

A Guide to Understanding Capacity and Activity

Mental Health Access Improvement Support Team

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1. What is capacity and activity?

Capacity is the total resource you have available to do the work. This includes staff with the right skills and any equipment needed (such as rooms).

Activity is the actual work done. It is different from capacity as you may have the ability to see 12 service users in a week but only see 10 of them as two of them do not attend – so your capacity was 12 but your activity was 10.

This guide helps with understanding how the team currently spend their time and provides ideas for actions you can take to optimise the time available for client work. However, in mental health, there are times when the problem is not lack of staff but lack of rooms to see people in. Therefore, you may also need to do work on assessing and maximising room utilisation rates.

2. Why look at capacity and activity?

By looking at and analysing your current capacity and how it is being used (activity) you can:

- identify opportunities to increase the amount of time spent in clinical work.
- improve staff morale. Practitioners don't enjoy wasting time on activities which aren't adding any benefit to the quality of service they deliver and prefer spending their time either in client work, developing the service or their own skills.
- analyse whether the service has enough staff to cope with the current workload.
- ensure you are making effective use of your current staff resources. If you have too much work to cope with then demonstrating that you are making effective use of your current resource is a vital part of making a legitimate case for more resources.
- work more efficiently as a team. If your team spend 50% of their time on clinical work (not unusual for a Community Mental Health Team) – then every additional hour you can redirect to clinical work is the equivalent of 2 hours if you bought it in as new staff time. Why is that? Well, let's say you've worked out that your team need 20 hours more clinical time. You couldn't just employ someone part time for 20 hours as you know that 50% of a staff member's time is spent on non-clinical work; so you would have to employ 40 hours more time to get the 20 hours of clinical work. However, if you can create that 20 hours by stopping doing something else, then you only need to find 20 hours.

3. Measuring capacity and activity

When assessing your current capacity and activity we recommend that you break it down into three broad categories:

- **direct client contact** – time spent with clients doing assessments, interventions, group work or time in case conferences where the client is present.
- **indirect client contact** – includes clinical admin duties, clinical meetings and clinical supervision.
- **supporting activities** – covers all other activities such as travel, business meetings, training.

3.1 Using job plans to measure capacity

Ideally, you want to use a job planning system to identify how a staff member should split their time over the week. A job plan should clearly identify how much time is available for direct client contact. Further, to enable effective management of the service you need to know how much of that time should be spent seeing new assessments and how much is allocated for follow-up work. The QuEST DCAQ tool (available from the Mental Health Access Improvement Support Team hcis.MHAIST@nhs.net) will undertake these calculations for you but a rough ratio can be worked out by looking at your average new to follow-up ratios across your team ([see handy guide to calculating new to follow-up ratios](#)).

An example of a job plan in mental health is shown below.

Day	Morning	Afternoon
Monday	Assessments/follow-ups	Clinical supervision
Tuesday	Multidisciplinary team case discussions	Meetings/project work
Wednesday	Assessments/follow-ups	Assessments/follow-ups
Thursday	Receiving clinical supervision/clinical admin	Assessments/follow-ups
Friday	Assessments/follow-ups	Duty

Time for writing up case records is built into the assessment/interventions sessions at the end of every appointment. Three service users can be seen per assessment/intervention session. Of the 15 in total per week, two of these will be new assessments and 13 will be follow-ups.

Job plans are already routinely used by consultant psychiatrists (they are a mandatory requirement of the consultant contract and the categories/advised splits in time are laid out in [national guidance](#)). Many psychology services in Scotland have moved to using job plans and some community mental health nursing services are now implementing them as well. For Child and Adolescent Mental Health Services, many teams have moved to using job plans.

An entire team completing job plans provide information to effectively calculate how much time is allocated for direct client work, indirect client work and supporting activities. However, to work out how time is actually being spent you will need to feed in more information and adjust for sickness, annual leave and special leave.

3.2 Measuring capacity without job plans

If you don't have job plans then you can still work out your team's capacity for client work by collecting the data outlined in Table 1. By taking the total time available and subtracting all of the indirect client contact and supporting activities identified in Table 1, you will find out how much time is left for direct client contact.

Table 1: Data for capacity analysis for a whole team

What information do I need?	Where can I get it from
Number of staff	Your team's budget statement should tell you how many whole time equivalents (WTE) you have. Some services refer to these as Full Time Equivalents (FTEs).
Annual leave (average days per person)	You can work this out accurately by adding up everyone's individual annual leave entitlement and then divide it by the number of WTEs. Alternatively you can estimate – knowing that the maximum for staff on A4C is 41 days.
Special leave (percentage) Special leave covers leave such as carer's leave, parental leave and compassionate leave.	You should be keeping records of special leave as it is recorded as part of most departmental payroll returns. So you may be able to get a figure from your HR or payroll department. If not, you could trawl local staff attendance records to work it out. Alternatively you can use an estimate as an interim – although we would recommend that you do start recording and analysing this.

