



Demand, Capacity & Flow QI Collaborative

Thursday 16 April 2026



Demand, Capacity & *Flow*
Quality Improvement Collaborative



NATIONAL
COLLABORATING
CENTRE FOR
MENTAL HEALTH

Welcome from our team!



Anna
QI Coach



Clem
QI Coach



Hannah
QI Coach



Jaz
QI Coach



Josh
QI Coach



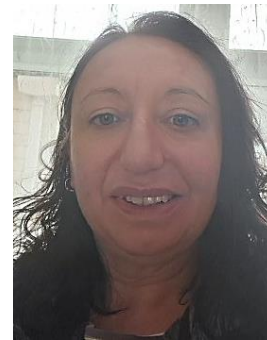
Rachael
QI Coach



Renata
Senior QI
Advisor



Lucy
Patient
Representative



Mary
Patient
Representative



Katherine
Project
Manager

Housekeeping

- No fire alarm tests are planned for today.
- Toilets are located to the right of the lifts on level 1 and the ground floor.
- Lunch will be from **12:40-13:25** in **Room 1.6**.
- **Room LG01** is available if anyone needs to take a break at any point or needs some space on their own.
- If you need to take a phone call or tend to an email during a presentation, please kindly leave the room.


Our shared principles

 **Collaborative learning** – Make the most out of the session, whatever that looks like for you.

 **Respect privacy** – Protect carefully the privacy of the storyteller. Ask what parts, if any, you can share with others.

 **Approach with kindness and curiosity** – We've all been through stuff so let's look after each other in this space.

 **Diversity of views** – respecting different viewpoints and experiences and being okay with sometimes disagreeing.

 **Language is important** – be mindful of how you speak to and about the people around you – it should support the building of trusting relationships.

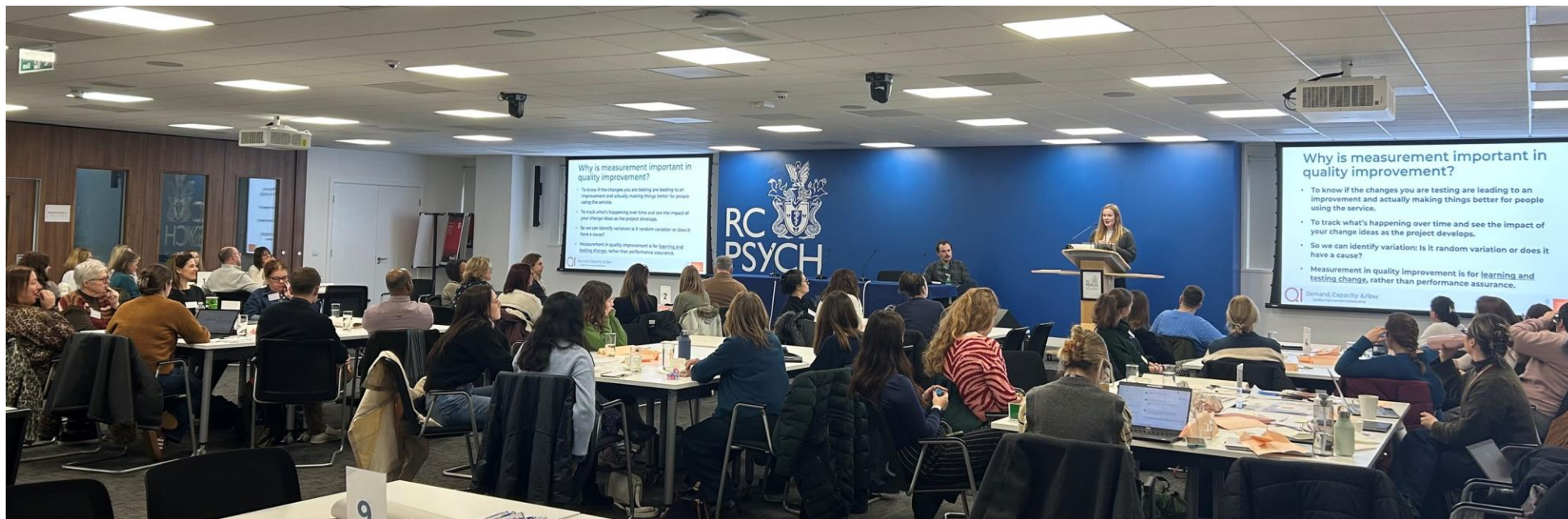
 **Be kind to yourself** – take breaks if needed, use our quiet space.

