Case Study:
City and Hackney Psychotherapy Service
Our journey in the new Access Collaborative

Rory Bolton (Clinical and Operational Lead)
& Emma Binley (Improvement Advisor)
City and Hackney Psychotherapy Service

Provides a range of evidence-based psychological treatment modalities for individuals with complex psychological needs requiring a secondary care intervention, who meet a range of psychiatric diagnoses and comorbidities, including moderate to severe depression and anxiety disorders, Obsessive Compulsive Disorder (OCD), Post-Traumatic Stress Disorder (PTSD), and Personality Disorder.

Treatments offered include:
- Cognitive Behaviour Therapy (CBT)
- Cognitive Analytic Therapy (CAT)
- Eye Movement Desensitisation and Reprocessing Therapy (EMDR)
- Narrative Exposure Therapy (NET)
- Schema Therapy (ST)
- Psychodynamic Therapies (both individually and group based)
- Interpersonal Therapy
- Couples and Family Therapy.

The service provides treatment pathways of varying intensity for individuals with significant Cluster B Personality Disorder characteristics, which are delivered according to a Mentalisation-Based Therapy (MBT) treatment model.
City and Hackney Psychotherapy Service

• Staff compliment within SPS of 14wte substantive staff, and within the specialist PD arm of the service of 7.5wte, making a total of 21.5wte. Many part-time and sessional workers, as well as a significant contingent of honorary therapists and trainees offering treatments under supervision.

• SPS is a partner within a local Psychological Therapies Alliance of other statutory and non-statutory organisations providing psychological therapy within the borough (‘No Wrong Door’ policy)
Referrals

Total Number of Referrals into SPS by month

Jan-16  Feb-16  Mar-16  Apr-16  May-16  Jun-16  Jul-16  Aug-16  Sep-16  Oct-16  Nov-16  Dec-16  Jan-17  Feb-17  Mar-17  Apr-17  May-17  Jun-17  Jul-17  Aug-17  Sep-17  Oct-17  Nov-17  Dec-17
Total Number of referrals by main referring agencies to SPS
Total Number of referrals by main referring agencies to SPS

**2016**
- PCP 20%
- CMHT 21%
- PCL/EPC 11%
- Other 8%
- GP 30%
- ACUTE 7%
- PCPCS 3%

**2017**
- PCP 29%
- CMHT 24%
- PCL/EPC 2%
- Other 6%
- GP 24%
- ACUTE 9%
- PCPCS 6%
Testing: use of an Information & Enrolment Session as the first Face to Face contact, following acceptance of referral. In place since August 2016 (11 month test).

What is it & how do we run it?

• 2 sessions offered each week, maximum 10 patients per session, lasting up to 1 hour
• First 30 minutes psycho-education providing information about SPS/TCOS/mental health services in Hackney. Then 30 minutes booking patients individual assessment appointments, answering questions, dealing with occasional urgent issues, supporting completion paperwork, etc.
• 2 therapists run each session, admin support for scheduling appointments
• Offered as standard to all accepted referrals to SPS and TCOS
• Most patients agree to attend and are opted-in by admin by phone. However, not mandatory, if insistent/has access needs (e.g., deaf) patient can currently be booked directly into an assessment date
## Information and Enrolment Sessions

### Predictions

<table>
<thead>
<tr>
<th>Will these sessions reduce DNAs for individual assessments appointments?</th>
<th>• Does this help to manage service users’ expectations regarding waiting times?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Is it helpful to provide them information about our treatments?</td>
</tr>
<tr>
<td></td>
<td>• Is it helpful to inform them of other local resources available whilst they wait for treatment, esp. ELFT Crisis Services &amp; Hackney Wellbeing Service?</td>
</tr>
</tbody>
</table>

**We predicted there would be a reduction in DNAs**

**We predicted that overall it would improve service user satisfaction by being better informed; it would help manage expectations & enable access to local statutory and third sector mental health and generic support services and resources.**
### Information and Enrolment Sessions

