



Demand, Capacity & Flow QI Collaborative

Launch Event

07 April 2025



Demand, Capacity & *Flow*
Quality Improvement Collaborative



NATIONAL
COLLABORATING
CENTRE FOR
MENTAL HEALTH

Housekeeping

- **No fire alarm tests** are planned for today.
- **Gender neutral and accessible toilets** are located on the ground floor, and gendered toilets are located on this floor, to the right of the lifts.
- **Lunch** will be from **12.30 - 13:15** and will be served on this floor in **room 1.6**.
- **Room 1.1** 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 attend to an email during a presentation, please kindly leave the room.

Agenda

10:30 – 10:45 Programme overview

10:45 – 10:55 Getting to know one another

10:55 – 11:45 Understanding demand and capacity, and why that is important

11:45 – 12:30 Demand, capacity and flow: How we centre lived experience and equality in this work

12:30 – 13:15 Lunch

13:15 – 13:35 Networking and team sharing

13:35 – 14:10 Learning from wave 1 of the Demand, Capacity and Flow collaborative

14:10 – 14:50 Starting to visualise your system

14:50 – 15:00 Next steps, feedback and close

Programme overview

Wave 2 is a two-year programme (April 2025 – April 2027)

The Collaborative will support you to:

- Understand demand and capacity, and manage demand in creative ways.
- Develop and test changes to make access to services quicker and easier, and improve flow.
- Improve patient experience and communication while they wait for support.

14 teams taking part

- 8 CAMHS Teams
- 1 Community Paediatrics
- 1 Community Adult Autism Service
- 1 Early Intervention in Psychosis Service
- 2 Adult Community Mental Health Teams
- 1 Psychological Therapies Service



DC&F Collaborative offer

Support to develop bespoke QI project

Regular QI coaching sessions

A learning community to share and learn with

Support with co-production & equity

Support to capture and record learning from your project



Coaching support (timeline)

0 – 6
months

- Map your system through flow charting.
- Develop your project aim and theory of change.
- Create your measurement plan.

6 – 24
months

- Explore creative ways to achieve your aim - generating and testing change ideas.
- Support the collection of data.

20 – 24
months

- Support with implementation and sustainability.
- Story-telling.



Our delivery team

Senior QI
Advisor



**Renata
Souza**

QI Coaches



**Anna
Roach**



**Clem Fitch-
Bunce**



**Hannah
Lautch**



**Jaz
Seehra**

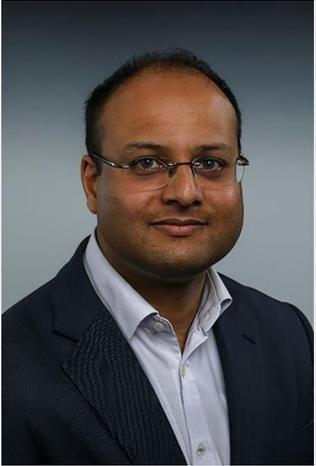


**Josh
Bailey**



**Rachael
McGowan**

Our programme team



Amar Shah
National
Improvement
Lead for
Mental Health



Tom Ayers
Director of
NCCMH



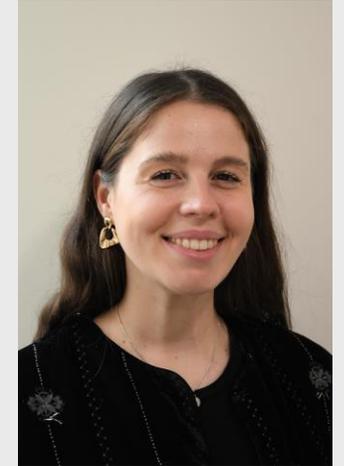
**Emily
Cannon**
Head of QI



**Matt
Milarski**
Head of QI



Sal Smith
Head of
Lived
Experience
and Co-
production



**Ruby
James**
Project
Manager

Getting to know one another

Please have a set of keys in your hand, from your personal belongings.

