AMHE
Advancing mental health equality

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Advancing Mental Health Equality Quality Improvement Collaborative

Evaluation Snapshot 3

December June 2023 – February 2024

National Collaborating Centre for Mental Health. Advancing Mental Health Equality Quality Improvement Collaborative: Evaluation Snapshot 3, December June 2023 – February 2024. London: National Collaborating Centre for Mental Health; 2025

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Contents

1. About the Evaluation Snapshots

This report, Evaluation Snapshot 3, presents an evaluation of the progress over 9 months made by the 12 project teams from Waves 1 and 2 of the Advancing Mental Health Equality (AMHE) quality improvement (QI) Collaborative.

Evaluation Snapshot 3 picks up where Evaluation Snapshot 2 left off, towards the end of Wave 2 of the Collaborative, from June 2023 to February 2024. See Table 1 for the status and time frames of, and links to, the last two Evaluation Snapshots.

Table 1: Reporting time frames for the development and publication of Evaluation Snapshots 1 and 2

Evaluation Snapshot	Teams involved	Time frame	Status
1	15 Wave 1 teams	July 2021 – November 2022	Published: February 2023 Available: here
2	14 Wave 1 and 2 teams	December 2022 – May 2023	Published: March 2024 Available: here

More information can be found at Advancing Mental Health Equity evaluation.

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.

Findings from focus groups (and other qualitative methods, as needed) with members of project teams and QI coaches will be published in an addendum to the current report in due course.

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

In Evaluation Snapshot 2, we reported on 14 organisations involved in Wave 2 of the AMHE QI Collaborative. These comprised 13 organisations from Wave 1 and one organisation who joined for Wave 2.

In the current Evaluation Snapshot, we report on **12 organisations** still taking part in the Collaborative, comprising 11 organisations from Wave 1 and one organisation that joined for Wave 2. Of these, eight were NHS Trusts and four were voluntary, community and social enterprise organisations (VCSEs).

NHS trusts involved in the Collaborative

1. Avon and Wiltshire Partnership NHS Trust
2. Devon Partnership NHS Trust
3. Herefordshire and Worcestershire Health and Care NHS Trust
4. Norfolk and Suffolk NHS Foundation Trust
5. Northamptonshire NHS Foundation Trust
6. Pennine Care NHS Foundation Trust
7. Somerset NHS Foundation Trust
8. Southern Health and Social Care Trust (Northern Ireland).

VCSEs involved in the Collaborative

1. Mind in Kingston
2. Mind in Hampshire (Andover, Havant and East Hampshire, Solent)
3. Mind in North Lincolnshire in partnership with Mind in North Staffordshire
4. Mind in Tower Hamlets and Newham.

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

Table 2: Characteristics of the 12 organisations involved in the AMHE QI Collaborative[a]

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	• Community MH • CYP • Inpatient • Specialist • Talking therapies • 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	• Community MH • CYP • Inpatient MH • Learning disabilities • Liaison 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

[a] 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
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
Mind in Tower Hamlets and Newham • VCSE	• Community MH: o advice o advocacy o support o therapies	London	• Tower Hamlets • Newham	933,000	EDI strategy

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

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

Abbreviations: 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[b] had between 5 and 46 members, with an average of 15 team members.

Table 3 shows the roles or professions of project team members for each team. Five of the 12 teams included lived experience advisers (also referred to as 'experts by experience' or 'service user representatives/consultants') or peer support workers, and these roles are shown in bold.

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 • 46 team members (23 in confirmed roles)	1. Assistant Psychologist 2. Associate Director of Nursing 3. Be Safe Clinical Team Manager/Lead Clinician 4. CAMHS Crisis Team Lead 5. Clinical and Secure Services team member 6. Clinical Lead (Specialised) 7. Clinical Psychologist 8. Community Outreach Worker 9. Consultant Child Psychiatrist 10. Consultant Clinical Psychologist 11. Delivering Health and Independence representative 12. EDI Project Officer **13. Expert by Experience/Service User representative (×2)** 14. Forensic Psychiatry Speciality Registrar 15. Head of Therapies for Specialised Services/Consultant Clinical Psychologist for Dual Diagnosis 16. Patient Participation Team Member (North Somerset) 17. Psychiatrist (Turning Point) 18. Representative from Barnardo's 19. Specialised Substance-use Service Team member (×3) 20. Trust EDI Lead *Note: When this report was prepared, 23 individuals in 20 roles were confirmed. The project team was reported to comprise 46 team members in total, with several in unconfirmed roles.*
Devon Partnership NHS Trust • 1 team member	• Director of Corporate Affairs (senior sponsor) *Note: At the start of Wave 1, the project team identified 6 project team members. The team was unable to then formalise that membership, due to resourcing constraints.*

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

Project team and number of team members	Team member professions/roles
Herefordshire and Worcestershire Health and Care NHS Trust (H&W) • 18 team members	1. Associate PCN Director of Prevention, Partnership and Transformation (Taurus Healthcare) 2. Associate Public Health Practitioner, Suicide Prevention (Public Head, Worcestershire) 3. Chaplain (Borderlands Rural Chaplaincy) 4. Community Builder, Community Services (Malvern Hills District Council) 5. Community MH Programme Manager (H&W) 6. Development Manager (Mind Herefordshire) 7. Director (Herefordshire Rural Hub) 8. Health and Sustainability Officer, Suicide Prevention (Wyre Forest District Council) 9. Management PA and Project Coordinator (H&W) 10. Managing Director (Herefordshire Rural Hub) 11. NHS Research Support Facilitator (H&W) 12. Operational Manager (Healthwatch Herefordshire) 13. Project Manager (We Are Farming Minds, WAFM) 14. Psychiatrist, Associated Medical Director and Project Lead (H&W) 15. Senior Corporate Performance Analyst (H&W) 16. Social Inclusion/Community Engagement Herefordshire (H&W) 17. *n.s.* (Public Health Herefordshire) 18. *n.s.* (Taurus Healthcare)
Mind in Kingston • 4 team members	1. Director of Services & Development 2. Volunteer Coordinator and Interim Engagement Coordinator 3. **Lived experience advisers (×2)** *Note: Mind in Croydon and Mind in Kingston entered Wave 1 as a joint project team. Mind in Croydon ceased involvement in the AMHE QI Collaborative during Wave 2.*
Mind in Hampshire (Andover, Havant and East Hampshire, Solent) • 10 team members	1. CEOs (×3) 2. Community Development Officer, Council 3. Community Member (Expert by Experience) 4. Director of Business Development and Resources 5. Diversity and Inclusion Outreach Worker 6. Lead for Equality & Diversity (Head of Communications & Community Engagement) 7. Researcher 8. Researcher *Note: This list represents project team members from Wave 1. We were unable to confirm the project team members for Wave 3.*
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. *n.s.*

Project team and number of team members	Team member professions/roles
Mind in Tower Hamlets and Newham (THN) • 11 team members	1. Expert by Experience/Service User Representative 2. Group Co-ordinator 3. Mental Health Services Manager (THN) 4. Operations Director for Mental Health Services 5. Peer Service Coordinator (THN) **6. Peer Support Worker (×2)** 7. Representative from Father 2 Father (Healthy Relationships Support for Families) 8. Representative from You vs You (Young People and Refugees) 9. Trust Chief Executive (interim) 10. Trust Head of EDI *Note: Mind in Tower Hamlets & Newham and Mind in Haringey entered Wave 1 as a joint project team. Mind in Haringey ceased involvement during Wave 2. We were unable to confirm the project team members for Wave 3.*
Norfolk and Suffolk NHS FT • 19 team members (2 confirmed roles)	Confirmed project team roles: 1. Chief Medical Officer 2. Medical Director for Quality *Note: When this report was prepared, the 2 roles above were confirmed. The project team was reported to comprise 19 team members, in unconfirmed roles.*
Northamptonshire NHS FT • 6 team members (0 confirmed roles)	*Note: When this report was prepared, the project team was reported to comprise 6 team members.*
Pennine Care NHS FT • 10 team members	1. Chief Operating Officer 2. Deputy Director of Service Development and Delivery 3. Director of Workforce 4. Executive Director of Nursing, Quality and Healthcare Professionals 5. Head of Patient and Carer Experience and Engagement 6. Interim Medical Director 7. Network Director of Quality 8. Regional Services Lead, Military Veterans Service 9. Senior Improvement Practitioner 10. Service Manager Oldham Mental Health Services
Somerset NHS FT • 9 team members	1. Community Development Project Manager (Open Mental Health), Spark Somerset 2. Co-Production Manager, Rethink 3. Equality, Diversity and Inclusion Lead Officer, Somerset Integrated Care Board 4. Expert by Experience and Peer Support Worker 5. Head of NHS Collaboration, Rethink 6. Health Promotion Manager, Somerset County Council 7. Nurse, Open Mental Health 8. Service Director for Mental Health and Learning Disabilities

