NAPT
NATIONAL AUDIT OF PSYCHOLOGICAL THERAPIES

CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Second Round of the National Audit of Psychological Therapies for Anxiety and Depression (NAPT)

National Report November 2013

HQIP
Healthcare Quality Improvement Partnership

This report has been compiled by

NAPT project team

Charissa Bhasi – Project Worker

Rohanna Cawdron – Project Administrator

Melissa Clapp – Project Worker

Jeremy Clarke – NAPT Clinical Lead

Mike Crawford – Director of the College Centre for Quality Improvement

Lorna Farquharson - Clinical Advisor

Elizabeth Hancock - Deputy Programme Manager

Miranda Heneghan - Project Worker

Rachel Marsh – Programme Manager

Lucy Palmer – Senior Programme Manager

Centre for Psychological Services Research, University of Sheffield

Michael Barkham and David Saxon

NAPT advisory group

Academic Centre for Defence Mental Health; Age UK; Anxiety UK; Association for Psychoanalytic Psychotherapy; British Association for Behavioural and Cognitive Psychotherapies; British Association for Counselling & Psychotherapy; British Association of Art Therapists; British Psychoanalytic Council; British Psychological Society; Centre for Workforce Intelligence; CORE Information Management Systems; Division of Clinical Psychology Managers' Faculty, British Psychological Society; Depression Alliance; East London NHS Foundation Trust; Faculty of Medical Psychotherapy, Royal College of Psychiatrists; Healthcare Quality Improvement Partnership; Improving Access to Psychological Therapies; Joint Commissioning Panel for Mental Health; Research Institute of Primary Care and Health Sciences, Keele University; Mayden Health; Mental Health Providers Forum; Mind; National Mental Health Development Unit; New Savoy Partnership; NHS Confederation's Mental Health Network, Workforce Reference Group; National Institute for Health and Care Excellence; Obsessive Compulsive Disorder UK; Patient Case Management Information System; Peninsula College of Medicine and Dentistry; Faculty of the Psychology for Older People, British

Psychological Society; Rethink Mental Illness; Royal College of General Practitioners; Royal College of Nursing; The United Kingdom Council for Psychotherapy; We Need to Talk

Correspondence: napt@cru.rcpsych.ac.uk

If citing this report, please reference it as: Royal College of Psychiatrists (2013). Report of the Second Round of the National Audit of Psychological Therapies (NAPT) 2013. London: Healthcare Quality Improvement Partnership.

Publication number: CCQI154 (November 2013)

Foreword

This national audit is currently the only means of measuring and comparing the wide range of services providing psychological therapies for adults with anxiety and depression in England and Wales. In total, the national audit has collected over 8,000 questionnaires from therapists, 25,000 questionnaires from service users and extracted data from over 170,000 anonymised individual case records. This unique body of information has enabled the audit team to provide the most comprehensive analysis of performance of these services to date and to provide a robust set of benchmarks for comparing individual services to clearly defined standards of best practice.

The second round of the audit found that whilst there have been some improvements since the baseline, including reduced waiting times and better recording of ethnicity and diagnostic data, there are a number of ongoing areas of concern. There is still marked variation in performance between services, some therapies are still being provided by therapists who do not have specific training to do so and older adults with anxiety and depression are not getting the help they need.

While it is important to recognise the considerable progress that has been made in delivering high quality psychological therapy to people with anxiety and depression in England and Wales, it is clear that further work needs to be done to ensure that treatment is delivered in a timely fashion to those who need it most.

We hope that commissioners, clinicians and those responsible for managing these services will all see the important contribution they can make to acting on the report's recommendations.

Professor Mike Crawford
Director, Royal College of Psychiatrists' Centre for Quality Improvement

Jeremy Clarke
NAPT Clinical Lead

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Executive summary

NAPT
NATIONAL AUDIT OF PSYCHOLOGICAL THERAPIES
CCQI

Executive summary

Background

The National Audit of Psychological Therapies (NAPT) aims to evaluate and improve the quality of treatment and care received by people with anxiety and depression in England and Wales. A baseline audit was carried out in 2010 and published in November 2011[1]. This report is based on findings from the second round of the audit, which collected data 18 to 24 months after the baseline to determine whether performance had improved.

Audit Standards

The ten audit standards we assessed map on to four dimensions of quality:

- Access – Standards 1-3
- Appropriateness – Standards 4-6
- Acceptability – Standards 7-8
- Outcomes - Standards 9-10

These standards are predominantly the same as in the baseline audit to allow for comparison. The main change we made for the second round of the audit was to replace a baseline standard on therapeutic alliance with one on service user choice.

Method

As in the baseline, all NHS-funded psychological therapy services for adults with anxiety disorders and depression in primary and secondary care in England and Wales were eligible to participate in the audit. A total of 220 services submitted data for the second round, 145 of whom had taken part in the baseline audit. As well as reporting the overall picture against the standards, we were able to analyse a subset of services that could show us change against the standards between the baseline and second round audits.

The following audit tools were used to assess performance against the standards:

- A service registration questionnaire that described the type of service and its local context
- A therapist questionnaire on the work, training and background of clinicians working in services
- A retrospective case record audit of people who completed therapy between 1st July and 31st October 2012
- A service user questionnaire "Talking Treatment" that examined people's experience of services and their preferences and priorities.

All data were collected between April 2012 and January 2013.

Contextual data

For the second round audit, data were submitted by 220 services across England (207) and Wales (13) from 97 different organisations. Questionnaires were completed by 4,771 therapists and 15,078 service users; resulting in a 73% and 20% response rate respectively. Services submitted a total of 155,316 clinical case records.

Table 1: Performance against the NAPT second round standards

	Standard	% of the total national sample meeting the standard	Absolute change since baseline (%)	Interquartile range across services
S1a	The service routinely collects data that can be used to ensure equity of access (including age, gender and ethnicity).	Age: 100	Age: +1	Age: 100-100
		Gender: 100	Gender: +1	Gender: 100-100
		Ethnicity: 83	Ethnicity: +7	Ethnicity: 82-100
S1b	People starting treatment with psychological therapy are representative of the population in terms of age, gender and ethnicity.	Age: older adults underrepresented	Generally consistent with baseline	N/A
		Gender: consistent with expected prevalence of anxiety and depression		
		Ethnicity: broadly consistent with Office for National Statistics (ONS)[2] data		
S2	A person who is referred for psychological therapy does not wait longer than 13 weeks from the time at which the initial referral is received to the time of the assessment.	92	+7	77-99
S3	A person who is assessed as requiring psychological therapy does not wait longer than 18 weeks from the time at which the initial referral is received to the time that treatment starts.	91	+6	63-98

	Standard	% of the total national sample meeting the standard	Absolute change since baseline (%)	Interquartile range across services
S4	The therapy provided is in line with that recommended by the National Institute for Health and Care Excellence (NICE) and guideline for the service user's condition/problem.	79	-4	69-93
S5	Treatment for high intensity psychological therapy is continued until recovery or for at least the minimum number of sessions recommended by the NICE guideline for the service user's condition/problem.	57	+3	52-67
S6	Therapists are providing therapy under supervision, and have received formal training to deliver the therapy provided.	80	-2	75-93
S7	Service users report being provided with information and choice about their treatment *N.B: (figures provided here relate to the provision of choice, if this was important to the service user)*	Time of day: 82	N/A This is a newly included standard for the second round	77-91
		Venue: 70		58-78
		Type of therapy:67		57-75
		Therapist gender: 42		30-54
		Access in another language: 63		50-81
S8	Service users report a high level of satisfaction with the treatment that they receive*	Access: 82	Access: -3	76-86
		Experience: 80	Experience: -10	77-87
S9a	The service routinely collects outcome data in order to determine the effectiveness of the interventions provided.	95	+14	79-100

	Standard	% of the total national sample meeting the standard	Absolute change since baseline (%)	Interquartile range across services
S9b	The service reports clinical outcomes of service users receiving psychological therapy comparable to benchmarks achieved from clinical trials and effectiveness studies.	Median recovery rate: 46	-3	38-53
S9c	The clinical outcomes of service users receiving psychological therapy in the therapy service were comparable to benchmarks achieved by similar profile therapy services.	Benchmarks differed according to type of service and measure of outcomes used	N/A	N/A
S10	The rate of attrition from commencing treatment to completing treatment is comparable to that of therapy services with similar profiles.	24	-1	13-30

* This change in service user satisfaction that we found could be the result of a change in scoring which is described in the Methods section of this report.

- More detailed analysis looking at the performance against the NAPT standards for different types of services is included in the main body of the report and Appendix A.

Key overall findings

The second round of NAPT has found evidence that waiting times for therapy are shorter and that more services are measuring their outcomes. However, serious concerns about access by older adults remain. In addition, more needs to be done to ensure that psychological therapy is continued until people either recover or receive at least the minimum number of sessions recommended by the NICE guideline[3 4 5 6] for the service user's condition. There are also skills and training deficits in the workforce.

From the perspective of service users, key areas of concern were waiting times and the number of sessions. Only two thirds of the respondents to the survey user survey thought it was a reasonable wait to start treatment and the feedback from the service user reference groups highlighted a desire for much shorter waiting times than indicated in the standards, as well as more help with managing the wait. Furthermore, it is clear that more attention needs to be given to the provision of information and choice.

In summary, the second round of the audit has demonstrated some improvements in service quality against agreed standards of care. However, there are ongoing areas of concern. Urgent attention needs to be given to these areas otherwise the sustainability of accessible, effective, safe and acceptable services will be undermined. More focused locally-led quality improvement work is needed and clinical leaders should be better supported to address underperformance in services.

Recommendations

A full list of detailed recommendations can be found on pages 139 to 143 of the report. These include the following key recommendations:

- Service staff need to provide service users, carers and referrers with better information on the remit of the service, including referral criteria, choice, alternative sources of support, equity of access, end of therapy, information sharing and confidentiality

- Commissioners must ensure that services are able to demonstrate they provide therapies that are adherent to NICE guidelines, of sufficient duration and delivered by a suitably trained and supervised workforce
- Supervisors need to have received specific training in providing supervision and qualified therapists should only deliver therapy that they have been specifically trained to provide
- Services need to take active steps to address service user sources of dissatisfaction and have systems in place to obtain anonymous service user feedback on an ongoing basis
- As a minimum, steps to understand and improve outcomes for service users need to consider type and duration of therapy, therapist training, service user feedback, attrition, reliable improvement and recovery rates

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Main report

NAPT
NATIONAL AUDIT OF PSYCHOLOGICAL THERAPIES
CCQI

Table of contents

List of figures

List of tables

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Introduction

NAPT
NATIONAL AUDIT OF PSYCHOLOGICAL THERAPIES
CCQI

Introduction

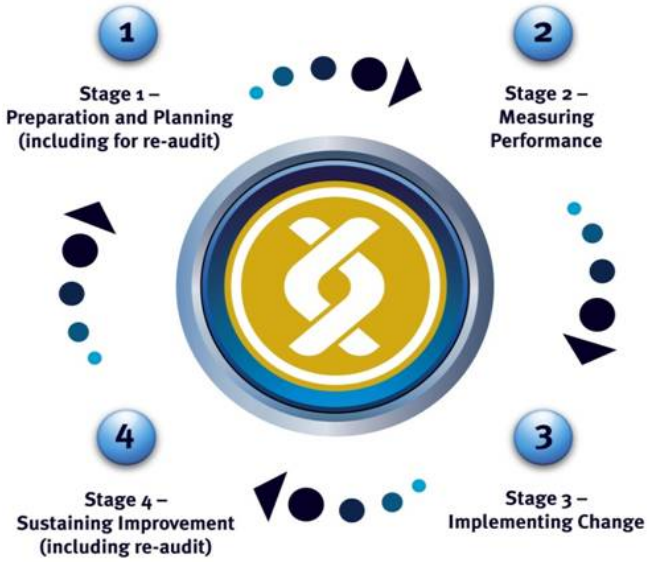
The National Audit of Psychological Therapies (NAPT) was established to evaluate the performance of NHS-funded services providing psychological therapies for adults with anxiety and depression in England and Wales. NAPT is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and is therefore one of the mandated national audits for all eligible NHS-funded services. It is managed by the College Centre for Quality Improvement (CCQI).

'*National Clinical Audits have a very important role to play in improving the quality of treatment and care. They allow:*

- *Individual healthcare professionals and teams to measure their care against national standards /guidelines*
- *Production of national comparative data for individual healthcare professionals and teams to benchmark their practice and performance*
- *Local bodies to identify and make improvements for patients*
- *Patients to question the quality of their care and exercise choice*
- *The Care Quality Commission to corroborate local bodies' self assessment against national standards*
- *NHS England and NHS Wales to assess progress against national initiatives.'*

(HQIP, 2012, p.4)[7]

Figure 1: The audit cycle (HQIP, 2013)[8]



The baseline audit included access, appropriateness, acceptability and outcomes as the main dimensions of quality and reported its findings in November 2011[1]. Overall, there were some encouraging findings with many services meeting the standards for waiting times, the majority of service users reporting a positive therapeutic alliance with their therapist and outcomes that were broadly consistent with the practice-based literature. However, there was wide variation between services and long waiting times was the most frequently cited area of concern by service users. The baseline findings also highlighted that there were a significant number of therapists who were delivering therapies for which they had received no specific training and a large proportion of service users were receiving high intensity therapy of insufficient duration. In addition, only one third of services reported adequate outcome data and some services were poor at recording ethnicity and diagnostic information. Furthermore, older people were less likely to receive therapy than younger people and over one third of participating services had a policy that excluded older people. The second round of NAPT commenced in 2012 with the aim of establishing whether performance against the standards had improved, been maintained or deteriorated.

Dissemination of the NAPT baseline findings

The dissemination strategy involved multiple ways of sharing the results and engaging all stakeholders, including press releases, conference presentations, involvement of regional leads and advisory group members. A service user/lay person report was also produced. The approach to supporting local interpretation of the findings included three main elements.

1. Baseline service level reports

Participating services were sent a service level report showing their performance against each audit standard and allowing them to benchmark their performance against other participating services. Services were asked to consider areas of achievement and areas for improvement.

2. Local action planning

An action planning toolkit was sent to each participating service. This included questions to consider for each standard, as well as sources of further information. Action plans were submitted by 60 services to the central team. Key information was then collated in a summary action planning document in order to share ideas and examples of good practice.

Action planning events took place across England and Wales, bringing together representatives from participating services, including service users, therapists, service managers, commissioners and clinical audit personnel. The events provided an opportunity to share experiences of participating in the baseline audit, consider the key findings and recommendations in a regional context, further develop action plans and discuss ways of overcoming potential barriers to their implementation. The feedback from those who participated in action planning events was that these were extremely useful.

3. NAPT quality improvement competition

NAPT launched a quality improvement competition to formally recognise the steps taken to facilitate change at a local level and share examples of good practice. The competition was open to all services that had taken part in the baseline, regardless of whether they had submitted an action plan. The winners

were announced at the New Savoy Partnership conference, "Psychological Therapies in the NHS 2012". Upon receiving their awards, the winning teams commented on how useful it was to take part in the audit process and what a difference it had made for their services.

"Taking part in the National Audit of Psychological Therapies gave us the chance to examine how we were doing, and to ask ourselves collectively why differences existed in relation to other services, and to agree areas for improvement. The feedback from users was especially helpful and challenging."

Jacqui Howard, Clinical Lead for Inclusion Matters, Liverpool

Scope and purpose of the second round of NAPT

The second round of NAPT looked at the same four areas of access, appropriateness, acceptability and outcomes as the baseline, to determine whether performance against the standards had improved. The standards predominantly remained the same to allow for comparison, but the following changes were made in response to feedback and recommendations from the first round of the audit:

- The standard on therapist training was broadened to include supervision
- The measure of therapeutic alliance was removed as the vast majority of service users had reported a very positive alliance with their therapist and there was very little variation found between services
- A new standard on the information and choice provided to service users was included

Contextual considerations for the second round

Since the baseline audit, there has been a change in the relationship between the Government and the NHS with the establishment of an independent NHS commissioning board on 1st October 2012 and the publication of the first Mandate from the Government [9]. In addition, there has been major reform within the NHS with new structures coming into effect from April 2013. There have also been developments in the Improving Access to Psychological Therapies programme with a report on the first million patients[10] and a payment by results (PbR) pilot study set up to test the feasibility of an outcomes based payment

system for improving performance and efficiency[11]. Furthermore, primary care psychological therapy services have been included in Any Qualified Provider developments with a view to extending patient choice in this area[12]. On 1st October 2012, the Government also fully implemented the ban on age discrimination in NHS commissioning and service provision[13]. In Wales, we have seen the launch of the first cross-department mental health strategy that covers all ages[14] and the introduction of the Mental Health Measure, which is new legislation to improve the support available for people with mental health problems. All of these changes need to be taken into account when making comparisons between the baseline and second round.

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Methodology

NAPT
NATIONAL AUDIT OF PSYCHOLOGICAL THERAPIES
CCQI

Methods

In line with the baseline audit, all English and Welsh NHS-funded services that provide psychological therapies to adults in the community for anxiety and depression were eligible to take part. Recruitment for the second round took place between January and June 2012.

A review of the baseline standards was undertaken using feedback and lessons learned from the baseline, advice from the NAPT advisory group and newly published information and guidelines. To ensure an appropriate level of compatibility between the baseline and the second round, revisions were only made where this was deemed necessary to improve the quality of the data and reporting. As in the baseline, the ten second round standards map onto the following four dimensions of quality:

- Access – standards 1-3
- Appropriateness – standards 4-6
- Acceptability – standards 7-8
- Outcomes – standards 9-10

Data collection was carried out in a phased manner between April 2012 and January 2013. The following audit tools were used to assess performance against the standards:

- A service registration questionnaire that described the type of service and its local context
- A therapist questionnaire on the work and training and background of clinicians working in services
- A retrospective case record audit of people who completed therapy between 1st July and 31st October 2012
- A service user questionnaire "Talking Treatment" that examined people's experience of services and their preferences and priorities.

An advisory group meeting and three service user reference groups were held to review the findings and develop the national recommendations.

A detailed account of the methods we used to recruit services, refine the second round standards and audit tools, collect data and analyse the data is provided in Appendix B.

Information about participating services, therapist sample and service user sample

Please note for the data analysis in this section:

- Percentages may not total 100 exactly due to rounding, e.g. 101 or 99
- TNS = total national sample, IQR = inter quartile range, N = services and n = service users
- Where numbers are shown, and this is appropriate, an improvement is shown in green and a worsening in red between the baseline and second round
- Where percentages are shown, and this is appropriate, improvements of >=5% are shown in green and worsening of >=5% in red between the baseline and second round
- Only services in the second round with 6 or more case records were used for the service level analysis. All available, appropriate and clean data were used for the TNS analyses.

Participating Services

Overall numbers of participating services

A total of 220 services across 97 organisations took part; 207 services in England and 13 services in Wales (see Tables 2 and 3 for comparisons with the baseline).

Table 2: Overall number of participating organisations and services

	Baseline	Second round
Organisations	120	97
Services	357	220

Table 3: Number of services participating in England and Wales

	Baseline (%)	Second round (%)
Wales	48 (13)	13 (6)
England	309 (87)	207 (94)

- A list of participating services and organisations by country/region is available in Appendix C
- Some services that registered for the second round merged with other services or chose to combine for the purposes of the audit. This needs to be taken into account when making comparisons between the two rounds.

The services participating in the second round consisted of 89 services that had remained 'unchanged' since the baseline, 56 services that had changed their remit or management since the baseline and 75 services that had not taken part in the baseline.

