSMs). Problem descriptors record patterns of symptoms and do not replace in any way the patient-centred assessment required to personalise treatment plans.

Reason for End of IAPT Care Pathway IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE	The IAPT v1.5 code list for Reason for End of IAPT care pathway includes codes relating to patients who have been Assessed, and patients who have been Assessed and Treated. There is not a code to cater for patients legitimately referred into service who do not engage with the service and have therefore had no appointment. In this circumstance please record the patient as Code 97 – Not known (assessed only). We will use this information, in conjunction with a check that there has been no appointments to infer that the patient 'did not engage'. Appropriate amendment to the data item will form part of the proposed requirements for v2.0. All Reason for End of IAPT Care Pathway related to a Date of End of IAPT Care Pathway which is greater than the current reporting period end date will be excluded from the data extracts produced at both pre deadline and post deadline stages. Please see the inclusion rules and guidance for Date of End of IAPT Care Pathway for further detail.
Date of End of IAPT Care Pathway END DATE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)	Some systems may be unable to capture end date when a referral is not accepted by the Service (e.g. reason for End of IAPT Care Pathway recorded as 10), in which case it is advised that these records should have the End Date populated with the same date that is recorded for the Date Referral Received data item. Should an IDB contain any Date of End of IAPT Care Pathway which are greater than the current reporting period end date, these dates will be excluded from the data extracts produced at both pre deadline and post deadline stages. All related Reason for End of IAPT Care Pathway will also be excluded.
ORGANISATION CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED TO PROVIDER)	All Organisation Code of Provider should be registered with the ODS.
MENTAL HEALTH CARE CLUSTER CODE (FINAL)	National code *[09] Cluster Under Review* is not appropriate for use within the IAPT v1.5 data set and will be highlighted in diagnostics for users to rectify. For detailed descriptions of care clusters please see the Mental health clustering booklet for 2013 to 2014 at: https://www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013-14

4.1.5 Table 4 - Appointment Table (APPOINTMENT)

Table 4 - Appointment Table (APPOINTMENT)
Description
An appointment is an interaction with a patient by a health care professional with the objective of making a contribution to the health care of the patient. This table holds details of each appointment. A patient may have multiple appointments which require recording. **Submission Requirements** At patient level, data can only be included where the following data items are present for each patient: Local Patient Identifier (there must be a corresponding entry for the Local Patient Identifier in the Person table), Organisation Code of Provider, Appointment Date, Attendance, Appointment Purpose and Service Request ID (there must be a corresponding entry for the Service Request ID in the Referral table). **Submission Validations** Submission will be rejected if: - this table is empty - this table is missing from the submission file - this table is missing any specified columns or the structure has been altered **General table guidance** On each appointment, the following data items should be updated/recorded: • Appointment date • Attended or did not attend code • Appointment type • Therapy type if one (or more than one) was used • Appointment medium Appointments must occur in the current reporting period. Appointments occurring outside the current reporting period will be ignored. Recording of Outcome scores and key dates Outcome scores and key dates are recorded to measure recovery rates and should be updated during the patient's care. These items should be recorded at every contact with the patient, including face-to-face, telephone and other methods such as email. The Appointment Table is intended to capture IAPT Recommended Clinical Outcome Measures. For more information on these measures please see the IAPT Data Handbook (Chapter 2) available from the IAPT Programme website: http://www.iapt.nhs.uk/data/ Provider submissions containing no appointments IAPT on-submission validations currently reject the IDB where a submission is made containing no appointments. However if for example: an IDB is submitted with appointments for the primary reporting period, but not the refresh reporting period, a joint primary/refresh submission IDB will pass on-submission validation as the Appointment table is not empty. Because the file has passed validation, a warning will not be generated and it will not be immediately apparent that no appointments have flowed for the refresh reporting period. This is most likely to occur where providers have selected an incorrect date range when extracting data from the PAS system required for submission. We are aware of this issue and will be looking to improve DQ feedback in this respect for future versions of the data set. In the meantime this issue can normally be identified by looking at the denominators for Diagnostics D14 and D15. Both these diagnostics rely on a denominator calculated from the number of appointments, which will be zero if no appointments have been submitted for the relevant reporting period.
Additional Notes on Data Items

