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A Guide to Understanding and Managing Demand

Mental Health Access Improvement Support Team

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1. What is demand?

This guide helps you to understand and manage the demand of a service. Services often refer to demand as the number of referrals received. But it is not that simple. Demand is better defined as the total resources needed to undertake the service required. For mental health, each referral is a request for clinical input so demand can be measured as the total time needed to respond to that request.

As different types of referrals require different inputs that last for different periods of time, using referrals as a proxy for demand can lead to underestimating or overestimating the resources needed. For example, the following teams both receive 100 referrals each quarter but the amount of resource needed to respond is very different.

Team	Number of referrals	Average number of hours clinical input per referral	Total number of clinical hours needed to respond to referrals
Team A	100	4	400
Team B	100	25	2,500

Put simply, demand is the total resources needed to respond to the referrals you receive.

2. Why look at demand?

Demand is multifaceted and something we can influence by our actions. It is not simply a never-ending stream of people coming through our doors that we have no control over. We know therapeutically that identifying the nature and extent of a problem is a good first step to looking for solutions. The same applies when thinking about the systems we work in so understanding your current demand is an important step in finding ways to influence it.

Understanding demand is important.

- If we know what our service demand is, it is easier to quantify what we need to do to meet that demand.
- It allows us to consider what we can do differently to reduce the demand.
- We know that one of the biggest contributors to stress is lack of control. Understanding that there are ways to influence demand can give teams back a sense of control; leading to increased morale and better working lives. Inevitably, this will then translate to better service user care.
- When we combine understanding our demand with understanding our capacity we can see if there is a match between the two. If not, and you are running the service as effectively and efficiently as possible, being able to demonstrate the difference is vital for putting together a case for additional resources.

3. Measuring demand

Demand can be broken down into the following categories.

Actual demand	What your service is asked for
Failure demand	What you have to do again because it was not done right the first time
Created demand	Demand which is created because of how your service responds (for example seeing people more times than they need to be seen)
Hidden demand	Demand is there but is not currently presenting

Breaking demand down in this way is useful as it highlights that services can release productive opportunities if they focus on **reducing both failure demand** and **created demand**.

You may also find the following definitions useful.

Total demand	= actual demand + failure demand + created demand + hidden demand
Current demand	= actual demand + failure demand + created demand

Current demand is the total resources currently needed to respond to the referrals you receive. To measure your current demand you will need to collect a number of different pieces of data. Some should be routinely collected on an ongoing basis (Table 1), others can be picked up through a one-off audit or estimated (Table 2).

Table 1: Data you should be collecting routinely that will feed a demand analysis

What information do I need?	Why do I need it?
Total number of referrals received We recommend using a years' worth of data. If you don't already collect this information, you won't want to wait a year to use the tool. However, we recommend you work with a minimum of 12 weeks' worth of data as you need this time to smooth out some of the peaks and troughs. Twelve weeks should provide a reasonably robust average, but this will depend on what is happening at	For mental health services, demand is the number of hours needed to respond to the referrals received. So unless you know how many referrals you are receiving, you can't calculate the demand. We recommend recording referrals daily so you can then start to analyse variations in demand. You'd probably do this weekly and monthly to begin with – but recording daily means you can drill down to this level if you need to.

What information do I need?	Why do I need it?
a local level. Putting the data into a run chart (using weekly figures) will help you to assess the stability of your current referral rates and the extent to which using a 12-week average is reasonable.	It is really important that you track how many referrals you receive. Otherwise, if your demand increases, how will you prove this? The best way to track your referral data is to put it into a Statistical Process Control (SPC) Chart. This will enable you to see variation in your referral patterns and will stop you wasting time looking into changes in referral levels that are not significant.
Opt-outs Some services run an opt-out system. This means they write to the person who has been referred and either: A. Give the appointment in the letter but ask them to phone and confirm, or B. Ask them to make contact to book an appointment. **Both approaches can reduce did not attend (DNA) rates.**	**As demand is the amount of time needed to respond to the referrals received – you need to know how many referrals don't require any intervention because the person opts out.**
Referred elsewhere as inappropriate for team Some services forward referrals without seeing or making telephone contact with the person. Some services return referrals to the GP as inappropriate without seeing or talking to the person. We recommend caution with this approach, as the referrer has sent it to you because they are unsure what to do. However, it is sometimes clear from the referral information that another service would be better placed to respond.	As demand is the amount of time needed to respond to the referrals received – you need to know how many referrals don't require any intervention because the person is immediately referred on. **If you record the source of the referral and where it was forwarded onto, you can then start to analyse this for trends. This analysis might indicate the need to do some work with particular referrers to try and ensure it goes to the right place first time.**
DNAs – new and follow-up These are people who failed to turn up for an appointment and didn't let you know in advance.	We split the new and follow-up rates as most services have a higher DNA rate for new appointments than follow-ups. If your appointment slots for new and follow-up are different lengths of time then you need to split the cancellation figures by new and follow-up. DNAs represent unused yet available capacity for client contact. We recognise that some clinicians make effective use of

