

IAPT OUTCOME FRAMEWORK AND DATA COLLECTION

Improving Access to Psychological Therapies Programme (IAPT)

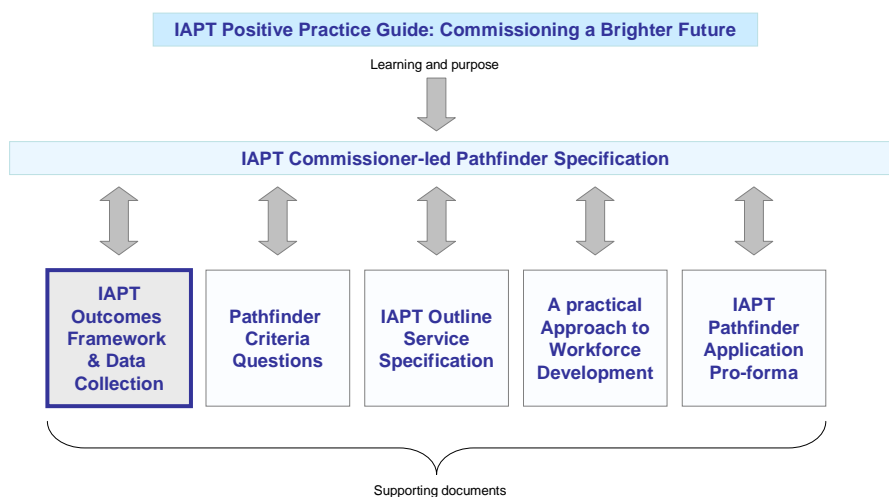
The IAPT Programme is a Department of Health initiative to improve access to psychological therapies. It was developed in 2005, following a white paper commitment in Our Health, Our Care, Our Say.

In 2006/7, the IAPT demonstration sites core purpose was to collect evidence of delivery to substantiate the development of a business case for a national roll-out of the IAPT service model.

The programme is now going to establish a number of IAPT Pathfinders, which will use service redesign techniques to implement a defined care pathway, service specification, and service framework.

In addition to this document, the following documents are available to support the development of these Pathfinder sites

- Pathfinder Criteria Questions
- IAPT Outline Service Specification
- A practical Approach to Workforce Development
- IAPT Pathfinder Application Pro-forma



IAPT OUTCOME FRAMEWORK AND DATA COLLECTION

Introduction

This is a technical document to support Section 6 of the IAPT Commissioner-led Pathfinder Specification. It provides a standard framework for data collection, monitoring and evaluation which is both practical and informative.

The outcome measures framework and minimum data set is imperative to ensuring the integrity, quality, and congruity of data/information that needs to be collected from IAPT commissioner-led Pathfinder sites. We would be encouraging all other psychological therapy services that are not part of these pilot sites to use the minimum data set as set out in this document.

“Services would benefit from opportunities to implement a more systematic approach of collecting qualitative data across all interventions offered within the stepped model of care, for example, clinical outcome data, service user satisfaction, and service/system impact data. This would assist the service and commissioners to more fully understand the treatments and interventions, their impact at each stage of the stepped care model and the resource requirements to deliver improved access to psychological therapies” Stericker, S. and Shaw, A (2006) ‘*Operational Service Portraits from North East Yorkshire and Humber region*’

Background

One of the key outputs of the Improving Access to Psychological Therapies (IAPT) Programme is to develop a routine outcome measuring tool to collate a set of data demonstrating whether or not the Pathfinder sites are successful in delivering psychological therapies to their target population, with the expected gain in mental health clinical outcomes, quality of life, patient experience and economic benefit.

The programme hypothesis described that the key benefits to people receiving the new service would be:

1. Improved health and wellbeing
2. Improved service user and carer experience and satisfaction
3. Improved choice and access of clinically effective psychological therapy services
4. Improved inclusion and employment status, including:
 - Maintaining people in work and involvement in activities of daily living
 - Supporting people in returning to work and participating in activities of daily living

Consequently, the IAPT Routine Outcome Measuring Tool (Minimum Data Set) should ensure that these four domains are addressed appropriately as detailed in Section 6 of the IAPT Commissioner-led Pathfinder Specification. (See www.mhchoice.csip.org.uk/Pathfinder for all referenced documentation) In addition to addressing the services needs of adults of working age, Pathfinder sites may choose to adopt a special interest group within their scope. Details of the tools to measure health and wellbeing outcomes will be developed as part of the consultation period.

