AMHE
Advancing mental health equality

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Advancing Mental Health Equality Quality Improvement Collaborative

Evaluation Snapshot 1

July 2021 – November 2022

Cite as: National Collaborating Centre for Mental Health. Advancing Mental Health Equality Quality Improvement Collaborative: Evaluation Snapshot 1, July 2021 – November 2022. London: National Collaborating Centre for Mental Health; 2023.

AMHE@rcpsych.ac.uk

Contents

1. About the Evaluation Snapshots

This report, Evaluation Snapshot 1, presents an evaluation of the progress made by the 15 teams from Wave 1 of the Advancing Mental Health Equality (AMHE) quality improvement (QI) Collaborative. It covers progress made over 16 months, from the launch of the AMHE Collaborative in July 2021, to November 2022.

A follow-up report, Evaluation Snapshot 2, will be developed towards the end of 2023, to cover progress made from December 2022 to May 2023.

1.1. Objectives of the meta-evaluation

To describe the organisations involved in the AMHE QI Collaborative, including descriptions of:

- The organisations taking part
- The overarching project teams overseeing the work in those organisations
- The subteams undertaking improvement work for identified populations
- The structure of the organisations, teams and subteams.

To describe the aims that were developed and the change ideas tested across the AMHE QI Collaborative, specifically:

- The populations identified
- The types of inequalities issues identified
- The progress made by the teams on the three-part data review (a tool to explore the assets and needs of a population)
- The most common types of change ideas tested and interventions introduced.

To evaluate the implementation, impact and success of the AMHE QI Collaborative model, specifically:

- The factors that contributed to the success of the programme
- The challenges of the AMHE QI Collaborative model
- Commonalities among teams that saw success and teams that did not
- New approaches that were used, and how any new approaches contributed to success.

This Snapshot includes data from and information on the AMHE QI Collaborative, gathered using several methods (surveys, use of organisation data, summaries of team objectives and more) that are described in this Snapshot.

Other qualitative methods (including focus groups and interviews with people with lived experience, project leads and QI coaches) are planned for the later stages of the evaluation of the AMHE QI Collaborative. We intend to gather and review data using these methods in future evaluation snapshots.

2. Characteristics of organisations and teams

2.1. Organisations in the AMHE QI Collaborative

Objective: To describe the organisations involved in the AMHE QI Collaborative

Fifteen organisations were involved in Wave 1. Of these, nine were NHS trusts and six were voluntary, community and social enterprise organisations (VCSEs). Characteristics of each organisation are in Table 1.

NHS trusts involved in Wave 1

- Avon and Wiltshire Partnership NHS Trust
- Barnet, Enfield and Haringey Mental Health NHS Trust
- Devon Partnership NHS Trust
- Herefordshire and Worcestershire Health and Care NHS Trust
- Leicestershire Partnership NHS Trust
- Norfolk and Suffolk NHS Foundation Trust (FT)
- Pennine Care NHS FT
- Somerset NHS FT
- Southern Trust Health and Social Care Trust (Northern Ireland).

VCSE involved in Wave 1

- Livewell Southwest
- Mind in Croydon in partnership with Mind in Kingston
- Mind in Hampshire (three local branches: Andover, Havant and East Hampshire, Solent)
- Mind in Tower Hamlets and Newham in partnership with Mind in Haringey
- Neath Port Talbot Mind
- Mind in North Lincolnshire in partnership with Mind in North Staffordshire.

*Table 1: Characteristics of the 15 organisations involved in the AMHE QI Collaborative**

Service/ organisation	Service type	Trust type	Region of England	Service specification(s)	Local area/borough served	Population served (approx.)	Equality work in the service/organisation
Avon and Wiltshire Partnership NHS Trust	NHS	Mental health (MH) trust	South-West	• Children and young people (CYP) • Community • Drug and alcohol • Inpatient • Specialist	• Bath and North-East Somerset • Bristol • North Somerset • South Gloucestershire • Swindon • Wiltshire	1.8 million	Equality, diversity and inclusion (EDI) strategy
Barnet, Enfield and Haringey MH NHS Trust	NHS	MH trust	North London	• Community • MH	• Barnet • Enfield • Haringey	1.2 million	Delivering Equal Opportunities Valuing Diversity Policy
Devon Partnership NHS Trust	NHS	MH trust	South-West	• CYP • Inpatient MH • Learning disabilities • Liaison MH • Community MH	• Devon	810,716	EDI strategy
Herefordshire and Worcestershire Health and Care NHS Trust	NHS	NHS trust	West Midlands	• Community health • Community MH • CYP • Families • Inpatient MH	• Herefordshire • Worcestershire	781,000	Inclusion Diversity and Equality Strategy 2018–22

* The information included in the Table 1 was obtained through web searching near the start of the AMHE QI Collaborative and as such does not reflect any changes since this time. Information will be updated in subsequent evaluation reports as needed.

Service/ organisation	Service type	Trust type	Region of England	Service specification(s)	Local area/borough served	Population served (approx.)	Equality work in the service/organisation
				• Learning disabilities • Liaison MH			
Leicestershire Partnership NHS Trust	NHS	MH trust	East Midlands	• Community health • Community MH • CYP • Families • Inpatient MH • Learning disabilities • Liaison MH	• Leicester • Leicestershire • Rutland	1.1 million	Diversity and Inclusion Approach for 2017–21
Livewell Southwest	VCSE	N/A	South-West	• Community health • Community MH • CYP MH • Inpatient MH • Learning disabilities • Liaison MH • Social care	• South Hams • West Devon • Plymouth	270,000	EDI strategy

Mind in Croydon in partnership with Mind in Kingston	VCSE	N/A	London	• Community MH:
				  ○ Advice
				  ○ advocacy
				  ○ counselling
				  ○ support
					• Croydon	379,000	Equality and Diversity Policy

Mind in Hampshire (Andover, Havant and	VCSE	N/A	Hampshire	• Adult MH and wellbeing	• Hampshire	1.3 million	EDI strategy

Service/ organisation	Service type	Trust type	Region of England	Service specification(s)	Local area/borough served	Population served (approx.)	Equality work in the service/organisation
East Hampshire, Solent)							
Mind in Tower Hamlets and Newham in partnership with Mind in Haringey	VCSE	N/A	London	• Community MH: o advice o advocacy o support o therapies	• Tower Hamlets • Newham	677,879	EDI strategy
Neath Port Talbot Mind	VCSE	N/A	N/A	• Community MH: o Counselling o support	• Neath • Port Talbot	139,812	EDI strategy
Norfolk and Suffolk NHS Foundation Trust (FT)	NHS	NHS FT	East Anglia	• Community MH • CYP • Inpatient MH • Learning disabilities • Liaison MH	• Norfolk • Suffolk	1.6 million	Equality delivery system and evaluation
Mind in North Lincolnshire in partnership with Mind in North Staffordshire	VCSE	N/A	East Midlands	• Community MH support • Counselling • Crisis prevention • Peer support	• North Lincolnshire • North Staffordshire	169,700 95,800	Equality and diversity policy
Pennine Care NHS FT	NHS	T MH Trust	North-West	• Adult • Community MH • CYP • Inpatient MH • Learning disabilities	• Bury • Oldham • Rochdale • Tameside and Glossop	1.3 million	EDI programme

Service/ organisation	Service type	Trust type	Region of England	Service specification(s)	Local area/borough served	Population served (approx.)	Equality work in the service/organisation
				• Liaison MH	• Stockport		
Somerset NHS FT	NHS	NHS FT	South-West England	• Acute hospital care • Community health • Community MH • CYP • Inpatient MH • Learning disabilities • Liaison MH	• Somerset	350,000	Inclusion strategy 2021–25
Southern Trust Health and Social Care Trust (Northern Ireland)	NHS	Health and Social Care Trust	N/A	• Community MH • CYP • Inpatient MH • Learning disabilities • Liaison MH • Social care	• Armagh • Banbridge • Craigavon • Dungannon • Newry and Mourne	383,541	Equality scheme

Key: CYP = children and young people; EDI = equality, diversity and inclusion; FT = foundation trust; MH = mental health; N/A = not applicable; VCSE = voluntary, community and social enterprise organisation.