Reasons for declining to participate

One-hundred and thirty-seven (137) services that took part in the baseline did not register for the second round. The most common reasons provided were:

- 39 services stated the audit was not appropriate for them at that time (e.g. they felt the standards did not reflect how they worked (25), the audit was not seen to be beneficial to the service (11), IAPT national reporting was felt to be sufficient (3))
- 32 services either no longer existed (13) or were no longer eligible due to service changes (19)

- 26 services cited a lack of resources and other priorities such as contract reviews and renewals
- 40 services had a mixture of other reasons or their reasons were unknown.

Contextual Service Data

All 220 services that participated in the second round provided contextual information as part of the registration process.

Configuration of services

Table 4 presents information on managing sector, level of provision, service size, involvement in the Improving Access to Psychological Therapies (IAPT) programme and age range of client group.

Table 4: Configuration of services

	Baseline (%)	Second round (%)
Sector managing the service		
NHS only	312 (87)	181 (82)
Voluntary sector only	30 (9)	29 (13)
Private only	7 (2)	5 (2)
NHS & voluntary mix	7 (2)	3 (1)
NHS & private mix	1 (<1)	1 (<1)
NHS, voluntary and private mixed	0	1 (<1)
Level of service provision		
Primary care	147 (41)	137 (62)
Secondary care	169 (47)	48 (22)
Both	41 (11)	35 (16)
Size of service based on number of 'whole time equivalent' (WTE) therapists providing therapy for the service at the time of registration		
Large (>20 WTE)	95 (27)	88 (40)
Medium (8-20 WTE)	103 (29)	71 (32)
Small (<8 WTE)	159 (45)	61 (28)
Age range of service users seen by the service		
Working age and older people (18+)	201 (56)	175 (79)
Working age adults only (18-65)	127 (36)	37 (17)
Older people only (65+)	29 8)	8 (4)
Therapy offered in a language other than English		
Through interpreting services only	185 (52)	127 (58)
Both (interpreters and therapists)	103 (29)	53 (24)
None	46 (13)	24 (11)
Through therapists only	23 (6)	16 (7)

	Baseline (%)	Second round (%)
Improving Access to Psychological Therapy Services (IAPT)		
IAPT	118 (33)	131 (60)
Non-IAPT	239 (67)	89 (40)

Table 5: IAPT by service level (second round only)

	Service level		
	Primary	Secondary	Mixed
IAPT	114	2	15
Non- IAPT	23	46	20

Table 6: IAPT by service size (second round only)

	Service size		
	Small	Medium	Large
IAPT	13	40	78
Non-IAPT	48	31	10

When making comparisons with the baseline, it can be seen that the majority of services are still NHS-managed. There have been increases in the proportion of large, primary care and IAPT services. Furthermore, the proportion of services that see both working age and older adults has increased since the baseline, but almost a fifth still have a policy that excludes older people, despite new legislation aimed at eradicating this practice.

The majority of services offer therapy in another language (89%), predominantly through interpreting services only (see Table 4). The proportion of services that do not offer access to therapy in a language other than English has remained similar to the baseline.

Therapist sample

Data from 4,661 therapists were included (although not all answered all questions). A total of 3,913 (84%) therapists reported that they were a qualified member of staff, 631 (14%) were currently in training, 86 (2%) were not qualified or in training and 24 (<1%) preferred not to say.

There were 3,464 (74%) therapists that stated they were registered with at least one professional body; this is similar to the baseline, which found that 77% of therapists were registered with at least one professional body. Of the 1,068 therapists that were not registered with a professional body, 649 (61%) were qualified members of staff, 345 (32%) were in training, 62 (6%) were neither qualified members of staff nor trainees, and 9 (<1%) preferred not to say.

Service user sample

Demographic and clinical information on service users who responded to the survey are presented in Table 7.

Table 7: Demographic and clinical information on service users responding to the NAPT second round survey

	n (%)
Age	
18-24	1,102 (8)
25-34	2,559 (18)
35-44	3,342 (23)
45-54	3,569 (25)
55-64	2,529 (17)
65-74	1,024 (7)
75 or older	300 (2)
Total	14,425
Preferred not to say/ missing	162
Gender	
Female	9,850 (69)
Male	4,370 (31)
Transgender	21 (<1)
Total	14, 241
Preferred not to say/missing	346

	n (%)
Ethnic background	
White	13,381 (94)
Asian/Asian British	362 (3)
Mixed	226 (2)
Black/Black British	163 (1)
Chinese or other ethnic group	145 (1)
Total	14,277
Preferred not say/missing	310
Type of therapy they were receiving	
Cognitive behavioural therapy (CBT)	7,415 (46)
Counselling	4,120 (25)
Not sure	2,022 (12)
Mindfulness-based cognitive therapy (MBCT)	543 (3)
Other therapy	531 (3)
Low intensity treatment	504 (3)
Psychodynamic/ psychoanalytic therapy	348 (2)
Person-centered/humanistic therapy	281 (2)
Solution-focused therapy	251 (2)
Cognitive analytic therapy (CAT)	170 (1)
Total number of therapies reported	16,185

- Some service users reported receiving more than one therapy. Therefore, the percentages have been calculated against the total number of therapies reported.

Table 8: Number of therapy sessions received at the time of completing the questionnaire

Sessions	n (%)
1-5	5,579 (40)
6-10	4,859 (35)
11-15	1,761 (13)
16-20	974 (7)
21-25	300 (2)
26 or more	542 (4)
Total	**14,015**
Prefer not to say/missing	572

Table 9: Waiting time for current talking treatment

Months	n (%)
Less than 1	4,183 (30)
1-3	6,132 (44)
4-6	2,202 (16)
7-9	777 (6)
10-12	334 (2)
More than 12	441 (3)
Total	**14,069**
Prefer not to say/missing	518

Measurement against NAPT standards

- Percentages may not total 100 exactly due to rounding, e.g. 101 or 99
- TNS = total national sample, IQR = inter quartile range, N = services and n = service users
- Where numbers are shown, and this is appropriate, an improvement is shown in green and a worsening in red between the baseline and second round
- Where percentages are shown, and this is appropriate, improvements of >=5% are shown in green and worsening of >=5% in red between the baseline and second round
- Only services in the second round with 6 or more case records were used for the service level analysis. All available, appropriate and clean data were used for the TNS analyses.

Access:
Measurement against NAPT standards 1, 2 & 3

- Standard 1: Equity of access
- Standard 2: Waiting time to assessment
- Standard 3: Waiting time to treatment

- Percentages may not total 100 exactly due to rounding, e.g. 101 or 99
- TNS = total national sample, IQR = inter quartile range, N = services and n = service users
- Where numbers are shown, and this is appropriate, an improvement is shown in green and a worsening in red between the baseline and second round
- Where percentages are shown, and this is appropriate, improvements of >=5% are shown in green and worsening of >=5% in red between the baseline and second round
- Only services in the second round with 6 or more case records were used for the service level analysis. All available, appropriate and clean data were used for the TNS analyses.

Standard 1a: Data to measure equity of access

The service routinely collects data that can be used to ensure equity of access (including age, gender and ethnicity for each person referred for psychological therapy).

A total of 122,812 case records were included for analysis of this standard in the second round.

Total national sample (TNS) analysis

Table 10: Data completeness for age, gender and ethnicity for the total national sample (baseline total national sample = 49,963; second round total national sample = 122,812)

	Baseline	Second round
	% Numerator / Denominator	% Numerator / Denominator
Age	**99** 49,582 / 49,963	**100** 122,740 / 122,812
Gender	**99** 49,536 / 49,963	**100** 122,585 / 122,812
Ethnicity	**76** 37,785 / 49,963	**83** 101,552 / 122,812

- There was little room for improvement for age and gender but the completeness of ethnicity data has increased by 7% since the baseline.

Service level analysis

Table 11: Percentage data completeness for age, gender and ethnicity at a service level

	Baseline: TNS = 49,963; 224 services	Second round: TNS = 122,812; 190 services
	Median % Inter-quartile range	Median % Inter-quartile range
Age	**100** 100-100	**100** 100-100
Gender	**100** 99.9-100	**100** 100-100
Ethnicity	**97** 80-100	**95** 82-100

- As would be expected, there is little variation between services for completeness of age and gender data; most services demonstrated 100% completeness
- There is considerable variation in the completeness of ethnicity data compared to age and gender; fewer services were able to demonstrate 100% completeness for ethnicity.

Table 12: Percentage data completeness for those services that participated in both the baseline and second round audit (without changes to the service)

	Baseline: 74 services	Second round: 74 services
	Median % Inter-quartile range	Median % Inter-quartile range
Age	**100** 100-100	**100** 100-100
Gender	**100** 99.8-100	**100** 100-100
Ethnicity	**92** 72.0-100	**96** 81.9-100

- Services that took part in the baseline and second round (without changes to the service) showed an increase in ethnicity completeness

Summary – Standard 1a
Nearly all services have 100% complete recording of age and gender. While recording of ethnicity has improved there is marked variation across services.

Standard 1b: Equity of access

People starting treatment with psychological therapy are representative of the population in terms of age, gender and ethnicity.

For the analysis of this standard, a total of 122,740 case records were included for age, 122,585 for gender and 101,552 for ethnicity.

Total national sample (TNS) analysis – age

Table 13: Age range of service users who completed treatment during the second round audit period.

Age Group	Baseline	Second round
	% Numerator / Denominator	% Numerator / Denominator
18-24	**13** 6,496 / 49,187	**13** 16,405 / 122,740
25-34	**25** 12,166 / 49,187	**25** 30,117 / 122,740
35-44	**25** 12,497 / 49,187	**24** 28,796 / 122,740
45-54	**20** 9,929 / 49,187	**21** 25,359 / 122,740
55-64	**11** 5,359 / 49,187	**12** 14,269 / 122,740
65-74	**4** 1,925 / 49,187	**5** 5,617 / 122,740
75+	**2** 815 / 49,187	**2** 2,177 / 122,740

- The proportion of service users in each age range is similar to those found in the baseline.

Comparisons to other datasets - age

Office for National Statistics (ONS 2011)

Table 14: Age range of people included in the NAPT second round dataset compared with ONS Census data (2011)[2]

Age Group	ONS 2011	NAPT second round
	% Numerator / Denominator	% Numerator / Denominator
18-24	**12** 5,267,401 / 44,105,545	**13** 16,405 / 122,740
25-44	**35** 15,351,774 / 44,105,545	**48** 58,913 / 122,740
45-64	**32** 14,263,297 / 44,105,545	**32** 39,628 / 122,740
65-74	**11** 4,852,833 / 44,105,545	**5** 5,617 / 122,740
75+	**10** 4,370,240 / 44,105,545	**2** 2,177 / 122,740

- The NAPT second round dataset appears to be over-representative of 25-44 year olds when compared to the general population in 2011 (48% vs. 35%)
- In addition older adults (65+) seem to be underrepresented (6% vs. 21%). This is consistent with the baseline (please note both the percentages for 65-74 and 75+ in the table above have been rounded to the nearest whole, when summed the percentage is 6% not 7%).

Adult Psychiatric Morbidity Study 2007

The National Centre for Social Research and the University of Leicester collaborated on a household survey between October 2006 and December 2007 to collect data on mental health among adults aged 16 and over in England and Wales[15]. The data provide prevalence rates of common mental health disorders, which include different types of depression and anxiety disorders, within the population.

These data showed that adults aged 16-54 years had the highest prevalence rates whilst older adults had the lowest prevalence rates of common mental

health disorders. Adults aged 65-74 years had a prevalence rate of 11% and adults aged 75+ years had a prevalence rate of 10%.

Table 15: The expected and observed number of older adults in the NAPT second round dataset with a common mental disorder

Age Group	Expected n (%)	Observed n (%)
65-74	8,592 (7)	5,617 (5)
75+	7,364 (6)	2,177 (2)

- A chi square test was conducted which showed statistically significant differences between the expected and observed values for both age groups; 65-74 year olds (X^2=1029.9, p<0.001) and for people aged 75+ (X^2=3653.9, p<0.001)
- Similar to the baseline, the observed proportion of older adults in the NAPT dataset is much lower than the expected rates of common mental health problems in this age group. This is particularly notable for people aged 75 and over.

Total national sample (TNS) analysis – gender

Table 16: Gender of people who completed treatment during the second round audit period

Gender	Baseline	Second round
	% Numerator / Denominator	% Numerator / Denominator
Female	**65** 32,444 / 49,536	**65** 79,157 / 122,585
Male	**35** 17,092 / 49,536	**35** 43,428 / 122,585

- Of those case records with gender recorded, 35% were male and 65% were female. This is consistent with the baseline findings.

Comparisons to other datasets - gender

Table 17: Gender of people included in NAPT second round vs. ONS (2011)[2] census data

	ONS 2011*	NAPT second round
	% Numerator / Denominator	% Numerator / Denominator
Female	**51** 22,663,751 / 44,105,545	**65** 79,157 / 122,585
Male	**49** 21,441,794 / 44,105,545	**35** 43,428 / 122,585

- *Only those aged 18+ were included from the ONS data[2]
- The NAPT second round data continues to show an over-representation of females compared to the ONS data (2011)[2]. However, the prevalence rate of common mental health disorders differs for males and females. The Adult Psychiatric Morbidity Study (2007)[15] found that the prevalence rate is higher for females compared to males (19.7% vs. 12.5%).

Table 18: The expected and observed number of males and females with a common mental disorder in the NAPT second round

Gender	Expected n (%)	Observed n (%)
Female	76,003 (62)	79, 157 (65)
Male	46,582 (38)	43,428 (35)

- Chi square tests were conducted and showed a statistically significant difference between the two groups. The chi square value for males was $X^2 = 213.6$, $p<0.001$. These findings are similar to the baseline.

Total national sample (TNS) analysis – ethnicity

Of the 101,552 case records that had ethnicity recorded, 83% were 'White British'. Overall, ethnicity of service users was consistent with the baseline.

Table 19: Ethnicity of people completing treatment during the second round audit period

	Baseline	Second round
	% Num / Den*	% Num / Den
White – British	**84** 31,552 / 37,617	**83** 84,733 / 101,552
White – any other	**5** 1,783 / 37,617	**5** 5,075/101,552
Asian or Asian British - Indian	**2** 584 / 37,617	**2** 1,801/101,552
Any other ethnic group	**1** 544 / 37,617	**2** 1,606/101,522
Black or black British - Caribbean	**2** 638 / 37,617	**1** 1,345/101,552
Black or black British - African	**1** 372 / 37,617	**1** 987/101,552
Mixed – any other mixed background	**1** 272 / 37,617	**1** 966/101,552
White – Irish	**1** 391 / 37,617	**1** 959/101,552
Asian or Asian British – any other Asian background	**1** 335 / 37,617	**1** 850/101,552
Asian or Asian British - Pakistani	**1** 361 / 37,617	**1** 742/101,552
Mixed – white and black Caribbean	**1** 216 / 37,617	**1** 687/101,552
Chinese	**0** 97 / 37,617	**1** 474/101,552
Black or black British – any other black background	**1** 188 / 37,617	**0** 456/101,552
Asian or Asian British - Bangladeshi	**0** 99 / 37,617	**0** 343/101,552
Mixed – white and Asian	**0** 107 / 37,617	**0** 328/101,552
Mixed – white and black African	**0** 78 / 37,617	**0** 200/101,552

Comparisons to other datasets - ethnicity

Comparing the NAPT second round dataset to the ONS 2011 census[2] data, it does not appear that any particular ethnic groups are underrepresented.

As the Adult Psychiatric Morbidity Study[15] collected ethnicity data split by gender, we were unable to compare the NAPT second round data with this.

Summary – Standard 1b

Older adults continue to be underrepresented in the NAPT second round dataset. The gender and ethnicity of the NAPT second round sample is broadly in line with what we would expect and is consistent with the baseline. However, there are limits to the conclusions that can be drawn at a national level. It will be important for services to use their local data to assess whether people starting psychological therapy are representative of the local population in terms of age, gender and ethnicity.

Service user feedback on these findings:

It was felt that services have a responsibility to look into the reasons why older people are less likely to receive psychological therapy. Suggestions to improve access included providing home visits, employing older adult advocates and joint working with Age UK.

People felt that they lacked the information about the different services available to them and the ways that people can refer themselves. Suggestions were made to improve this by educating and promoting psychological therapy services in the local community.

Standard 2: Waiting time to assessment

A person who is referred for psychological therapy does not wait longer than 13 weeks from the time at which the initial referral is received to the time of the assessment.

Case record data were submitted for a total of 122,812 service users. However, waiting time to assessment data for 746 (<1%) of these were incorrect and data for 492 (<1%) were incomplete. A total of 121,574 service user case records were therefore included in the analysis for this standard.

Although all possible steps were taken to ensure the accuracy of the data included in the analysis for this standard, it is possible that some of the waiting times are the result of errors in the dates submitted.

Total national sample (TNS) analysis

In the second round, 92% (111,793 / 121,574) of service users were assessed within 13 weeks of their referral, which is an increase from the baseline percentage of 85%.

Table 20: Waiting time from referral to assessment in the baseline and second round NAPTs

	Baseline: TNS = 46,942		Second round: TNS = 121,574	
	Mean SD	Median Range	Mean SD	Median Range
Days	**51** 68.31	**29** 0-2047	**35** 48.95	**21** 0-1974
Weeks	**7** 10	**4** 0-292	**5** 6.99	**3** 0-282

Service level analysis

Due to the effect on the mean caused by the outliers, the median waiting times are used when comparing types of service.

Table 21: Percentage of service users, by service, who were assessed within 13 weeks of referral in baseline (N=214) and second round (N=187)

Baseline Median % Inter-quartile range	Second round Median % Inter-quartile range
80 60.7-95.1	**93** 76.5-98.8

Table 22: Percentage of service users, by service, who were assessed within 13 weeks of referral for services that have participated in both rounds and essentially stayed the same (N=71)

Baseline Median % Inter-quartile range	Second round Median % Inter-quartile range
81 70.0-93.8	**96** 71.9-99.0

Summary – Standard 2

Overall, this standard was met for 92% of service users. This is an increase from the baseline, which found that 85% of service users were seen for assessment within 13 weeks of their referral.

At a service level, the median percentage of service users meeting the standard was 93% (80% at baseline).

The median percentage of service users seen within 13 weeks has increased from 81% to 96% for the sub-group of services that participated in both the baseline and second round audits.

Service user feedback on these findings:

People who used psychological therapy services felt that treatment should be made available much earlier than the 13 and 18 week standards used by the NAPT audit. They felt that a standard wait of up to two weeks should be aimed for by services. This feedback fits with the finding that 28% of people receiving therapy felt that their waiting time for treatment was too long.

It was felt that contact should be made with people that are on waiting lists for psychological therapy. Alternatively, a buddy system could be offered to people. Both options could help minimise the uncertainty and feelings of abandonment described by some people whilst waiting for treatment.

Standard 3: Waiting time to treatment

A person who is assessed as requiring psychological therapy does not wait longer than 18 weeks from the time at which the initial referral is received to the time that treatment starts.

Case record data were submitted for 122,812 service users. However, the waiting time to treatment data for 15,229 (12%) were incomplete (either because the dates were missing or the service user had only an assessment and no treatment) and data for 518 (0.4%) were incorrect; a total of 107,065 service user case records were therefore included in the analysis for this standard.

Total national sample (TNS) analysis

In the second round, 91% (97,086 / 107,065) of service users began treatment within 18 weeks of their referral, which is an increase from the baseline of 85%.

