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Health & Social Care Information Centre

Responses to a consultation on reporting from the Improving Access to Psychological Therapies (IAPT) dataset

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Introduction

The Improving Access to Psychological Therapies (IAPT) dataset was first mandated from April 2012, and since then reports have been produced on a quarterly basis to give information on activity levels in the service such as numbers of referrals received and numbers of referrals with a first treatment. Throughout 2012/13 and 2013/14 these measures have been developed and improved, allowing more detailed reports to be generated including information on outcomes and recovery.

There has been an increasing demand for this information to be published sooner after submission, and to a greater level of detail. This consultation was therefore undertaken to inform the development of the 2014/15 reports from the dataset, and to generate opinions about proposed changes to the dataset reports to ensure that these met users' needs (Principle 1 of the Code of Practice for Official Statistics[1]) and made efficient and effective use of available resources (Principle 7 of the Code of Practice for Official Statistics).

The aims of this consultation were:

- To ensure that reports produced by the HSCIC meet the needs and requirements of all our users;
- To collect opinion on proposed changes to the dataset reports and ensure that any changes would reflect these needs;
- To understand how the HSCIC reports are currently utilised, and how their utility can be optimised.

The responses to this consultation will inform discussion and development of reporting solutions for the next financial year and beyond, and the proposed changes will be evaluated in respect of concerns and opinions raised through this process.

This document provides information on:

- The results of the public consultation exercise;
- Recommendations as a result of this exercise;
- Ongoing work and next steps relevant to this exercise.

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[1] http://www.statisticsauthority.gov.uk/assessment/code-of-practice/

The Consultation

Background Information

In line with the European Statistical System (ESS) dimension 'Assessment of user needs and perceptions', we launched a public consultation which opened on 12th March 2014 and closed on 21st April 2014. The consultation was released alongside the IAPT Data Quality Reports for March on the Health and Social Care Information Centre (HSCIC) website and was announced at a number of user engagement events coordinated by the HSCIC. We also sent out email invitations to participate using our mental health contact and mailing lists, and to relevant organisations e.g. providers, commissioners, professional bodies including stakeholders, researchers and charities. A link to the consultation was also included in the Quarterly IAPT Report that was released in April.

The consultation consisted of an online questionnaire (also available in downloadable format for printing), and we welcomed written responses on any matters relevant to the consultation as part of the exercise.

The public consultation, including the full list of questions, can be found at:
http://www.hscic.gov.uk/iaptconsult

The consultation sought views on a proposed change from monthly to quarterly activity reporting, and to user's views on the granularity, regularity and format of future data releases.

It asked for responses regarding:

- The use of existing publications including the annual, quarterly and monthly reports;
- The utility of the provisional diagnosis field which shows consistently low data completeness;
- The proposal to change the frequency of reporting activity data to a monthly basis;;
- Increasing the granularity of data, by reporting at CCG – Provider combination level;
- The utility of proposed measures that could make up the content of these monthly reports.

We also asked a series of questions about the respondent's organisation and role in order to better understand our user base and the opinions in different sectors.

Summary of Results

Responses and respondents

We received 36 responses to the public consultation questionnaire. Not all questions were answered by all respondents and full information on the number of responses to each question is provided in the Appendix to this report.

Of those that submitted a response, 23 (64%) provided a single response, whilst 13 (36%) submitted on behalf of their organisation. The majority of those submitting a response belonged to a provider organisation which submits IAPT data to the HSCIC (67% compared to 33% who did not). All respondents provided information about the nature of their parent organisation which can be seen in Figure A below. Three individuals also identified themselves as working for a system supplier (such as IAPTus or PCMIS).