Join in a group of 3 people, with someone you don't know well, or don't work with often

Talk with the people in your group, using the next few points as facilitation points:

- What is this the key to? Are there other keys on the bunch? What are they for?
- Is there a key ring attached – what's the story behind this?

Repeat the process for each of you in the group.



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Understanding demand and capacity, and why that is important

Tom Ayers, Director, NCCMH

Learning about how people and information move through services

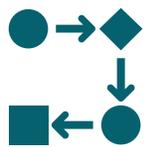




Let's organise ourselves so we are 6 or 7 people on a table.



We're going to simulate a care pathway.



Each person represents a step in the pathway.

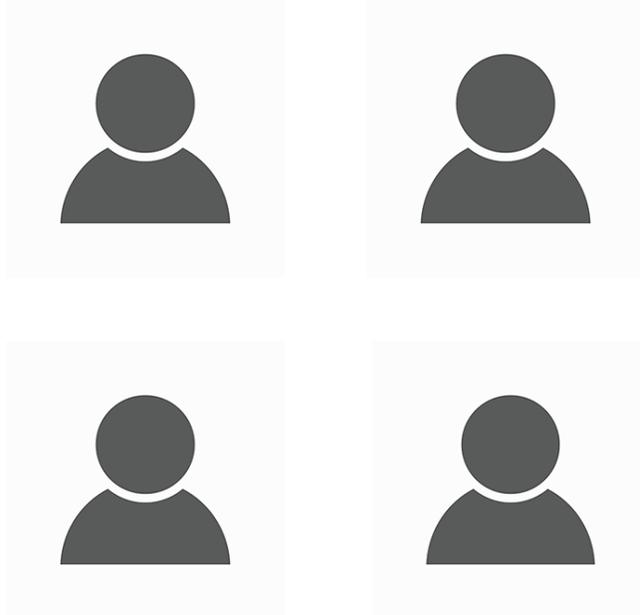


Each person has:

- a workstation (piece of paper with two boxes)
- 1 dice
- 4 'people' waiting at your step in the pathway

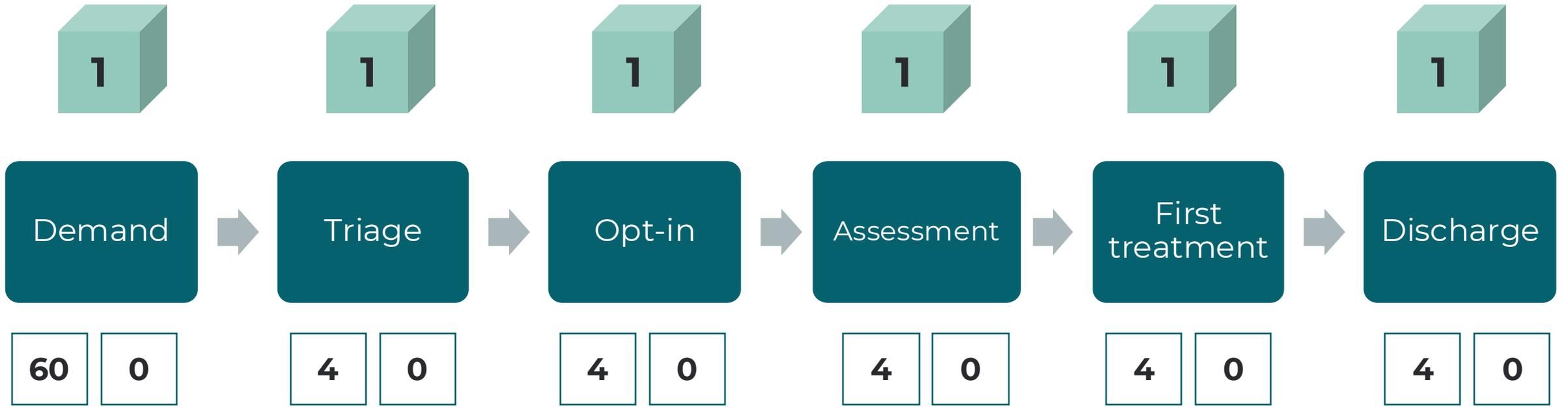
The person that represents referrals/demand has unlimited 'people' waiting to enter the pathway

