AMHE
Advancing Mental Health Equality

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Advancing Mental Health Equality Quality Improvement Collaborative

Evaluation Snapshot 3 Addendum: Qualitative analysis of a focus group with Quality Improvement coaches

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Contents

1. Purpose of this document

This report offers the detailed analysis of the findings from a focus group that was held with quality improvement (QI) coaches at the end of Wave 2 of the Advancing Mental Health Equality (AMHE; now called Advancing Mental Health Equity) QI Collaborative.

This report is an addendum to AMHE Evaluation Snaphsot Report 3, so we recommend that the two reports are read together. This report shares the perspectives of QI coaches who worked on the AMHE QI Collaborative across Waves 1 and 2, and it supplements the main evaluation report.

Readers working on similar QI or co-production initiatives that focus on addressing inequities in mental healthcare (stakeholders) may find helpful learning in the successes, challenges and learning outcomes described in this report. To aid this, a series of reflective questions are provided in the appendices to this report to support any evaluations that stakeholders wish to apply to their own work. We have included reflective questions aimed at:

- QI coaches (Appendix 1)
- project team members (Appendix 2)
- people with lived experience (Appendix 3).

2. Overview and objectives

To evaluate the implementation, impact and success of the AMHE QI Collaborative, a focus group was held with QI coaches. The focus group was used to gather information that supplements the quantitative data collected several times over the duration of the AMHE QI Collaborative, between December 2022 and February 2024 (summarised in three evaluation snapshot reports).

This report is an addendum to Evaluation Snapshot Report 3. It outlines the results of a thematic analysis[a] of the focus group, which explored the perspectives of coaches who worked with project teams during Waves 1 and 2 of the AMHE QI Collaborative. The AMHE QI Collaborative was made of up a core team of NCCMH QI coaches, each of whom worked with a number of different mental health trusts and services that formed a 'project team'.

More information on the structure of the AMHE QI collaborative is available in the evaluation snapshot reports, which can be found on the AMHE evaluation web page.

Focus groups aimed to address the following questions:

1. What were the main successes achieved by teams and what factors contributed to the successes achieved?
2. What were the main challenges experienced and what steps were taken (or could have been taken) to overcome these challenges?
3. What steps were taken towards co-production?
4. What could be done to improve the Collaborative?

a Thematic analysis is a method used in qualitative research to identify, analyse and report patterns (themes) within data. It's often used to analyse focus group transcript data, to identify meaningful patterns of information that researchers can use to inform their understanding of a concept, or to answer one or more research questions.

3. Methods

3.1. Participants

NCCMH QI coaches who had worked in a coaching capacity with a project team as part of the AMHE QI Collaborative during Waves 1 or 2 were invited to take part. Coaches were invited using internal channels, through discussions in team meetings and MS Teams messaging. A Participant Information Sheet (Appendix 4) was provided to focus group participants, containing information about the focus group and its process. Participants signed a consent form to agree to take part (Appendix 5).

3.2. Setting

The focus group was conducted in an online video call, using Microsoft Teams from the Royal College of Psychiatrists.

3.3. Data collection

The focus group topic guides (Appendix 1, Appendix 2 and Appendix 3) were co-produced with two lived experience advisers to the NCCMH. Discussions were facilitated by a member of the NCCMH research team and one of the lived experience advisers. The focus group was recorded and transcribed using Microsoft Teams' recording and automatic transcription feature. Transcripts were anonymised by researchers after the recording and formed the data for the thematic analysis.

Transcripts and recordings were stored according to the RCPsych data protection policy and GDPR principles. Only NCCMH staff and the two lived experience advisers were able to access to the files.

3.4. Analysis

Thematic analysis was applied to identify themes from the transcripts. First, *a priori* code categories were created based on the focus group topic guide. Codes for each category were derived from the data using an inductive approach.

The code categories were:

- Successes
- Challenges of coaching teams
- Challenges experienced by project teams
- Co-production/lived experience engagement by project teams
- Co-production/lived experience engagement by the QI team
- Improving the AMHE QI Collaborative model.

Next, three independent researchers (one NCCMH researcher and two lived experience advisers) applied the coding process to the focus group transcript. Then, data from the transcript and the coding process were pulled together to derive a set of themes – constructed patterns derived from the data, to explore how the data met the focus group aims.

A qualitative descriptive approach was used for the thematic analysis.[1–3] The analysis followed the six phases of thematic analysis as outlined by Braun and Clark (2006).[4] NVivo 14[5] was used for the data coding and thematic analysis.

The findings from the focus groups were synthesised narratively for their write-up in this report. This report is an addendum to the AMHE Evaluation Snapshot 3 Report.

4. Results

Focus group questions could be grouped into four themes:

1. Successes achieved and contributing factors
2. Challenges experienced
3. Steps taken toward co-production
4. Suggestion for improvements.

A series of subthemes were derived from the transcript data. The themes and subthemes are shown in Table 1. In Section 4.1, each subtheme is presented sequentially and is illustrated by excerpts from focus group transcripts.

Table 1: Themes and subthemes from focus group transcripts.

Themes	Subthemes
1. Success achieved and contributing factors	(a) Building relationships and collaborative working
	(b) Learning community[b] and shared resources
	(c) Understanding underserved communities of people
	(d) Evidence-based decision-making
	(e) Leadership and motivation
2. Challenges experienced	(a) Structural barriers to co-production
	(b) Sustaining engagement and motivation
	(c) Organisational buy-in and senior leadership support
	(d) Limited resources and funding
3. Steps taken towards co-production	(a) Flexible and adaptive engagement
	(b) Structured guidance and strategies
	(c) Embedding lived experience
4. Suggestions for improvements	(a) Established goals and shared expectations
	(b) Structured support
	(c) Leadership engagement

b A series of learning sessions that brought together the collaborating teams. In these, they shared case studies and covered different learning topics related to co-production and inequity in mental health services.