2.2. Overarching project teams

In the overarching project teams, there were between four and 17 members, with an average number of 10 team members. One team had only one member, with only the lead identified.

The structure and the different roles or professions varied across teams (see Table 2 for a full list of roles or professions in teams). At the time of compiling this report, four teams (27%) had members with roles about which the QI coach was not given information (noted in Table 2 as 'role needs to be confirmed'). One team included lived experience advisers.

*Table 2: Overarching project teams, members and professions/roles**

Team	Number of members	Team members' professions/roles
Avon and Wiltshire NHS Trust	9	• Associate Director of Research & Development • Business Intelligence • Business Manager • Consultant Clinical Psychologist • Divisional Medical Lead • Head of Nursing – Safety and Inclusion • Medical Director • Research and Development • *Role needs to be confirmed*
Barnet, Enfield and Haringey Mental Health NHS Trust	1	• Project Lead/Community Engagement Lead for EDI group
Devon Partnership NHS Trust	6	• Clinical Psychologist • Deputy Director of Safeguarding • Director of Corporate Affairs/Executive Lead for Equality and Inclusion • EDI Manager • Governance Manager • Operational and Strategic Lead
Herefordshire and Worcestershire Health and Care NHS Trust	17	• Associate Director for Performance and Informatics • Associate Medical Director • Chief Officer, Healthwatch Herefordshire • Data Scientist • Deputy Associate Director for Primary Care and Community Mental Health Services

* Number of team members involved in addition to team members' professions/roles were accurate at the time of data collection.

Team	Number of members	Team members' professions/roles
		• Deputy Director of Innovation and Improvement • Digital Innovation and Change Manager and Head of Project Management Office • Digital Project Manager Officer • EDI Lead • Engagement Officer, Healthwatch Worcestershire • Managing Director, Taurus Healthcare and Worcestershire Council • Medical Director • Medical Directorate Support Team • Mental Health Lead • Programme Manager • Public Health Consultant, Herefordshire Council • Quality Lead
Leicestershire Partnership NHS Trust	12	• Business Support Officer • Clinical Psychologist, Children and Adolescent Mental Health Service • Communications Manager • Community Psychiatric Nurse, Systemic Practitioner and Operations Manager • Deputy Head of Nursing, Urgent Care Pathway, Directorate of Mental Health • Deputy Head of Patient Experience and Involvement • Head of EDI • Head of MH, Clinical Network and Transfers East Midlands, NHS England and NHS Improvement • Lead Commissioner for Mental Health and Dementia, Leicestershire County Council • Strategic Lead, Mental Health, Leicester County Council • Transformation Associate Director for Mental Health • *Role needs to be confirmed*
Livewell Southwest	4	• Head of Strategy and Improvement • Lived Experience Lead for QI from Heads Count • Medical Director • Team Administrator
Mind in Croydon/Mind in Kingston	6	• Chief Executive Officer (CEO) (Kingston) • Deputy CEO/Director of Services (Croydon) • Deputy Manager of Social Networking Service Users and Carers Support Service Coordinator

Team	Number of members	Team members' professions/roles
		• Head of Mental Health and Support Services (Croydon) • Interim Community Inclusion Manager • Trustee and EDI Lead (Kingston)
Mind in Hampshire (Andover, Havant and East Hampshire, Solent)	10	• 4x CEOs • Area Manager for North and Northeast Hampshire • Director of Business Development and Resources • Lead for Equality and Diversity (Head of Communications and Community Engagement) • Programme Lead Employment and Inclusion • 2x *Roles need to be confirmed*
Mind in Tower Hamlets and Newham (THN)/Mind in Haringey	6	• CEO (Haringey) • CEO (THN) • Director of Mental Health Services (THN) • EDI Community Engagement Lead • Mental Health Services manager (THN) • Peer Service Coordinator (THN)
Neath Port Talbot Mind	12	• BAME Mental Health Support • Business Development Officer • Community Cohesion Coordinator, Swansea Council (covering Swansea and Neath Port Talbot) • Counselling Coordinator and Active Monitoring Project Lead • Director • Director, African Community Centre • Family Support Worker with Ethnic Youth Support Team and long-term resident of Neath Black, Asian, Minority Ethnic Outreach Lead • Investing in Mental Health Project Lead • Retired third sector Volunteering Officer • Senior Project Manager, Directorate of Strategy, Swansea Bay University Health Board • Swansea Bay University Health Board • Third Sector Social Housing Manager
Norfolk and Suffolk NHS Foundation Trust (FT)	15	• Autism Spectrum Disorders Lead • Consultant psychiatrist • Director of Communications and Involvement • EDI Lead • 2x Experts by experience • GP

Team	Number of members	Team members' professions/roles
		• Head of Research (specialising in equality) • Lecturer in mental health • Lived experience equality role • PPI Manager • QI Coach • QI Comms and Data Officer • QI Facilitator • QI PPI Lead
Mind in North Lincolnshire/Mind in North Staffordshire	5	• CEO (Lincolnshire) • Chief Executive (Staffordshire) • Support Worker (Lincolnshire) • User Engagement Coordinator (Staffordshire) • *Role needs to be confirmed*
Pennine Care NHS FT	10	• Deputy Director of Service Development and Delivery • Director of Workforce • Executive Director of Nursing, Quality and Healthcare Professionals • Head of Business Intelligence • Head of EDI • Head of Patient and Carer Experience and Engagement • Medical Director • Network Director of Quality • Non-Executive Director • Senior Improvement Practitioner
Somerset NHS FT	17	• Consultant Psychiatrist • Co-Production Manager, Rethink • Co-Production Practice Manager, Rethink • Expert by Experience, Open Mental Health • Expert by Experience, Open Mental Health • Head of NHS Collaboration, Rethink • Head of Patient Safety and Learning • Health Champions and Mental Health Hub – Coordinator, Spark Somerset • Health Promotion Manager, Somerset County Council • Inclusion Lead • Nurse, Open Mental Health • Quality and Equality Officer

Team	Number of members	Team members' professions/roles
		• Recovery Partner • Representative from Somerset Country Council • Service Director for Mental Health and Learning Disabilities • 2x Team Managers, Community Mental Health Team
Southern Health and Social Care Trust	10	• Assistant Director of Disability Services • Associate Medical Director and Consultant Psychiatrist • CEO • Consultant Psychiatrist • Director of Mental Health and Disabilities Services • Director of Nursing • Lead Nurse • Lead Nurse • Lead Nurse, Mental Health and Learning Disabilities Division • Service User Representative

Key: BAME = Black, Asian and minority ethnic; CEO = chief executive officer; EDI = equality, diversity and inclusion; FT = foundation trust; PPI = patient and public involvement; QI = Quality Improvement; THN = Tower Hamlets and Newham.