Project team and number of team members	Team member professions/roles
	9. Voluntary Sector Development Lead, Spark Somerset
Southern Health and Social Care Trust • 11 team members	1. Admin. Manager within Mental Health & Disability 2. Assistant Director of Disability Services 3. Assistant Director, Mental Health and Disability Inpatients 4. Associate Medical Director & Consultant Psychiatrist 5. Consultant Psychiatrist 6. Director of Nursing 7. Interim Professional Lead Nurse Mental Health 8. Lead Nurse (×2) 9. Nurse Development Lead 10. **Service User Representative/Consultant**

Abbreviations: CAMHS = child and adolescent mental health service; CEO = Chief Executive Officer; EDI = equality, diversity and inclusion; FT = Foundation Trust; H&W = Herefordshire & Worcestershire Health and Care NHS Trust; n.s. = not specified; PA = personal assistant; PCN = Primary Care Network; QI = Quality Improvement; THN = Tower Hamlets and Newham.

2.3. Project subteams

The 12 project teams each formed a subteam for each of their identified population subgroups. We reported on the project subteams and their identified populations in Evaluation Snapshot 2. When Evaluation Snapshot 3 was developed, there were 17 active subteams. Twenty subteams had been discontinued or paused, meaning that teams had narrowed their focus down to one to two population subgroups.

A list of subteams' identified populations is in Table 4. Lived experience has been defined as lived experience roles; however, some project team members may have brought other lived and learned experience to their team.

Table 4: Total number of subteam members and lived experience adviser roles for each of the identified populations

Team Identified population	Total subteam members (n)	Lived experience advisers (n)
Avon and Wiltshire NHS Trust		
Black, Asian and minoritised ethnicity children and young people	8	0
Adults with dual diagnosis	25	2
Devon Partnership NHS Trust		
Black, Asian and minoritised ethnicity adults – Black men	*n.a.*	*n.a.*
Herefordshire and Worcestershire Health and Social Care Trust		
Agricultural and rural communities	18	0
Mind in Hampshire (Andover, Havant and East Hampshire, Solent)		
People seeking asylum in Southampton and South Asian communities in Portsmouth	1	0
Mind in Kingston		
Korean Community in New Malden	2	0
Neurodivergent people	2	2
Mind in North Lincolnshire/Mind in North Staffordshire		
Autistic people	5	0
Norfolk and Suffolk NHS FT		
Black men	*n.a.*	*n.a..*
Refugees and migrants	*n.a.*	*n.a.*
Northamptonshire NHS Foundation Trust		
Refugees, asylum seekers and migrant community	6	0
Pennine Care NHS FT		
Women military veterans	4	0
Bangladeshi and Pakistani men and women in Oldham	2	0
Somerset NHS FT		
GRT community	10	0
Farming/rural communities specifically adults in Sedgemoor and Exmoor	7	1
Southern Health and Social Care Trust		
Adults with a serious mental illness who require an interpreting service	2	0
GRT community in Armagh	9	0

Abbreviations: FT = Foundation Trust; GRT = Gypsy, Roma and Traveller; LGBTQ+ = lesbian, gay, bisexual, transgender and queer plus; n = number of participants; n.a. = not available.

The discontinued or inactive subteams had identified the following populations:

- African and Asian Muslim women
- ×2 black, Asian and minoritised ethnicity men
- ×2 children and young people
- ×4 LGBTQ+ community
- neurodivergent people
- older carers (70+)
- people with learning disabilities
- transgender community
- ×7 not specified.

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 were the most common types of change ideas tested and interventions introduced?

3.1. Identified populations

As outlined above, by February 2024, subteams reported that they were focusing on the following subgroup populations:

- adults with dual diagnosis (mental illness and substance use)
- adults with serious mental illness (SMI) who require an interpreting service
- agricultural/rural communities
- autistic people
- Bangladeshi and Pakistani men and women
- children and young people from minoritised ethnic communities
- Black men
- Gypsy, Roma and Traveller (GRT) community
- neurodivergent people
- people from the Korean community
- people seeking asylum and South Asian communities
- refugees, asylum seekers and forced migrants/migrant communities
- women military veterans.

Because several of the subteams discontinued their work between when Evaluation Snapshot 2 and Snapshot 3 were developed, there are fewer population subgroups for Snapshot 3 than there were for Snapshot 2.

We will aim to explore the reasons for work being discontinued across the AMHE QI Collaborative using qualitative methods. Findings from focus groups (and other qualitative methods, as needed) with members of project teams and QI coaches will be published in due course, in an addendum to the current report.

3.2. Identified inequality issues

Table 5 outlines the inequality issues that were identified for each population by the 12 teams in the AMHE QI Collaborative by the time data was collected for Evaluation Snapshot 3. Several teams, including some that had identified populations to focus on, did not manage to identify an inequality issue during Evaluation Snapshot 3 (these are labelled as 'not specified' [n.s.]).

Populations and inequality issues are discussed further in 3.4. Content analysis of driver diagrams.

Table 5: Population and inequality issues[d] identified by the 12 teams for each of the three populations

Team Identified population	Identified inequality issues
Avon and Wiltshire NHS Trust	
1. CYP from minoritised ethnic communities	Access to CAMHS
3. Adults with dual diagnosis (of substance use and a mental health condition)	Access to mental health services
Devon Partnership NHS Trust	
1. Men (18+) from minoritised ethnic groups	Restraint and the use of the Mental Health Act
Herefordshire and Worcestershire Health and Care NHS Trust	
2. Agricultural/rural communities	Increase awareness of mental illness and access to services
Mind in Kingston	
1. Korean community in New Morden (Kingston)	Improving access to mental health services and reducing mental health stigma
2. Neurodivergent people	Improve access and experience of mental health services
Mind in Hampshire (Andover, Havant and East Hampshire, Solent)	
1. Refugees and asylum seekers (Solent)	*n.s.*
Mind in North Lincolnshire/Mind in North Staffordshire	
1. Autistic people in Staffordshire	Access to services
Mind in Tower Hamlets and Newham	
1. African and Asian women in Tower Hamlets	Access to services

[d] 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
Norfolk and Suffolk NHS Foundation Trust	
1. Black men	*n.s.*
2. People seeking sanctuary (e.g., refugees and forced migrants)	Access to services
Mind in Lincolnshire/Mind in North Staffordshire	
1. People with autism	*n.s.*
Pennine Care NHS FT	
1. Women military veterans	Access to services
2. Bangladeshi and Pakistani men and women in Oldham	Access to services
Southern Health and Social Care Trust	
1. Adults with a serious mental illness who require an interpreting service	Access to services
2. GRT community in Armagh	Increase awareness of mental illness and access to services
Northamptonshire NHS Foundation Trust	
1. Refugees, asylum seekers and migrant community	*n.s.*

Abbreviations: CAMHS = child and adolescent mental health service; CYP = children and young people; FT = Foundation Trust; GRT = Gypsy, Roma and Traveller; n = number of participants; n.s. = not specified.

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. In the tool, 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]

The three-part data review was carried out by teams in the early stages of the AMHE Collaborative and is reported on in detail in Evaluation Snapshot 2.