4.1. Summary of themes

Theme 1: Success achieved and contributing factors

(a) Building relationships and collaborative working

One of the AMHE teams' key successes that was most often recognised by QI coaches was building trust, relationships and community among different sectors and organisations involved in the AMHE QI Collaborative:

> *"People have had the opportunity to build relationships with the people that they work with but also work for, and provide services for, that they possibly wouldn't have had without AMHE."*

(b) Learning community and shared resources

A series of learning sessions brought together the collaborating teams, to share case studies and cover different learning topics related to co-production and inequity in mental health services. This was particularly empowering for the teams taking part in the Collaborative. It fostered deep connections and wider shared learning, both in the physical events and outside of them:

> *"The learning community that we were left with was really, really strong and they really valued the time together and helped them build relationships with each other [...] the work that they were doing and that other people were doing meant a lot to them."*

One coach gave an example of a final learning community session, in which people from two trusts said they wanted to connect the trusts and collaborate on a future project. This demonstrates the value of the learning community and its lasting benefit, even after QI projects end:

> *"The fact that it was even happening right to the very end is testament to the work that not only the organisations have done, but the community that was formed and those relationships that have been built that will continue even though the Collaborative for that wave has ended."*

Coaches spoke positively about the resources produced as part of the AMHE QI Collaborative. One coach mentioned online materials and resources, saying they will benefit future initiatives. Co-production in the AMHE QI Collaborative: A Step-by-step Resource[6] (the Co-production Guidance) was referred to by coaches:

> *"I think we have produced quite a lot of resources through AMHE that will remain after that [the AMHE QI Collaborative]. I think about the Co-production Guidance and all sorts of other like resources that are freely available and on the website."*

> *" [...]the different resources that we produce, so where we produce the Co-production Guidance based on the feedback we got from the teams."*

(c) Understanding underserved communities of people

Identifying and understanding the communities and which populations to focus on at the start was recognised as differentiating the AMHE QI Collaborative from other projects. Exercises at the start of the project, to help identify local underserved populations, were considered one of the main drivers of success:

> *"I don't think that they [the trust] would have necessarily focused on it (the underserved population) had it not been for sort of really thinking about different populations at the start and who to focus on."*

Two QI coaches raised that the Collaborative was able to help identify the underserved population and build trust with them:

> *"The relationships that have been forged between the services or the organisations with the communities that they serve and particularly for populations that there wasn't much out there for."*

(d) Evidence-based decision-making

The processes undertaken to understand what action was needed to address inequalities and how to prioritise population groups were valued, and informed the decision-making. Coaches appreciated the fact that teams' abilities to understand and address the mental health inequalities that communities were experiencing, and to make decisions, was based on evidence rather than assumptions:

> *"It felt like it wasn't so much people at the top making decisions on what they thought, which some sometimes can feel a bit like what happens, but people had to go and find the evidence to make decisions on. And I think that can only be a success if we're, you know, making decisions based on evidence rather than what people kind of are just presuming."*

(e) Leadership and motivation

Three QI coaches said that the project team leaders' passion for the work was one of the main drivers of success. The personal motivation of senior managers or leaders was seen as a contributing factor to sustained engagement and project momentum:

> *"I think the personal motivation also linked in with people in the organisations finding the time and making the time for the work [...] you could sort of tell from meetings and the people involved that they were there because they wanted to be there, and they were really passionate and really cared."*

> *"You can't do this work without it, and I think a lot of the success for the individual teams was because at least one of those passionate people was kind of senior management leadership."*

Lived experience leadership was also raised by coaches, although not discussed in as much detail as senior organisational leadership. Lived experience leadership was discussed in the context of being a successful outcome rather than as a factor contributing to success:

> *"I'm seeing people with lived experience also kind of lead of elements of work as well."*

Theme 2: Challenges experienced

(a) Structural barriers to co-production

QI coaches identified barriers to engagement and co-production as major challenges. Factors such as stigma and competing commitments (such as caring responsibilities) were discussed:

> *"I think I can be really honest here and say this [co-production] is where it's been really, really hard [...]especially, I think, when you have quality improvement work, where if it's a mental health ward in an inpatient setting, it's much more contained whereas [when] people are trying to work with people in the community, you don't have much control on that. And so, just by that set-up, it made it even more challenging to think about how people could then co-produce the work. Because not only was it hard for them to even get people from those communities into their project teams, but it was hard for them to even speak to those communities because there were so many barriers or things like stigma [...] to get a person from that population on a team would have been next to impossible [...] the young people that did want to try to kind of engage with the professionals that were representatives on that team, often they had duties – that they had to take care of their siblings whilst their parents would work [...] it was really, really challenging and there was so many different factors outside in the community that contributed to that."*

Coaches felt that many teams were not prepared internally to take up the co-production approach and relied heavily on coaches for direction rather than taking ownership. Also, coaches felt they lacked the authority to influence engagement at a strategic level, and that they were under-equipped in the early stages to guide teams through meaningful co-production:

> *"I guess partly because the people that I was working with were from the organisations who might have been generally more senior, I felt like I kind of lacked a bit of power and authority and actually maybe a bit of expertise in order to try and get that buy in and sort of redirect them in a in a better way to do the work. And I think that had a knock on effect, and we did lose quite a few teams on AMHE and I wonder if that that was probably a part of it."*

> *"I was felt like I was almost like care taking teams rather than starting out from the beginning and having, like, a process with teams [...] AMHE didn't have the structure of some of the other collaboratives that as a new coach, I sort of went on a little bit more... you're designing like a new project for each of these teams. And I found that quite challenging in a way that I didn't have a (structure or resource) whereas other collaborative is like here's a collaborative here's all the resources like off you go kind of thing."*