Figure A: Number of respondents by organisation type
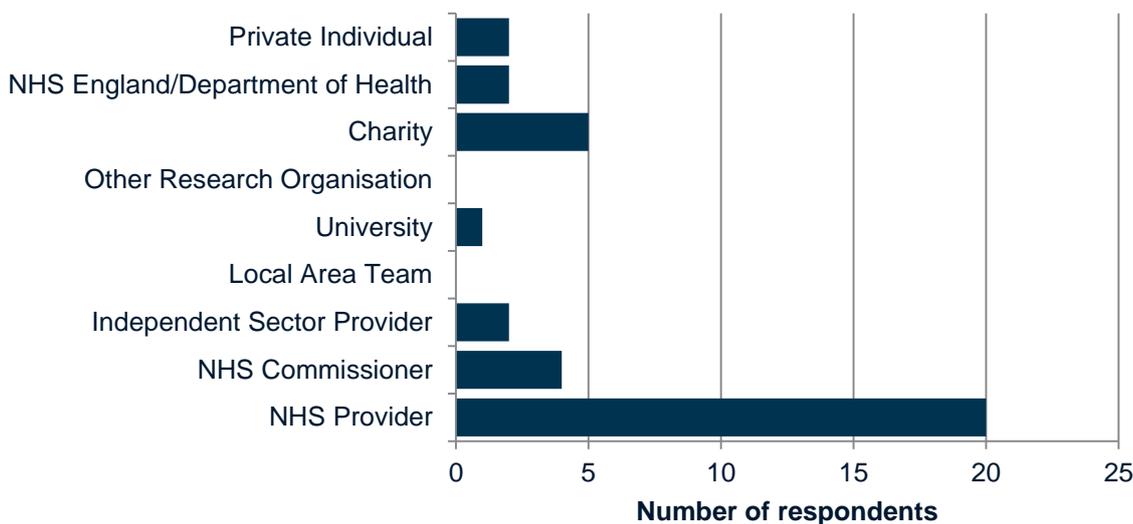
All respondents completed the question about their primary role and of these 11 worked in Data analysis (31%), 11 worked in Management (31%) and 9 worked in Clinical roles (25%). Other respondents were spread across IT, research and campaigning.

Use of current publications

Questions about IAPT publications that are currently produced by the HSCIC showed that the quarterly reports are the most commonly used, with 32 respondents stating that they made use of these (89%). A similar volume of respondents had read the Psychological Therapies, Annual Report (83%), whilst only 67% currently use the Monthly IAPT data quality reports.

On the Provisional Diagnosis field

Provisional Diagnosis is a field that is used for the calculation of outcomes in the current reports, and basic activity such as the number of referrals received is reported by provisional

diagnosis. Data quality measures, however, show that it has a consistently low completion rate, with only around 50% of all referrals having a provisional diagnosis recorded. In order to try and understand the opinion of respondents about this data item, and some of the reasons for the low rate of completion, we asked about how the field was used within their organisation and how useful they found it.

Figure B: Reasons[2] for poor completion of the Provisional Diagnosis Field
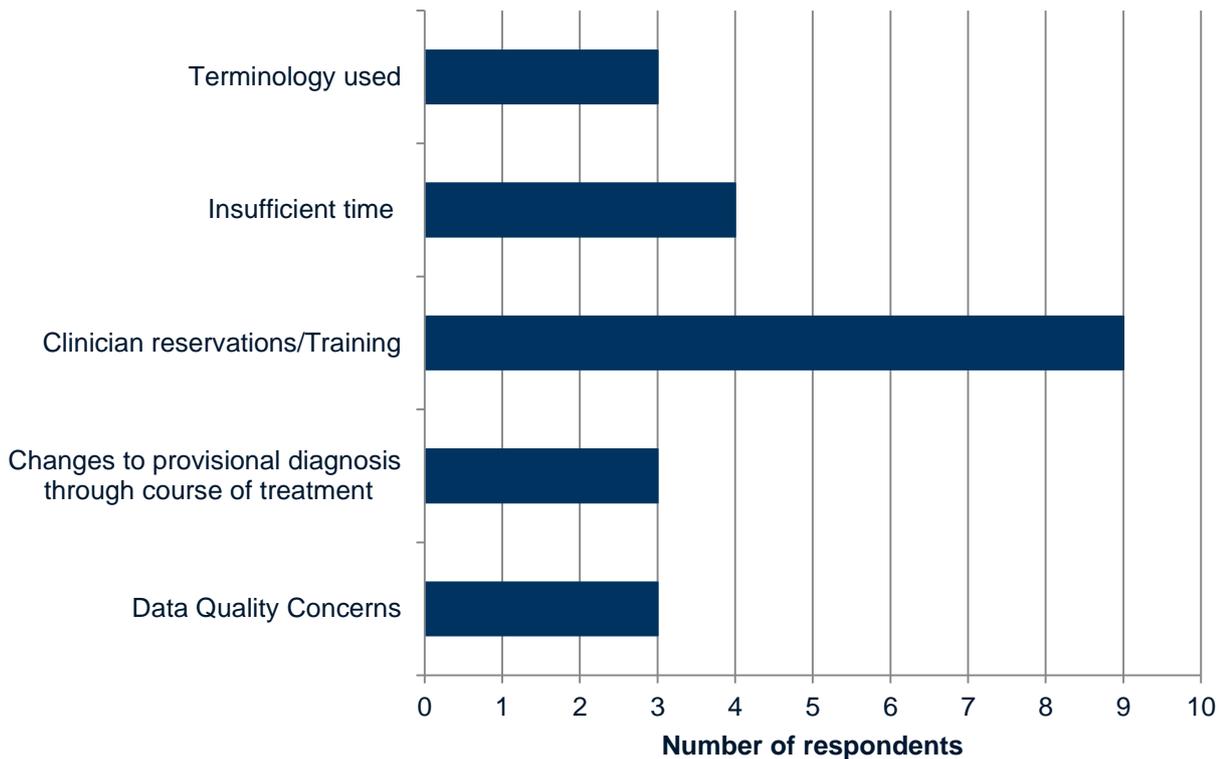
This question received a range of responses. Although most responders commented on the importance of the provisional diagnosis field, some appeared to believe that the consultation proposed the removal of this field from the IAPT reports. Some respondents stated that this field was not of use to them, and this seemed particularly to be true of those that identified themselves as commissioners.

