

Improving Access to Psychological Therapies (IAPT) Waiting Times Guidance and FAQ's



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Improving Access to Psychological Therapies (IAPT) Waiting Times Guidance and FAQ's

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¹ The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

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1 Introduction

“*Achieving Better Access to Mental Health Services by 2020*”² has identified three key areas where additional investment will be made to implement an NHS Mandate³ commitment for 2015/16 to access and/or waiting time standards. This includes a specific standard for adult IAPT services that in addition to maintaining at least 15% of adults with relevant disorders will have timely access to IAPT services, with a recovery rate of 50% NHS England will ensure that:

“...by March 2016, 75% of people referred to the IAPT programme begin treatment within 6 weeks of referral, and 95% begin treatment within 18 weeks of referral.”

CCGs are required to submit plans to meet this standard in 2015/16 these plans will be monitored throughout the year. “Forward view into action 2015/16”⁴ provides technical definitions, this document provides further guidance and clarification. Further guidance on the submission process can be found on UNIFY⁵

Monitoring of this standard will be at CCG level however national reports will also include a service Provider view. Reporting will start from April 2015, reporting for the first time on all patients completing a course of treatment.

The new IAPT standard will be supported by £10m to support delivery (criteria for distribution in development)

2 Measuring Progress & Success

The intention of the mandate commitment is to ensure no person waits longer than necessary for a course of treatment, however the IAPT service model acknowledges that some people may benefit from a single treatment session and need no further treatment or are signposted to another more appropriate service. In order to differentiate between the two groups of people and provide greater transparency the headline indicator will capture:

Waits from referral to the start of a course of treatment i.e. for those people who have two or more treatment sessions.

This will be measured retrospectively at the end the course of treatment.

It is acknowledged that beyond a certain point patient-initiated delay makes it unreasonable or impossible for the NHS to provide treatment in a timely manner. Lessons learnt from earlier waiting times initiatives have shown that introducing measurement pauses in headline targets may lead to errors and inconsistency in reporting. For this reason pauses will not be taken into consideration when

² <https://www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020>

³ <https://www.gov.uk/government/publications/nhs-mandate-2015-to-2016>

⁴ <http://www.england.nhs.uk/ourwork/forward-view>

⁵ <http://nww.unify2.dh.nhs.uk/INSTANTFORUM414/Topic10123745-10008511-1.aspx>

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calculating waiting times, instead the national targets have built in tolerances to offset this activity i.e. 75% and 95%

It is however important to understand the impact of such delays therefore this document provides guidance on when a clock pause may be initiated locally. These delays should be managed locally but will not be reflected in the nationally reported headline indicator. Services may wish to record on local IT systems for management purposes and share intelligence with commissioners. The IAPT data standard also provides the facility to flow this data centrally.

A secondary measure which should be monitored locally should capture waits from referral to first treatment appointment for all people who enter the service, this will include those people who receive a single treatment session. The expectation is that this will be monitored locally for breaches at 6 weeks and 18 weeks.

A number of additional measures will be captured in national reports to guard against the introduction of perverse incentive into local commissioning arrangements by:

- giving a larger proportion of patients a single session of assessment and advice, rather than a course of therapy
- reducing the average number of sessions that are given to those people who have a course of therapy
- re-focusing service provision on less severe cases
- artificial treatment starts where patients have an early appointment but are then put on an 'internal' waiting list before a full course of treatment starts
- offering a limited choice of NICE approved therapies for depression and anxiety disorder

Additionally, local partnerships should ensure protocols are in place to monitor waits across the pathway where patients are 'stepped up' to a higher intensity treatment package. It is good practice that CCGs ensure that the national waiting standards are also met for subsequent courses of treatment including stepping up, and that local monitoring is in place ensure that all waits are visible and minimised.

All patient activity should be recorded routinely on local IT systems. The IAPT data standard was mandated for central collection from 2012 and requires all IAPT services to submit a monthly extract of activity to the HSCIC for secondary uses (current version 1.5). Full guidance on data requirements and how to submit can be found at <http://www.hscic.gov.uk/iapt>.

Indicators will be published at National, Provider and CCG level on the HSCIC website.

3 How to Measuring IAPT Referral to Treatment (RTT)

Under the IAPT Data Standard, waiting times will be derived from patient level data submitted to the IAPT central reporting system. The fields used to calculate the time waited are:

IAPT RTT clock start = 'Date Referral Received'

IAPT RTT clock stop = 'Appointment Date' of the first treatment appointment in the Referral table. In Version 1.5 of the IAPT data set (implemented in July 2014) this is based on the Appointment Type 02 – Treatment, 03 - Assessment and Treatment, and 05 - Review and Treatment being used to identify a treatment appointment.