What information do I need?	Where can I get it from
Sickness absence (percentage)	You should be keeping records of sickness absence. Hopefully, your NHS board's data systems will let you see this figure at a team level. If not, ask your line manager or local IT administrator for guidance. If you don't have a way of monitoring this for your team every month you need to put a system in place.
Time spent travelling per week (average hours per staff member)	Some teams collect actual data on amount of time spent travelling – if you do then this will be the most accurate figure to use. However, if you don't record this then there are other ways of working it out for those who drive. If the majority of your staff use motor vehicles, then the simple way to work this out is using the formula from the Wiseman Workload Management Tool . We suggest you take 3 months' worth of completed travel expenses for the team and from this work out the total mileage. Then divide this by the number of staff. This will give you the average per staff member for those 3 months. If you then divide that by the number of weeks in your 3-month period (will be around 12 weeks), this will give you average miles per staff member per week. If staff spend a lot of time using public transport – then you will need to do an audit of how much time is spent travelling. A month's worth of data is probably good enough.
Average days spent in training per year	You should have good enough training records to be able to work this out.
Average hours spent at meetings per week	This is probably best collected through a diary audit on how staff spend their time over a minimum of a month.
Average hours spent at supervision per week	If you have set supervision arrangements then you can take a fairly accurate estimate from this (for example you might have an agreement that every staff member has 2 hours supervision a month). Alternatively, a diary audit of how staff are spending their time will tell you this.
Average hours spent on clinical admin	The QuEST Mental Health DCAQ tool (available from the MHAIST team) includes a Capacity Calculator that asks you to input an estimate for the total time each week spent on clinical admin and then works out how many hours you have left for seeing clients.
Average hours spent on other activity. This is the catch all for any regular commitment that is not captured in any of the above.	Work out the total other commitments per week for all of the staff and then divide this by the number of WTEs to get your average per staff member.

3.3 Doing capacity sums

Now you need to use the information you have collected to work out how much time you have available to do clinical work. One way is to use the QuEST Mental Health DCAQ Tool. You enter the data; it does all the sums for you, and gives you the answer at the other end. We know that some of you will want to know how to do the sums yourselves, so we've included the following example.

Example

Step 1

Write down a list of all your clinical staff and how many hours they work.

Name	Professional hours
Harry – Community Psychiatric Nurse	37.5
Sally – Psychologist	18.5

Step 2

Ask each member to keep a record of their work for 2 weeks. Use this to work out the amount of time (in hours) spent on direct clinical work. Also record: meeting time, clinical admin, supervision, CPD/training, travelling and any other relevant categories (for instance if you spend a couple of hours a week doing a piece of improvement work).

For example, Harry, who is contracted to work a 37.5 hour week, spends 2 weeks keeping a record of what he does.

He allocates hours spent to a few main categories as follows:

Harry's record of work	Hours (2 weeks)	Average hours spent
Direct clinical work	40	20
Clinical admin	12	6
Training/CPD	4	2
Supervision	2	1
Referral meeting	4	2
Team meeting	3	1.5
Travel	10	5
Totals	75	37.5

Step 3

Add everyone's information together to get the team's capacity. The following table shows the results of all team members' record of their average weekly time allocation.

Activity	Harry	Sally	Thelma	Louise	Totals
Direct clinical work	20	6	19	19	64
Clinical admin	6	2	6	6	20
CPD	2	2	4	2	10
Supervision	1	1	1	1	4
Supervising	0	3	0	0	3
Referral meeting	2	2	2	2	8
Team meeting	1.5	1.5	1.5	1.5	6
Travel	5	1	4	6	16
Totals	37.5	18.5	37.5	37.5	131

To calculate your capacity you first need to take into account annual leave, sick leave and special leave. On average, 1 day per week is already accounted for by annual leave and sickness (no one works 52 weeks a year). It can help to remember this when you are thinking about your capacity: a full time staff member is only there for an average of 4 days a week, not 5 days. We will do all our calculations in the following examples based on a 42-week year as we've made the following capacity assumptions: 8 weeks leave and 2 weeks sickness (4%) per annum.

At its simplest, the team's clinical capacity is the sum of the clinical hours. So using our example above, we have 64 clinical hours per week which equates to 2,688 a year (64 x 42) and 224 hours a month (2,688/12). If the average number of appointments per case is 8 and each appointment takes 1 hour then the average demand per case is 8 hours.

This means we have a total team capacity of 28 new cases a month (224/8).

Help! That sounds complicated...let's break that down step by step:

- Each referral is seen an average of 8 times for 1 hour a time.
- This means in total each referral has 8 hours (8 x 1) of clinical contact time.
- You've got 224 hours a month of staff time available to see patients (you've already adjusted for time spent doing other things).
- So to work out how many new cases you can see a month – simply divide the total amount of clinical time you have (224) by the total number of clinical hours you spend with each referral (8). This equals 28 new cases a month.