2.3. Subteams

In summary:

- 14 of the 15 teams (93%) had identified at least one of the three population sub-groups. Of these:
  - 2 roles needed were **unknown** by the QI coach at the time of this Snapshot
  - 1–28 (average: 9) total subgroup **members** (per population identified)
  - 1–21 (average: 4) total subgroup members (per population identified) with a **clinical role**
  - 1–11 (average: 4) total subgroup members (per population identified) with a **non-clinical/managerial role**
  - 1–2 total number of subgroup members (per population identified) with a lived experience adviser role
- 6 teams (40%) had identified 2 population sub-groups
- 7 teams (47%) had identified 3 population sub-groups
- 4 teams (27%) had included a lived experience adviser in at least one of the population sub-groups.

3. Team objectives and approaches

Objective: To describe the aims developed and change ideas tested across the AMHE Collaborative

- What populations were identified?
- What types of inequality issues were identified?
- What progress was made by the teams on the three-part data review?
- What were the most common types of change ideas tested and interventions introduced?

3.1. Populations identified

Figure 1 illustrates 14 main population categories and the number of populations identified within each. An identified population can be included in more than one category (for example, children and young people from minoritised ethnic communities). The three categories in which most of the populations were identified were:

- children and young people
- people belonging to LGBTQ+ communities
- people from minoritised ethnic communities

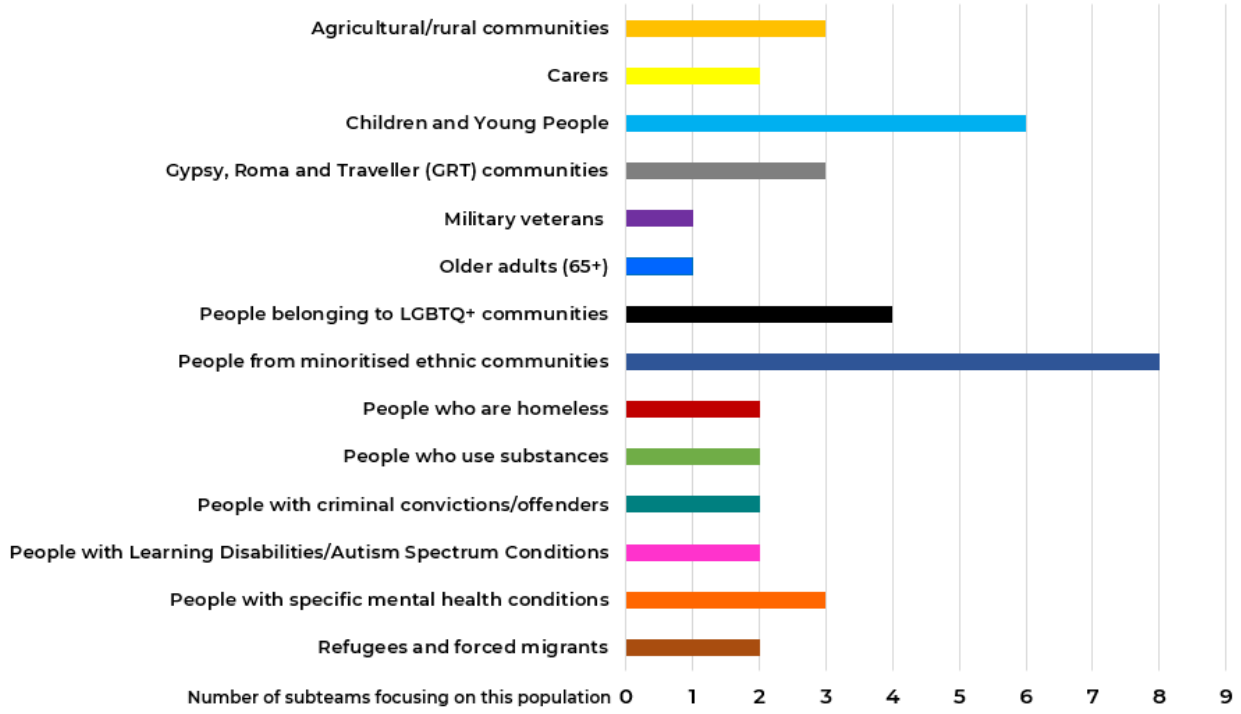

Figure 1: Number of populations identified per population category

3.2. Inequality issues identified

Figure 2 shows the main categories of inequality issues: (1) access to services; (2) experience of services; and (3) use of the Mental Health Act (including reducing the use of Sections 135 and 136 detention). In summary:

- Six of the 15 teams (40%) had not specified any of the inequality issues for the populations identified
- Nine of the 15 teams (60%) had specified at least one of the inequality issues for the populations identified
- Two of the 15 teams (13%) had specified the inequality issues for all three populations identified.

Figure 2 also shows the number of inequalities in each category. Note that a population can be in more than one category (for example, difficulty accessing services as well as poor experience for people from the GRT community). The most common inequality issues identified were access and experience of services.

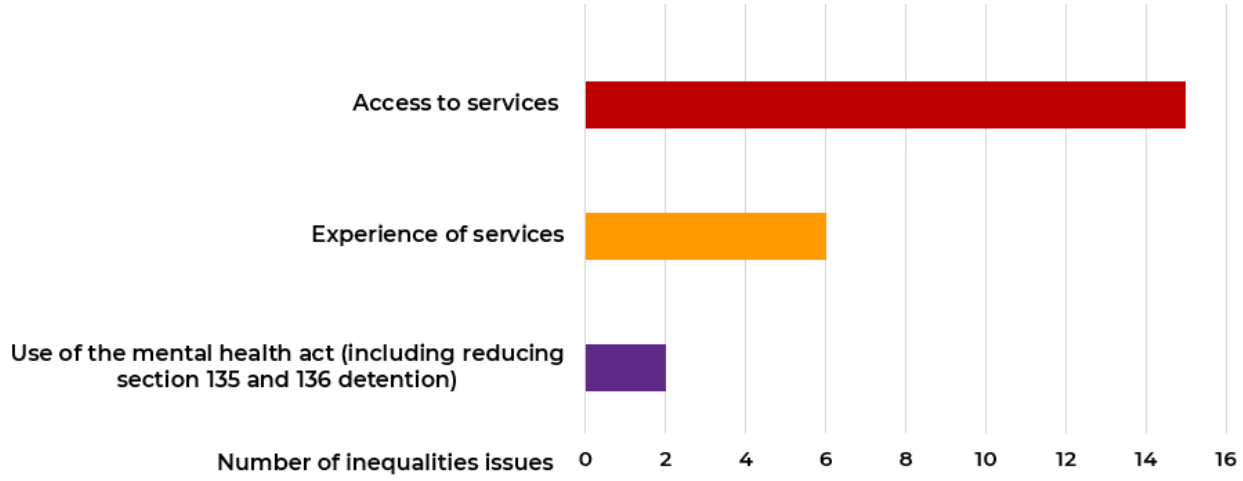

Figure 2: Number of inequality issues identified in each main category

Table 3 outlines the inequality issues identified for each population by the 15 teams whose organisations are involved in the AMHE Collaborative.