Today's agenda

Time	Item
10:00 – 10:15	Welcome, housekeeping & recap
10:15 – 10:30	Warm up activity
10:30 – 11:25	Equity session
11:25 – 11:40	BREAK
11:40 – 12:40	World café conversations
12:40 – 13:25	LUNCH
13:25 – 13:40	Post lunch energiser
13:40 – 14:00	Your lived experience pledges
14:00 – 14:45	Working on your projects
14:45 – 15:00	Final reflections and close
15:00 – 15:30	Optional time with your coach



Recap



Children and Young People ADHD team, Hertfordshire

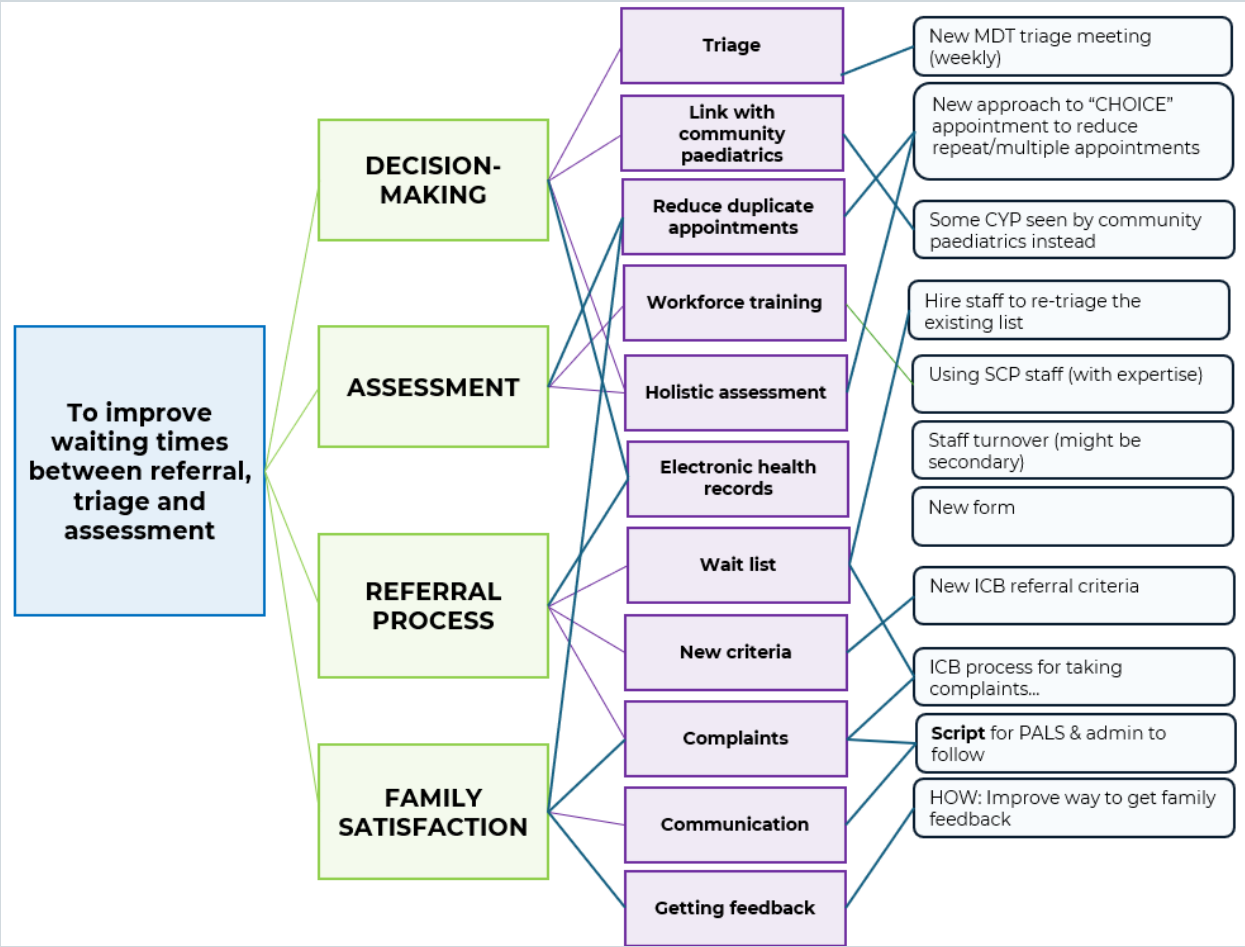


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CAMHS, Manchester



PATH, Hertfordshire

PDSA worksheet
(See full PDSA guidance in the Annex)

PATH HPFT

Change idea:
Replace the current referral form into social care STAR workers with a shorter email

PDSA cycle number: 1

Objective of this cycle (What are you trying to learn from this PDSA cycle?);
To find out whether changing the referral form will make it easier to make referrals and increase communication between hub and spokes for better joint working

1. Plan
What do you want to know/learn? What can this idea help improve? What do you think will happen when you run this test and why?

Questions and predictions

Q1. **Does this streamline the process?**
Prediction: This will make it easier for referrals to be made

Q2. **Does this improve communication between the teams?**
Prediction:

Q3.
Prediction:

Q4.
Prediction:

Challenges:
May not work for all staff
May create more work elsewhere eg meet

Plan to run the test

Who will lead and take actions forward to make it happen?

What are you going to do?

ACTION:
Send blank for to co-pilot and ask how to transform this into an email with the key pieces of information that's needed. 4 main issues to list
Will go to a designated mailbox

ACTION:
Link in the STAR workers and the rest of the team by next 3 weeks

When will you start?

How long will you run this test for?

Think about equity – will this idea benefit all the groups you care for? (e.g. autistic people, marginalised groups, people from different ethnicities). What adaptations do you need to make to meet their needs, who do you need to involve to better understand their needs?