3.1 Indicator Construction

The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Numerator: The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 6 weeks of referral.

Denominator: The number of ended referrals who finish a course of treatment in the reporting period.

and

The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Numerator: The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 18 weeks of referral.

Denominator: The number of ended referrals who finish a course of treatment in the reporting period.

Note: In IAPT, a course of treatment is defined as having attended at least two treatment contacts.

3.2 IAPT RTT Clock Starts

The waiting time clock starts when:

- i) Any care professional (GP or other) or service permitted by an English NHS commissioner to make such referrals, refers to an IAPT service with the intention that the patient be assessed and, if appropriate, treated.

- The clock will start when the referral letter is received. The commissioner and providers should agree locally what information the referral is expected to contain.
 - Some localities operate a 'single point of access' approach where all referrals for mental health services are processed by a central multi-disciplinary team and referred on to the appropriate service. In- line with wider NHS guidance the IAPT clock will start when the referral is received by the single point of access. It is the responsibility of the single point of access to ensure that essential information regarding the person is sent to the provider, this should include the date the referral was received. It is important that local protocols are put in place to ensure the referral is progressed through the system in a timely manner.
- ii) The patient refers themselves to an IAPT service and the referral is deemed appropriate for the service. The clock will start when the patient first contacts the service and requests to be seen. This should exclude general enquiries.

3.3 IAPT RTT Clock Stops (waiting time ends)

A clock stops when:

- i) A patient receives their first treatment. In version 1.5 this will be the first appointment with an appointment type of 02-Treatment, 03-Assessed and Treated or 05-Review and Treatment.

Example 1 - IAPT clock start/ stop

An IAPT service receives a GP referral on 4th April. On 7th April, the service telephones the patient and offers an appointment on 15th April. This is accepted and the patient attends the appointment where assessment takes place. The patient is then booked in for treatment on 19th April.

Clock start – 4th April

Clock Stops – 19th April

Total waiting time = 15 days

3.4 IAPT RTT Clock Stops (and is nullified)

A clock stops when:

A patient does not attend (DNAs) their first appointment, provided that the provider can demonstrate that the appointment was clearly communicated to the patient. A new clock for that patient restarts on the date the patient DNA the appointment⁶.

⁶ This specific scenario will not be reflected in initial national reporting on waiting times in 2015, but will be added later in the year.

3.5 Clock Stops for non-treatment:

Patients who are referred but not treated are excluded from the national RTT indicator. Service waiting list management protocols should be used to manage on local IT systems.

A clock should not stop when a patient cancels an appointment.

3.6 Reporting

The HSCIC will publish the IAPT RTT headline indicator from April 2015 in-line with guidance outline above. Further to this additional reports will be developed during 2015/16 to provide further context.

3.7 Delays in the pathway

To get a clear picture of the whole pathway it is necessary to understand where the start of treatment is delayed due to patient choice. A number of supporting measures will be published that will put the 'referral to treatment' indicator in context with patient initiated delays.

i) Opt-in and starting the clock

Many IAPT services adopt an 'opt-in' model where on receipt of a referral (other than from the patient), the patient is contacted and asked to confirm if they would like to be considered for treatment. This has been found to be an effective way of managing inappropriate referrals, limits DNAs and utilises staff time more effectively. In effect the patient is referring themselves to the service. The IAPT Programme accepts that where this model has been clearly specified and agreed with the commissioner then this is acceptable. However, local processes must be put in place to ensure that patients are contacted within the timeframe agreed with the commissioner - this should not be more than two weeks. National publications will report opt-in to treatment separately from RTT indicators for the services that operate this model from October 2105.

ii) Patient initiated delays and Clock Pauses

The national headline indicators will measure the time from referral to treatment, this will not take into consideration pauses. However local services may wish to monitor the impact of patient initiated delays for management purposes and in doing so must adhere to the following rules in order to ensure consistency across services:

- A patient chooses to delay attendance of their first appointment, for example due to work commitments, religious reasons or holidays.
- A referral or self-referral has been made, and the patient has declined at least two reasonable appointments. The clock is paused for the duration of the time between the earliest reasonable offer and the date from which the patient

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makes themselves available again for treatment. An appointment offer is considered reasonable where the offer is for a time and date three or more weeks from the time that the offer was made.