3.4. Content analysis of driver diagrams

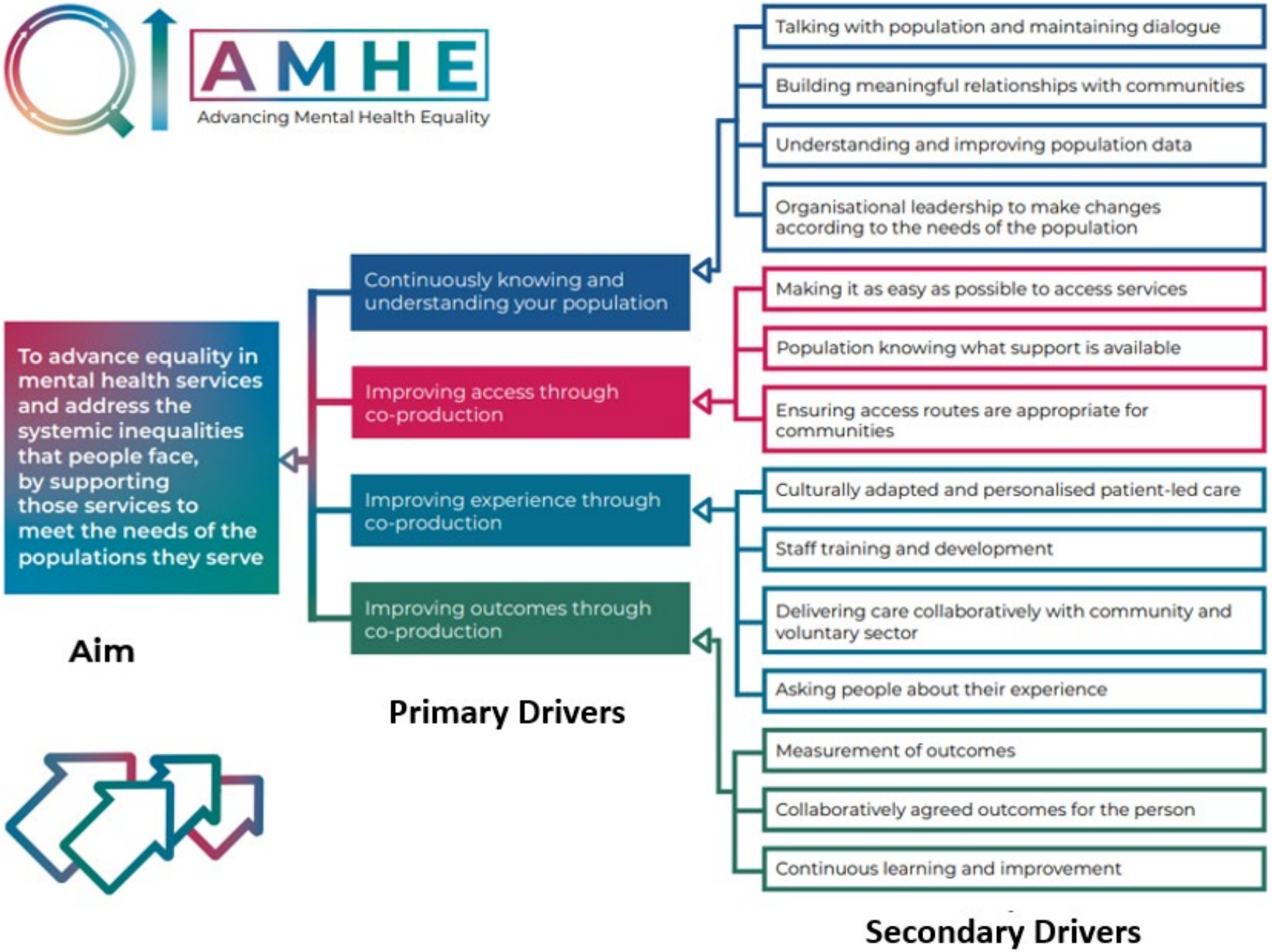
Content analysis of driver diagrams was used to describe the subteams' **aims**, **primary drivers** and **change ideas tested**.

In November 2022 (end of Wave 1), no subteams had developed their driver diagrams. By May 2023 (during Wave 2) eight (61%) subteams had started to develop driver diagrams. By February 2024 (towards the end of Wave 2), nine (69%) subteams had developed 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 broken down in to smaller topics/areas of focus, called **secondary drivers**. Teams 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 into a secondary driver, a corresponding primary driver and the aim, as shown in Figure 1.

Figure 1: AMHE QI Collaborative driver diagram



3.4.2. Coding the driver diagrams for content analysis

Codes[4] were attached to aims, primary drivers and change ideas of driver diagrams using the structure outlined in Table 6.

Table 6: Coding structure content analysis of driver diagrams

Aims (see Table 7)	
Code	**Detail**
Wider population category • Adults • Carers • Children & and young people (up to 25)	The broad group that the driver diagram is focused on.
Population characteristics (see Table 8)	Used to further specify and code the driver diagram's population in terms of characteristics identified (e.g., if the focus is on people of a particular age, belonging to a specific community or people with specific diagnoses, etc.). Some driver diagrams may cover an intersectional population, where multiple codes are applied (e.g., an aim focused on men of mixed ethnicity under 25 years of age might be coded with population characteristics of age, ethnicity and gender).
Inequality issue	The category of the inequality issue (e.g., related to access, uptake, experience, awareness or outcomes).
Primary drivers	
Deductive codes	**Detail**
Continuously knowing your population	Keeping up to date with the local population served, including an understanding of unmet need, community assets and population demographics.
Improving access	Supporting people to access mental health care services with ease and in a timely manner.
Improving experience	Supporting people to have the best possible experience of mental health support, care and treatment.
Improving outcomes	Supporting people to achieve the best outcomes of care possible, to maximise quality of life, aid recovery and meet individual goals.

[4] Codes were pulled using a hybrid of deductive and inductive approaches. This allowed for the categorisation of codes to reflect the contents of the driver diagrams developed

Inductive codes	
• Celebrating or championing diversity • Co-production • Improving capacity or resource • Improving collaboration and connections with patients and carers • Improving collaborative working and communication between services • Improving community connections • Improving data collection or maintenance • Improving service systems and infrastructure • Improving treatment or support • Psychoeducation • Staff competence and training • Staff wellbeing • Supporting patient wellbeing • Trauma-informed care	
Change ideas tested	
Type of intervention or strategy	For example, may include cultural adaptation to intervention, change in form of intervention, new process or policy, new intervention etc. (see Table 8).
Level	The level at which the change idea is applied for example: organisational/wider service level, specific team level, treatment delivery level, content level etc. (see Table 9).
Number of change ideas tested	The number of change ideas that have been or are being tested in the service.

The code types correspond to the AMHE QI Collaborative driver diagram (Figure1), which teams used as a template for their own driver diagrams. Codes were used to categorise and quantify:

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

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

3.4.3. Results of the content analysis

The content of driver diagrams was analysed, focusing on aims (including population characteristics and inequality issues identified) and change ideas. You can find further discussion of the results, and tables presenting the information, further on. Those tables present:

- each project team's aims (Table 7)
- the number of project teams and which characteristics they focused on (Table 8)
- the change idea codes for 'type' (Table 9) (includes examples from driver diagrams)
- the change idea codes for 'level' (Table 10) (includes examples from driver diagrams)
- which change ideas were tested by which teams (Table 11).

Thirteen driver diagrams were completed by nine (69%) teams (Table 11). While all the driver diagrams included change ideas, only three (33%) teams had begun testing change ideas at the time data was collected for this snapshot report.