Patients Waiting (in)



Patients Treated (out)





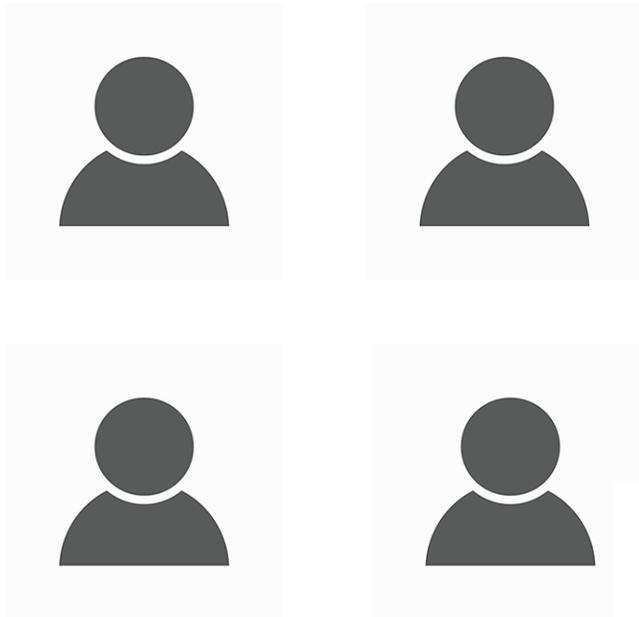
20 patients 'waiting' in the system

Instructions for each round

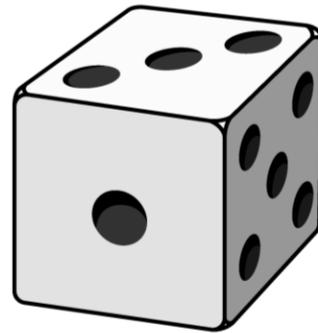
1. When instructed to THROW, roll your dice.
2. MOVE that number of people from the **“Patients waiting (in)”** box to the **“Patients treated (out)”** box

If you don't have enough patients, move all that you have (e.g. if you throw a 5 but only have 2 patients in the 'in' box, just move the 2 patients).

Patients Waiting (in)



Patients Treated (out)



Instructions for each round (cont.)

3. When instructed to TRANSFER, move the patients from your 'Patients treated (out)' box to the next person's 'Patients waiting (in)' box.

You will also receive more patients into your 'Patients waiting' area.

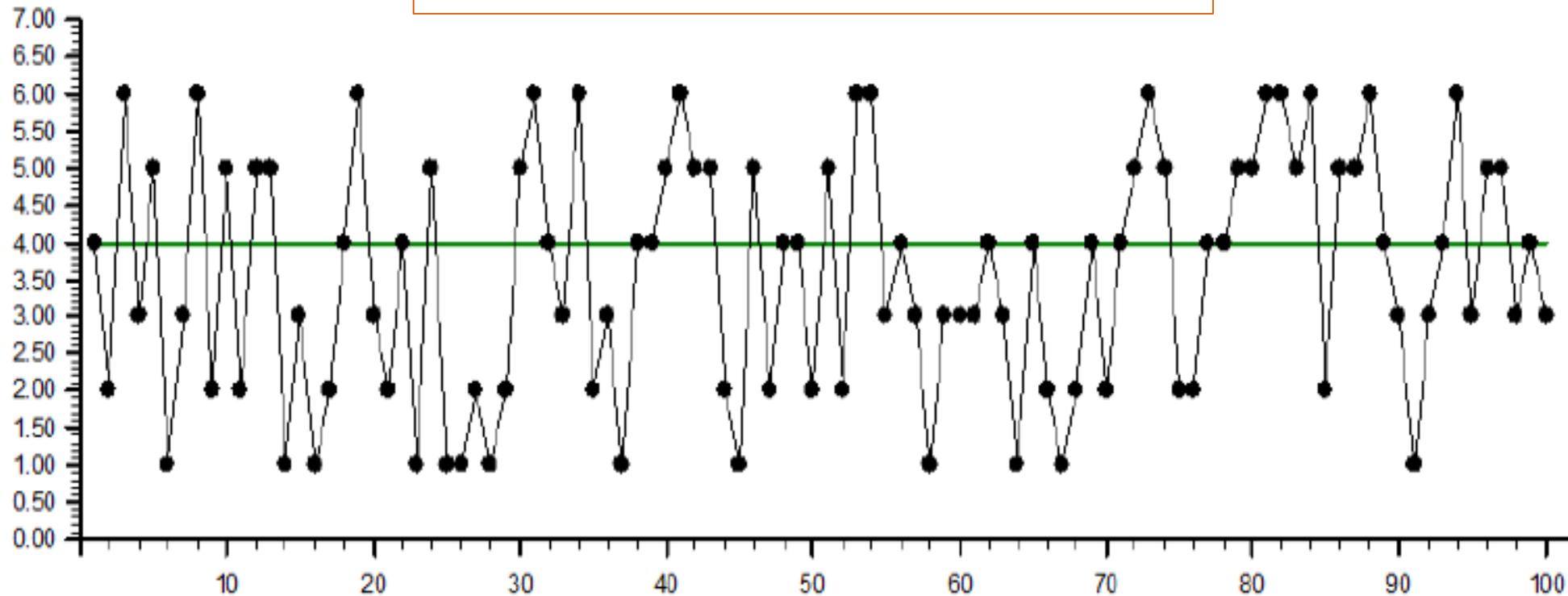
Before we start...

