Psychological Therapies

Annual report on the use of IAPT services, England 2017-18

Published 20 November 2018

This report examines activity, waiting times and outcomes in the Improving Access to Psychological Therapies (IAPT) programme from 1st April 2017 to 31st March 2018.

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

Key findings between 1st April 2017 and 31st March 2018:

1. 1.44M referrals to talking therapies
   - 3.9% from 1.39M in 2016-17

2. 89.1% started treatment within 6 weeks
   - 1.6% from 87.5% in 2016-17

3. 1.01M referrals started treatment
   - 4.5% from 965,379 in 2016-17

4. 6.8 sessions of treatment on average

5. 554,709 referrals completed course of treatment
   - 2.2% from 567,106 in 2016-17

6. 50.8% referrals moved to recovery
   - from 49.3% in 2016-17

1. Please note that these numbers reflect activity in the year and are not based on the same group of referrals.
2. The proportion of referrals starting treatment within 6 weeks, mean treatment sessions, and the recovery rate are based on referrals completing a course of IAPT treatment in the year.

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

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

The IAPT programme is supported by a regular return of data generated by providers of IAPT services in delivering those services to patients. These data are received by NHS Digital and published in monthly and annual reports\(^2\).

This report summarises activity in the IAPT programme for the annual period 1\(^{st}\) April 2017 to 31\(^{st}\) March 2018. It shows key information about activity, patient outcomes and waiting times.

**Main findings**

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

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

**Activity**

1,439,957 new referrals were received in the year.

1,009,035 referrals entered treatment in the year.

1,376,920 referrals ended (for any reason) in the year.

**Outcomes**

517,942 referrals finished a course of treatment in the year having started at caseness, of which 263,295 (50.8%) moved to recovery.

**Waiting times**

Of the 554,709 referrals that finished a course of treatment in the year, 89.1% waited less than 6 weeks and 98.8% waited less than 18 weeks to enter treatment.

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\(^1\) [https://www.nice.org.uk/](https://www.nice.org.uk/)

\(^2\) [www.digital.nhs.uk/iaptreports](http://www.digital.nhs.uk/iaptreports)
Outcomes

Outcomes in IAPT are measured in terms of three measures;

- Recovery;
- Reliable improvement;
- Reliable recovery.

For a full explanation of each of these terms, see the ‘Guide to IAPT data and publications’, available at www.digital.nhs.uk/iaptreports.

Recovery

Recovery in IAPT is measured in terms of ‘caseness’ – a term which means a referral has severe enough symptoms of anxiety or depression to be regarded as a clinical case. A referral has moved to recovery if they were a clinical case at the start of their treatment (‘at caseness’) and not a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition. Full details of how to calculate recovery rates can be found in the ‘Guide to IAPT data and publications’, available at www.digital.nhs.uk/iaptreports.

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

Figure 1: recovery rates over time, England, 2012-13 to 2017-18

![Graph showing recovery rates over time](image)

Figure 1 shows that recovery rates have increased gradually year-on-year since the dataset was established in 2012-13\(^3\), reaching 50.8% in 2017-18.

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\(^3\) Please note that there were methodological changes to published IAPT data part way through the 2014-15 year due to a dataset version change, which may have impacted recovery rates. Full details are published in the November 2014 Methodological Change Notice at www.digital.nhs.uk/iaptreports.
Reliable improvement and reliable recovery

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

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

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

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

For further information about these measures, see the ‘Guide to IAPT data and publications’, available at www.digital.nhs.uk/iaptreports.

The accompanying interactive data report allows users to see outcomes for the following geographies:

- NHS Commissioning Region
- Strategic Transformation Partnership
- NHS Clinical Commissioning Group
- IAPT service provider
Waiting times

One of the stated targets of the IAPT programme is that for new referrals, 75% enter treatment within 6 weeks and 95% within 18 weeks. These are based on the waiting time between the referral date and the first attended treatment appointment, for referrals finishing a course of treatment in the year 4.