Driver diagram aims

Table 7: AMHE QI Collaborative project teams and driver diagram aims

Team	Aim
Avon & Wiltshire NHS Trust	'No wrong door': By end of 2024, we will offer people with co-occurring mental health and substance misuse issues joined-up experience between mental health services and drug and alcohol services, delivered by staff who are confident and skilled to support people with co-occurring mental health and substance misuse issues, using co-production throughout
Herefordshire & Worcestershire Health and care NHS Trust	Increase awareness and understanding of mental health and mental illness, and improve access to support, in the local farming and agricultural communities
Mind in Kingston	Improve the access and experience of mental health support services for people who are neurodivergent
Mind in THNR	To increase the diversity of ethnic groups of women accessing Sakinah
Norfolk and Suffolk NHS FT	100% of available clinic appointments are utilised
Pennine Care NHS Trust	We will increase the number of people of South Asian heritage engaging with mental health services in Oldham by March 2024
Pennine Care NHS Trust	We will increase referrals of women into veterans services from 5% to 11% and increase the number of women veterans who remain engaged with mental health services by March 2024
Solent Mind Portsmouth	To improve support to South Asian communities in Portsmouth through improved partnership-working with community groups. Long-term goal: Improve access to Solent Mind services

Team	Aim
Solent Mind Southampton	Improve access to wellbeing support offer for refugees and people seeking asylum that are residing in bridging hotels in Southampton
Somerset NHS FT	Increase access to services for GRT communities
Somerset NHS FT	Increase access to the support offer (Open Mental Health) and reduce isolation in rural communities
Southern Health & Social Care Trust	By June 2024, all patients admitted to the Bluestone Inpatient Unit who require an interpreting service, will be able to self-refer to Interpreting Services NI and have full access to this during their admission and post-discharge
Southern Health and Social Care Trust	Improve mental health awareness/understanding among 14–18-year-olds in Armagh Roma community to improve access and uptake to MH services

Abbreviations: FT = Foundation Trust; GRT = Gypsy, Romany and Traveller; MH = mental health; NI = Northern Ireland; THNR = Tower Hamlets & Newham.

Population characteristics

Most (12 out of 13 [92%]) driver diagram aims focused on adult populations, one (8%) focused on children, adolescents or young people and none focused on carers. Table 8 and present population characteristics from driver diagram aims in table and bar chart forms.

Table 8: Population characteristics identified in driver diagram aims

Wider population category	
Adults	
Children, young people or adolescents	1 (8%)
Population characteristics	**Number of driver diagram aims**
People of a specific age or age range	1
People with dual diagnosis (comorbid mental health condition and substance use)	1
People belonging to a specific ethnicity or ethnic group	3
People in farming and/or rural community	2
People of a specific gender	2
People belonging to the GRT community	2
People who are neurodivergent	1
People who do not speak English or for whom English is not their native language	1
People who are refugees, asylum seekers or migrants	2
People who are veterans	1

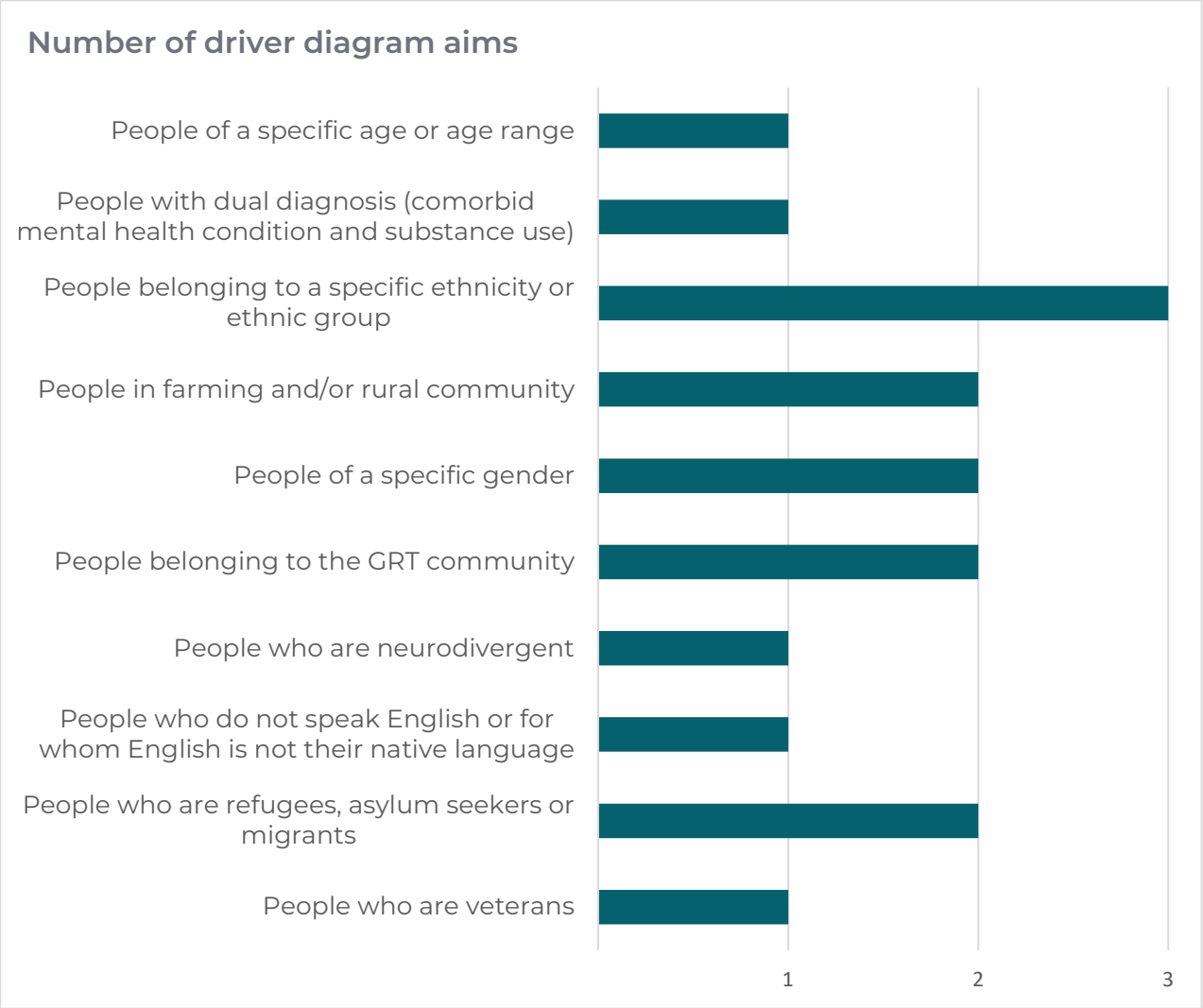


Figure 2: Population characteristics identified in driver diagram aims

Inequality issues

Inequality issues referenced in driver diagram aims were coded using the following categories:

- access
- awareness
- experience
- outcomes
- retention/engagement.

Access was the main area that teams focused on, with all 13 driver diagram aims including a focus on access to some degree. Two driver diagram aims also included focus on improving awareness. Only one focused on retention/engagement in addition to access, another one focused additionally on experience and another one on outcomes.

While retention/engagement, awareness, experience and outcomes were coded as additional issues identified, all can be interpreted in relation to access. From a temporal perspective, access can be viewed as a process, not an event. For example:

- Awareness: important **prior** to access
- Experience: important **during** access
- Retention: important **during** access
- Engagement: important **during** access
- Outcomes: important **during/after** access.

Interpreting inequalities issues in relation to access is shown as a graphic in Figure 3).