#### Results

<table>
<thead>
<tr>
<th>Does attendance at these sessions reduce DNAs at individual assessment appointments?</th>
<th>• Does this help to manage service users’ expectations regarding waiting times?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Is it helpful for them to receive information about the psychotherapy treatments and to be informed of other local resources available whilst they are waiting to be seen (Crisis services &amp; Hackney Wellbeing Network)?&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provisional results indicate reduction in DNAs at assessment appointment from 25% to 15% (of the people who have attend the I&amp;E session)</th>
<th>• 88% of patients who attended found the session useful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• 90% of patients said as a result of coming today they were more likely to attend their assessment appointment</td>
</tr>
</tbody>
</table>
Information and Enrolment Sessions

Results: Some example comments:

Positive
“I wasn’t sure what to expect from this meeting but found it helpful and informative. The clinicians gave plenty of opportunity to ask questions and were welcoming”

“It’s nice to approach this in a group and although I knew most of the info already it makes you feel like things are moving forwards”

But there were also some negative experiences
“It’s not that it wasn’t useful as such – but I don’t think it made a difference – I am committed to coming to any appointment I am offered. I didn’t think the session added much for me”

“This is a relatively daunting experience for an individual. Not sure about mental health in terms of being a group scenario straight away”
Information and Enrolment Sessions

Development over time (adjustments to test, based on feedback, reflection)

• Due to patient feedback, now give less detailed description about the different treatment modalities, which is provided in the leaflets. However, time is given to describe our new trial phased treatment approach including mandatory Introduction Groups (Intro Complex Trauma Group and Intro to Psychotherapy & Formulation Group).

• Speeding up scheduling by pre-allocation of appointments, only changing if doesn’t work for service user.

• Changing seating position into classroom style rows, rather than circle, in keeping with psycho-education format. Also, allowing patients to return to waiting room to wait for appointment allocation. Both changes more sensitive to needs of severely anxious and complex patients.

• Addition of more psycho-ed material into sessions so this can count as first contact for commissioners (Focus now is on time to treatment, so not so relevant to consider).

• No longer specifically ask patients to fill in clinical questionnaires during session as significant proportion are illiterate/ have poor literacy or have English as second language, so this activity was potentially quite shaming (and therefore could subsequently increase DNA rate at assessment).

Other learning

• Initially delivered by core QI Project team senior staff: Rory Bolton (Overall PTS Service Lead), Caroline Ben Zaina (Senior CBT Therapist) & Michael Mlilo-Mabaso (TCOS Personality Disorder Service Lead). Not straight forward initially to lead session, needed to understand issues as they arose and develop protocol before we could hand over to other staff. Now delivered in protocolized format, by 2 x B7 therapists + 2 x TCOS staff as standard.

• Big challenges in scheduling this and getting staff to provide availability – tried rotating across whole team, but took too much time to coordinate/ organise, most staff fractional with existing clinical commitments. Building into job plans of four clinicians has been most effective and reliable method.

• Time built in and prior agreement between staff regarding management of any occasional risk issues or challenging behaviour that may inevitably arise, with a group of unassessed patients (to date have effectively managed occasional issues of expressed suicidality, psychosis, intoxication, and confrontational behaviour).
• Joined previous Access Collaborative in 2015

• Previous big PDSA: Information & Enrolment Sessions

• Pressures & challenges; increasing demand, shift to focus on Time to Treatment

• The need for a more detailed understanding of our pathway; ensuring PDSAs take the whole pathway into account

• Positive service user experience

• DNAs at Assessment down from 25% to 15%
Work since June 2017

1. High level Flowcharting to identify the steps in the pathway and map service demand and capacity

2. Developing a Demand and Capacity Model in partnership with the QI Team

3. Sharing results with whole service, DMT & commissioners

4. New PDSAs
   1. Development of psycho-education groups, as step 1 for treatment
   2. Reducing service capacity used in Assessment through opportunity afforded by psycho-education groups
High level Flowcharting to identify the steps in the pathway and map service demand and capacity

High Level Blocks: Main stages/steps in the pathway

New Demand/ New referrals and drop out rate between each step

Staff required and time taken for each detailed process.
What did this involve:

AIM: to reflect as accurately as possible in an Excel model how the clinical service is functioning in terms of demand and capacity

1. Inputting data and information on service capacity
   - Broken down into different roles, bandings and activities
   - Length of time taken for each process (based on cycle time).

