This statistical release makes available information about activity and outcomes for patients taking part in a pilot programme offering integrated IAPT services.

IAPT is run by the NHS in England and offers NICE-approved therapies for treating people with depression or anxiety. Pilot services are those integrating IAPT care into existing medical pathways and services for patients with long term conditions or medically unexplained symptoms.

The integrated services started to treat patients in January 2017. This publication makes available the data for February 2019.
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This is an Experimental Statistics publication

This document is published by NHS Digital, part of the Government Statistical Service

Experimental statistics are official statistics which are published in order to involve users and stakeholders in their development and as a means to build in quality at an early stage. It is important that users understand that limitations may apply to the interpretation of this data. More details are given in the report.

All official statistics should comply with the UK Statistics Authority’s Code of Practice for Official Statistics which promotes the production and dissemination of official statistics that inform decision making.


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

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.

There is good evidence that psychological interventions can reduce the cost of physical healthcare\(^2\). There may also be areas of current good practice which mental and physical health areas want to build services around, for instance medically unexplained symptoms, musculoskeletal disease or cancer with a good prognosis. For these reasons, the expansion of IAPT services will focus on people with long term conditions or medically unexplained symptoms\(^3\).

New psychological therapy provision will see physical and mental health care provision co-located. Therapy will be integrated into existing medical pathways and services – either primary or secondary care services. Such services are referred to as ‘integrated’ services\(^4\).

This report summarises activity for a group of IAPT care providers taking part in a pilot programme for this new integrated model of care, and supplements the current routine IAPT publication\(^5\) for the period 1st January 2017 to 28th February 2019. It shows key information about activity and patient outcomes along with a range of data quality measures.

The initial reports were based on data collected since January 2017 by Wave 1 early implementers. Wave 2 providers started submitting in autumn 2017. There was a large increase in integrated services listed in the reports in September 2017 as Wave 2 providers started submissions.

As these are experimental statistics, their scope and methodology may change over time, and users should exercise caution when comparing different months of integrated data. These data do not affect routine IAPT reports. NHS Digital welcomes feedback from users about the content of this publication series, and users can contact us through enquiries@nhsdigital.nhs.uk.

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


\(^4\) More information about this pilot programme can be found on NHS England’s IAPT webpages, at [https://www.england.nhs.uk/mental-health/adults/iapt/mus/](https://www.england.nhs.uk/mental-health/adults/iapt/mus/)

\(^5\) Information about monthly IAPT publications can be found at [http://www.digital.nhs.uk/iaptreports](http://www.digital.nhs.uk/iaptreports)
The integrated care pathway

The integrated care pathway is a pilot programme that offers IAPT care alongside the treatment of associated physical health problems, so as to offer these patients the best possible outcomes. As well as having anxiety or depression, a patient will go through the integrated care pathway if they also have a long term condition (LTC), a medically unexplained symptom (MUS), or both. Organisations taking part in this pilot will continue to care for patients who have anxiety or depression but do not have an LTC or MUS as part of their routine service. Figure 1 demonstrates the relationship between the routine IAPT care pathway and the integrated care pathway.

Figure 1: The relationship between integrated and routine IAPT care pathways

Integrated services

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

Integration not only applies to treating patients with comorbid mental and physical health conditions but also integrating into existing physical health care pathways and into co-located premises. It is more than simply using a room in a GP clinic – which is no different from routine IAPT service working practices – it is an integrated approach to patient-centred care. IAPT clinicians will learn to adapt their treatments with patients with comorbid anxiety/depression and LTCs and those with persistent distressing symptoms of an MUS.

For further details about which conditions are within scope of the pilot, see Appendix 3.
Reporting on integrated IAPT services

IAPT providers taking part in the integrated pilot programme are required to provide additional data to NHS Digital alongside their routine IAPT data. This additional information is used to identify those patients within the providers who have, at some point in their overall care pathway, been treated for anxiety and/or depression alongside a long term condition, a medically unexplained symptom, or both.

Alongside the existing current monthly IAPT publication series, NHS Digital will publish an additional set of measures specific to the group of integrated patients as defined above. These measures will be published each month for the duration of the pilot programme.

Submissions

- Starting in the November 2017 publication, a new ‘Data Submissions’ worksheet in the Integrated Data File lists the providers involved in the pilot and the record of valid data submissions that have been received from them since January 2017.