Data Item Name	Additional Notes
Organisation Code of Provider ORGANISATION CODE (CODE OF PROVIDER)	This is the Organisation Code of the organisation acting as the IAPT Heath Care Provider. A valid Organisation code (Code of Provider) must be provided (as defined by ODS). ODS Default Codes: 89997 - Non-UK provider where no ORGANISATION CODE has been issued 89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued The Organisation Data Service is provided by the Health and Social Care Information Centre (HSCIC). It is responsible for the publication of all ORGANISATION and practitioner codes and for the national policy and standards with regard to the majority of ORGANISATION CODES.
APPOINTMENT TIME	The time, recorded using the 24 hour clock, advised to a PATIENT for when they can expect to see a relevant CARE PROFESSIONAL.
Primary Role in IAPT Service CARE PROFESSIONAL ROLE CODE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES	The primary role undertaken by a Care Professional refers to the lead therapist. Where group therapy sessions include more than one therapist administering treatment, then this should be flowed as a single record (containing the lead therapist details only). Group therapy sessions should NOT be reported using multiple records for each combination of therapists' present during the contact. Further guidance can be found in IAPT Data Set v1.5 guidance available from the IAPT Programme website: http://www.iapt.nhs.uk/data/
Attendance ATTENDED OR DID NOT ATTEND	This data item must be recorded at each appointment for every patient. If the appointment is conducted via text message or email details of this event must be recorded in the normal manner i.e.; Code 5 – 'Attended on time or, if late, before the relevant care professional was ready to see the patient'.
APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR	The precise definition of 'short notice' should be determined locally. The APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR is only relevant where the submitted code for the Attendance data item is 2 - Appointment cancelled by, or on behalf of, the patient. However, the APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR must be submitted on each occasion where 2 - Appointment cancelled by, or on behalf of, the patient is the submitted code for the Attendance data item. If the APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR is not submitted under these circumstances a warning will be displayed against the record. The definition for Short notice cancellation indicator is: "An indication of whether the APPOINTMENT SLOT could be reallocated, where the ATTENDED OR DID NOT ATTEND National Code is 'APPOINTMENT cancelled by, or on behalf of, the PATIENT', where the APPOINTMENT was cancelled at short notice." Please record this data item as 'Y – Appointment slot could be reallocated' where the appointment slot was cancelled at short notice and so made available

	to be reallocated. It is not necessary to track whether a new appointment has been allocated to the slot vacated. **Please note:** this guidance has been amended as a result of further consultation and may be contrary to earlier guidance supplied.
Contact Duration (Clinical time) CLINICAL CONTACT DURATION OF APPOINTMENT	The duration of the clinical contact should be recorded and accounted for, regardless of the type of contact. The duration field should only be left blank if the appointment did not take place (E.g. DNA or cancelled).
Appointment Purpose APPOINTMENT TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)	Appointments that occur after the associated referral for treatment has been ended should be recorded with an Appointment Type of '06 - Follow-up appointment after treatment end'.
Appointment Medium CONSULTATION MEDIUM USED	The telephone or telemedicine consultation should directly support diagnosis and care planning and must replace a face to face Out-Patient Attendance Consultant, Clinic Attendance Nurse or Clinic Attendance Midwife, types of CARE ACTIVITY. A record of the telephone or telemedicine consultation must be retained in the PATIENT's records. Telephone contacts solely for informing PATIENTS of results are excluded. For further details see: http://www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultation_medium_used_de.asp?shownav=1
EMPLOYMENT STATUS	[01] Employed: Employed refers to those who are employed by a company and have their National Insurance paid for directly from their wages. It also includes those who are self-employed (i.e. those who work for themselves and generally pay their National Insurance themselves); those who are in supported employment; and those who are in permitted work (i.e. those who are in paid work and who are also receiving Incapacity Benefit). It should also include those who are unpaid family workers (i.e. those who do unpaid work for a business they own or work for a business a relative owns). [02] Unemployed and Seeking Work: Unemployed refers to those who are not in paid work but are actively seeking work and are available to start, or are waiting to start a paid job they have already obtained. Other Employment Status codes include those who are economically inactive (03, 04, 05, 06, 07, 08, ZZ), that is, those who are not in paid work and who are not actively seeking work, or they are not available to start. If the Employment Status of the patient remains the same, Trusts are advised against leaving the original date unchanged, until such a time there is a change to the Employment Status. Therefore the Date of Employment Status should change with each review even if the Employment Status remains the same. This is to evidence and report against the National Indicators that providers are asking these questions on a regular basis. **Additional guidance on inclusion/submission of Employment Support Data:**

