AMHE
Advancing mental health equality

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Advancing Mental Health Equality Quality Improvement Collaborative

Evaluation Snapshot 2

December 2022 – May 2023

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Contents

1. About the Evaluation Snapshots

This report, Evaluation Snapshot 2, presents an evaluation of the progress made by the 14 teams from Waves 1 and 2 of the Advancing Mental Health Equality (AMHE) quality improvement (QI) Collaborative over 18 months, from December 2022 to May 2023. It picks up where Evaluation Snapshot 1 left off, after the end of Wave 1 of the AMHE QI Collaborative. A follow-up report, Evaluation Snapshot 3, is in development. See Table 1 for the status and time frames of the three Evaluation Snapshots.

Table 1: Reporting time frames for the development and publication of the Evaluation Snapshots

Evaluation Snapshot	Teams involved	Time frame	Current status
1	15 Wave 1 teams	July 2021 – November 2022	Published February 2023
2	14 Wave 1 and 2 teams	December 2022 – May 2023	Publishing March 2024
3	Waves 1 and 2 teams: *Number to be confirmed*	June 2023 – February 2024	In development: *Data collection phase*

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 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 that were identified
- The types of inequalities issues that were identified
- The progress made by the teams in the three-part data review
- 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
- Any commonalities between teams that had success and between teams that did not
- New approaches that were used, and how any new approaches contributed to success.

1.2. Data used in the Evaluation Snapshots

Data and information from the AMHE QI Collaborative was gathered using several methods (including surveys, use of organisations' data and summaries of team objectives), described in Section 3.

For Evaluation Snapshot 3, we will hold focus groups (and use other qualitative methods, as needed) with members of project teams and QI coaches. We will then gather and review that data for the evaluation.

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

Fourteen organisations were involved the collaborative (13 organisations from Wave 1 and one that joined Wave 2).[a,b] Of these, nine were NHS trusts and six were voluntary, community and social enterprise organisations (VCSEs).

NHS trusts involved in the collaborative

- Avon and Wiltshire Partnership NHS Trust
- Devon Partnership NHS Trust
- Herefordshire and Worcestershire Health and Care NHS Trust
- Norfolk and Suffolk NHS Foundation Trust
- Northamptonshire NHS Foundation Trust
- Pennine Care NHS Foundation Trust
- Somerset NHS Foundation Trust
- Southern Health and Social Care Trust (Northern Ireland).

VCSEs involved in the collaborative

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

Characteristics of each organisation (trust and service type; regions; services provided; size of population served; equality work being done in the organisation) are in Table 2.

[a] Northamptonshire NHS Foundation Trust joined for Wave 2. All other organisations were involved in Wave 1.
[b] Barnet, Enfield and Haringey Mental Health NHS Trust and Leicestershire Partnership NHS Trust were involved in Wave 1 only. Greater Manchester NHS Foundation Trust joined for Wave 2, but challenges with engagement in the programme mean the team is not included in this report.

Table 2: Characteristics of the 14 organisations involved in the AMHE QI Collaborative[c]

Trust/organisation name and type	Service specification	Region	Local areas served	Population served (approx.)	Equality work in the service/organisation
Avon and Wiltshire Partnership NHS Trust • MH trust	• CYP • Talking therapies • Community MH • Inpatient • Specialist • Urgent care	South West	• Bath and North East Somerset • Bristol • North Somerset • South Gloucestershire • Wiltshire	1.6 million	EDI strategy
Devon Partnership NHS Trust • MH trust	• CYP • Inpatient MH • Learning disabilities • Liaison MH • Community MH	South West	• Devon	894,000	EDI strategy
Herefordshire and Worcestershire Health and Care • NHS trust	• Community health • Community MH • CYP • Families • Inpatient MH • Learning disabilities • Liaison MH	West Midlands	• Herefordshire • Worcestershire	800,900	Inclusion Diversity and Equality Strategy 2018–22

[c] The information in Table 2 is from Internet searches carried out when teams joined the AMHE Collaborative and was accurate at the time of collection.

Trust/organisation name and type	Service specification	Region	Local areas served	Population served (approx.)	Equality work in the service/organisation
Livewell Southwest • VCSE	• Community health • Community MH • CYP MH • Inpatient MH • Learning disabilities • Liaison MH • Social care	South West	• South Hams • West Devon • Plymouth	270,000	EDI strategy
Mind in Croydon in partnership with Mind in Kingston • VCSE	• Community MH: o advice o advocacy o counselling o support	London	• Croydon	390,000	Equality and Diversity Policy
Mind in Hampshire (Andover, Havant and East Hampshire, Solent) • VCSE	• Adult MH and wellbeing • CAMHS • Family services • Workplace wellbeing	South East	• Hampshire	1.5 million	EDI strategy
Mind in North Lincolnshire in partnership with Mind in North Staffordshire • VCSE	• Community MH support • Counselling • Crisis prevention • Peer support	East Midlands	• North Lincolnshire: • North Staffordshire	172,000 95,800 (North and South Staffordshire)	Equality and diversity policy