2. Inputting data on the service demand (new referrals, wait lists etc.)

3. Regular meetings to check the accuracy of the model and outputs

4. Developing questions and hypothetical scenarios to understand implications and options of service change
## How it works (1)

1. For each modality all staff capacity entered

<table>
<thead>
<tr>
<th>CAPACITY</th>
<th>Input</th>
<th>Current No. of Clinicians</th>
<th>Max. No. of Clinicians Utilised</th>
<th>Working hours per clinic per week</th>
<th>% time worked</th>
<th>% Clinical time</th>
<th>Total working hours (Current Capacity)</th>
<th>% Clinical time</th>
<th>Total Clinical Hours (Current Capacity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological</td>
<td>20.00</td>
<td>20.00</td>
<td>NA</td>
<td>50.00</td>
<td>20.00</td>
<td>50.00</td>
<td>25.00</td>
<td>50.00</td>
<td>50.00</td>
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<tr>
<td>CBT</td>
<td>19.00</td>
<td>19.00</td>
<td>NA</td>
<td>30.00</td>
<td>55.00</td>
<td>50.00</td>
<td>30.00</td>
<td>15.00</td>
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<td>CAT</td>
<td>18.00</td>
<td>18.00</td>
<td>NA</td>
<td>25.00</td>
<td>75.00</td>
<td>50.00</td>
<td>30.00</td>
<td>20.00</td>
<td>20.00</td>
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<tr>
<td>Couples/Family</td>
<td>19.00</td>
<td>19.00</td>
<td>NA</td>
<td>25.00</td>
<td>75.00</td>
<td>50.00</td>
<td>30.00</td>
<td>20.00</td>
<td>20.00</td>
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</tbody>
</table>

...first stage – Screening...

2. Left to right across spreadsheet, time taken for each stage of pathway mapped in detail for each staff member, calculating remaining clinical time for later stages

...then Information & Enrollment Sessions, then Assessments...
...then Low Intensity Treatment (LIT), then supervision

...then Psychoeducation Groups, then Treatment pulling from a number of sub-sheets for each speciality (CBT, PDP, CAT, Couples/families)
Some of the questions we’ve used the model to answer...

Assessment

• How does the assessment stage of the pathway function with 24 referrals per week? (estimate of 75th percentile now) (Is there enough capacity?)

• How does the assessment stage of the pathway function with 28 referrals per week? (Upper Control Limit at beginning of financial year) (Is there enough capacity?)

• What happens if capacity for assessment varies below the intended 14 slots per week?

Whole pathway scenarios

• Scenarios 1&2: if we could reduce the time we spent doing assessment, what would happen to the whole pathway?

• Scenarios 3&4: if we could reduce the length of therapy, what would happen to the whole pathway?

Current PDSA 1: Psycho Education Groups

• How many Psycho-Education Groups do you need to meet demand? (Just looking at new demand, assuming no backlog)

• How many Psycho-Education Groups do you need to clear back-log?

• How many people need to be diverted from individual treatment to make Psycho-Education Groups worth running? (in terms of capacity usage)
Scenario 1: Consistent availability of 14 assessment slots
Demand: 28 referrals per week
Assumed DNA rate: 15%
Required assessments: 12 new demand, 2 DNA re-book
Total Wait List: 0 (not considering backlog)

Assessment slots available: 14
Impact on wait list: 0

Scenario 2: What happens if capacity for assessment varies below the intended 14 slots per week? (between 9 and 14)
Demand: 28 referrals per week
Assumed DNA rate: 15%
Required assessments: 12 new demand, 2 DNA re-book
Total Wait List: 0 (not considering backlog)

Assessment slots available: 9-14
Impact on wait list: building wait list
Sharing results with whole service, DMT & commissioners - reflections
New PDSA: (1) Psycho-Education Groups