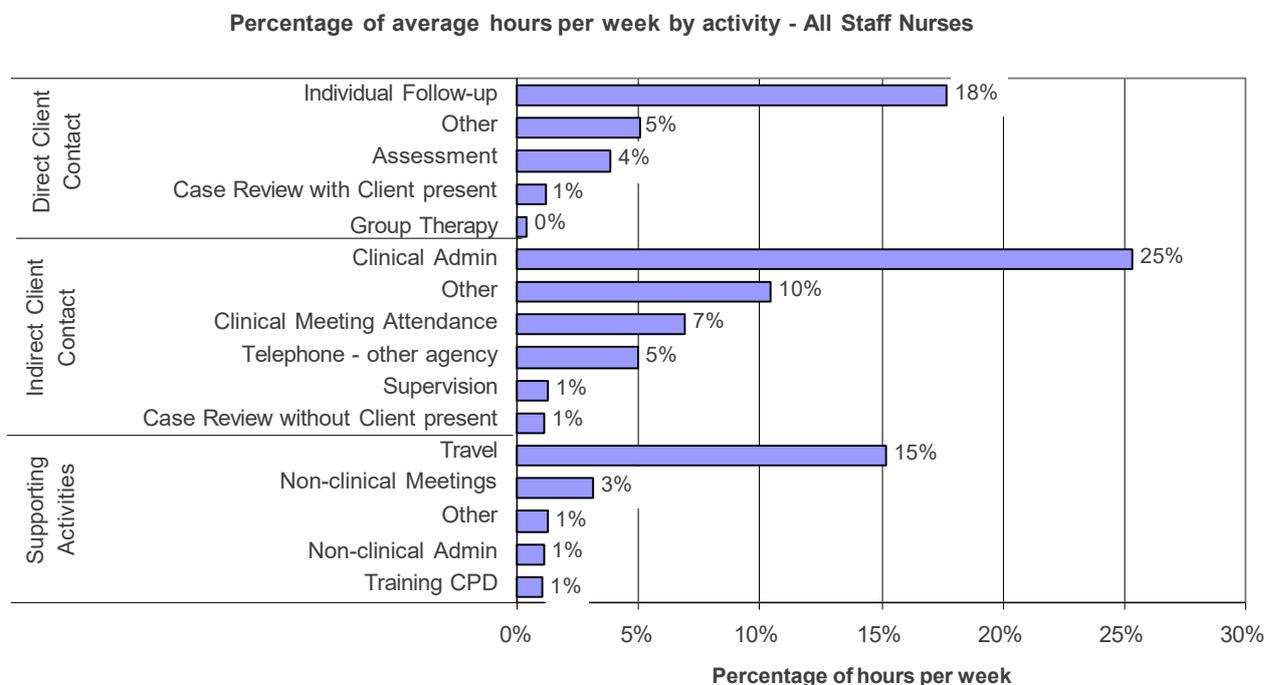
4. Understanding how time is actually spent (activity)

If you do not use job plans then you will need to find a way to be clear about how staff are currently allocating their time. If you do use job plans, you will still need to check if what is actually happening is the same as what you think should happen.

You can measure direct client contact time using an activity audit or undertake an analysis of activity data from your IT system. This will allow you to get a more in-depth understanding of the breakdown of direct client contact time. You can also customise the activity tracker to pick up additional information, such as intensity levels for those in therapy, which can provide useful information for work on skill mix.

Ideally, you want to get to a position where your routine activity data provides this level of information and then you can get activity analysis reports directly from your information systems. However, at the moment, most community mental health services can only pick up this level of information after completing an activity audit. Figure 1 below illustrates the kind of information you can get from an activity audit. We recommend that each staff member completes the analysis for 10 working days.

Figure 1: Example of analysis into how staff capacity is split



As well as looking at how staff are spending their time, you will also want to look at how many client sessions are not used due to those people who did not attend (known as DNAs) and those who could not attend (known as CNAs).

Ideas for making better use of your current capacity

Your current state assessment will give you information on how much time you currently have available for client work and how staff are currently spending the rest of their time. This will help you identify where you might want to focus some more detailed work to release time for client work. The key issues that tend to come up from undertaking an analysis of current capacity are:

- level of DNA/CNA and cancellation rates
- questions about whether the current skill mix of the team is right
- time spent in meetings and the need to streamline who attends which meetings and improve the effectiveness and efficiency of meetings
- the amount of time clinical staff are spending on administrative tasks, some of which could be performed more efficiently by administrative staff
- sickness levels and the impact these have on your capacity
- availability of information for referrers and patients, and
- the amount of time spent on non-value adding activities, such as unnecessary travel, unnecessary data collection and process steps, that add no value to patient/staff experience or deliver no organisational benefit.

5. Optimising capacity

5.1 Reducing DNAs and CNAs

What is did not attend (DNA)

A patient may be categorised as did not attend (DNA) when the hospital is not notified in advance of the patient's unavailability to attend on the offered admission date, or for any appointment (ISD Scotland data dictionary).