Outcomes Framework: Minimum Data Set (MDS)

The functions and benefits of the minimum data set (MDS) are:

- The collection of outcome data and the analysed results can be used in a way that enhances the care experience of Service Users who are providing the data, by informing and improving the service provided.
- In addition to enhancing the individual patient care experience, resulting data can be used in the following ways:
 - For therapists as part of their individual professional development
 - At service level for service development (including providing information to Service User forum)
 - Locally for informing commissioners
 - Nationally for supporting the final IAPT business case
- Outcome Measures should be administered to collect data from four domains:
 - Health and well being
 - Inclusion and employment
 - Choice and Access
 - Patient Experience


Figure 1 (below) depicts the balanced scorecard (BSC) for these four domains. It is mandatory for IAPT pathfinder sites to use the routine outcome measuring tools detailed in this annex to collect data within **all** four of the outcome domains. Data should be collected at the 5 'flagged' 🚩 points and routine outcome measuring points  (including assessment) as identified on the IAPT Care Pathway (see Figure 2).

Figure 1 Health & Wellbeing Outcomes Framework



The outcome measures described in this minimum data set represent the most suitable, free to access tools, which are widely used in practice as recommendations of how to best achieve the balance scorecard (see figure 1). It is not our intention that our recommendations countermand existing good practice - for instance, where good progress has been made already in data collection. As such, measures in this MDS are supplemented with examples of other measures which are being used in some localities to contribute in a similar way to the balanced scorecard. As part of the consultation period we will consult with regions to identify other effective measures used to incorporate with the examples.

Figure 2 - Routine Data Collection points mapped to the Care Pathway

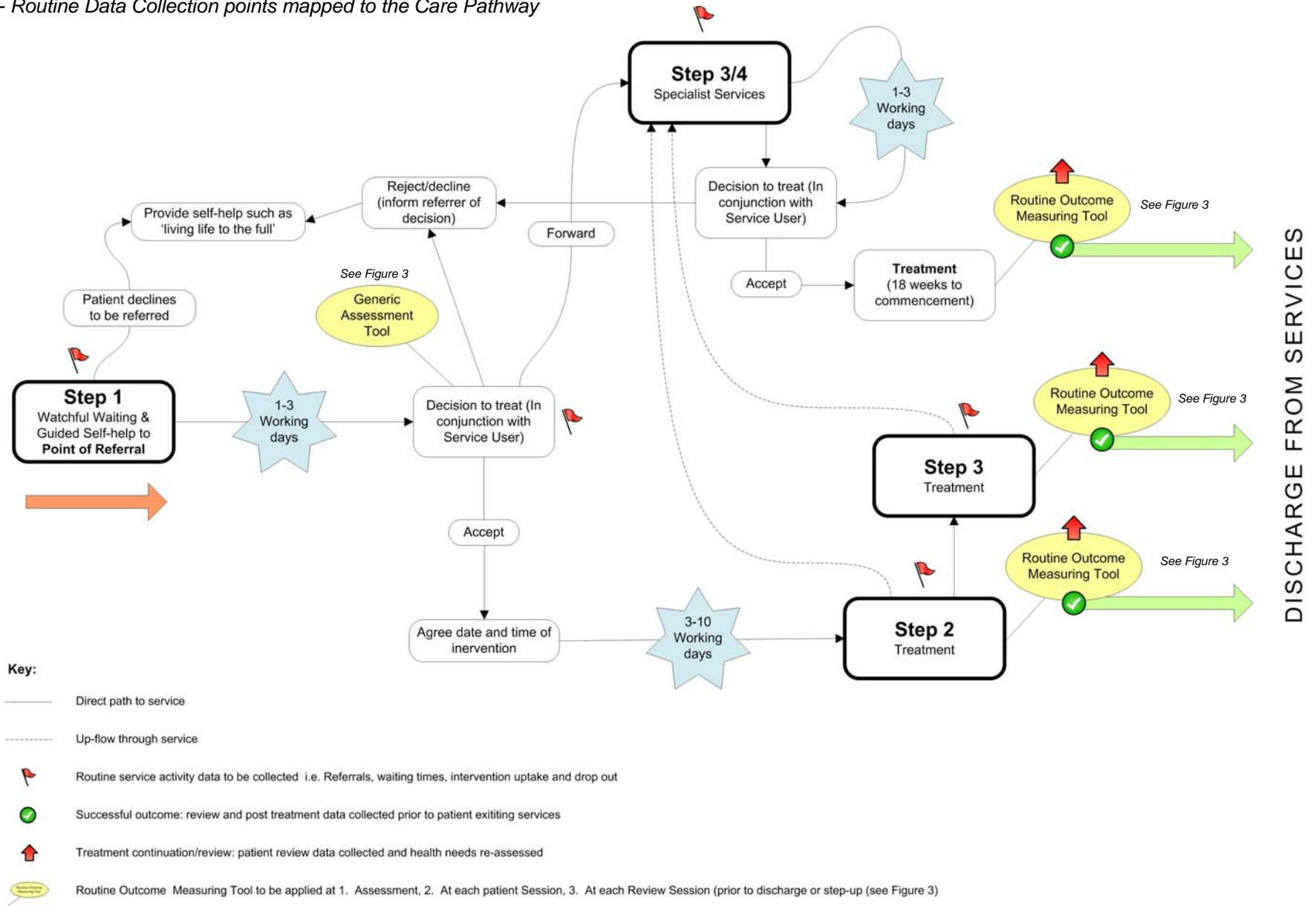
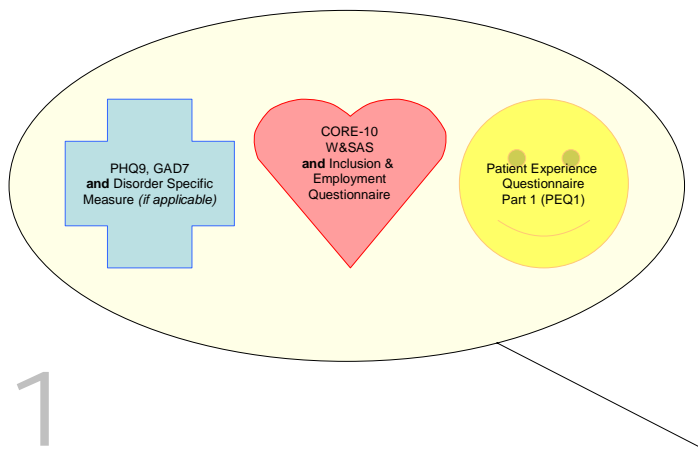