- What's your prediction?
- How many patients will the system treat?
- How many patients would go through the pathway in one day?
- How many in ten days?

Each roll of the dice represents your 'capacity' to treat patients at your step of the pathway, and represents demand for the next step in the pathway.

What will you deliver?

1 Dice – 100 random throws



Mean average	Total number
3.56	356

Let's go!



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Instructions (round 1)

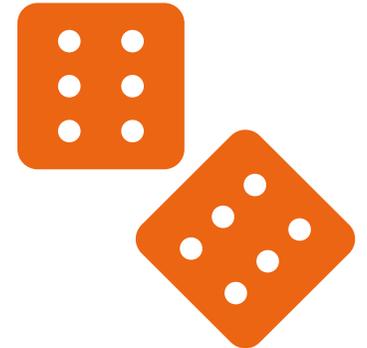
1. **THROW**, roll your dice.
2. **MOVE** that number of people from the “Patients waiting (in)” box to the “Patients treated (out)” box
3. **TRANSFER** the patients from your ‘Patients treated’ area to the next person’s ‘Patients waiting’ area.

Report your scores

- How many patients did you discharge?
- How many patients are now in the system?
- What happened?
- How did this make you feel....?

Round two

- A flow coordinator has been engaged to help improve the system.
- The flow coordinator will allocate an extra dice where they feel it has the greatest benefit and they can move it between throws.



Let's go!



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Instructions (round 2)

1. **The flow coordinator** allocates dice to a step in the pathway.
2. **THROW**, roll your dice.
3. **MOVE** that number of people from the “Patients waiting (in)” box to the “Patients treated (out)” box
4. **TRANSFER** the patients from your ‘Patients treated’ area to the next person’s ‘Patients waiting’ area.

Report your scores

- How many patients did you discharge?
- How many patients are now in the system?
- What happened?
- How did this make you feel....?

Round three

- Reducing variation.
- Remove dice and instead flip a coin:
 - **Heads means 3 people move on.**
 - **Tails means 4 people move on.**



Let's go!



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Instructions (round 3)

1. FLIP COIN

- **Heads: 3 people** move on.
- **Tails: 4 people** move on.

2. **MOVE** that number of people from the “Patients waiting (in)” box to the “Patients treated (out)” box.

3. **TRANSFER** the patients from your ‘Patients treated’ area to the next person’s ‘Patients waiting’ area.

Report your scores

- How many patients did you discharge?
- How many patients are now in the system?
- What happened?
- How did this make you feel....?