- If a patient declares a period of unavailability before the Provider makes an offer of an appointment then this may mean that offering actual dates which meet the reasonableness criteria would be inappropriate (as the patient would be offered dates that the provider already knew they couldn't make). In this case, then the Provider should record the earliest reasonable offer that it could have genuinely offered that patient. It is good practice to also record the second reasonable offer that could have been made. The waiting time clock can be paused from the earliest reasonable offer date that the provider could have given the patient (had they been available) up until the time that the patient makes themselves available again.

The start and end of such pauses should be recorded in the IAPT dataset in the Waiting Time Pauses Table, to support potential future national reporting on pauses.

Example 2: IAPT clock paused following 2 reasonable offers

An IAPT service receives a referral on 29th May. The service offers the patient an appointment for 29th June, the patient declines this offer. The service offers a second appointment on 1st July which the patient also declines and advises that they will be available to attend an appointment from 5th July. An appointment is booked for 10th July.

Clock start – 29th May
Clock paused – 29th June
Clock restarts – 5th July
Clock stops – 10th July

Calculation:

29th May to 29th June = 31 days wait
30th June to 5th July = 6 days pause
6th July to 10th July = 5 days wait

Total time waiting = 36 days + 6 days pause

Note: the national indicator will record this as 42 days as the pause is not taken into consideration

Example 3: IAPT clock paused as patient unavailable

An IAPT service receives a referral on 2nd Aug. The patient states they are not available for an appointment until 1st Sept (due to school holidays). It would not be appropriate for the service to offer the patient appointments in August that they already knew the patient couldn't make. An appointment is booked for 1st Sept. The clock can be paused from the earliest reasonable offer date that the service could have offered the patient (three or more weeks from the time that the offer was made). In this example the first reasonable date available with the therapist was the 25rd Aug

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Clock start – 2nd Aug
Clock paused – 25th Aug
Clock restarts – 1st Sept
Clock stops – 1st Sept

Calculation:

2nd Aug to 25th Aug = 23 days wait
26th Aug to 1st Sept = 7 days pause

Total time waiting = 23 days + 7 days pause

Note: the national indicator will record this as 30 days as the pause is not taken into consideration

iii) Delays within treatment packages

It is good practice to agree a treatment plan as part of the assessment process which will include expected frequency of contact. It is acknowledged that an early first appointment will often provide an opportunity to ask questions and provide reassurance. However it is not good practice to then delay the start of the full course of treatment for an extended period. In order to guard against this practice and monitor breaks in treatment national publications will report the proportion of people who enter a course of treatment who wait more than 30 day from 1st appointment to 2nd appointment

3.8 Unintended consequences

In order to guard against perverse incentives from October 2015 national reports will monitor patterns of treatment across the pathway as follows:

- A. Taken from closed cases in the reporting period, the ratio of people who have a course of treatment (i.e. at least two treatment sessions) against all people who access services (i.e. all people who have treatment including those who only have one appointment). In Version 1.5 of the IAPT data set this is determined by any combination of the following Appointment Types: 02 – Treatment, 03 - Assessment and Treatment, and 05 - Review and Treatment.
- B. Average number of treatment sessions for people who have finished a course of treatment in the reporting period
- C. Measure of severity of condition treated by the service - average assessment score (by measurement tool) at the first appointment with standard deviation for the service.
- D. The proportion of people treated within 6 and 18 week broken down by the type of treatment received.

4 Frequently Asked Questions

4.1 Clock starts

- 1. Question:** We have agreed an 'opt in' model of treatment with our commissioner, should the clock start from the date the patient confirms they would like to opt into treatment?

Answer: No, the RTT indicator will measure the time between the date the referral is received and the date of treatment. Opt-in is a recognised service model and has been shown to help reduce DNAs. National publications will report opt-in to treatment along-side RTT indicators for the services that operate this model from October 2015.

- 2. Question:** Should the clock start on the date the referral is received by the single point of access/Triage service for the IAPT service?

Answer: The patient is likely to perceive the wait as starting at the time they are referred by their GP or self-referral therefore the clock should start at this point regardless of the local operational model. The clock starts on the date the referral is received by the clinical triage, assessment or single point of access service **not** the date that the onward referral is received by the IAPT service provider. If after assessment a decision is made not to treat (as they are not appropriate for treatment or the person decides they do not want treatment) then they are excluded from the calculation.

