Connecting for Life Implementation Strategies and Structures

Findings of a Survey

Monitoring & evaluating the implementation of C*f*L

December 2018

Background: Implementing *Connecting for Life* (C*f*L) Ireland's national strategy to reduce deaths by suicide and self-harm (2015-2020) is a complex process, as it is a cross-cutting, whole of society strategy which requires consistent coordination and communication between relevant stakeholders. There is often a substantial gap between a strategy's design and its execution. Enormous amounts of time and resources are put into strategic planning processes, yet many struggle when it comes to the implementation of a strategy. The literature indicates that a key factor in the failure to deliver upon a strategy is often down to the simple fact that implementation or the crucial work of translating strategy into an operational reality and 'making it happen' is not adequately considered.

In July 2018 the Monitoring & Evaluation (M&E) Team in the HSE National Office for Suicide Prevention (NOSP), as part of the evaluation of the implementation of C*f*L, set out to identity the evidence-informed implementation strategies used by the HSE (the lead agency with most strategic commitments) to drive the work, and to review national C*f*L implementation structures. To this end, all relevant stakeholders were invited to take part in a survey and share their reflection on their experiences to date. This document summarises the key findings from this point in time survey.

This paper identifies key evidence-informed implementation strategies used (by the HSE) to drive C*f*L. It also summarises the findings from a survey of stakeholders involved in national C*f*L implementation structures.

Key points:

- The HSE is the lead agent with the most commitments under C*f*L. A broad range of evidence-informed implementation strategies are also being used by HSE Mental Health (and the HSE NOSP) to drive the top-down and bottom-up implementation of C*f*L.
- In addition to these discrete implementation strategies, a number of implementation structures are in place that serves as a guide or framework for the implementation of C*f*L.
- A crucial implementation structure is the HSE NOSP, which has responsibility for the overall implementation of the national strategy. The vast majority of stakeholders reported that they sought support and strategic guidance from the HSE NOSP, thus reinforcing the need for a high functioning office with implementation expertise.
- The majority of stakeholders were of the opinion that the HSE NOSP has the leadership and enhanced programme management and evaluation capacity needed to implement the national strategy.
- The C*f*L Cross Sectoral Steering and Implementation Group, chaired by the Department of Health and comprised of representatives from 17 C*f*L action lead agencies/government departments, was recognised by the majority of stakeholders as playing an instrumental role in implementing C*f*L.
- The evidence suggests that stakeholders were less aware of the function, role and decision making of other (HSE) implementation structures.

Background

A range of factors can contribute to suicide; consequently, a multifactorial, coordinated, whole-of-government approach to suicide prevention is necessary. The 69 actions under *Connecting for Life* (C*f*L) Ireland's National Strategy to Reduce Suicide 2015-2020, focus on the primary and secondary prevention of suicidal behaviour; they address a broad range of risk and protective factors. Collectively, they contribute towards the overarching vision of an Ireland where fewer lives are lost through suicide. Realising the strategy's vision is (in part) dependent upon 22 lead agencies/government departments and the funded NGO partners delivering on their strategic commitments.

The Health Service Executive (HSE) is the lead agent with the most commitments under the strategy. More specifically, HSE Mental Health[1] is the implementation lead on 33 of the 69 C*f*L actions (and support on a further 20 actions). To this end, the HSE National Office for Suicide Prevention (NOSP) is lead on 17 actions, most of which have a strategic focus. In addition to the aforementioned C*f*L actions, the HSE NOSP is also responsible for providing "cross sectoral support for implementation" and ongoing "monitoring and evaluation of the implementation of the strategy to guide the on-going implementation process"(CfL, p. 37). The HSE Mental Health is lead on 17 actions which have a more operational/service delivery focus.

Importantly, Action 2.1.1 of C*f*L is the responsibility of the HSE Mental Health. It requires that "*consistent multi-agency suicide prevention action plans*" be implemented "*to enhance communities' capacity to respond to suicidal behaviours, emerging suicide clusters and murder suicide*". The significance of this action cannot be underestimated, as these (17) area-level suicide prevention action plans are the key mechanisms through which the national strategy is being implemented across the country. There are 22 HSE Resource Officers for Suicide Prevention (ROSPs) who are responsible for driving the C*f*L area-level planning and implementation processes[2].