A larger contingent however, concentrated on the reasons for the poor completion of this field, with clinician reluctance or lack of training being the most prevalent reason. It was felt that, often staff are not confident in making a diagnosis due to not being qualified to do so. It was also mentioned that making a provisional diagnosis was not part of current training. Responses suggested that gaps in data may also occur where a client fails to engage with the service as this information may never be obtained. The issue of being unsure how to submit this data field if a client's diagnosis changed over time or the client had multiple issues was also raised.

A number of respondents also suggested improvements that could be made to the dataset or reports to increase the data completeness of this field and its utility. These included:

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[2] Counts may not sum to the total number of respondents as some respondents cited more than one reason

- Changes to how provisional diagnosis is reported on. Currently we present information on referrals received and referrals completing treatment, as well as providing data quality information for all records by provisional diagnosis. Respondents suggested that reporting on provisional diagnosis early in the referral does not allow enough time for provisional diagnosis to be collected, and so data quality and reporting by diagnosis should only be done for those records that have been seen at least once.
- Adding the capacity to record multiple provisional diagnoses where a patient presents with more than one condition.
- A change in the terminology used – one reason cited for why clinicians are reluctant to record provisional diagnosis is the term 'diagnosis', especially as the patient may not meet diagnostic criteria for a condition. An alternative term suggested by respondents was 'Presenting Issue', which may encourage more clinicians to complete the field.

Overall, most respondents reinforced the importance of this field and stated that it is used for monitoring the performance of services, determining appropriate treatment for patients, and identifying gaps in service, as well as training and resource needs. It was also clear that there is a need for reporting by diagnosis to continue in future reporting.

## On the frequency and granularity of data

This consultation sought to gather views on a proposal to change the reporting of IAPT activity from a monthly to a quarterly basis, and to report on CCG-Provider combinations rather than presenting CCGs and Providers in separate tables. A list of proposed measures comprising the new monthly file were provided in the consultation documentation, with the aim of receiving feedback on these and ensuring that they met user needs.