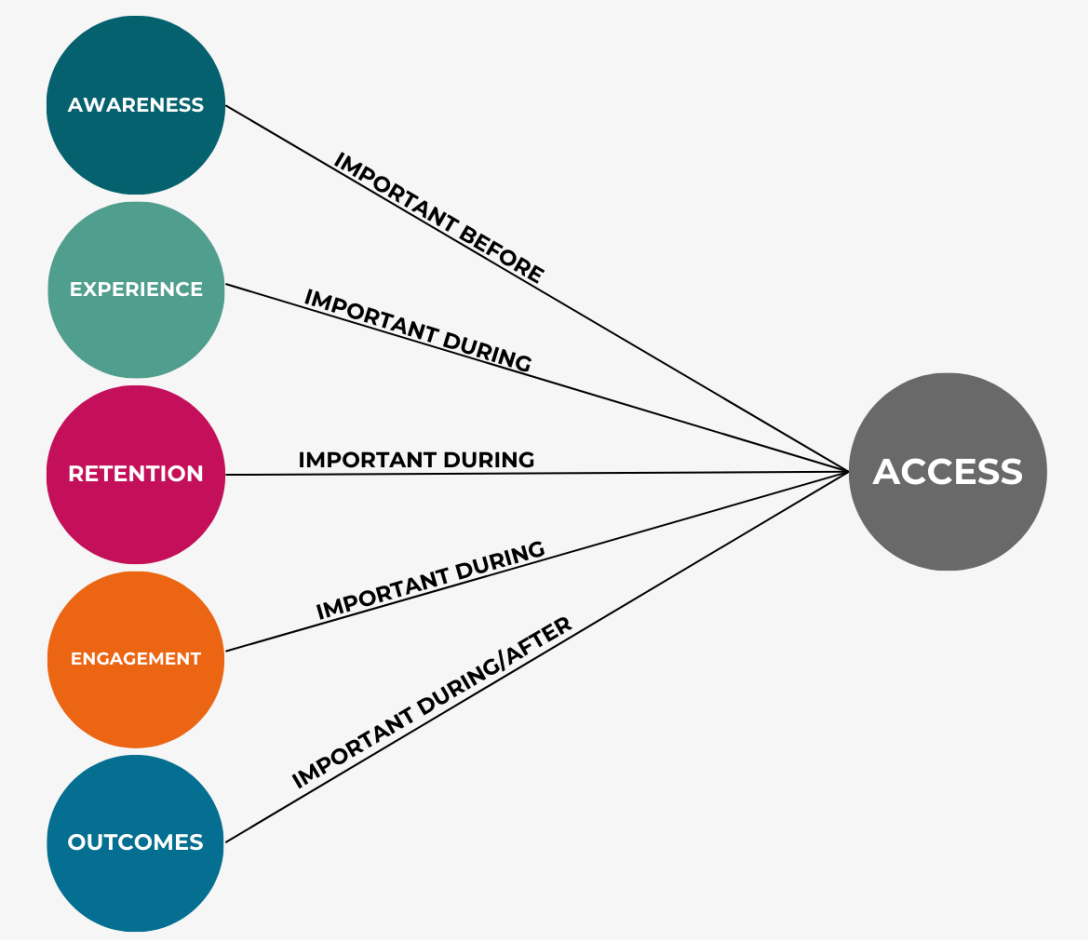


Figure 3: How access underpins other inequality issues experienced

Change ideas

Change ideas developed

Teams developed multiple change ideas per driver diagram, and it was not uncommon for each driver diagram to contain up to 20 change ideas. Change ideas were coded according to the 'type' of intervention or strategy outlined and by the 'level' at which they would be implemented (Table 9 and Table 10).

Table 9: Codes for 'type' of intervention or strategy of change ideas developed (driver diagrams n=13)

Change ideas Type of intervention or strategy codes	Driver diagrams No. including this type of change idea	Examples from driver diagrams	Sources of examples
Accessibility	8	*'Offer check-ups (e.g., blood pressure, cholesterol, weight and general wellbeing) alongside mental health wellbeing checks at various locations (e.g., livestock markets, agricultural events/shows and community halls)'*	Herefordshire and Worcestershire Health and Care NHS Trust
		'Ensure all Solent Mind services have access to translation services'	Solent Mind Southampton
Addressing needs and engagement	5	*'Speak to community about what skill-building activities they want'*	Solent Mind Southampton
		'Engage Open Mental Health to ensure the service meets the needs of the community'	Somerset NHS Foundation Trust
Change in format or location of care	3	*'Identify and approach community spaces that are culturally appropriate and to run gender specific groups/sessions'*	Solent Mind Portsmouth
		'A dedicated space for women (and their children)'	Solent Mind Southampton
Collaboration with communities and partners	8	*'Joint engagement and relationship building events between statutory and non-statutory providers'*	Herefordshire and Worcestershire Health and Care NHS Trust
		'Co-producing with community spaces supporting specific communities (faith leaders in each borough, Somali Community in Tower Hamlets partnership work, Heal Together, Somali Community in Newham)'	Mind in Tower Hamlets and Newham
Collaborative working between staff or teams (including new methods of working)	3	*'Shared calendar across organisation for outreach events'*	Solent Mind Southampton
		'Create regular space for outreach workers to share information/plans'	Solent Mind Portsmouth

Change ideas Type of intervention or strategy codes	Driver diagrams No. including this type of change idea	Examples from driver diagrams	Sources of examples
Communication with patients, families and carers	6	*'Increase involvement of carers in assessment and correspondence'*	Avon and Wiltshire NHS Trust
		'Clear messaging and communication on interpreting service for patients'	Southern Health and Social Care Trust
Community training initiative	4	*'Develop a group of people from within farming and agricultural community who have had personal experience of using mental health services or are caring for someone who uses these services. These people would be trained to work closely with and be supported by services such as the NHS, voluntary and community services (e.g., Mind, WAFM, Yellow Wellies) to be a link between them'*	Herefordshire and Worcestershire Health and Care NHS Trust
		'Promote/support community members to become Open Mental Health champions'	Somerset NHS Foundation Trust
Cultural adaptation or modification	2	*'Translating Sakinah [Project] materials'*	Mind in Tower Hamlets and Newham
		'Ensure all Solent Mind services have access to translation services'	Solent Mind Southampton
Data collection processes	2	*'Review and update template for recording community feedback from outreach activities (update process entirely when new CRM system is in place)'*	Solent Mind Portsmouth
		'Capturing data from secondary school numbers accessing counselling service'	Southern Health and Social Care Trust
Funding plans	2	*'Allocate budget within individual services for outreach and EDI activities (e.g., to develop new outreach locations, attend events, carry out community research)'*	Solent Mind Southampton
		'Influence funding and create awareness of the resource that is available'	Southern Health and Social Care Trust

Change ideas **Type of intervention or strategy codes**	**Driver diagrams** **No. including this type of change idea**	**Examples from driver diagrams**	**Sources of examples**
Mental health literacy and awareness	4	*'Mental Health week with Dahabshill webinar'*	Mind in Tower Hamlets and Newham
		'Develop and deliver programme for mental health education talks'	Solent Mind Portsmouth
New group or event	1	*'Facilitate peer support groups'*	Solent Mind Southampton
New or pilot intervention	4	*'Co-produced MOAT (Moving on After Trauma) groups in more areas – pilot in a MINT team'*	Avon and Wiltshire NHS Trust
		'Counsellors and therapists to offer therapeutic alternatives to CBT'	Mind in Kingston
New service initiative	8	*'Set up a Neurodiverse peer support service'*	Mind in Kingston
		'Team up with GP and nursing outreach team. *Test a Hub approach similar to homeless Hub'*	Somerset NHS Foundation Trust
Patient feedback	4	*'Realtime feedback from patient after sessions with interpreters'*	Southern Health and Social Care Trust
		'Introduce monthly feedback review of community insights'	Solent Mind Portsmouth
Patient record keeping processes	2	*'Up-to-date record-keeping of existing initiatives (to avoid duplication)'*	Solent Mind Portsmouth
		'Specific services forms capturing ethnicity'	Southern Health and Social Care Trust
Person-centred care	5	*'Make reasonable adjustments on a case-by-case basis'*	Mind in Kingston
		'Promote patient choice: during admission process offer patient choice'	Southern Health and Social Care Trust

Change ideas Type of intervention or strategy codes	Driver diagrams No. including this type of change idea	Examples from driver diagrams	Sources of examples
Promotion of events and awareness for staff	1	*'Newsletter to share information about outreach events/ EDI activities'*	Solent Mind Portsmouth
Promotion of lived experience knowledge	5	*'Share the stories of people with lived experience'*	Mind in Kingston
		'Poster to seek volunteers within the community to share their skills with others'	Solent Mind Southampton
Promotion or advertisement of services for patients and communities	10	*'Simple flyer with information such as: DDA (Dual Diagnosis Anonymous), AA (Alcoholic Anonymous), SMART (Self-management and Recovery Training) meetings etc., with weblinks, local meetings, brief description of 12-step versus self-empowerment/CBT approach, AWP helpline. Flyers to be specific to each locality'*	Avon and Wiltshire NHS Trust
		'Produce an easy-to-read list of contact details and access information for mental health services, with clear and brief outlines/description of what to expect from the point of contact onwards'	Herefordshire and Worcestershire Health and Care NHS Trust
Recruitment	4'	*'Recruit volunteers from the community to support delivery of change ideas'*	Solent Mind Portsmouth
		'Recruit peer workers who are Kurdish or Nigerian'	Mind in Tower Hamlets and Newham
Service mapping	1	*'Map/directory of support services for staff to know what exists'*	Avon and Wiltshire NHS Trust
Signposting	5	*'Solent Mind signposting to education and training opportunities'*	Solent Mind Southampton
		'Direct people to https://www.dualdiagnosis.org.uk/ to avoid needing to update any directory'	Avon and Wiltshire NHS Trust