[1] The HSE NOSP forms part of HSE Mental Health. Within the C*f*L strategy, specific actions are assigned to both HSE Mental Health and HSE NOSP

[2] Of note about ROSPs is (i) their reporting structures vary across CHO Areas (ii)one is a member of the CHO Mental Health Management Team (iii) the majority are employed under HSE Mental Health, however, some are under HSE Health & Wellbeing

Evidence-Informed Implementation

The process of implementing a cross-sectoral national strategy is complex and fraught with challenges. Often efforts to implement new ways of working designed to improve the quality and outcomes of services do not reach their full potential due to a variety of challenges. The default trajectory for many strategies/initiatives is poor implementation, poor fidelity and poor sustainability.

Increasingly, the importance of the (art &) science of implementation is being recognised, and its distinctiveness from the innovation and/or the strategy being implemented. For example, the activities and metrics of C*f*L are different to the activities and metrics of implementing C*f*L (i.e. the 'what' and the 'how' nationally and at an area level).

There is a deep and broad body of literature that defines and informs the core components of implementation and implementation practice. From the literature we know that high quality implementation does not happen on its own: it requires dedicated resources (e.g. systems for using data to monitor implementation) and time (e.g. protected time for members of an implementation team to meet). We also know that there is a range of evidence-informed implementation strategies i.e. methods and/or techniques that can enhance the adoption, implementation and sustainability of practices/strategies/innovation[3]. These strategies can be used as the building blocks for constructing multifaceted, multilevel implementation efforts.

As part of the evaluation of the implementation of C*f*L, the HSE NOSP Monitoring and Evaluation (M&E) Team set out to identify and describe strategies and structures being used to drive C*f*L. More specifically, the study had two distinct objectives:

- **Objective 1:** To identify and illustrate the evidence-informed implementation strategies adopted by HSE Mental Health to drive C*f*L at a national and local level; these are the methods/ techniques used to enhance the, implementation and sustainability of C*f*L.

- **Objective 2:** To identify the key national C*f*L implementation structures and seek stakeholders' perspectives on the functioning of these structures.

[3] Proctor, E., *et al* (2013) Implementation strategies: recommendations for specifying and reporting. Implementation Science 8: 1-11.

Method

In order to address Objective 1 of the study, a review of the literature was carried out to identify recognised implementation strategies. The 73 discrete evidence-informed strategies identified by and included in the Expert Recommendations for Implementing Change (ERIC)[4] study were selected. All strategies were reviewed against *CfL* HSE Mental Health work (inclusive of the HSE NOSP) at a local and national level.

As part of Objective 2, the HSE NOSP M&E Team conducted one-to-one interviews with key stakeholders (n=5)[5] to gain a deeper understanding of the HSE *CfL* implementation structures and strategies. Figure 1 presents the identified structures. Data from the interviews and from the broader literature on implementation science, informed the survey which was intended to elicit stakeholder perspectives on *CfL* implementation structures. The key domains of the survey included:

1. Stakeholder perspectives on the HSE NOSP as a key driver for the implementation of *CfL* including its leadership, capacity and capability to deliver on its strategic commitments. All stakeholders were invited to complete this section of the survey.
2. Stakeholder perspectives on other *CfL* implementation structures, including the National Cross Sectoral Steering and Implementation Group and the HSE structures.

All stakeholders involved in national *CfL* implementation structures, other than the HSE NOSP (unless participants in external implementation groups), were invited to take part in the survey (n=79). It was circulated to relevant implementation structure group members via email with a Qualtrics ® link from the HSE NOSP's M&E function. The survey was carried out in June/July 2018: there was an overall response rate of 59% (47/79).

Table 1 presents a breakdown of the response rate by implementation structure. While the ideal is a survey response rate of 80%, a response rate approximating 60% is the goal and the expectation. Table 1 shows a non-response bias of 70% for the HSE National *CfL* Steering Group. This has an effect on the validity and reliability of the data; consequently the findings related to the survey section on this HSE implementation structure are not reported on in this briefing.