What is could not attend (CNA)

A patient may be categorised as could not attend (CNA) when the hospital is notified in advance of the patient's unavailability to attend on the offered admission date, or for any appointment. (ISD Scotland data dictionary).

Why is this important?

A large proportion of appointments in mental health are lost each year due to service users not attending or cancelling their appointments. Whilst many staff use this time to catch up on clinical admin, emails or other work, you cannot predict when it will happen and, therefore, it is not the most effective way to manage time and can actually put additional stresses in the system when service users don't DNA.

Understanding your current state

Calculating your DNA rate

- You need to know as a service how many appointment slots were offered over a specified period of time and how many slots were not attended.
- You then work out the number of DNAs over that period of time as a percentage of the total appointments offered (total number of appointments that were not attended in time period /total number of appointments offered in time period):

$$\% \text{ DNA rate} = \frac{\text{Number of appointments **not attended** in the time period}}{\text{Number of appointments **offered** in the time period}} \times 100$$

Splitting out new and follow-up DNA rates

- You need to split out new and follow-up DNAs as they often require different solutions to address them (the reason someone doesn't attend a first appointment can be very different to the reason they don't attend follow-up appointments).
- Ideally you want to convert your DNA rate back to the average face-to-face time lost and number of additional service users who could have been seen.
- Focusing on follow-up DNAs initially is usually more productive, even though the DNA rate for new appointments is generally higher. This is because a 1% reduction in DNAs across five appointments (follow-ups) will release more time than a 1% reduction in DNAs for one appointment (new assessments). It is also generally considered an easier area for interventions as the individuals are known to the service.

Tracking DNA rates over time

- Depending on the throughput in your service you will want to track DNAs on either a weekly or monthly basis.
- DNA rates will naturally vary over time so to understand this variation it is recommended that teams put the data into a run chart so that you can easily identify random and non-random variation.
- You need to annotate these charts so that you can see if there are improvements or deteriorations in rates when you are making changes.
- Ideally you want to put the data into a control chart so that you can identify whether you have any statistically significant impacts on your system.
- For improvement work, due to the different context affecting teams, it is recommended that you look at the DNA rate at an individual team level.

For most services, this data will already be available from your information department and all you need to do is to get an arrangement in place whereby you receive regular reports and make sure the data is presented in the appropriate graphical format.

Undertaking a more detailed assessment

The basic assessment will tell you whether DNAs are a significant issue for you and which teams have the biggest problem. However, if you are testing some of the ideas suggested further on and there is no impact on your DNA rate, then you will need to start looking at it in more depth. As part of this more detailed assessment you may want to consider the following.

- What reason are service users giving for their DNA? It can be really useful to conduct a survey of service users who DNA to understand why and from this you may also identify opportunities for improvement.
- Are DNAs higher at a specific time in the day or day of the week?
- How do DNA rates vary over diagnostic groups? Have you considered that the problem for which the service user was referred may be preventing them from attending? To do this assessment on new referrals you could split the referrals into clinical categories using the reason for referral from the referrer as this may be the only information you have; if you have a provisional diagnosis from the referrer then use this. This will help you identify if there is a specific service user group who are more likely to DNA and you can then start to target your improvement work appropriately.
- How do your first assessment DNA rates vary across referrers? If there is significant variation, is this due to differences in demography, or does it indicate the need to do some targeted work with those referrers attached to high DNA rates.
- In rural areas – is there a connection between DNA rates and public transport times?
- Where in the treatment pathway are service users not attending?
- Are people using DNA to self-discharge? If your DNA rate goes up near the end of treatment then the DNA may be a form of self-discharge. You may need to review case notes for these service users to identify if service users were nearing discharge or if discharge had been discussed to identify if the reason for the DNA is that service users are self-discharging.
- Where and when appointments are offered may also be having an impact on your DNA rates. Collect data for new and follow-up appointments; identify the location for the appointment slot and the time offered. Is there a pattern emerging?
- Is there an administrative process which is impacting on service users receiving appointments on time which then results in service users missing appointments?
- For teams which have a low DNA rate – is there anything they are doing that you could spread to other areas?

If this information is not available from your information department then you may need to carry out a retrospective audit of:

- referrals for new assessments, and
- case notes for follow-up appointments.

Ideas for reducing DNAs

The following are provided as ideas for you to test.

- Introducing a text reminder service where the service user receives a text two days before their appointment.
- Offer full booking, which means service users are asked to phone in and book a time that is convenient to them.
- Offer a choice of appointment time, day of the week and location. This has been shown to have a positive impact on reducing DNA rates.
- When a service user calls to cancel an appointment, ask if there is a particular reason and capture the information so it can inform your improvement work on this topic.
- Ensure the service has a well-defined DNA and CNA policy and that staff know the detail of the policy and how to apply it. Fully explain your DNA policy and CNA policy to those who have been referred to the service in order that they understand what will happen if they DNA or CNA.
- Review your administrative processes, for instance are appointment letters being sent out to give the service user enough notice of the appointment.