	• Employment support is a complimentary service provided to those who need it in addition to therapy such as CBT etc. Most commonly the employment support appointment will take place separately from the therapy session but could be offered as part of a low intensity treatment session. • Employment support would be classed as an intervention rather than what is classed as a 'treatment' which is generally reserved for CBT, IPT, counselling etc. • The service could be provided by someone within the IAPT service or could be provided by an outside organisation. • The IAPT data set requires services to state i) if employment support is indicated ii) and if so the Employment support referral date. This could be an internal referral or referral to employment support agency however it should be part of the 'episode' otherwise we run the risk of double counting. • If the employment support service collects IAPT data standard items and has access to the PAS, then they should record the therapy type for the appointment as 'employment support' and record scores to any assessments they take. If they do not have access to the PAS, then there should be locally agreed protocols in place to share progress. • The last outcome score (i.e. PHQ/ GAD or ADSM) should be taken at the final appointment when treatment is completed and the therapist responsible for the case discharges the patient from the IAPT service. These are the scores used to measure recovery in our reports. • If employment support continues after the patient has been discharged from the service, then activity should be reported locally but there is no requirement to flow this data to the HSCIC, indeed if they do flow this data, it will be rejected as the referral is closed. • However, progress should be reviewed at the 'follow up' appointment (it is best practice to conduct a follow-up following discharge) and any subsequent outcome scores taken at the appointment should be recorded accordingly.
WORK AND SOCIAL ADJUSTMENT SCALE SCORE (WORK)	*1.Because of my [disorder], my ability to work is impaired. 0 means not at all impaired and 8 means very severely impaired to the point I can't work.* The Work and Social Adjustment Scale (WSAS) is a simple 5-item patient self-report measure, which assesses the impact of a person's mental health difficulties on their ability to function in terms of work, home management, social leisure, private leisure and personal or family relationships. The WSAS is used for all patients with depression or anxiety as well as phobic disorders. It looks at how the disorder impairs the PATIENT's ability to function day to day with depression and / or anxiety as well as phobic disorders. For more information about the W&SAS please see: -IAPT Data Handbook http://www.iapt.nhs.uk/data/ - http://bjp.rcpsych.org/content/180/5/461.full When completing the Work and Social Adjustment Scale, if a patient has selected 'non-applicable' for question 1, or if one value is missing, then total scores can be pro-rated from non-missing items. Questionnaires with more than one missing value should be excluded from analysis.

WORK AND SOCIAL ADJUSTMENT SCALE SCORE (HOME MANAGEMENT)	*2.Because of my [disorder], my home management (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired. 0 means not at all impaired and 8 means very severely impaired.* For further information please see guidance for the WORK AND SOCIAL ADJUSTMENT SCORE (WORK) data item.
WORK AND SOCIAL ADJUSTMENT SCALE SCORE (SOCIAL LEISURE ACTIVITIES)	*3.Because of my [disorder], my social leisure activities (with other people, such as parties, bars, clubs, outings, visits, dating, home entertainment) are impaired. 0 means not at all impaired and 8 means very severely impaired.* For further informaition please see guidance for the WORK AND SOCIAL ADJUSTMENT SCORE (WORK) data item.
WORK AND SOCIAL ADJUSTMENT SCALE SCORE (PRIVATE LEISURE ACTIVITIES)	*4.Because of my [disorder], my private leisure activities (done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired. 0 means not at all impaired and 8 means very severely impaired.* For further informaition please see guidance for the WORK AND SOCIAL ADJUSTMENT SCORE (WORK) data item.
WORK AND SOCIAL ADJUSTMENT SCALE SCORE (FAMILY AND RELATIONSHIPS)	*5.Because of my [disorder], my ability to form and maintain close relationships with others, including those I live with, is impaired. 0 means not at all impaired and 8 means very severely impaired.* For further informaition please see guidance for the WORK AND SOCIAL ADJUSTMENT SCORE (WORK) data item.