Harrogate ADHD Assessment - Tees, Esk and Wear Valleys



3. PDSA worksheet



Organisation and team name: TEVV Northallerton and Harrogate ADHD assessment

Change idea: CLS slot following initial assessment

PDSA cycle number: 1

Objective of this cycle (What are you trying to learn from this PDSA cycle?):

If clinicians feel confident and competent in their clinical decision making this will support the right children to access the right pathway within CAMHS. This will increase the capacity to complete ADHD assessments within 15 weeks from referral as fewer inappropriate referrals will progress onto the pathway.

1. Plan

What do you want to know/learn? What can this idea help improve? What do you think will happen when you run this test and why?

Questions and predictions

Q1. Does adding a CLS slot increase staff's confidence when feeding back formulations to families of whether an ADHD assessment is indicated?

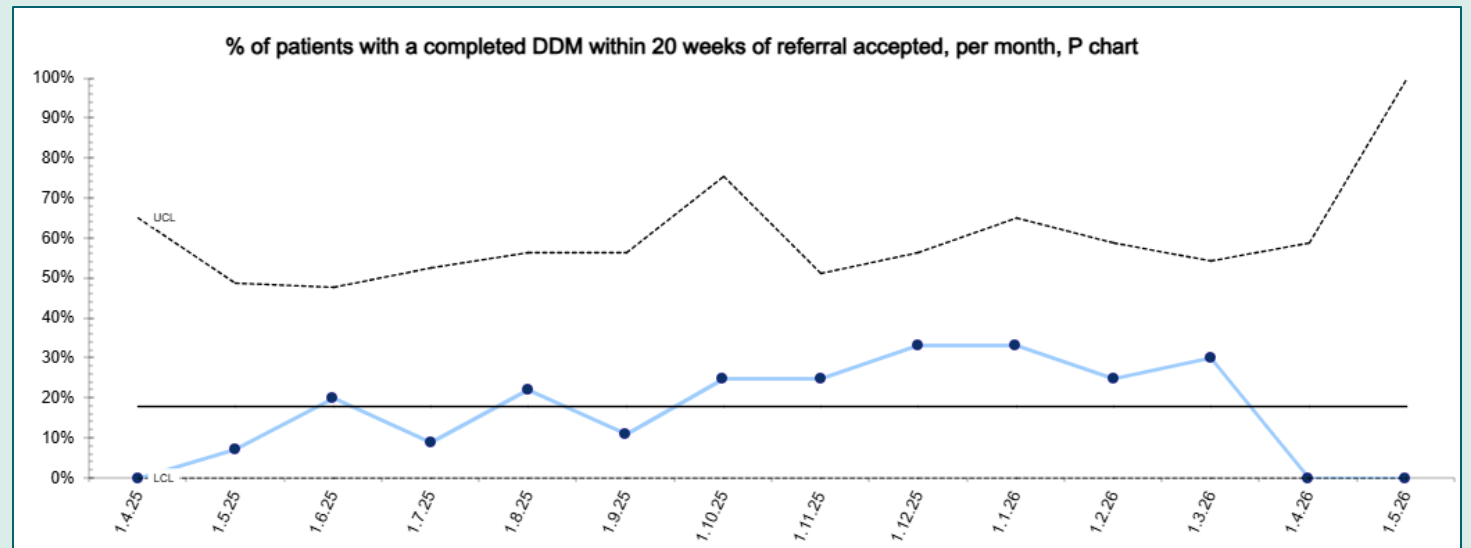
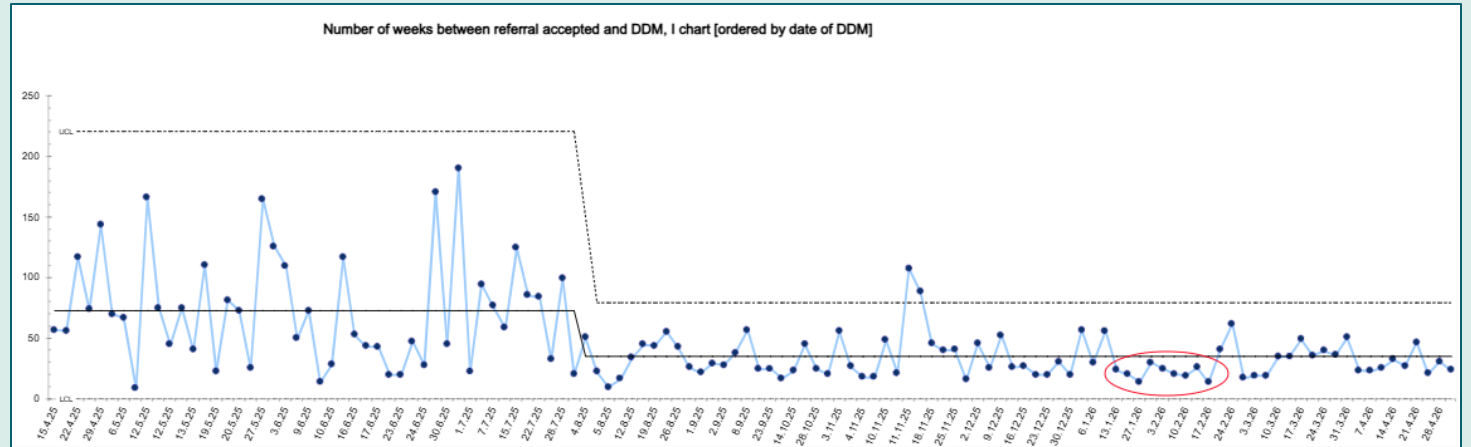
Prediction: Staff will feel more confident having discussed the young persons needs in an MDT slot, therefore it not being an individual decision, and will therefore feel more able to feed this back to families.