Table 1: Survey Response Rate (by implementation structure)

Survey	Response	
	N	%
The National *CfL* Cross Sectoral Steering & Implementation Group	19/35	54%
The HSE National *CfL* Steering Group	3/10	30%
HSE MH /NOSP Group – with representation from local areas, including ROSPs & Heads of Service for Mental Health	9/12	69%
Resource Officers for Suicide Prevention	15/22	68%

Key Findings

Analysis showed that the HSE Mental Health/the HSE NOSP are using a broad spectrum of **evidence-informed implementation strategies** to drive the strategy nationally and locally. Figure 1 shows the key implementation strategies being used.

Figure 1: HSE Implementation Strategies

National

1. Obtain formal commitments
2. Create a learning collaboration
3. Provide ongoing consultation
4. Recruit, designate & training for leadership
5. Revise professional roles
6. Facilitation
7. Stage implementation scale up
8. Assess for readiness & identify barriers & faciltators
9. Tailor implementation strategies
10. Use train-the-trainer strategies

Local

1. Conduct local needs analysis
2. Conduct local census meetings
3. Conduct educational meetings
4. Create a learning collaboration
5. Inform local opinion leaders

Both

1. Mandate change
2. Bulid a coalition
3. Develop a formal implementation blueprint/ plan
4. Develop academic partnerships
5. Conduct on-going training
6. Work with educational institutions
7. Use advisory boards & working groups
8. Develop & implement monitoring systems
9. Purposively re-examine implementation
10. Use data experts
11. Develop educational materials

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[4] Powell, B., Waltz, T., Chinman *et al* (2015) A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project. Implementation Science 10:21:

[5] Involving: (i)HSE ROSP rep (ii)Programme Manager MH SPPMO (iii)HSE MH *CfL* Implementation Lead (iv)HSE MH Service Improvement Lead rep (v)Assistant National Director HSE Mental Health Community Strategy.

Some are discrete implementation strategies such as the assessment of NGO partners' readiness to engage with and implement the Best Practice Guidance for Suicide Prevention Services[6]. Others are multi-faceted implementation strategies (i.e. using two or more discrete strategies[7]) such as the use of train-the-trainer strategies to deliver on-going suicide prevention training across the country, or using data from the HSE NOSP monitoring system to purposively (re)examine implementation of C*f*L (through an interim strategy review process).

The strategies employed differ somewhat depending on the level of implementation (national or local), the stage of implementation and what is being implemented. Generally, the discrete implementation strategies can be classified as follows;

- Planning strategies which can help stakeholders gather data (i.e. conducting local needs analysis, assessment for readiness) select strategies (i.e. developing implementation plans, staged implementation scale-up), build buy-in (i.e. conducting census meetings) initiate leadership (i.e. recruit, designate & train for leadership, mandate change) and develop the relationships (i.e. building a coalition, obtaining formal commitments, developing academic partnerships) necessary for successful implementation
- Education strategies of various levels of intensity such as developing materials, educating (i.e. conducting educational meetings, on-going training, using train-the-trainer strategies, providing on-going consultation) educating through peers (i.e. inform local opinion leaders, create learning collaborative), and informing and including stakeholders (i.e. working with educational institutions)
- Restructuring strategies that facilitate implementation by altering staffing and/or professional roles and/or physical structures and data systems (i.e. revising professional roles)
- Quality management strategies focused on putting data systems and support networks in place to continually evaluate and enhance implementation (i.e. developing monitoring systems, use of advisory boards & working groups, purposively re-examining implementation & using data experts)

[6] https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/research-evaluation/findings/best-practice-guidance-for-suicide-prevention-services-survey-sept-2018.pdf

[7] Powell, B. et al (2012) A compilation of Strategies for Implementing Clinical Innovations in Health and Mental Health Medical Care Research and Review 69:2:123-157.