Coaches expressed that some teams struggled to integrate lived experience voices in organisations where there weren't paid roles, or because of challenges when processing the payment:

> *"The first one that came to mind was co-production, and by that I mean supporting the teams with co-producing their work. It was really hard, like where they didn't have, for example, lived experience roles, paid roles [...] there were quite a few teams that didn't have any lived experience voices on their kind of project teams, for example. I found it quite challenging to be able to support them. To do that, it felt a bit outside of my ability."*

(b) Sustaining engagement and motivation

Some coaches considered the project length (3 years) too long to maintain motivation and engagement with the project teams:

> *"We've never done a 3-year programme before, and it was quite hard for some teams to maintain the drive and the engagement in the work, and the motivation for it. Both with the teams that were taking part in [it] and me, but also within our own team [...]that was reflected within our own team and they were [...]periods of time where our team were really struggling with motivation for work, feeling like we haven't done as good a job as we wanted to."*

However, coaches acknowledged the tension between the length of the Collaborative and how long it can take for efforts to reduce inequalities to be meaningfully realised. The long time frame also posed challenges for the QI coaches and the project teams, in terms of planning for the progress against the timeline. This resulted in an imbalanced use of time at the start and end of the project:

> *"Something around the timeframe, I think I found quite challenging. Three years felt like a long time. It sort of felt like a luxury at the start, and I think that maybe we also took our time because I think the organisations took their time a little bit as well, though we did start with quite a detailed process. and I think that one of the reasons that the things accelerated towards the end of the Collaborative is because everyone knew that the time on the Collaborative was coming to an end."*

(c) Organisational buy-in and senior leadership support

A significant challenge that coaches identified was that some AMHE team members did not get enough support from senior leaders in their organisations. This meant it was challenging for team members to move forward with productive actions and overcome barriers:

> *"It felt [like] there was no one to go to within their organisation to help them overcome these barriers, which sort of links in with resources and buy-in from senior people within an organisation."*

Linked to the theme of sustaining engagement, a lack of organisational buy-in and senior leadership in some project teams was described as limiting project sustainability. A few examples were given by the QI coaches about projects that were terminated because their organisations couldn't prioritise them or allocate resources to the work:

> *"I think one of the main challenges is it just didn't feel to us or to some of the project teams that it was really a priority for the organisation. Both the AMHE project specifically, but also sometimes it just felt like the approach to change and the focus on equity didn't really feel like and a priority. And there wasn't really anything to, or anyone to, tap into you, to kind of get that changed…."*

(d) Limited resources and support

A lack of internal resources and funding limited the involvement of people with lived experience and posed challenges on engagement work:

> *"Payment for people [with] lived experience has been so difficult […]It's just non-existent, or just goes through this really tortuous process of just going through so many different people, trying to work out how to pay someone for their time… that was a real challenge, particularly because we were really emphasising how vital that is to their work and really, it's not going to be a success without it, but then they're not able to pay these people."*

> *"There were certain things that are outside of our control – for example, funding – so, working with [organisation name] was really, really difficult because of challenges that we didn't have any control over. So they weren't able to engage in their way that they wanted to, because simply they didn't have the funding to do the work, which was really difficult."*

Staffing resources also posed challenges in project progress. For example, if a key project lead was to leave the team, this could cause disruption to the whole project:

> *"With any typical project, people might leave and can, kind of, destabilise a project. […] in this case, on AMHE, because it was over 3 years, when you have project leads that were key and central to driving forward the work [who] suddenly were leaving, then [the] entire project would collapse because it was them that were the driving people for that. And then the changes in the cultures or again over the 3-year period can be disjointed and disconnected, and can cause how you experience it to not be as positive."*

In particular, some teams were felt to be very short of staff resources where, in some instances, teams were left with only one person responsible for working on the AMHE QI Collaborative:

> *"I think, for me, a massive thing is resource [...] at some point, every single [organisation name] team was a team of one, and for a significant length of time [...] A lot of it was about [...] there was restructuring going on, and there was a lot of [...]resource issues, and state or political issues as well. But then other[wise] it was just a resource issue, and people wanted to do it but just couldn't [...] You have these meetings [where] I need to make these plans, but it just felt really, really difficult having these [...]one-to-one meetings, trying to do this quite big work with you know, one really passionate person."*

Theme 3: Steps taken toward co-production

(a) Flexible and adaptive engagement

QI coaches discussed how they employed flexible and adaptive engagement strategies tailored to the context and needs of each team to support meaningful co-production practices:

> *"My team has not been able to engage in the way that they like to because of the funding element, so we were trying to meet them where they were at. We were trying to think what would be helpful if you can't come to a learning set, could be to create a workshop where you could drop in. And we have several of those, and we've had a handful of people that would come regularly to those sessions and, you know, share frustrations, share challenges that they were experiencing, and learning from each other as well. Minimising [or] mitigating some of the things that were around some of that, even if it was things that were sometimes out of our control."*

(b) Structured guidance and resources

The coaching team produced Co-production in the AMHE QI Collaborative: A Step-by-step Resource (the Co-production Guidance[6]) to support project teams in engaging marginalised communities and implementing co-production in different settings:

> *"People are finding it difficult to know how to co-produce when working in the community. So on the back of that, we're listening to that, and we acted on that, and we created the Co-production Guidance. So those are tangible action we took there.*

> *"We produced the Co-production Guidance based on feedback that we've got from the teams, who said, 'Actually, we need support with this – we want to be able to do this thing justice and we want to be able to do co-production in the right way, but we're not sure how to when it comes to working with [...]', not only was it a range of like different, kind of, projects, they were kind of within hospitals or out in the community, and they needed support with that..."*