4.1.6 Table 5 - Waiting Time Pauses Table (WAITING TIME PAUSES)

Table 5 - Waiting Time Pauses Table (WAITING TIME PAUSES)
Description
This table should contain a record for each separate period of Activity Suspension for a patient. **General table guidance** The waiting time for a first appointment should be calculated from the date when the Referral Request is received by the service. If opt in date is available and used, the Time from Patient Opt-in to Treatment Measurement should be calculated from the date the patient opts in. For electronic referrals the referral request received date is the date the referral is received electronically by the Health Care Provider. For Choose and Book, the referral is received when the patient's Unique Booking Reference Number (UBRN) is used to book the first outpatient appointment slot (i.e. converted). Where an electronic referral made through Choose and Book is rejected by the chosen provider, the original referral request received date should be used when the patient is subsequently re-referred to another service, so that patients are not unfairly disadvantaged when their waiting time calculations are made. In the circumstance that a patient calls the national Choose and Book Appointments Line and an appointment slot is not available with the chosen Health Care Provider, the national Choose and Book Appointments Line will electronically forward the referral details to the chosen Health Care Provider so the Health Care Provider can liaise directly with the patient to arrange their appointment. The referral request received date will be the date that the Health Care Provider receives electronic notification from the national Choose and Book Appointments Line that the patient has experienced slot unavailability. (Note that this is NOT the date that the Health Care Provider opens or actions the electronic notification). Written referral letters must be opened and date stamped on the day of receipt. It is this date that must be entered on any PAS or similar system, not the date on which the information is fed into the system if this is later than the date of receipt. If the referral takes the form of a phone call followed by a letter, record the date when the letter arrives. If there is no following letter, the date of the verbal request should be recorded. For the latest Waiting Times guidance, please see the IAPT Programme website: http://www.iapt.nhs.uk/data/ **Submission Requirements** At patient level, data can only be included where the following data items are present for each patient: Local Patient Identifier (there must be a corresponding entry for the Local Patient Identifier in the Person table), Organisation Code of Provider, Activity Suspension Identifier, Activity Suspension Start Date and Service Request ID (there must be a corresponding entry for the Service Request ID in the Referral table). **Submission Validations** Submission will be rejected if: - this table is missing from the submission file - this table is missing any specified columns or the structure has been altered
Additional Notes on Data Items

Data Item Name	Additional Notes

Organisation Code of Provider ORGANISATION CODE (CODE OF PROVIDER)	This is the Organisation Code of the organisation acting as the IAPT Heath Care Provider. A valid Organisation code (Code of Provider) must be provided (as defined by ODS). ODS Default Codes: 89997 - Non-UK provider where no ORGANISATION CODE has been issued 89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued The Organisation Data Service is provided by the Health and Social Care Information Centre (HSCIC). It is responsible for the publication of all ORGANISATION and practitioner codes and for the national policy and standards with regard to the majority of ORGANISATION CODES.
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION IDENTIFIER	The activity suspension identifier should be unique to the Local Patient Identifier (Extended), Service Request Identifier and activity suspension period. In order for waiting times to be calculated accurately, this should be the case for the whole period of the referral, not just within the current reporting period.
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION REASON	Clocks/Activity may be paused for social reasons and when initiated by the patient. There is no facility for pausing clocks due to clinical delays, where there is a clinical reason why a patient cannot be assessed/treated. Where there are any clinical/service related delays, the patient's waiting time clock would keep ticking until start of treatment.