Table 23: Waiting time from referral to treatment in the baseline and second round audits

	Baseline (TNS = 45,209)		Second round (TNS = 107,065)	
	Mean SD	Median Range	Mean SD	Median Range
Days	**69** 84.15	**41** 0-1800	**52** 73.4	**28** 0-1974
Weeks	**9** 12	**6** 0-257	**7** 10.5	**4** 0-282

Service level analysis

Due to the effect on the mean caused by the outliers, the median waiting times are used when comparing types of service.

Table 24: Percentage of service users who began treatment within 18 weeks of referral in the baseline (N=216) and second round (N=180) audits

Baseline Median % Inter-quartile range	Second round Median % Inter-quartile range
80 50-93.4	**91** 63.1-98.1

Table 25: Percentage of service users who began treatment within 18 weeks of referral for services that participated in both rounds and have essentially stayed the same (N=70)

Baseline Median % Inter-quartile range	Second round Median % Inter-quartile range
80 58-92.3	**92** 58.5-99.3

Summary – Standard 3

Overall this standard was met for 91% of service users in the second round. This is an increase from the baseline, which found that 85% of service users started treatment within 18 weeks.

At a service level, the median percentage of service users meeting this standard was 91%, an increase from the baseline where the median percentage of service users meeting the standard was 80%.

The median percentage of service users starting treatment within 18 weeks has increased from 80% to 92% for the sub-group of services that participated in both the baseline and second round audits.

Service user feedback on these findings:

See previous feedback under Standard 2.

Appropriateness:

Measurement against NAPT standards 4, 5 & 6

- Standard 4: Therapy in line with NICE guidance
- Standard 5: Satisfactory number of sessions
- Standard 6: Therapist training and supervision

- Percentages may not total 100 exactly due to rounding, e.g. 101 or 99
- TNS = total national sample, IQR = inter quartile range, N = services and n = service users
- Where numbers are shown, and this is appropriate, an improvement is shown in green and a worsening in red between the baseline and second round
- Where percentages are shown, and this is appropriate, improvements of >=5% are shown in green and worsening of >=5% in red between the baseline and second round
- Only services in the second round with 6 or more case records were used for the service level analysis. All available, appropriate and clean data were used for the TNS analyses.

Standard 4: Therapy in line with NICE guidance

The therapy provided is in line with that recommended by the NICE guideline for the service user's condition / problem

Further details about the NICE guidelines used for this standard are included in Appendix B.

Diagnostic categories

To align with the NHS minimum dataset and to support data extracts from NHS IT systems, the way diagnosis was recorded in the second round was amended slightly from the baseline. In the second round the ICD-10[16] categories were used rather than over-arching groupings, as in the baseline.

Inclusion of 'problem for which therapy was offered'

Some services reported in the baseline that they did not record a 'diagnosis' because of the theoretical position of the service or other reasons. Some of these services did report recording 'problem for which therapy is offered' and so this was included in the case record data collection tool and analysis of this standard. Therefore, some services that would have previously not been included in analysis for this standard, using the baseline data collection method of diagnosis only, now are. Twenty-four thousand, four-hundred and ninety-three (24,493) (20%) service users in the second round dataset who had a 'problem for which therapy was offered' recorded had no diagnostic information; these service users would previously not have been included in any analysis for this standard.

Case records included in analysis

The measurement of this standard required data on primary diagnosis and/or problem for which therapy was offered, as well as the type of therapy received. These data were obtained from the case record audit part of NAPT. A total of 39,525 case records were included in the analysis when using the primary diagnosis for which there is a relevant NICE guideline[3 4 5 6] and 34,990 when the problem for which therapy was provided was used. Further details of the steps

taken to select the sample are provided in the next sections, followed by the results of the two approaches to measuring the standard.

Total national sample (TNS) analysis

Diagnostic analysis - Total national sample (TNS)

Table 26: Percentage of service users who had primary diagnosis data in the baseline and in the second round audit

Baseline % Numerator / Denominator	Second round % Numerator / Denominator
54 26,855 / 49,963	**60** 73,349 / 122,812

- A total of 73,349 (60%) service users had a primary diagnosis and 8,922 (7%) service users had a secondary diagnosis recorded
- The proportion of service users with a diagnosis has increased since the baseline.

Table 27: Percentage of service users for each primary diagnosis

Primary diagnosis of anxiety or depressive disorder covered by a NICE guideline	n (%)
Depressive episode	19,589 (27)
Generalised anxiety disorder	8,694 (12)
Recurrent depressive episode	4,609 (6)
Panic disorder	4,168 (6)
Post-traumatic stress disorder	1,983 (3)
Obsessive compulsive disorder/ Body dysmorphic disorder	1,661 (2)
Agoraphobia	607 (<1)
Primary diagnosis of other disorders	
Mixed anxiety and depressive disorder	20,534 (28)
Other diagnosis	6,286 (9)
Social phobia	1,425 (2)
Specific (isolated) phobia	1,214 (2)
Adjustment disorders	789 (1)
Reaction to severe stress and adjustment disorders	585 (<1)
Somatoform disorders	553 (<1)
Bipolar affective disorder	246 (<1)
Other anxiety disorders	140 (<1)
Anxiety disorder, not otherwise specified	136 (<1)
Persistent mood disorder	68 (<1)
Phobic anxiety disorders	28 (<1)
Other mood disorder	23 (<1)
Acute stress reaction	11 (<1)
Total	**73,349**

- The most frequently reported primary diagnoses were mixed anxiety and depressive disorder (28%); depressive episode (27%) and generalised anxiety disorder (12%)
- The frequencies for the most commonly reported primary diagnoses are similar to those of the baseline audit.

Problem for which therapy was offered analysis - Total national sample (TNS)

24,493 (20%) service users in the second round dataset who had a 'problem for which therapy was offered' recorded had no diagnostic information. It should also be noted that 49% of service users in the second round audit sample did not have 'problem for which therapy was offered' recorded.

Table 28: Percentage of service users for each 'problem for which therapy was offered'

Problem for which therapy was offered	n (%)
Depression	22,095 (36)
Mixed anxiety and depression	19,180 (31)
Generalized anxiety disorder	8,634 (14)
Other diagnosis	3,759 (6)
Panic disorder (with or without agoraphobia)	2,830 (5)
Other anxiety disorder	1,821 (3)
Post-traumatic stress disorder	1,289 (2)
Obsessive compulsive disorder	1,119 (2)
Specific (isolated phobias)	764 (1)
Social phobias	546 (<1)
Body dysmorphic disorder	12 (<1)
Total	**62,049**

- The most frequently reported presenting problems were depression (36%); mixed anxiety and depression (31%); and generalized anxiety disorder (14%).

Measurement of the standard using primary diagnosis – total national sample (TNS)

Table 29: Percentage of service users who received a NICE recommended therapy in the baseline and second round

Primary Diagnosis	Baseline % Num / Den	Second round % Num / Den
Obsessive compulsive disorder/ Body dysmorphic disorder	**90** 664 / 741	**91** 1,456 / 1,594
Generalised anxiety disorder	**82** 3,004 / 3,662	**83** 6,913 / 8,335
Panic disorder/ agoraphobia	**89** 855 / 961	**78** 3,621 / 4,667
Depressive Episode or Recurrent or chronic depression	**82** 6,979 / 8,499	**78** 17,867 / 23,051
Post-traumatic stress disorder	**75** 525 / 698	**72** 1,357 / 1,878
Total	**83** **12,027 / 14,561**	**79** **31,214 / 39,525**

- The overall proportion of service users with a primary diagnosis that had a NICE anxiety or depression guideline relating to it was 56% (41,311 / 73,349). Of these, 39,525 had data on the type of therapy received
- Overall, it was found that 79% received therapy in line with NICE guidance
- The proportion of service users receiving a NICE recommended therapy has predominantly stayed the same with the exception of 'panic disorder/agoraphobia', where there has been an 11% reduction. This may be partly explained by the fact that 62% of those that did not receive the NICE recommended therapy for panic disorder were recorded as receiving 'other therapy'. Recoding the 'other therapy' free text answers might have resulted in a greater proportion being recorded as receiving a NICE-recommended therapy. Although this was possible to do in the baseline, the much larger sample in the second round meant that this was not a feasible task.

Measurement of the standard using presenting problem - total national sample (TNS)

Table 30: Percentage of service users who received a NICE recommended therapy according to the problem for which therapy was offered

Problem for which therapy was offered	Second round % Numerator / Denominator
Obsessive compulsive disorder/ body dysmorphic disorder	**87** 972 / 1,113
Generalised anxiety disorder	**80** 6,777 / 8,491
Depressive episode or recurrent or chronic depression	**75** 16,074 / 21,381
Panic disorder/ agoraphobia	**73** 2,030 / 2,775
Post-traumatic stress disorder	**65** 796 / 1,230
Total	**76** **26,649 / 34,990**

- The overall proportion of service users with a 'problem for which therapy was offered' that had a NICE anxiety or depression guideline relating to it was 58% (35,979 / 62,049). Of these, 34,990 had data on therapy received
- Overall, it was found that 76% of these service users received therapy in line with NICE guidance. This is a similar finding to that for service users with a primary diagnosis.

Service level analysis

Diagnostic data completeness – service level

Table 31: Percentage of service users who have primary diagnosis/problem for which therapy was offered data in the baseline and second round of NAPT

	Baseline: N services = 224 Median % Inter-quartile range	Second round: N services = 190 Median % Inter-quartile range
Primary diagnosis	**96** 41.7-100	**92** 55.5-100
Primary presenting problem	**N/A**	**91** 26.4-100

- There was a slight decrease in the median proportion of service users by service with primary diagnosis data
- There are no notable differences between the proportion of service users with data on primary diagnosis and data on problem for which therapy was offered
- There was a marked increase in diagnostic data completeness between the baseline and second round for the sub-sample of services that took part in both rounds and fundamentally stayed the same (N=74); the median percentage of service users with a diagnosis increased from 73 to 88%.

Performance against the standard – service level

Table 32: Percentage of service users by service with a primary diagnosis of anxiety or depression who received a NICE recommended therapy

Baseline: N services =173 Median % Inter-quartile range	Second round: N services =168 Median % Inter-quartile range
87 77.5-96.4	**82** 69.3-93.3

- There has been a 5% decrease in the median proportion of service users by service receiving a NICE-recommended therapy

- At a national level there are no notable differences in performance against the standard when primary presenting problem is used instead of primary diagnosis.

Table 33: Percentage of service users who received a NICE-recommended therapy in the baseline audit and in the second round audit for the sub-group of services taking part in both rounds (N = 55)

Baseline Median % Inter-quartile range	Second round Median % Inter-quartile range
89 82.8-97.6	**82** 73.9-93.2

- The median proportion of people by service who received a NICE-recommended therapy decreased between the baseline and second round.

Summary – Standard 4

Overall, this standard was met for 79% of service users who had a primary diagnosis of anxiety or depression covered by a NICE guideline. This is broadly in line with the baseline finding of 83%.

At a service level, the median proportion of patients with a primary diagnosis of anxiety or depression who received a NICE-recommended therapy was 82%. This was a reduction from the baseline, which reported a median proportion of 87%.

Service users with a primary diagnosis of obsessive compulsive disorder / body dysmorphic disorder were most likely to receive therapy in line with NICE guidance (91%) and service users with a diagnosis of post traumatic stress disorder were least likely to receive therapy in line with NICE guidance (72%).

Service user feedback on these findings:

People felt that both GPs and services should have up to date knowledge about the clinical guidelines and the types of therapies offered for different mental

health conditions. It was felt that this would help to avoid inappropriate referrals, too many assessments and long waiting times.

Standard 5: Satisfactory number of treatment sessions

Treatment for high intensity psychological therapy is continued until recovery or for at least the minimum number of sessions recommended by the NICE guideline for the service user's condition / problem.

The analysis for this standard used data from the retrospective case record audit and included those service users who:

- Had attended two or more therapy sessions, and
- Had a primary diagnosis of anxiety or depression for which there is a NICE guideline [3 4 5 6], and
- Received a NICE-recommended high intensity therapy.

Therefore, only those who met Standard 4 (the therapy provided is in line with that recommended by the NICE guideline for the service user's condition/problem) and received two or more high intensity therapy sessions were included. The resultant sample comprised 17,313 service users.

Total national sample analysis (TNS)

Recommended number of sessions – total national sample (TNS)

Table 34: Percentage of service users with a primary diagnosis of anxiety or depression who received a NICE high intensity therapy and the NICE recommended number of sessions

Primary diagnosis	Baseline % Num / Den	Second round % Num / Den
Panic disorder/agoraphobia	**62** 307 / 494	**59** 1,051 / 1,784
Post-traumatic stress disorder	**61** 304 / 499	**56** 672 / 1,196
Obsessive compulsive disorder/ body dysmorphic disorder	**56** 325 / 585	**52** 611 / 1,173
Depressive episode or recurrent or chronic depression	**24** 1,151 / 4,872	**25** 2,551 / 10,425
Generalised anxiety disorder	**18** 225 / 1,280	**19** 529 / 2,735
Total	**30** **2,312 / 7,730**	**31** **5,414 / 17,313**

- Just under a third of service users in the audit sample received the recommended number of sessions of high intensity therapy according to the NICE guidance for their condition/problem; 69% did not
- Those service users with a diagnosis of panic disorder / agoraphobia were most likely to receive the NICE-recommended number of sessions; this was the case for over half of patients with this diagnosis
- These findings are similar to the baseline.

Determining caseness, recovery and reliable improvement - TNS

The approach to determining caseness took account of the different types of outcome measures that were used in participating services and was based on the following algorithm:

- If both the Patient Health Questionnaire (PHQ-9) and the Generalised Anxiety Disorder Assessment (GAD-7) had been used then caseness was defined as above the cut-off on at least one of these

- If they had not both been used, but there was a pre-treatment Clinical Outcomes in Routine Evaluation (CORE) score then caseness was defined as above the cut-off on CORE
- If the above did not apply, the measure used depended on the primary diagnosis:
    - If the primary diagnosis was depression, a measure of depression was used with the following order of priority: PHQ-9, Hospital Anxiety and Depression Scale for Depression (HADS-D), Beck Depression Inventory (BDI).
    - If the primary diagnosis was an anxiety disorder, then a measure of anxiety was used with the following order of priority: GAD-7, Hospital Anxiety and Depression Scale for Anxiety (HADS-A), Beck Anxiety Inventory (BAI).

Following this algorithm, 86% (14,876 / 17,313) of the sample met caseness criteria pre-treatment and had post-treatment scores that could be used to determine recovery and improvement rates. 'Recovery' was defined as moving from caseness to non-caseness based on the algorithm above. 'Reliable improvement' was determined by calculating the reliable change index for the relevant measure (Jacobson & Truax, 1991)[17].

Of those service users (14,876) it was found that:

- 6,848 / 14,876 (46%) recovered
- 2,134 / 14,876 (14%) did not recover, but showed reliable improvement
- 5,894 / 14,876 (40%) neither recovered nor showed reliable improvement.

Number of sessions in relation to recovery and reliable improvement – total national sample (TNS)

Of the 14,876 sample who met caseness criteria pre-treatment and for whom both pre- and post-treatment scores were available, it was found that 10,181 (68%) did not have the minimum recommended number of sessions.

Of those service users (10,181) it was found that:

- 4,405 / 10,181 (43%) recovered
- 1,398 / 10,181 (14%) did not recover but made reliable improvement
- 4,378 / 10,181 (43%) neither recovered nor made reliable improvement.

Reasons for ending therapy before the recommended number of sessions – total national sample (TNS)

Of the 17,313 service users included for this standard, 11,899 service users did not receive the recommended number of sessions.

Table 35: Reasons for ending therapy for those service users who ended therapy before the recommended number of sessions

Reason why therapy ended	n (%)
Completed treatment	7,338 (62)
Dropped out/unscheduled discontinuation	2,763 (23)
Declined treatment	796 (7)
Referral to another service	596 (5)
Not suitable for service	309 (3)
Not known	70 (<1)
Deceased	5 (<1)
Total	**11,877**
Missing	22

- The most frequent reasons for therapy ending were completing treatment (62%) or dropping out/unscheduled discontinuation (23%).

Reasons for ending therapy for service users who did not receive the recommended number of sessions and neither clinically nor reliably improved

Table 36: Reasons for ending therapy for those service users who ended therapy before the recommended number of sessions and neither recovered nor reliably improved (n=4,378)

Reason why therapy ended	n (%)
Completed treatment	1,702 (39)
Dropped out/unscheduled discontinuation	1,570 (36)
Declined treatment	461 (11)
Referral to another service	379 (9)
Not suitable for service	217 (5)
Not known	37(<1)
Deceased	3(<1)
Total	**4,369**
Missing	9

National level summary

The percentage of service users who met the standard was calculated by adding:

- The percentage of service users who had received the recommended number of sessions of high intensity therapy, depending on therapy type and their condition, and
- The percentage of service users who had not received the recommended number, but who had recovered.

Table 37: Percentage of service users who received the recommended number of NICE high intensity therapy sessions or who recovered

	Baseline % Num / Den	Second round % Num / Den
Received recommended number of sessions	**30** 2,312 / 7,730	**31** 5,414 / 17,313
Did not receive recommended number of sessions, but recovered	**24** 1,844 / 7,730	**25** 4,405 / 17,313
Total: received recommended number of sessions or recovered	**54** **4,156 / 7,730**	**57** **9,819 / 17,313**

- A total of 9,819 service users (57%) continued treatment for at least the minimum number of sessions recommended by the relevant NICE guideline or until recovery. This was similar to the baseline figure of 54%.

Service level analysis

Table 38: Percentage of service users by service who received the recommended number of NICE high intensity therapy sessions or who recovered

Baseline: N services = 149 Median % Inter-quartile range	Second round: N services = 147 Median % Inter-quartile range
56 42.3-65.7	**60** 52.4-67.1

- The calculation of the percentage for some services was based solely on the number of sessions, as they had not provided usable outcome data
- The median number of service users by service who received the NICE-recommended number of therapy sessions or recovered was similar to the baseline.

Table 39: Percentage of service users who received the NICE-recommended number of sessions or recovered for the sub-sample of services taking part in both rounds (N=45)

Baseline Median % Inter-quartile range	Second round Median % Inter-quartile range
56 47.3-65.9	**60** 53.7-66.7

- There were no notable changes in performance against the standard between the two rounds of the audit for this sub-sample of services.

Summary – Standard 5

Overall, this standard was met for 57% of service users. At a service level, the median percentage of service users who received the recommended number of sessions or who recovered was 60%. These are similar to the baseline figures, which were 54% and 56% respectively.

31% of service users received the minimum number of sessions recommended in the specific NICE depression or anxiety disorder guideline for the service user's condition/problem.

The diagnosis most likely to receive the recommended number of sessions was panic disorder / agoraphobia (59%) and the diagnosis least likely was generalised anxiety disorder (19%).

Service user feedback on these findings:

People receiving psychological therapies felt strongly about the need for services to be flexible with the number of sessions they provide and to make sure that this is tailored to what each person needs. This feedback fits with the finding that 15% of people receiving therapy felt that they did not receive the right number of sessions.

Standard 6: Therapist supervision and training

Therapists are providing therapy under supervision, and have received formal training to deliver the therapy provided.

Data from 4,661 therapists were included in the analysis for this standard. This section first presents the level of training for each high and low intensity therapy, followed by therapist ratings of the quality of supervision and level of organisational support with meeting continuing professional development (CPD) requirements. Formal training and supervision across therapies and services are then presented at a therapist and service level.