Q2. Does the addition of a CLS slot reduce the number of inappropriate referrals progressing into an ADHD assessment?

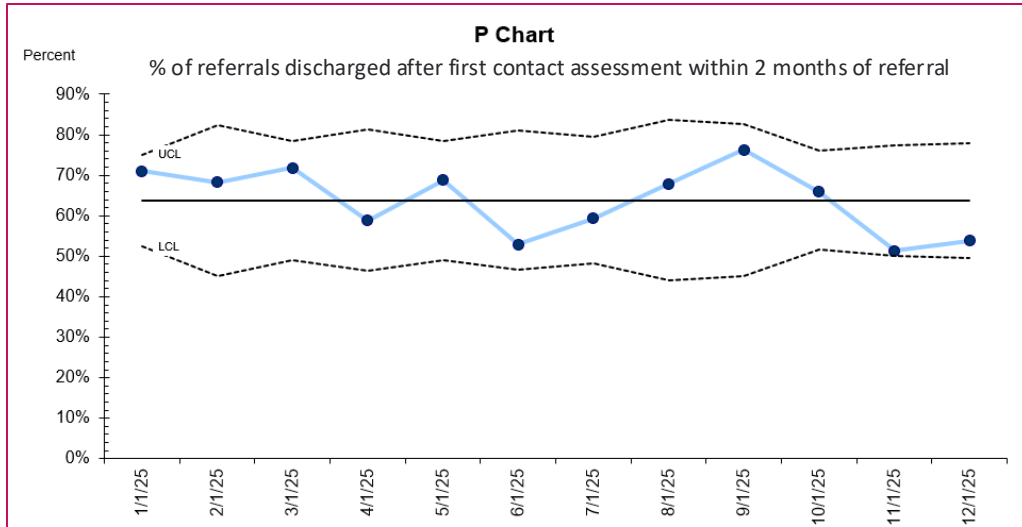
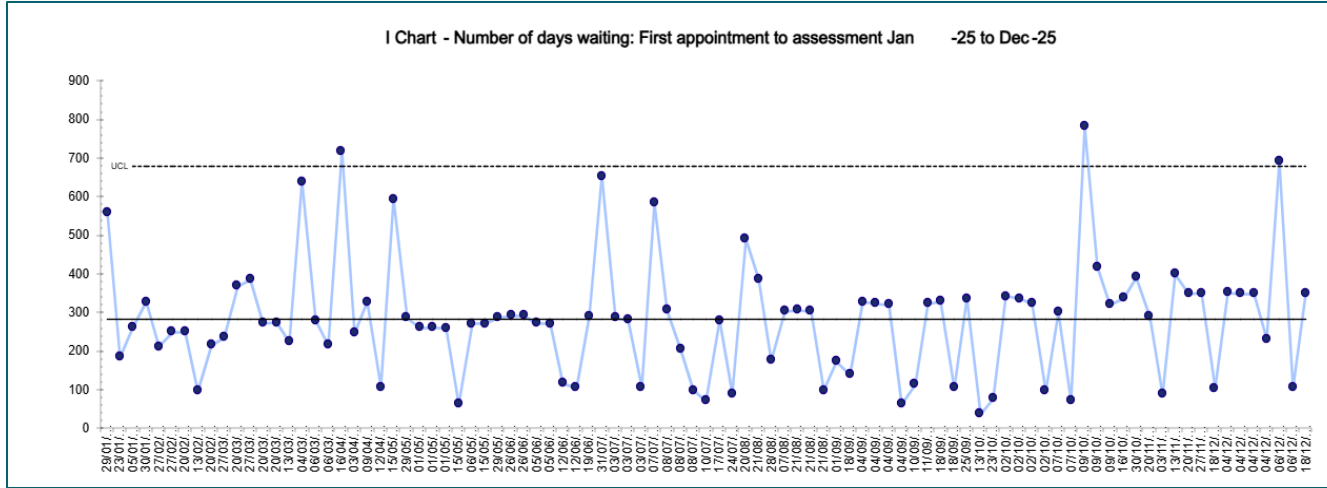
Prediction: The conversion rate for ADHD diagnosis will increase as fewer inappropriate referrals will be assessed.

Q3. Do families find it helpful to have a formulation of need at the time of ICA rather than progressing onto an inappropriate pathway.