Table 3: Inequality issues identified by the 15 teams for each of the three populations

Team Population identified	Inequality issues identified
Avon and Wiltshire NHS Trust	
1. Children and young people from minoritised ethnic groups	Access to CAMHS
2. 18+ Black, Asian and minority ethnic men accessing secondary mental health services	Restrictive practices in access to secondary mental health services
3. Adults with dual diagnosis[b]	Access to mental health services (which services needs to be defined)
Barnet, Enfield and Haringey Mental Health NHS Trust	
1. Young Black men detained under sections 135 and 136 (in Haringey)	Not specified (N/S)
2. N/S	N/S
3. N/S	N/S
Devon Partnership NHS Trust	
1. Adults from minoritised ethnic groups	Restraint and the use of the Mental Health Act
2. People with learning disabilities	Access and experience of services
3. Looked-after children, homelessness or GRT community	N/S
Herefordshire and Worcestershire Health and Care NHS Trust	
1. Children and young people	N/S
2. Agricultural/rural communities	N/S
3. People belonging to LGBTQ+ communities	N/S
Leicestershire Partnership NHS Trust	
1. Areas of deprivation in the city (with a focus on ethnicity and culture)	N/S
2. Isolated and/or rural communities, focusing on access to services/health checks	N/S
3. Alcohol and substance use in people with severe and multiple disadvantage	N/S
Livewell Southwest	
1. Most deprived areas of Plymouth	Outcomes
2. Family and friend carers	N/S
3. Children transitioning to adult mental health services	N/S
Mind in Croydon/Mind in Kingston	
1. Korean community in New Morden (Kingston)	N/S
2. Older carers 70+ (Croydon)	N/S
3. N/S	N/S
Mind in Hampshire (Andover, Havant and East Hampshire, Solent)	
1. Being redefined (Solent)	Access to Improving Access to Psychological Therapies services

[b] Dual diagnosis of substance use and a mental health condition.

Team Population identified	Inequality issues identified
2. People belonging to LGBTQ+ communities (Andover)	N/S
3. People belonging to LGBTQ+ communities. Focus on transgender (Havant and East Hants)	N/S
Mind in Tower Hamlets and Newham/Mind in Haringey	
1. Young Black men in Haringey – Mixed race men under 30 years involving CAMHS	Reducing Section 135 and 136 detentions
2. African and Asian Muslim women in Tower Hamlets, Newham and Redbridge	Access and engagement
3. N/S	N/S
Neath Port Talbot Mind	
N/S yet	N/S yet
Norfolk and Suffolk NHS Foundation Trust	
1. Black men	Access and experience
2. Refugees and forced migrants (Norfolk)	Access
3. Refugees and forced migrants (Suffolk)	Access
Mind in North Lincolnshire/Mind in North Staffordshire	
1. Autistic people in Staffordshire	Access
2. Other potential populations of people who are homeless, or offenders	N/S
3. N/S	N/S
Pennine Care NHS FT	
1. Women military veterans in Greater Manchester and Lancashire, both currently accessing and not accessing the Military Veterans Service at Pennine Care NHS FT	Increase access to veterans' service and increase number of women who remain engaged
2. Bangladeshi and Pakistani men and women in Oldham	Increase access to Oldham mental health service
3. People belonging to LGBTQ+ communities	N/S
Somerset NHS FT	
1. GRT community – male adults (in the Frome area)	Difficulty accessing services/poor experience due to lack of understanding of cultural needs, illiteracy, fear of discrimination
2. Rural communities specifically adults in Sedgemoor and Exmoor with a focus on prevention	Access to services due to isolation and lack of information
3. N/S	N/S
Southern Health and Social Care Trust	
1. Adults with a serious mental illness who require an interpreting service	Experience of services
2. GRT community in Armagh	Access to services
3. N/S	N/S

3.3. Three-part data review

The three-part data review is a useful tool to explore the assets and needs within a population. The assets are the collective resources that individuals and communities have at their disposal, which can help promote health and wellbeing; the needs involve the challenges within the population.[1] A brief description of the three-part data review elements and a summary of the progress made by the teams by October–November 2022 are set out in sections 3.3.1.–3.3.3.

3.3.1. Data review

This involves reviewing data to identify overall patterns that impact the chosen population. We found that, of the 15 teams:

- 9 (60%) had started the data review for all of the populations identified
- 11 (73%) had started the data review for at least one of the populations identified
- 4 (27%) had not started the data review for any of the populations identified.

3.3.2. Staff engagement

This entails engaging with staff that support and work with the identified population to understand their perspective on the population's greatest needs and assets. We found that, of the 15 teams:

- 3 (20%) had started staff engagement for all of the populations identified
- 5 (33%) had started staff engagement for at least one of the populations identified
- 10 (67%) had not started staff engagement for any of the populations identified.

3.3.3. Community engagement

This involves engaging with people in the identified population or community to understand their experiences and perspectives, including what is important to them, the real-world challenges they face in managing their health and living situations, and what might help. We found that, of the 15 teams:

- 3 (20%) had started community engagement for all of the populations identified
- 7 (47%) had started community engagement for at least one of the populations identified
- 8 (53%) had not started community engagement for any of the populations identified.

Overall, of the 15 teams:

- 1 (7%) had started all the three elements in the three-part data review
- 10 (67%) had started at least one of the three elements in the three-part data review
- 3 (20%) had not started any of the three elements in the three-part data review.

3.4. Content analysis of driver diagrams

Content analysis of driver diagrams will be used to describe the aims developed by subteams, the primary drivers and the change ideas tested. The primary drivers are the first set of underpinning goals as they 'drive' the achievement of the aims. The change ideas are the change initiatives that the subteams will be 'trying out' or testing.[2]

The aims, primary drivers and change ideas of these driver diagrams will be 'coded' using a deductive approach. 'Codes' will be attached to areas identified by services in finalised driver diagrams. The code types correspond to the co-developed driver diagram for the AMHE QI Collaborative (see Figure 3), which teams will use as a template for their own driver diagram development. Then codes will be used to categorise and quantify the types of inequalities identified, populations focused on, change ideas developed and methods of implementation across teams involved in the AMHE Collaborative. The number of change ideas tested will also be collected.

In November 2022, no subteams had developed their driver diagrams.