Figure 3 - Frequency and use of data collection measures as shown in the Care Pathway

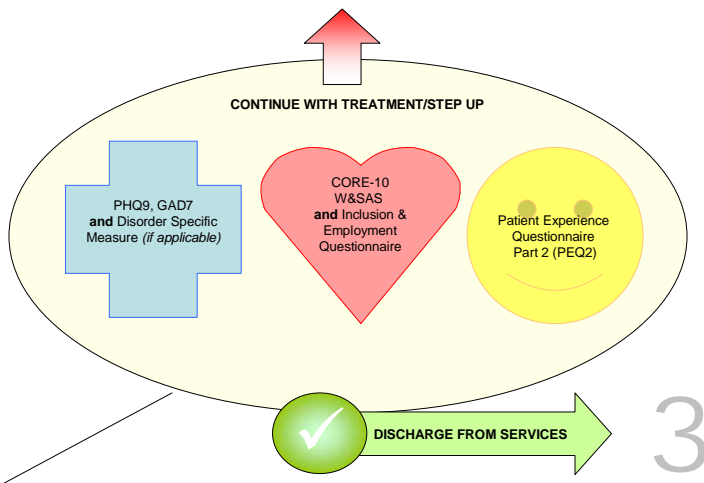
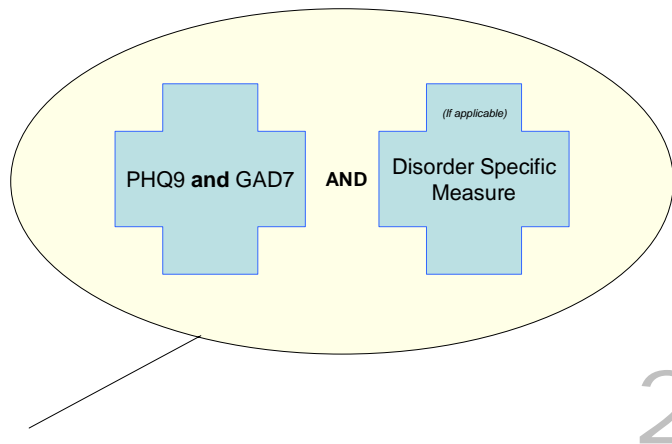


1. Generic Assessment Tool

- This figure provides a summary of the data collection measures to be used at assessment.

2. Routine Outcome Measuring Tool - Sessional

- This figure provides a summary of the data collection measures to be used at each patient session



3. Routine Outcome Measuring Tool – Review Sessions

- This figure provides a summary of the data collection measures to be used at each patient review session (or prior to the end of a step of care whichever occurs first)

Definitions

Intake is defined as the first face to face contact. The questionnaire can be administered before, during or after the first contact, and services should aim to have questionnaire(s) completed before the second contact.

The **end of a step of care** is defined as a session before the end of that step of care, which varies in each step and for the different interventions. For example, for step 3 (formal psychotherapy less than 20 hours of treatment) it would be in the final session or session 19 or 20.

Irrespective of how short the duration of treatment in that step of care, a **review set** is administered before the Service User moves up or down the stepped care framework, it therefore also acts as the intake measure for the next step of care. For patients going into **follow up**, end of the step is defined as when session frequency falls beneath one session every 6 weeks.

1. Improved Health & Wellbeing

Demonstrating benefits: The key impact area for this domain is the ability for Pathfinder sites to demonstrate improved wellbeing for people using the new services. To achieve this tools are required for:

i. Obtaining caseness

Why?: To ensure that people with the appropriate caseness, i.e. mild to moderate depression and/or anxiety, receive treatment within the programme.