Figure C: Responses regarding the usefulness of monthly rather than quarterly data
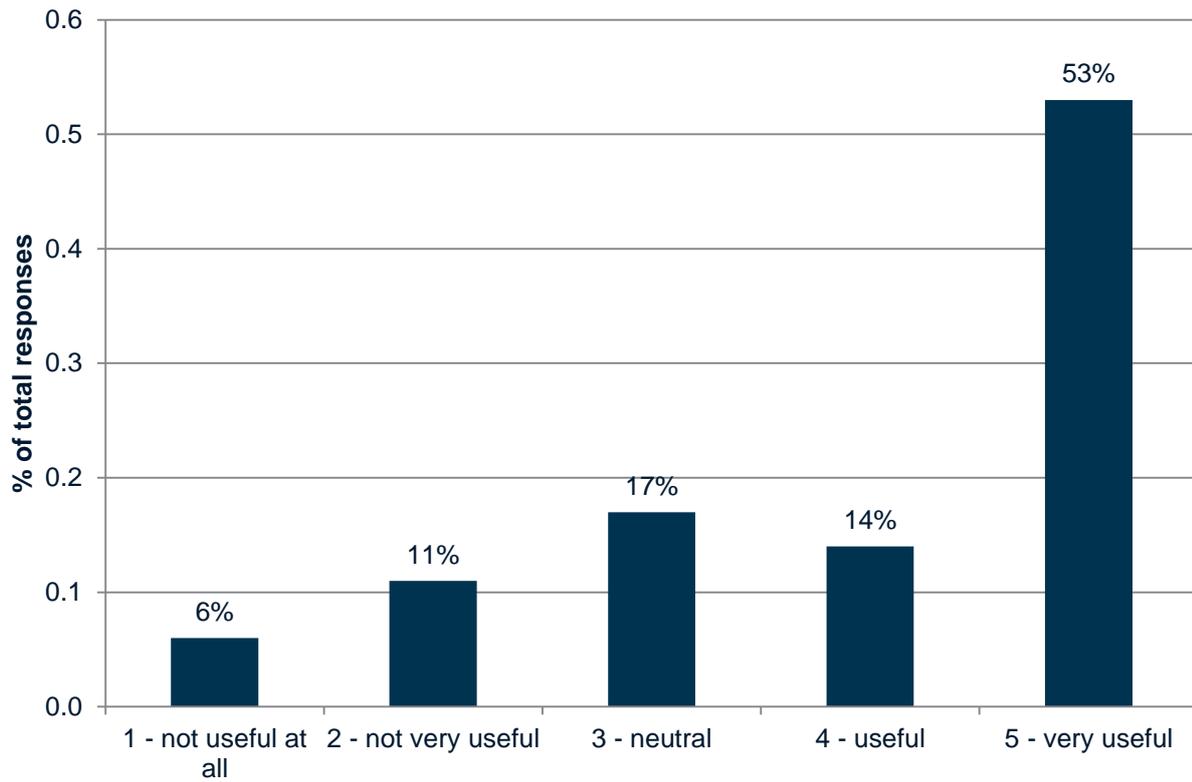
Respondents were asked to rate on a scale of 1 (Not Useful) to 5 (Very Useful) whether they would find a change from quarterly to monthly reporting of activity data useful. Twenty four respondents (67%) stated that this would be useful (rating of 4 or 5), whilst only 6 respondents (17%) stated that this would not be very useful (rating of 1 or 2).