  The intention is to allow providers and users to identify gaps in the submission record during the pilot programme.

- The reporting within the integrated data file was changed from November 2017 (August 2017 Final data) to include all providers who had ever made a valid integrated data submission. All integrated data from January 2017 onwards have been reproduced using this new methodology.

- Wave 1 of integrated service providers started sending data from January 2017 and Wave 2 started submitting in autumn 2017. There was a large increase in integrated services listed in the reports in September 2017 as Wave 2 providers started submissions.

Data measures

The included data measures are currently as follows:

- Number of referrals with a first integrated contact in the month;
- Number of referrals having a first integrated treatment appointment in the month;
- Number of integrated referrals finishing a course of treatment in the month;
- Number of core-only referrals finishing a course of treatment in the month;
- Standard recovery calculation for integrated patients:
  - Number of finished integrated referrals that started treatment at caseness (for standard recovery calculation);
• Number of finished integrated referrals that started treatment not at caseness (for standard recovery calculation);
• Number of finished integrated referrals that moved to recovery (for standard recovery calculation);
• Moved to recovery rate for integrated referrals (for standard recovery calculation);
• **MUS Recovery calculation incorporating MUS scores for integrated patients:**
  • Number of finished integrated referrals that started treatment at caseness (for MUS_recovery calculation);
  • Number of finished integrated referrals that started treatment not at caseness (for MUS_recovery calculation);
  • Number of finished integrated referrals that moved to recovery (for MUS_recovery calculation);
  • Moved to recovery rate for integrated referrals (for MUS_recovery calculation);
• **Standard recovery calculation for core-only patients:**
  • Number of finished referrals that started treatment at caseness (for standard moved to recovery calculation) which had no integrated activity;
  • Number of finished referrals that started treatment not at caseness (for standard moved to recovery calculation) which had no integrated activity;
  • Number of finished referrals that moved to recovery (for standard moved to recovery calculation) which had no integrated activity;
  • Moved to recovery rate for referrals (for standard moved to recovery calculation) which had no integrated activity.

As these are experimental statistics, there is scope for the above measures and their methodologies to change over time, and users should exercise caution when comparing different months of integrated data. These data do not affect routine IAPT reports.

These measures can be found in the ‘Data Measures’ tab of the accompanying Excel workbook. It is recommended that users also read the ‘Metadata – Data measures’ tab to understand the constructions of these measures.

**Data quality measures**

A series of data quality measures are also published on a monthly basis to allow users to make an assessment of the utility of the data. These measures are currently as follows:

• Number of appointments submitted in the month in Core tables only;
• Number of appointments submitted in the month in integrated tables;
• Number of integrated appointments with a valid MUS recorded;
• Number of integrated appointments where PRIMEDUNEXPSYM is in 10,11,12 and relevant MUS-specific measure has been submitted and is valid;
• Number of integrated appointments where PRIMEDUNEXPSYM in 10,11,12 and no or invalid MUS-specific measurement recorded;
• Number of integrated appointments where PRIMEDUNEXPSYM in 10,11,12 and primary problem descriptor is Somatization disorder;
• Number of integrated appointments where 1 or more valid LTC recorded;
• Number of integrated appointments where LTC = diabetes;
• Number of integrated appointments where LTC = COPD;
• Number of integrated appointments where LTC = Asthma;
• Number of integrated appointments where LTC = Other Respiratory Disease;
• Number of integrated appointments where LTC = Heart Disease;
• Number of integrated appointments where LTC = Cancer;
• Number of integrated appointments where LTC = Musculoskeletal Disorder (MSK);
• Number of integrated appointments where LTC = Chronic pain, including fibromyalgia;
• Number of integrated appointments where LTC = Epilepsy;
• Number of integrated appointments where LTC = Skin condition including Eczema;
• Number of integrated appointments where LTC = Digestive tract condition;
• Number of integrated appointments where LTC in 96, 98, 99 (other, unknown, not stated);
• Number of finished integrated referrals where PRIMUNEXPSYM = 10 and have paired, valid scores on Francis IBS Symptom Severity Scale;
• Number of finished integrated referrals where PRIMUNEXPSYM = 11 and have paired, valid scores on Chalder Fatigue Questionnaire;
• Number of finished integrated referrals where PRIMUNEXPSYM = 12 and have paired, valid scores on PHQ-15;
• Number of finished integrated referrals where LTC = 10 and have paired, valid scores on Diabetes Distress Scale;
• Number of finished integrated referrals where LTC = 11 and have paired, valid scores on COPD Assessment Test (CAT);
• Number of finished integrated referrals where LTC = 17 and have paired, valid scores on Brief Pain Inventory;
• Number of integrated appointments with one or more entries in the CSRI table.