In 2017-18, 89.1% of referrals were seen within 6 weeks, and 98.8% were seen within 18 weeks – both above the targets.

**Figure 3:** Distribution of waiting times between referral and first treatment for referrals finishing treatment in 2017-18, England

![Distribution of waiting times](image)

Figure 3 shows that the peak number of referrals entered treatment between 0 and 7 days (193,073 referrals), with only 1.1% (6,251) of referrals waiting over 18 weeks to enter treatment.

The average waiting time to enter treatment was 20.7 days.

The accompanying interactive data report allows users to see waiting times for the following geographies:

- NHS Commissioning Region
- Strategic Transformation Partnership
- NHS Clinical Commissioning Group
- IAPT service provider

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4 Since July 2014. Comparisons with waiting times in annual data prior to 2015-16 should be made with caution, as these were based on referrals entering treatment in the year.
Activity

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

There are four key stages in an IAPT pathway:

- **Referral received**: This is the date on which an IAPT care provider receives a referral for a patient. In 2017-18, there were 1,439,957 new referrals to IAPT care providers.
- **Referral enters treatment**: This is the date of a patient’s first attended treatment appointment. In 2017-18, 1,009,035 referrals entered treatment.
- **Appointments**: Appointments are the way in which patients’ contact with IAPT services is recorded. There are a range of appointment types in IAPT, such as assessment, treatment, and review. In 2017-18, there was a mean of 6.8 treatment appointments for referrals finishing treatment in the year.
- **Referral ends**: A referral most commonly ends having completed a course of IAPT treatment, but there are other reasons a referral may end, such as the patient declining treatment. In 2017-18, 1,376,920 referrals ended, of which 554,709 completed a course of treatment.

Figure 4 shows that activity of all types has continued to increase over time, though the rate of increase continues to reduce year on year.

It is important to note that these numbers are not based on the same group of referrals as each other. A referral that was received in 2017-18 did not necessarily enter treatment or end in the year. Likewise, referrals that ended in 2017-18 may have been received or entered treatment before 2017-18.

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The number of referrals that finished a course of treatment is a subset of all referrals that ended in the year. Many referrals end without having been seen by the service; i.e. there were no attended appointments during the referral. Figure 5 describes the different levels of contact an ended referral may have.

554,709, or 40.3% of all referrals ending in 2017-18, finished a course of treatment. Only referrals having finished a course of treatment are assessed against measures of waiting times and outcomes such as recovery, reliable improvement, and reliable recovery.

59.7% of referrals that ended in 2017-18 did not complete a course of IAPT treatment. There are many reasons why a patient may be referred to an IAPT care provider but not finish a course of treatment. For example, the patient may decline to attend an initial appointment offered, an initial assessment may determine that the patient is not suitable for IAPT services, or a patient may start a course of treatment but then decide not to continue.

The accompanying interactive data report allows users to see activity for the following geographies:

- NHS Commissioning Region
- Strategic Transformation Partnership
- NHS Clinical Commissioning Group
- IAPT service provider
Appendix 1: Data source and considerations

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

Providers of adult IAPT services are required to submit data for patients with open referrals (or ending in the month) every month, in accordance with the IAPT data standard\(^6\).

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

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

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

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

Additionally, we have excluded any referrals that started prior to the IAPT dataset version change on 1\(^{\text{st}}\) July 2014. Alongside the implementation of IAPT v1.5, a large amount of key definitions and methodologies changed (including, but not limited to, definitions of therapy types and the identification of treatment appointments). In the annual data view, applying previous methodologies and definitions to referrals that are submitted across both versions of the dataset is resource-intensive and of little value. An assessment of v1.0 activity found that 565 referrals that started prior to July 2014 had activity during 2017-18, which is 0.03% of all referrals with activity in 2017-18. Therefore, these referrals have been excluded and v1.5 definitions used exclusively.

