IMPROVING ACCESS
TO PSYCHOLOGICAL THERAPIES SERVICES

START HERE

By The Mental Health Collaborative

Health Delivery Directorate: Improvement & Support Team
Introduction

Is your Psychological Therapy Service ill?
Is your Psychological Therapy Service unwell?
Do you recognise any of the following? Tired clinicians, fed up referrers, agitated managers, or patients feeling their needs are not being met. Have you tried waiting list initiatives and yet waiting times are the same or worse? Do you feel you are expected to do more and more and increasingly have no time left to think? Are you beginning to think it will never improve?

As a staff member do you feel?
‘I can’t go on like this, I want to provide a good psychological therapy service with a smooth patient journey and timely appropriate psychological therapy. I’m working hard – but everyone is fed up with me.’

Take a moment ... 
Imagine a world where your service is without a waiting list and there are no unnecessary delays before patients are seen. Clinicians are able to focus their energies on treating people, doing what we came into the service to do!
HELP is here

We have prepared some resources to help in the treatment of ailing psychological therapies services. They are an introductory guide to demand and capacity theory as it applies to psychological therapy services. The intention is that they will plant a few seeds of interest and hope to help you with your own service.

Why Demand and Capacity?

Most of the targets our services face are about queues. Queues are about managing service demand and service capacity. Requests to increase service resources are actually about increasing service capacity. Does increasing resources solve queues? Often not without work on Demand and Capacity.

Definition of a Psychological Therapy Service?

A Psychological Therapy Service is any local service providing psychological therapy. Examples might include: Primary Care Mental Health Teams, Community Mental Health Teams, Clinical Psychology Service and Psychological Therapies Services.
Why is work on demand and capacity important?

It helps us understand; what we do, who we do it for and how we work. Knowing this helps us to make sensible changes and think about whether we can make better use of the resources we already have.

Jargon Alert - ‘Don’t Panic’

At first glance the world of demand and capacity appears to be full of jargon, but it can be kept quite simple. 

**Demand** is not how many people are referred, it is the time they need to be treated.

**Capacity** is not the number of staff we have, it is the total resource available to do the work, which includes staff and any equipment needed (such as rooms).

**Activity** is not the same as capacity – activity is how much work we actually do and is often less than we have the capacity to do (because so often we spend time doing things we don’t need to such as chasing around trying to find notes, re-booking appointments etc).

Our waiting list is actually a **Queue**. For the sake of quickness and because everyone loves an acronym we refer to it as **DCAQ** (**Demand, Capacity, Activity and Queue**).
Administration – making it work better

We’ve developed a separate guide on clinical administration for psychological therapy services, as good admin support is essential to effectively managing our demand and capacity. They help us manage our appointments (DNAs, cancellations, follow-up appointments etc). They can use our electronic diaries to book first and follow up appointments, and in doing so, free up clinical time. Admin staff can ensure clinical staff are making the best us of their time by keeping empty spaces in clinics full.
Improving Services

The Mental Health Collaborative promotes an approach to change that focuses on helping those who deliver a service to make improvements to that service. Evidence shows that this approach to change does lead to better services and more motivated staff.

CHANGE

• Change can be difficult and can be threatening
• Change can be time-consuming
• Change involves understanding people, systems and processes
• Healthcare systems are often complex and fragmented

BUT

‘If you always do what you have always done, you will always get what you have always got.’

AND

• Change can also be motivating and inspiring
• Change can lead to better services and happier staff
• Change can be implemented incrementally so it has the minimum of disruption
• Done in the right way – change can be something you enjoy
A wee bit of improvement theory

There is a whole world of improvement theory that can help us make changes. Whilst this may seem to be confusing and yet another area of jargon and ‘management speak’, it can help, and psychology therapists will recognise and feel comfortable with the concepts – once they have translated them back into their own jargon.

The Mental Health Collaborative (MHC) has a huge amount of expertise in supporting improvement and local support from the MHC will be available in all areas. In this leaflet we will cover ‘The Model for Improvement’ which the Mental Health Collaborative promotes as the main approach for making change. It is also used widely by Patient Safety and other Improvement Programmes.
Start with the three key questions

The Model for Improvement consists of two parts. The first part contains three fundamental questions that need to be considered before you do any improvement work (though you can answer them in any order).

1. What are you trying to accomplish?
Improvement work requires clear aims that will guide the work and keep your efforts focused. Ideally you want to be able to measure whether you have achieved your aim and for it to have clear timescales.

For instance, you might be working in a service with a high Did Not Attend (DNA) rate, which means that a lot of time is spent waiting for people who never turn up. You might decide to work on this issue and set yourself an aim to reduce the level of DNAs for first appointments to 10% by December 2010.

2. How will you know that a change is an improvement?
We live in a constantly changing world, but how much of that change leads to actual improvements? And how will you know if the changes you are making are actually resulting in an improvement? Is it possible they’ve made things worse? We know it’s not always easy to measure the impact of what we do and all measures have their limitations. However, used appropriately, data can be really helpful. And what’s the alternative - keep making changes in the absence of any measurement about whether they work?
The MHC encourages teams to use quantitative and qualitative data to see if the changes being made are actually making a difference. Include capturing views from those who use our services. If you are worried that a change to improve one bit of your service might make other things worse, then you need to collect data to see if that happens. And remember, it’s not a research project. Think ‘pilot’ study: quick, possibly dirty, but systematically using and analysing data. In clinical terms, the methodology used for Single Case Studies is directly applicable.