Learning

- Having a mismatch between demand and capacity causes backlogs and waits.
- Sporadic, reactive increases in capacity destabilises the system.
- Diverting lots of additional capacity at one stage does not change the overall output.
- More steps leads to greater levels of variation (more queues also leads to greater levels of variation).
- Reducing variation will help to improve flow and therefore performance.
- Planning on the average is planning for a wait. To avoid developing a backlog and waiting list, you need to set capacity above the average level of referrals/input at each step in the pathway (and for every queue).



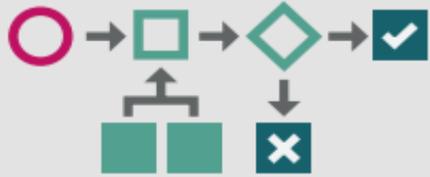
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Key steps

Visualise the system

Flow chart to help understand how the service is currently operating



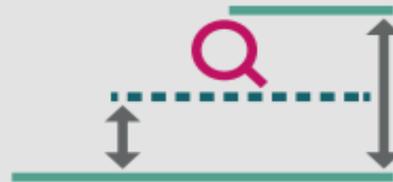
Review data

Data to better understand patient flow and bottlenecks



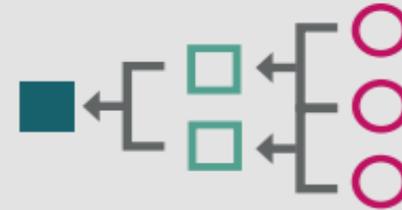
Understand demand and capacity

Identify key areas of focus and opportunities for improvement



Build theory of change

Visual strategy for tackling problems that impact patient flow



Aim, measures, change ideas

QI approach to testing change ideas and measuring impact





Demand, capacity and flow; How we centre lived experience and equality in this work

Sal Smith, Head of Lived Experience and Co-production,
NCCMH

Garrick Prayogg, Member of the Equality Advisory Group,
NCCMH

What do we mean by lived experience?

- Lived experience can mean many different things in different contexts.
- Of course, we all have lived experience of pain, loss, suffering. It is part of being human.
- In this context, lived experience refers to people who have had life changing experience of mental illness and using services, either themselves as a patient or as a carer.
- **How do we work together in partnership with the people and families who use our services?**