Structures support strategy implementation. The alignment of a strategy with/to structures often determines how well a strategy gets implemented. Existing and new implementation structures (and processes) are being used to support the (top-down) implementation of C*f*L. Figure 2 presents the key national C*f*L implementation structures. Included is the HSE NOSP, set up in 2005 to oversee the implementation of *'Reach Out'* the first Irish National Strategy for Action on Suicide Prevention. Thereafter, the HSE NOSP led out on the planning process for the subsequent (and current) suicide prevention strategy.

Under C*f*L, the **HSE NOSP's role** is to support, inform, monitor and co-ordinate the implementation of the strategy. To this end, developing, supporting and maintaining relationships with and between implementation partners is crucial.

- Most survey respondents (85%) were of the opinion that the HSE NOSP was (substantially/ almost entirely) respected by key partners and external agents, and in turn respects the role and contribution of all C*f*L stakeholders (79%) regardless of discipline, seniority and status. The majority also (79%) reported that they (substantially/almost entirely) looked to the office for 'support, strategy guidance and leadership'. This reinforces the need for the HSE NOSP to be a high functioning office with implementation, monitoring and evaluation expertise. (FIGURE 3)
- While most respondents (89%) were of the opinion that the HSE NOSP (substantially/ almost entirely) "owns and nurtures C*f*L and its shared vision'" one- third (32%) of those surveyed stated that the HSE NOSP is only 'somewhat' effective in communicating the strategy's vision. (FIGURE 3)

Leadership and enhanced (programme management and evaluation) capacity within the HSE NOSP is crucial for the successful implementation of C*f*L.

- Three-quarters of respondents were of the opinion that the HSE NOSP has (substantially/ almost entirely) built a highly functioning team capable of driving the national C*f*L implementation plan. Two-thirds were of the opinion that the HSE NOSP (substantially/ almost entirely) has a team capable of evaluating the implementation and outcomes of C*f*L. A similar proportion (62%) reported that the HSE NOSP was (substantially/ almost entirely) providing effective communication streams with relevant stakeholders. While

more than one-in-two respondents (55%) reported that the HSE NOSP was (substantially/ almost entirely) capable of providing the (NGO) organisations working in suicide prevention with standards and guidelines to ensure safe and effective service delivery (AS PER CfL ACTION 5.1.1). (FIGURE 4)

- Respondents were not as confident in the HSE NOSP's competence in developing, coordinating and implementing a national training and education plan. More than half of the respondents (53%) reported the HSE NOSP was "not at all/somewhat" capable in this regard. At the time of the survey (June/July 2018) the HSE NOSP Education and Training Manager post had been vacant for approximately one year and there was no formal CfL Education and Training Plan in place (CfL Action 2.3.1). Survey respondents were also less confident in the capability of the HSE NOSP to provide a clinical advisory function. This may in part be due to respondents not clearly understanding the function of the role (evidenced by the fact that 34% of responses were 'I don't know') (FIGURE 4).

The National Cross Sectoral Steering and Implementation Group was established under CfL. Chaired by the Department of Health, membership comprises of representatives from 17 state agencies/government departments that have commitments as part of the strategy. This group is the leadership team driving top-down implementation of the national strategy.

- The majority (61%) of the broader CfL stakeholder respondents were of the opinion that the work of the Cross Sectoral Steering and Implementation Group (substantially/ almost entirely) "plays an instrumental role in driving the implementation of CfL". That said, one quarter of respondents reported that they were "not at all" informed about the role and function of the Group and 50% reported that they were not updated on the working of the group and its decision making[8]. (FIGURE 5)

Members of the Cross Sectoral Steering and Implementation Group were also asked their perspective on the group.