Change ideas **Type of intervention or strategy codes**	**Driver diagrams** **No. including this type of change idea**	**Examples from driver diagrams**	**Sources of examples**
Staff support	4	*'Supervision forum for counsellors and volunteers working with community'*	Herefordshire and Worcestershire Health and Care NHS Trust
		'Create a formalised network (e.g., professional peer support, learning)'	Avon and Wiltshire NHS Trust
Staff training initiatives	6	*'Staff training – cultural awareness'*	Solent Mind Portsmouth
		'Reciprocal training in COMHAD (co-occurring mental health problems and drug and alcohol use) including staff attitudes. Not just on Learn'	Avon and Wiltshire NHS Trust
Understanding the population	5	*'Continue to attend and build relationships at community groups (e.g., Chat over Chai, cross-cultural women's group and Bangladeshi welfare association, etc.)'*	Solent Mind Portsmouth
		'Hold focus group with community members to review information about Open Mental Health, if they'd like to test a hub approach; identify needs'	Somerset NHS Foundation Trust

Note: Change ideas could be coded with more than one type of intervention or strategy code.

Abbreviations: AWP = Avon and Wiltshire Mental Health Partnership; CBT = cognitive behavioural therapy; CRM = Customer Relationship Management; MINT = mental health integrated network teams; WAFM = We Are Farming Minds.

Table 10: Codes for 'level' of change ideas developed

Level code	Description	Examples from driver diagrams
Treatment content	A change to the content of a treatment or intervention to improve its reception or suitability for the population of interest.	*'Providing translated Sakinah [Project] materials'* *'Develop easy read information about the current offer'*
Treatment delivery	A change to how treatment or intervention is delivered by staff or providers. Includes delivery of any new treatments or interventions.	*'Provide mental health training to anyone who is in regular contact with the farming and agricultural community'* *'Facilitating face-to-face interpreting services'* *'Identify and approach community spaces that are culturally appropriate and to run gender specific groups/sessions'*
Service	A change to the service itself, including small service changes, service re-design or providing a new service.	*'Develop and deliver programme for mental health education talks'* *'Take learning from focus groups, research, data and engagement to co-produce a women-specific pathway with project team and other external stakeholders.'*
Wider organisational	Changes made at the wider organisation level, beyond individual service changes, that impact care delivery on an organisational (e.g., trust) level.	*'EDI champions across the organisation'* *'Shared calendar across organisation for outreach events'*

Change ideas tested as reported by teams (by February 2024)

While all driver diagrams contained multiple change ideas developed, only three included change ideas tested at the time of data collection (shown in bold in Table 11).

Table 11: Change ideas tested by teams

No.	Team	Population	No. of change ideas tested	Change ideas tested	Outcomes/measures used to test change idea
1.	Avon & Wiltshire NHS Trust	People with dual diagnosis	None reported	*n.a.*	*n.a.*
2.	Herefordshire & Worcestershire Health and care NHS Trust	Agricultural, farming, rural communities	None reported	*n.a.*	*n.a.*
3.	Mind in Kingston	Neurodivergent people	None reported	*n.a.*	*n.a.*
4.	**Mind in THNR**	**Diverse Muslim women**	**4**	**1. Explore people or organisations doing similar work already by connecting with Faith Leaders in each borough** **2. Explore people or organisations doing similar work already via Mental health week with Dahabshill webinar (May 2024)** **3. Advertise to audiences via Tower Hamlets fair (July 2024)** **4. Celebrate diversity of Sakinah Our Voices Participants via Meet My Country event**	**No usable measure of change ideas was provided by the team**
5.	Norfolk and Suffolk NHS FT	People seeking sanctuary	None reported	*n.a.*	*n.a.*
6.	Pennine Care NHS Trust	Bangladeshi and Pakistani communities in Oldham	None reported	*n.a.*	*n.a.*

No.	Team	Population	No. of change ideas tested	Change ideas tested	Outcomes/measures used to test change idea
7.	Pennine Care NHS Trust	Women veterans	None reported	*n.a.*	*n.a.*
8.	Solent Mind Portsmouth	South Asian Population	None reported	*n.a.*	*n.a.*
9.	Solent Mind Southampton	People seeking asylum	None reported	*n.a.*	*n.a.*
10.	**Somerset NHS FT**	**GRT communities**	**3**	**1. Meet the community in their environment via someone from Open Mental Health to join council's market stall at Bridgewater Fair (Sept 2023)** **2. Understand community needs via regular visits to Pines (traveller site) to walk to community members about needs and challenges** **3. Outreach approach – [team member] testing an assertive outreach approach with one patient and dual diagnosis key worker involvement**	**No measurement was reported by the project team for any of the change ideas tested**
11.	**Somerset NHS FT**	**Rural communities**	**6**	**1. Engage with local communities via feedback collected by [team member], views from community partners** **2. Help local communities to set up initiatives to support wellbeing and reduce isolation by holding weekly coffee mornings – use learning to apply approach more widely. A second coffee morning has been set up** **3. Distribute Open Mental Health flyers to 65 dairy farms***	**2. Attendees to coffee mornings: n = 10–15.**

No.	Team	Population	No. of change ideas tested	Change ideas tested	Outcomes/measures used to test change idea
				4. Help organise MHFA training and Orange Badge scheme (suicide prevention) to young farmers)* ** Change ideas 3 and 4 were added retrospectively by the QI coach on 3 May 2024.*	**4. Young farmers who have completed MHFA training: n = 10**
5.	Southern Health & Social Care Trust	Adults with SMI who require interpreting service	None reported	*n.a.*	*n.a.*
6.	Southern Health & Social Care Trust	14–18 year olds from the Armagh Roma Bulgarian community	None reported	*n.a.*	*n.a.*

Abbreviations: FT = Foundation Trust; MHFA = Mental Health First Aid; n.a. = not applicable; SMI = serious mental illness.

Narrative summary of change ideas tested

There were 11 change ideas tested across the three teams who reported that they had started this process (see Table 11, above).

Several of the change ideas that were tested explored collaboration with community groups and partners. From this, it was clear that teams recognised the value and importance of engaging with communities when looking at advancing equality and improving care for the population of interest. In a similar way, community outreach approaches were commonly tested, focusing on services meeting with communities in their own environments and attending community-organised events to spread awareness and understand more about local population needs. Advertisement and promotion of available services was also a part community outreach, with teams recognising the importance of improving awareness of the available support through signposting and advertising. Community training initiatives were also trialled.

Teams experienced challenges when it came to measuring the impact of change ideas[f]. Measurement of the impact of change ideas was provided by one of the three teams who tested change ideas. However, a baseline comparison was not provided to enable us to measure impact of the change ideas. We were therefore unable to assess the impact or results of the implementation of change ideas for teams who tested them.

[f] We aim to explore challenges project team members using qualitative methods.

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?

4.1. The Normalisation Measure Development (NoMAD) questionnaire

The NoMAD[3] is a validated research questionnaire based on the Normalisation Process Theory (NPT). 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 how they 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).

The questionnaire was sent to all overarching and subteam members. Nine responses were received. Respondents self-reported their roles as:

- community leader representing service users
- QI adviser
- director of services
- organisational representative
- project team member
- VCSE team member
- project lead
- operations director
- staff member.

In the next sections, the responses are described and are grouped according to the four parts of the NPT 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 2).

Figure 4 shows that 72% of respondents either agreed or strongly agreed with the statements about coherence.