High intensity therapies and level of training -TNS

4,208 therapists reported that they provide high intensity therapies. Table 40 presents the highest level of training for each high intensity therapy provided. Therapists were most likely to have completed formal training in cognitive behavioural therapy (CBT), behavioural activation, person-centred therapy and counselling. Arts psychotherapies, dialectical behavioural therapy and cognitive analytic therapy had the highest proportion of therapists reporting that they had not received any formal training (>40%). These were also the least frequently provided high intensity therapies. Further information on therapies being provided without formal training is presented in Fig 2.

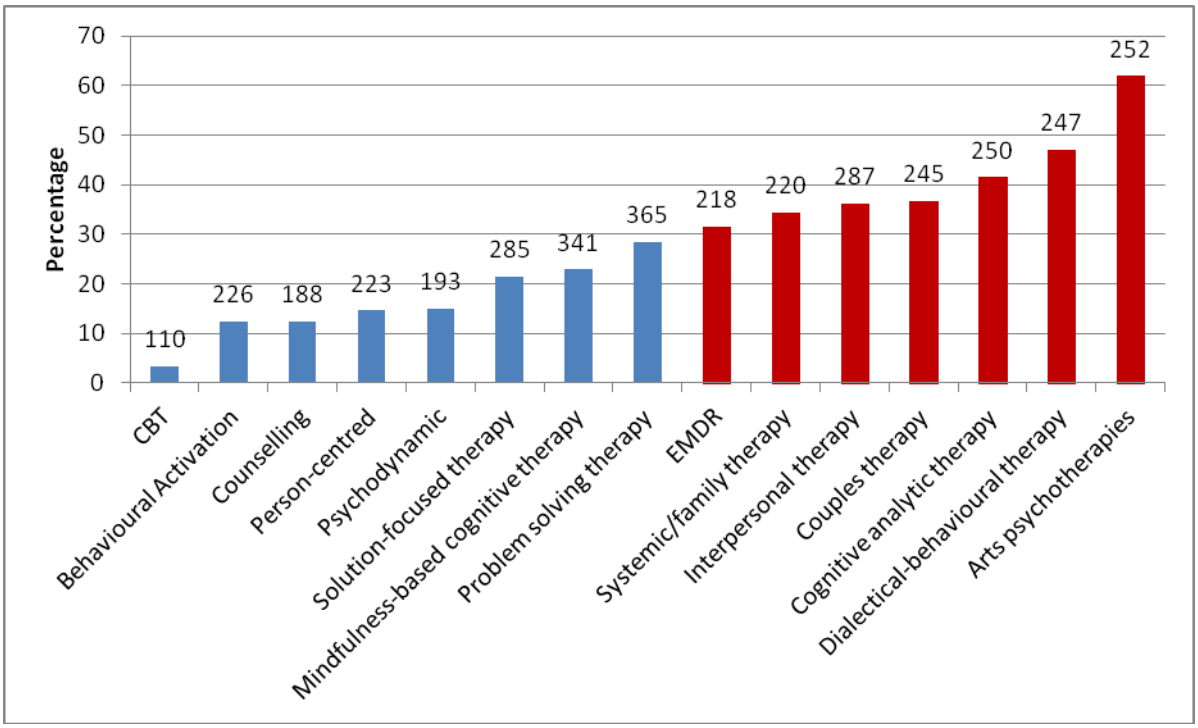
Table 40: The highest level of training reported by therapists for each high intensity therapy they provided (n=4,208)

	Formal training completed % Num / Den	Currently undertaking formal training % Num / Den	Post-qualification CPD e.g. short workshops % Num / Den	Working with supervision (without training) % Num / Den	No formal training % Num / Den
Cognitive behavioural therapy (CBT) *	**65** 2133 / 3,260	**10** 337 / 3,260	**16** 525 / 3,260	**5** 155 / 3,260	**3** 110 / 3,260
Behavioural activation*	**57** 1036 / 1,815	**8** 140 / 1,815	**15** 265 / 1,815	**8** 148 / 1,815	**12** 226 / 1,815
Person-centred	**61** 933 / 1,527	**5** 75 / 1,527	**13** 203 / 1,527	**6** 93 / 1,527	**15** 223 / 1,527
Counselling*	**71** 1067 / 1,509	**4** 64 / 1,509	**8** 125 / 1,509	**4** 65 / 1,509	**12** 188 / 1,509
Mindfulness-based cognitive therapy*	**14** 207 / 1,493	**4** 66 / 1,493	**41** 608 / 1,493	**18** 271 / 1,493	**23** 341 / 1,493
Solution focused therapy	**22** 292 / 1,336	**2** 26 / 1,336	**44** 591 / 1,336	**11** 142 / 1,336	**21** 285 / 1,336
Psychodynamic therapy*	**46** 597 / 1,284	**13** 172 / 1,284	**16** 209 / 1,284	**9** 113 / 1,284	**15** 193 / 1,284
Problem solving therapy	**31** 401 / 1,284	**4** 52 / 1,284	**23** 291 / 1,284	**14** 175 / 1,284	**28** 365 / 1,284
Interpersonal therapy (IPT)*	**24** 191 / 795	**10** 83 / 795	**20** 161 / 795	**9** 73 / 795	**36** 287 / 795
Eye-movement desensitisation & reprocessing* (EMDR)	**45** 310 / 690	**14** 94 / 690	**9** 63 /690	**1** 5 / 690	**32** 218 / 690
Couples therapy*	**27** 177 / 667	**5** 34 / 667	**23** 151 / 667	**9** 60 / 667	**37** 245 / 667
Systemic/family therapy	**22** 143 / 640	**6** 35 / 640	**30** 193 / 640	**8** 49 / 640	**34** 220 / 640

	Formal training completed % Num / Den	Currently undertaking formal training % Num / Den	Post-qualification CPD e.g. short workshops % Num / Den	Working with supervision (without training) % Num / Den	No formal training (%) Num / Den
Cognitive analytic therapy (CAT)	**19** 115 / 603	**6** 35 / 603	**24** 143 / 603	**10** 60 / 603	**41** 250 / 603
Dialectical behavioural therapy (DBT)	**13** 69 / 524	**1** 5 / 524	**30** 156 / 524	**9** 47 / 524	**47** 247 / 524
Arts psychotherapies	**17** 68 / 407	**1** 5 / 407	**16** 67 / 407	**4** 15 / 407	**62** 252 / 407

- The type of high intensity therapy is presented according to the frequency of provision
- * denotes NICE-recommended therapy
- The colours used in this table are used to highlight the acceptable (green) through to the unacceptable (red) levels of training for the provision of these high intensity therapies

Figure 2: Percentage of therapists with no formal training in high intensity therapies from the second round of NAPT (n=860)



- Seven high intensity therapies had >30% therapists delivering them without any formal training; 3 of which are NICE recommended therapies for anxiety and depression
- In the baseline, five high intensity therapies had >30% therapists delivering them without any formal training. All five still had >30% therapists delivering them without any formal training in the second round. The two additional high intensity therapies that had >30% therapists delivering them without formal training were systemic/family therapy and cognitive analytic therapy (21% and 29% respectively in the baseline)
- Of the 252 therapists that were delivering arts psychotherapies with no formal training, 211 (84%) had completed formal training in at least one other therapy.

Low intensity therapies and level of training - TNS

3,245 therapists reported that they provide low intensity therapies. The data on level of training for low intensity therapies are presented in the same format as high intensity therapies (see Table 41 and Fig 3). As can be seen, therapists

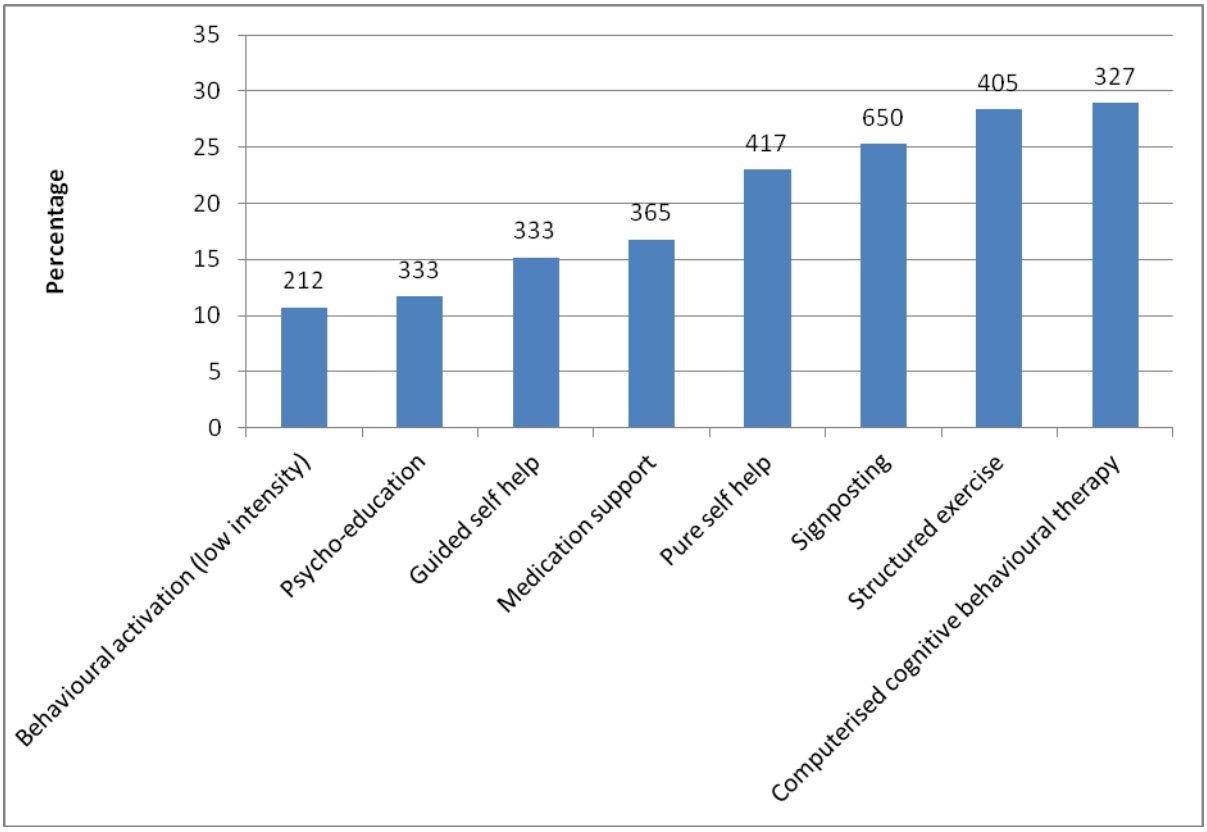
were most likely to have completed formal training in psycho-education, medication support, behavioural activation and guided self help. No low intensity therapies had >30% therapists delivering them without any formal training. This is an improvement from the baseline, which found that 33% of therapists delivering computerized cognitive behavioural therapy had received no formal training.

Table 41: Level of training for low intensity therapies provided from the second round of NAPT (n=3,245)

	Formal training completed % Num / Den	Currently undertaking formal training % Num / Den	Post-qualification CPD e.g. short workshops % Num / Den	Working with supervision (without training) % Num / Den	No formal training % Num / Den
Psycho-education *	**57** 1,626 / 2,853	**7** 208 / 2,853	**12** 354 / 2,853	**12** 332 / 2,853	**12** 333 / 2,853
Signposting	**39** 1,011 / 2,574	**6** 142 / 2,574	**10** 247 / 2,574	**20** 524 / 2,574	**25** 650 / 2,574
Guided self help*	**52** 1,136 / 2,200	**7** 160 / 2,200	**12** 272 / 2,200	**14** 299 / 2,200	**15** 333 / 2,200
Support with medication	**53** 1,166 / 2,182	**6** 140 / 2,182	**11** 240 / 2,182	**12** 271 / 2,182	**17** 365 / 2,182
Behavioural activation*	**59** 1,168 / 1,978	**9** 170 / 1,978	**12** 230 / 1,978	**10** 198 / 1,978	**11** 212 / 1,978
Pure self help *	**44** 806 / 1,815	**5** 92 / 1,815	**11** 208 / 1,815	**16** 292 / 1,815	**23** 417 / 1,815
Structured exercise *	**42** 601 / 1,429	**5** 73 / 1,429	**11** 162 / 1,429	**13** 188 / 1,429	**28** 405 / 1,429
Computerised cognitive behavioural therapy*	**40** 447 / 1,131	**4** 50 / 1,131	**17** 189 / 1,131	**10** 118 / 1,131	**29** 327 / 1,131

- *NICE recommended therapies

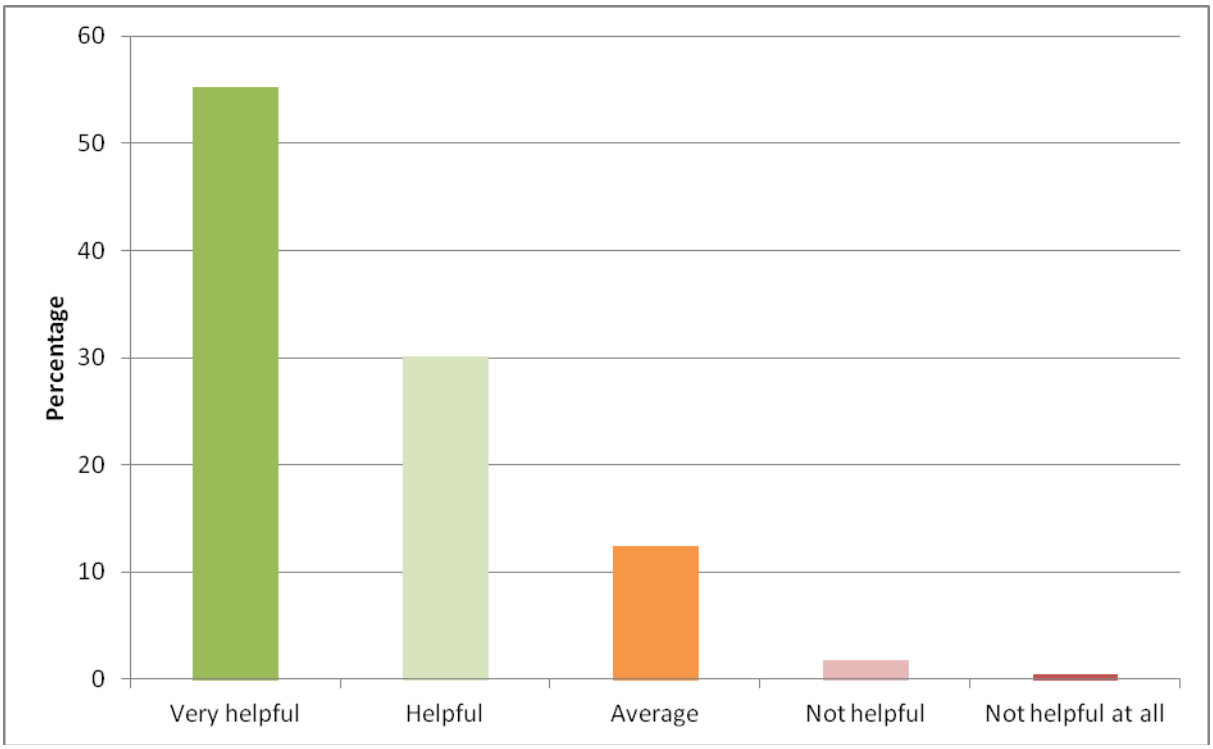
Figure 3: Percentage of therapists with no formal training in low intensity therapies from the second round of NAPT (n=1,149)



Supervision - TNS

4,533 (98%) therapists reported that they received formal supervision, 66 (1%) reported that they did not receive supervision and 47 (1%) preferred not to say.

Figure 4: Ratings from therapists in the second round for the question 'How would you rate the formal supervision you receive for your psychological therapy work in this service (e.g. frequency, quality, appropriateness)?' (n=4,533)

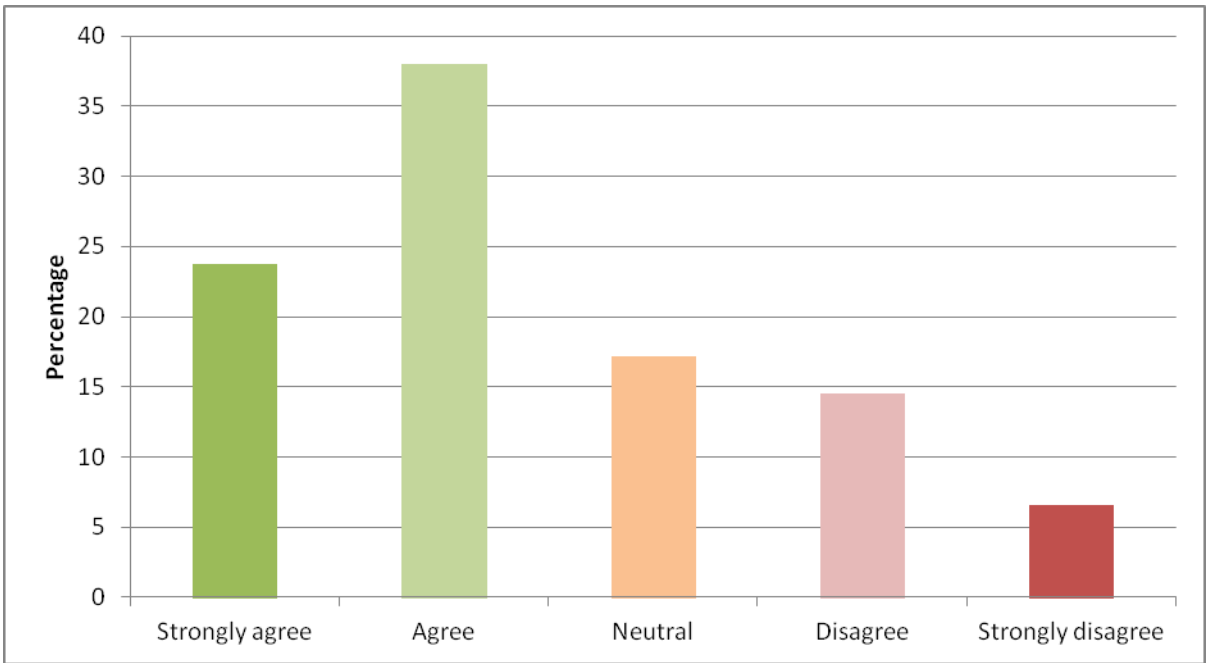


41% (1,892 / 4,661) therapists reported that they provided supervision. Although the majority had been trained to provide supervision, of the 1,892, 238 (13%) had not received any training and 20 (1%) preferred not to say. A total of 30 / 1,892 (2%) therapists indicated that they were supervising other therapists' clinical work, whilst not receiving any supervision themselves.

Appraisals and continuing professional development - TNS

Although 4,102 (88%) therapists said that they had at least one annual appraisal, there were mixed views about the level of support with meeting the CPD requirements of professional bodies.

Figure 5: Level of agreement with the statement "The CPD support I receive from this service/organisation is sufficient to meet the requirements of my professional body" (n=3,405)



- Almost a quarter of respondents did not think that they were getting sufficient support from the service/organisation to meet the CPD requirements of their professional body.

Formal training and supervision across therapies and services - TNS

Formal training and supervision were investigated separately and in combination for all therapists (see Table 42).