What information do I need?	Why do I need it?
	this time to catch up on other issues such as emails and paperwork. However, a well-run service will seek to minimise DNAs as high rates inevitably lead to wasted time and frustration. ***A Demand, Capacity, Activity and Queue (DCAQ) analysis can help you work out how much direct client contact time you lose per week because of DNAs.***
Could not attends (CNAs) – new and follow-up It's important to record CNA slots. If you have a high level of cancellations at short notice (and you are unable to offer the appointment slot to someone else) then you will need to consider these as well.	If your appointment slots for new and follow-up are different lengths of time then you need to split the cancellation figures by new and follow-up. Short notice cancellations, where you don't have the time to offer the appointment to someone else, represent unused yet available capacity for client contact. Ideally you need to put systems in place to offer cancelled appointments to other clients so that you minimise the numbers of unused slots.
If you do group work – the total number of people who go into group work If you do group work then you need to know: a) How many people went to group work b) How many people went to individual work (and remember some people might be included in both lines as they go through both) c) On average how many sessions each group runs for d) On average, how many people are in a group. If you run lots of different groups which take different numbers of people and run for different lengths of time then you will need to work out the demand for each type of group separately.	Where clinically appropriate, using groups can be a much more efficient way of managing demand.
Average number of follow-up visits per new client Please see the MHAIST Handy guide on calculating new to follow-up ratios for	How often you see clients has a big impact on your demand. We are not recommending seeing people less times than is necessary – but we all know of people in teams who are reluctant to

What information do I need?	Why do I need it?
more information on working this out.	discharge and continue to see clients who are well, just to keep an eye on things. Sometimes this is necessary, but other times it would be just as helpful to discharge them but give the client direct access back to the team if they start to find themselves deteriorating. An audit across one community mental health area showed that differences in waiting lists between teams were up to five times more likely to be connected to what they did with each case (that is differences in number of sessions and duration) than the number of referrals the teams received. When doing work around demand and capacity there is a lot more you might want to do around new to follow-up analysis including looking at this by diagnostic groupings, by individual clinicians and looking at the distribution. Please see guide on Handy guide to calculating new to follow-up ratios for more information.

Some services already collect the above information electronically; ask your information department to provide it. If you can, look at the most recent 12 months' worth of data. However, before you use it, you do need to sense check it to see whether it is accurate. Experience of doing work with Community Mental Health Teams is that often the first step involves clarifying and simplifying data collection processes to ensure that accurate data is collected.

If you don't already collect this information, you will need to put a system in place to do this. This is vital information for the management of your service, so we recommend that you continue to collect it on an ongoing basis.

There are limitations to using historic data to predict future demand. Some people refer to this as being similar to trying to drive your car by looking in the rear view mirror. If your demand is relatively stable, it is not a problem. To assess this you need to put the data into a run chart or ideally, an SPC Chart. If you have growing demand you will want to adjust your data to look at predicted demand over the next year.

There are techniques for doing this that are not covered in this guide, so if you are not sure, then do seek further advice from your information department or your improvement team.

Table 2 below highlights the information you will need for the demand analysis that you can either estimate or establish through a one-off audit.