Trust/organisation name and type	Service specification	Region	Local areas served	Population served (approx.)	Equality work in the service/organisation

Mind in Tower Hamlets and Newham in partnership with Mind in Haringey
• VCSE
	• Community MH:
	  ○ advice
	  ○ advocacy
	  ○ support
	  ○ therapies
		London	• Tower Hamlets
			• Newham
				933,000	EDI strategy

Neath Port Talbot Mind
• VCSE
	• Community MH:
	  ○ talking therapies
	  ○ support
	  ○ young people
		South Wales	• Neath
			• Port Talbot
				143,000	EDI strategy

Norfolk and Suffolk • NHS FT	• Community MH • CYP • Inpatient MH • Learning disabilities • Liaison MH	East of England	• Norfolk • Suffolk	1.6 million	Equality delivery system and evaluation
Northamptonshire • NHS FT	• CYP • Community MH • Learning disabilities • Inpatient MH	East Midlands	• Northamptonshire	733,000	Workforce Race, Equality & Inclusion Strategy

Trust/organisation name and type	Service specification	Region	Local areas served	Population served (approx.)	Equality work in the service/organisation
Pennine Care NHS FT • MH trust	• Adult • and Community MH • CYP • Inpatient MH • Learning disabilities • Liaison MH	North West	• Bury • Oldham • Rochdale • Tameside and Glossop • Stockport	1.3 million	EDI programme
Somerset • NHS FT	• Acute hospital care • Community health • Community MH • CYP • Inpatient MH • Learning disabilities • Liaison MH	South West	• Somerset	340,000	Inclusion strategy 2021–25
Southern Health and Social Care Trust (Northern Ireland) • Health and social care NHS trust	• Community MH • CYP • Inpatient MH • Learning disabilities • Liaison MH • Social care	Northern Ireland	• Armagh • Banbridge • Craigavon • Dungannon • Newry and Mourne	384,000	Equality scheme

Note. CAMHS = child and adolescent mental health service; CYP = children and young people; EDI = equality, diversity and inclusion; FT = foundation trust; MH = mental health; VCSE = voluntary, community and social enterprise organisation.

2.2. Project teams

Project teams[d] had between 4 and 17 members, with an average of 10 team members. One project team had just one member, the project lead.

Table 3 shows the roles or professions of project team members for each team. At the time of writing, QI coaches had not been given information on four roles across three (21%) teams (noted in Table 3 as 'not specified'). This had not changed since data was collected for Evaluation Snapshot 1. Three project teams included lived experience advisers (also referred to as 'experts by experience' or 'service user representatives').

Table 3: Project teams and the professions/roles of the members

Project team and number of team members	Team member professions/roles
Avon and Wiltshire NHS Trust • 9 team members	1. Associate Director of Research and Development 2. Business Intelligence 3. Business Manager 4. Consultant Clinical Psychologist 5. Divisional Medical Lead 6. Head of Nursing – Safety and Inclusion 7. Medical Director 8. Research and Development [team member] 9. *Role not specified*
Devon Partnership NHS Trust • 6 team members	1. Clinical Psychologist 2. Deputy Director of Safeguarding 3. Director of Corporate Affairs/Executive Lead for Equality and Inclusion 4. EDI Manager 5. Governance Manager 6. Operational and Strategic Lead
Herefordshire and Worcestershire Health and Care NHS Trust • 17 team members	1. Associate Director for Performance and Informatics 2. Associate Medical Director 3. Chief Officer, Healthwatch Herefordshire 4. Data Scientist 5. Deputy Associate Director for Primary Care and Community Mental Health Services 6. Deputy Director of Innovation and Improvement 7. Digital Innovation and Change Manager and Head of Project Management Office 8. Digital Project Manager Officer 9. EDI Lead 10. Engagement Officer, Healthwatch Worcestershire

[d] Referred to as 'overarching project teams' in Evaluation Snapshot 1.