Table 42: Formal training and supervision across therapists

	Second round % num / den
Completed formal training in at least one therapy	**83** 3,852 / 4,661
Completed or currently undertaking formal training in at least one therapy	**93** 4,332 / 4,661
In receipt of formal supervision	**97** 4,533 / 4,661
Completed formal training and working under supervision	**80** 3,748 / 4,661
Completed or currently undertaking formal training and working under supervision	**91** 4,218 / 4,661

Service level analysis

Formal training and supervision - service level analysis

Table 43: Formal training and supervision at a service level

	Baseline: N services = 205 Median % IQR	Second round: N services = 185 Median % IQR
Completed formal training in at least one therapy	**86** 73.0-95.3	**86** 76.8-94.4
Completed or currently undertaking formal training in at least one therapy	**97** 89.7-100	**95** 89.8-100
Completed formal training and working under supervision	**N/A**	**84** 74.5-93.4
Completed or currently undertaking formal training and working under supervision	**N/A**	**93** 85.7-100

- The median percentage of therapists who had received formal training in at least one therapy was consistent with the baseline finding.

Table 44: Proportion of therapists with formal training for services that participated in both rounds and fundamentally stayed the same (N=69)

	Baseline Median IQR	Second round Median IQR
Completed formal training in at least one therapy	**85** 72.5-94.5	**89** 77.4-94.8
Completed or currently undertaking formal training in at least one therapy	**96** 89.4-100.0	**95** 91.4-100

- Performance against the standard for this sub-group of services is broadly consistent with the baseline.

Summary – Standard 6

At a therapist level, 80% had completed formal training in at least one therapy and were working under supervision.

At a service level, the median percentage of therapists who had received formal training in at least one therapy was 86%, which is the same as the baseline.

When supervision was included, there was a small reduction in the median percentage of therapists meeting the standard (84%).

The following seven high intensity therapies had more than 30% therapists delivering them without any formal training: eye movement desensitisation and reprocessing, systemic/family therapy, interpersonal therapy, couples therapy, cognitive analytic therapy, dialectical behaviour therapy and arts psychotherapies .

Service user feedback on these findings:

People were surprised at the finding that for seven psychological therapies, more than 30% of therapists were delivering them without formal training. It was felt that therapists and GP training should be kept up to date. More therapists with lived experience should be employed and more peer support provided.

Acceptability:

Measurement against NAPT standards 7 & 8

- Standard 7: Service user choice
- Standard 8: Satisfaction with treatment

- Percentages may not total 100 exactly due to rounding, e.g. 101 or 99
- TNS = total national sample, IQR = inter quartile range, N = services and n = service users
- Where numbers are shown, and this is appropriate, an improvement is shown in green and a worsening in red between the baseline and second round
- Where percentages are shown, and this is appropriate, improvements of >=5% are shown in green and worsening of >=5% in red between the baseline and second round
- Only services in the second round with 6 or more case records were used for the service level analysis. All available, appropriate and clean data were used for the TNS analyses.

Standard 7: Service user choice

Service users report being provided with information and choice about their treatment.

This standard was assessed by using data from the service user questionnaire 'Talking Treatment'. The sample included a total of 14,587 respondents (demographic data are included in the contextual data section of this report).

Total national sample (TNS) analysis

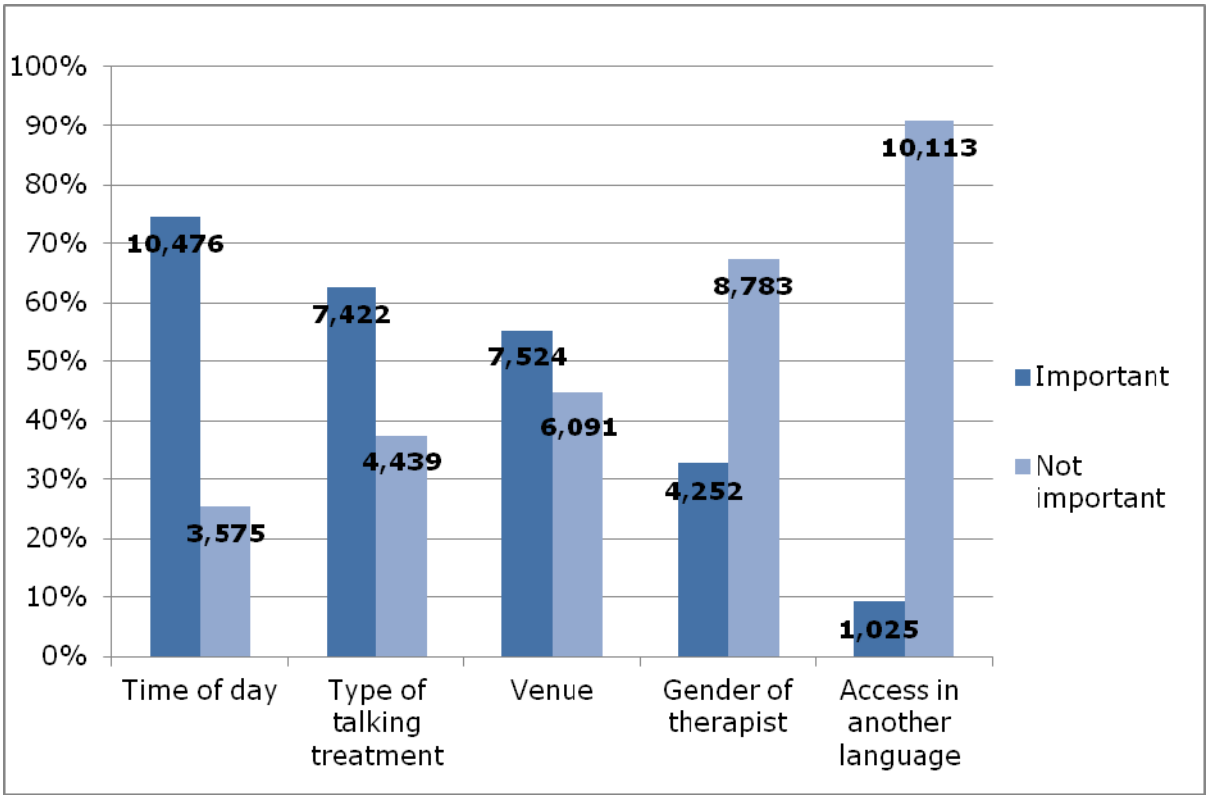
Table 45 shows the responses to the choice questions in the second round service user questionnaire (n=14,587).

Table 45: Responses to the choice questions in the second round service user questionnaire (n=14,587)

	This was important to me and I was given enough choice n(%)	This was important to me but I was not given enough choice n (%)	This was not important to me - I had no strong preference either way n (%)	Unsure n (%)	Missing n
I was offered choice about the venue where my talking treatment would take place	5,282 (37)	2,242 (16)	6,091 (42)	764 (5)	208
I was offered choice about the time of day my talking treatment would take place	8,639 (60)	1,837 (13)	3,575 (25)	375 (3)	161
I was offered choice about the gender of my therapist	1,769 (12)	2,483 (17)	8,783 (62)	1,244 (9)	308
I was offered my talking treatment in another language or with an interpreter	643 (5)	382 (3)	10,113 (79)	1,630 (13)	1,819
I was offered choice about the type of talking treatment I would receive	4,981 (35)	2,441 (17)	4,439 (31)	2,405 (17)	321

Importance of choice

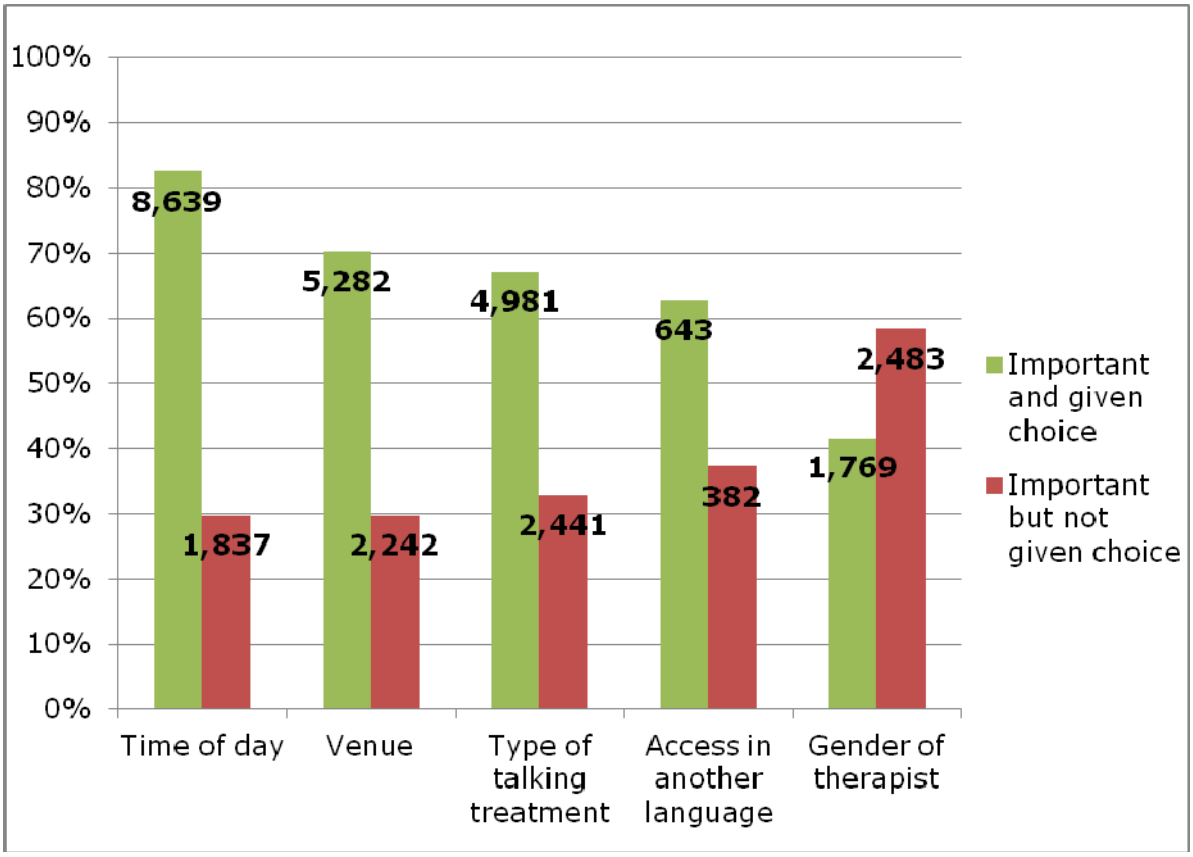
Figure 6: Percentage of service users reporting importance of choice



- Time of day was reported most often (75%) as being important to service users
- Although access in another language was the least frequently reported, the demography of the sample needs to be taken into account when interpreting this finding. That is, it is likely to have been 'not applicable' rather than 'not important' for a large proportion of respondents.

Provision of choice

Figure 7: Provision of choice



- As well as being the aspect of choice that was most frequently reported, time of day was the aspect of choice most frequently met
- Choice of therapist gender was highlighted as the area that was being met the least.

Service level analysis

Table 46: Service users in the second round who were given a choice, if they identified that it was important to them

Area of choice	N services	Median % Inter-quartile range
Time	162	**84** 77.3-91.2
Venue	152	**70** 58.1-78.1
Type of talking treatment	153	**68** 57.1-75.1
Access in another language	58	**63** 50.0-80.8
Therapist gender	144	**43** 30.0-53.5

- Provision of choice was a new area included in the second round audit and therefore cannot be compared to baseline findings

Summary – Standard 7

Choice of time of day was seen as the most important with 75% of service users reporting that it was important to them.

Choice of time of day was also the aspect of choice that was being met most frequently with 82% of service users reporting that they had been given enough choice.

At a service level, the median percentage of service users reporting sufficient choice of time of day was 84%.

Choice of therapist gender was highlighted as the aspect of choice that was met the least. At a service level, the median percentage of service users reporting sufficient choice of therapist gender was 43%.

Service user feedback on these findings:

People felt strongly that services should take action to reduce dissatisfaction and improve the level of choice that people receive about the gender of their therapist, and the time and location of their appointments. This feedback is consistent with the finding that 16% of people receiving therapy had not been given enough choice about the gender of their therapist. It was felt that services should employ enough staff to be able to offer this level of choice and felt that it would be important for therapists to review how satisfied people are with this choice.

Standard 8: satisfaction with treatment

Service users report a high level of satisfaction with the treatment that they receive.

This standard was assessed by using data from the service user survey 'Talking Treatment'. The sample included a total of 14,587 respondents, demographic and clinical information for the respondents is provided in the contextual data section of this report. The measurement of the standard was divided into two parts:

- Access to services
- Experience of therapy.

It is important to note the way that the service users were asked to respond differed between the baseline and second round. In the baseline response answers were 'yes' and 'no' and in the second round a Likert scale was used.

Total national sample (TNS) analysis - access to services

Table 47: Service user responses about access to talking therapy (original 5 items from the baseline) from the second round service user questionnaire

	Strongly or slightly agree n (%)	Unsure n (%)	Strongly or slightly disagree n (%)	Missing n
I was referred for talking treatment at the right time	10,969 (76)	1,513 (11)	1,883 (13)	222
The waiting time for my talking treatment to start was reasonable	9,621 (67)	693 (5)	4,093 (28)	180
My appointment was scheduled on a day/time that was convenient to me	13,393 (92)	228 (2)	813 (6)	153
I was able to get to my appointment location without much difficulty	13,439 (94)	186 (1)	697 (5)	265
I received enough information about my talking treatment before it began	11,243 (78)	1,400 (10)	1,776 (12)	168
Total	**58,665 (82)**	**4,020 (6)**	**9,262 (13)**	

- The positive responses column in this table has been highlighted green and the negative responses column red
- As found in the baseline, the highest levels of satisfaction were the time and location of the appointment
- The waiting time for treatment to start had the lowest proportion of positive responses with only two thirds of respondents reporting that they thought it was a reasonable wait
- It should be noted that the calculation of percentages did not include missing data.

Total national sample (TNS) analysis - experience of therapy

Table 48: Service user responses about experience of talking therapy (original 5 items from the baseline) from the second round service user questionnaire

	Slightly agree or strongly agree (%)	Unsure (%)	Strongly or slightly disagree (%)	Missing
The talking treatment helped me to understand my difficulties	12,783 (89)	827 (6)	806 (6)	171
I am getting the right kind of help	11,248 (78)	2,011 (14)	1,113 (8)	215
I am receiving the right number of sessions of talking treatment	9,590 (67)	2,554 (18)	2,075 (15)	368
If I have similar difficulties in the future, I would take up this talking treatment again	11,976 (83)	1,491 (10)	929 (7)	191
This talking treatment helps me cope with my difficulties	11,911 (83)	1,300 (9)	1,177 (8)	199
Total	**57,508 (80)**	**8,183 (11)**	**6,100 (8)**	

- The positive responses column in this table has been highlighted green and the negative responses column red
- As in the baseline, the highest satisfaction level was for helping service users to understand their difficulties
- The aspect that service users were least satisfied with was the number of sessions that were receiving; only two thirds thought that they were receiving the right number of sessions
- As previously, the calculation of percentages did not include missing data.

Table 49: Responses to the additional experience questions included in the second round service user questionnaire

	Slightly agree or strongly agree (%)	Unsure (%)	Strongly or slightly disagree (%)	Missing
I feel that my needs were taken seriously, understood and appropriately considered	13,040 (91)	587 (4)	780 (5)	180
I am asked by the therapist to give feedback on how helpful I am finding the treatment	10,094 (71)	2,346 (16)	1,817 (13)	330
I understand where my information is kept who can see it and when it might be shared	8,063 (56)	3,776 (26)	2,509 (18)	239
I have experienced lasting bad effects from the treatment	763 (5)	1,099 (8)	12,408 (87)	317

- The positive responses in this table have been highlighted green and the negative responses column red, please note the last item was reverse scored.

Table 50: Percentage of service users who showed satisfaction with their treatment, at the level of the service user

	Agreed or strongly agreed % Numerator / Denominator
Access (original 5 items also asked in the baseline)	**82** 58,665 / 71,947
Experience (original 5 items also asked in the baseline)	**80** 57,508 / 71,791
Needs taken seriously, understood and appropriately considered	**91** 13,040 / 14,407
Asked by therapist to give feedback	**71** 10,094 / 14,257
Information storage and confidentiality	**56** 8,063 / 14,348
Lasting bad effects	**5** 763 / 14,270

Service level analysis

Table 51: Percentage of service users who showed satisfaction with their treatment, at the service level

	Baseline: N services=235 Median % Inter-quartile range	Second round: N services=174 Median % Inter-quartile range
Access	**86** 81.0-89.0	**82** 76.5-86.3
Experience	**92** 88.0-95.0	**81** 76.9-86.8
Needs taken seriously, understood and appropriately considered	**N/A**	**92** 88.4-96.5
Asked by therapist to give feedback	**N/A**	**73** 66.7-80.1
Information storage and confidentiality	**N/A**	**58** 50.0-66.3
Lasting bad effects	**N/A**	**6** 2.8-7.7

- Satisfaction with accessing services is similar to the baseline, but satisfaction with the experience of therapy is lower this time
- The changes to the response scale need to be taken into account when making comparisons between the baseline audit and the second round audit.

Table 52: Satisfaction levels for the sub-group of services that participated in both rounds of the audit (N=60)

	Baseline Median % Inter-quartile range	Second round Median % Inter-quartile range
Access	**85** 81.0-88.0	**82** 75.6-86.4
Experience	**90** 88.0-94.8	**82** 77.1-86.9

- There have been no notable changes in the level of satisfaction with access, but there appears to be a lower level of satisfaction with the experience of therapy

- The changes to the response scale need to be taken into account when interpreting these results.

Summary – Standard 8
Overall, 82% of responses were positive for access to therapy and 80% for experience of therapy. **There appears to have been a lower level of satisfaction with the experience of therapy than in the baseline audit but the change to the questionnaire response scale needs to be taken into account when interpreting this finding.** **The aspects of access that had the highest levels of satisfaction were the time and location of the appointment. For experience of therapy, the highest rating was in relation to therapy helping service users to understand their difficulties.**

Service user feedback on these findings:

It was felt that healthcare workers should be routinely evaluating their services by taking part in compulsory audits and seeking anonymous feedback from people about their services, being clear that this feedback would not impact on their therapy or care.

People felt that more should be done to understand why people may experience lasting negative effects from therapy.

People agreed that it is essential that they know how to get access to their own information and what confidentiality means. This feedback is consistent with the finding that 18% of people receiving therapy did not know where their information is kept. They suggested that therapists should be clearer about the sharing of information between themselves and GPs.

Outcomes:

Measurement against NAPT standards 9 & 10

- Standard 9: Outcome measurement
- Standard 10: Attrition

- Percentages may not total 100 exactly due to rounding, e.g. 101 or 99
- TNS = total national sample, IQR = inter quartile range, N = services and n = service users
- Where numbers are shown, and this is appropriate, an improvement is shown in green and a worsening in red between the baseline and second round
- Where percentages are shown, and this is appropriate, improvements of >=5% are shown in green and worsening of >=5% in red between the baseline and second round
- Only services in the second round with 6 or more case records were used for the service level analysis. All available, appropriate and clean data were used for the TNS analyses.

Standard 9a: Outcome measurement

The service routinely collects outcome data in order to determine the effectiveness of the interventions provided.

Standards 9a – 9c were measured using data from the retrospective case record audit. The analysis for these standards included individuals who had attended at least two sessions; 80,302 case records.

Total national sample (TNS) analysis

The analysis showed 95% (76,331/80,302) of service users had a pre and post-treatment score recorded for at least one measure. This is an increase from the baseline, which found that 81% had both a first and last score on at least one measure.