Further details about the construction of the annual dataset are available on request and the details of the logic we apply in calculating key measures are described in the ‘Guide to IAPT data and publications’, available from www.digital.nhs.uk/iaptreports.

\(^6\) See http://wwwdigital.nhs.uk/iapt
Appendix 2: Data Quality Statement

Detailed information about data quality relevant to the IAPT dataset, from which these data have been produced, can be found in the ‘IAPT DQ Notes’, available from www.digital.nhs.uk/iaptreports. This section provides details and data quality information specific to this publication.

Accuracy and Reliability

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

This report is supported by a Data Quality summary report in an Excel spreadsheet format. The purpose of the DQ summary is to present users with information about the validity, completeness and accuracy of records that have been used in this annual analysis.

In addition, we publish a record of specific data quality issues found in the dataset or reported by IAPT service providers, including an estimate of the impact and affected period in the data. This can be found within the ‘IAPT DQ Notes’, available from www.digital.nhs.uk/iaptreports.

Relevance

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

Data in this publication are presented in various ways to meet user needs: summary report and key findings (this document), an interactive suite of data visualisations, a data quality report published in Excel and CSV data files.

Where possible the data are presented at the following NHS Geographies as well as national level to allow users to access information about the IAPT services in their areas:

- Commissioning Region
- Strategic Transformation Partnership (STP)
- Clinical Commissioning Group (CCG)
- IAPT service provider

Comparability and Coherence

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

The IAPT publication uses clinical terms and definitions wherever possible.

As described in the ‘Guide to IAPT data and publications’, available from www.digital.nhs.uk/iaptreports, a patient has recovered if they were above the caseness threshold for either anxiety or depression or both at the start of treatment and if they are below the caseness threshold for both anxiety and depression at the end of treatment. This ‘double’ recovery measure is specific to IAPT and will continue to be the measure used in regular reporting as it is the most patient-centred method of assessing the outcome of treatment.
In many academic and clinical research studies, anxiety and depression are studied in isolation; rather than together. When considering ‘recovery’ for anxiety and depression separately, it is anticipated that more patients will have dropped below the caseness threshold on one of the scales, irrespective of whether they are above or below the caseness threshold on the other scale. The table below provides information on the number of patients who moved below the caseness threshold for anxiety and depression separately, alongside the standard IAPT recovery measure.

**Comparison of recovery for anxiety and depression separately and the IAPT definition of recovery, 2017-18**

<table>
<thead>
<tr>
<th></th>
<th>Number of patients at caseness at the start of treatment</th>
<th>Number of patients below caseness threshold at the end of treatment (recovered)</th>
<th>Recovery rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety and depression (IAPT recovery definition)</td>
<td>517,942</td>
<td>263,295</td>
<td>50.8%</td>
</tr>
<tr>
<td>Depression only</td>
<td>451,579</td>
<td>247,778</td>
<td>54.9%</td>
</tr>
<tr>
<td>Anxiety only</td>
<td>487,333</td>
<td>258,643</td>
<td>53.1%</td>
</tr>
</tbody>
</table>

The integrated services pilot programme

From January 2017, a subset of IAPT providers are taking part in a pilot programme offering psychological therapy that is integrated with physical healthcare for patients with pre-existing long-term health conditions and/or medically unexplained symptoms. This pilot programme is being supported by the collection of additional data items alongside routine IAPT submissions. An assessment has been made of the impact of this new collection on the data submitted by providers taking part in this pilot that has contributed to this report, which is summarised below.

The additional items collected are appointment-level fields; that is, they are collected during each patient contact for relevant referrals and submitted as an additional data table that is linked to the main appointment table in the IAPT dataset. Where this additional information is not provided, it does not affect the main appointment table, and for referrals where the new information is present, it does not affect the methodologies used in any of the analyses in this annual publication, or routine monthly or quarterly IAPT publications. New data items are analysed and reported in a separate publication product, available alongside monthly publications from March 2017 Final at [www.digital.nhs.uk/iaptreports](http://www.digital.nhs.uk/iaptreports). Please refer to these monthly publications for further details of the pilot including details of the providers who are participating in the pilot collection.