4.1.7 Table 6 - Treatment Questionnaire Table (TREATMENT QUESTIONNAIRE)

Table 6 - Treatment Questionnaire Table (TREATMENT QUESTIONNAIRE)	
Description	
This table should contain details of each IAPT Treatment Patient Experience Questionnaire administered for a patient by a healthcare professional. **General table guidance** The IAPT Treatment Patient Experience Questionnaire should be given to patients at the end of treatment. For further information on the Improving Access to Psychological Therapies Treatment Patient Experience Questionnaires, see the Improving Access to Psychological Therapies programme website: • Further guidance relating to the administration of Patient Experience Questionnaires can be found in IAPT Data Set v1.5 guidance available from http://www.iapt.nhs.uk/data/ • A link to the Patient Experience Questionnaire can be found at: http://www.iapt.nhs.uk/silo/files/iapt--pbr--peq.pdf **Submission Requirements** At patient level, data can only be included where the following data items are present for each patient: Local Patient Identifier (there must be a corresponding entry for the Local Patient Identifier in the Person table), Organisation Code of Provider and Service Request ID (there must be a corresponding entry for the Service Request ID in the Referral table). **Submission Validations** Submission will be rejected if: - this table is missing from the submission file - this table is missing any specified columns or the structure has been altered For further guidance relating to submission requirements for national reporting and payment purposes, please refer to Appendix A – PEQ Submission – Clarification to Guidance	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
Organisation Code of Provider ORGANISATION CODE (CODE OF PROVIDER)	This is the Organisation Code of the organisation acting as the IAPT Heath Care Provider. A valid Organisation code (Code of Provider) must be provided (as defined by ODS). ODS Default Codes: 89997 - Non-UK provider where no ORGANISATION CODE has been issued 89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued The Organisation Data Service is provided by the Health and Social Care Information Centre (HSCIC). It is responsible for the publication of all ORGANISATION and practitioner codes and for the national policy and standards with regard to the majority of ORGANISATION CODES.

ASSESSMENT TOOL COMPLETION DATE	PEQs will flow provided they are dated within the reporting period for the current submission. PEQs that have a Null or blank date will be ignored as they do not fall within the inclusion rules. Whilst PEQs dated within the current reporting period will flow, if they are not dated prior to the end of the reporting period subsequent to the date of End of IAPT care pathway, they will not be included in Payment and Pricing calculations.
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 1	The score range for Question 1 is between 0-4 and is scored as follows: 4 - At all times 3 - Most of the time 2 - Sometimes 1 - Rarely 0 - Never
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 2	The score range for Question 2 is between 0-4 and is scored as follows: 4 - At all times 3 - Most of the time 2 - Sometimes 1 - Rarely 0 - Never
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 3	The score range for Question 3 is between 0-4 and is scored as follows: 4 - At all times 3 - Most of the time 2 - Sometimes 1 - Rarely 0 - Never
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 4	The score range for Question 4 is between 0-4 and is scored as follows: 4 - At all times 3 - Most of the time 2 - Sometimes 1 - Rarely 0 - Never
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 5	The score range for Question 5 is between 0-4 and is scored as follows: 4 - At all times 3 - Most of the time 2 - Sometimes 1 - Rarely 0 - Never