Table 53: Percentage of service users with both a first and last score for each clinical measure used

	Both pre- and post-treatment scores n (%)	Pre-treatment scores only n (%)	Post-treatment scores only n (%)	Not completed pre- or post-treatment scores n (%)
PHQ-9	74,656 (93)	1,757 (2)	708 (<1)	3,181 (4)
GAD-7	74,544 (93)	1,792 (2)	737 (<1)	3,229 (4)
WSAS	68,023 (85)	3,383 (4)	1,771 (2)	7,125 (9)
CORE-OM	2,426 (3)	987 (1)	37 (<1)	76,852 (96)
CORE-10	3,353 (4)	850 (1)	712 (<1)	75,387 (94)
HADS Anx	77 (<1)	35 (<1)	3 (<1)	80,187 (100)
HADS Dep	76 (<1)	36 (<1)	10 (<1)	80,180 (100)
CES_D	1 (<1)	0 (0)	0 (0)	80,301 (100)
HONOS	133 (<1)	23 (<1)	7 (<1)	80,139 (100)
BAI	36 (<1)	18 (<1)	2 (<1)	80,246 (100)
BDI-II	85 (<1)	77 (<1)	0 (0)	80,140 (100)
Other	1,003 (1)	156 (<1)	0 (0)	79,143 (99)

- PHQ-9, GAD-7 and WSAS were the most frequently reported outcome measures. These are also part of the IAPT minimum dataset.

Service Level Analysis

Table 54: Percentage of service users with a pre and post score on at least one outcome measure

Baseline N services =222 Median % Inter-quartile range	Second round N services =186 Median % Inter-quartile range
76 37.6-93.3	**96** 79.1-99.6

Table 55: Percentage of service users with a pre and post score for at least one measure for the sub-group of services that took part in both rounds (N=73)

Baseline Median % Inter-quartile range	Second round Median % Inter-quartile range
86 52.0-95.0	**97** 87.5-99.9

- The proportion of service user with a pre and post score for at least one outcome measure has increased since the baseline for the sub-group of services that took part in both rounds.

Summary – Standard 9a
95% of service users had both a first and last score on at least one measure. **At a service level, the median percentage of service users with both a first and last score on at least one measure was 96%.**

Standard 9b: Outcomes comparable with clinical trials and effectiveness studies

The service reports clinical outcomes of service users receiving psychological therapy comparable to benchmarks achieved from clinical trials and effectiveness studies.

The analyses for this standard were firstly conducted at a service user level and then at a service level. The first stage included individuals who:

- Had attended at least two sessions
- And had a pre and post score on at least one measure.

A total of 76,331 case records were included in the service user level analysis.

The service level analysis included services that had:

- Six or more cases records
- and an outcome measure return rate of ≥35%.

Effect sizes

Effect sizes were derived by dividing the difference between the mean intake score and the mean outcome score by the intake standard deviation. Table 56 provides a breakdown of the means, standard deviations, effect sizes and 95% confidence intervals (CIs) for each outcome measure. It indicates a slight improvement in the effect size for PHQ-9 and GAD-7 between the baseline and second round (from 0.81 to 0.89 and from 0.89 to 0.96 respectively). Similarly, for CORE-OM, there is a larger effect size in the second round and the CIs for the two rounds of the audit do not overlap. CORE-10 was not included in the baseline analysis, but it shows a slightly smaller effect size than CORE-OM. HAD-D and HADS-A also show some improvement, but the effect sizes in the current analysis fall within the 95% CI of the baseline analysis, suggesting similar effect sizes between the two rounds of the audit. BDI-II and BAI show slightly smaller effect sizes in the current analysis but the numbers are relatively small and again there is considerable overlap of the 95% CIs. For WSAS the median effect sizes are the same (0.62) in both analyses, with almost identical 95% CIs.

Table 56: Pre and post means and effect sizes at a service user level

Measure	N	Time 1: Mean (SD)	Time 2: Mean (SD)	Second round pre-post effect size (95% CI)	Baseline pre-post effect size (95% CI)
Depression:					
PHQ-9	74,655	14.8 (6.43)	9.1 (7.06)	0.89 (0.88, 0.90)	0.81 (0.80, 0.83)
HADS-D	75	9.4 (4.46)	5.0 (3.67)	0.99 (0.65, 1.33)	0.91 (0.72, 1.11)
BDI-II	53	31.8 (13.16)	19.3 (13.11)	0.95 (0.55, 1.35)	1.15 (0.83, 1.48)
Anxiety:					
GAD-7	74,543	13.2 (5.30)	8.1 (6.07)	0.96 (0.95, 0.97)	0.89 (0.87, 0.91)
HADS-A	76	12.0 (3.70)	7.3 (4.29)	1.27 (0.92, 1.62)	1.13 (0.93, 1.33)
BAI	35	29.3 (13.85)	17.2 (13.83)	0.87 (0.38, 1.36)	0.98 (0.64, 1.32)
Generic:					
CORE-OM	1,025	19.2 (6.85)	10. 5 (7.52)	1.27 (1.18, 1.36)	1.07 (1.00, 1.14)
CORE-10	264	21.0 (7.74)	13.9 (7.92)	0.92 (0.74, 1.10)	N/A
Functioning:					
WSAS	68,023	18.5 (9.51)	12.6 (10.09)	0.62 (0.61, 0.63)	0.62 (0.60, 0.63)

Table 57: Effect size benchmarks

Treatment setting, sample, & source	Design	N, n or k	Measure	Pre-post effect size (95% CIs)
IAPT service-level data				
IAPT/Received 2 or more sessions (*Glover et al., 2010*)	Evaluation of IAPT pilot services roll out	N=30 (services)	PHQ-9	0.69 Range: 0.38–0.95
			GAD-7	0.72 Range: 0.41–1.09
IAPT patient-level data				
IAPT/Received 2 or more sessions (*Glover et al., 2010*)	Evaluation of IAPT pilot services roll out	n=23,163 (service users)	PHQ-9	0.74 (0.72–0.76)
		n=23,037 (service users)	GAD-7	0.79 (0.77–0.81)
Single IAPT service & service user-level data				
IAPT/Received 2 or more sessions (*Parry et al., 2011*)	NIHR SDO evaluation of IAPT demonstration sites	n=4,154 (service users at Doncaster site)	PHQ-9 GAD-7	1.17 (1.13–1.22) 1.17 (1.12–1.22)
		n=1,148 (service users at Newham site)	PHQ-9 GAD-7	0.98 (0.90–1.07) 1.06 (0.98–1.15)
IAPT/ Received 2 or more sessions (*Richards & Borglin, 2011*)	Evaluation of Doncaster demonstration service	n=4,183 (service users at Doncaster site)	PHQ-9	1.17[a] (1.12–1.21)
			GAD-7	1.17[a] (1.12–1.21)
Data drawn from pre-IAPT initiative				
Primary care counsellors; CBT subsample (Stiles et al., 2008)	Routinely collected data from services (2001-05)	n=1,045 (service users)	CORE-OM	1.30[b] (1.20–1.39)
Primary care counselling (34 services); attending at least 1 session (*Barkham et al., 2012*)	Routinely collected data from services (2001-08)	Clinical service users n=18,094	CORE-OM	0.91 (0.88–0.93)
		Clinical & subclinical service users n=16,145	CORE-OM	1.19 (1.17–1.21)
Secondary care services (*Barkham et al., 2001*)	Routinely collected data	n=224 (service users at 6 services)	CORE-OM	0.87 (0.67–1.08)

Treatment setting, sample, & source	Design	N, n or k	Measure	Pre-post effect size (95% CIs)
Data drawn from pre-IAPT initiative (contd)				
CBT Mental Health Service (*Westbrook & Kirk, 2005*)	Routinely collected data	n=1,276 (service users)	BDI	0.68 (0.57–0.78)
Trials				
UK trials of CBT-based interventions for depression (*cited in Parry et al., 2011*)	Trials-based	k=8 (studies)	BDI	1.49 (1.24–1.73)
UK trials of CBT-based interventions for anxiety (*cited in Parry et al., 2011*)	Trials-based	k=9 (studies)	BAI	1.42 (1.18–1.65)
US and UK trials of psychological therapies (*Minami et al., 2007*)	Trials-based	k=11 (studies)	BDI	1.71 (1.60–1.82)

[a] Recalculated ES using pre-treatment SD as the denominator
[b] Recalculated ES using pre-treatment SD of this subsample

Recovery and improvement rates

In line with the baseline, 'recovery' was defined as scores moving from above the clinical cut-off at intake to below the cut-off at the end of treatment. For service users that had both PHQ-9 and GAD-7, caseness at intake was defined as above the clinical cut-off on either or both measures (cut-offs of 10 or more for PHQ-9, 8 or more for GAD-7). Recovery was defined as being in the non-clinical range on both measures at the end of treatment. Reliable improvement was based on the reliable change index for each measure: PHQ-9 = 6; GAD-7=4; CORE-OM & CORE-10=5; HADS-D=6; HADS-A=5; BDI & BAI=8.

Table 58 shows the number of services in each service type category overall and following the imposition of exclusion criteria. The final sample shows the number of services included in the recovery analysis and the percentages indicate that a smaller proportion of secondary care, small, non-IAPT services are included in the analysis than larger, primary care, IAPT services.

Table 58: Selection of services for inclusion in the calculation of recovery and improvement rates across services (measures for depression, anxiety and common mental health disorders only)

	Total services	Level of care			IAPT		Service size		
		Primary	Secondary	Mixed	Yes	No	Small	Medium	Large
Overall	196	126	42	28	121	75	52	61	83
Does not have at least 1 pre & post score on one of the measures	11	1	7	3	1	10	8	3	0
Return rate<35%	7	0	4	3	0	7	3	1	3
<6 returns	9	2	6	1	0	9	5	4	0
Final sample N (% of overall)	169 (86)	123 (98)	25 (60)	21 (75)	120 (99)	49 (65)	36 (69)	53 (87)	80 (96)

Table 59 presents the recovery and improvement rates for the baseline and the second round, across all services included in each. This indicates that all measures of recovery and improvement were similar in the two rounds of the audit.

Table 59: Comparison of recovery and improvement rates across all services in the baseline and second round

	Baseline: N services= 130 Median % IQR	Second round: N services=169 Median % IQR
Clinical at intake rate	**86** 82.2-88.9	**90** 85.9-92.1
Neither recovery nor reliable improvement	**37** 31.0-44.9	**38** 30.8-45.2
Did not recover, but showed reliable improvement	**12** 9.5-14.1	**13** 11.0-16.7
Recovery rate	**49** 41.5-56.7	**46** 38.3- 53.2
Recovered and showed reliable improvement	**44** 35.9-51.2	**41** 35.0-47.4

When making comparisons between the baseline and second round for the sub-set of services that participated in both rounds, there were no statistically significant differences for any of the measures of recovery and/or improvement (see Table 60). Considering the CIs, only those for 'clinical at intake rate' did not overlap. Services were on average taking more clinical service users in round 2 than the baseline and this was significant at the 0.05 level.

Table 60: Mean (standard deviation) and 95% confidence intervals of recovery and improvement rates for the sub-group of services that took part in both rounds and fundamentally stayed the same (N=58)

	Baseline Mean % (SD) 95% CI	Second round Mean % (SD) 95% CI
Clinical at intake rate	86.2 (5.4) 84.8-87.6	89.0 (5.3) 87.7-90.4
Neither recovery nor reliable improvement	39.2 (12.5) 36.0-42.4	37.3 (11.1) 34.4-40.2
Did not recover, but showed reliable improvement	12.1 (5.8) 10.6-13.6	16.0 (10.1) 13.4-18.6
Recovery rate	48.7 (12.4) 45.5-51.8	46.7 (11.0) 43.8-49.5
Recovered and showed reliable improvement	43.4 (11.9) 40.3-46.5	42.0 (10.3) 39.4-44.7

Table 61: Recovery benchmarks

Treatment setting, sample, & source	Design	N, n or k	Measure	% recovery
IAPT services (moving to recovery: MTR1 rates[a])				
IAPT (pilot roll out)/Received 2 or more sessions (*Glover et al., 2010*)	Evaluation of IAPT pilot roll out (n=30)	n=19,467 (service users)	PHQ-9 & GAD-7	42.2 (MTR1) (41.6–42.9)
IAPT summary of Routine Quarterly IAPT Dataset Report (*17 July 2013*)	First quarterly data 2013	n=97,107 (service users)	PHQ-9 & GAD-7	41.6 (MTR1) (41.3–41.9)
IAPT/Received 2 or more sessions (*Parry et al., 2011*)	Evaluation of IAPT demonstration sites	n=3,767 (service users at Doncaster site)	PHQ-9 & GAD-7	45.8 (MTR1) (44.2–47.4)
		n=1,000 (service users at Newham site)	PHQ-9 & GAD-7	43.2 (MTR1) (40.1–46.3)

IAPT/ Received 2 or more sessions (*Richards & Borglin, 2011*)	Evaluation of Doncaster demonstration service	n=3,756 (service users at Doncaster site)	PHQ-9 & GAD-7	46.0 (MTR1) (44.3–47.5)
IAPT services (reliable & clinically significant improvement: RCSI rates[b])				
IAPT/Received 2 or more sessions (*Parry et al., 2011*)	Evaluation of IAPT demonstration sites	n=3,767 (service users at Doncaster site)	PHQ-9 & GAD-7	40.4 (RCSI) (38.8–42.0)
		n=1,000 (service users at Newham site)	PHQ-9 & GAD-7	36.0 (RCSI) (33.0–39.1)
Data drawn from pre-IAPT initiative (reliable & clinically significant improvement: RCSI rates)				
Primary care counselling attending 1 or more sessions (*Barkham et al., 2012*)	Routinely collected data from 34 services	n=16,145 (service users)	CORE-OM	36.7 (RCSI) (36.0–37.4)

[a] *Moving to recovery* (MTR1) defined as cited in Glover et al (2010): Either First PHQ-9 score of 10 or more OR first GAD-7 score of 8 or more; Latest PHQ-9 less than 10 AND latest GAD-7 score less than 8

[b] *Reliable and clinically significant improvement* defined as in Jacobson and Truax (1991) in which a patient's change score has to exceed the reliable change index AND fall below the clinical cut off score for the outcome measure used.

Summary – Standard 9b

There have been small increases in the effect sizes for PHQ-9, GAD-7 and CORE-OM since the baseline. The effect sizes for the other outcome measures have remained the same.

There have been no notable changes in recovery and improvement rates since the baseline.

As in the baseline, few participating services had effect sizes that would be comparable to clinical trials, but the outcomes are broadly similar to the ones reported in effectiveness studies.

A smaller proportion of small, secondary care, non-IAPT services were included in the analysis when compared to the larger, primary care, IAPT services.

Services are seeing a greater proportion of clinical cases than at baseline.

Standard 9c: Outcomes comparable with similar services

The clinical outcomes of service users receiving psychological therapy in the therapy service were comparable to benchmarks achieved by similar profile therapy services.

Service effect sizes

Pre-post effect sizes were calculated for service users, clinical and non-clinical at intake, on measures of depression (PHQ-9, HADS-D and BDI-II), anxiety (GAD-7, HADS-A and BAI) and generic measures (CORE-OM and CORE-10).

Depression: Of the 196 services, 163 had at least 1 pre and post depression measure. A total of 138 services provided 6 or more case records and had a return rate of 35% or more. A total of 135 services collected PHQ-9, two services collected HADS-D, and one collected BDI-II. Table 61 shows that secondary care services had a larger effect size than primary care, although the number included for secondary care was small (N=4). Non-IAPT services also had a larger effect size compared with IAPT services and smaller services had a slightly larger effect size than larger services.

Anxiety: Of the 196 services, 162 had at least 1 pre and post anxiety measure. 136 provided 6 or more cases and had a return rate of 35% or more. 134 collected GAD-7, and 2 collected HADS-A.

The small number of secondary care services made it impossible to derive the IQR, but the medians suggest that the pattern is the same as with depression. However, the differences between the types of services were smaller.

Generic: A total of 50 services collected a generic measure, 29 provided 6 or more cases and had a return rate of 35% or more. A total of 26 services collected CORE-OM while 3 collected CORE-10.

Table 62: Service pre-post effect sizes (medians & inter-quartile range) - depression

	All	Level of care			IAPT		Service size		
		Primary	Secondary	Mixed	Yes	No	Small	Med	Large
N services	138	118	4	16	119	19	20	41	77
Median effect size	0.90	0.90	1.40	0.80	0.88	1.15	1.10	0.98	0.88
IQR	0.79-1.04	0.79-1.04	1.15-1.81	0.66–1.05	0.78–1.00	1.02–1.44	0.84–1.42	0.81–1.07	0.78–0.99

Table 63: Service pre-post effect sizes (medians & inter-quartile range) - anxiety

	All	Level of care			IAPT		Service size		
		Primary	Secondary	Mixed	Yes	No	Small	Med	Large
N services	136	118	3	15	119	17	18	41	77
Median effect size	0.98	0.98	1.02	0.88	0.98	1.08	1.07	0.98	0.96
IQR	0.83-1.11	0.85–1.11	N/A	0.68–1.01	0.81–1.09	0.94–1.25	0.91–1.23	0.80–1.18	0.84–1.07

Table 64: Service pre-post effect sizes (medians & inter-quartile range) - generic

	All	Level of care			IAPT		Service size		
		Primary	Secondary	Mixed	Yes	No	Small	Med	Large
N services	29	8	15	6	4	25	13	12	4
Median effect size	1.37	1.33	1.37	1.54	1.37	1.37	1.47	1.26	1.23
IQR	1.10-1.58	0.94–1.47	1.11–1.57	1.19–2.08	0.98–1.57	1.10–1.58	1.36–1.66	0.90–1.55	1.05–1.54

Although the numbers of services included is smaller, the effect sizes for generic measures are generally larger than for condition specific measures reported above. Table 64 provides a breakdown for the different service groupings. This shows

that effect sizes for primary and secondary care are similar, but mixed services have a larger effect size. The effect sizes for IAPT and non-IAPT services are identical but the number of IAPT services that collected CORE was small. As with Tables 61 and 62, smaller services had larger effect sizes.

Service recovery and improvement rates

Table 65 shows recovery and improvement rates for the final sample. These are based on service users who were above the clinical cut-off at intake, on whichever measure was used. It indicates that primary care services had better recovery rates than secondary care services with mixed services in between. However, the proportion of service users that made reliable improvement was greater in secondary care than in primary care and mixed services. The recovery rates for IAPT and non-IAPT services were similar, but non-IAPT services had higher improvement rates. For service size, the pattern was the same for both rates, with smaller services having both a higher recovery rate and a higher improvement rate than larger services, although the differences were greater for improvement rates.

Table 65: Median (inter-quartile range) service recovery & improvement rates (depression, anxiety & common mental health measures)

	Level of care			IAPT		Service Size		
	Primary	Secondary	Mixed	Yes	No	Small	Med	Large
N services	123	25	21	120	49	36	53	80
Recovery rate	47.8 (42.1 – 54.0)	35.3 (27.1 – 44.2)	43.8 (34.5 – 57.5)	46.0 (40.7 – 51.8)	42.9 (30.8 – 60.3)	50.5 (35.7 – 61.1)	45.1 (37.0 – 56.4)	45.5 (40.9 – 49.5)
Improvement rate	60.4 (53.6 – 66.0)	72.2 (66.7 – 86.2)	58.7 (50.3 – 76.3)	59.3 (53.1 – 64.6)	74.0 (66.2 – 83.7)	76.8 (63.7 – 85.2)	64.6 (53.5 – 71.8)	59.1 (53.8 – 62.4)

Table 66 provides greater detail of service user outcomes for the different service types. It shows the proportion of service users above clinical cut-off at intake and indicates broadly similar rates across service types. The proportion of service users that did not change, that is neither recovered nor made reliable improvement, was greater for primary and mixed services compared with secondary care services, for IAPT services compared with non-IAPT services and for larger services compared with smaller ones.