Figure D: Responses regarding the usefulness of CCG-Provider level data
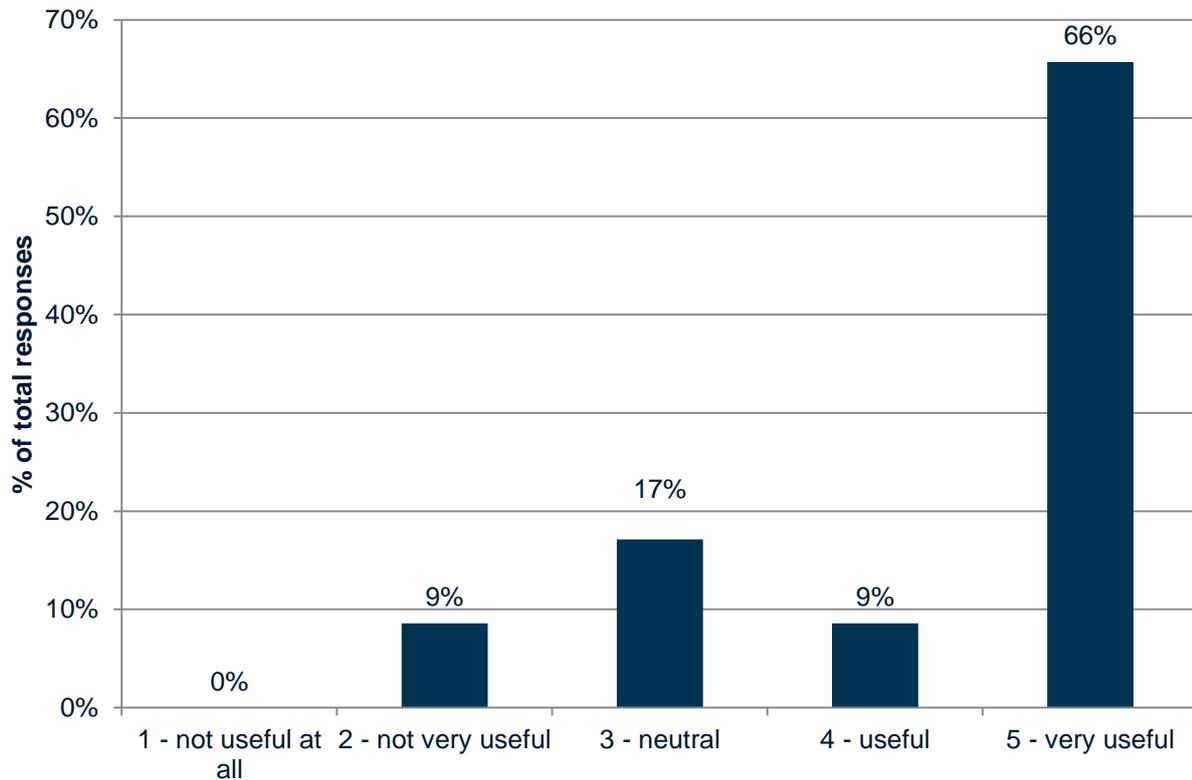
Respondents also favoured the approach of presenting data by CCG-Provider combinations. This will allow a greater understanding of commissioning relationships and will allow understanding of the contribution each provider makes to overall CCG level performance. No respondents classed this as 'not useful at all' (rating 1), and 23 (66%) stated that this would be very useful (rating 5).

Comments received in response to questions 8-11 suggested that a number of respondents were positive about the proposed changes and the measures put forward, stating that this would increase timeliness of reporting. Respondents also commented that they were happy with the move to providing data in a csv format to increase accessibility, and also the proposed reporting by CCG-Provider combination was also welcomed.

Overall 25 respondents answered the question "Do you have any concerns about the replacement of the existing Quarterly Improving Access to Psychological Therapies reports with the proposed monthly release?" of which 9 (36%) had no concerns, and 15 (60%) gave details of concerns they held, including ways in which the proposal could be improved.

Of those expressing concerns, some respondents mentioned the need to inform users including commissioners about the changes to presentation and methodology, and any relevant caveats, particularly regarding comparability to previous measures. By far the most reported concern was a loss of detail in the proposed measures and a desire to keep, and expand upon, current demographic and diagnosis level reporting.

There was also uncertainty from respondents as to whether monthly reports would affect an organisation's ability to submit refresh data. Monthly activity data would report on refresh data, in the same way that quarterly data is reported, but the concerns raised indicate that this would need to be made clear in any documentation about any new monthly reporting products. Finally, there were some concerns that a change to the new format could represent additional burden to data users when analysing the figures.