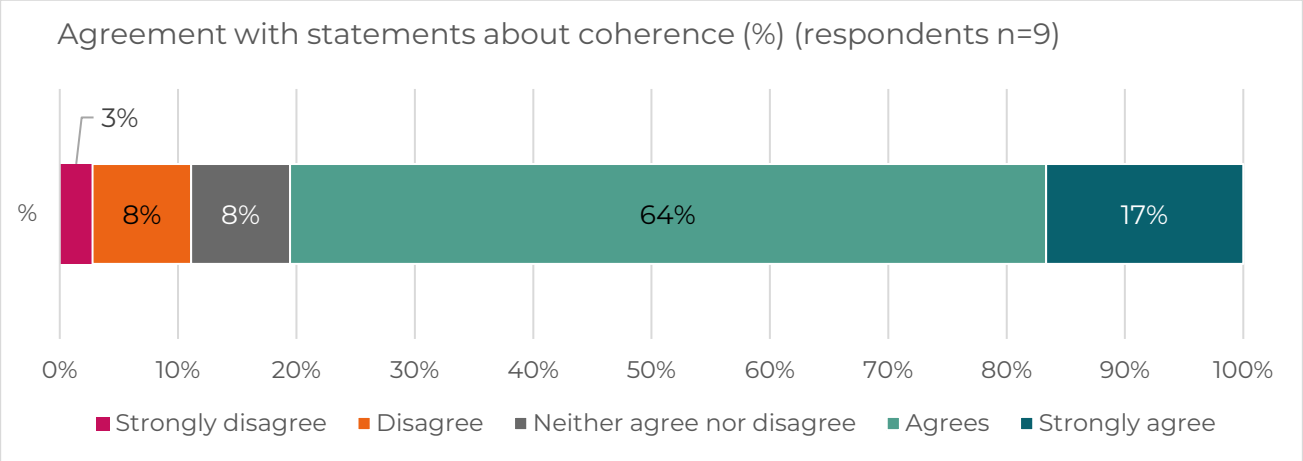


Figure 4: Total percentages of the responses received for questions about coherence

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 Collaborative forward and promote teamwork (statements 5–8 in Appendix 2).

Figure 5 shows that 97% of respondents either agreed or strongly agreed with the statements about cognitive participation.

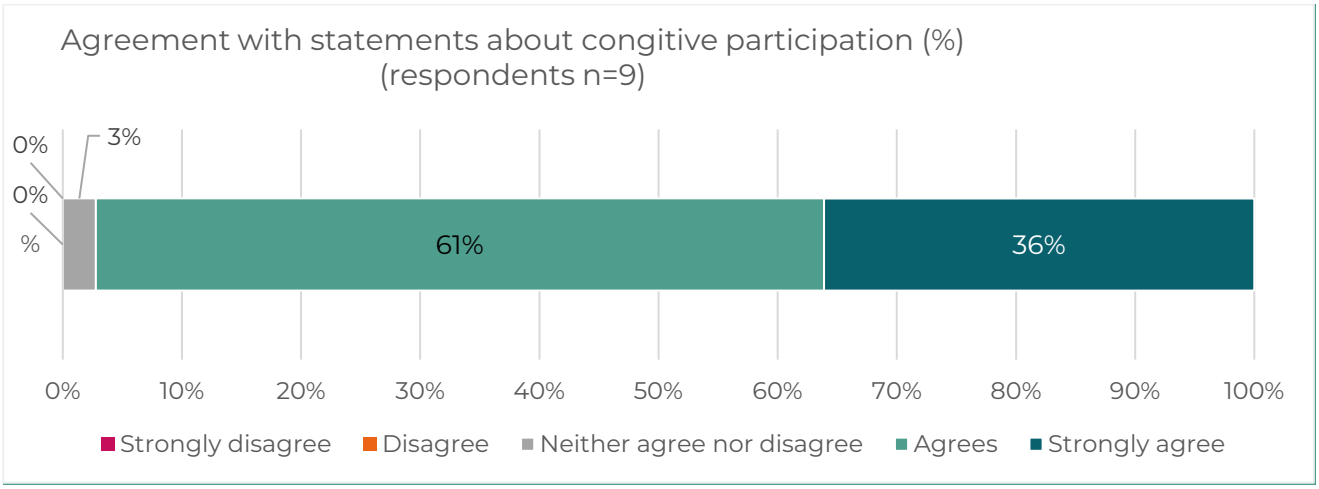


Figure 5: Total percentages of the responses received for cognitive participation

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 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 in Appendix 2).

Figure 6 shows that 75% of the respondents either agreed or strongly agreed when responding to the statements about collective action.

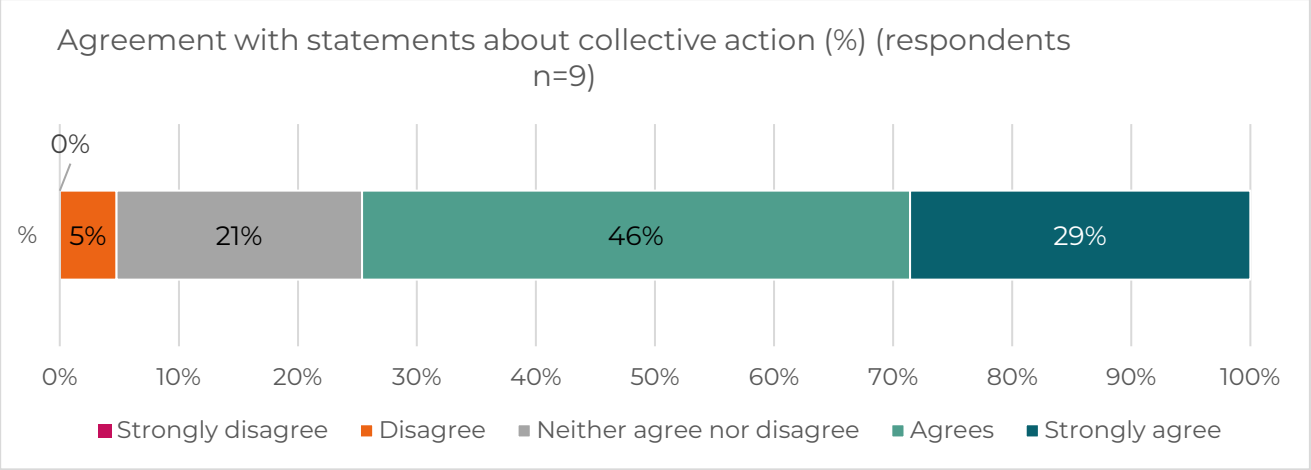


Figure 6: Total percentages of the responses received for collective action

4.1.4. Reflexive monitoring

Reflexive monitoring 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 in Appendix 2).

Figure 7 shows that 80% of the respondents either agreed or strongly agreed with the statements about reflexive monitoring.

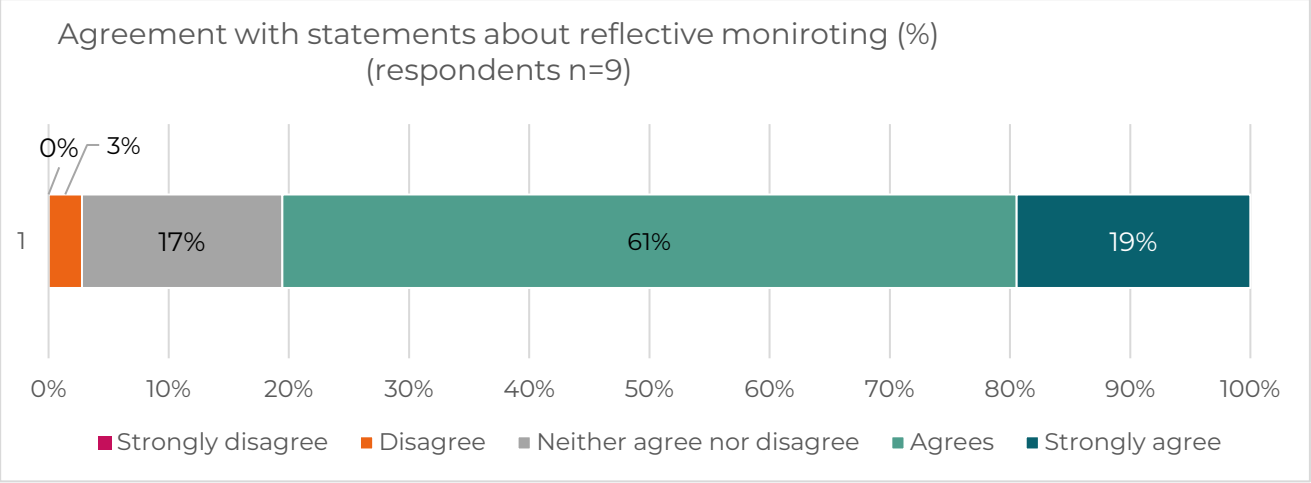


Figure 7: Total percentages of the responses received for reflexive monitoring

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 contained 16 questions (see Appendix 3) that covered 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.