Project team and number of team members	Team member professions/roles
	11. Managing Director, Taurus Healthcare and Worcestershire Council 12. Medical Director 13. Medical Directorate Support Team [member] 14. Mental Health Lead 15. Programme Manager 16. Public Health Consultant, Herefordshire Council 17. Quality Lead
Livewell Southwest • 4 team members	1. Head of Strategy and Improvement 2. Lived Experience Lead for QI from Heads Count 3. Medical Director 4. Team Administrator
Mind in Croydon/Mind in Kingston • 6 team members	1. CEO (Kingston) 2. Deputy CEO/Director of Services (Croydon) 3. Deputy Manager of Social Networking Service Users and Carers Support Service Coordinator 4. Head of Mental Health and Support Services (Croydon) 5. Interim Community Inclusion Manager 6. Trustee and EDI Lead (Kingston)
Mind in Hampshire (Andover, Havant and East Hampshire, Solent) • 10 team members	1. 4x CEOs 2. Area Manager for North and Northeast Hampshire 3. Director of Business Development and Resources 4. Lead for Equality and Diversity (Head of Communications and Community Engagement) 5. Programme Lead Employment and Inclusion 6. *2x roles n.s.*
Mind in North Lincolnshire/Mind in North Staffordshire • 5 team members	1. CEO (Lincolnshire) 2. Chief Executive (Staffordshire) 3. Support Worker (Lincolnshire) 4. User Engagement Coordinator (Staffordshire) *5. Role n.s.*
Mind in Tower Hamlets and Newham/Mind in Haringey • 6 team members	1. 2x CEOs (Haringey and THN) 2. Director of Mental Health Services (THN) 3. EDI Community Engagement Lead 4. Mental Health Services manager (THN) 5. Peer Service Coordinator (THN)
Neath Port Talbot Mind • 2 team members	1. Business Development Officer and Sustainability Officer 2. Director

Project team and number of team members	Team member professions/roles
Norfolk and Suffolk NHS FT • 15 team members	1. Autism Spectrum Disorders Lead 2. Consultant Psychiatrist 3. Director of Communications and Involvement 4. EDI Lead 5. 2x Experts by Experience 6. GP 7. Head of Research (specialising in equality) 8. Lecturer in Mental Health 9. Lived Experience Equality Role 10. PPI Manager 11. QI Coach 12. QI Comms and Data Officer 13. QI Facilitator 14. QI PPI Lead
Northamptonshire NHS FT • Unknown team members	• *Team member roles not specified*
Pennine Care NHS FT • 10 team members	1. Deputy Director of Service Development and Delivery 2. Director of Workforce 3. Executive Director of Nursing, Quality and Healthcare Professionals 4. Head of Business Intelligence 5. Head of EDI 6. Head of Patient and Carer Experience and Engagement 7. Medical Director 8. Network Director of Quality 9. Non-Executive Director 10. Senior Improvement Practitioner
Somerset NHS FT • 17 team members	1. Consultant Psychiatrist 2. Co-Production Manager, Rethink 3. Co-Production Practice Manager, Rethink 4. 2x Experts by Experience, Open Mental Health 5. Head of NHS Collaboration, Rethink 6. Head of Patient Safety and Learning 7. Health Champions and Mental Health Hub –Coordinator, Spark Somerset 8. Health Promotion Manager, Somerset County Council 9. Inclusion Lead 10. Nurse, Open Mental Health 11. Quality and Equality Officer 12. Recovery Partner 13. Representative from Somerset Country Council

Project team and number of team members	Team member professions/roles
	14. Service Director for Mental Health and Learning Disabilities 15. 2x Team Managers, Community Mental Health Team
Southern Health and Social Care Trust • 10 team members	1. Assistant Director of Disability Services 2. Associate Medical Director and Consultant Psychiatrist 3. CEO 4. Consultant Psychiatrist 5. Director of Mental Health and Disabilities Services 6. Director of Nursing 7. 2x Lead Nurse 8. Lead Nurse, Mental Health and Learning Disabilities Division 9. Service User Representative

Abbreviations: CEO = Chief Executive Officer; EDI = equality, diversity and inclusion; FT = Foundation Trust; PP = Patient and Public Involvement; QI = Quality Improvement; THN = Tower Hamlets and Newham.

2.3. Project subteams

The 14 project teams formed a subteam for each of their identified population subgroups. In summary:

- 13 (93%) project teams had identified at least one of the three population subgroups. Of these, for each identified population there were:
  - One to 28 (average: nine) subteam members, with:
    - One to 21 (average: four) in a clinical role
    - One to 11 (average: four) in a non-clinical/managerial role
    - One to two in a lived experience adviser role.
- Of the 13 (93%) project teams with at least one population subgroup:
  - Five (36%) had identified two population subgroups
  - Eight (57%) had identified three population subgroups
- Five (36%) project subteams had included a lived experience adviser in at least one population subgroup.

3. Team objectives and approaches

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

What populations were identified?

- What types of inequality issues were identified?
- What progress did the teams make in the three-part data review?
- What were the most common types of change ideas tested and interventions introduced?

3.1. Identified populations

Figure 1 shows the 14 main population categories, and the number of populations, and therefore subteams, within each category. A population can be in more than one category; for example, children and young people from minoritised ethnic communities are in two categories.

The populations that had the most subteams focusing on them were:

- children and young people
- people from LGBTQ+ communities
- people from minoritised ethnic communities.