Figure E: Concerns[3] raised regarding the proposed changes
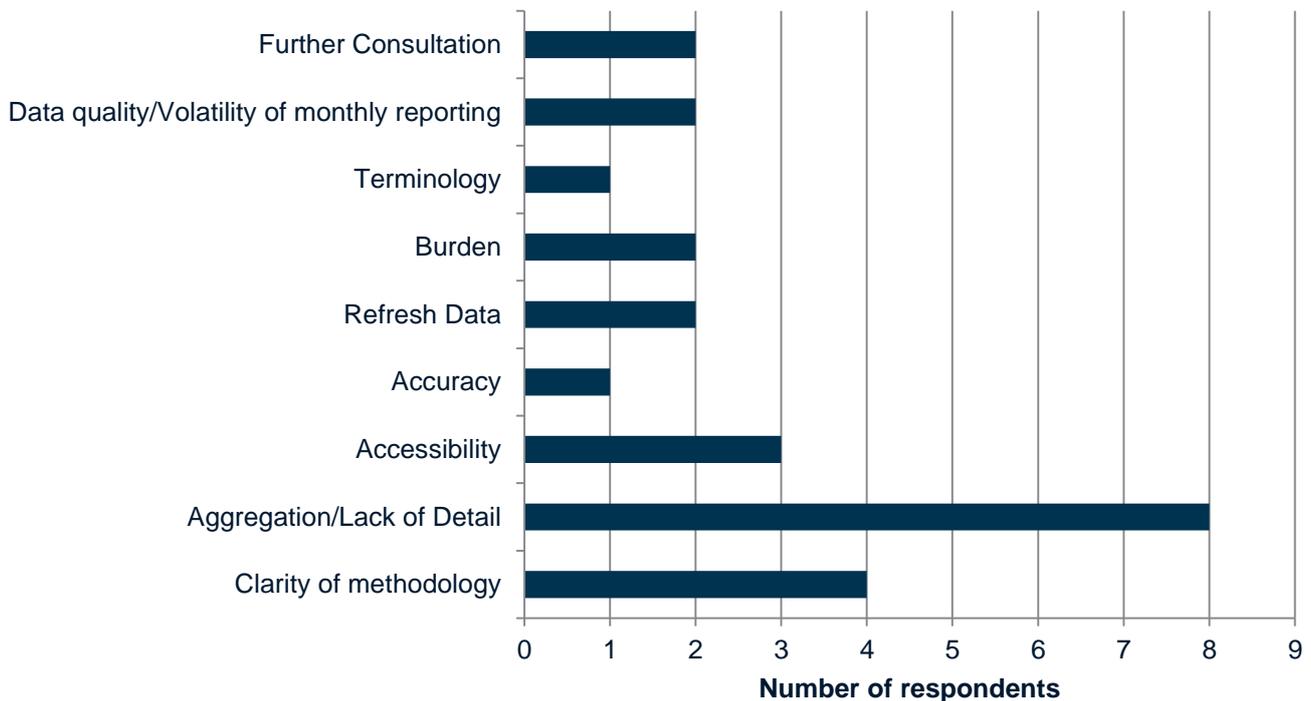
Further to this, the consultation asked for any additional comments were sought when about users' thoughts on the proposed changes; this question was answered by 20 respondents, of which 8 (40%) suggested further work or improvements, while 30% welcomed the changes as a positive step, and a further 30% thought the changes represented a negative move.

Respondents objecting to the changes did so on the grounds that the change would represent a loss of detail currently available, whereas supporters of the changes were positive about the increased utility this would bring for activity figures including some who made particular reference to the utility of csv files.

Some respondents requested further consultation on the changes and some of this was from a viewpoint that the proposed reports had already been decided upon. This is not the case, however, and we will take on board all feedback from the consultation before a future reporting strategy is finalised.

A summary of all concerns raised in responses to the open consultation questions can be seen in Figure D.

As part of the consultation, respondents were asked to identify additional measures that would be of use, and a wide variety of responses were received as can be seen from the list below. Some of these alterations will be possible in a new version of the dataset (version 1.5, from which data will begin to be collected in July 2014), and others may be able to be implemented in future reports, while some may not be possible at present.

Suggestions received included:

- Present the number of appointments cancelled by provider;
- Present activity measures broken down by step of care;

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[3] Counts may not sum to the total number of respondents as some respondents cited more than one concern

- Present expanded waiting time measures with more time periods such as "fewer than 56 days";
- Present expanded waiting times for those that are still waiting for treatment at the end of the period;
- Present waiting times from first to second appointment;
- Present the number of referrals that closed without assessment;
- Limit data quality reporting on provisional diagnosis to those records that have had an attended appointment;
- Provide data quality notices that contain details of all problem records;
- Present counts of the number of open referrals that were present in the previous period but did not flow in the current period;
- Present counts of referrals who did not opt in to treatment;
- Present a measure of 'Subjective Wellbeing';
- Report on Outcomes by diagnosis;
- Report on Outcomes by therapy type;
- Report on Outcomes by age, gender and ethnicity;
- Report on IAPT for children and young people;
- Report on time waited between steps in treatment;
- Count the number of people opting out of flowing data to the HSCIC;
- Present data at Lower Super Output Area(LSOA) or Middle Layer Super Output Area(MSOA) levels;
- Calculate a % recovery rate;
- Add further data completion measures to the data quality report, to cover all fields used in the calculation of monthly measures;
- Produce data by IAPT service, rather than by Provider or Commissioner;
- Present a breakdown of ended referrals by those that finished a course of treatment and those that were only seen once and did not enter treatment.