As these are experimental data quality measures, there is scope for the above measures and their methodologies to change over time, and users should exercise caution when comparing different months of
integrated data. These data quality measures do not affect those in routine IAPT reports.

These measures can be found in the ‘Data Quality Measures’ tab of the accompanying Excel workbook. It is recommended that users also read the ‘Metadata – Data quality’ tab to understand the constructions of these measures.
Further information

Key resources

For an explanation of all measures in the Monthly & Quarterly Activity Data File CSVs, see the IAPT Metadata Document and the Guide to IAPT data and publications.

For the specification of the IAPT dataset, see the IAPT v1.5 Technical Output Specification.

For the Public Health England Common Mental Health Disorder Profiling Tool (‘Fingertips tool’), see http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders.

For the IAPT Manual, see the NHS IAPT website with supporting information: https://www.england.nhs.uk/mental-health/adults/iapt/

NHS Digital IAPT webpages

For resources related to monthly IAPT publications and links to all historical IAPT publications: http://www.digital.nhs.uk/iaptreports

For resources related to the IAPT dataset: http://www.digital.nhs.uk/iapt

Low numbers and suppression

In order to protect patient confidentiality in IAPT publications, any figures based on a count of less than 5 referrals is suppressed by replacing the number with an asterisk (*).

In order to prevent suppressed numbers from being calculated through differencing other published numbers from totals, all sub-national counts have been rounded to the nearest 5.

Rates are presented as percentages and are based on unrounded numbers. Sub-national rates are rounded to the nearest whole percent and national rates are rounded to one decimal place to prevent disclosure.
Appendix 1: Data source and considerations

A single authoritative national database of integrated IAPT data was created to be the source data for this report, which exists alongside the routine (core) IAPT database. This section explains some of the features of the data flow and how we manage the data assets for monthly reports.

Providers of adult IAPT services (including, but not limited to those who are participating in the integrated pilot programme) are required to submit data for all patients with open referrals (or ending in the month) every month, in accordance with the IAPT data standard\(^7\). This routine (core) submission occurs for all patients within the service, regardless of whether or not the patient was seen as an integrated patient.

In addition to the routine (core) submission described above, providers participating in the integrated pilot programme are also required to submit additional data related to a specific cohort of patients who have been seen and treated as part of their integrated service.

Submissions to NHS Digital are validated and pseudonymised by the Open Exeter Bureau Service provided by the Systems and 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 changes across submissions and this could lead to inconsistencies in our published reports.

In order to ensure a stable view of the data for each of our monthly reports, we have to apply a set of business rules to our analysis, to ensure that the same instance of each referral is 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. The details of the logic we apply in calculating key measures are described in the ‘Guide to IAPT data and publications’ document available on the NHS Digital website\(^8\).

Referrals are counted as being part of the integrated pilot where they have at least one contact with this type of service, determined by the presence of an integrated appointment in the additional submission that links to the equivalent record of that appointment in the routine (core) IAPT data.

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\(^7\) See [http://digital.nhs.uk/iapt](http://digital.nhs.uk/iapt)

\(^8\) See [http://www.digital.nhs.uk/iaptreports](http://www.digital.nhs.uk/iaptreports)
Appendix 2: Data quality statement

This section provides details and data quality information for the data used in this publication. It aims to provide users with an evidence based assessment of the quality of the statistical output by reporting against those of the European Statistical System (ESS) quality\(^9\) and related dimensions and principles appropriate to this output\(^{10}\).

In doing so, this meets the NHS Digital obligation to comply with the UK Statistics Authority (UKSA) Code of Practice for Official Statistics\(^{11}\), and the following principles in particular:

- **Trustworthiness pillar, principle 6 (Data governance) which states** “Organisations should look after people’s information securely and manage data in ways that are consistent with relevant legislation and serve the public good.” See the ‘Confidentiality, transparency and security’ section below.