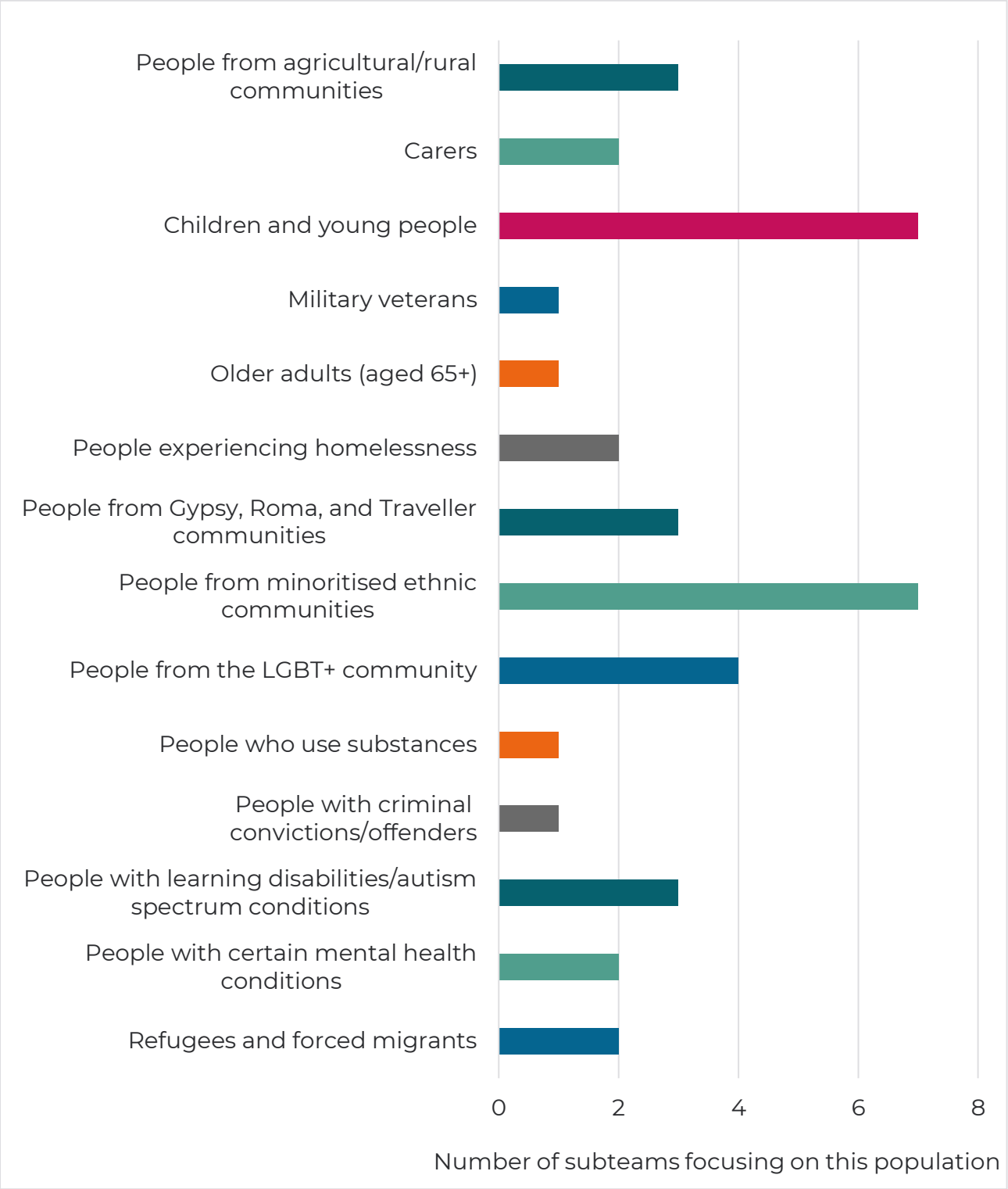

Figure 1: Number of identified populations per population category

3.2. Identified inequality issues

During the time frame covered by Evaluation Snapshot 2, out of the 14 teams:

- three (24%) had not specified an inequality issue for a population
- 11 (76%) had specified one or two inequality issues
- two (14%) had specified inequality issues for all three populations.

For comparison, out of the 15 teams in Evaluation Snapshot 1:

- six (40%) had not specified an inequality issue for a population
- nine (60%) had specified one or two inequality issues
- two (13%) had specified inequality issues for all three populations.

For the identified inequality issues, Figure 2 shows how many inequality issues are in each of the three main categories:

1. Access to services (15 inequality issues – no change from Snapshot 1)
2. Experience of services (seven inequality issues – one more since Snapshot 1)
3. Use of the Mental Health Act (including reducing the use of Sections 135 and 136 detention) (three inequality issues – one more since Snapshot 1).

Again, note that a population can be in more than one category if they experience more than one inequality issue; for example, having difficulty accessing services and also having poor experience of services leads to being in two categories.