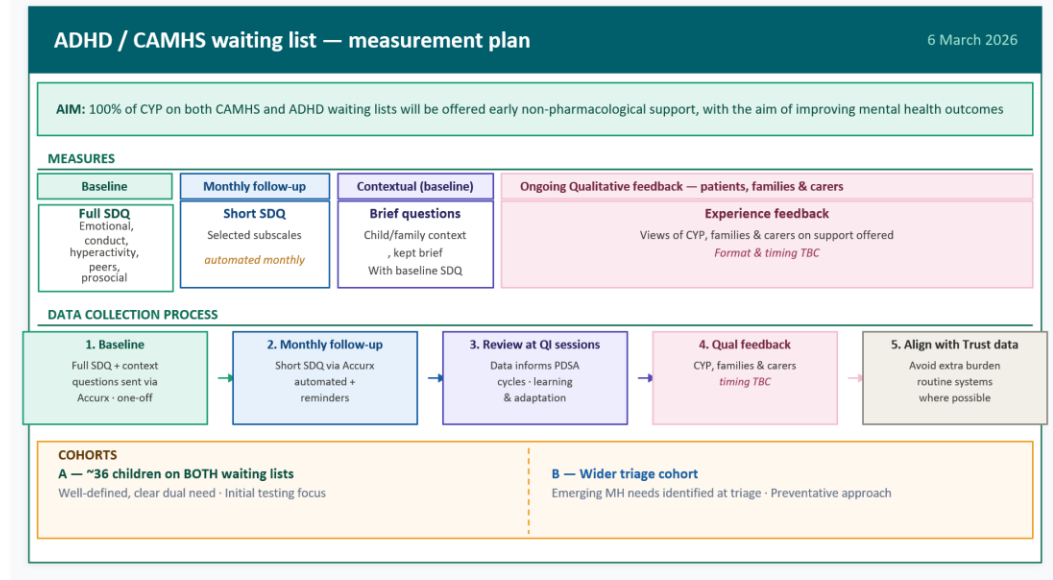
Prediction: Families will find it helpful to have an understanding of their child's needs sooner rather than later and will be signposted/supported accordingly.



Westminster CAMHS, Central and North West London



CAMHS ADHD, Hull and East Riding



Dacorum Adult Community Mental Health Service, Hertfordshire

Connecting to each other



10 mins

The Name Story:

As a table, or in pairs:

SHARE A STORY ABOUT YOUR NAME/NICKNAME

(You could include its origin, who chose it, cultural significance.....)



The importance of equity in mental health care

Dr Laura-Louise Arundell
Senior Researcher



Impact of inequity on access, experience and outcomes

- Disparities in mental health care are influenced by multiple factors such as (but not limited to):
 - Socio-economic status
 - Age
 - Ethnicity (or 'race')
 - Geography
 - Gender
 - Other social determinants
- These factors (among others) can intersect to create **overlapping systems** of discrimination, which can increase the risk of unequal treatment.
- **Intersectionality** magnifies the barriers that individuals face and can exacerbate inequities in mental health access, experience and outcomes.

Why is inequity so important for your service?

- Inequity is not a side issue but one that directly affects who gets care, how they are treated and their outcomes
- Delayed care → crisis presentations
- Poorer experiences → mistrust and disengagement
- Worse outcomes → chronic poorer health, higher risk, inequality across life course

If services don't actively address inequity, they reinforce it

Why is inequity so important for your service?

Examples:

Children and young people

- Looked-after children
- Young carers
- Neurodivergent young people
- Racialised minority/minoritised ethnicity families (stigma, access, language)

Risk = delayed intervention → lifelong impact (education, long-term health, developmental outcomes)

Opportunity = early, equitable access, removing the barriers to access for the best chance of long-term positive outcomes

Why is inequity so important for your service?

Examples:

People with a diagnosis of Autism

- Diagnostic overshadowing (MH symptoms missed)
- Poor adaptation of services

Risk = Inappropriate intervention available → exclusion from the right type of support

Opportunity = Reasonable adjustments and truly personalised care

Why is inequity so important for your service?

Examples:

People with a diagnosis of psychosis

- Marked ethnic inequalities (linked to systemic racism and stereotyping)
- Negative experiences of care

Risk = Delayed access → use of coercive care → perpetuated distrust

Opportunity = Community engagement + early, culturally competent pathways to care

Why is inequity so important for your service?

Examples:

People with a diagnosis of eating disorder

- Stereotypes and underdiagnosis in males, racialised minorities and people in larger bodies
- Dismissal or minimisation of severity

Risk = Later, more severe illness at presentation → undermined therapeutic trust → missed opportunities for recovery

Opportunity = Inclusive identification + equitable referral pathways

How can we achieve equity in mental health care

**** Equity as a foundational aspect of care (not an afterthought) ****

- Use **Equality Impact Assessments** to:
 1. Define the change (what are we introducing/what is the change idea?)
 2. Identify who might be affected (consider protected characteristics [Equality Act] and other characteristics) and apply an intersectional lens
 3. Ask key questions: Who might benefit most? Who might be disadvantaged? Could this change idea widen any gaps in access, experience or outcomes for certain people?
 4. Use data and lived experience to inform ideas and ways of measuring impact
 5. Mitigate the risks, build in adjustments
 6. Review and measure (review during and after implementation to see if inequities reduce, stayed the same or worsened)

Factors that can put people at risk of inequitable care

Protected Characteristics (Equality Act 2010):

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Other characteristics covered in NICE and other organisational resources:

- Socioeconomic status
- Refugees and asylum seekers
- Migrant workers
- Looked-after children
- Unhoused people and people in unstable housing situations
- Prisoners and young offenders
- Gypsy, Roma and Traveller communities
- Young and unpaid carers

Equality vs equity

Equality



Equity



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Team work



25 mins

In your teams, discuss...