(c) Embedding lived experience

Continuous efforts were made to integrate lived experience perspectives throughout the duration of the Collaborative, as far back as the planning processes:

> *"[What] I do think I was able to, and the coaching team were able to do, was really advocate for lived experience voices and be an advocate for it right from the start and throughout the programme."*

Theme 4: Suggestion for improvements

(a) Establish goals and share expectations

Waves 1 and 2 of the AMHE QI Collaborative were seen as trying to work beyond the scope, which involved (a) understanding and identifying the populations and communities in need, and (b) designing a QI project for the identified population or community. It was suggested that for Wave 3, clear goals should be established early in the process, with the expectation that organisations would onboard with pre-identified service teams and populations:

> *"I think what's going to improve that is ahead of time, knowing what our process is and our actions are for those teams, rather than wait until we get there and then to sort of be like oh, we need to do this now … I think we've done in thinking about AMHE Wave 3 is being really clear about what our goals are, what we want teams to achieve from and knowing what we know from Wave 1 and Wave 2. So it feels like we were trying to achieve too much in in Waves 1 and 2 […] but then hopefully what we're doing for Wave 3 is we're trying that they (organisations) are going to bring teams and populations, and we'll work with them to use QI methodology to support."*

The importance of establishing clear boundaries and requirements for co-production work beforehand were also emphasised:

> *"I think for AMHE, like, part of the charm of it to start with was, like, that it was sort of quite novel and quite like free spirit, if you will. And you did have, like, so much flexibility, but I think having a few kind of like boundaries in place would be really helpful […]having a really, really clear boundary about co-production, because I feel really confident going into teams and reflecting that boundary back to them and telling them this is how we're gonna do it […] if you don't have lived experience representation on your team, your team isn't complete, and you're not in a position to move forward with this project.. it would have been transformational if that had kind of been nailed in some of the teams.."*

(b) Structured support

More structured and consistent coaching materials were suggested, to help coaches guide teams more effectively – especially those new to co-production or equity work:

> *"I wonder if I'd like had that knowledge beforehand or the structure to lean on, or something like that, it may have been easier."*

> *"They [service teams] were working under different conditions, so I think working out where they wanted to get to and then putting in a bit of a sort of timetable and structure and to get them there […]."*

(c) Leadership engagement.

Stronger and earlier engagement from senior leadership at the organisational level were seen as essential for ensuring team buy-in, resourcing and project sustainability:

> *"For Wave 3 to get people to buy into it, you know, which could be sort of like data that they're required to collect and things like that. And I don't really feel like we had any of that on Wave 1 and Wave 2."*

> *"Just think how can we make it more inclusive to include people, people, organisations like [organisation name]. Given the challenges that come with funding, it felt really sad that many of those teams did such great work and they're really embedded in the communities [...]But when it came to the end of the Collaborative, all of that team disintegrated. That's because the senior leadership had changed, and things just fell through."*

5. Discussion

This qualitative analysis of a focus group with QI coaches provides valuable insights into the implementation and outcomes of the AMHE QI Collaborative. The findings highlight several key successes, including:

- the establishment of strong relationships among stakeholders
- the development of a robust learning community
- the use of evidence-based approaches to address mental health inequalities.

However, the study also reveals some notable challenges, particularly in co-production, organisational engagement and resource limitations.

The findings align with broader literature on QI collaboratives, particularly the importance of relational trust[7,8] and adaptive leadership.[9] QI coaches' accounts of teams building strong inter-organisational relationships and developing shared learning communities resonate with the findings of Shortell et al. (2004),[8] which emphasised that trust enables knowledge exchange and collective problem-solving. This can be especially important when addressing complex challenges such as mental health inequalities.

However, the focus the AMHE QI collaborative has on equity introduced challenges beyond those encountered in conventional QI models, such as engaging marginalised communities amid systemic barriers. While we recognised that the co-production approach[c] we used was what differentiated the AMHE QI Collaborative from other QI projects, it brought extra challenges. Engaging underserved communities was hindered by structural barriers within services, including a lack of payment structure for lived experience contributors and inflexible organisational policies. The difficulties in facilitating meaningful community engagement identified by QI coaches under these constraints suggest that equity- and equality-focused QI initiatives need more than the standard collaborative methods. Organisations need to consider how to shift the power dynamics and allocate the necessary resources to establish the infrastructure of co-production.[10]

QI coaches partly attributed the structural barriers to a lack of organisational buy-in and support from senior leadership. This demonstrates how equity-focused initiatives often need to compete within organisational priorities, particularly when they challenge power structures or traditional ways of allocating resources. The recurring theme of having 'no one to go to' reveals a structural gap, in which frontline project team members lacked leverage or support to navigate structural constraints and sustain AMHE's agenda. These findings suggest that it is important to secure executive-level commitment as a prerequisite, rather than relying on voluntary engagement.

c The co-production approach employed by the NCCMH is outlined in the AMHE Coproduction Guide.

The tension between flexibility and structure emerged as a central theme. On one hand, the Collaborative's flexible approach (for example, meeting teams 'where they were at', as described by one QI coach) allowed coaches and teams to find solutions that adapted to the local contexts. This was considered valuable for fostering innovation, as seen in teams that developed creative workarounds for to engage with communities. On the other hand, a lack of standardised co-production requirements led to inconsistent implementation across teams, with some bringing in meaningful lived experience involvement while others struggled to include community voices. This variability suggests that effective equity-focused QI projects may need clear prerequisites (such as mandatory lived experience roles with dedicated funding) within an otherwise adaptive framework; that is, fidelity to core components and adaptability to local contexts. These prerequisites should not be used as exclusion criteria for participating in the Collaborative, but as clearly articulated standards to help project teams understand what support they may need for additional resource- and capacity-building in preparation as part of onboarding.