**Theory**

Will the implementation of 1\textsuperscript{st} Stage Treatment Groups as an integral part of the pathway within SPS:

1. Reduce waiting time to treatment.

2. Decrease Demand for 2\textsuperscript{nd} stage treatments (i.e. Individual Therapy)
Measures

- Waiting time to treatment
- No. of cases going forward for 2\textsuperscript{nd} Stage Treatment
- Pre/Post Outcome Measures for 1\textsuperscript{st} Stage Treatment Groups
- Service User Feedback on content and relevance of 1\textsuperscript{st} Stage Treatment Groups.
(1) Psycho-Education Groups: Preliminary Results

A comparison of pre & post PHQ-9 mean scores across the 3 trauma groups
(1) Psycho-Education Groups: Preliminary Results

A comparison of pre & post GAD-7 mean scores across the 3 trauma groups

Pre GAD-7 Mean Score | Post GAD-7 Mean Score
(1) Psycho-Education Groups: Preliminary Results

A comparison of pre & post IESR mean scores across the 3 trauma groups
Overall, how would you rate your experience of the group?

- 50% Extremely Good
- 33.33% Very Good
- 16.67% Good
- Not at all

(1) Psycho-Education Groups: Preliminary Results
(1) Psycho-Education Groups: Preliminary Results

How relevant was the group to your life and situation and why?

- Extremely: 16.67%
- Very: 16.67%
- Relevant: 33.33%
- Somewhat: 16.67%
- Not at all
Psycho-Education Groups

Results: Some example comments:

What was the most useful thing about the group?
“Knowing that there are other people going through something similar”
“That you are not alone. To take baby steps”
“Trying to find things that I like and that can calm me down, not just talking about sad things. Also helping me to breathe better.”

What was the least useful thing about or what was actually unhelpful about the group?

“The questionnaire is so complicated and I don't understand them and they bring a lot of thinking which makes me sad.”
“It wasn't available to me a few years ago.”
“Completion of the questionnaires”
New PDSAs: (1) Psycho-Education Groups

Summary
• Aiming to set a culture whereby this is standard first step of treatment
• 8 weeks, once a week
• 1.5 hours, 45 mins write up
• 2 therapists facilitate
• 3 different groups running:
  1. Trauma - 2 8b CBT therapists
  2. Compassion focused skills - 8a CBT, B7 CBT
  3. Generic - 1 PDP 8c, 1 B7 CAT / 2 B7 PDP

• Post group: should enable reduction in individual treatment (number needing individual therapy / amount of time in individual therapy)

Modelling how many people need to be diverted from individual therapy to reduce wait list

<table>
<thead>
<tr>
<th></th>
<th>Referral</th>
<th>Screening</th>
<th>I&amp;E Sessions</th>
<th>Assessment</th>
<th>PE Groups</th>
<th>LIT</th>
<th>Treatment</th>
<th>Discharge</th>
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<tbody>
<tr>
<td><strong>Summary</strong></td>
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<td>1. Trauma -  2 8b CBT therapists</td>
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<td>2. Compassion focused skills - 8a CBT, B7 CBT</td>
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<td>3. Generic - 1 PDP 8c, 1 B7 CAT / 2 B7 PDP</td>
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<td><strong>Number of referrals</strong></td>
<td>24</td>
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<tr>
<td><strong>New places required for groups</strong></td>
<td>8</td>
<td>8</td>
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<td><strong>Dropout rate</strong></td>
<td>40%</td>
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<tr>
<td><strong>Total number remaining in group</strong></td>
<td>5 (per week)</td>
<td>5 (per week)</td>
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<td>5 (per week)</td>
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<td>5 (per week)</td>
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<td>10 (per fortnight group)</td>
<td>10 (per fortnight group)</td>
<td>10 (per fortnight group)</td>
<td>10 (per fortnight group)</td>
<td>10 (per fortnight group)</td>
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<tr>
<td><strong>Total number of service users still requiring 1:1 therapy</strong></td>
<td>3 (70% still requiring 1:1 therapy)</td>
<td>2 (50% still requiring 1:1 therapy)</td>
<td>1 (30% still requiring 1:1 therapy)</td>
<td>0.5 (10% still requiring 1:1 therapy)</td>
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<tr>
<td><strong>Impact on wait list (how much wait list will reduce by)</strong></td>
<td>Decrease by -3 per year</td>
<td>Decrease by -2 per week, -95 per year</td>
<td>Decrease by -4 per week, -186 per year</td>
<td>Decrease by -5 per week, -278 per year</td>
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</table>
(2) Reducing service capacity used in Assessment, through opportunity afforded by psycho-education groups