- What are the inequities in your local area / service? Have you looked at data? Which groups are at disadvantage when it comes to access, experience and outcomes?
- Think about one or more change idea(s) you're currently testing / planning to test. Are they equal and equitable, or just equal?
- Can you think of change ideas to address inequity in your service?
- **Identify at least one action to take forward.**



Room reflection

Comfort break



11:25 – 11:40

World café conversations

- A networking space to connect with each other and hear about the work going on in the Collaborative.
- Teams will be sharing their work.
- This is an informal, conversational space. Ask questions, share examples of your work, take ideas back to your project.

You will have
15 mins per table

Rotate to another
table

3 rotations



Team sharing and networking

Location		Team
Main room	Table 3	North Lincs CAMHS – Rotherham, Doncaster & South Humber <i>'Digital Poverty & change ideas'</i>
	Table 1	CAMHS – Tees, Esk & Wear Valley <i>'Clinical Leadership Slots (PDSA)'</i>
Breakout rooms	Room 1.2/1.3	Dacorum Adult CMHT – Hertfordshire Partnership Trust <i>'DCF Journey so far'</i>
	Room 1.1	Community Adult Autism Team – Dorset NHS Trust <i>'Change Idea working groups + measuring patient experience'</i>

Lunch

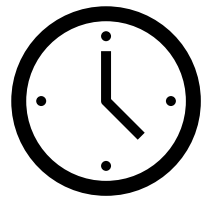


12:40 – 13:25



Post lunch energiser

The birthday paradox



15 mins

- 1. What are the chances that two people in this room share the same birthday?**
Shout out a percentage!
- 2. Stand up and line up along the wall in birthday order**
You'll need to talk to each other to work out the order
- 3. Now turn to the person next to you and find a few things you have in common**





Your Lived Experience Pledges

Lucy Jenkinson

Lived Experience Representative

Rachael McGowan and Jaz Seehra

QI coaches

HPFT, ADHD CYP PLEDGE

- INVITE EBE PARENT/CARER TO BE A PARTICIPANT IN OUR PROJECT.
- WORK MORE CLOSELY WITH THE MHST/SCHOOLS TO GATHER VIEWS FROM CYP.
- TAP IN TO HERTS YOUTH COUNCIL FOR VOICE OF THE CHILD
- IDENTIFY A LEAD/CO-ORDINATOR SUPPORT WORKER.

Tew canals (Kangas + ...)

Before engagement - set out a clear + simple version of the project so those who would be invited understand the parameters

Create 3 layers of engagement for 4 people and parents and carers to be involved in:

- Those not currently in service
 - Target schools
 - Community centre
 - Social media
- Those accessing our service
 - Drop in to waiting rooms
 - Follow invitation to workshop
 - Waitlist
- Those who have previously accessed our support
 - Send letters and texts to those who have accessed service previously
 - Newsroom

To understand what is happening locally with regards to co-production and for opportunities to work together

PATH - HPFT

using our feedback more effectively within the project.

Exploring ways in which we can get more feedback/discussion re: service delivery.

DACORUM ACIMHS

Challenge staff about language

- Do you remember something unkind someone has said to you? How did it make you feel?
- Point out unhelpful ways of speaking about service users and carers eg. meltdown, manipulative, attention seeking ... etc

HPFT CYPED

Incorporating service user/family involvement and feedback to inform the 12 week review process and to develop a better review process 😊

HERTFORDSHIRE CYP EATING DISORDERS TEAM

WASH

- Ensure we have a robust feedback loop to ALL our lived experience partners.
- facilitate ~~involved~~ involvement of lived experience voices at our catch up meetings and attendance at the Workshops.

WATFORD, HPFT

Methods

- Targeted uses of LE within our project team
- sustainability of use
- consider how expert reference group can have longevity + value

Staves

- directs in team
- From + return
- with public/Broad diverse voice
- how do we connect with third sector, Ascape groups etc

Practices

1. develop targeted strategies for incorporating lived exp voice into service in a consistent sustainable way
2. Approach 10 groups for feedback, third sector lived exp groups
3. more regular Ref group/strategy for it

① 2023 part of pop. who have been on waiting list + 2024 live - passed waiting list in new letter

② Lots ways of engaging eg. drop in in case of not possible, access, weekly drop in

Find out if there are any colleagues with LE who are willing to be involved.

WATFORD, HPFT

Table 10

Trauma informed training - ask for training for team that Michelle is involved in (language/communication)

Online course being devised

Challenge staff - culture

Start conversations with staff - bite size conversations.

Embed in huddle/MOTs/scrums

"Think of language"

How?