Table 2: Data for demand analysis that you can estimate or establish from a one-off audit

What information do I need?	Why do I need it?
Average time taken per new assessment This should include both face-to-face client contact time and clinical admin such as preparation and telephone calls.	As demand is the number of hours needed to respond to the referrals received, we need to know, on average, how long each new assessment takes. You probably allocate a given time slot for new assessments. Most services allocate 1 hour. We recommend you work on the basis that each hour of face-to-face work has an additional half hour of clinical admin attached. This has been tested through the Wiseman Workload Management Tool and appears fairly consistent. Alternatively you might want to sample a number of new cases and audit how long they take you.
Average time taken per follow-up assessment This should include both face-to-face client contact time and clinical admin such as preparation and telephone calls.	As demand is the number of hours needed to respond to the referrals received, we need to know, on average, how much time you spend at each follow-up visit. You probably allocate a given time slot for follow-up visits. Most services allocate between 30 minutes to 1 hour. We recommend you work on the basis that each hour of face-to-face work has an additional half hour of clinical admin attached. This has been tested through the Wiseman Workload Management Tool and appears fairly consistent. Alternatively you might want to sample a number of follow-up visits and audit how long they take you.

Ideally you want to split your referrals into different types of problems, as this will enable you to undertake a more detailed analysis. There are different ways to do the grouping and, as with all attempts to group unique individuals, they will all be flawed to some extent.

The following is an example from the Psychological Therapies 'Matrix'[1], with level of service, types of intervention and number of treatment sessions associated with each level (Table 3).

Table 3: Level of service, types of intervention and number of treatment sessions associated with each level

Level of service	Types of intervention	Number of treatment sessions
Low Intensity	Protocol-driven interventions aimed at less complex mental illness and disorder and normally lasting between two and six sessions. Waiting times for Low Intensity treatments will be counted under the PTs HEAT Access target if those treatments are delivered to people with a mental illness or disorder, person-to-person (or in group settings), in protected time, to protocol, by properly trained staff under appropriate supervision.	2-6 sessions
High Intensity and Specialist	Traditional, standardised psychological therapies (Cognitive Behavioural Therapy (CBT), Interpersonal Psychotherapy (IPT), Short-term, focused Psychodynamic Psychotherapy etc) aimed at moderate to severe mental illness and disorder with significant complexity, sometimes within a specialist service.	6 to 20 sessions
Highly Specialist	Individually tailored interventions based on case formulations drawn from a range of psychological models, aimed at service users with highly complex and/or enduring mental illness and disorder.	16+ sessions

Some types of referrals are relatively easy to quantify in terms of the time needed, for example intellectual assessments and fixed programmes such as Beating the Blues or a Core CBT skills group programme. As you collect data on case types and hours needed to treat, you may find you can refine your estimate.

[1] The Matrix (2015): A Guide to Delivering Evidence-Based Psychological Therapies in Scotland

However, this is only one way of splitting referrals; you may come up with better ways. Also, you don't need to split referrals into type to get started with work around demand, so don't get too hung up on this point. You can do really useful work just by thinking about referrals into your team as a whole.

3.1 Doing the demand sums

You can probably see from the number of data fields collected that working out your demand is not a simple calculation.

Demand for new assessments	**=**	(total number of referrals – opt outs – referred elsewhere)	**X**	length of new assessment slot		
Demand for follow-ups*	**=**	new assessments – people who drop out via DNA/CNA)	**X**	length of follow-up slot	**X**	average number of follow-ups per new assessment~

Note: Remember to use a consistent unit of measurement to ensure the output data makes sense, for example don't switch between sessions and hours.

* This calculation only covers individual follow-ups, not group work.

~ Please note that your average number of follow-ups per new assessment needs to include follow-up DNAs.

4. Ideas for influencing your demand

There are three key areas to think about when looking to influence your demand.

- Your **eligibility criteria** – are you doing work that someone else could do, or work that does not need to be done?
- **Failure demand** – are you creating unnecessary demand by not doing things right first time and then having to do them again? Or not doing something at all which means the person then presents at a later stage in their illness with more acute needs? Or taking so long between appointments that assessment needs to be redone?
- **Created demand** – are you creating unnecessary demand by having steps in your processes that don't add value? This includes seeing people more times than they need to be seen? Key issues to look at here include goal setting, case review and caseload management.

5. Managing demand

It is crucial to have clarity about what the service will and will not do. Whilst acknowledging that every referral will be different, there will be limits at the upper and lower tiers. All areas will have other services that work with mental health and related issues, as well as having inpatient units and crisis teams. Goal setting, case review, caseload management and supporting discharge are crucial aspects of managing demand in community mental health services. In any service it is important to be clear about the goals of the intervention. They need to be achievable and should match as closely as possible both the identified needs of the service user and their expectations. Improving our ability to set appropriate treatment goals, building in case review and reviewing existing caseloads will notably improve the efficiency of our service and the treatment of our clients.