How?: To determine caseness, Pathfinder sites should use the Patient Health Questionnaire (PHQ9) (for depression) and the Patient Health Questionnaire GAD7 (GAD7) (for anxiety) at intake. These measures are integral to the MDS and are used in all aspects of the routine outcome measuring and generic assessment tools (see figure 2 and 3). The PHQ9 and the GAD7 are free to use measures. The PHQ9 in particular is linked to the Quality Outcomes Framework (QoF) and is available in multiple languages. Disorder specific measures should also be used at assessment (as part of the generic assessment tool) to aid identification and severity of the disorder.

Other measures that have been used include the HADS (Hospital Anxiety and Depression Scale), BDI (Beck Depression Inventory) and BAI (Beck Anxiety Inventory), however these are optional as they incur cost per use.

ii. Measuring change

Why?: Following assessment and during the course of the delivery of the appropriate psychological interventions, measures are required to monitor each service user's progress

How?: In order to ensure >95% collection of clinical outcome data, services will use clinical outcome measures at each session. Where sessions are provided more than once per week, a questionnaire(s) need only be administered in one session that week.

The recommended sessional measures are the PHQ9 and GAD7. Where the service user is receiving an intervention for a specific disorder, the sessional PHQ9/GAD7 should be replaced by a sessional disorder specific measure as detailed in section 1iii below.

In addition, the CORE-10 will be used at intake (as part of the generic assessment tool) and before the end of that step of care (at review sessions). The CORE-10 is part of the family of CORE measures which also includes the CORE-OM, a 34-item measure often used at pre- and post-therapy assessment which is available in various languages. As such, the CORE-10 language translations can be formulated.

The CORE-10 comprises 10 items from the original CORE-10 and was designed to be used to screen or review clients in busy practice based clinics. The CORE-10 is free to use with conditions (see ‘Sourcing MDS measures and further reading’ section) and takes approximately 2 minutes to complete.

Other measures that have been used widely in practice to measure changes in health and wellbeing include the CORE-OM (34 item) as it enables a wider range of client presenting problems than obtained by just using the PHQ9 and GAD7.

iii. Ensuring sensitivity to specific disorders

The recommended disorder specific measures are:

Social Phobia	Social Phobia Inventory (SPIN)
Obsessive Compulsive Disorder	Obsessive Compulsive Inventory (OCI)
Post-traumatic Stress Disorder	Impact of Event Scale (IES)
Health Anxiety	Health Anxiety Inventory (HAI)
Panic/Agoraphobia	Mobility Inventory
Depression	PHQ9 - other options include HAD & BDI (incur costs)
Phobia	Fear Questionnaire
Anger	No free measure identified, use PHQ/GAD in conjunction with general measure of severity, frequency duration and impairment. (A sample questionnaire is available at www.mhchoice.csip.org.uk/Pathfinder/Re-sources)
Generalised Anxiety Disorder	Penn State Worry

2. Improved Patient Choice and Access

Demonstrating benefits: The key impact areas for this domain are as follows:

i. Information for Choice of clinically effective psychological therapy services appropriate to the populations served

Why?: A measure of choice is used to determine whether service users have been empowered to make a choice on the options of care and treatment available to them. It should also demonstrate that a choice of date, time and venue has been offered and whether information about the service was available.

How?: A measurement of patient choice should be taken at intake after the initial consultation once the care pathway has been agreed. This is administered once at the start of each step of care. The IAPT Patient Experience Questionnaire Part 1 (PEQ1) should be used pending the development of a patient-centred questionnaire.

Other recommendations:

- Service User and Carer focus groups can also be established to determine whether choice of evidence based psychological therapies has been integral to the service users experience. Further guidance on engaging service users and carers is available upon request from the Choice and Access Team.
- Referrer questionnaires such as a questionnaire to GPs to identify what choices referrers have been able to offer people with common mental health problems. This can be linked with Satisfaction (*see section 3 below*) to see how satisfied GP's are with those choices available.

ii. Access

Why?: Pathfinder sites will measure the referral information for commissioning planning and waiting times throughout the care pathway to ensure capacity planning is accurate.

How?: Access information should be collated from service throughput data, not from patient questionnaires. Pathfinder sites should use the IAPT Reporting Template 1 'Service Activity Data' (*see appendix 1*) to update the National programme on a **monthly** basis. In addition to sourcing data locally, waiting times data can also be obtained from QM08 returns from the respective PCTs/Health Trust's that submit them.

3. Improved Patient Experience

Demonstrating benefits: The key impact area for this domain is:

i. Satisfaction

Why?: A measure of satisfaction is essential as it helps determine quality, efficiencies and the effectiveness of services provided. It also enables service providers to appropriately re-design services so that they may have an equal place in the market of contestability.