The survey was sent to all overarching and subteam members, and ten responses were received. Of these, respondents reported their roles as:

- four project team leads
- three subteam staff members
- one:
    - lived experience adviser
    - QI adviser
    - charity worker (self-reported).

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

> *'Linking staff and service users across different organisations together, shared learning and decision-making, and co-production e.g. designing surveys and the QI project itself. Trying to improve and evaluate service user, carer and staff experience. Having a QI coach from the [RCPsych] is helpful in encouraging busy staff to give their time.'*
>
> – Project team lead on the benefits of the AMHE model

Ten (100%) respondents said they saw benefits of the AMHE QI Collaborative model, including:

- raising awareness about barriers to mental health services
- achieving goals/outcomes, change, delivery and learning
- working with a team with similar values and direction
- working with multidisciplinary teams
- working across organisations, co-production, shared learning and decision-making
- improving and evaluating service user, staff and carer experiences
- having structure and guidance, encouraging teams to dedicate time to QI, keeping momentum going

- understanding their own services better
- the grassroots community/client-centred approach that can be applied to other parts of their work.

AMHE QI Collaborative model challenges

> *'Having enough time to action all that we would like to action, having enough group members across all organisations represented at each meeting.'*
>
> – Project team lead on the challenges of the AMHE model

Challenges raised by survey respondents included:

- attending collaborative events in London
- change of QI coaches
- collaboration, consultation and ongoing review altogether can be being overwhelming.
- financial/resourcing constraints.
- having enough team members
- lack of awareness in their wider team
- making progress without drastically reinventing standard procedures.
- time commitments
- understanding and reconciling different and shared perspectives.

Benefits of working with the QI coaches

> *'Personal support and mentor-type feedback, and safe space to share, also networking opportunities allowing sharing and learning of best practice.'*
>
> – Project team lead, on the benefits of working with QI coaches

Nine (90%) respondents to the survey reported benefits of working with the QI coaches, including:

- commitment to tackling inequalities
- expertise and adhering to QI models
- independent oversight
- maintaining motivation and focus
- networking and learning opportunities
- providing mentorship, guidance and support
- time management.

Challenges when working with the QI coaches

> *'Availability and time pressures, both ways'.*
>
> – Project team lead on challenges of working with QI coaches

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

- adapting to QI model when using it for the first time
- attending in-person events
- change of coach working with a team
- finding meeting times
- reaching consensus in discussions.

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 QI Collaborative.

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

> *'Meeting new people with shared views and being able to make others aware of the work we do.'*
>
> – Project team member with lived experience on the benefits of working alongside other organisations

Ten (100%) respondents mentioned benefits of working alongside other organisations and services, including:

- ensuring that the needs of the community are considered
- finding it helpful to work with organisations with similar initiatives and challenges
- having a shared vision with different delivery styles.
- hearing multiple perspectives or voices
- inspiring innovation
- learning and sharing best practice, expertise, resources and research
- networking.

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

> *'Ensuring clarity of focus as well as honest conversations about services limitations.'*
>
> – Project subteam staff member on challenges of working alongside other organisations

Seven of the ten (70%) responses reported the following challenges when working alongside other organisations and services:

- communication
- differences between the needs of specific people using services and people from the wider community
- ensuring clarity of focus
- lack of diversity in some organisations
- reconciling differences of ethos
- time constraints
- transparency around service limitations
- travel logistics
- working with organisations with more resources and/or capacity that had high expectations of smaller teams, which was experienced as demoralising.

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

> *'Supporting group endeavours and increasing communication with other members.'*
>
> – Project subteam staff member on challenges of working alongside other organisations

All ten (100%) teams reported that their teams had engaged with establishing the QI approach in their organisations or services, namely that:

- they were already implementing a similar approach
- they had past awareness or experience of QI
- there was organisational support for initiatives and encouraging communication/reaching out
- they were building on research recommendations
- there were challenges in inter-organisational governance, staff changes and/or capacity, and a lack of understanding of QI.

Using new approaches

> *'Supporting group endeavours and increasing communication with other members.'*
>
> – Project subteam staff member on challenges of working alongside other organisations

Nine out of ten (90%) respondents indicated their teams had used new approaches, including:

- attending meetings, events and, networking groups
- co-production
- engaging in person or digitally with multiple organisations, to develop a sustainable network
- increasing visibility/access.
- internal patient experience team and processes
- new relationships to increase reach
- new staff training programs
- online peer support
- platforms
- survey to collect views and feedback from people using services and staff
- using pronouns in emails.

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

> *'We have engaged with patients and community groups to identify issues and create solutions.'*
>
> – Project QI advisor on steps taken towards co-production

Nine out of ten (90%) respondents mentioned that they have taken steps towards co-production, including:

- attending events/support spaces for chosen population
- engaging with service-user networks, patients and community groups to identify issues and find solutions
- engaging with VSCEs

- focus groups, outreach events, questionnaires, interviews and meetings with people using services and communities
- having a lead who specialising in service user and carer involvement/co-production
- having team members who use are services users and/or have lived experience
- teaching other services within the organisation how to utilise co-production skills and resources.

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 projects .

4.3.1. Areas assessed by the MUSIQ tool

The MUSIQ tool includes questions to assess six contextual aspects 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 National Collaborating Centre for Mental Health (NCCMH) research team for 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 were defined as follows.

1. The QI team

That 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 MUSIQ tool are about decision-making processes and teamwork.

2. The microsystem

That is, 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

That 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

That is, the organisation or service taking part in the AMHE QI Collaborative.
The questions are about:

- education and training opportunities on methods that support QI
- how far the QI work has been embedded in the organisation
- how much the QI project aligns with the organisation's key strategic goals
- staff recognition of QI
- the involvement of and support from senior executives in QI activities
- the value that the organisation places on QI.

5. The environment

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

6. Other

The tool assesses if there was any particular event that prompted the launch of the team's QI project. One question was included for this purpose.

4.3.2. Responses to the questions

Each of the six contextual factors described in 4.3.1. Areas assessed by the MUSIQ tool contains questions that are responded to using a Likert scale from one to seven.
One indicates 'Totally disagree', and seven indicates 'Totally agree'. There is also a 'Don't know' or 'Not applicable' response option, indicated with a zero. All 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 February 2024, three out of 12 teams had completed the MUSIQ tool. All three completed the tool at the overarching team level as opposed to subteam level. Members of the teams completed the tool with their QI coaches. Of the three completed tools, one team scored in the 80–119 range (indicating that the project has the potential to be successful, but the team could encounter some contextual barriers). Two teams scored in the 120–168 range (indicating that the projects have a reasonable chance of success) (Table 12).

Table 12: Completed MUSIQ tool scores by project team

Team	Date completed	Total score
Avon and Wiltshire Partnership	Jan 2024	93.17
Somerset NHS FT	Jul 2023	123.83
Southern Health and Social Care Trust	Dec 2023	135.75

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
MHFA	Mental Health First Aid
MUSIQ	Model for Understanding Success in Quality
NCCMH	National Collaborating Centre for Mental Health
n.a.	not applicable
n.s.	not specified
NoMAD	Normalisation Measure Development
NPT	Normalisation Process Theory
QI	Quality Improvement
SMI	serious mental illness
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
What experiences are this population having?	Data review
	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)

_____