- **Quality pillar, principle 3 (Assured Quality) which states** “Producers of statistics and data should explain clearly how they assure themselves that statistics and data are accurate, reliable, coherent and timely.” See the ‘Accuracy and Reliability’ and ‘Comparability and Coherency’ section below.

- **Value pillar, principle 1 (Relevance to Users) which states** “Users of statistics and data should be at the centre of statistical production; their needs should be understood, their views sought and acted upon, and their use of statistics supported.” See the ‘Relevance’ and ‘Assessment of user needs and perceptions’ sections below.

- **Value pillar, principle 2 (Accessibility) which states** “Statistics and data should be equally available to all, not given to some people before others. They should be published at a sufficient level of detail and remain publicly available.” See the ‘Accessibility and Clarity’ section below.

This publication is being released as an experimental statistics publication. This allows data of value to be published in order to involve users and stakeholders in their development and as a means to build in quality at an early stage. There are a number of known data quality issues in these pilot data, therefore caution is advised when interpreting the outputs.


\(^{10}\) The original quality dimensions are: relevance, accuracy and reliability, timeliness and punctuality, accessibility and clarity, and coherence and comparability; these are set out in Eurostat Statistical Law. However more recent quality guidance from Eurostat includes some additional quality principles on: output quality trade-offs, user needs and perceptions, performance cost and respondent burden, and confidentiality, transparency and security.

Accuracy and reliability

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

Each month, an overview of data quality (DQ) in the integrated IAPT data is published. These measures relate to specific aspects of the integrated data that should be submitted in order for NHS Digital to publish accurate data about patients' activity and outcomes within integrated services and in order to make valid comparisons between patients in integrated services and those in routine (core) services. As these are experimental data quality measures, it is expected that the scope and methodologies of the measures will change over time as we aim to publish measures that most effectively inform the utility of the integrated services data.

In addition, an overview of Data Quality (DQ) in the routine (core) IAPT dataset is published each month. The report includes the VODIM (Valid, Other, Default, Invalid, Missing) tables showing metrics as counts and percentages, both nationally and by provider, for the reporting month and for key data items. It also includes the previously produced tables showing percentage of valid records, by data item and provider, for the reporting month and previous 12 months.

The monthly data quality reports include measures related to dataset coverage, data consistency and data integrity.

Known issues with the quality of integrated data:

The following are known issues which impacted on integrated data.

Submitting correct appointments into the integrated services.

Integrated data should only be collected from patients receiving care in an integrated service. An error in filtering the data prior to submitting to NHS Digital led to all the patients in certain providers being recorded as having received treatment in an integrated service. This artificially increased the number of integrated appointments. It also had an ongoing impact for these providers as it has not been possible to ascertain which appointments, and therefore referrals, were integrated and which received services in core IAPT only. The impact will decrease over time as the referrals open between January 2017 and April 2017 end.

Several providers have gaps in their data submission records in June 2017, July 2017 and August 2017. The Data Submissions worksheet allows users to identify when providers have missed submissions.

A processing issue with the May 2017 refresh data led to the conversion of missing questionnaire score values to zeros in the monthly pseudonymised XML extract. This led to the possible over-reporting of the following two data quality measures:

- Number of integrated appointments where PRIMEDUNEXPSYM is in 10, 11, 12 and relevant MUS-specific measure has been submitted and is valid.
• Number of integrated appointments where PRIMEDUNEXPSYM in 10, 11, 12 and no or invalid MUS-specific measurement recorded

The processing issue has been corrected and the May data has been revised. Corrected results for the above-mentioned measures have been included within the data file.

An amendment was made to the inclusion rules for the calculation of historic measures in May 2017. The previous rules neglected to exclude integrated appointments that occurred after the reporting month when determining whether a referral was categorised as either core-only or integrated. The possible impact of this on the calculation of historic measures is that the amount of integrated activity would have been overestimated. This has been corrected so that any activity post the reporting month is now disregarded.