- Mapping patient journey - timeline, new process (visual flowchart)
- Questions a about
 - Divis diagram
 - aim
 - change ideas.

How? = Participate group, speak with peer support workers, bring on recruited group person and parent

NOTTINGHAM

To identify a trained psychologist to conduct groups and distribute questionnaires to get experience and feedback on their journey the LMMT and step 4

HPFT

MULTI-METHODS TO GATHER DIVERSE VIEWPOINTS AND EXPERIENCES FROM YOUNG PEOPLE'S VOICES WE WOULDN'T OTHERWISE HEAR; DUE TO THEM FEELING UNABLE TO JOIN SERVICE USER FORUMS.

Lived Experience Pledges - Activity



On your tables, you have a worksheet with your pledge from the Jan-26 learning set.

In your teams, reflect on:

- What have you done to action on your pledge since the last learning set?
- What next steps could you take to build on your commitment to co-production?

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ORGANISATION:
SERVICE:

YOUR PLEDGE FROM LEARNING SET 3 IN JANUARY 2026
WHAT HAVE YOU ACTIONED SINCE MAKING THIS PLEDGE?
NEXT STEPS TO BUILD ON YOUR COMMITMENT TO CO-PRODUCTION

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Examples of pledges made by other teams:

Incorporating Service user/family involvement and feedback to inform the <u>12 week</u> review process and/or develop a better review process.
Invite EbE parent/carer to be a participant on our project Work more closely with the Mental health in <u>schools</u> team to gather views from CYP. Tap into the Herts youth council for voice of the child. Identify a lead/co-ordinator support worker.
Create 3 layers for Lived experience YP, carers and parents. - Those not accessing our service – target schools, community venues, social media? - Those accessing our service currently. - Those who have accessed the service previously.
To understand what is happening locally with regards to co-production and opportunities to work together.
Build a targeted strategy for bringing in LE voice sustainably. Introduce a feedback loop so people who contribute get updates. Find LE within project team Facilitate involvement of lived experience voices at our <u>catch up</u> meetings and attendance at the learning events.
Gather diverse viewpoints and experiences from young people's voices we wouldn't otherwise hear due to them feeling unable to join service user forums.
Think about and train staff to use inclusive language.
Find out if there are any colleagues with LE who are willing to get involved in the work
To identify a trainee psychologist to conduct focus groups and distribute questionnaires to get – experience and feedback on their journey between the LMHT and step 4.
Using our feedback more effectively within the project. Exploring ways in which we can get more feedback/discussion re: service delivery.

New Co-production – top tips Document

QI Demand, Capacity & Flow

Demand, Capacity and Flow Top 10 Tips for Coproduction

- 1 Commitment to increasing patient and carer involvement in ALL we do ...**

Do clinicians regularly seek the feedback and opinions of the patients and families they work with? Are they open to hear negative feedback or challenge? How might we hear from more people, especially those who have had a negative experience?

Do we share with people what difference their feedback has made?

Do we involve patients and carers in all our service design, delivery and evaluation?

Example idea: create robust feedback loop to ALL lived experience partners
- 2 The Spectrum of Coproduction**

Do we consider all the different ways people can participate?

Inform - Do we inform everyone in the community we serve about our services, what we offer, any changes?

Involve - Do we involve patients and families in their own care? Do we involve people with lived experience in quality improvement?

Collaborate - Do we try to share power and work together right across a project? Are people with lived experience involved in agenda setting, sharing, presenting?

Coproduction - Are people with lived experience equal in decision-making? Paid equally for their contributions? Do we have good peer workers and lived experience leaders in our team and services?

Good practice: offer necessary training to support people
- 3 Power**

Many patients will have experienced powerlessness in their lives and in accessing mental health care. Do we think about power in coproduction? Who have we excluded from being part of the work? Who is holding the pen? Who has the final say on decisions? What meetings and shared conversations happen without the people with lived experience? Whose knowledge is most respected?

- 4 Language and accessibility**

Do we use human language that is accessible and avoid jargon, acronyms and first speak? Do we ever mediate human experiences with the language we use?

When working with lived experience partners do we establish a shared understanding of how we work together? Do we have ground rules, clear terms of reference? Are we transparent about what is in and out of scope?

Are we curious and sensitive about the language we use? Do we value lived experience perspectives on language that is harmful or outdated? Do we respect people's preferences around language? Do we use sensitive and respectful language? Would you be open to being challenged on your language?

Do we make reasonable adjustments to help to an autistic person, rather than a person with autism support people to participate fully.

Good practice: Share documents beforehand, offer digital support, be flexible with timing of meetings, introduce all team members and explain their role, Offer to print slides for events, adjust fonts, separate meetings or use closed captions, Have flexibility to turn off camera for a few minutes during a meeting or take a short break.
- 5 Support and training**

Do we recognise the emotional toll of coproduction and provide people with lived experience good support?

Good practice: offer a point of contact within the organisation or a buddy system with other expert by experience, with whom people can debrief after every meeting?

This might include emotional support like peer meets, debriefs, supervision, a key contact, a buddy, breaks in meetings, quiet spaces available.

Making sure this is sustained rather than something that is just spoken about.