The proportion of service users that did not recover but showed reliable improvement was greater for secondary care, non-IAPT and smaller services. However, primary care and mixed services had higher recovery rates than secondary care and small services had higher rates than medium and large services. There were no notable differences in recovery rates between IAPT and non-IAPT services. Table 66 also shows the rates for those service users that both recovered and showed reliable improvement, that is those that changed from above clinical cut-off to below clinical cut-off and also changed by an

amount equal to or greater than the RCI. The rates follow a similar pattern as for those for recovery only, with primary care and mixed services having a higher rate than secondary care.

Table 66: Reliable improvement and recovery rates (%) (median & inter-quartile range)

	Level of care			IAPT		Service size		
	Primary	Secondary	Mixed	Yes	No	Small	Med	Large
N services	123	25	21	120	49	36	53	80
Clinical at intake rate	89.0 (86.0 – 91.1)	92.6 (82.0 – 100)	90.0 (83.4 – 93.5)	88.9 (85.8 – 91.1)	90.6 (86.6 – 100)	90.2 (86.7 – 100)	88.9 (85.8 – 92.8)	89.5 (85.9 – 91.1)
Neither recovery nor reliable improvement	39.6 (34.0 – 46.4)	27.8 (13.8 – 33.3)	41.3 (23.7 – 49.7)	40.8 (35.4 – 46.9)	26.0 (16.3 – 33.8)	23.2 (14.8 – 36.3)	35.4 (28.2 – 46.5)	40.9 (37.6 – 46.2)
Did not recover, but showed reliable improvement	12.7 (10.5 – 14.4)	36.4 (27.0 – 53.1)	14.7 (11.2 – 22.0)	12.5 (10.5 – 14.0)	26.3 (15.4 – 46.2)	20.2 (10.0 – 44.0)	13.2 (10.6 – 17.4)	13.1 (11.1 – 14.4)
Recovered	47.8 (42.1 – 54.0)	35.3 (27.1 – 44.2)	43.8 (34.5 – 57.5)	46.0 (40.7 – 51.8)	42.9 (30.8 – 60.3)	50.5 (35.7 – 61.1)	45.1 (37.0 – 56.4)	45.5 (40.9 – 49.5)
Recovered and showed reliable improvement	42.7 (36.9 – 48.5)	33.3 (23.6 – 39.4)	39.5 (31.4 – 55.5)	41.1 (36.7 – 45.8)	36.8 (29.6 – 54.2)	43.4 (31.6 – 55.1)	39.5 (33.7 – 51.1)	40.8 (36.8 – 44.4)

Summary – Standard 9c
The effect sizes for generic measures were generally larger than for condition specific measures. **Smaller services tended to have bigger effect sizes than larger services.** **Primary care and mixed services had higher recovery rates than secondary care. Small services had higher recovery rates than medium and large services. However, the proportion of patients that did not recover but showed reliable improvement was greater for small, secondary care, non-IAPT services.** **A smaller proportion of small, secondary care, non-IAPT services were included in the analysis when compared to the larger, primary care, IAPT services. This needs to be taken into account when interpreting the findings.**

Service user feedback on these findings:

It was felt that the effectiveness of the long term benefits of therapy should be looked into by services. It was suggested that post-discharge, follow-up questionnaires should be given to people in order to measure whether their mental health had been maintained, improved or got worse.

Standard 10: Attrition

The rate of attrition from commencing treatment to completing treatment is comparable to that of other therapy services.

Of the 122,812 service users that ended therapy in the audit period, information on the reason for ending therapy was provided for a total of 122,599.

Total national sample (TNS) analysis

Table 67: Reasons for ending therapy

Reason for ending treatment	Baseline % Num / Den	Second round % Num / Den
Completed treatment	**64** 31,303 / 48,962	**49** 60,472 / 122,599
Dropped out of treatment (unscheduled discontinuation)	**25** 12,061 / 48,962	**24** 29,179 / 122,599
Declined treatment	**5** 2,649 / 48,962	**11** 13,051 / 122,599
Referred on to another service	**N / A**	**9** 10,644 / 122,599
Not suitable for the service	**5** 2,523 / 48,962	**6** 7,509 / 122,599
Unknown	**1** 399 / 48,962	**1** 1,659 / 122,599
Deceased	**<1** 27 / 48,962	**<1** 85 / 122,599

- The attrition rate in the second round is consistent with the baseline audit
- The proportion of service users recorded as having completed therapy was lower than the baseline. This may be partly explained by the inclusion of an additional category. It may be that those that were referred on to another service in the baseline would have been recorded as having completed therapy
- A higher proportion of service users declined treatment in the second round when compared to the baseline audit.

Of those that completed therapy, the mean number of sessions attended was seven. Of those that dropped out of therapy, the mean number of sessions

attended was three. This is consistent with the baseline. Furthermore, of those that dropped out of therapy, 2,856 (10%) did not attend their first appointment.

Service level analysis / benchmarking

Table 68: Baseline and second round comparisons of attrition at the service level

	Baseline: N services = 221 Median % IQR	Second round: N services =190 Median % IQR
Dropped out of treatment/ unscheduled discontinuation	**19** 10-28.5	**22** 13.4-29.6

Table 69: Attrition rates for the sub-group of services that participated in both rounds (N=74)

	Baseline: Median % IQR	Second round: Median % IQR
Dropped out of treatment/ unscheduled discontinuation	**21** 9.8-29.4	**22** 14.2-28.9

Table 70: Median (inter-quartile range) attrition rates for the different service groupings (N=190)

	Level of care			IAPT		Service size		
	Primary N=125	Secondary N=38	Mixed N=27	IAPT N=121	Non-IAPT N=69	Small N=47	Medium N=60	Large N=83
Dropped out	22.2 (15.3-30.4)	14.8 (6.2-28.6)	19.8 (13.8-27.3)	22.1 (17.0-29.9)	18.2 (8.0- 29.3)	19.2 (9.1-29.1)	22.4 (10.7-28.7)	21.8 (16.6-32.0)

- Primary care and mixed services had higher attrition rates than secondary care
- There were minimal differences in attrition rates according to size of service and involvement in the IAPT programme

Summary – Standard 10

The attrition rate for people ending therapy in the second round was 24%.

The median attrition rate at a service level was 22%.

The median attrition rates for primary care and mixed services were higher than secondary care.

There were no notable changes between the baseline and second round.

Service user feedback on these findings:

People were surprised by the amount (24%) of people who dropped out of therapy in an unplanned way. They felt that there could be a number of reasons for this including a) lack of rapport with their therapist or feeling that they could not progress any further with their therapist b) the type of therapy they were getting c) long waiting times for treatment or d) their assessment or therapy was too intense and brought up difficult emotions.

People felt that services should contact those who have ended their therapy abruptly or in an unplanned way to explore and better understand their reasons for this.

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Discussion

NAPT
NATIONAL AUDIT OF PSYCHOLOGICAL THERAPIES
CCQI

Discussion

The profile of services participating in the second round of the NAPT has changed since the baseline. Less than half participated in both rounds and fundamentally stayed the same. The total number of participating services is smaller, and there is a bigger proportion of large, primary care services that are part of the IAPT programme. All of these factors need to be taken into account when considering any changes between the baseline and second round.

Access

There have been encouraging improvements in waiting times for assessment and starting therapy. An even larger improvement in waiting times was found for those services that participated in both rounds, suggesting that this improvement is not just the result of the change in profile of the services participating in the second round. However, it is important to note that a minority of service users still have unacceptably long waits. Service users were least satisfied with waiting times, with only two thirds of respondents reporting that they thought it was a reasonable wait to start treatment. Feedback in the service user reference groups also highlighted a desire for waiting times to be much shorter than indicated in the standards and for more help with managing the wait.

Appropriateness

Although a large majority of service users received a type of therapy that was in line with NICE guidance, less than a third of those receiving NICE recommended high intensity therapies received the minimum number of sessions. Concerns about the number of sessions were also highlighted in the service user survey and service user reference groups. In addition, three of the therapies that have more than 30% of therapists delivering them without any training are NICE recommended therapies. Although it is important to bear in mind that NICE guidelines do not replace professional expertise and the reasons for non-adherence were not established, it is equally important to recognise that a therapy cannot be considered NICE adherent if it is of insufficient duration and/or delivered by a therapist that has not received appropriate training. It is

also important to note that almost a quarter of the therapists did not think that they were getting sufficient support from their service/organisation to meet the CPD requirements of their professional body.

Acceptability

As already highlighted, key areas of service user dissatisfaction were around waiting times and the number of sessions provided. The additional questions that were included for the second round also indicated that just under half of the service user respondents did not understand where their information was kept, who could see it and when it might be shared. Findings also indicated that 5% of service users had experienced 'lasting bad effects' from therapy. We do not have detailed information about the nature of these experiences but the possibility of negative effects associated with psychological treatment needs to be explored further so that service user and therapists can better understand how to avoid the development of negative effects and manage them if they do occur. More encouragingly, the vast majority of respondents felt that their needs were taken seriously, understood and appropriately considered. The responses to the questions on choice highlighted that time of day was the most important and most frequently provided aspect of choice, followed by choice of venue. These may help to explain the high levels of satisfaction with the time and location of appointments. However, the provision of choice was variable with choice of therapist gender found to be the least frequently provided. Overall, there were no notable changes in the level of satisfaction with access, but there was a decrease in the level of satisfaction with the experience of therapy between the baseline and second round. However, changes to the response scale (from 'yes' 'no' to Likert) need to be taken into account when making these comparisons. It is also important to consider the overall response rate of 20%. Although the profile of service users that responded to the survey was broadly in line with case record audit, the responses may not be fully representative.

Outcomes

There have been no notable changes in outcomes between the two rounds, but the second round has highlighted differences found between the different types of services. The performance against standard 9c, which used benchmarks for

similar profile therapy services, particularly highlighted the importance of looking at both recovery and improvement rates. Primary care and mixed services had higher recovery rates than secondary care. Small services had higher recovery rates than medium and large services. However, the proportion of service users that did not recover but showed reliable improvement was greater for small, secondary care, non-IAPT services.

It is acknowledged that the approach to determining recovery and improvement rates predominantly used standardised measures of symptoms. Therefore, they do not capture changes in other areas, such as quality of life and well-being. Service user feedback on the findings highlighted the need to bear in mind that there is often a discrepancy between service definitions of recovery and service user perspectives on recovery. The feedback from the advisory group and service user reference groups also highlighted the importance of looking at sustainability of improvements in future work.

Variation in performance across services

The second round of NAPT has benefited from the learning from the baseline and included benchmarks for different service groupings, but we are some way off understanding the complex interactions causing the variations in performance across services. In addition, the level of funding has not been taken into account so it may be that some services are performing excellently given the resources that they have available. The baseline audit primarily relied on local clinical leadership to take responsibility for responding to the findings. However, it was recognised that more specific and targeted recommendations were required for the second round.

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Recommendations

NAPT
NATIONAL AUDIT OF PSYCHOLOGICAL THERAPIES
CCQI

Recommendations

The NAPT second round recommendations have been drawn from the findings from NAPT and developed in conjunction with the NAPT advisory group and service user reference groups. They are grouped according to the individuals and organisations to whom they are primarily addressed.

1. NAPT service leads

1.1. By 1 March 2014, the findings and recommendations of the service level report should be disseminated to all stakeholders with information appropriately tailored to the different audiences. As a minimum, this should include all staff in the participating service, users of the participating service, service managers, directors, commissioners and referrers.

2. Service managers

2.1 By 1 June 2014, service managers should ensure that every referrer to their service has received clear information on the range of service users that should be referred to their service and how the service is making improvements in its accessibility for under-represented groups.

2.2 If a service is open to self-referrals: By 1 June 2014, service managers should ensure that their publicity materials and communication strategies are up to date and their self-referral service has been promoted as widely as possible in their catchment area.

2.3 By 1 June 2014, every service manager, in partnership with individual therapists, should ensure that each therapist is suitably trained and receiving regular and appropriate clinical supervision in accordance with the guidelines and accreditation standards for their clinical role within the service. If this cannot be demonstrated, therapists should not be allowed to continue to provide therapies for which they are not appropriately trained or supervised.

2.4 By 1 June 2014, service managers, in partnership with therapists, should have taken active steps to address any areas of service user dissatisfaction highlighted in their NAPT service level report. With immediate effect, service managers should ensure that all therapists, and through them all

service users, understand that choice is multi-dimensional and that service users should be routinely offered choices, including location and time of appointment, type of therapy, therapist gender and access in another language. Any constraints on choice should be made explicit and services should also be able to explain in an unbiased manner what, if any, effect a choice may have on waiting times for assessment and starting therapy.

2.5 With immediate effect, service managers, in partnership with therapists, should take action to reduce service users' waiting times from initial referral to psychological therapy services to assessment and beginning therapy. Consideration should be given to added waiting times caused by referrals between services, the negative impact of repeated assessments, the impact of staff sickness and leave.

2.6 With immediate effect, service managers should ensure that service users on a waiting list are provided with regular updates of any changes to the start date, as well as details of how they can access further support while they wait for therapy to commence.

2.7 With immediate effect, service managers should ensure that the service understands why each service user who ends therapy unexpectedly has done so. Action should be taken to review, understand and act on this information to reduce attrition rates.

3. Supervisors of psychological therapists

3.1. With immediate effect, any supervisors who have not received specific training to provide supervision should raise this issue with their line manager with a view to taking immediate action to address this training need.

3.2. With immediate effect, supervisors should gather specific information from therapists under their supervision about why patients who have not recovered end therapy when they do and where appropriate act on this information.

4. Therapists

4.1 With immediate effect, qualified therapists should only deliver therapy that they have been trained to provide (in accordance with the guidelines and accreditation standards for their clinical role within the service). They should be aware that there are legal implications to not being trained properly and it breaches professional guidelines.

4.2 With immediate effect, every service user should be told at their first point of contact how their information will be stored and full details of confidentiality outlined. Every therapist must ensure that before starting therapy the service user has received and understood this information and any questions have been addressed to the service user's satisfaction.

4.3 With immediate effect, therapists should ensure that they are open and transparent with clients about what is involved in therapy. This should include making it clear that, while most people experience benefits from psychological treatment, some aspects can be difficult. Therapists should provide the service user with options about who to speak to if they are experiencing difficulties with the therapy process, which they do not feel able to speak to the therapist about.

5. Referrers to psychological therapy services

5.1 By 1 June 2014, every referrer to psychological therapy services, primarily GPs, must be aware of the range of service users that should be referred to each psychological therapy service in their area and recognise the need to make appropriate and timely referrals.

5.2 With immediate effect, referrers, particularly GPs, should take active steps to reduce any inequalities in referrals and ensure that people with anxiety and depression have equal access to psychological therapy whatever their age.

6. Clinical Commissioning Groups (CCGs)

6.1 With immediate effect, commissioners must ensure that services awarded contracts to provide NHS-funded psychological therapies are able to continually demonstrate how their service provides safe and appropriate care/treatment. This must include demonstration that therapies are

compliant with NICE guidelines, including recommendations on treatment duration, and are only provided by therapists who engage in regular clinical supervision and have received formal training to provide that therapy.

6.2 Commissioners should ensure that psychological therapy services are accessible across the lifespan and do not discriminate against service users based on age.

7. Local Education and Training Boards (LETBs)

7.1 LETBs should take steps to address therapists providing therapy for which they have not received specific training or supervision.

8. Chief Executives of Trusts, Health Boards and other organisations responsible for the management of psychological therapy services

8.1 With immediate effect, Chief Executives of Trusts, Health Boards and other organisations responsible for the management or commissioning of psychological therapy services should ensure that service managers are supported to meet the recommendations made for them in this report.

8.2 By 1 June 2014, Chief Executives of Trusts, Health Boards and other organisations responsible for the management or commissioning of psychological therapy services, should ensure that each therapist is receiving regular and appropriate clinical supervision (in accordance with the guidelines for their grade and accrediting body).

8.3 By 1 June 2014, Chief Executives of Trusts, Health Boards and other organisations responsible for the management or commissioning of psychological therapy services should ensure that each therapist has received training in each of the therapies they provide on behalf of the service.

8.4 Chief Executives of Trusts, Health Boards and other organisations responsible for the management or commissioning of psychological therapy services should ensure that such services will be able to demonstrate equity of access for all age groups in future audits.

8.5 Chief Executives of Trusts, Health Boards and other organisations responsible for the management or commissioning of psychological therapy

services should ensure that such services will be able to demonstrate that service users are being provided with the NICE recommended number of therapy services in future audits.

9. Therapists' professional and regulatory bodies

9.1 Therapists' professional and regulatory bodies need to respond to concerns about therapists' training and supervision. Their action plans will need to show how and when adherence will be able to be demonstrated for future audits.

10. National bodies, organisations and programmes responsible for the collection and reporting of NHS data

10.1 The National Director for Mental Health should continue to take steps to ensure services are compliant with age discrimination legislation.

10.2 Health Education England should take steps to address therapists providing therapy for which they have not received specific training or supervision.

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Learning points and future of NAPT

NAPT
NATIONAL AUDIT OF PSYCHOLOGICAL THERAPIES
CCQI

Learning points and future of NAPT

What went well

We have supported local engagement in quality improvement work since the baseline reports were issued through the use of the action planning toolkits, regional events, national events and a quality improvement competition.

"It really pushed us to think about all the initiatives we have implemented over the year and how and where we have engaged with service users to ensure we are continuously improving and delivering a service that meets their needs. We feel there is also so much more we could be doing as a service to continue meeting the needs of our clients, so this process enabled us to see that, but also learn from other services whilst sharing the initiatives that have worked for us."

Quote from a participating service

The second round of NAPT collected more data than in the baseline with improved processes, more data collection time, regular updates to service leads and support from the central team and regional leads:

"Nothing has been too much trouble and your patience outstanding!"

Quote from a participating service

"The monthly updates have been useful and the audit has been a much smoother process this time around; it has been much easier taking part this time as it is our second go and NAPT have listened to feedback which has improved the overall process."

Quote from a participating service

Through the collection of over 15,000 service user questionnaires and the engagement of service users in the review of the findings and development of the NAPT recommendations, we have worked hard to ensure that service users' voices are heard. NAPT is taking steps to improve the quality of psychological therapy provision in a way that responds to service users' needs and concerns.

"Validating/dignifying" "Empowering" "I gained a multidimensional understanding on some issues that I was not aware of".

Feedback from service users on their involvement with NAPT

"NAPT provided our clients with a greater opportunity to voice their thoughts and experience of our service. In turn this enabled the team to assess its work and its core values and principles."