Of those listed, the measures for which there was the highest demand appeared to be outcome measures by diagnosis and also by therapy type, as well as expansion of the existing waiting time measures. There was also a lot of support for further reporting at other organisational and geographic levels and in particular at IAPT service level which would require future development of the dataset.

A number of respondents mentioned the impact of patients who decline to share their data with the HSCIC. The HSCIC does not receive any information about these patients so it is currently not possible for us to report on the number of patients this affects, but it is possible that this information can be collected and reported at a local level.

Conclusions

Overall this consultation provided a range of views from a range of users both within and external to IAPT services about the utility of current reports and potential directions for future reporting.

In general there appears to be a consensus that more activity measures should be reported monthly, and there is a demand for more granular data at a CCG-Provider level. Whilst some responses were in favour of using csv files for this, there were some concerns about accessibility. This could suggest that if csv files are taken forward there may be a need for other additional presentation methods, or guidance on how the files can be used.

A number of recommendations for improvement were provided which will need to be considered in the design future reports. In particular there is concern about the clarity of changes and a loss of detail in the reports that should be taken into consideration, as well as the potential for additional measures to be added to the proposal.

With regard to the 'Provisional Diagnosis', this consultation has helped provide a greater insight into the barriers IAPT service providers are experiencing in populating this field, the predominant one being clinician reluctance to complete it. It has also highlighted the importance of this field in informing service provision and identifying issues, as well as informing interested parties such as patients and the charities which represent them. It is clear that further work should be done in reinforcing its importance and how this can be used to encourage more complete reporting.

Next steps

Following this consultation the HSCIC will take into account the feedback we have received into decisions to be made about the content of future reports. Once these decisions have been taken it is clear that communicating any changes will be important and we will ensure that the details of future reporting are published on our website and communicated at future events. Any methodological changes will also be detailed, including the publication of the constructions of key methods.

The findings of this consultation will also feed into discussions with key stakeholders regarding future development work such as new versions of the IAPT dataset, with a view to improving data quality, completeness and utility.

We would like to thank all respondents to this consultation, and continue to encourage feedback on the IAPT dataset and central reporting to allow us to continue to improve the publications and data sources we produce and to ensure user needs are met. If you would like to contact the HSCIC regarding any issues discussed in this consultation, or any wider comments regarding the IAPT dataset, please contact iapt@hscic.gov.uk

Appendix

Number of responses received for each question.

Question Number	Question	Number of Responses
1	Do You Currently Use the Quarterly Improving Access to Psychological Therapies reports? (these replaced the IAPT KPI reports from Q1 2013/14)	36
2	Do you currently use the Monthly Improving Access to Psychological Therapies Data Quality Reports?	36
3	Have you read the Psychological Therapies, Annual report on the use of IAPT services publication?	36
4	Provisional diagnosis is a key field used in our publications, but has consistently low data quality, being completed in only 50% of cases. If relevant, could you provide any information on how you use this field in your organisation and how useful you find it?	33
5	Please rate how useful it would be to have activity information on a monthly rather than quarterly basis	36
6	Please rate how useful it would be to have activity reported at a CCG-Provider combination level	35
7	Are there any other measures that would be useful that are not listed in the file above?	25
8	Are there any measures that you do not find useful at all?	15
9	Do you have any concerns about the replacement of the existing Quarterly Improving Access to Psychological Therapies reports with the proposed monthly release?	25
10	Is there anything else you would like to tell us about your thoughts on the proposed changes	26
11	Is this a single or coordinated response (i.e. are you replying on behalf of yourself or an organisation or group)?	36
12	Please choose the word that best describes the type of organisation you work for	36
13	Does your organisation submit IAPT data	35
14	Please choose the word that best describes your role	36

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