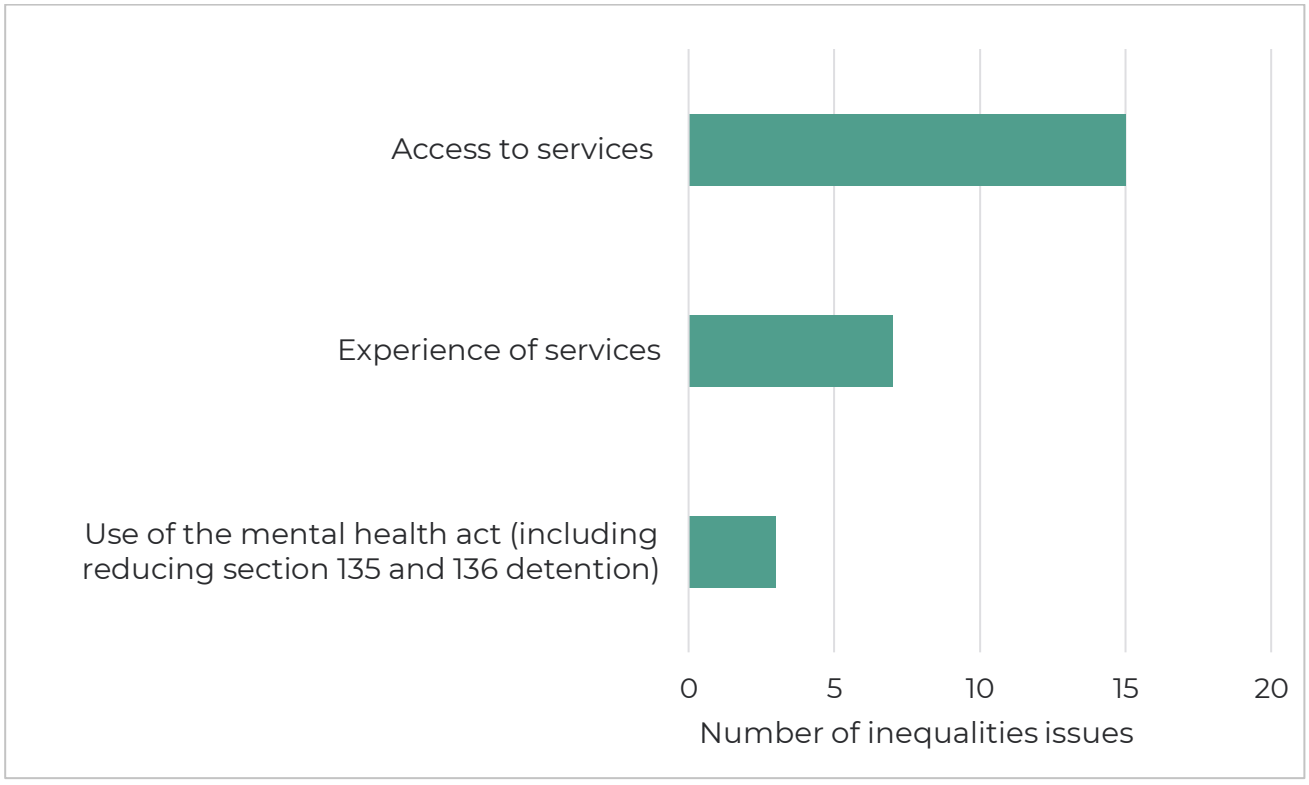

Figure 2: Number of identified inequality issues in each main category

Table 4 outlines the inequality issues that were identified for each population by the 14 teams in the AMHE Collaborative by the time data was collected for Evaluation Snapshot 2.

Several teams had not managed to identify an inequality issue during Evaluation Snapshot 2, even where they had identified populations to focus on. Where this was the case, it should be noted that this had not changed since data were collected for Evaluation Snapshot 1.

Table 4: Population and inequality issues[f] identified by the 14 teams for each of the three populations

Team Identified population	Identified inequality issues
Avon and Wiltshire NHS Trust	
1. CYP 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 (of substance use and a mental health condition)	Access to mental health services
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	Not specified (n.s.)
Herefordshire and Worcestershire Health and Care NHS Trust	
1. CYP	n.s.
2. Agricultural/rural communities	n.s.
3. People belonging to LGBTQ+ communities	n.s.
Livewell Southwest	
1. Most deprived areas of Plymouth	Outcomes

[f] When the AMHE Collaborative was launched, teams were advised to identify three population groups and focus their work on the inequality issues faced by these groups. Differences in need across the country, as well as trust and organisational capacity, meant not all teams could identify three population groups, so some teams may only have identified one or two population groups.

Team Identified population	Identified inequality issues
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)	Improving access to mental health services and reducing mental health stigma
2. Older carers 70+ (Croydon)	n.s.
3. n.s.	n.s.
Mind in Hampshire (Andover, Havant and East Hampshire, Solent)	
1. Refugees and Asylum Seekers (Solent)a	n.s.
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 North Lincolnshire/Mind in North Staffordshire	
1. Autistic people in Staffordshire	Access to services
2. Homeless people or offenders	n.s.
3. n.s.	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.	n.s.
Norfolk and Suffolk NHS Foundation Trust	
1. Black men	Access and experience
2. Refugees and forced migrants (Norfolk)	Access to services

Team Identified population	Identified inequality issues
3. Refugees and forced migrants (Suffolk)	Access to services
Northamptonshire NHS FT	
1. Afghan population who were residing in bridging hotels that are now living in the community	Access to services
2. CYP	n.s.
3. Neurodiverse people	n.s.
Pennine Care NHS FT	
1. Women military veterans in Greater Manchester NHS FT 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.