- The majority of respondents (66%) reported that the Government Department/Agency they represented (substantially/almost entirely) considered the implementation of CfL as a priority. Most (74%) felt that their roles and responsibilities as a member of the Cross Sectoral Group are (substantially/ almost entirely) clear, however only 40% of respondents reported that they (substantially/almost entirely) actively participated at meetings. (FIGURE 6)

- The majority (73%) of respondents were of the opinion that the implementation of CfL is (substantially/ almost entirely) realistic and achievable, and that they understand national CfL implementation processes and structures. Furthermore, most (87%) were of the option that there is (substantially/ almost entirely) an adequate monitoring system in place to drive implementation of the strategy. However, the survey findings suggest that more could be done to cultivate strategy champions and promote active member participation in the group. (FIGURE 6)

The HSE National CfL Steering Group was established under CfL and is chaired by HSE Mental Health. It is intended to provide strategic direction and accountability on the implementation of all 40 HSE actions under the national strategy. The group convenes in advance of every National Cross Sectoral Steering and Implementation Group meeting, and a HSE specific quarterly Implementation Report is generated by the HSE NOSP's M&E Team to focus and direct the meeting discussion.

- Two thirds of broader CfL stakeholders' constituent reported that they were not (not at all/somewhat) informed about this implementation structure's role and function in relation to CfL or updated in relation to its work and decision making. Consequently, only half the survey respondents were of the opinion that the work of this group (substantially/almost entirely) plays an instrumental part in driving the implementation of the strategy. (FIGURE 7)

The HSE Mental Health and NOSP National Steering Group was set up to advise on, and provide strategic direction on the implementation, nationally and locally, of HSE Mental Health and NOSP actions in CfL. In Q3, 2018 the composition of the group changed to include the work of a Mental Health specific actions Steering Group and that of a HSE NOSP-HSE Mental Health-Project Management Office Working Group.

- While more than half of survey respondents (58%) were of the opinion that this group (substantially/almost entirely) plays an instrumental part in driving the

[8] As of Quarter 3 2018 CfL Implementation Progress Report, which given an analysis of (top-down) implementation activity, have been available on the CfL website. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/strategy-implementation/implementation-progress-reports/

implementation of C*f*L, knowledge of the group's role, function and decision making was limited, which is to expected considering the group was not formally established at the time of the survey. (FIGURE 8)

The HSE Resource Officer for Suicide Prevention (ROSP) Learning Community of Practice was formed in Q3, 2017 and was set up as a vehicle for connecting the HSE ROSPs in the spirit of learning, knowledge sharing, and collaboration and building individual, group, and community (suicide prevention and implementation) capacity.

- Less than half of the survey respondents (45%) recognise the ROSP Learning Community of Practice as (substantially/almost entirely) playing an instrumental part in driving the implementation of C*f*L. This is perhaps due to the fact that knowledge of the group's role and function in relation to C*f*L was limited; 68% of respondents reporting being "not at all/somewhat informed". In addition, only one-in-four respondents reported feeling (substantially/almost entirely) adequately updated in relation to the work of this group and the decisions that it makes. (FIGURE 9)

The **Strategic Portfolio and Programme Management Office** (SPPMO) was established in 2015 by HSE MH in conjunction with the Centre for Effective Services (CES). As per the office's guide, the purpose of the SPPMO is to 'support HSE MH in delivering successful strategic change leading to improved outcomes'. The SPPMO provides support to project managers, project sponsors and executive sponsors, supports the governance processes and advises on project methodology for the Mental Health Change Board (MHCB) group. The MHCB group was established to provide oversight and executive decision making for the Mental Health Portfolio of Projects. Table 2, below, shows that a total of six CfL projects have been brought into the MHCB structure. Table 2, below, shows that a total of six C*f*L projects have been brought into the MHCB structure.

- More than half of respondents (55%) reported that the work of the MHCB group (substantially/ almost entirely) plays an instrumental part in driving the implementation of C*f*L. However, approximately one-third of respondents felt that they were "not at all" adequately informed as to this group's role and function in relation to C*f*L, and 43% reported that they were "not at all" adequately updated in relation to the work of this group and the decisions that it makes. (FIGURE 10)