We recommend you test these ideas within the [Model for Improvement](#) Framework. This enables you to test it at a small scale. We would also encourage you to use creative approaches with your team to generate further ideas locally for testing. What matters is getting an understanding of why people DNA and then generating sensible ideas that address root causes and testing these in practice to see if they work.

5.2 Skill mix

Why is this important?

Skill mix has a role to play in improving organisational and team effectiveness and quality of care. Skill mix can refer to the mix of posts in the team, the mix of employees in post and/or the combination of skills available at a specific time. It can be looked at with specific staff groups, across the whole team and across various care groups. It is often seen as being purely cost driven. However, this should not be the case; it is about analysing the quality and competence of staff required to deliver high quality care in an efficient and productive way.

Understanding your current state

Understanding the skills and current utilisation of your staff can help you identify areas where workload can be shifted to other professionals and where there are skills deficits or gaps. It will also help you identify the training needs of the staff working within your service. You can determine skill mix across teams using various methods.

- Analyse the tasks carried out within the team against the grade of the individual doing them. One way of doing this is to complete a skills matrix for the whole team. The skills matrix, which should be reflective of all the tasks and interventions required to meet the demands on the service and the needs of those who are receiving care from the team. The main purpose of this is to map the staff in the team against the skills, interventions and tasks required to facilitate an efficient and effective community mental health service.
- Analyse the activity of the team, for instance using the Mental Health Activity Tracker (available from the MHAIST team) but customising the tracker to pick up relevant information that will help you to assess complexity of interventions against grade of staff.
- Review caseload mix, as you would expect higher graded staff to carry a more complex caseload.
- Interview staff to assess their professional judgement, carry out job analysis interviews and focus groups.

Optimising your skill mix

Many services across Scotland have already completed work around the skill mix of their community services. To maximise productive opportunities it is vital that this work is completed on a cross-professional basis rather than just a uni-disciplinary basis.

Completing a skill mix review will allow you to consider the following.

- For the tasks that a number of different professionals are doing across different grades, is this appropriate? Or is there an opportunity to redesign a more efficient skill mix?
- Is there an appropriate match between the grading of a team member and the tasks being carried out? Or is there an opportunity to redesign a more efficient skill mix?
- Are there any key skills gaps that indicate a need for targeted training and/or a change in skill mix?

In conducting a skill mix review, a key area to look at is the amount of time that clinical staff are spending doing administrative tasks. Some of the administrative duties could be more efficiently performed by administrative staff, though services report significant challenges in ensuring appropriate levels of admin are funded. Table 2 below shows the cost of different grades of staff spending 5 hours a week of their time on admin and the potential productivity release if this was transferred to an admin professional.

Table 2: Comparison of costs for different grades of staff spending 5 hours on admin

Agenda For Change Banding	Annual cost of 5 hours per week (£)*	Annual savings using 5 hours weekly of Band 3 admin (3247) (£)	Annual savings using 5 hours weekly of Band 4 admin (3744) (£)	Annual savings using 5 hours weekly of Band 5 admin (4219) (£)
6	5,105	1,858	1,361	886
7	6,367	3,120	2,623	2,148
8a	7,589	4,342	3,845	3,370
8b	8,925	5,678	5,181	4,706
8c	10,675	7,428	6,931	6,456
8d	12,805	9,558	9,061	8,586
9	15,355	12,108	11,611	11,136

* Calculated from mid-point per band rate 2018/2019 pay scale at total cost to organisation for 52 weeks.

Note: These savings are not cash releasing unless resources are being moved from vacant posts.

One of the concerns that teams have about transferring resources from clinical budgets to admin is that the admin resource will then be targeted at a later stage for savings or there will be an admin review which results in some of their admin resource being moved to another team who is not as well resourced. If a team has higher levels of admin because they have moved resources out of the clinical budget to fund this then clearly redistributing their admin to other teams without also considering the numbers of clinical posts is considered unfair. If you are going to transfer resources from clinical to admin to improve overall efficiency then you will need to address these concerns, otherwise the service could end up being worse off overall in the longer term. This also highlights the need for any reviews of staffing to be done on a multidisciplinary basis, including service managers. As community mental health teams work as a team, looking at any profession in isolation (including admin) and redistributing resources on the basis of a profession only analysis is rarely appropriate or effective in the long run.

5.3 Effective meetings

Why is this important?

A number of activity audits with community mental health teams have shown that meetings feature significantly in the use of time. It is often necessary for community mental health services staff to attend a range of meetings which can be both clinical and non-clinical. However, in order to optimise your capacity for clinical work, the function and effectiveness of meetings within your service should be reviewed.

Understanding your current state

You need to know as a team and as a service what capacity (time) is currently being spent in meetings. In order to understand your current state you may wish to consider the following questions.