5.1 Set clear eligibility criteria

To assess whether or not there are any issues around eligibility criteria for your team you can look at the following:

1. **Does the team have clear, documented eligibility criteria?**
    - Simply, can you put your hands on a document that clearly specifies what the team does?
2. **Are they understood?**
    - To assess whether it is understood by referrers you can look at how many referrals you receive that you then send on elsewhere without seeing. You will want to break this data down by referrer to see whether it is a bigger issue for some referrers. If you are doing this, remember to adjust the data for the size of the practice population otherwise you may end up wrongly identifying a practice as an outlier simply because it covers a bigger population. If you find there is an issue with particular practices then you will want to do some work with them to understand why this is happening and agree jointly a solution.
    - You will also want to see whether team members have a similar understanding of eligibility criteria. You can discuss this with them or ask them how they would respond to particular case scenarios.
3. **Are they appropriate?**
    - The team may have clear eligibility criteria but these could be set either too tightly or too loosely. You may want to consider whether you are doing things that other services could do more effectively and efficiently.

- Another indicator that there is a problem with eligibility criteria is when a lot of time is spent debating who should see someone and referrals end up getting passed from team to team. This is a clear signal that either teams are not clear or the system as a whole has been badly designed leaving individuals who need a service that no team provides. Either way, it indicates that work needs to be done. The amount of time that can be wasted by teams disagreeing on who should pick up a case should not be underestimated and it can also carry significant clinical risks if it leaves someone with complex needs falling through the net. This is often a particular issue around individuals with both mental health and substance misuse problems.

4. Delivering clear eligibility criteria

- There is no point in making your demand more manageable if you simply move it to someone else who also doesn't have the capacity to meet the needs. So any changes to your eligibility criteria need to be agreed across the whole system and should be based on who is best placed to meet the need. The assessment of who is best placed to meet the need will need to consider both the skills and grading/type of profession required.

The following table provides some guidance on how to go about reviewing your eligibility criteria.

1. Be clear on what other resources exist.
There will be many service providers in your area who respond to issues relating to your service users. It is essential that your service knows what else is available and has up-to-date information on their contact details and referral procedures. There are a number of examples of this, mainly web-based. By their nature such sources of information can quickly go out of date. It is useful to allocate someone to check the accuracy of the information on a 3-monthly basis.
2. Write down your current eligibility criteria.
Clarify what you do and do not do, and what other services are available to respond to work you don't cover.
3. Define your priority criteria.
A. Be explicit about what will happen and when for priority referrals. B. Ensure referrers know your priority criteria. C. Don't have more than two priority streams as the more you sub-divide the work, the more complications you are adding, and the longer your waiting lists will become.

4.	**Having defined your criteria, inform referrers about them.**
A.	Ensure they know the information you need with a referral to allow allocation to the most appropriate treatment.
B.	Agree that, if after assessment it is felt that your service is not appropriate, you will refer onwards and give feedback to the referrer about why you did this.
C.	Encourage referrers to phone you if they are uncertain about whether to refer someone.
D.	Consider using an e-referral process to ensure that you receive the minimum data you need to make informed decisions about the referral. If taking this route, you will need to consult with your GP colleagues and involve them in agreeing the final data set.
5.	**Make it easy for referrers to send people to the right place.**
A.	Provide referrers with referral criteria and contact details for other agencies in writing or on the web. Referrers are often busy and not sure where to send referrals. Clarifying what type of referral should go where, and making close links with partner agencies, will ensure a smoother journey for the service user. It will also reduce duplication and wasted effort when responding to referrals.
B.	If there are Tier One services such as book prescribing or websites, be clear about when these could be considered as a first intervention before referral to you.
6.	**Aim to assess and allocate by direct contact.**
A.	The ideal way of ensuring referrals meet your criteria and are allocated to the best treatment option is by direct screening. This will only work if you have a short waiting time.
B.	The referral screening should be a dynamic process with clear, rapid feedback to referrers.
C.	Avoid 'bouncing' back to referrers. Redirect to the better matched service, letting the referrer know why.
D.	Be careful about using the term 'inappropriate referral'. Remember the referral has been made because the referrer is not sure what to do and is looking for advice. Your advice may be that they don't need your service and are better matched to another service. This doesn't mean the referrer was wrong to ask for your advice and the challenge for you is how you help them to know where to send future similar cases.
E.	Check every referral against new criteria. Keep a note of those that do not match any current service – this is unmet need and will inform future service planning. If you have the skills to see and meet the needs of these individuals then you may need to expand your own eligibility criteria to cover them. If they represent significant numbers of referrals then this should be discussed through your