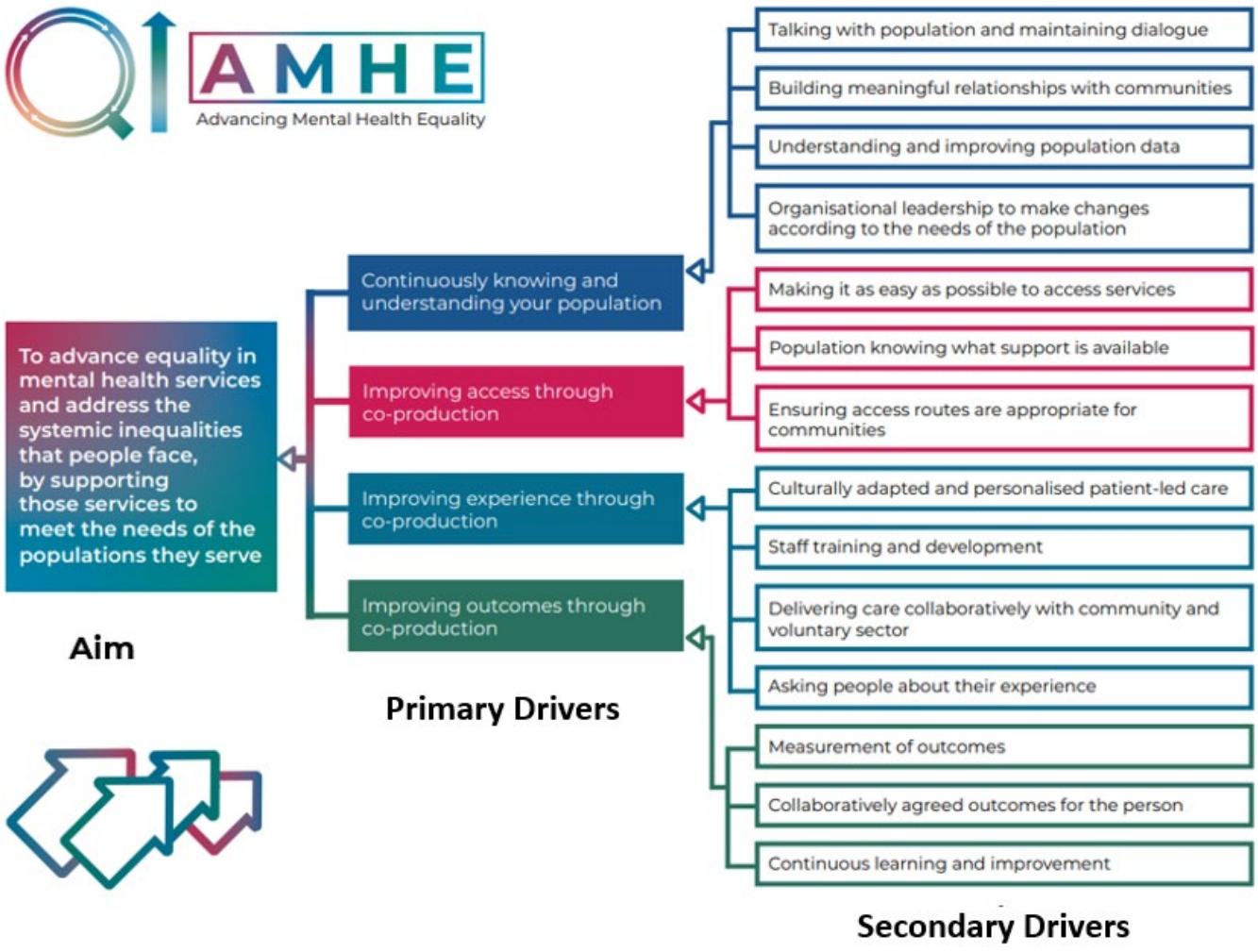

Figure 3: AMHE QI Collaborative Driver Diagram

4. Process evaluation – assessment of implementation, impact and success

Objective: To evaluate the implementation, impact and success of the AMHE QI Collaborative model

- What factors contributed to the success of the programme?
- What were the challenges of the AMHE QI Collaborative model?
- Are there commonalities among teams that saw success and teams that did not?
- What new approaches were used? How did any new approaches contribute to success?

4.1. The Normalisation Measure Development (NoMAD) questionnaire

NoMAD[3] is a validated research measure based on the Normalisation Process Theory (NPT). NoMAD identifies, characterises and explains mechanisms that motivate and shape implementation processes. The questionnaire has been adapted for the AMHE QI Collaborative, to assess how people implement AMHE in their everyday work and how they are supported to implement it.

In NoMAD, there are 19 statements with which respondents can indicate their agreement (see Appendix 1). The statements can be grouped into the four parts of the NPT:

- Coherence
- Cognitive participation
- Collective action
- Reflexive monitoring.

The questionnaire was sent to all overarching and subteam members. Fourteen responses were received. Of these, five were from project team leads, five from project staff members, three from subteam staff members and one from a peer worker. In terms of their professional role, three were clinical, 10 non-clinical or managerial, and one peer worker.

In the next sections, the responses are described and are grouped according to the four parts described above.

4.1.1. Coherence

Coherence refers to: (a) having a shared understanding of the purpose of the AMHE QI Collaborative; (b) how it differs from the usual ways of working; and (c) its potential value for people's roles and everyday work (statements 1–4 in Appendix 1).

Figure 4 shows that 73% of the respondents either agreed or strongly agreed with the statements about coherence.

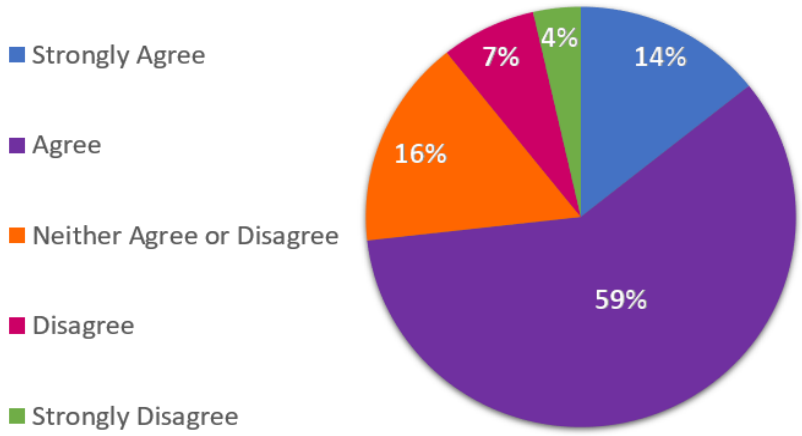

Figure 4: Total percentages of the responses received for questions about coherence

4.1.2. Cognitive participation

Cognitive participation refers to: (a) being open to working with colleagues in new ways, to implement and support the AMHE QI Collaborative model; and (b) having people in the teams who drive the AMHE Collaborative forward and promote teamwork (statements 5–8).

Figure 5 shows that 85% of respondents either agreed or strongly agreed with the statements about cognitive participation.

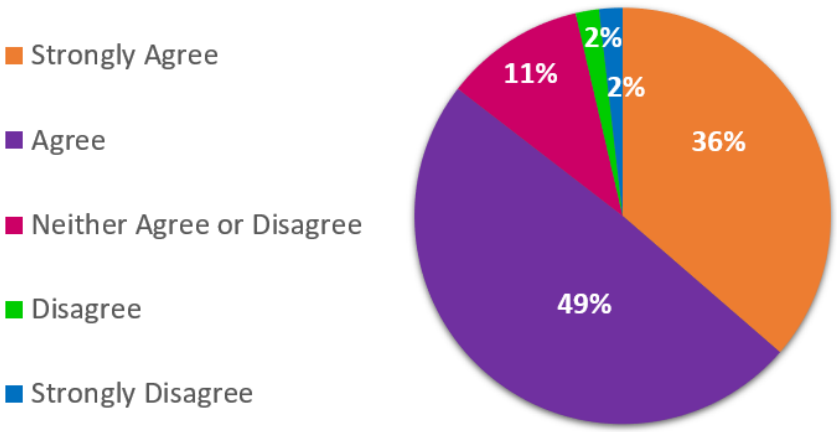

Figure 5: Total percentages of the responses received for cognitive participation

4.1.3. Collective action

Collective action refers to: (a) having the confidence in the team's ability to implement the AMHE QI Collaborative; (b) integrating relevant elements of the AMHE Collaborative model into existing work; (c) having enough resources and training to support the Collaborative; and (d) having support from managers to take part in the Collaborative (statements 9–15. Figure 6 shows that 54% of the respondents either agreed or strongly agreed when responding to the statements about collective action.

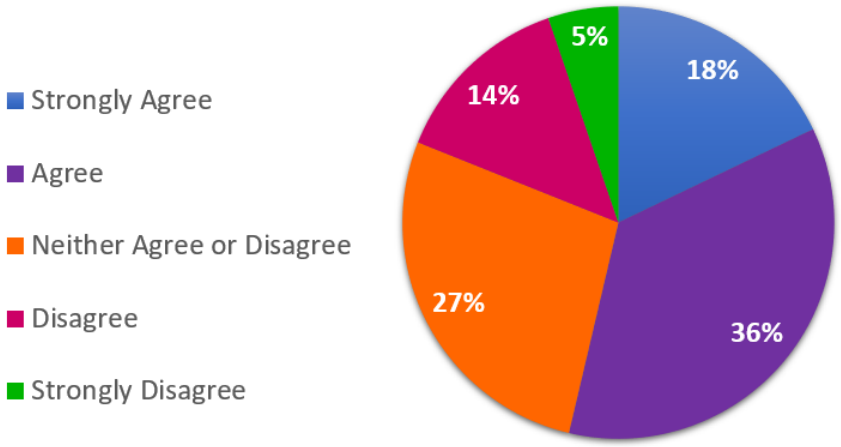

Figure 6: Total percentages of the responses received for collective action

4.1.4. Reflexive monitoring

This refers to: (a) the process of appraising people's views on the value that the AMHE QI Collaborative has had so far; and (b) the potential for using feedback to modify and improve their work and the delivery of care (statements 16–19). Figure 7 shows that 82% of the respondents either agreed or strongly agreed with the statements about reflexive monitoring.