- What meetings are currently held within your service and are they all necessary?
- What function/purpose do the meetings serve?
- Is there a clear Terms of Reference and remit for the meeting?
- Who currently attends the meetings?
- Who needs to attend?
- Have you considered a different method for doing business, for example could you consider a different method for screening and allocating referrals?
- How are outcomes/actions shared and communicated with the whole team?
- Is there a system in place to monitor the effectiveness of the meeting on an ongoing basis?
- What amount of capacity (time) is being used when staff attend meetings outwith the team/service?

Mapping out this information over a month will allow you to identify how much time is being spent attending meetings. It will provide you with a clear picture of what meetings are currently being held and the purpose of each meeting, as well as who attends from the team and what their role is. You can then consider whether there are ways in which the capacity which is currently being used in meetings can be released into delivering direct clinical care.

5.4 Removing non-value adding work

Why is this important?

Time spent doing things that add no value is time wasted that is no longer available for seeing clients, developing skills or developing services. In many NHS services, team processes have evolved over a long period of time and they may contain redundant steps that are not actually needed or adding any value.

Understanding your current state

Process mapping

Mapping your current processes is a great way of highlighting visually what happens and enables you to identify unnecessary steps and duplication ([see MHAIST Handy guide to process mapping](#)).

When you process map you must get the perspective of the people using the service, otherwise you may just end up mapping what people think happens rather than what actually happens. Ideally you want to map a couple of individuals' actual experience of using the service and ask them for their opinions about what did and didn't add value.

Once you have mapped your processes you then want to start challenging yourselves on whether the step actually adds value. To help you think about the type of activities that happen in mental health that don't add value also see the MHAIST handy guide to [Mental Health Waste Spotters](#).

You may also want to pick up a couple of cases where you have multiple individuals involved from different agencies and analyse the different roles and contributions to understand whether there is duplication or indeed whether some of the different interventions are actually contradictory.

Activity audit

Undertaking an activity audit will also provide you with information on how staff are currently using their time and can help you identify opportunities for releasing time back into client work. Work to streamline clinical admin processes and make better use of technology should release time for clinical work, although this needs to be tested in practice.

There may be other issues that come up from an activity audit. The value of doing this locally is that you will identify the issues that are relevant in your area.

Delivering a reduction in work which does not add value

Redesigning your processes

If your current state process map identifies duplication and waste then clearly you will want to redesign your processes to address this. You need to agree an ideal state map and then agree a plan on how to get there. You may not be able to move to your ideal state in one go; what matters is that you put a plan in place to progress from your current state to the ideal state.

Allocation meetings

A number of services have moved from allocating new referrals through a meeting to direct allocation and this shows considerable productive opportunities. One of the problems with allocation meetings is that they can result in an unfair distribution of workload, with the most conscientious in the team taking more work on. Therefore, another advantage of allocating directly is that it ensures referrals are allocated fairly on the basis of individuals' capacity.

If the team does not already have a process in place for multidisciplinary discussions of cases where the worker is struggling then you may want to use some of the time released for these types of discussions.

5.5 Reducing sickness rates

Why is this important?

Evidence shows that work is generally good for your health and that often going back to work can actually aid a person's recovery. On the other hand, staying off work can lead to long-term absence and job loss with the risk of isolation, loss of confidence, mental health issues, de-skilling and social exclusion.

If there is a significant issue with sickness absence within a team or service, it is difficult for that team or service to plan and manage the workload, especially if the sickness and absence is short term and unpredictable. There are also significant costs associated with people being absent from work, both in funding cover arrangements for critical posts and the time spent managing sickness and absence within teams and services.

Understanding your current state

As an employer or a manager within a team or service you need to have an understanding of rates and reasons for sickness absence. You can achieve this through a review of sickness and absence records which will help you to identify your rate of sickness absence. The most common measure of absence is lost time rate and this can be worked out using the following equation:

$$\text{Lost time rate} = \frac{\text{Total absence (hours or days) in the period}}{\text{Possible total (hours or days) available in the period}} \times 100$$

There are a range of areas you can look at and review to assist you in diagnosing the factors that are likely to influence absence levels and these include:

- role and organisational factors
- work and role design
- workload and stress
- organisation and team size
- occupational sick pay
- organisational culture and climate
- medical factors
- lifestyle factors
- persistent and recurring conditions
- external and social factors, and
- travel difficulties.

5.6 Information for referrers and patients

Information about the service is essential for referrers to know what clinicians do and for patients to know what to expect. In both cases, information can be used to help inform, guide and shape behaviour.

A psychological therapy service should know the most about what alternative resources are available, including having an expert opinion on self-help resources such as books and websites. Does your service have:

- self-help leaflets
- book lists or book prescribing
- a list of contact details and referral criteria for other agencies, or
- a website?

If so, does anyone outside the service know? Can a member of the admin team be allocated as a first point of contact for the dissemination of resources? Can a member of the admin team be tasked with keeping this information up to date? Do you routinely send this information out to people who have been referred to the service?