How?: A questionnaire assessing the quality of patient experience is administered once at around the end of that step of care. It can either be administered before the end of treatment, or in the final session. Services may choose to administer the questionnaire after the final session but this will require significant additional administrative support due to higher non-return rates. The IAPT Patient Experience Questionnaire Part 2 (PEQ2) should be used pending the development of a patient-centred questionnaire. This questionnaire focuses on patient satisfaction.

Another measure that has been used by localities to capture patient satisfaction is the CSQ8, however this measure incurs a cost per use.

4. Inclusion and Employment Status

Demonstrating benefits. This benefits domain includes measures of how the service has helped service users to maintain employment, and how it has assisted them in returning to work or engaging with local communities and activities of daily living.

i. Change in employment status

How?: IAPT Inclusion & Employment Questionnaire should be administered at intake and prior to the end of the step of care to monitor change in employment status. The questionnaire will also capture changes in number of sick days taken for those in employment to measure economic benefit.

ii. Change in incapacity benefits

Why?: This measure is fundamental to show the efficiencies of services. It also demonstrates not just a reduction/change in the number of people claiming incapacity benefits, but an improvement in service user's wellbeing outcomes as patients must have felt better and empowered enough to make that proactive change to their economic status.

How?: IAPT Inclusion and Employment Questionnaire should be administered at intake and prior to the end of the step of care. Responses to this questionnaire will not affect the care or benefits that the patient receives.

iii. Changes in levels of social inclusion

Why?: Measuring changed levels of social inclusion demonstrated whether people feel well enough to engage with their community and social environment as a result of receiving psychological therapy.

How?: Changes in patients employment and social inclusion status will be measured using the Work and Social Adjustment Scale (W&SAS). Supporting inclusion data can also be captured from the IAPT Employment & Inclusion Questionnaire as detailed in 4i and 4 ii above.

Another measure for consideration that some localities may choose to adopt is a health related quality of life (HRQoL) (such as the SF6-D and EQ5-D). These are multidimensional generic utility measures that have become widely used by clinical researchers rather than for routine data collection. However, they may provide a useful tool for policy makers as well as researchers wishing to assess and quantify the cost-effectiveness of interventions. Analysis of this type of data can generate Quality Adjusted Life Years (QALYs) which provide a common currency to evaluate the benefits gained from a variety of health interventions. Use of a HRoL measure is an optional substitute to the W&SAs should Pathfinders wish to collect this type of data to enrich the balanced score card.

Other routine data collection issues

- It is essential for Pathfinder sites to collect routine data on the nature of the interventions offered, average number or length of sessions in each step, and the type of therapist offering the intervention (i.e. GPCMHW, CBT therapist, Employment coach etc). To address this issue, sites should use the 'Stepped Care Model Service Overview' IAPT Reporting Template 2 (see *Appendix 2*) which should be completed

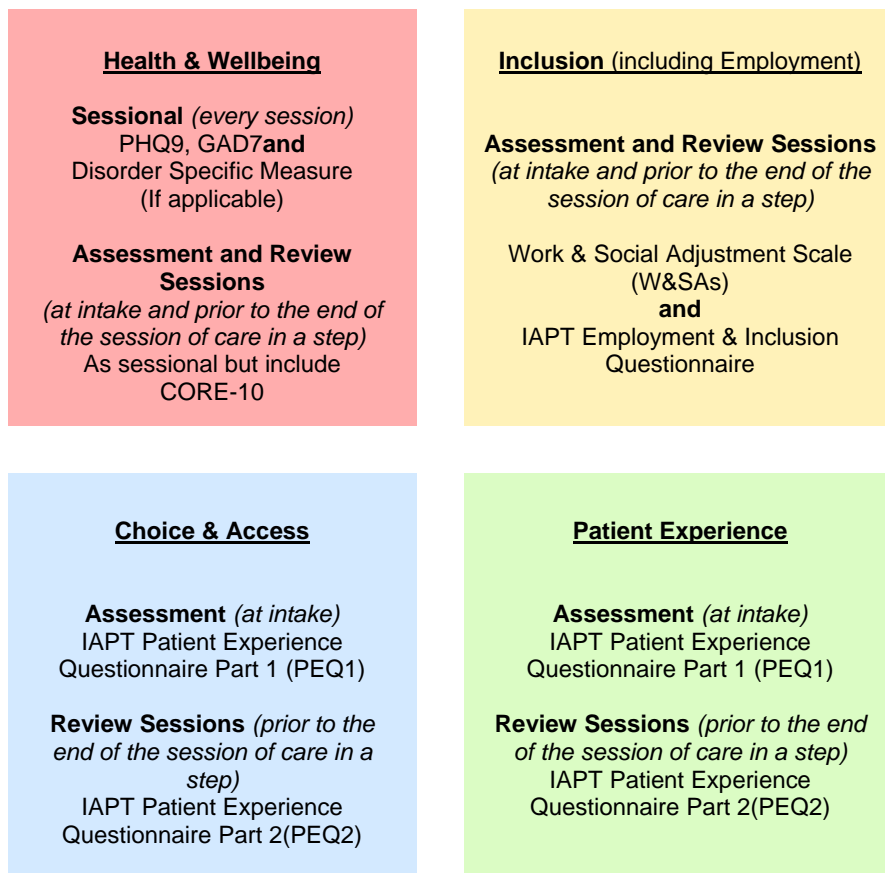
and returned to the National Programme on a **3 monthly** basis. This template requires sites to give details of service provisions and interventions offered as part of the stepped care model, including the clinicians responsible for delivering those services, and average duration of sessions.