Abbreviations: CAMHS = child and adolescent mental health service; CYP = children and young people; FT = Foundation Trust; GRT = Gypsy, Roma and Traveller; LGBTQ+ = lesbian, gay, bisexual, transgender, queer plus; n.s. = not specified.
[a] Population focus was changed by the project team between snapshot 1 and snapshot 2

3.3. Three-part data review

The three-part data review is a useful tool to explore the assets and needs within a population. A copy of the three-part data review tool is in Appendix 1. The 'assets' refer the buildings and resources that are there for the use of individuals and communities, to promote their social, mental and physical wellbeing; the 'needs' involve the challenges within the population (for example, the recognition of barriers to access to a certain service or identification of poorer outcomes that need to be addressed).[1] A brief description of the three-part data review and which teams have started the data review, and a summary of teams' progress between **December 2022 and May 2023**, are set out in Sections 3.4.1.–3.4.3.

3.3.1. Data review

This involves AMHE teams reviewing any data available to them that can help them identify overall patterns that impact the chosen population. We found that, by May 2023, of the 14 teams:

- four (29%) had both **identified and started the data review for all three populations**
- eight (57%) had started the data review for **all of the identified populations** even where they had not identified all three populations yet (for example, if a team had identified two populations and had started the data review for both)
- 11 (79%) had started the data review for **at least one** of the identified populations
- three (21%) had started the data review for **none** of the identified populations.

3.3.2. Staff engagement

This involves the teams engaging with staff who support and work with the identified population to understand their perspective on the population's greatest needs and assets. We found that by May 2023, of the 14 teams:

- one (7%) had started engaging with staff working with **all three** of the identified populations
- eight (57%) had started engaging with staff working with **at least one** of the identified populations
- six (42%) had not started engaging with staff working with any of the identified populations.

3.3.3. Community engagement

This involves teams engaging in any way 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 accessing services, and what might help. We found that by May 2023, of the 14 teams:

- one (7%) had started community engagement for **all three** of the identified populations

- 10 (71%) had started community engagement for **at least one** of the identified populations
- four (29%) had not started community engagement for any of the identified populations.

3.3.4. Project team progress in the three-part data review

For each identified population, teams indicated which elements of the three-part data review they had started.

Of the 14 teams, by May 2023:

- six (43%) had started **all three** elements in the three-part data review
- 10 (71%) had started **at least one** of the three elements in the three-part data review
- three (21%) had not started any elements in the three-part data review

3.4. Content analysis of driver diagrams

Note: The content analysis of driver diagrams will be part of Evaluation Snapshot 3 and is not included here. This section describes what the content analysis will involve.

We will use content analysis of **driver diagrams** to describe the subteams' **aims**, **primary drivers** and **change ideas**.

In November 2022 (end of Wave 1), no subteams had developed their driver diagrams. By May 2023 (end of Wave 2), eight subteams had started to develop driver diagrams.

3.4.1. Elements of a driver diagram

Once the aim has been identified, the first step of developing a driver diagram is to consider between three and five big topics that the team believe can help achieve the aim. These will be the team's primary drivers.

These primary drivers are then broken down in to smaller topics/areas of focus, called secondary drivers. Teams will then generate, and test, change ideas related to the secondary drivers. This approach ensures the team's work remains focused on achieving their aim as the ideas will always feed in to a secondary driver, corresponding primary driver, and the aim, as demonstrated by the arrows in Figure 3.