Information for referrers could include:

- clear referral criteria
- advice on information needed for referrals
- details of alternative services for people who don't meet your criteria
- links to self-help resources
- a description of how referrals are dealt with
- the did not attend (DNA) and could not attend (CNA) policies
- details of the process from the patient point of view
- descriptions of the psychological therapies offered, and
- clarity on what will be expected of the patient.

Information for patients could include:

- details of additional complementary services
- links to self-help resources – sending out the appropriate information early to referred patients allows them to start 'therapy' earlier
- clarity on what patients can expect from the service, for example through contracting, namely:
 - the did not attend (DNA) and could not attend (CNA) policies
 - details of the process from the patient point of view
 - descriptions of the psychological therapies offered, and
 - what will be expected of the patient.

Most services have an information booklet that they include with acknowledgement or first appointment letter.

5.7 Clinical admin

Every service will have clinical admin processes that are performed by a range of staff within the service. Good clinical admin involves a joint working approach, with clinicians working closely with admin staff to ensure the system runs smoothly.

Administrative support for clinical work is a crucial part of the service. How the service is administrated will have a significant impact on clinical demand and capacity. Understanding how much clinical admin is performed and by who can help services identify duplication, waste and opportunities to release capacity to undertake other work.

There should be appropriate administrative support for clinical staff. To have routine admin being done by clinical staff is a waste of clinical capacity and is an inefficient use of resources.

This section looks at ways of running the admin system to increase efficiency. A number of simple procedures can have an effective impact without increasing the administrative workload.

If there is not enough admin time to implement the ideas discussed in this guide, a demand and capacity model can be applied to the admin work to inform the service about appropriate levels of staffing.

The admin steps

Who does the following steps will depend on local arrangements. We have suggested the usual allocation of duties indicated by **A for admin, C for clinician**.

When is also a local issue, but generally it makes sense to do each step as soon as possible. Not to do so is adding an unnecessary delay. For services with no waiting list, some of the following steps will not apply.

Referral arrives

1. Check all essential information provided, including contact information. (A)
2. Basic screen for eligibility. (A)
3. Clinician screens and allocates. (C)
 - a) If not appropriate, rapid reply with specific information on more appropriate services.
 - b) If appropriate, identify useful additional resources to include with acknowledgement or appointment letter.

First contact with patient

What happens here will depend on whether there is a waiting list.

Waiting list

1. Letter to patient acknowledges referral, advises on approximate waiting time. (A)

2. Include:
 - a) Service information (A)
 - b) Targeted resources - (C) provides and (A) sends
 - c) Contact details form (A)
 - d) Advice that short notice appointments may be offered. (A)

No waiting list

1. Letter to patient acknowledges referral, offers appointment or provides information on who to contact to book appointment (see First appointments below). (A)
2. Include:
 - a) Service information (A)
 - b) Targeted resources - (C) provides and (A) sends
 - c) Assessment questionnaires (A) - these could include space for patients to note issues and questions for their first appointment.

First appointments

Partial booking is a system that allocates a slot or two for the first appointment but requires contact from the patient confirming they will attend before the clinician's diary is filled. This greatly reduces first appointment DNA rates and allows for reallocation of unconfirmed first appointment slots.

Admin tasks (A)

1. Inform patient that they are being offered a first appointment, providing partial details such as date.
 - a) Be specific about limitations regarding clinic days/locations.
2. Ask that they contact your service to choose/confirm the appointment.
 - a) Ideally there will be a choice of appointment times available.
 - b) The letter needs to be clear that if the date offered is not suitable they can phone to agree an alternative date.
3. Specify a response time, after which you will reallocate to another patient.
4. When patient contacts service, make full appointment, confirming by letter, email or text.

Clinician tasks (C)

1. Identify new patient appointment times.
2. Provide admin staff with at least 2 weeks' notice.
3. Allow admin access to diaries.
4. Identify new patients to be booked in:
 - a) Identify a minimum of two potential patients from waiting list for each appointment time.
 - b) Attach relevant specific information to be sent with appointment letter.

Full booking

Full booking is a system that allows the patient to phone and choose their appointment slot. This greatly reduces first appointment DNA rates and improves patient satisfaction by giving them choice over the appointment times. It also reduces the risks of a patient turning up for an appointment that they failed to confirm (as they won't get a time until they phone up). To speed the process up, some areas get GPs to fax the referral over (or send via clinical email) and the patient leaves the GP surgery with the phone number to call to arrange the appointment. For this system to work, you need to have agreed in advance who can see first assessments and have agreed new assessment slots allocated in the diary.

Keeping the clinics full

A main priority of admin should be to keep the clinic slots full – no one likes empty clinic slots because they are a waste of resource and a frustrating gap in a clinical day. A system that records appointments offered and confirmation cut-off dates is beneficial as once this is in place, if someone has not responded to their appointment offer in time, another waiting patient can be selected.