So in our example we would look at what is happening to the DNA rate as we make changes. We would record the DNA rate for first appointments, and report this on a regular basis, probably weekly. Using simple tables and graphs can help us to see what is happening. Noting the timing of the changes we make and including this in our graph can be a very powerful way of recording and reporting the changes.

You might be concerned that actions to improve your DNA rate will have a negative impact. One unintended consequence may be that you are making changes that put up barriers to access. For example, if one of your actions was to require that appointments are only confirmed once the patient phones in, how will you know if this disadvantages one particular group (ie young men). How might you collect data on this? There are many options: polling referrers, consulting with your user group, following up non-responders for more information would all provide useful data. But remember to keep it simple, this is not a research project, you only need enough data to make informed decisions about your particular context.
3. What changes can you make that will result in improvement?

So now you know what you are trying to achieve and what data you will collect to know if you have achieved it. The next step is to think about what actual changes you are going to make to deliver those improvements. Ideally, you want to involve everybody who might have to make the change in generating ideas for change. You might also want to look at what has worked elsewhere.

However, it is often difficult to know in advance what the impact of a change will be - and even if something has worked in one area - it doesn’t mean it will work for you. This lack of certainty about whether a change will work, and a fear of the consequences if it doesn’t, can lead teams to just talking over the same issue again and again and again. One way through this is to use PDSA cycles to initially test the change at a small scale.

**PDSA – number 1 in the improvement charts**

Jargon confusion warning: PDSA in this context is not to do with sick animals. PDSA Means **PLAN, DO, STUDY ACT** and comes with it’s own logo!
PDSA is:
• A simple tool for staff to use to test out ideas that will improve healthcare systems and processes;
• A structured approach for making small incremental changes to systems;
• A way of helping you to move to action, even where some uncertainty exists about whether the change will lead to improvement;
• A full cycle for planning, testing, studying and acting on the learning gained from the first three phases.

Principles of PDSA:
• Breaks down change into manageable, bite-sized time-limited chunks;
• A PDSA cycle cannot be too small;
• Small changes can be tested without causing upheaval to the whole system;
• If it doesn’t work, try something different based on your learning.

Advantages of PDSA:
• It is small in scope and builds incrementally – small rapid cycles lead to improvement;
• It is highly effective, changes are quick and immediately evident;
• It is a powerful tool for learning. As much is learned from ideas that don’t work as from those that do.
Testing change ideas using PDSA

**PLAN**
- Set objectives
- Identify the changes you want to test
- Make predictions
- Plan how to measure outcomes
- Define roles and responsibilities

**DO**
- This is the stage where the plan is put into action
- Remember to keep it small and manageable initially, i.e. one patient, one therapist, one day
- Collect data to see what impact the change is having

**STUDY**
- Reflect with all relevant stakeholders
- Analyse data collected and compare with predictions
- Summarise what was learned
- Decide whether to change anything prior to testing the change again

**ACT**
- If you decide not to change anything, the cycle should be tested again under different conditions
- Alternatively, you may decide to amend your plan to reflect learning from the first cycle and re-test
So in our example, someone might come up with the idea to put the information about the importance of keeping first appointments in large bold red font. The revised letters are sent out and the DNA rate measured for the following four weeks. The data shows no change.

**Another idea ...**
Ask patients to phone to confirm, and advise that if they do not, they will not be seen. The revised letters are sent out and the DNA rate measured for the following four weeks. It reduces from 20% to 15%, BUT some patients arrive without having phoned, and they are fed up that they cannot be seen. Two of these point out that they tried to phone but could not get through.

**Another idea ...**
Answer machine bought and turned on... the DNA rate measured for the following four weeks. It reduces from 15% to 12% and no-one turns up who hasn’t phoned.

**Another idea ...**
and so on.
Repeat as necessary

Repeated small scale changes will eventually add up to large scale change.

What is so special about PDSA?

This may sound like a scientist practitioner approach, stating and testing hypotheses, it is! The simplicity of PDSA, with an emphasis on very small scale change, is more liberating than ‘doing research’. It allows changes to be made and tested quickly. Also it is an approach that all staff can use and it is in use across the NHS in Scotland.

For further details about The Model for Improvement see the Institute for Healthcare Improvement site at: www.ihi.org. The Improvement Guide (1996), Langley et al, is an excellent resource that goes through the theory and application of The Model for Improvement in depth.
Not too sure about PDSA
- try the HAIRDRYER

Another model, similar to PDSA, is used by the Releasing Time to Care project. The principle is exactly the same: assess the issue, diagnose, plan, treat, see how it went, repeat as necessary. However, this model looks very similar to the way we approach psychological therapy so you might find it easier to relate to.