- It is also essential for Pathfinder sites to collect epidemiology data such as gender, sexuality, age, disability, ethnicity and race concurrently with the outcome measures detailed in the previous sections. Many services integrate collection of epidemiology onto other standard forms such as Patient Summary Sheets. This data can also be used to enhance the service redesign process.
- From a workforce perspective it would be useful to have some idea of the skills mix of the staff delivering interventions, including their level of competence and skill. Further guidance on workforce issues are detailed in 'A practical approach to IAPT Workforce Development' available from www.mhchoice.csip.org.uk/Pathfinder/Resources

Summary of the Minimum Data Set relevant to the Outcomes Framework

Figure 5 below provides an overview of the measures that make up the minimum data set (including the frequency) and the four outcomes framework domains to which they belong.

Figure 5 – Summary of the Minimum Data Set (MDS)



Sourcing MDS measures and further reading

1. Health and Wellbeing Measures

- **Patient Health Questionnaire (PHQ9)**

The Patient Health Questionnaire (PHQ) is designed to facilitate the recognition and diagnosis of the most common mental disorders in primary care patients. PHQ materials were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

To obtain the PHQ-9, including permission for clinical/research use visit www.pfizer.com/phq-9. Further guidance and information can be found in 'PHQ9 & GAD7 Guidance Notes' available at www.mhchoice.csip.org.uk/Pathfinders/Resources

- **Patient Health Questionnaire (GAD7)**

In addition to the PHQ9, the GAD7 is designed primarily as a screening and severity measure for generalized anxiety disorder. As above, PHQ materials were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

A version of the GAD7 questionnaire and guidance and information notes can be found in 'PHQ9 & GAD7 Guidance Notes' (page 6) available at www.mhchoice.csip.org.uk/Pathfinders/Resources

- **CORE-10**

To obtain the CORE-10 visit http://www.coreims.co.uk/forms_mailer.php. Alternatively, the forms and user manual are available at www.mhchoice.csip.org.uk/Pathfinders/Resources. Forms are copyrighted but free to photocopy provided that copyright is acknowledged, it is not changed in any way, and it is not used for financial gain. Conversion to electronic versions requires written permission from the Trustees of the CORE System Trust. More information and guidance is available from the CORE website <http://www.coreims.co.uk>

- **Disorder Specific Measures**

Social Phobia Inventory (SPIN) - The SPIN demonstrates solid psychometric properties and shows promise as a measurement for the screening of, and treatment response to, social phobia.

Kathryn M. Connor, MD, Jonathan R. T. Davidson, MD, I. Erik Churchill, MS, Andrew Sherwood, PHD and Richard H. Weisler, MD Psychometric properties of the Social Phobia Inventory (SPIN) *British Journal of Psychiatry* (2000) 176: 379-386 <http://bjp.rcpsych.org/cgi/content/full/176/4/379>

Obsessive Compulsive Inventory (OCI) – A self-report inventory for determining the diagnosis and overall severity of obsessive-compulsive disorder (OCD).

Foa, E.B., Kozak, M.J., Salkovskis, P.M., Coles, M.E., and Amir, N. (1998). The validation of a new obsessive-compulsive disorder scale: The Obsessive-Compulsive Inventory. *Psychological Assessment*, 10(3), 206-214

Impact of Event Scale (IES) – For more than 20 years, the Impact of Event Scale (IES) has been widely used as a measure of stress reactions after traumatic events.

Sundin, E., Horowitz, M. Impact of Event Scale: psychometric properties. *British Journal of Psychiatry* (2002) 180: 205-209
<http://bjp.rcpsych.org/cgi/reprint/180/3/205.pdf>

Horowitz, M., Wilner, N., Alvarez, W. Impact of Event Scale: a measure of subjective stress. *Psychosom Med.* 1979 May; 41(3):209-18

Health Anxiety Inventory (HAI) - The HAI is a reliable and valid measure of health anxiety.

Salkovskis, P.M., Rimes, K.A., Warwick, H.M.C., Clark, D.M. The Health Anxiety Inventory: development and validation of scales for the measurement of health anxiety and hypochondriasis *Psychological Medicine*, 2002, 32, 843-853
<http://journals.cambridge.org/production/action/cjoGetFulltext?fulltextid=114466>

Mobility Inventory - A short self-complete questionnaire such as the panic subscale of the agoraphobic mobility inventory should be used for individuals with panic disorder.