Often there will not be enough time to write another letter to offer a “short notice” appointment to another waiting patient. Using the contact information slips, working through the list supplied by the clinician, admin staff can telephone patients to offer the vacant slot.

It can seem a lengthy process phoning and chasing up, but an hour spent filling a clinic slot is another patient into the system and an hour less of clinic time wasted.

Also remember to call the patients who have waited the longest first (unless there is a clinical reason to prioritise someone waiting for less time).

Did not attend (DNA) and could not attend (CAN) policies

DNA and CNA policies will set out standard practice for services. However, clinical decisions must be allowed to override routine policy, especially for patients for whom attendance problems are part of their clinical presentation.

Did not attend (DNA) policies

Referrers, clinicians and patients should be fully aware of how non-attendance will be handled. An explicit policy will help all concerned and can be designed to reduce wasted time. There will need to be a policy for DNA and cancellations both at the beginning (access) and during therapy (treatment).

Once a patient has started therapy, the therapist should give clear, explicit details of the DNA policy.

This may include:

- counting non-attendance that has not been informed in advance as part of the initially contracted number of sessions, and
- identifying poor attendance as a crucial aspect of case review.

Some services offer text, email or phone reminders of coming appointments and this may help reduce DNA rates.

However, clinical decisions must be allowed to override routine policy, especially for patients for whom attendance problems are part of their clinical presentation.

Could not attend (CNA) policies

A CNA policy will be similar to a DNA policy. It is good practice to discuss cancellations with patients so that they understand the local policy and the reasons why, if they can't make an appointment, it is important to let you know as soon as possible (so the appointment can be reallocated). Problems with variable attendance should be discussed with patients as part of the therapy process.

When taking messages about cancellations, admin staff need to be clear about whether or not the patient actually wants another appointment. Ideally, with open diaries, this can be allocated at the time of the patient's call.

Make it easy for the patients to let you know they can't attend

There should be a number of ways that the service can be contacted. Text, email and phone messaging should all be available. This will allow people to advise easily if they are unable to attend. The more notice there is, the more chance an empty clinic slot can be used.

Be aware of communication needs

Referral forms and referral information should include space for the referrer to advise of specific communication issues. For instance, English may not be the patient's first language or they may need large print or Braille.

Diary management tips

Allow admin staff to book directly into clinicians' diaries

The ideal diary system allows admin staff to have full access to clinicians' diaries.

Clinical staff need to allocate 'new' and 'follow-up' slots as far in advance as they can. If they know that they have contracted for a number of sessions with a patient, they may pre-book these slots.

If clinical staff give full access and booking permission to admin staff, then patients contacting the service can be responded to immediately. This provides a better service for the patient and reduces the 'wasted' admin time having to contact the patient

(which can sometimes mean multiple phone messages) once they have the information to hand.

When new appointments are being offered, the admin staff will have immediate access to the options available. Cancelled follow-up appointments can be reallocated at the time of cancellation.

Make effective use of electronic diaries

Where clinicians are working peripherally and booking their own appointments, there is a danger of both the clinician and the administrator filling the same slot. In this situation, clinicians should be allocated IT equipment, such as mobile phones with internet access, which will update the main diary remotely. This enables both the clinician and the administrator to book directly into the diary without the risk of double bookings.

Work out the ratio of new to follow-up slots that are needed

When planning clinics, it is good practice for clinicians to differentiate between new and follow-up appointment slots. This is vital if they do not wish to end up with too many cases and if they allocate more time to an initial assessment than a follow-up.

Plan the diary against your job plan

A well planned diary means more efficient working. If you identify your patient appointment times for each clinic in advance – you will never end up with too many people to see in a clinic.

The number of patients you see in a clinic will be determined by your job plan. Some people allocate their time to allow for immediate admin; others, especially if clinic rooms are scarce, allocate more slots in a clinic and do their admin outwith clinic times. Whatever your approach – it is important that clinical admin is done as close to the patient contact as possible.

The following checklist will help you decide whether the admin of your service is helping you to deliver an efficient service. Rather than choosing '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 probably have an efficiently administered service. If you answer no or partly to questions, then this indicates an area where you could do further work.

Admin for Psychological Therapies	Yes	Partly	No
Is there clear service information for referrers?			
Is there clear service information for patients?			
Are partial first appointment booking systems in place?			
Is there a system for recording appointments offered and cut off dates for responses?			
Is there a clearly stated Did Not Attend (DNA) policy?			
Is there a clearly stated Cancellation Policy?			
Is the service easily contactable for patients (phone, email or text)?			
Does the service hold comprehensive contact information for patients?			
Do admin staff have full access and booking permission for clinic diaries?			
Do clinicians identify appointment slots in each clinic in advance?			
Do clinicians differentiate between new and follow up slots in diaries?			
Is there a system in place to allow unused appointment slots to be filled quickly?			
Is short notice booking a priority for admin staff?			
Is there an admin team member allocated to disseminate resources?			

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