4.1.8 Table 7 - Assessment Questionnaire Table (ASSESSMENT QUESTIONNAIRE)

Table 7 - Assessment Questionnaire Table (ASSESSMENT QUESTIONNAIRE)	
Description	
This table should contain details of each IAPT Assessment Patient Experience Questionnaire administered for a patient by a healthcare professional. **General table guidance** The Improving Access to Psychological Therapies Assessment Patient Experience Questionnaire is made up of separate questions for: - Choice - Satisfaction For further information on the Improving Access to Psychological Therapies Patient Experience Questionnaires, see the Improving Access to Psychological Therapies programme website: • Further guidance relating to the administration of Patient Experience Questionnaires can be found in IAPT Data Set v1.5 guidance available from http://www.iapt.nhs.uk/data/ • A link to the Patient Experience Questionnaires can be found at http://www.iapt.nhs.uk/silo/files/iapt--pbr--peq.pdf **Submission Requirements** At patient level, data can only be included where the following data items are present for each patient: Local Patient Identifier (there must be a corresponding entry for the Local Patient Identifier in the Person table), Organisation Code of Provider and Service Request ID (there must be a corresponding entry for the Service Request ID in the Referral table). **Submission Validations** Submission will be rejected if: - this table is missing from the submission file - this table is missing any specified columns or the structure has been altered For further guidance relating to submission requirements for national reporting and payment purposes, please refer to Appendix A – PEQ Submission – Clarification to Guidance	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
Organisation Code of Provider ORGANISATION CODE (CODE OF PROVIDER)	This is the Organisation Code of the organisation acting as the IAPT Heath Care Provider. A valid Organisation code (Code of Provider) must be provided (as defined by ODS). ODS Default Codes: 89997 - Non-UK provider where no ORGANISATION CODE has been issued 89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued The Organisation Data Service is provided by the Health and Social Care Information Centre (HSCIC). It is responsible for the publication of all ORGANISATION and practitioner codes and for the national policy and standards with regard to the majority of ORGANISATION CODES.

ASSESSMENT TOOL COMPLETION DATE	PEQs will flow provided they are dated within the reporting period for the current submission. PEQs that have a Null or blank date will be ignored as they do not fall within the inclusion rules. Whilst PEQs dated within the current reporting period will flow, if they are not dated prior to the end of the reporting period subsequent to the date of End of IAPT care pathway, they will not be included in Payment and Pricing calculations.
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT SATISFACTION PATIENT EXPERIENCE QUESTION 1	The score range for this satisfaction questions is between 0-4 and is scored as follows: 4 - Completely Satisfied 3 - Mostly Satisfied 2 - Neither Satisfied nor Dis-satisfied 1 - Not Satisfied 0 - Not at All Satisfied

Appendix A: PEQ Submission – Clarification to Guidance

Providers have highlighted issues around the timing of submissions for the Treatment Questionnaire and Assessment Questionnaire tables. The following guidance aims to highlight the differences between national reporting requirements, and payment requirements.

1) National reporting inclusion criteria

- PEQs will be accepted if they have a completion date within the reporting period for the current submission.
- PEQ can be submitted in the Primary and/or Refresh Submission for the relevant reporting periods as long as the PEQ completion date falls within the inclusion dates for Primary and Refresh data submissions
- PEQs that have a Null or blank date will be ignored as they do not fall within the inclusion rules.

Examples:

a) A PEQ handed to the patient on 20th April 2014 at an appointment, that also has the completion date populated as 20th April 2014, relating to a referral which ended on 30th April, but is not received until 15th July 2014 when returned by the patient will not meet the inclusion rules and will not flow. As it is dated 20th April it must flow in May (April Primary) or June (April Refresh).

b) A PEQ handed to the patient on 20th April at an appointment, relating to a referral which ended on 30th April, is taken away, then completed on and dated 15th July, and received in August will flow, provided it is submitted in either August (July Primary) or September (July Refresh).

2) Payment

The same national reporting inclusion criteria exist:

- PEQs will be accepted if they have a completion date within the reporting period for the current submission.
- PEQ can be submitted in the Primary and/or Refresh Submission for the relevant reporting periods as long as the PEQ completion date falls within the inclusion dates for Primary and Refresh data submissions
- PEQs that have a Null or blank date will be ignored as they do not fall within the inclusion rules.

Plus:

- PEQs must have a completion date within 2 full reporting periods after the end of Referral (Date of End of IAPT Care Pathway). This means PEQ's received more than 2 months after the end of the Referral, will be excluded from any Payment calculations

Example:

A PEQ handed to the patient on 20th April at an appointment, relating to a referral which ended on 30th April, is taken away, then completed on and dated 15th July, and received in August, will flow as above; BUT will not be recognised for payment because data supplied for payment will be extracted prior to submission of the PEQ questionnaire.