	management processes to agree whether it is a priority for you to expand the team's remit. If you don't have the skills to meet their needs then you need to highlight this gap in service provision to the relevant individuals in your organisation together with data on how many individuals are being referred.
7.	**If you experience ongoing issues with people being referred to your service who do not meet your eligibility criteria then you need to do further work to understand why.**
A.	If there is another service in place that the referrals should be going to then you need to talk to your referrers to find out why they are still sending them to you. This should be done from an attitude of genuinely exploring the reasons why and seeking to agree together how you make sure they go to the right place first time.
B.	If there is no other service in place that meets their needs then see point 6E above.

5.2 Goal setting

You can use both supervision sessions and random audits of case notes to assess the extent to which staff are routinely setting appropriate treatment goals which then guide their interventions. Goal setting is a crucial aspect of managing demand in psychological therapies services. In any service it is important to be clear about the goals of the intervention. They need to be achievable and should match as closely as possible both the identified needs of the patient and their expectations.

Improving our ability to set appropriate treatment goals, building in case review, and reviewing existing caseloads will notably improve the efficiency of your service and the treatment of your patients.

Some may say that the goal setting approach only works with a CBT treatment model. Certainly, the method and language used fit well with a CBT model, however all therapeutic interventions could reasonably be expected to set clearly defined and measurable goals, albeit using a different framework or language.

It is not unusual for people to be referred for psychological therapy when the identified need may not be best met by therapy. For example, someone whose psychological distress is the result of notable debt problems may need help from a specialist debt advice service.

Often people have high and unrealistic expectations of what can be achieved with psychological therapy. Understandable and normal reactions to events such as bereavement are not likely to need, or benefit from, psychological therapy. A person's goal of not experiencing a feeling of loss would not match the likely outcome of psychological therapy.

It is also important to consider the expectations of referrers and patients with respect to the goals of different levels of service. A brief guided self-help programme with a limit of three sessions, a stress control class of four sessions, six brief counselling sessions, and 16 High Intensity CBT contacts would all have their own limits on what was achievable.

SMARTER[2] clinical work

One way of considering clinical interventions is to be SMARTER. For each patient we can ask ourselves a number of questions about the goals of the intervention.

S	Are the treatment goals **specific?**
M	Are the therapist and patient able to **measure** whether they are meeting their goals?
A	Are the goals set, **achievable** and **attainable**? Is the service user ready to change? Change is a process that unfolds over time. For some interventions, the service user needs to be ready to make changes and undertake the work required to make progress. In these situations a lack of readiness means you are unlikely to succeed, and may be a significant cause of 'drop-out'. Shared goals can be considered, regardless of the therapeutic model, to be important. Active participation in the therapeutic process is an important variable. Thus a shared view of goals and methods of treatment can be seen as essential to the establishment of a sound therapeutic alliance.
R	Can you **realistically** achieve the goals with the resources you have? (This will include therapist and patient resources, as well as the impact of external factors). It is worth considering what % improvement is realistic and possible, 80% improvement may well be enough to allow the service user to move forward. Is it worth trying for a possibly unrealistic 100% improvement? For some, the role of external factors and social stressors may act as a significant barrier to the intervention you are considering. In such cases you may want to ensure these factors are addressed prior to then progressing to other interventions. In some cases supporting the person to address these external factors will be the main intervention.
T	Have you set a **time** for achieving the goals?
E	How will you measure if the goals are **effective?**
R	How will you ensuring the goals are **reviewed?**

[2] Adapted from Yemm, Graham (2013). Essential Guide to Leading Your Team: How to Set Goals, Measure Performance and Reward Talent. Pearson Education. pp. 37–39. ISBN 0273772449.

Starting SMARTER

The best place to start SMARTER working is at the first assessment interview. This allows more accurate matching to the referral criteria for your service(s) than using referral letters.