- 3. Question:** Where a single point of access or triage service operates as a stand-alone service, how should the onward referral be recorded?

Answer: The provider of a stand-alone triage / assessment service should end the referral at the point of onward referral and record a Reason for End of IAPT Care Pathway of Referred to another therapy service by mutual agreement (code 13). It is important that local protocols are put in place to ensure that the original Date Referral Received is sent to the provider of the IAPT service and used as the Date Referral Received for the onward referral.

Where the single point of access or triage service is provided by the same organisation as provides the IAPT service (and submits the IAPT dataset) a single referral covering the full pathway should be recorded for the patient.

- 4. Question:** Guidance states that those people assessed and deemed not suitable for treatment are excluded from the indicator. What about referrals that are never seen by the service?

Answer: It is the responsibility of every service to ensure all referrals are followed up and every effort made to understand why patients may disengage with the service. However this information is not captured in the IAPT data standard therefore people who are referred but never seen will be excluded from waiting time calculations.

5. Question: As people who only receive a single treatment session are excluded from the headline target should they be excluded from the 'entering treatment' target?

Answer: In certain situation it is appropriate to provide a single IAPT treatment session and many people benefit from this intervention. Therefore these people should be counted as 'entering treatment'. However those people who only have an assessment should be excluded. IAPT will continue to monitor access to treatment and recovery throughout 2015-16 and CCG are required to submit plan to demonstrate sustained commitment to the 15% access and 50% recovery targets.

6. Question: Previously group therapy sessions were excluded from the IAPT waiting times indicator, is this still the case?

Answer: During the early years of IAPT implementation guidance did exclude people attending group therapy session from waiting times analysis. This will no longer be the case as services are now sufficiently mature to ensure that waits are kept to a minimum for all modes of treatment.

7. Question: Many patients complete treatment and decide to take up a place on a Mindfulness course, should this be recorded as a referral and start of a waiting times clock?

Answer: No, an episode of care is from referral to discharge so all treatment including step-up and mindfulness should be recorded as a continuation of treatment and as part of the same episode. The exception is when the patient is discharged back to GP and later refers themselves to mindfulness course at some point in the future or is re-referred by their GP

8. Question: If a patient is discharge and later is re-referred to the service, should this be recorded a new case or a continuation of the previous episode of care? Is there a minimum period of time expected between discharge and referral?

Answer: The decision to discharge is based on clinician judgement in consultation with the patient. It is important that when a patient is discharged final outcome scores are taken and the reason for discharge is recorded. Services should refer to local protocols when managing re-referrals, however it is not acceptable to record 'stepping up' as a new episode of care even if treatment is provided by a different service.

9. Question: How should we record 'stepping up'?

Answer: IAPT adopts a stepped care model therefore stepping up/down should be counted as one continuous episode of treatment. In order to allow the HSCIC to track a person across the pathway it is important that every effort is made by Providers to process cases according to the following rules.

If a referral has been stepped to another provider it should be ended in the current provider and a new referral (with a new service ID) should be started in the new provider. The referral should be ended with an end code of 40 - Stepped up from low

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intensity Improving Access to Psychological Therapies Service or 41 - Stepped down from high intensity Improving Access to Psychological Therapies Service, and the new organisation should be recorded in the Organisation Code (IAPT Stepped To Provider) field.

The new provider should then start the new referral with a referral received date on or later than the previous end date, and record a source of referral of either N1 (stepped up from low intensity IAPT service – where the previous end code was 40) or N2 (stepped down from high intensity IAPT service – where the previous end code was 41).

This should only be used when stepping to another IAPT provider. If the referral is being stepped down to primary care then the discharge code of 42 – Completed scheduled treatment should be used, whereas if a patient is stepped up to secondary care then the code 44 - Referred to non IAPT service should be used.

If a referral is stepped up or down within the same provider (i.e. it will be included under the same Provider code in your submission) then the referral should NOT be ended. Instead the step of care can be tracked at each appointment through using the Stepped Care Intensity Delivered field. This allows providers to code whether the appointment was high or low intensity, and whether it is the first step of care or a later step.

Please note, when using this field, that although the codes available are 01, 02, 03 and 04, these DO NOT represent steps of care 1, 2, 3 and 4. Instead codes 01 and 03 identify low intensity (either the first step or a later step in the pathway), whilst 02 and 04 identify high intensity (again, either the first step or a later step in the pathway).