A further correction has been made to data quality measures that refer to Long Term Conditions. The inclusion rules had previously been implemented so that only the first instance of a LTC per referral were included in the calculation of those measures. This had the potential to lead to the under-reporting of the respective counts. The inclusion rules have now been amended so that all LTCs related to a referral are included.

Some organisations may submit data for both pilot and non-pilot provider sites and may therefore have a high proportion of core appointments that do not link to an appointment in the pilot.

The IAPT Data Quality Notes contains details of all known DQ issues that impact on the IAPT dataset and is available on the IAPT reports page. We recommend that users refer to this new document in conjunction with the information published here to gain a full understanding of the quality of the IAPT data.

The mandated IAPT data standard (core IAPT) allows providers to submit duplicate appointments, i.e. the same patient having two appointments at the same time and date within the same provider. There are no issues with processing these in the core data, however, NHS Digital identified an issue with processing these duplicate appointments in the LTC pilot data. Following discussions with key stakeholders, it was decided to remove the small number of true duplicates that have been submitted in the LTC pilot data table from the LTC data. From May 2018, publications have had these duplicate appointments removed. Due to this change, there could be small differences when comparing published figures prior to May 2018, as approximately 0.3% of appointments have been removed across all LTC data. Further details of this issue are available on request, please contact enquiries@nhsdigital.nhs.uk

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 a summary report (this document) and detailed data tables published in Excel. The content of this publication may change over time as we aim to meet users’ needs and maximise the utility of these data.

Due to the limited number of providers participating in the integrated pilot programme, data are not presented at CCG level or at England level.

**Comparability and coherence**

Coherence is the degree to which data derived from different sources or methods, but which refer 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.

Comparability between routine (core) IAPT data and these data should be made with caution. This is a new data collection relating to a pilot programme, and it is expected that data quality will improve as the pilot progresses.

This publication provides comparative measures of recovery that can be used to compare the patients’ outcomes within the participating providers. A recovery is provided using the standard methodology for routine (core) IAPT\(^\text{12}\) applied to integrated patients only. This rate can be compared to the recovery rate in the Monthly Activity Data File CSV (see column RecoveryRate), which represents the recovery rate for all patients within that provider, regardless of whether or not they were seen as integrated patients. This shows the extent to which the integrated patient group’s recovery differs from the overall group.

In addition, this publication presents a second recovery measure that uses a different methodology to the standard measure, incorporating additional patient questionnaire scores related to specific types of medically unexplained symptoms\(^\text{13}\). This is known as ‘MUS\_recovery’, and can be compared to the standard recovery measure for the integrated patient group within that provider. This shows the extent to which the integrated patient group’s recovery differs if it is assessed using their medically unexplained symptom data rather than their anxiety-disorder specific data where both are present.

\(^{12}\) See the ‘Metadata – data measures’ tab of the spread sheet, or the Appendix of the Executive Summary report, that accompany this publication for details of the standard recovery methodology.

\(^{13}\) See Appendix 3 for the scores and caseness thresholds relevant to each specific type of medically unexplained symptom.
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. This publication consists of a number of data measures and data quality measures; as these are experimental statistics these measures may change over time. In addition to the integrated data, routine (core) IAPT publications include measures of activity, waiting times and outcomes.

Accessibility and clarity

Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and availability of supporting information.

From May 2018 the format of the data tables for this publication has changed in order to reduce the number of worksheets.

Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice.

This publication includes this report, providing explanatory and contextual information about the data that are aimed at a range of audiences. More detailed information is published in a set of Excel data tables accompanying this publication.

This publication may be requested in large print or other formats through the NHS Digital contact centre: enquiries@nhsdigital.nhs.uk.

Assessment of user needs and perceptions

This section describes the processes for finding out about users and their views on the IAPT 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

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 the course of delivering those services to patients.
Information about the administrative sources and their use for statistical purposes is included in the NHS Digital’s Statement of Administrative Sources at:


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 experimental Official Statistics. The code of practice for official statistics is adhered to from collecting the data to publishing. The “experimental” designation acknowledges that the content and methodologies used in this publication may be refined over time.

This publication is subject to a standard NHS Digital risk assessment prior to issue. Disclosure control is implemented where this is deemed to be necessary in accordance with the protocols associated with the underlying data sources. Further details of the risk assessment are available in the NHS Digital’s Disclosure Control Procedure.