Benefits of coproduction and valuing lived experience

Bring about change in services

Improve service outcomes

Right thing to do

Help humanize healthcare

Reduce waste

Improve patient experience

Bring a different type of knowledge and expertise to bear

Connect staff with their values

Build trusted relationships

Help spot problems, provide early warning signs

Save money

Challenge health inequalities

Support people to be heard and believed about their experiences

Support individuals, both patients and staff to develop new skills

Challenge stigma and discrimination

A way of valuing people and families

Prioritise person centred perspective

Support justice for harm caused

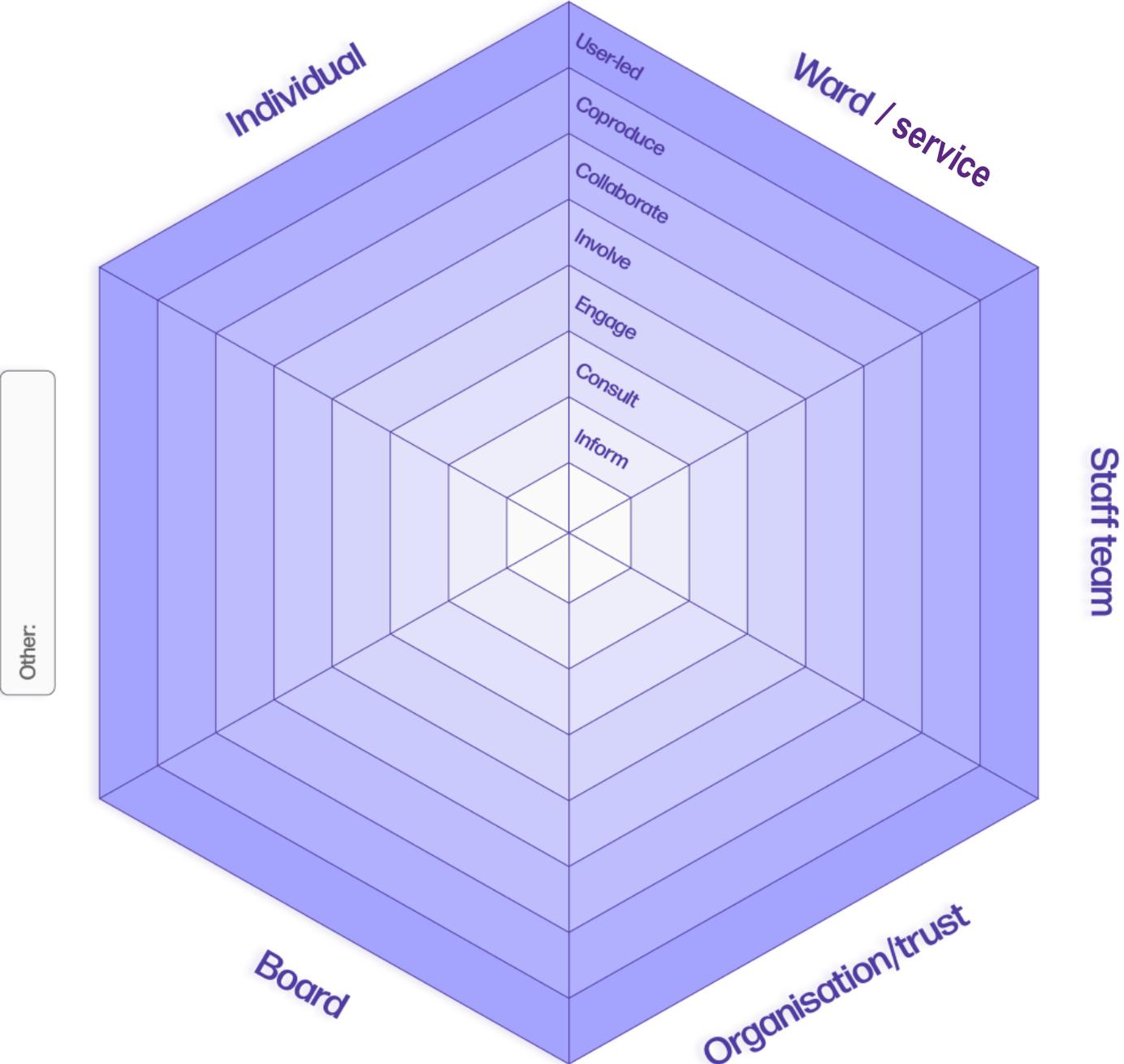
Ground discussions in reality

Increase individual self worth and confidence

Spectrum of coproduction?

- Traditionally we have used a ladder of participation to depict how we move towards coproduction.
- We want to encourage you to think of participation as a full spectrum where you work together with people and families as much as possible and at all levels.
- What opportunities are there for you as an individual, a team, a service, an organisation to lift up and amplify patient and family voice and perspectives?

Spectrum of coproduction?



Spectrum of coproduction?

This may include:

- Engaging a broad range of patient/carer views to inform this DCF work. How are we reaching the communities we serve?
- Having patients and carers as an equal part of your project team? Are they paid? Well supported?
- Involving peer workers from your service in the project team?
- Engaging local VCSE/user led organisations to help us understand what people with lived experience are saying?
- Do all patients and carers have the opportunity to feedback, compliment and complain about any changes. How do we listen and act upon that?
- Do we have lived experience leadership within the work?

Coproduction to support anti-oppression

- Mental health services cannot coproduce the way out of oppression and discrimination.
- However, the voices and experiences of people from marginalized groups are fundamental in bringing about the changes needed.
- How do we ensure we hear from people who are most impacted by any given issue?

Things to consider...

- Diversity of voice
- Power
- Remuneration
- Training and support
- Valuing lived experience
- Are we open to challenge and doing things differently?

Demand, capacity and flow

What might be the impact for patients and families of;

- Long wait times
- Being passed between services multiple times
- Being assessed and have to tell story multiple times
- Long wait between assessment and treatment
- No voice or choice in assessment process
- Being discharged when still struggling
- Poor communication about what is happening

Now consider if the patient is neurodivergent, traumatised, has experienced racism in their lives...