The 3-year duration of the project was intended to allow for deep engagement, but led to challenges in time management. Initial flexibility gave way to last-minute urgency. This challenges the assumption that longer timelines inherently benefit complex QI projects, and suggests that equity work might benefit from shorter, more intensive phases that have clear intermediate goals as milestones to check in and evaluation progress. Timelines and plans should use time, people and financial resources efficiently, while also proceeding at a pace that enables and empowers communities to affect meaningful change.

6. Implications and learning for future work

The findings from this evaluation have the following implications for future waves of the AMHE QI Collaborative to improve their support and practices:

1. Strengthening co-production practices

- Establish clear boundaries, definitions for co-production and a supportive framework for implementing co-production at a local level.
    - Establish co-production from the initial planning phase, for example emphasising lived experience team members as equal partners who are essential to the project.
- Identify and address structural barriers within services for co-production; for example, whether there is dedicated funding and streamlined processes that support co-production (such as the processes and funding to pay people with lived experience for their participation).

2. Enhancing structural support

- Develop standardised coaching materials, processes and frameworks that give structured guidance for QI coaches and project teams, particularly for those new to equity-focused QI work.
- Offer targeted training or extra support for coaches, to enable them to (a) support teams to facilitate co-production and (b) be supported to address power dynamics within teams.

3. Engaging leadership early

- Secure senior leadership commitment before the project starts, to ensure organisational buy-in and resource allocation.
- Align project goals with organisational priorities, to enhance sustainability and integration into workflows.
- Develop relationships between senior leaders and project teams, so the leaders can keep an overview of the progress and address any barriers as the project progresses.

4. Refining project design

- Clarify the scope and expectations for teams upfront.
    - Make sure teams understand what they need to do, and agree which communities and services they should focus on. This avoids confusion and makes sure everyone is working together.
- Plan for future initiatives to either (a) run for a shorter duration than 3 years or (b) be structured in distinct phases.
    - A phased approach would help maintain momentum and allow for greater agility when responding to evolving circumstances.
    - While the AMHE QI Collaborative's 3-year duration enabled comprehensive work, it led to significant challenges in sustaining the motivation and engagement of participating teams.

5. Building on successes

- Use and build on the learning community model and use a common set of shared resources, to foster collaboration and knowledge exchange.
- Continue to use learning events and share knowledge and materials[d] openly and transparently.
    - Document and disseminate best practices, particularly around flexible engagement strategies and evidence-based decision-making.

The learning and implications from the focus group can be applied to projects beyond the AMHE QI Collaborative. Sharing learning across other collaboratives may avoid 'reinventing the wheel', where repeatedly taking actions may hinder efficiency and avoiding this could save significant time and resources. More importantly, these discussions often reveal fundamental community needs and perspectives that are relevant to multiple initiatives. Applying these proven insights from the outset allows any new collaboration to begin with a deeper understanding and a solid foundation of evidence, leading to smarter decisions. As such, these focus group findings can be viewed not as a final report, but as a live resource to inform and strengthen all future collaborations that the NCCMH undertakes.

d All of the resources developed throughout the AMHE Collaborative, including Learning Community outputs are available on the AMHE website.

7. Limitations

One notable limitation of this work is that it relied on a single focus group of QI coaches, which may not represent the range of perspectives of project teams and people with lived experience. If future evaluations include a broader range of stakeholders, this could enable a more comprehensive understanding of the experiences of the Collaborative. Also, holding one focus group with QI coaches may reflect the challenges around power systems and co-production that were present throughout the AMHE Collaborative work.

The qualitative element of the AMHE Evaluation had been planned to include a focus group with team members involved in the AMHE QI Collaborative. We had intended to host a focus group of project team leads, team members and people with lived experience. However, factors (including Collaborative team dropout and staff changes) led to significant recruitment challenges. As such, we were unable do any qualitative evaluation with team members and hear about their experiences, thoughts and opinions. In particular, we missed out on an opportunity to understand how co-production was embedded in teams' approaches to the AMHE QI Collaborative from the perspectives of team members and people with lived experience.

Appendix 4 contains a co-produced topic guide that can be used by project team members including people with lived experience. The discussion topics and questions it contains can be adapted for use with future QI evaluations. The questions can also be adapted for organisations to use, to self-evaluate their approaches to co-production. Appendix 5 contains questions that were co-produced for people with lived experience involved in the AMHE QI Collaborative, but which it was not possible to use. Organisations working with people with lived experience can adapt these questions to explore successes, challenges and experiences of the co-production processes, from a patient and carer perspective.

8. Conclusions

The AMHE QI Collaborative demonstrated the potential of QI methods to address mental health inequalities, with successes rooted in collaboration and evidence-based practice. Barriers and challenges of project implementation are tied to the specific nature of equity-related work and the co-production approach.

To improve on the current model, future iterations of the AMHE QI Collaborative should balance flexibility with clearer structures, ensuring that equity remains central to design and implementation.

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Appendix 1: Copy of the focus group topic guide for NCCMH QI coaches

'The purpose of this focus group(s) is to discuss your experiences coaching teams as part of the AMHE QI collaborative. You will be asked about topics such as successes and challenges experienced by yourselves as coaches and your perceptions of teams successes and challenges. We will also ask you about ways you feel the delivery of the collaborative during Waves 1-2, could be improved for Wave 3.

You have all read the participant information sheet and signed a consent form. You have been notified that the session today is being recorded for transcription and interpretation needs only, and that all data collected will be anonymised and non-identifiable in any subsequent reports or dissemination resulting from this work. This discussion should last ***up to 2 hours (including a short break)****. We will start with the first topic of discussion now.'*

Successes – overall

1. **What do you think have been the main <u>successes</u> of the AMHE QI collaborative?**

   Prompts [use as needed – not all prompts will need to be used]

   - What went well?
   - What benefits do you think the AMHE collaborative has had for underserved groups and the people at risk of mental health inequalities?
   - What benefits do you think the AMHE collaborative has had for people working in mental health services?