Version 1.5 of the IAPT data standard provided guidance on new data items and stepping care which can be found here <http://www.iapt.nhs.uk/silo/files/data-set-v15.pdf>. Further guidance and information on stepped care and replicating published figures can be found in the HSCICs “Understanding and replicating our published reports” document www.hscic.gov.uk/iaptmonthly

10. Question: Guidance states the clock stops and is nullified when a patient does not attend (DNAs) their first appointment, what is meant by ‘first’ appointment.

Answer: The ‘first’ appointment is the first contact following the initial referral regardless of the type of appointment, so in IAPT this could be a telephone assessment. DNA at subsequent appointments does not reset the clock. Trusts should agree and publish local DNA policies that are visible to the public.

4.2 Clock stops

11. Question: Many of our patients choose to delay treatment for personal reasons, earlier IAPT guidance put rules around clock pauses. Will these pauses be taken into consideration when measuring referral to treatment?

Answer: Pauses will not be taken into consideration when calculating the RTT indicator. It's acknowledged that patient initiated delays will have an impact on waiting time, for this reason tolerances have been built into the IAPT waiting times standard. However it is useful to understand the impact of patient initiated delays for local waiting list management purposes and services may wish to monitor on local IT systems. From July 2014 the central reporting system incorporated the functionality to capture pauses so if recorded this data will flow centrally and will be used by NHS England to inform indicator development in the future.

12. Question: What is meant by the terms 'assessment appointment' and an 'assessment with treatment appointment'?

Answer: An 'assessment' appointment is when the service makes initial contact with the patient (face-to-face, telephone or email) in order to assess the patient's condition and whether they are suitable for treatment. This is sometime carried out by a triage or single point of access service. An 'assessment with treatment' appointment is when the initial contact is extended by the healthcare profession to include an IAPT compliant treatment.

13. Question: How is first treatment defined?

Answer: The decision on what is treatment is a local decision that should to be clearly laid out in written, local pathways and have senior clinical sign off in the organisation. Such protocols should also clarify when an appointment should not be recorded as treatment. The final decision on whether a particular appointment is the start of treatment should not be a blanket decision but be made by the healthcare professional undertaking the appointment in the knowledge of those pathways. It is important to ensure the 'Appointment purpose' field is completed on clinical systems as this is a mandatory field.

14. Question: What is meant by the terms 'Review' and 'follow-up'?

Answer: A 'review' appointment is when the clinical team and patient review the treatment accesses how the patient is responding to treatment and makes any necessary amendment. This may happen periodically throughout the course of an 'open' episode. A follow-up appointment occurs after the case has been closed and will assess the continued well-being of the patient in order to prevent relapse.

15. Question: Where a care plan consists of two different treatment administered at the same time e.g. group therapy and individual CBT at what point does the waiting time clock stop?

Answer: The waiting time clock will stop at first i.e. earliest definitive treatment session for either treatment type.

16. Question: We often receive referrals which are incomplete so are unable to process, should the waiting time clock start on the date we receive the referral or the date we get all the necessary information?

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Answer: During early roll out of IAPT services the clock started when the referral was complete with all the relevant information. However services should now be sufficiently mature to ensure treatment is not delayed unnecessarily and it is expected that systems are in place to ensure referral procedures are robust. The waiting time clock starts when the referral is first received even if it is not fully complete, it is the responsibility of the service to follow-up and ensure they record all necessary information.

17. Question: A reasonable appointment is “where the offer is for a time and date three or more weeks from the time that the offer was made”. Given the target to treat is 6 weeks then 3 weeks seems to long?

Answer: The concept of ‘reasonable appointment’ is only relevant when recording clock patient choice delays (pauses). It is good practice to offer earlier appointments, if they can be mutually agreed with the patient.

It is understandable that an appointment offer may not fit in with other commitments we all have (work, childcare etc) and we can reasonably refuse such appointment offers. In line with RTT standards elsewhere in the NHS a reasonable appointment is defined as “three or more weeks from the time that the offer was made. It is only when a patient refuses two offers that are more than three week in the future that we say they are not cooperating and choosing to delay their treatment. At that point a patient choice delay can be recorded, in line with the definitions given in this document.

Please note that an appointment sent in the post that is not been accepted by the patient is not offering patient choice and is not considered to be good practice. If the patient then contacts the service to change that appointment, the three week period starts from the date of that contact.

18. Question: are the 6 and 18 week standard working days or calendar days?

Answer: Calendar day, so, 6 weeks = 42 days (including weekends) and 18 weeks = 126 day (including weekends)