Demand, capacity and flow

What opportunities might come from;

- Taking an opening up approach rather than narrow down.
- Focusing on relationships and connection.
- Considering trauma informed care.
- Really listening and being curious about what patients and families need.

What opportunities are there to coproduce this work with the communities you serve?

Over to you.....

- What do you have in place already to help you centre patient and carer voice in this work?
- What could you possibly do to improve coproduction of this collaborative?
- What is the one action you are going to commit to following today's event?



Lunch



12.30 - 13.15



Networking and team sharing

- Choose one of the numbered sheets on your table – this number will match a breakout area you'll head to shortly.
- In this session, you have an opportunity to connect with other teams working on Demand, Capacity & Flow.
- Here are a few prompts to help get the conversation started:
 - Share a bit about your team and service
 - Why did your team decide to join DC&F?
 - What are you hoping to achieve from being part of DC&F?



Learning from wave 1

Q&A with Renata, Adele and Jaz



Starting to visualise your system: Understanding the whole pathway using a high-level block diagram



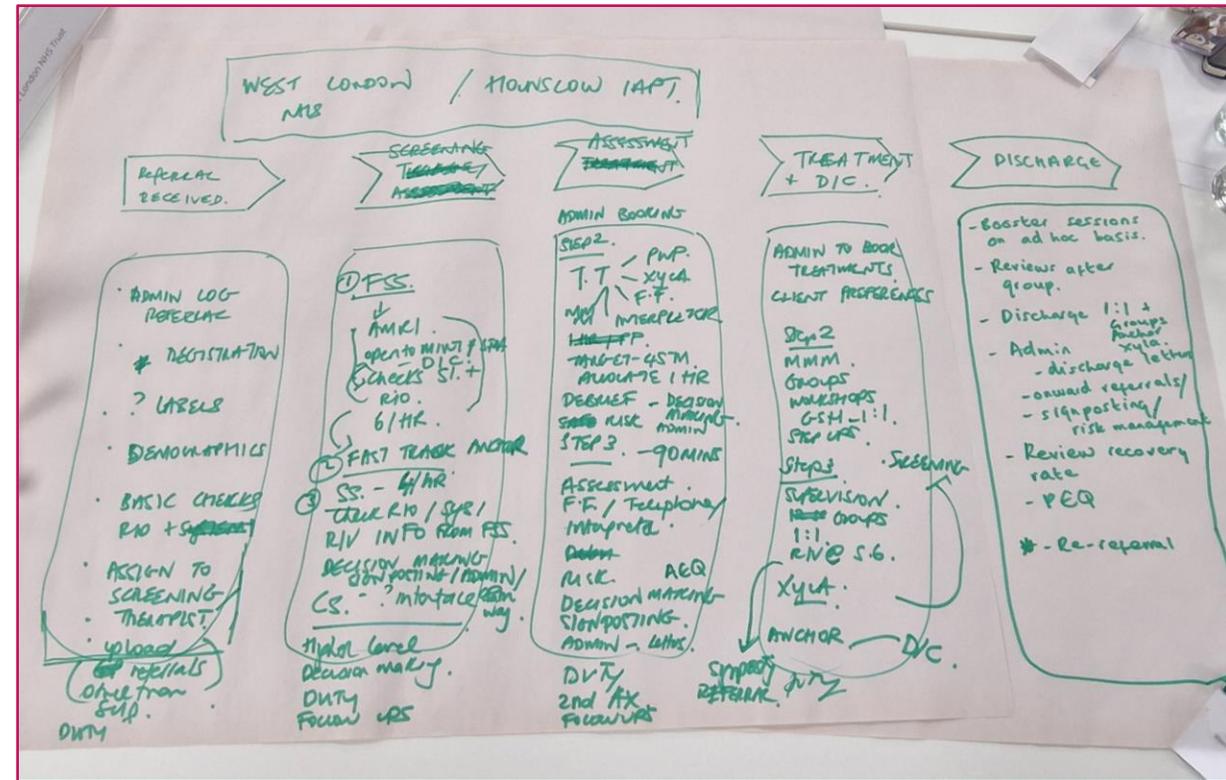
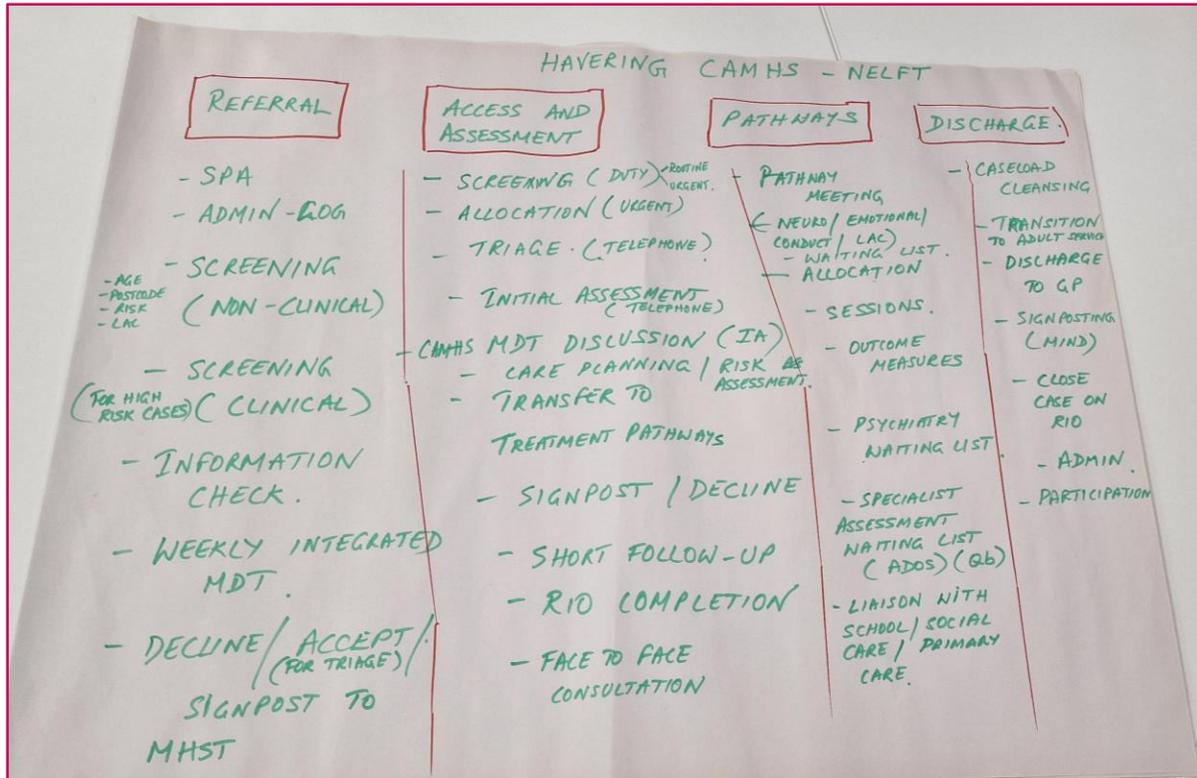
Let's create your high-level block diagram

- **Create a block for each key process/step of the pathway (approx. 3-5 high-level blocks)**
- **List the key steps/activities that fall under each block (using sticky notes or bullet points)**
 - Include clinical and administrative tasks, meetings and/or any contact with other services

Add an additional box at the top to capture the service user experience:

- How do you think patients/carers feel at each stage or between stages? What might this look like for them?
- Are there any groups that could have a more difficult or negative experience?

Example of high-level block diagrams from wave 1 teams



- How do you think patients/carers feel at each stage or between stages?
- Are there any groups that could have a more difficult or negative experience?



Next steps

- Form your project team, including lived experience representation.
- Protect time to do the work.
- Liaise with your QI coach to arrange the first session to start developing your detailed process map.

Feedback and close

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