2. **What factors do you think have contributed to any successes achieved?**

   Prompts [use as needed – not all prompts will need to be used]

   - When you think about successes from AMHE, what were some of the driving factors behind these successes?

   [If struggling suggest e.g., supportive management/leaders, the will of project team members, time and resources allocated by the service/trust]

Challenges – coaching teams

'The following questions are about ***<u>challenges specific to coaching</u>*** *as part of the AMHE collaborative. Here we want you to think about challenges you experienced coaching teams so think about this question in terms of yourself as a coach and what has been challenging for you (we will talk about teams' and other challenges later)*

3. **What are some of the main challenges you as coaches have experienced coaching teams as part of the AMHE QI collaborative?**

4. **What steps have you taken to overcome these challenges?**

   Prompts [use as needed – not all prompts will need to be used]

   - What steps have you taken to overcome challenges individually and as a QI team?

Challenges – AMHE project teams

*'The following questions are about **challenges experienced by the AMHE project teams**. Here we want you to think about challenges that you felt project teams experienced as part of the collaborative. Think about difficulties team members may have expressed to you, or challenges you witnessed team members' experiencing.'*

5. **What are some of the main challenges you felt that AMHE project teams experienced as part of the collaborative?**

[If co-production and lived experience involvement is discussed here as a challenge, allow the conversation to continue and skip questions from section on 'co-production' below as necessary]

6. **What steps have you taken to support AMHE project teams to overcome these challenges?**

   Prompts [use as needed – not all prompts will need to be used]

   - What steps have you taken to support teams to overcome challenges individually and as a QI team?

Co-production, lived experience engagement and involvement – AMHE project teams

*'The following questions ask about the roles of co-production, lived experience engagement and involvement in the AMHE collaborative from your perspectives as coaches. These questions relate to **how co-production has been a part of your teams' work** across the AMHE QI collaborative.'*

7. **Can you tell us about how AMHE teams incorporated lived experience engagement and involvement as part of their work with the AMHE QI collaborative?**

   - [If co-production and lived experience involvement was already discussed above, focus on PROMPTS about co-production not yet discussed]

   Prompts [use as needed – not all prompts will need to be used]

   - What role(s) have people with lived experience played within the teams you coach?

   - If people with lived experience were not involved in your teams' work, why was this? / What challenges were there? / What were the barriers to teams engaging in co-production?

   - What do you think could have helped teams to embed lived experience involvement and co-production in their work as part of the collaborative – who or what could have helped to do this better? (think about the lever or influence)

- If teams had been able to do co-production better, what benefits do you think this would have had?

- What are some examples of where co-production was done well by the teams that you coach?

- What do you think could be done to improve involvement of people with lived experience in the AMHE collaborative in future?

Co-production, lived experience engagement and involvement – QI team

*'The following questions seek to gather your thoughts on co-production, lived experience engagement and involvement in **your work as coaches** on the AMHE QI collaborative. These questions relate to how working with people with lived experience has been a part of your work coaching teams.'*

8. **How do you feel your own knowledge, skills and abilities regarding co-production and lived experience involvement impacted how *you were able to coach teams*?**

   Prompts [use as needed – not all prompts will need to be used]

   - What are your strengths and abilities when it comes to lived experience involvement and co-production?

   - In which areas do you feel you might benefit from more learning, support or training on co-production and lived experience involvement to be better able to support your teams to do this?

9. **What impact did working with the Equality Advisory Group (EAG) have on your work as coaches within the AMHE QI collaborative?**

   Prompts [use as needed – not all prompts will need to be used]

   - What benefits did working with the EAG have?

   - What challenges did working with the EAG pose?

Improving the AMHE QI collaborative model

10. **What could be done to improve the delivery and success of the AMHE QI collaborative going forward?**

END OF TOPIC GUIDE

Appendix 2: Copy of the focus group topic guide for AMHE project team members

Introduction

'The purpose of this focus group(s) is to discuss your experiences as part of a project team involved in the AMHE QI Collaborative. You will be asked about topics such as successes and challenges experienced by your teams, how the QI approach has been used in your organisations/services, building relationships with communities and the role of co-production in your team and organisation.

You have all read the participant information sheet and signed a consent form. You have been notified that the session today is being recorded or transcription and interpretation needs only, and that all data collected will be anonymised and non-identifiable in any subsequent reports or dissemination resulting from this work. Should you wish to leave the focus group at any time, you are welcome to do so. This discussion should last ***up to 1.5 hours****. We will start with the first topic of discussion now.'*

Establishing the QI approach

1. **Could you tell us about your experience implementing the AMHE QI model/ approach in your service?**

   Prompts [use as needed – not all prompts will need to be used]

   - Can you say a bit more about your familiarity and confidence with the approach?

Successes

2. **What do you think are the main successes achieved by your team as part of the AMHE QI collaborative?**

   Prompts [use as needed – not all prompts will need to be used]

   - What factors do you think have contributed to any successes achieved?

Challenges

3. **What are some of the main challenges your teams have experienced as part of the AMHE QI collaborative?**

   Prompts [use as needed – not all prompts will need to be used]

   - What steps were taken to overcome challenges?
   - What were the barriers to overcoming challenges?

Co-production, lived experience engagement and involvement

'The following questions relate to how co-production and relationships with communities have been a part of your work in the AMHE QI collaborative. When we refer to lived experience, we are referring to people with experience of mental health problems or those that have experience caring for people with mental health problems.'