Chambless, D. L., Caputo, G. C., Jasin, S. E., Gracely, E. & Williams, C. (1985). The Mobility Inventory for Agoraphobia. *Behaviour Research and Therapy*, 23, 35-44.

HAD - The Hospital Anxiety and Depression Scale is a screening device for measuring the severity of anxiety and depression separately.

For more information visit http://www.nfer-nelson.co.uk/health_and_psychology/resources/hospital_anxiety_scale/hospital_anxiety_scale.asp

Zigmond A.S., Snaith R.P. The Hospital Anxiety And Depression Scale. *Acta Psychiatr Scand* 1983, 67:361-70

BDI - The BDI is a 21 item self-report rating inventory measuring characteristic attitudes and symptoms of depression (Beck et al., 1961). The BDI questionnaire is copyrighted by The Psychological Corporation. <http://www.psychcorp.com>

Beck, A.T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961) An inventory for measuring depression. *Archives of General Psychiatry* 4, 561-571.

Fear Questionnaire - The Fear Questionnaire is an internationally popular measure in anxiety disorder research

Cox, B.J., Parker, J.D., Swinson R.P. Confirmatory factor analysis of the Fear Questionnaire with social phobia patients *The British Journal of Psychiatry* (1996) 168: 497-499

Penn State Worry - Worry is often assessed with the 16-item Penn State Worry Questionnaire.

Meyer TJ, Miller ML, Metzger RL, et al. Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy*. 1990; 28: 487-495.

2. Patient Choice & Access Measures

IAPT Patient Experience Questionnaire (PEQ) Part 1 - focuses on the views and experience of the choices patients have whilst accessing the service. This questionnaire is available from www.mhchoice.csip.org.uk/Pathfinders/Resources .

3. Patient Experience Measures

IAPT Patient Experience Questionnaire (PEQ) Part 2 - focuses on how satisfied patients are with the services received. This questionnaire is available from www.mhchoice.csip.org.uk/Pathfinders/Resources .

4. Inclusion and Employment Measures

Work & Social Adjustment Scale (W&SAS) – The Work and Social Adjustment Scale (WSAS) is a simple 5-item measure of general impairment which grew out of a study of change during psychotherapy. It was adapted as a 4-item scale (work, home, social, and private leisure) to rate disability in psychotherapy studies in phobics. Marks et al adapted it further to measure the outcome of most patients in treatment and later added its fifth item concerning interpersonal relations. The referenced paper below by Mataix et al 2005 includes the Work and Social Adjustment Scale towards the end of the report, and how it is scored. Pathfinder sites are recommended to utilise this version.

Mataix-Cols, D., Cowley, A.J., Hankins, M., Schneider, A., Bachofen, M., Kenwright, M., Gega, L., Cameron, R., Marks, I.M. Reliability and validity of the Work and Social Adjustment Scale in phobic disorders *Comprehensive Psychiatry* 46 (2005) 223– 228

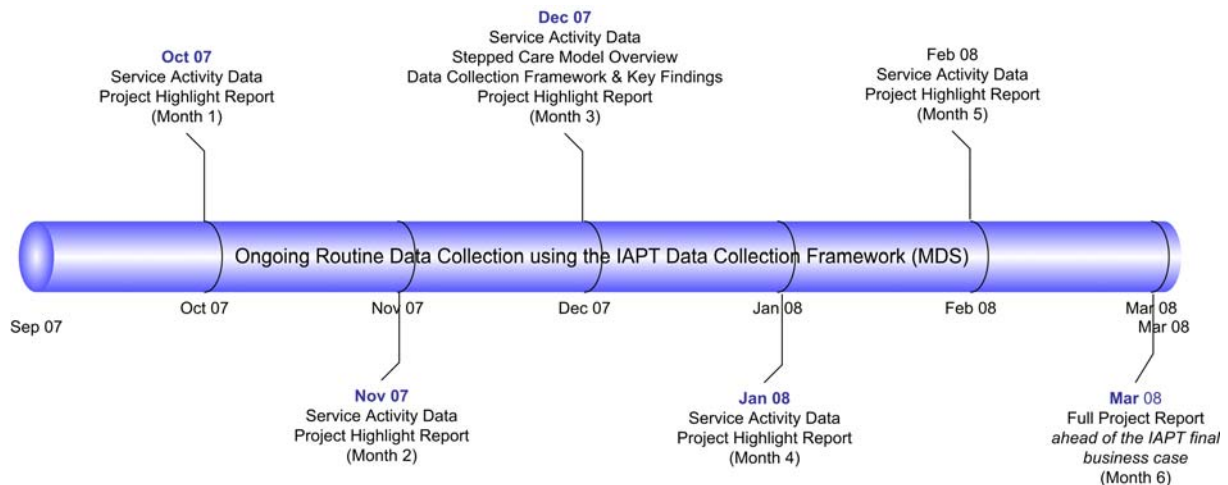
Mundt, J.C., Marks, I.M., Greist, J.H., Shear, K. The Work and Social Adjustment Scale: A simple accurate measure of impairment in functioning. *Brit J Psychiatry*, 2002, 180, 461-464.