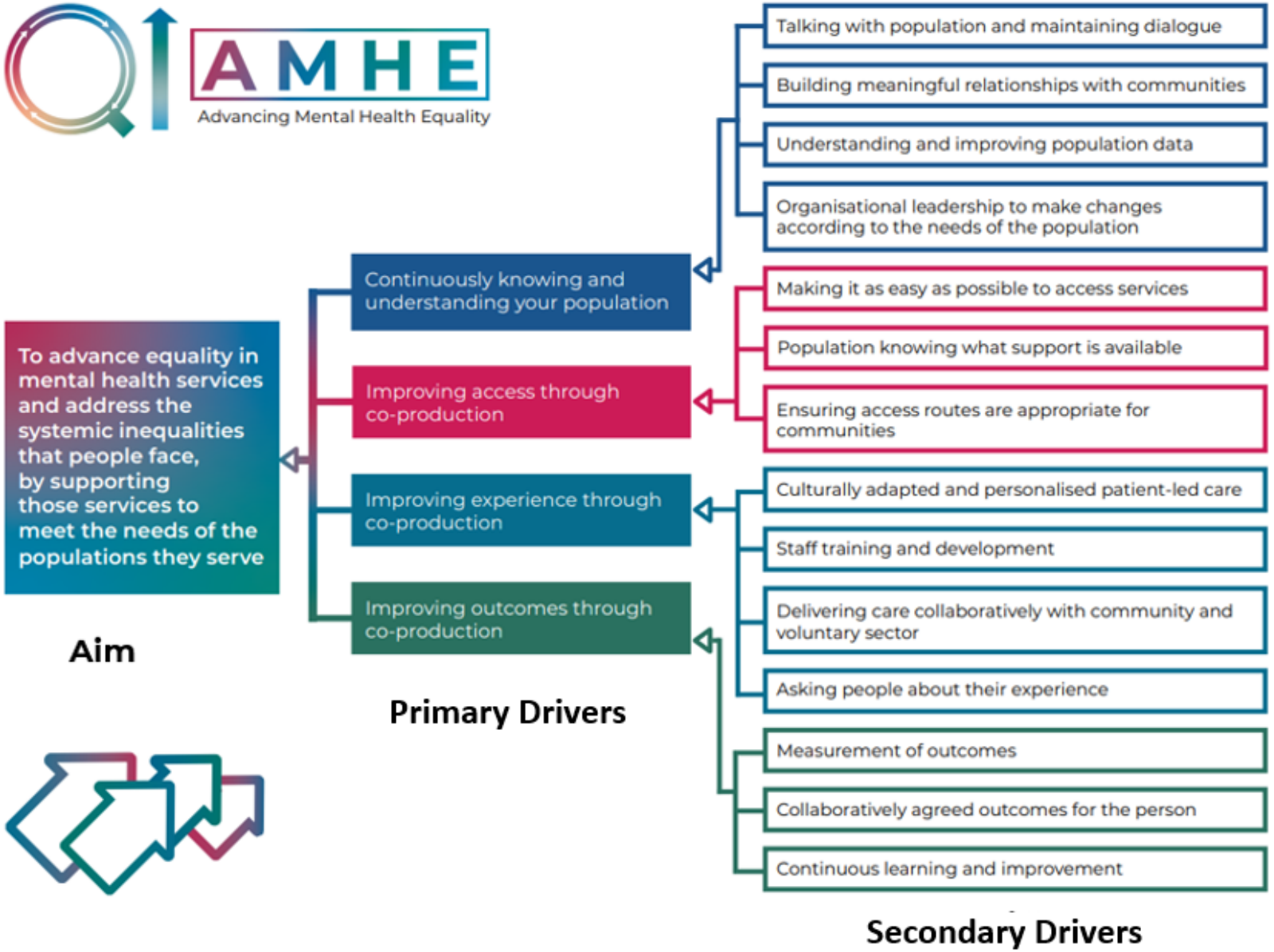

Figure 3: AMHE QI Collaborative driver diagram

3.4.2. Coding the driver diagrams for content analysis

The aims, primary drivers and change ideas of the teams' driver diagrams will be 'coded' using a deductive approach (secondary drivers will not be explored as part of the content analysis). 'Codes' will be attached to areas identified by services in finalised driver diagrams. The code types correspond to the driver diagram for the AMHE QI Collaborative (shown in Figure 3), which teams will use as a template for their own driver diagram. Then, for the content analysis, codes will be used to categorise and quantify:

- the types of inequalities that teams have identified
- the populations teams have focused on
- the change ideas teams have developed
- the methods of implementation across teams.

The number of change ideas that have been tested by teams will also be collected and reported.

4. Evaluation of the AMHE QI process

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 between teams that had successes and between teams that did not?
- What new approaches were used? How did any new approaches contribute to success?

To assess the implementation, impact and success of the AMHE QI Collaborative process, we aimed to collect results from the Normalisation Measure Development (NoMAD) questionnaire, AMHE survey and the Model for Understanding Success in Quality (MUSIQ) tool.

We did not receive any new or updated results from these measures during the snapshot 2 time period (between Dec 2022-May 2023), so please see Snapshot 1 for more information about the tools and results from that period. We aim to present updated results in Evaluation Snapshot 3.

4.1. What is the NoMAD?

The NoMAD[3] is a validated research measure based on the Normalisation Process Theory (NPT), with data gathered from responses to a questionnaire. The 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 put AMHE into practice in their everyday work and are supported to do so.

In the NoMAD questionnaire, there are 19 statements with which respondents can indicate their agreement (see Appendix 2). The statements are grouped into the four parts of the NPT, which are:

- coherence (NoMAD statements 1–4)
- cognitive participation (NoMAD statements 5–8)
- collective action (NoMAD statements 9–15)
- reflexive monitoring (NoMAD statements 16–19).

4.1.1. Summary of NoMAD findings (Evaluation Snapshot 1)

The results of the NoMAD indicate that, overall, teams were positive about the implementation of the AMHE QI collaborative model into their everyday work.