4. **Can you talk to us about lived experience engagement and involvement as part of your AMHE work?**

   Prompts [use as needed – not all prompts will need to be used]

   - What role(s) have people with lived experience played within your teams?
   - What were the barriers to co-production?
   - Did you experience any barriers engaging with specific populations you wanted to work with?
   - What could help to overcome this barrier – who or what would help to do this better? (think about the lever or influence)
   - What were you limited from doing (not able to do) without involvement from people with lived experience in the work?
   - If you were able to do co-production better, what benefits do you think this would have had? (think about how your work might have differed if people with lived experience were more involved)

5. **What do you think could be done to better involve people with lived experience in the AMHE collaborative in future?**

Learning events hosted by the NCCMH

'The following questions seek to explore your thoughts on the various AMHE Learning Events held by the NCCMH team at the College.'

6. **What impact did you feel that the AMHE Learning Events had on your team's involvement in the AMHE collaborative?**

   Prompts [use as needed – not all prompts will need to be used]

   - What did you find helpful about the learning events?
   - Can you provide any examples of learning you took from the events to your own team's work as part of the AMHE collaborative?
   - What could be improved/done better about the Learning Events?
   - If you did not attend any learning events, why was this?

Improving the AMHE QI collaborative model

7. **What could be done to improve the delivery and success of the AMHE QI collaborative?**

END OF TOPIC GUIDE

Appendix 3: Copy of questions for lived experience project team members

The following questions have been put together to ask lived experience project team members in the event that recruitment of such participants to focus groups is limited or unsuccessful.

If we need to seek the input of people with lived experience outside of the focus group setting, we will invite participants to respond to the following questions about their experience of the AMHE QI collaborative. There will be options given to participants to respond to the questions below:

1. Participants can respond using Microsoft Forms via the following link: [INSERT LINK]
2. Participants can write their responses and email them to the NCCMH research team
3. Participants can answer the questions over the phone or via Microsoft Teams and a member of the research team will make a note of their responses

Responses will be anonymised and stored using the same data protection processes as outlined above for storage of focus group data.

Questions

Establishing the QI approach

1. **Could you tell us about your experience implementing the AMHE QI model/ approach in your service?**

Successes

2. **What do you think are the main successes achieved by your team as part of the AMHE QI collaborative?**

Challenges

3. **What are some of the main challenges your teams have experienced as part of the AMHE QI collaborative?**

Co-production, lived experience engagement and involvement

4. **Please tell us about your lived experience engagement and involvement as part of your AMHE work? Think about:**
    - Your level of involvement in the project team (e.g., Did this feel equal? Did you feel empowered or not?)
    - The relationships between people with lived experience and staff members involved in your work as part of the collaborative
    - How conflicts or differences in opinion were managed
    - Whether you identified any power imbalances and/or hierarchies

Learning events hosted by the NCCMH

5. **What impact did you feel that the AMHE Learning Events had on your team's involvement in the AMHE collaborative?**

Improving the AMHE QI collaborative model

6. **What could be done to improve the delivery and success of the AMHE QI collaborative?**

END OF QUESTIONS

Appendix 4: Copy of the Participant Information Sheet

AMHE QI Collaborative Evaluation

Focus group participant information sheet

Title of Project: *Advancing Mental Health Equality Evaluation Focus Group*

You are invited to take part in a focus group exploring your experiences of taking part in the Advancing Mental Health Equality (AMHE) Quality Improvement (QI) collaborative.

The aim of the focus group is to find out more about your experiences working on the AMHE QI collaborative. Focus groups will be used to explore the impact, successes and challenges of the AMHE QI collaborative model from the perspectives of:

1. NCCMH QI coaches
2. Project team members (any member of a service's AMHE project team involved in the collaborative, including team leads, service user representatives/people with lived experience or any other team member)

The focus groups will aim address the following broad areas:

1. What are the main successes achieved by the team as part of the collaborative?
2. What factors have contributed to the successes achieved?
3. What are some of the main challenges experienced?
4. What steps have been taken/could be taken to overcome these challenges?
5. What steps have been taken towards co-production?

What is the purpose of this research?

The focus groups are being conducted to supplement other data collection methods and to inform our understanding of the successes and challenges of the AMHE QI collaborative model from the perspectives of different stakeholders. The focus groups will include people involved in Wave 1 (launched in July 2021) and Wave 2 (launched in October 2022) of the collaborative. The ultimate aim of this work is to evaluate the impact of the AMHE QI collaborative.

What would taking part involve?

If you agree to participate, you would be invited to take part in a Focus Group facilitated by at least one lived experience member of the AMHE project team in addition to researchers from the NCCMH. The length of the focus group will be between 1.5-2 hours. You will be invited to a specific focus group depending on your role (as a QI coach or a project team member).

The focus group facilitators will take you through a series of discussion topics and questions, asking you and the other participants to reflect on your experiences of the AMHE QI collaborative. The focus group will follow a loose structure in which you will be invited to speak on different topics, share your experiences and views in response to questions asked. You will be encouraged to contribute to discussions with other participants.

The focus groups will take part via video call. This call would be audio-recorded and eventually transcribed by the researchers, at which point it will be anonymised and audio files deleted. The transcripts will not be sent to participants for verification unless there is a specific query requiring clarification with a participant. You will also be asked to fill out a brief tick-box questionnaire which will ask you about your age bracket, ethnicity, gender and other information about your role in the AMHE collaborative. This data will be kept anonymous and does not require you to give any personal or sensitive data apart from your age bracket, ethnicity and your gender identity. This form **will not** collect any identifiable information such as your name or date of birth.

What are the possible benefits of taking part?