IAPT Inclusion and Employment Questionnaire (IEQ) – collects and measures the change in patients and employment and inclusion status. This questionnaire is available from www.mhchoice.csip.org.uk/Pathfinders/Resources .

Essential Reporting: Using the Appendices

The timeline in figure 6 below depicts when key reporting templates that Pathfinders should submit to the National Programme to monitor progress around improving access standards and health and wellbeing outcomes. These returns are concurrent with the submission of monthly Project Highlight reports and the Full Project report at month 6 prior to the final business case.

Figure 6 – Timeline of Data Collection Returns



Appendix 1 – IAPT Reporting Template 1 – Service Activity Data

This template collects quantitative service access information such as the number of **referrals** and **waiting times** to support the qualitative **access** information gained from the PEQ1. Pilot sites should complete this reporting template and return to the National Programme every month (*as shown in the diagram above*).

Appendix 2 – IAPT Reporting Template 2 – Stepped Care Model Overview

This template gives an overview of how the stepped care model is applied in each of the pilot sites. It collects **service provisions** and **interventions** and some **workforce** data by asking pilot sites to detail the workforce responsible for administering the interventions. Pilot sites should complete this reporting template and return to the National Programme every 3 months (*as shown in the diagram above*).

Appendix 3 – IAPT Reporting Template 3 – Data Collection Framework & Key Findings

This methodology template provides a framework for Pathfinder sites to detail how they have applied the minimum data set to the four domains of the balanced score card, and completion rates. Page 2 of this template should be utilised by giving **statistical headlines** in the 'Key Findings' column and the **implications** of the findings in the 'Comments' column. Pathfinder sites should complete this reporting template and return it to the National Programme every 3 months as shown in the 'Timeline of Data Collection Returns'. It is acknowledged that services may not be able to provide complete Step 3/4 outcomes data for the first return date due to the longer length of treatment time for those steps.

Appendix 1 – IAPT Reporting Template 1

Service Activity Data

Please provide activity data for the treatment of all mental health problems within the service. Supporting data to be submitted with this template be found at the end of the page.

Service:		Time Period:		
No. of GP's:		Level of Investment:		
Resident Population:		Staff Ratio to Population:		
Source of data:				
Step 1		Step 2	Step 3	Step 4
Number of people referred for treatment from GP <ul style="list-style-type: none"> Anxiety Depression Mixed Other 	Total number of referrals received: Inappropriate referrals			
	Number of people self-referred for treatment <ul style="list-style-type: none"> Anxiety Depression Mixed Other 	Total number of appt offered for initial assessment Number of service users who attended assessment		
Number of people referred for treatment from Other (please give details) <ul style="list-style-type: none"> Anxiety Depression Mixed Other 	Number of people who received treatment after assessment Total number of people completed treatment			
	Number of people waiting to Step up Number of people waiting to Step down			
	Average mean waiting time for initial assessment Average mean waiting time treatment Average mean waiting time Step 2-3 Average mean waiting time Step 3-4			
	Rates of non-attendance Assessment Treatment Rates of drop-out			

Adapted from 'Operational Portraits from NEYH' page 22 Stericker, S and Shaw, A (2006) CSIP NEYH RDC

Accompaniments

- Details of treatment uptake by breakdown by intervention for each step.
- A flowchart to show the Service Care Pathway

Stepped Care Model Service Overview

Please give details of service provisions and interventions offered as part of a stepped model of care and clinicians responsible for delivering those services.

	Step 1	Step 2	Step 3	Step 4
Stage, Interventions and other relevant service provision details				
Assessment/ psychometric tools				
Workforce responsible				
Mean average duration of session				

Adapted from 'Operational Portraits from NEYH' page 15 Stericker, S and Shaw, A (2006) CSIP NEYH RDC

Appendix 3 - IAPT Reporting Template 3

Data Collection Framework & Key Findings

IAPT Outcome	Measures	Usage	Monitoring/Collection Period	Participant Breakdown
Health and Wellbeing				
Inclusion				
Choice and Access				
Patient Experience				

Other Supporting Data Collected	Usage	Period	Participant Breakdown

Key Findings	Comments
1. Health & Wellbeing Outcomes	•
2. Inclusion (including Employment)	•
3. Choice & Access	•
4. Patient Experience	•
5. Other (e.g. GP views, and emerging epidemiology and ethnicity trends)	•