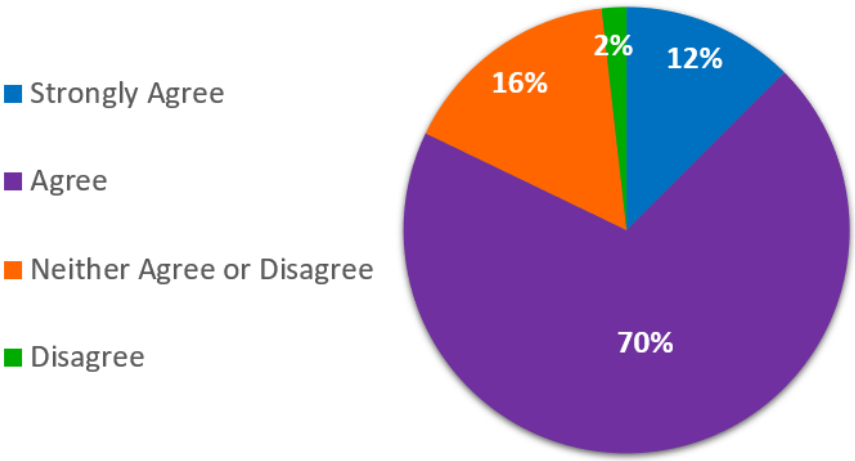

Figure 7: Total percentages of the responses received for reflexive monitoring

4.2. AMHE survey

A survey was designed to collect information from the teams about what went well, and the challenges and difficulties they had experienced. The survey has 16 questions covering four areas: (1) the AMHE QI Collaborative model; (2) working as part of the wider AMHE QI Collaborative team; (3) establishing the QI approach; and (4) co-production. Appendix 2 shows a copy of the survey.

The survey was sent to all overarching and subteam members (*n*= ~190), and 16 responses were received. Of these, seven were from project leads, one from a subteam lead, four from project staff members, three from sub-project staff members and one from a lived experience adviser. The professions/roles of the respondents were four clinical, 11 non-clinical or managerial and one lived experience adviser.

4.2.1. The AMHE QI Collaborative model

The AMHE QI Collaborative model refers to the structure of the QI programme, how QI coaches work with teams, and how the programme helps the service to improve.

AMHE QI Collaborative model benefits

Fifteen (94%) respondents said they saw benefits of the AMHE QI Collaborative model, including:

- recognising the need for equality as a central driver for service set-up and delivery
- identifying communities that need prioritisation as a result of experiencing high levels of inequality
- providing a structured approach and useful evidence collection guidance
- focusing on making incremental and achievable changes
- bringing together colleagues from across health care and facilitating joint working and co-operation
- thinking about how to engage populations.

> ***It [the AMHE QI Collaborative] has focused managers, nurses and doctors to consider how equality needs to be a central driver for how we set up our service and has highlighted blind spots in how we deliver our service.***
>
> Project Team Member

One respondent (6%) did not perceive any benefits.

AMHE QI Collaborative model challenges

Challenges mentioned in survey responses included:

- gaining momentum and having the right people in the team
- pressures on staff and managers
- lack of funding, resources, capacity, time and leadership support
- lack of clarity on timelines, possible barriers, expectations and processes

- time required to move through the programme
- case studies that teams found difficult to relate to
- keeping the 'vision' tangible, contained and achievable
- working across multiple agencies/stakeholders
- taking a values-based approach from start to finish
- engaging with people in the identified population or community
- focusing team members' mindsets to work in a 'QI way'
- getting the right and enough data for the three-part data review.

> ***Lack of resourcing within the organisation. Needing to do it on top of an already challenging role. Lack of priority given by the organisation.***
>
> Project Team Member

Of the 16 responses, 13 (81%) reported that the team has discussed how to overcome these challenges. Three (19%) have not had these discussions.

Benefits of working with the QI coaches

Thirteen (81%) respondents to the survey reported benefits of working with the QI coaches, including:

- providing support and positive encouragement to overcome barriers
- asking challenging questions
- connecting with the broader AMHE QI Collaborative
- providing support and guidance
- helping maintaining momentum
- helping steer the project
- facilitating discussions and generating ideas
- providing expertise
- helping to stay motivated and focused
- helping to implement actions to move the project forward
- facilitating reflective practice
- clarifying the requirements
- managing expectations.
- training offers for staff.[c]

> ***Having someone who is based at the Royal College of Psychiatrists is really beneficial, it connects you more to what is happening across AMHE/the country, opens the project up a bit more.***
>
> Project Team Member

[c] Formal training is not offered by the NCCMH as part of the AMHE QI Collaborative.

Two (12.5%) respondents did not perceive any benefits, and one (6%) responded with 'not applicable' because they had not been involved in the AMHE QI Collaborative for long enough.

Challenges of working with the QI coaches

Challenges described by survey respondents when working with QI coaches included:

- lack of clarity and information about the role of QI coaches and the College in this work
- changes of QI coaches
- lack of clarity over the team's progress within the timeline
- lack of funding, time, capacity and resources
- joining up AMHE QI coaches with in-house QI leads or approaches
- working with QI coaches who are from outside the community.

> ***Feeling as though we are letting them down when we have not been able to progress what we have wanted to do. Principally as short-term deadlines get in the way of longer-term development work, unless we have a dedicated person responsible for doing the development work.***
>
> Project Team Member

Fifty-four percent reported that the team had discussed these challenges. Two of the 16 responses received (12.5%) did not report any challenges. Another one was not applicable (6%) as the team member had not been involved for long enough.

Although challenges in funding, time, capacity and resource are not directly related to working with coaches, responses showed that the trickle-down effects of poor resourcing affect all aspects of the AMHE QI Collaborative model.

On meetings with coaches, opinions were mixed. Some team members preferred to meet in-person, while others found it difficult to attend in-person meetings (for example, because of a long commute). One person said they have too many meetings, and another said they have very few meetings held leading to a long time between meetings if one was cancelled.

4.2.2. Working as part of the wider AMHE QI Collaborative team

Working as part of the wider team involves working alongside and together with other services and organisations involved in the AMHE Collaborative.

Benefits of working alongside other organisations and services who are part of the AMHE QI Collaborative team

Fourteen of the 16 respondents (75%) mentioned benefits of working alongside other organisations and services, including:

- highlighting blind spots about equality

- sharing ideas, experiences and learning from other organisations, including on encountering and overcoming barriers
- feeling part of a bigger team
- developing links within the organisation and with external organisations
- starting to think about how to use the data and existing resources to identify inequalities
- space to think collectively and more broadly on the subject.

> ***Motivating to learn from colleagues in other organisations, also really inspirational.***
>
> Project Team Member)

Two of 16 respondents (12.5%) mentioned that benefits have not been evident yet as their teams have now only started their project. Another two respondents (12.5%) said that they have not been involved in working alongside other organisations or services yet.