**Theory**

We can reduce the length of initial assessment and create more capacity in our pathway by:

- 1. Refining our focus and expectation on what we really need to know at this stage.
- 2. Then utilising the Psycho-Education Groups as a means and opportunity for us to gather a deeper sense of our service users' presentation (i.e. deeper elements of assessment) so achieving the same things, but later on in the pathway.
(2) Reducing service capacity used in Assessment, through opportunity afforded by psycho-education groups

The key things we really need to know at the outset are...

- Is the person appropriate for the service?
- Can the person do Psycho-Education Groups?
- Understand why person is with us, what they want from treatment?
- PHQ, Dialog; Previous therapies; Main presentations; Risk to themselves; Safeguarding concerns; e.g. children; Protective factors; Substance misuse

Things we are postponing to review following Psycho-Education Groups and no longer aiming to achieve in initial assessment:

- Decision around specific treatment modality
- Detailed formulation
- Test of whether people respond to treatment modality (for PDP) > this to be done in course of Psycho-Education Groups instead
(2) Reducing service capacity used in Assessment, through opportunity afforded by psycho-education groups

Predictions
• These changes will mean we make more space in our pathway; initially for more initial assessment slots (as taking less time for each clinician) > this will also help to clear backlog
• Reducing the time at the outset will mean we can get people into the Psycho-Education Groups (and therefore treatment) more quickly which will help to meet expectations of commissioners
• Sharing D&C model output and reassuring staff that we are not losing what we do, but are changing the order we do it will help to reassure staff and build will in these changes

Measures
• Length of time assessment is taking (Face-to-Face and writing up)
• Review selection of notes to check level of detail, what included following assessment
Learning from City & Hackney
Improving Access and Flow across Whole Service Pathways (All Psychotherapy Services and CAMHS)

Emma Binley
The Psychotherapy Services (and all CAMHS teams) are looking at improving flow throughout the whole care pathway with a particular focus on reducing the length of time from referral to start of treatment.

**AIM:** To reduce the length of time from referral to completion of treatment for CAMHS, PTS and Newham Community Mental Health Services.
Working Across a Whole Service Pathway

City and Hackney PTS

1. Referral
2. Information and Enrolment Session
3. Assessment
4. Psychoeducation Groups
5. Treatment (Individual and Group)

Newham PTS

1. Referral
2. Information Giving Session
3. Briefer Assessment
4. Psychoeducation Groups
5. Increase in Treatment Groups

Tower Hamlets PTS

1. Referral
2. Assessment (Modality Specific)
3. Welcome Group
4. Treatment Groups

Previous Test

Current/Future Test
Integrating QI Projects across Newham Secondary Care Psychological Services to Address Capacity and Demand

Erasmo Tacconelli
| 1. | Assessment and Brief Treatment (ABT) Psychology Service |
| 2. | Early Intervention Service (EIS) Psychology Service |
| 3. | Ageless Early Intervention Service (AEIS) Psychology Service |
| 4. | North and South Community Recovery Teams (CRTs) Psychology Service |
| 5. | North and South Community Recovery Teams (CRTs) Psychosocial Intervention Practitioner (PSI) Service |
| 6. | Home Treatment Team (HTT) Psychology Service |
| 7. | Rapid Assessment, Interface and Discharge (RAID) Psychology Service |
| 8. | Inpatient Psychology Service |
| 9. | Psychotherapy Enrolment Programme |
| 10. | Arts Psychotherapies Service |
| 11. | Cognitive Behavioural Psychotherapy Service |
| 12. | Integrative Psychotherapy Service |
| 13. | Psychodynamic Psychotherapy |
| 14. | Systemic Psychotherapy Service |
| 15. | Complex PTSD/Trauma Psychotherapy Service |
| 16. | Dialectical Behaviour Therapy Personality Disorder Service |
| 17. | Mentalisation Based Therapy Personality Disorder Service |
| 18. | ‘Getting There...’ Acute and Community Recovery Group Programmes |
Newham’s Integrated Psychological Services
Three ‘Quality Principles’ now underpin all NHS services provided to meet the physical health and mental health needs of the population and are key to the commissioning of local services.