*Releasing Time to Care, The Productive Mental Health Ward, Project Leaders Guide, NHS institute for improvement and Innovation 2008*
Where do I start? - anywhere!

It does not really matter where you start. Change and improvement take time, and rather than worry about the best place to start, just start.

We have produced a series of introductory guides for psychological therapies services. These guides cover four areas: Demand, Capacity, Goal setting/Case Review and Clinical Administration.

Each booklet has a checklist at the end to help you see where your service is, and to help you decide where you may wish to begin. These checklists are reproduced below and can be used as a way of checking where your service is in relation to each of the four main areas and to help you choose the relevant guide. Rather than a simple yes/no choice you can select ‘partly’, as we recognise that most services will be in the process of looking more closely at what they are doing. If you can answer yes to every question in a section then you probably don’t need to refer to this booklet. If your answer is no or partly – then you might find some useful information in the booklet to help you along.

However, as much of this work involves systems that are linked, starting anywhere will lead naturally to another piece of work to be done.
## Demand

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<tr>
<th></th>
<th>Yes</th>
<th>Partly</th>
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<tr>
<td>Can you quantify the demand for your service?</td>
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<td>Are you doing work that someone else could do or work that does not need to be done?</td>
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<td>Do you have clear eligibility criteria?</td>
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<td>Does work have to be redone because it was not done right the first time?</td>
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<td>Do you spend lots of time waiting to see people who don’t turn up?</td>
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<td>Have you streamlined all your processes to ensure you don't have unnecessary steps?</td>
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<td>Have you implemented matched care?</td>
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<td>Do you have effective caseload management and review systems in place?</td>
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<td>Are you making effective use of group work?</td>
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## Capacity

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<th>Question</th>
<th>Yes</th>
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<tr>
<td>Do you know how your team members currently spend their time – and how much of this is on clinical work and how much on other activities?</td>
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<td>Do you know what your team’s capacity is in terms of number of new referrals you can see and number of interventions you can provide?</td>
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<td>Do you manage sickness effectively?</td>
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<td>Are community visits well organised so they minimise time spent travelling between places?</td>
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<td>Are you certain you have the right people doing the right things? (or do you have highly skilled / specialist staff spending lots of time on work that other staff could do just as effectively?)</td>
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<td>Are your staff appropriately trained so they have the skills needed to do the work that presents?</td>
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<td>Are your meetings well run so they are an effective use of time?</td>
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<td>Have you removed all duplication and unnecessary steps from your clinical admin procedures?</td>
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### Goal Setting/Case Review

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<th>Goal Setting and Case Review</th>
<th>Yes</th>
<th>Partly</th>
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<td>Are all cases checked for match to service criteria?</td>
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<td>Does the service use a goal setting approach?</td>
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<td>• Are the goals of therapy explicit?</td>
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<td>• Are the goals S.M.A.R.T.?</td>
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<td>Is there a seamless system for stepping up/down to services that best match goals?</td>
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<td>Is there a system of case review built into supervision?</td>
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<td>Do you regularly review case loads against treatment and service goals?</td>
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<td>Do you regularly check progress against aims?</td>
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<td>Is there a good match between level of skill and identified needs?</td>
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<td>Are there flexible arrangements possible for follow-up appointments?</td>
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<td>Are there systems to deal with dependency issues?</td>
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<tr>
<td>Is the DNA policy clear and is it being applied?</td>
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### Clinical Administration

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<th>Administration for Psychological Therapies</th>
<th>Yes</th>
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<tr>
<td>Is there clear service information for referrers?</td>
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<td>Is there clear service information for patients?</td>
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<td>Are partial first appointment booking systems in place?</td>
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<td>Is there a system for recording appointments offered and cut off dates for responses?</td>
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<tr>
<td>Is there a clearly stated Did Not Attend (DNA) policy?</td>
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<td>Is there a clearly stated Cancellation Policy?</td>
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<td>Is the service easily contactable for patients (phone, email or text)?</td>
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<td>Does the service hold comprehensive contact information for patients?</td>
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<td>Do admin staff have full access and booking permission for clinic diaries?</td>
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<td>Do clinicians identify appointment slots in each clinic in advance?</td>
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<tr>
<td>Do clinicians differentiate between new and follow up slots in diaries?</td>
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<tr>
<td>Is there a system in place to allow unused appointment slots to be filled quickly?</td>
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<td>Is short notice booking a priority for administration staff?</td>
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<td>Is there an admin team member allocated to disseminate resources?</td>
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These booklets have been produced by the Scottish Mental Health Collaborative. For further information about the work of the Scottish Mental Health Collaborative please visit its website: www.scotland.gov.uk/PsychologicalTherapiesServicesIntroductoryGuides/ImprovingAccess

These booklets are a series of five. These are listed below:

• Improving Access to Psychological Therapies Services
• Capacity for Psychological Therapies Services
• Demand for Psychological Therapies Services
• Clinical Administration for Psychological Therapies Services
• Goal Setting & Case Review for Psychological Therapies Services

PDF copies of these booklets can be assessed at the Scottish Government website: www.scotland.gov.uk

Further copies are available from:
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ISBN: 978-0-7559-9342-0