- You will be contributing to the evaluation of the AMHE QI collaborative
- Taking part supports the effort to further develop and improve AMHE QI collaborative model by understanding challenges, what worked well and what did not work so well
- Your views, advice and suggestions would be heard and we hope these can be used to inform changes which could be made to improve the model
- Taking part is easy, requiring only a small amount of your time – up to 2 hours
- Confidentiality will be maintained at all times.

What are the possible risks/disadvantages of taking part?

1. **Discomfort or distress** – You will be asked about challenges taking part in the AMHE QI collaborative. Discussions may involve sensitive topics as we will be asking participants about the things they found challenging about the collaborative and what could be improved in their opinions. These discussions may cause some discomfort.
2. **Intrusion** – You will be asked to speak about your own experiences as AMHE project team members (including as lived experience advisers, clinicians, health workers) and QI coaches. The questions could be perceived as intrusive, but it will be up to you how much you wish to share.

A full debrief with one of the researchers, on a confidential, one-to-one basis will be offered to participants should they wish to do this.

What is expected of me as a participant?

- You would be expected to attend the full focus group (unless of course you had to leave in the case of an emergency or decided to withdraw your participation)
- You would be expected to contribute to discussions and share your views/perspectives and experiences
- You would be expected to engage with other participants in accordance with the principles of respect and confidentiality – you will be expected to conduct yourself professionally and not to share information discussed in the focus group outside of this
- You would be expected to speak openly and honestly about your experiences, including those that were challenging

Confidentiality

There will be strict measures in place, as required by the Data Protection Legislation to ensure that information collected in the study is kept anonymous. All research conducted in this way has gone through checks and has been approved by the Data Protection Office at the Royal College of Psychiatrists (RCPsych). Involvement in the study will in no way affect your role within the AMHE QI collaborative, the NCCMH or RCPsych. Anonymization will ensure that participants will not be able to be identified in any reports, publications or conference documentation.

Further supporting information

Project Manager Contact Details: [INSERT]@RCPsych.ac.uk

Frequently Asked Questions (FAQs)

What will happen if I don't want to carry on with the study?

You can withdraw your involvement in the study at any time. Data given before withdrawal will still be used for the study.

How will my information be kept confidential?

The interview would be audio-recorded and transcribed. Transcripts will be anonymised and audio/video files deleted. The anonymised transcripts of interviews would form the data. This data will not be linked to any other data or information. Transcripts will be stored on the Royal College of Psychiatrists' (RCPsych/The College) secure SharePoint platform, in a folder accessible only by members of the research team conducting the study. All data will be destroyed following the completion of the study (including write-up and dissemination); it is expected this this will be one year from the collection of data (summer 2025). A Data Protection Impact Assessment will be performed in accordance with the College policy on Data Protection and GDPR. All of the researchers are competent and up to date with online GDPR training provided the RCPsych or UCL Legal Services. Data on gender, ethnicity and age bracket will be collected by way of a brief data collection form. The data collection form does not require any information by which participants can be identified but is intended to provide descriptive statistics about the participants as a group. Data collected from any forms will immediately be transferred to a password protected Excel spreadsheet, also saved on SharePoint. Participants will not be able to be identified from the information provided on the form or in the Excel sheet.

What are my choices about how my information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

What will happen to the results of this study?

The results of the study will be used as part of the Evaluation of the AMHE QI collaborative. It is intended that the results will be written up as a report for internal publication by the National Collaborating Centre for Mental Health (NCCMH) and written up as an article for submission to a peer-reviewed journal. It is possible that results may be presented at relevant conferences and professional events (e.g., webinars, seminars). Anonymisation will ensure that participants will not be able to be identified in any reports, publications or conference documentation. Results and ensuing reports are likely to be shared with NHS Trusts and stakeholder bodies to hopefully influence future direction of the AMHE QI collaborative and other relevant quality improvement programmes.

Who is organising and funding this study?

The study is organised by the NCCMH at the Royal College of Psychiatrists. The NCCMH is a partnership organisation between the RCPsych and the UCL Department of Clinical, Educational and Health Psychology. The study is funded as part of the AMHE QI Collaborative, a subscription-based programme run by the NCCMH.

How have patients and the public been involved in this study?

The focus group protocol, procedures and topic guides have been co-produced with two people with lived experience of mental health services. These lived experience experts are recruited by the NCCMH and work with the internal NCCMH team in their capacity as experts by experience. Ethical considerations for the focus group were also brought to the NCCMH Equality Advisory Group (EAG), a standing group of lived experience experts (patient and carer representatives) who advise the NCCMH on matters of equality and co-production across projects and programmes.

What to expect during the consent process?

If you agree to take part after reading this information sheet, you will be given a consent form to read and sign. You can either sign this consent form manually using a pen, and email your signed copy back to the researchers, or you can sign this electronically using the Microsoft Word Digital signature feature, which has been enabled on the consent form. In either case, you will need to email the consent form back to the researchers. If you are uncertain about the consent form or need to ask any questions, you may contact the NCCMH staff using the contact information provided on this information sheet.

What will happen if something goes wrong?

In the unlikely event that something goes wrong and you need to make a complaint, in the first instance, participant complaints will be reported to the Project Manager. The complaint will be escalated via the appropriate channels at the College as necessary. The College has a dedicated complaints handing procedure which is managed by HR who will support the participant through the complaints process.

END OF INFORMATION SHEET

Appendix 5: Copy of the focus group participant consent form

IRAS ID: ####

Centre Number: ###

Study Number: ###

Participant Identification Number for this study: ###

CONSENT FORM

Title of Project: Advancing Mental Health Equality Evaluation

Name of Researcher: [insert]

Please tick the boxes:

1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐
3. I agree to have my personal data audio/video recorded. ☐
4. I agree to take part in the above study. ☐

Name of Participant: Date:

_____ _____

Signature of participant:

_____

FOR RESEARCH USE:

Name of Person taking consent: Date

_____ _____