<table>
<thead>
<tr>
<th>Quality Principle (1)</th>
<th>PATIENT SAFETY</th>
<th>Safety of Services: That the right staff are correctly trained learning from experience.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Principle (2)</td>
<td>PATIENT EXPERIENCE</td>
<td>Patient Centred: That Service Users feel valued and cared for.</td>
</tr>
<tr>
<td>Quality Principle (3)</td>
<td>CLINICAL EFFECTIVENESS</td>
<td>Evidence Based: That the right care is offered at the right time, and at the right place.</td>
</tr>
</tbody>
</table>

Trust priorities/themes will be paramount in guiding the topic/subject matter of projects. Based on the three overarching quality principles, related Trust clinical drivers and efficiency drivers, SRRPs are encouraged to focus on:

- Referral Care Pathways
- Waiting List Management
- Access
- Choice of Evidenced-Based Intervention
- Service User/Carer/Referrer Experience
- DNA Analysis
- Measurement Outcomes/Systems
- Staff Governance Systems
### Traditional Model
- **Referral**
- **Assessment**
- **1:1 & Group Therapy**

<table>
<thead>
<tr>
<th>Stepped Care Model</th>
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<tbody>
<tr>
<td>Referral</td>
</tr>
<tr>
<td>Assessment/Consultation</td>
</tr>
<tr>
<td>Stabilisation Groups</td>
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<tr>
<td>Assessment/Consultation</td>
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<tr>
<td>1:1 &amp; Group Therapy</td>
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‘Getting There…’
Acute & Community Services Group Programme
WELLBEING WORKSHOPS

1. Recovery
2. Anxiety Management
3. Depression Management
4. Anger Management
5. Distress Tolerance
6. Mindfulness

SHORT TERM GROUPS

1. New Horizons Recovery Skills Group
2. Mindfulness-Based Stress Management Group
3. Sensory Integration for Mental Wellbeing Group
4. Mood Management Group
5. Coping In The Moment Group
6. Bipolar Affective Disorder Group
7. Wellbeing Group
8. Relationships Skills Workshops
9. Pharmacy Group
10. Copperbox Healthwise Group
11. Sports Health & Fitness Short-Term Groups
12. Exploring Community Options Group
13. Peer Support Worker’s Group
14. Psychosis and Mental Health Seminars

LONGER TERM GROUPS

1. Tai Chi Group
2. BoxFit Long-Term Group
3. Walking Group
4. Arts Psychotherapies Groups
5. Psychodynamic Group Psychotherapy Groups
6. Hearing Voices Group
7. User Led Hearing Voices Group
8. Asian Women’s Group
10. Body Oriented Psychotherapy Trauma Group
11. Let’s Make Music Group
12. Sensory Garden Group
13. Allotment Group
Newham’s Integrated Community QI Projects

1. ABT WELLBEING WORKSHOPS QI PROJECT:
Aimed at maximising psychological intervention opportunities with focussed psychoeducation workshops to prevent unnecessary referral on to psychotherapy unless clearly indicated. 2 trainees

2. NEW HORIZONS GROUP QI PROJECT:
Aimed at ensuring holistic care and Recovery Focussed interventions to facilitate stepping down to primary care. 2 trainees

3. STEPPED CARE PSYCHOTHERAPY MODEL QI PROJECT:
Aimed at management of capacity-demand and ensuring any lengthy interventions are for those Service Users that most need them. 2 trainees
Questions