The initial assessment could have a solution focused aspect to it, building in discharge planning from the start. This may include:

- clarifying problem areas
- setting SMARTER treatment goals
- agreeing what is expected of therapist AND patient
- identifying supporting activities that the patient can undertake in addition to the therapy, and
- identifying and addressing potential barriers to progress.

SMARTER matching

If you are working with a matched/stepped care model then it will be easier to be SMARTER. Once a case has been assessed it should be matched to the most appropriate level of service. This matching needs to include patient characteristics. For example, if guided self-help will involve reading and record keeping, a level of literacy will be required.

SMARTER reformulation

It is not uncommon for the initial formulation to be revised in the course of therapy. This may lead to revised SMARTER treatment goals and may mean that the patient should be transferred to another therapist or service where there is a better match between competency and need. In a stepped care model, this would be a transfer to a more intense/longer duration psychological therapy or a step down to guided self-help or practical support rather than active therapy.

SMARTER stepping

Stepping up or down should be arranged within a service and should happen as seamlessly as possible, without the need for a further referral that could lead to another wait for the patient.

5.3 Case reviews

Monitoring and reviewing cases is an important part of our work as psychological therapists. It allows us to monitor progress towards a good outcome and check that our input/competency matches the needs of the patient.

In practice many clinicians, especially the less experienced, greatly appreciate the learning they gain from regular case review. For case review to be effective:

- the process should be non-threatening, supportive and used to inform both the individual and the service about clinical issues that arise
- occur in supervision, as well as forming part of a psychological therapist's individual reflective practice, and
- allow the recording of information that will help planning of training.

You can assess the effectiveness of your current case review procedures by looking at the following issues.

Issue	What to consider
Do you have a clear process in place for case reviews?	• Is the process written down? • Is the process well understood by the team?
How effective do staff think the review process is?	• Is the process perceived as non-threatening, supportive and used to inform the individual and the service about clinical issues that arise? • Does the process allow recording of information that will help in the planning of training? • Does the process allow the practitioner to gain input from other disciplines. One of the benefits of multidisciplinary working is that different professional groups can often bring a different perspective to the problem that might help, particularly when the clinician feels stuck.
What does your data tell you about how often people are being seen?	Looking at new to follow-up ratios can be very informative and can identify situations when teams or individuals are outliers in terms of how long they see people for. However, there are significant risks of over-interpreting or misinterpreting this data. This is particularly the case once you break the data down to individual levels so great care needs to be taken when looking at data at this level. Further, the data should be used to identify areas where you want to do some more qualitative work with teams or individuals to ensure effective caseload management systems are in place, rather than using it to make judgements about practice that may then turn out to be based on an over-interpretation of the data.

From the operational point of view, there is a need to monitor the demand generated by each case and to compare this with predicted demand. There is also a need to monitor fit with service/team criteria. Regular recording and collation of service use information should be an integral part of the service manager's role.

The following is an example of a checklist that could be used by clinicians on their own, or in supervision. The language used may not suit the therapy model, and not all points may be relevant. It is the concept of a systematic, goal orientated review that is important.

A checklist will work best if the clinical staff in the service have contributed to its development. Different levels and types of services will require different review checklists.

Checklist item	Yes/No	Action Planned	By Whom	By When
Does the case meet service criteria?				
What are the aims of therapy? Are they SMARTER? Will you know when they have been achieved?				
Have you checked progress against aims? If aims met but problems remain, have you reformulated?				
Do they need your level of skill? Could someone else do the work?				
Do they still need the service?				
Is there a follow-up appointment – if yes is it necessary? Could the follow-up be by phone?				
Are there dependency issues?				
Are you 'worried' that they have nothing else?				
Are there attendance problems? Is the DNA policy clear to the patient and is it being applied?				

The following checklist will help you decide whether you are making effective use of your current capacity. Rather than choosing either 'yes' or 'no' 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 this checklist, then you are probably doing everything you can to make the most effective use of your current capacity. If you answer no or partly to questions, then this indicates an area where you could do further work.