When it came to statements about coherence, which focus on a shared understanding of the purpose of the collaborative, how it works and its potential value, many respondents felt that the AMHE QI Collaborative showed promise. Almost three-quarters (73%) of

respondents strongly agreed or agreed with statements such as, '*I can see the potential value of being part of the AMHE QI Collaborative for my work*'.

For cognitive participation (which focuses on openness to new ways of working with colleagues, key players within the team and one's own feelings of support for the AMHE QI Collaborative model), most team members responded positively. Most (85%) respondents strongly agreed or agreed with statements such as, '*I'm open to working with colleagues in new ways to implement the AMHE QI Collaborative model'.* Only 4% disagreed or strongly disagreed with statements about cognitive participation.

Responses to statements about collective action were a little more mixed. Over half (54%) of respondents reported that they agreed or strongly agreed with statements to do with:

- their self-confidence or the confidence of the wider team in implementing the model
- perceived competence of oneself or colleagues
- support from management
- availability of sufficient resources.

Almost one-fifth (19%) of respondents disagreed or strongly disagreed with statements such as, '*I have confidence in my team's ability to implement the AMHE QI Collaborative model',* while over one-quarter (27%) were neutral in their responses to statements, choosing 'neither agree nor disagree'.

When it came to statements about reflexive monitoring, which focus on perceptions of the value of the model so far, the potential utility of feedback on progress and feeling able to modify and improve one's practice at work, most team members responded positively. Most (82%) respondents agreed or strongly agreed with statements such as, *'I believe that feedback about the AMHE QI collaborative will be useful to improve the delivery of care'.* While only 2% of respondents disagreed with these statements, 16% chose 'neither agree nor disagree'.

Overall, the responses to the NoMAD suggest that team members understood and appreciated the AMHE QI Collaborative model, and that they recognised its value and potential. Despite this, the findings indicate that team members felt a lack of confidence, competence, support from management and adequate resources to implement the model to the best of their ability.

For further details on the results from the NoMAD, see Snapshot 1.

4.3. What is the AMHE survey?

The AMHE survey was designed by the National Collaborating Centre for Mental Health (NCCMH) research team to collect information from the teams about what went well, and the challenges and difficulties they had experienced so far. The survey has 16 questions that cover four areas:

1. The AMHE QI Collaborative model
2. Working as part of the wider AMHE QI Collaborative team
3. Establishing the QI approach
4. Co-production.

Appendix 3 contains a copy of the survey.

For Snapshot 1, the survey was completed by:

- five project team leads
- five project team members
- three subteam members
- one peer worker.

The professional roles of the 14 team members were three in clinical roles, 10 in non-clinical or managerial roles, and one in a peer worker role.

For detail on the results from the AMHE survey, see Snapshot 1.

4.4. What is the 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).

The MUSIQ tool assesses six areas of contextual factors at multiple levels:

1. The QI Team
2. The microsystem
3. The QI support infrastructure
4. The organisation
5. The environment
6. Other.

The original tool was adapted by the NCCMH research team for the AMHE QI Collaborative (see Appendix 4, in which the adaptations to the tool are highlighted).

For detail on the results from the MUSIQ tool, see Snapshot 1.

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, bisexual, transgender, queer plus
MH	mental health
MUSIQ	Model for Understanding Success in Quality
NCCMH	National Collaborating Centre for Mental Health
n.a.	not applicable
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: Three-part data review tool

An important aspect of beginning the journey to advance mental health equality for your chosen populations is to ensure that you understand the experiences , needs and assets of those groups of people. Having this understanding will allow your project team to ensure that the right stakeholders are involved, that your project is meaningful to the populations you're working with, and that you make best-use of the existing resources.

A three-part data review is a useful tool to develop your understanding by looking at relevant data, speaking to your staff, and engaging with members of the communities you're looking to support. The template below has been provided by the AMHE Collaborative team as a resource to help you with the three-part data review, but teams can choose to record the information in any way that is helpful to them.

The questions below align with the Box 3 of the AMHE Resource. These coproduced questions were identified by the AMHE Expert Reference Group as vital in understanding local mental health inequalities. Information gathered from the data review, engagement with staff, and engagement with people from the community will support teams to answer these questions.

Population 1:		
What are the mental health needs of this population?	Data review	
	Staff engagement	
	Engagement with people from the community	
Is this population accessing our services? Which services?	Data review	
	Staff engagement	
	Engagement with people from the community	
Which treatments are this population receiving?	Data review	
	Staff engagement	
	Engagement with people from the community	
	Data review	

What experiences are this population having?	Staff engagement	
	Engagement with people from the community	
What do the outcomes of mental health care look like for this population?	Data review	
	Staff engagement	
	Engagement with people from the community	
Which local organisations work with this population?	Data review	
	Staff engagement	
	Engagement with people from the community	
Summary:		

Appendix 2: 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 3: 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)

_____