Challenges when working alongside other organisations and services who are part of AMHE QI Collaborative team

Seven of the 16 responses received (44%) reported the following challenges when working alongside other organisations and services:

- hard to find time to fully appreciate and understand each other's work, remit and roles, and pursue links in a meaningful way
- limited capacity and resources
- few people joining the team
- meeting cancellations
- lack of consistent attendance by group members
- slow progress in identifying and implementing actions.

Of these, four (57%) reported that the team had discussed these challenges. Of the 16 responses, six (37%) had not been involved in this process. Three (19%) had not perceived any challenges.

> ***Hard to make the time to fully appreciate/understand each other's work, remit and role.***
>
> Project Team Member

4.2.3. Establishing the QI approach in the organisation

How the QI approach has been used in the organisation or service, and how it has been received there.

Engagement with establishing the QI approach in the team's organisations or services

Nine of the 16 responses received (56%) reported that their teams had engaged with establishing the QI approach in their organisations/services, namely that:

- the team started thinking about the driver diagram, theory of change and project roadmap
- the team was encouraged, valued and supported by the organisation/trust
- the team implemented follow-up actions
- the team was committed to the project's progress
- members of the team were encouraged to be more proactive
- there was a positive response to the project and aims from staff in the service.

Of those nine, four (44%) said that arranging meetings, not having enough time and having limited capacity were challenges during this process.

Two of the total 16 responses received (13%) mentioned that their teams had not engaged with establishing the QI approach in the team's organisations or services. They reported that reasons for this included lack of capacity and clarity about how the QI approach should be engaged with, at a team level, due to barriers.

Five of the 16 responses received (31%) reported that they had not achieved this stage yet.

> ***It was difficult trying to arrange an initial meeting with colleagues from around the organisation, but with guidance and seeing the benefits of this work, everyone who was interested came on board enthusiastically because of the real possibility of positive changes for our service users.***
>
> Project Team Member

Using new approaches

Ten of the 16 responses received (63%) had used new approaches, including:

- engaging with communities, voluntary groups, schools and youth organisations
- hosting community information stands
- empowering communities
- engaging with stakeholders
- staff surveys
- engaging staff to feedback service insights and service user feedback
- staff communications
- half a day per week of staff time to begin local community engagement work

- asset mapping
- engaging the research and development team
- online peer to peer groups
- engaging with colleagues from other directorates and other trusts
- working alongside lived experience colleagues
- using interpreters when working with non-English speaking populations
- conducting the British Association for Behavioural and Cognitive Psychotherapies Improving Access to Psychological Therapies audit
- looking at processes and procedures around increasing accessibility/anti-oppressive practice.

There has been good engagement with all stakeholders, staff communications and attending community events with lived experience in the project group.

Project Team Member

Five of the 16 responses received (31%) mentioned that they had not reached this stage yet. One respondent (6%) did not understand the question.

4.2.4. Co-production

Co-production refers to an ongoing partnership between people who design, deliver and commission services, people who use the services and people who need them.

Steps teams have taken towards co-production

Eight of the 16 respondents (50%) mentioned that they have taken steps towards co-production, including:

- having a service user consultant as a subteam lead
- having people with lived experience in the team
- scoping how to connect with people with lived experience
- encouraging people with lived experience to share their stories
- carrying out initial interviews with people from the community
- engaging with the local groups and organisations who work within target communities
- receiving feedback from people in the identified population or community
- engaging with local participation groups to ask about how to improve engagement with families from all races/ethnicities.

Currently service users provide feedback through our Wellbeing Practitioners; non-service users will feedback through community groups and peer-to-peer supported by our Researcher.

Project Team Member

Two of the 16 respondents (12.5%) reported that their teams were in the process of planning co-production, including planning a workshop and engaging with the Community Mental Health Framework.[4]

Four (25%) mentioned that they have not reached this stage yet. Of these four, one highlighted that starting co-production has been challenging due to limited staff resources.

Two (12.5%) said that co-production was already embedded in their organisation/service.

4.3. The Model for Understanding Success in Quality (MUSIQ) tool

The MUSIQ tool is a validated measure that explores how contextual factors influence the implementation of QI[5] (in this case, the AMHE QI Collaborative).

4.3.1. Areas assessed by the MUSIQ tool

The MUSIQ tool includes questions to assess six contextual aspects at multiple levels including: (1) the QI Team; (2) the microsystem; (3) the QI support infrastructure; (4) the organisation; (5) the environment; and (6) other. Adaptations to the original tool were made by the team to suit the purposes of the AMHE QI Collaborative (see Appendix 3 in which the adaptations to the tool are highlighted).

For the AMHE QI Collaborative, the different contextual factors are defined.

1. The QI team

This is the project team undertaking the QI work. It may include people working across the trust, service or organisation from several different disciplines, depending on the team structure. Most questions in the tool are about decision-making processes and teamwork.

2. The microsystem

This refers to the service or department in the organisation within the project team that is doing the QI work. Questions are mainly about the use of QI methods and commitment to quality improvement.

3. QI support infrastructure

This is the financial support, resources and time, and information systems that allows the team to pull data. Two questions in the tool are about the support infrastructure.

4. The organisation

This is the organisation or service taking part in the AMHE QI Collaborative. The questions in the tool are about the involvement of and support from senior executives in QI activities, the value that the organisation places on QI, how far the QI work is embedded in the organisation, education and training opportunities on methods that support QI,

staff recognition for QI and how much the QI project aligns with the organisation's key strategic goals.

5. The environment

The environment is the community and society surrounding each organisation. It includes the geographical, political and economic environment in which the organisation exists. Two questions in the tool explore pressures or incentives from outside the organisation that motivate participation in the AMHE Collaborative and external groups that have provided personnel, money, resources or training to support the project.

6. Other

The tool assesses if a particular event prompted the launch of the team's QI project. One question is included in the tool for this purpose.

4.3.2. Responses to the questions

Each of the six contextual factors described in section 4.3.1. contain questions that are responded to using a Likert scale from one to seven. One indicates 'totally disagree', and seven indicates 'totally agree'. There are also 'don't know' or 'not applicable' response options, indicated with a zero. All of the scores are entered in a Microsoft Excel spreadsheet created by the tool's authors, and a total score is calculated.

The lowest possible total score in the MUSIQ tool is 24 and the highest possible is 168. Within those parameters, ranges of scores are used to indicate the project's chances of success:

120–168 = Project has a reasonable chance of success
80–119 = Project could be successful, but possible contextual barriers
50–79 = Project has serious contextual issues and is not set up for success
25–49 = Project should not continue as is; team should consider deploying resources to other improvement activities

4.3.3. Completion of the MUSIQ tool by teams

By November 2022, six teams had completed the MUSIQ tool. Members of the teams completed the tool with their QI coaches. Three of the MUSIQ tools were completed on an overarching level and three on a subteam level.

Five teams scored in the 80–119 range, indicating that the projects have the potential to be successful, but the teams could encounter some contextual barriers. The score for one team was in the 50–79 range, meaning the team needs to address contextual issues in order for the project to be successful.