Quote from a participating service

Recommendations for the future

Following feedback from our partner organisations, services and service users, NAPT makes the following recommendations for future work:

- Engage the new clinical commissioning groups in the design and implementation of future work to ensure that it is relevant to their needs, includes a larger proportion of eligible services and addresses funding issues
- Further work is needed to ensure that future work responds to the needs and priorities of small and secondary care services
- The equality of access measures should be widened to include other protected characteristics
- Assess strategies for reducing inequalities in access, including the level of training that therapists have received for engaging and working with ethnic minority groups, older adults and other people with specific needs e.g. hearing difficulties, language barriers, physical health issues
- Investigate the full care pathway to address waiting times before referral, inequalities in access, ways of reducing attrition rates and better understand the long term effects of therapy, including any negative effects
- Try to better understand the process and impact of choice for service users. For example, does having or getting your choice in one area impact upon another?
- Future work should try to collect qualitative data in a way that is meaningful and manageable to help better understand the quantitative information collected

- Outcomes should take account of service user perspectives on recovery and be considered more broadly, for example, including social functioning and well-being
- Therapists could be directly involved with developing recommendations, as service users were in this round

The future of NAPT

The findings of the second round of NAPT will be presented at various national events in England and Wales; service level reports will be issued shortly after the national report. Services will be supported in interpreting their reports, producing action plans to respond to the data and recommendations and implementing quality improvement initiatives through webinars, a number of regional action planning events and resources made available on the NAPT website.

At the time of going to print the commissioning of a future audit of psychological therapies is being considered by HQIP, however, it is not yet clear exactly what this audit will look like.

The information and knowledge gathered through the NAPT pilot, baseline audit, second round and a stakeholder scoping exercise have fed into the development of a new Accreditation Programme for Psychological Therapy Services (APPTS).

Acknowledgements

NAPT Regional Leads and Service User Lead

We would like to thank the NAPT second round regional leads (Olga Luzon – London, Esther Cohen-Tovee – North East, Catherine O'Neill – North West, Chris Powell – Yorkshire and the Humber, Brenda Wilks – East Midlands, Pavlo Kanellakis – West Midlands and South East Coast, Karl Williams – East of England and South Central, George Pidgeon – North Wales, Amanda Hall and her assistants Hannah Smith and Kathy Williams – South Wales) for feeding into the methodology used; facilitating the promotion of NAPT and the recruitment of services in their local areas; supporting services to collect and submit data; providing input into the development of reports and recommendations and supporting local action planning and implementation of recommendations. We would like to thank Catherine O'Neill for her other work as the NAPT Service User Lead; Cat has worked hard with the team to ensure that NAPT has remained accessible to all and focuses on what service users say is important to them.

Development of standards and recommendations

We would like to thank all those involved in the NAPT baseline for their contribution to the original NAPT standards and recommendations; the baseline services for their feedback on how the standards could be revised and improved and Olga Luzon for leading the standards review and revision for the second round. We would also like to thank the service user representatives for their contribution to the development of the second round recommendations through the NAPT reference groups and email feedback process.

Service recruitment

We would like to thank the Welsh Government, the IAPT national team and regional leads, the NAPT advisory group, audit departments, local commissioners and other CCQI projects for their support in recruiting services to the second round of the audit.

Service user questionnaires

We would like to thank Colleen Roach for her work on revising the service user questionnaire, Mind for their advice and Rethink Mental Illness for their work on the National Audit of Schizophrenia (NAS) service user materials, as these were used to make improvements to those used by NAPT. A special thank you goes to the 15,000+ service users who took the time to complete a NAPT questionnaire. We would also like to thank Tim Wilson and the many colleagues at the CCQI who helped with data entry of the service user questionnaires as well as Daniel Gooding for helping with the administration of the prepaid envelopes.

Data extracts

We would like to thank John Mellor-Clark, Alex Curtis-Jenkins and Stuart Brown from CORE-IMS, Chris Eldridge from Mayden Health (suppliers of IAPTUS), and Byron George from PC-MIS for their support in extracting data from services' clinical record systems for the retrospective case record audit.

Data cleaning and analysis

We would like to thank the NAPT baseline services who provided feedback on baseline reports and how analysis and data presentation could be improved for the second round. We would like to thank colleagues from the CCQI research team, the National Audit of Schizophrenia (NAS), the National Audit of Dementia (NAD), the Prescribing Observatory for Mental Health (POMH-UK) and Paul Bassett (statistical consultant) for their advice and support in developing the analysis and reporting strategy for this report. We would also like to thank the NAPT service leads for their prompt response to data cleaning queries and for completing the questionnaire asking for their input on the format and use of their local NAPT reports.

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

References

NAPT
NATIONAL AUDIT OF PSYCHOLOGICAL THERAPIES
CCQI

References

1. Royal College of Psychiatrists (2011): National Audit of Psychological Therapies for Anxiety and Depression, National Report 2011. Available at www.rcpsych.ac.uk/napt
2. Office for National Statistics (2011). Census data. Available at: http://www.ons.gov.uk/ons/index.html
3. NICE (2010). CG90 Depression: the treatment and management of depression in adults (update). London: National Institute for Clinical Excellence
4. (NICE 2011). CG113 Anxiety: Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. Management in primary, secondary and community care. London: National Institute for Clinical Excellence
5. NICE (2005a). CG31 Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. London: National Institute for Clinical Excellence
6. NICE (2005b). CG26 Post-traumatic stress disorder: the management of PTSD in adults and children in primary and secondary care. London: National Institute for Clinical Excellence
7. HQIP (2012). How to Implement Changes from National Clinical Audit: A guide for Audit Professionals in Healthcare Organisations. Available at http://www.hqip.org.uk/assets/Downloads/Implementing-Local-Change-from-National-Audit.pdf
8. HQIP (2010). Local Clinical Audit. Handbook for Clinicians. Available at http://www.hqip.org.uk/assets/Guidance/Local-clinical-audit-handbook-for-physicians-August-2010-FINAL.pdf
9. Department of Health (2012). The Mandate: A Mandate from the Government to the NHS Commissioning Board: April 2013-March 2015. London: DH
10. Department of Health (2012a). IAPT three year report: The first million patients. London: DH

11. IAPT (2013). IAPT Payment by Results Pilot Feasibility Study Final Report. London: IAPT
12. Department of Health (2011). Operational Guidance to the NHS: Extending Patient Choice of Provider. London: DH
13. Department of Health (2012b). Implementing a ban on age discrimination in the NHS –making effective, appropriate decisions. London: DH
14. Welsh Government (2012) Together for Mental Health: A strategy for mental health and well-being in Wales. Cardiff: Welsh Government
15. McManus, S., Meltzer, H., Brugha, T., Bebbington, P., Jenkins, R. (2009) Adult Psychiatric Morbidity in England, 2007: results of a household survey, National Centre for Social Research.
16. World Health Organisation (2010). International Statistical Classification of Diseases and Related Health Problems 10th Revision. Available at www.who.int/classifications/ICD
17. Jacobson, N., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. Journal of Consulting and Clinical Psychology. 59(1), 12-19
18. Glover, G., Webb, M., & Evison, F. (2010). Improving Access to Psychological Therapies: A review of the progress made by sites in the first roll-out year. North East Public Health Observatory.
19. Parry, G., Barkham, M., Brazier, J., Dent-Brown, K., Hardy, G., Kendrick, T., Rick, J., Chambers, E., Chan, T., Connell, J., Hutten, R., de Lusignan, S., Mukuria, C., Saxon, D., Bower, P., & Lovell, K. (2011). An evaluation of a new service model: Improving Access to Psychological Therapies demonstration sites 2006-2009. Final report. NIHR Service Delivery and Organisation programme
20. Richards, D.A. & Borglin, G. (2011). Implementation of psychological therapies for anxiety and depression in routine practice: Two year prospective cohort study. Journal of Affective Disorders, 133: 51-60.
21. Stiles, W.B., Barkham, M., Mellor-Clark, J. & Connell, J. (2008). Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies in UK primary care routine practice: Replication with a larger sample. Psychological Medicine, 38: 677-688.
22. Barkham, M., Stiles, W.B., Connell, J. & Mellor-Clark, J. (2012). Psychological treatment outcomes in routine NHS services: What do we

mean by treatment effectiveness. Psychology and Psychotherapy: Theory, Research and Practice, 85 (1): 1-16.

23. Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., Benson, L., Connell, J., Audin, K., & McGrath, G. (2001). Service profiling and outcomes benchmarking using the CORE-OM: toward practice-based evidence in the psychological therapies. Clinical Outcomes in Routine Evaluation-Outcome Measures. Journal of Consulting and Clinical Psychology, 69 (2): 184-196.
24. Westbrook, D. & Kirk, J. (2005). The clinical effectiveness of cognitive behavior therapy: outcome for a large sample of adults treated in routine practice. Behaviour Research and Therapy. 43 (10): 1243-61.
25. Minami , T., Wampold, B. E., Serlin, R. C., Kircher, J. C., & Brown, G. S. (2007). Benchmarks for psychotherapy efficacy in adult major depression. Journal of Consulting and Clinical Psychology, 75, 232–243
26. Improving Access to Psychological Therapies, Key Performance Indicators (IAPT KPIs) – Q4 2012-13 final: Q4 final tables. http://www.hscic.gov.uk/catalogue/PUB11365

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Appendices

NAPT
NATIONAL AUDIT OF PSYCHOLOGICAL THERAPIES
CCQI

Appendix A: Service level comparison tables

Table 71: Standard 1: Service level comparisons of age, gender and ethnicity completeness (N=190)

	Level of Care			IAPT		Service Size		
	Primary N=125 Median (IQR)	Secondary N=38 Median (IQR)	Mixed N=27 Median (IQR)	Yes N=121 Median (IQR)	No N=69 Median (IQR)	Small N=47 Median (IQR)	Medium N=60 Median (IQR)	Large N=83 Median (IQR)
Age	100 (100-100)	100 (100-100)	100 (100-100)	100 (100-100)	100 (100-100)	100 (100-100)	100 (100-100)	100 (100-100)
Gender	100 (99.9 -100)	100 (100-100)	100 (100-100)	100 (99.9-100)	100 (100-100)	100 (100-100)	100 (100-100)	100 (99.9-100)
Ethnicity	92.2 (79.9-98.1)	100 (97-100)	97.8 (77.6-100)	91.1 (78-98)	100 (96.4-100)	100 (95.8-100)	97.5 (88.8-100)	87.8 (77.6-96.6)

Table 72: Standard 2: Waiting time to assessment (N=187)

	Size of service			IAPT		Level of care		
	Small N = 45 Median (IQR)	Medium N = 59 Median (IQR)	Large N = 83 Median (IQR)	Yes N=121 Median (IQR)	No N =66 Median (IQR)	Primary N = 125 Median (IQR)	Secondary N =36 Median (IQR)	Mixed N = 26 Median (IQR)
Percentage of service users that meet Standard 2 (%)	92.1 (66.1-100)	91.1 (75-97.2)	94.8 (82.5-99)	94.6 (81.8-99)	86.4 (62.3-97)	94.7 (81.8-99)	83.7 (61.8-95.3)	87.9 (61.9-97.3)
Waiting times in days	42.5 (17.0-68.8)	41.5 (24.0-60.0)	24.0 (15.0-42.0)	24.0 (14.8-43.5)	47.8 (30.3-66.9)	26.0 (15.0-46.3)	48.8 (35.5-76.6)	42.5 (17.4-67.4)
Waiting times in weeks	6.1 (2.4-9.8)	5.9 (3.4-8.6)	3.4 (2.1-6.0)	3.4 (2.1-6.2)	6.8 (4.3-9.6)	3.7 (2.1-6.6)	7.0 (5.1- 10.9)	6.1 (2.5-9.6)

Table 73: Standard 3: Waiting time to treatment (N=180)

	Size of service			IAPT		Level of care		
	Small N = 41 Median (IQR)	Medium N = 57 Median (IQR)	Large N = 82 Median (IQR)	Yes N=119 Median (IQR)	No N =61 Median (IQR)	Primary N = 123 Median (IQR)	Secondary N =31 Median (IQR)	Mixed N = 26 Median (IQR)
Percentage of service users that meet Standard 3 (%)	90.9 (50-99.4)	85.7 (54.4-97)	92.6 (77.9-98.7)	94 (78.8-98.7)	78.6 (40.3-94.2)	94.1 (80.2-99)	73.3 (31.6-86)	79 (35.7-92.1)
Waiting times in days	66.5 (35.0-120.0)	57.0 (32.5-120.0)	40.5 (20.0-78.3)	39.0 (20.0-77.0)	77.0 (50.8-141.0)	42.0 (20.0-77.0)	93.0 (55.0-160.0)	73.0 (34.8-142.4)
Waiting times in weeks	9.5 (5.0-17.1)	8.1 (4.6-17.1)	5.8 (2.9-11.2)	5.6 (2.9-11.0)	11.0 (7.3-20.1)	6 (2.9-11.0)	13.3 (7.9-22.9)	10.4 (5.0-20.3)

Table 74: Standard 4: Data completeness for primary diagnosis for the three service groupings (N=190)

	Level of Care			IAPT		Service Size		
	Primary N=125 Median (IQR)	Secondary N=38 Median (IQR)	Mixed N=27 Median (IQR)	Yes N=121 Median (IQR)	No N=69 Median (IQR)	Small N=47 Median (IQR)	Med N=60 Median (IQR)	Large N=83 Median (IQR)
Percentage of service users with primary diagnosis complete	86.1 (42.6-99.2)	100 (92.6-100)	80.0 (50.8-99.1)	82.0 (45.3-98.7)	99.0 (87.8-100)	98.6 (86.7-100)	95.6 (78.2-100)	72.0 (30.4-96.7)

Table 75: Standard 4: Percentage of service users with a Primary diagnosis of anxiety or depression who receive NICE recommended therapy for the three service groupings (n=168)

	Level of Care			IAPT		Service Size		
	Primary N=111 Median (IQR)	Secondary N=35 Median (IQR)	Mixed N=22 Median (IQR)	Yes N=112 Median (IQR)	No N=56 Median (IQR)	Small N=37 Median (IQR)	Med N=55 Median (IQR)	Large N=76 Median (IQR)
Percentage of service users who received the NICE-recommended therapy	82.3 (71.4-93.3)	79.3 (62.0-92.0)	86.9 (60.6-97.1)	82.5 (72.7-93.6)	81.7 (67.1-91.4)	81.0 (60.4-97.5)	81.7 (67.7-93.6)	83.5 (74.1-93.2)

Table 76: Standard 5: Percentage of service users who recovered or received the NICE-recommended number of sessions for the three service groupings (N=147)

	Level of Care			IAPT		Service Size		
	Primary N=99 Median (IQR)	Secondary N=28 Median (IQR)	Mixed N=20 Median (IQR)	Yes N=101 Median (IQR)	No N=46 Median (IQR)	Small N=23 Median (IQR)	Med N=49 Median (IQR)	Large N=75 Median (IQR)
Percentage of service users who recovered or received the NICE-recommended number of sessions	59.8 (53.9-67.1)	62.5 (47.3-77.6)	54.1 (49.4-66.4)	59.4 (52.9-65.5)	64.1 (48.9-78.3)	75.00 (60.0-83.3)	57.5 (44.6-67.1)	59.1 (53.3-65.2)

Table 77: Standard 6: Formal training and supervision for the three service groupings (N=185)

	Level of Care			IAPT		Service Size		
	Primary N=124 Median (IQR)	Secondary N=35 Median (IQR)	Mixed N=26 Median (IQR)	Yes N=121 Median (IQR	No N=64 Median (IQR)	Small N= 36 Median (IQR)	Med N=65 Median (IQR)	Large N=84 Median (IQR)
Completed formal training in at least one therapy and working under supervision	85.7 (77.6-93.5)	77.8 (62.5-93.8)	78.0 (68.6-92.8)	85.0 (77.1-93.1)	80.0 (66.7-94.7)	86.6 (64.0-100)	81.3 (70.7-92.3)	85.5 (77.6-93.3)
Completed/currently undertaking formal training in at least one therapy and working under supervision	94.2 (88.2-100)	88.8 (78.6-100)	93.6 (84.6-100)	94.1 (87.8-100)	90.9 (82.2-100)	100 (83.7-100)	90.9 (82.1-100)	94.0 (88.8-97.7)

Table 78: Standard 7: Provision of choice by service type (presented by Median and IQR)

	Level of Care			IAPT		Service Size		
	Primary	Secondary	Mixed	Yes	No	Small	Med	Large
Venue (N=152)	71.4 (64.0-81.4) N=105	50.0 (37.6-71.4) N=24	66.7 (56.7-75.0) N= 23	71.4 (63.7-80.7) N=104	65.5 (44.6-73.7) N= 48	72.1 (50.8-83.3) N= 32	70.6 (54-81.3) N=47	70 (62.4-76.7) N=73
Time (N=162)	84.6 (79.8-91.4) N= 109	77.7 (72.2-88.9) N=28	84.8 (69.8-93.0) N=25	84.4 78.6-91.1 N=107	83.3 75.0-93.3 N=55	86.7 81.8-95.3 N=37	82.9 75.0-94.3 N=51	83.7 77.8-88.3 N=74
Gender (N=144)	42.9 30.5-52.0 N=102	50 29.4-58.6 N=21	40.7 31.5-62.9 N=21	40.4 29.5-50.0 N=100	48.1 33.3-65.0 N=44	53.8 4.0-71.4 N=27	41.1 28.6-53.1 N=46	39.3 29.4-49.1 N=71
Language (N=58)	63.6 54.1-83.3 N=49	50.0 N/A N=3	59.3 45.8-64.7 N=6	62.5 50.0-80.0 N=51	61.9 55.6-88.9 N=7	75.0 N/A N=3	61.7 55.2-83.3 N=16	62.5 50.0-75.00 N=39
Type of talking treatment (N=153)	69.7 58.7-75.4 N=107	60.0 54.0-75.0 N=23	66.7 59.3-75.0 N=23	69.7 59.2-75.3 N=106	65.2 54.0-75.0 N=47	70.0 57.1-80.0 N=31	68.9 56.1-75.6 N=50	67.0 57.8-73.7 N=72

Table 79: Standard 8: Service user satisfaction (presented by Median and IQR) (N=174)

	Level of Care			IAPT		Service Size		
	Primary N=115	Secondary N=33	Mixed N=26	Yes N=111	No N=63	Small N=45	Med N=54	Large N=75
Access	82.5 (78.3-86.4)	76.3 (73.4-88.8)	81.0 (76.0-84.5)	81.9 (77.7-85.2)	81.3 (75.0-88.8)	83.4 (75.4-90.6)	81.4 (75.2-87.0)	81.5 (78.0-84.5)
Experience	81.6 (77.0-86.3)	82.5 (76.9-88.9)	80.2 (75.0-88.7)	79.6 (76.0=83.6)	83.6 (78.5-90.3)	85.7 (80.0-92.6)	80.7 (75.5-86.9)	79.5 (76.9-82.8)
Needs taken seriously, understood and appropriately considered	92.3 (88.7-95.6)	92.3 (86.7-100)	90.7 (86.5-100)	91.2 (88.4-94.7)	94.1 (88.6-100)	96.7 (91.4-100)	92.0(85.7-95.8)	91.0 (88.2-94.2)
Lasting bad effects	4.9 (2.9-7.2)	7.4 (0-11.1)	6.2 (3.2-10.8)	5.5 (3.3-7.6)	5.9 (0-10.0)	4.7 (0-10.9)	5.8 (2.4-7.7)	5.3 (3.4-7.6)
Asked by therapist to give feedback	73.3 (67.9-79.3)	69.0 (58.2-83.3)	71.4 (65.6-85.0)	73.3 (67.6-79.4)	70.3 (62.3-83.3)	71.4 (63.4-83.5)	72.1 (67.8-80.1)	72.9 (66.9-78.6)
Information storage and confidentiality	58.6 (52.4-66.1)	51.4 (43.1-63.9)	60.7 (46.7-73.6)	58.1 (50.8-64.6)	57.2 (47.2-66.7)	61.1 (52.1-71.9)	57.4 (49.0-66.7)	57.0 (49.1-63.2)

The service level analysis for Standards 9 and 10 are included in the body of the main report.