Goal setting and case review	Yes	Partly	No
Are all cases checked for match to service criteria?			
Does the service use a goal setting approach? • Are the goals of therapy explicit? • Are the goals SMARTER?			
Is there a seamless system for stepping up/down to services that best match goals?			
Is there a system of case review built into supervision?			
Do you regularly review caseloads against treatment and service goals?			
Do you regularly check progress against aims?			
Is there a good match between level of skill and identified needs?			
Are there flexible arrangements possible for follow-up appointments?			
Are there systems to deal with dependency issues?			
Is the DNA policy clear and is it being applied?			

A healthy community mental health service has a system that automatically builds case review into a service user's journey. This would include:

- ensuring new cases meet referral criteria
- building in discharge from the outset
- where appropriate, contracting an initial number of sessions – for services working with individuals with complex needs this may not be appropriate
- setting a review date

- revising aims and reformulating if needed
- not routinely offering 'check-up' appointments, but instead putting in place systems to allow individuals to self-refer if they need additional support, and
- routinely monitoring and measuring caseload activity.

There are a range of approaches to embedding caseload reviews into your service. The following are provided as ideas that have been used by Community Mental Health Teams.

- Regular multidisciplinary meetings where individuals bring cases that are not achieving good outcomes or seem 'stuck', for discussion.
- You may also want to initiate a process whereby all cases which exceed a given number of appointments are reviewed at this session. The number of appointments will depend on the type of service. For instance, a primary care mental health team has a process where anyone exceeding six sessions is discussed at a multidisciplinary team meeting. A Community Mental Health Team may set a higher number of sessions before the case is routinely brought to the multidisciplinary team meeting.
- The Choice and Partnership Approach (CAPA) highlights the need to be clear on why you are offering each and every appointment and promotes an approach of no follow-up unless there is a specific reason.
- CAPA also promotes an approach where the person who does the assessment is not necessarily the person who provides the intervention. This creates a useful accountability within the system. The assessor has to work with the client to agree a clear intervention goal to hand over to the person providing the intervention. It enables them to pick the person in the team best skilled to provide the specific intervention. It also helps with effective planning of new and intervention sessions as this is done on the basis of referral volume rather than having to try and cope with an unpredictable amount of follow-up activity at an individual practitioner level. This then enables a fair distribution of work and effective management of workload levels.
- Other services have put in place a process whereby the service user is asked at the end of the session whether they feel another appointment would be useful and, if so, when do they want to be seen. Clearly there is a small group of individuals where this approach is not appropriate, but this shouldn't prevent you from using it with those where it is appropriate.

5.4 Caseload management

In addition to having a mechanism for reviewing cases, teams also need to have a way of ensuring the fair distribution of work between individual team members.

- **The Wiseman Workload Measure (WWM**) is a tool that can help staff to better understand and manage their current caseload. It is designed to be used on a recurrent basis within the context of individual line management supervision and can also help with identifying staff who may have too much work and those who may have capacity for additional work. This tool includes a turnover and time on caseload monitor. The WWM is completed by individual practitioners but can be aggregated to represent team and service total activity and total capacity. A spreadsheet has been developed which automatically aggregates individual clinician data up to a team level.
- **The Choice and Partnership Approach (CAPA)** is another system for enabling effective workload management. As identified above, by separating out the person doing the assessment from the person providing the intervention, it enables effective planning of new and intervention sessions. This is done on the basis of referral volume rather than having to try and cope with an unpredictable amount of follow-up activity at an individual practitioner level. This then enables a fair distribution of work and effective management of workload levels.
- There are also other caseload management systems in place. You need to ensure that the team has an approach to caseload management that ensures a fair and reasonable distribution of work. This means the system must adjust for dependency levels and frequency of contact, as two members of staff with the same level of individuals on their caseload could actually be experiencing very different workloads depending on frequency and length of contact.

5.5 Supporting discharge

Sometimes practitioners hold onto people for too long because they don't feel safe to discharge them. For instance, they may be worried about what happens if the individual relapses so they keep seeing the person 'just in case'.

Methods to support discharge include the following.

- **Discussion within supervision** – the practitioner has the opportunity to talk through any concerns and work through ways to manage these.
- **Direct access re-referral** – some Community Mental Health Teams operate a system whereby individuals who have previously received a service from the team can directly self-refer back in if necessary. This removes the barrier of the individual having to go back through the GP and empowers the individual client to self-manage.
- **Relapse planning** – if the individual has previously relapsed then doing work to identify early warning signs and agreeing jointly the response to these can again provide the security on both sides to enable discharge.

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