It might include practical support with diaries, arranging meetings, completing ongoing claim forms, arranging travel, access to an IT's email address.

Good practice: provide training to people in lived experience roles including training on human rights, trauma informed care, peer support, chairing a meeting, facilitation skills, understanding data, closed captions, Have flexibility to turn off camera for a few minutes during a meeting or take a short break.
- 6 Diversity of voice**

How are we thinking about diversity? How do we hear from the people and communities most impacted? Who is over and under represented in your services? What does data tell you about different communities, ages, cultures and experience? How do we ensure we are working with people from marginalised communities and people who face multiple disadvantage? How might the Voluntary, Community and Social Enterprise help us do this better?

- 7 Payment and reimbursement**

Are we paying people fairly for the work they are doing with us? Does our organisation have a payment policy that can support live our good peers and lived experience roles paid fairly for their expertise and responsibility? Do we have flexible ways to pay young people, people on benefits for example? Are we paying people to complete mandatory training, in the same way that staff are paid?
- 8 Trauma informed approach to coproduction**

Are we sensitive and aware of the prevalence and impact of trauma for the people we serve and the people with lived experience we work with? Do we take action to work in a way that is not re-traumatizing. How do we foster trust, safety, empowerment, choice and collaboration?

For example, not holding meetings in a potentially triggering environment, not excluding people from decision making, believing people's accounts of their experiences, not expecting someone to re-live traumatic events, giving notice of traumatic content on and agenda.
- 9 Autism informed approach to coproduction**

Do we have a good understanding of autism and the potential needs of autistic people? Are we thinking about how we share information, the timing, environment of where the meeting is held, are we making space for different forms of communication?

For example, giving people permission to use the chat or respond by email.
- 10 Anti-racist approach to coproduction**

Coproduction is rooted in the civil rights movement, it fosters inclusive processes that challenge to seek and dismantle systemic barriers faced by racialised minorities. How are you considering 'The patient and carer race equality framework in your approach to coproduction?

Useful resources

- Best Evidence Co-production
- The Lundy model of child participation | ChildHub - Child Protection Hub
- Outline: SPICE, a novel framework for meeting the needs of autistic people in healthcare settings

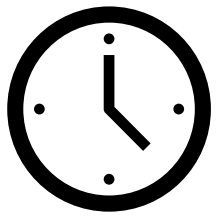
A decorative border on the left and right sides of the slide, consisting of overlapping teal squares, circles, and rectangles in various shades of teal and pink.

Working on your project

Anna Roach

QI coach

Working on your project



45
minutes

- This is time for you, as a team
- If helpful, please mix and discuss with other teams



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Share one take away from the session today

Clementine Fitch-Bunce

QI Coach

Knowledge Hub

An online platform for all teams on the Demand, Capacity & Flow Collaborative

- Space to share information, queries and receive advice/insights from peers and programme team.
- Peer-to-peer learning and collaboration.
- Central space for sharing resources.

The screenshot shows the interface of the Demand, Capacity & Flow (DCF) QI Collaborative Knowledge Hub. At the top left is a circular logo with the letters 'DC' in red. Below the logo, the title 'Demand, Capacity & Flow (DCF) QI Collaborative' is displayed, followed by metadata: 'Restricted group | Started - May 2025 | Last activity - December 2025 | 41 members'. A navigation bar contains tabs for 'Home', 'Discussion', 'Library', 'Blogs', 'Events', 'Wiki', 'Ideas', 'Members', 'Search', and 'Admin'. Below the navigation bar is a 'Group information' section with a dropdown arrow. The group information text states: 'Group facilitator: Josh Bailey, Clementine Fitch-Bunce, Ruby James, Hannah Lautch, Rachael McGowan, Katherine Molyneux, Anna Roach, Jaz Seehra, Renata Souza. Demand, Capacity and Flow (DCF) is a quality improvement collaborative that aims to support Mental Health Services across the UK to improve the demand, capacity and flow of their services. This group is for members of the teams taking part in the collaborative, as well as the coaches who are supporting the teams through their journey. The teams taking part in the collaborative can use this space as a platform to share updates about their projects, as well as sharing their learnings from the work. Four different service types are being supported in the collaborative, so Knowledge Hub will provide a platform for general discussions, as well as allowing each service type to support each other through their journeys.'

Below the group information are two main sections: 'Recent activities' and 'Announcements'. The 'Recent activities' section shows a comment by Lisa McIntyre and a new discussion started by Ashlea Sands on 12 Dec 2025 at 10:27. The discussion title is 'Advice - how to engage and plan this project with young people & families'. The discussion content begins with 'Morning everyone, Ashlea here from MFT CAMHS. I have taken over this project from my colleague and have lots of catching up to do... Any advice, best practice etc. would be so helpful. ... See more'. The 'Announcements' section has a '+ Add Announcement' button, tabs for 'New', 'Archive', and 'Future', and a message 'No entries were found.' with a 'Manage polls' button.

Feedback and close

- We value your feedback as this helps us to continue to improve these events.
- **Please use the QR displayed here,** or the paper copies on your tables.



Optional drop-in sessions



15:00 – 15:30

**Time with the QI team to
discuss your project**