The Employment Advisers in IAPT pilot programme

From August 2018, a subset of IAPT providers are taking part in Employment Advisers pilot that is being led by the Work and Health Joint Unit (WHU). This pilot increases the number of Employment Advisers embedded in IAPT services, who will support more people with depression and anxiety to receive combined psychological therapy and employment support. The pilot will provide skills-based interventions, information and practical support to help people receiving IAPT services to remain in, return to, and find work.

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7 For more information about the integrated services pilot and statistical publications, see monthly IAPT publications from March 2017 Final data onwards, available from [www.digital.nhs.uk/iaptreports](http://www.digital.nhs.uk/iaptreports).
Additional items are being collected by the pilot IAPT service providers from approximately 40 per cent of Clinical Commissioning Groups (CCGs) in England. Pilot services have been selected to be a representative sample of IAPT CCGs across England. Where this additional information is not provided, it does not affect the main appointment table, and for referrals where the new information is present, it does not affect the methodologies used in any of the analyses in this annual publication, or routine monthly or quarterly IAPT publications. New data items are analysed and reported in a separate publication product, available alongside monthly publications from March 2017 Final at www.digital.nhs.uk/iaptreports.

It is anticipated that there will be an increase in the number of appointments where therapy type is recorded as ‘Employment Support (Low Intensity)’ and ‘Employment Support (High Intensity)’ in those providers and CCGs that are participating in this pilot. Please refer to the monthly Employment Adviser publications for details of participating IAPT providers.

**Timeliness and Punctuality**

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

IAPT data is published monthly, within 3 months of the end of the reporting period. An extensive range of measures of activity, waiting times and outcomes are released each month. This 2017-18 annual publication was released 8 months after the end of the financial year.

**Accessibility and Clarity**

Accessibility is the ease with which users can access the data, also reflecting the format in which the data are available and the availability of supporting information. Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice.

This publication includes this report, presenting headline figures and key findings that are aimed at a range of audiences. More detailed information is published in an interactive suite of data visualisations, a data quality report published in Excel and CSV data files to facilitate further investigations and local analysis.

Where possible the data is presented at the following NHS Geographies as well as national level to allow users to access information about the IAPT services in their areas:

- Commissioning Region
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- Clinical Commissioning Group (CCG)
- IAPT service provider

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**Assessment of user needs and perceptions**

This section describes the processes for finding out about users and their views on the IAPT publication.
In May 2018, we ran a user consultation to help better understand the user requirements for the IAPT publication. Results of this and actions taken are described in the ‘Consultations’ section of www.digital.nhs.uk/iaptreports.

Based on the feedback from this consultation, the structure of this annual publication, its format and data contents have changed significantly when compared to the 2016-17 annual publication.

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

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

Users of this report are also encouraged to complete a short customer satisfaction survey at http://web.ict.hscic.gov.uk/hscicgovuk-ammje/pages/7f454cb28f9fe711811670106fa55dc1.html

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

**Performance Cost and Respondent Burden**

This section describes the effectiveness, efficiency and economy of the statistical output. Data for this publication is collected by providers of IAPT services in delivering those services to patients. For further details see the ‘IAPT DQ Notes’, available from www.digital.nhs.uk/iaptreports.

**Confidentiality, Transparency and Security**

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

The data contained in this publication are Official Statistics. Further details about this and links to the NHS Digital Disclosure Control Procedure, privacy policy and Freedom of Information process can be found in the ‘IAPT DQ Notes’, available from www.digital.nhs.uk/iaptreports.

**Low numbers and suppression**

Suppression of data has been applied to protect patient confidentiality in IAPT publications. Further details can be found in the ‘IAPT DQ Notes’, available from www.digital.nhs.uk/iaptreports.
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