In July 2017, a risk assessment was undertaken that considers the suppression rules in the calculation of Recovery and MUS_Recovery fields. These calculations have a two-part denominator based on the number of referrals that finish a course of treatment minus the number starting treatment below the caseness threshold. From that publication onwards, the recovery rates are only suppressed when either the numerator is less than 5 and/or the number of referrals completing treatment is less than 5. No other changes to the suppression methodology have been introduced.
Appendix 3: List of medically unexplained symptoms and long term conditions in scope

Patients undergoing integrated care will also be present in the routine IAPT data submission, and will therefore have a primary problem recorded that identifies their specific condition\(^{14}\).

For those in integrated care with a long term condition (LTC), the purpose of treatment is to treat the patient’s anxiety or depression in the context of their long term condition. Though they would be given an LTC questionnaire relevant to their long term condition that would be used by their care professional to assess the severity of that condition, the LTC questionnaire scores would not be used in assessing recovery from their anxiety or depression. Recovery for these patients will continue to be assessed using PHQ-9 and GAD7 or ADSM questionnaires.

For those in integrated care with a medically unexplained symptom (MUS), ‘Somatization Disorder’ (ICD-10\(^{15}\) code F45.0) should be selected as the primary problem to identify their specific condition. The relevant MUS-specific outcome measure can then be used for the calculation of recovery (provided paired scores are available).

For full details of the calculation of the recovery measures presented in this report, see Appendix 4 and the ‘Metadata – data measures’ tab of the accompanying spread sheet.

Medically unexplained symptoms

A single referral can have no more than one medically unexplained symptom recorded, though it is also possible to have none. This should be the primary medically unexplained symptom only. This is to ensure that the relevant measure is used in the assessment of outcomes.

The outcome measures for medically unexplained symptoms can be used to calculate recovery, and therefore needs to be completed at every session.

<table>
<thead>
<tr>
<th>Medically unexplained symptom</th>
<th>Assessment measure</th>
<th>Caseness threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritable Bowel Syndrome</td>
<td>Francis IBS Symptom Severity Scale</td>
<td>≥ 75</td>
</tr>
<tr>
<td>Chronic Fatigue Syndromes/</td>
<td>Chalder Fatigue Questionnaire</td>
<td>≥ 19</td>
</tr>
<tr>
<td>Myalgic Encephalopathy (ME)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUS – not otherwise specified</td>
<td>PHQ-15</td>
<td>≥ 10</td>
</tr>
</tbody>
</table>

\(^{14}\) For further details, see https://www.england.nhs.uk/mental-health/adults/iapt/mus/

\(^{15}\) http://apps.who.int/classifications/icd10/browse/2010/en
Long term conditions

A single referral can have none, one, or several long term conditions recorded. LTC measures will not be used to calculate recovery from the primary mental health problem. Best practice suggests these should be completed as a minimum at the beginning and end of treatment to support and guide treatment interventions.

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Other respiratory disease</td>
</tr>
<tr>
<td>Heart Disease</td>
</tr>
<tr>
<td>Cancer</td>
</tr>
<tr>
<td>Musculoskeletal Disorder (MSK)</td>
</tr>
<tr>
<td>Chronic pain, including Fibromyalgia</td>
</tr>
<tr>
<td>Epilepsy</td>
</tr>
<tr>
<td>Skin condition including Eczema</td>
</tr>
<tr>
<td>Digestive tract conditions</td>
</tr>
<tr>
<td>Other (tick box)</td>
</tr>
</tbody>
</table>
Appendix 4: Calculation of MUS\_recovery for patients in integrated services

Standard recovery in IAPT is calculated based on the presence of paired scores being present on both the depression (PHQ-9) and anxiety (GAD7 or relevant anxiety disorder specific measure) both being present, and at least one of these measures having a first score that is above the caseness threshold. Further details about the standard IAPT recovery calculation are available in the Executive Summary reports that form part of routine IAPT publications.

This measure is presented in the accompanying data tables for the group of integrated patients. In addition to this measure, a second measure has been developed for comparison, based on the presence of paired scores on a further measure relevant to a specific medically unexplained symptom (see Appendix 3 for further details of the MUS-specific scores). For this group of patients, the process of calculating recovery is illustrated in the below diagram.