Glossary of abbreviations

AMHE	Advancing Mental Health Equality
CAMHS	Child and adolescent mental health services
CEO	Chief Executive Officer
CYP	Children and young people
EDI	Equality, diversity and inclusion
FT	Foundation trust
GRT	Gypsy, Roma and Traveller
LGBTQ+	lesbian, gay, bi, trans, queer, questioning and ace
MH	Mental health
MUSIQ	Model for Understanding Success in Quality
NCCMH	National Collaborating Centre for Mental Health
N/E	Not established
N/S	Not specified
NoMAD	Normalisation Measure Development
NPT	Normalisation Process Theory
QI	Quality improvement
VCSE	Voluntary, community and social enterprise organisation

References

1 Institute for Healthcare Improvement. Guide for Undertaking a 3-Part Data Review. Boston, MA: IHI; Available from: www.ihi.org/Topics/Population-Health/Documents/IHI_PopulationHealth_GuideforUndertaking3PartDataReview.pdf

2 NHS England and NHS Improvement. Online Library of Quality Service Improvement and Redesign Tools. Driver Diagrams. Available from: www.england.nhs.uk/wp-content/uploads/2022/01/qsir-driver-diagrams.pdf

3 Finch TL, Girling M, May CR, Mair F, Murray E, Treweek S. NoMAD: Implementation measure based on Normalization Process Theory [measurement instrument]. 2015. Available from: www.implementall.eu/17-nomad.html

4 NCCMH, NHS England, NHS Improvement . The Community Mental Health Framework for Adults and Older Adults. London: NHS England and NHS Improvement, and NCCMH, 2019. Available from: www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

5 Kaplan HC, Provost LP, Froehle CM, Margolis PA. The Model for Understanding Success in Quality (MUSIQ): building a theory of context in healthcare quality improvement. BMJ Quality & Safety. 2012;21:13–20.

Appendix 1: The Normalisation Measure Development questionnaire (NoMAD)

This questionnaire is used to collect data and information from Teams and Services involved in the National Collaborating Centre for Mental Health (NCCMH) Advancing Mental Health Equality (AMHE) Quality Improvement (QI) Collaborative. The information collected will be used in the evaluation of the AMHE Collaborative as well as to track progress of individual teams who are involved in this work.

CONFIDENTIALITY: Data provided in this form will be kept strictly confidential and will not be accessible by anyone outside of the NCCMH internal team. Data collected in this form will be used strictly for the purposes of evaluation of the AMHE Collaborative by the internal NCCMH team. No personal or identifiable information pertaining to individuals will be shared or made available to anyone outside of the NCCMH. Reporting of the results of this survey will also be anonymised so no respondent will be identified by the presentation of the findings.

Useful information about filling in the form:

This questionnaire asks questions about the implementation of the AMHE QI Collaborative and should take approximately 10 minutes to complete. It needs to be completed in one attempt as it is not possible to save and return to the form.

We are asking project team leads and lived experience advisers to fill in this form to get a range of perspectives so please ensure you indicate your role in the space below and the organisation you work for.

Your role within the AMHE QI Collaborative

What is your role with your project team as part of the AMHE Collaborative?

- *Project team lead*
- *Project team member – lived experience adviser*

The organisation you work for

Please tell us the name of the organisation you work for

_____

Questions about the AMHE QI Collaborative

1. *I can see how working as part of the AMHE QI Collaborative model differs from our usual ways of working.*
2. *Staff in my organisation have a shared understanding of the purpose of the AMHE QI Collaborative*
3. *I understand how being part of the AMHE QI Collaborative affects the nature of my own work*
4. *I can see the potential value of being part of the AMHE QI Collaborative for my work*

5. *There are key people within my team who drive the AMHE QI Collaborative forward and get others involved*
6. *I believe that participating in the AMHE QI Collaborative is a legitimate part of my role*
7. *I'm open to working with colleagues in new ways to implement the AMHE QI Collaborative model*
8. *I will continue to support the AMHE QI Collaborative*
9. *I can easily integrate relevant elements of the AMHE QI Collaborative model into my existing work*
10. *The AMHE QI Collaborative does not disrupt working relationships*
11. *I have confidence in my team's ability to implement the AMHE QI Collaborative model*
12. *I believe that the members of my AMHE team have the appropriate skills to work on the project*
13. *My organisation provides sufficient training to enable staff to implement the AMHE QI Collaborative model*
14. *Sufficient resources are available to support the implementation of the AMHE QI Collaborative model*
15. *Managers within my organisation adequately support the AMHE QI Collaborative*
16. *The staff in my organisation agree that the AMHE QI Collaborative is worthwhile*
17. *I value the effects that being part of the AMHE QI Collaborative has had on my work so far*
18. *I believe that feedback about the AMHE QI Collaborative will be useful to improve the delivery of care*
19. *I believe that I will be able to modify my work as a result of being part of the AMHE QI Collaborative*

Answer options for all 19 questions

- *Strongly Agree*
- *Agree*
- *Neither Agree or Disagree*
- *Disagree*
- *Strongly Disagree*

Appendix 2: AMHE survey questions

This form is used to collect data and information from Teams and Services involved in the NCCMH Advancing Mental Health Equality (AMHE) Quality Improvement (QI) Collaborative. The information collected will be used in the evaluation of the AMHE Collaborative as well as to track progress of individual teams who are involved in this work.

CONFIDENTIALITY: Contact details provided in this form will be kept strictly confidential and will not be accessible by anyone outside of the NCCMH internal team. Data collected in this form will be used strictly for the purposes of evaluation of the AMHE Collaborative by the internal NCCMH team. No personal or identifiable information pertaining to individuals will be shared or made available to anyone outside of the NCCMH. Reporting of the results of this survey will also be anonymised so no respondent will be identified by the presentation of the findings.

Useful information about filling in the form:

This form should take approximately 10 minutes to complete. It needs to be completed in one attempt as it is not possible to save and return to the form.

We are asking project team leads, members and lived experience advisers to fill in this form to get a range of perspectives so please ensure you indicate your role in the space below.

Your role within the AMHE Collaborative

What is your role with your project team as part of the AMHE Collaborative?

- *Project team lead*
- *Project team member – staff*
- *Project team member – lived experience adviser*
- *Sub-project (project focusing on a specific population or equality) team lead*
- *Sub-project (project focusing on a specific population or equality) team member – staff*
- *Sub-project (project focusing on a specific population or equality) team member – lived experience adviser*
- *Other: _____*

Questions about the AMHE QI Collaborative model overall

The 'model' refers to the method used in this work. It includes things like how the QI programme is structured, the way QI coaches work with teams how the programme helps the service to improve.

What have been the main benefits of the AMHE QI Collaborative model in focusing staff on improving service quality?

_____

What have been the main challenges of using the AMHE QI model?

_____

Has the team discussed how to overcome these challenges?

Yes, please provide details

_____

No, please provide details

_____

What have been the benefits of working with the QI coaches in the AMHE QI Collaborative?

_____

What have been the main challenges of working with the QI coaches in the AMHE QI Collaborative model so far?

_____

Has the team discussed how to overcome these challenges?

Yes, please provide details

_____

No, please provide details

_____

Questions about working as part of the wider AMHE QI Collaborative team

Here we want you think about working as part of the wider AMHE QI Collaborative team. This refers to working alongside and together with other services involved in the Collaborative.

What have been the main benefits of working alongside other organisations and services who are part of the AMHE QI Collaborative team?

_____

What have been the main challenges when working alongside other organisations and services who are part of the AMHE QI Collaborative team?

_____

Has the team discussed how to overcome these challenges?

- *Yes, please provide details*
  _____
- *No, please provide details*
  _____

Questions about your team – establishing the QI approach in your organisation

Here we want to understand more about how the QI approach has been used in your organisation/service and how this has been received by the project team.

How has your team engaged with establishing the QI approach in your organisation?

_____

What new approaches have the team used so far (e.g., engaging communities and staff)?

_____

Co-production

Co-production refers to an ongoing partnership between people who design, deliver and commission services, people who use the services and people who need them.

What steps have your team taken towards co-production? (e.g., people with lived experience on the team, focus groups with communities, events)

_____