Table 2

Project Name	Status as of January 2019	Comment
Future of Mental Health Stigma reduction campaigns: C*f*L Action 1.3.1	Implementation	
Alignment of CHO C*f*L Action Plans: C*f*L Action 2.1.1	Closed	A consultant was hired by the HSE NOSP to conduct the majority of this work – the project went into the MHCB after a considerable amount of work was already completed as part of the C*f*L local area plan alignment to the national strategy process
Standard availability of Talking Therapies in Mental Health Services C*f*L Action 4.2.1	Initiation	
Uniform Assessment for those at risk of Self-Harm C*f*L Action 4.1.4 & 5.2.1	Initiation	
Deliver enhanced bereavement support services to families and communities affected by suicide C*f*L Action 4.3.1	Initiation	
HSE Best Practice Guidance Suicide Prevention Services C*f*L Action 5.1.1	Implementation	This project entered the MHCB after a considerable amount of work was completed (draft guidance themes for NGOs were available). A specific post is sanctioned in the HSE NOSP since 2014 to focus on conducting this work hence the level of progress prior to this work entering the MHCB.

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Figure 2: National *CfL* Implementation Structures

Connecting for Life National Cross Sectoral Steering and Implementation Group

Role: High-level oversight of the implementation of *CfL* and addressing national barriers to implementation

Membership: Dept Health, Dept Communications Climate Action & Environment, Dept Rural & Community Development, Dept Transport Tourism & Sport, Dept Defence, Dept Education, Dept Employment Affairs & Social Protection, Dept An Taoiseach, Dept Children & Youth Affairs, Dept Jobs Enterprise & Innovation, Dept Justice, Dept Agriculture, TUSLA Child & Family Agency, Irish College of General Practitioners, Local Authorities, HSE Mental Health Operations, HSE NOSP, HSE Primary Care, HSE Health & Wellbeing, Academic Rep, Psychiatry Rep, NGO Reps

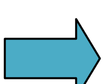
HSE National Office for Suicide Prevention (NOSP)

Role: Responsible for the overall implementation of *CfL* at a national level

Consists of the following core functions:

- Communications
- Best Practice Guidance for Suicide Prevention Services
- Monitoring & Evaluation
- Clinical Advisory
- Training Strategy development and implementation

Staff composition of the office includes: (i) Director of Office (ii) PA to Head of Office (iii) Lead for Strategy Coordination, Quality & Education (iii) National Ed & Training Programme Manager (iv) Lead for Best Practice Guidance development for NGO Partners (v) Monitoring & Evaluation Manager (vi) Research & Data Officer (vii) Research Assistant (viii) Communications Manager (ix) Content Development Officer (x) Administrative Posts *3 (xi) Strategy Implementation Support post



HSE Connecting for Life Steering Group

Role: To provide strategic direction and accountability on the implementation of the 40 actions in *CfL* for which the HSE has a lead role in implementing.

Membership:
Chaired by HSE Mental Health, comprised of:
- National Clinical Lead – Addiction Services **(HSE PC rep)**
- (i) National Director of Operations HSE MH (ii) HSE MH Implementation Lead **(HSE MH reps)**
- GM, Health Promotion & Improvement Dublin Mid Leinster **(HSE H&W rep)**
- National Director Acute Operations **(HSE Acute Hosp rep)**
- (i)Assistant ND HSE MH Community Strategy and Head of NOSP (ii) Lead for Strategy Coordination, Quality & Education (iii) Research Assistant **(HSE NOSP reps)**

HSE Mental Health and NOSP National Steering Group for the implementation of *CfL*

Role: To advise on, and provide strategic direction on the implementation, nationally and locally, of MH and NOSP actions in *CfL*. The group brings together the work of the original HSE MH Steering Group and the NOSP-Mental Health-PMO Joint Action Planning Group

Membership: National Director of Operations HSE MH, Director of NOSP, HSE MH Implementation Lead, CHO MH Leads, Reps from Resource Officers for Suicide Prevention, rep of the SPPMO Office

Mental Health Change Board (MHCB) Group

Role: The MHCB provides oversight and executive decision making for the Mental Health Portfolio of Projects. The SPPMO provides support to project managers, project sponsors and executive sponsors and supports the governance processes for the MHCB.

Membership: Consists of members of the National Mental Health Management Team, Heads of Service for Mental Health, Chief Officers, Head of EPMO, Office of Chief Information Officer and Director of NOSP.

Figure 3: Feedback on the HSE NOSP

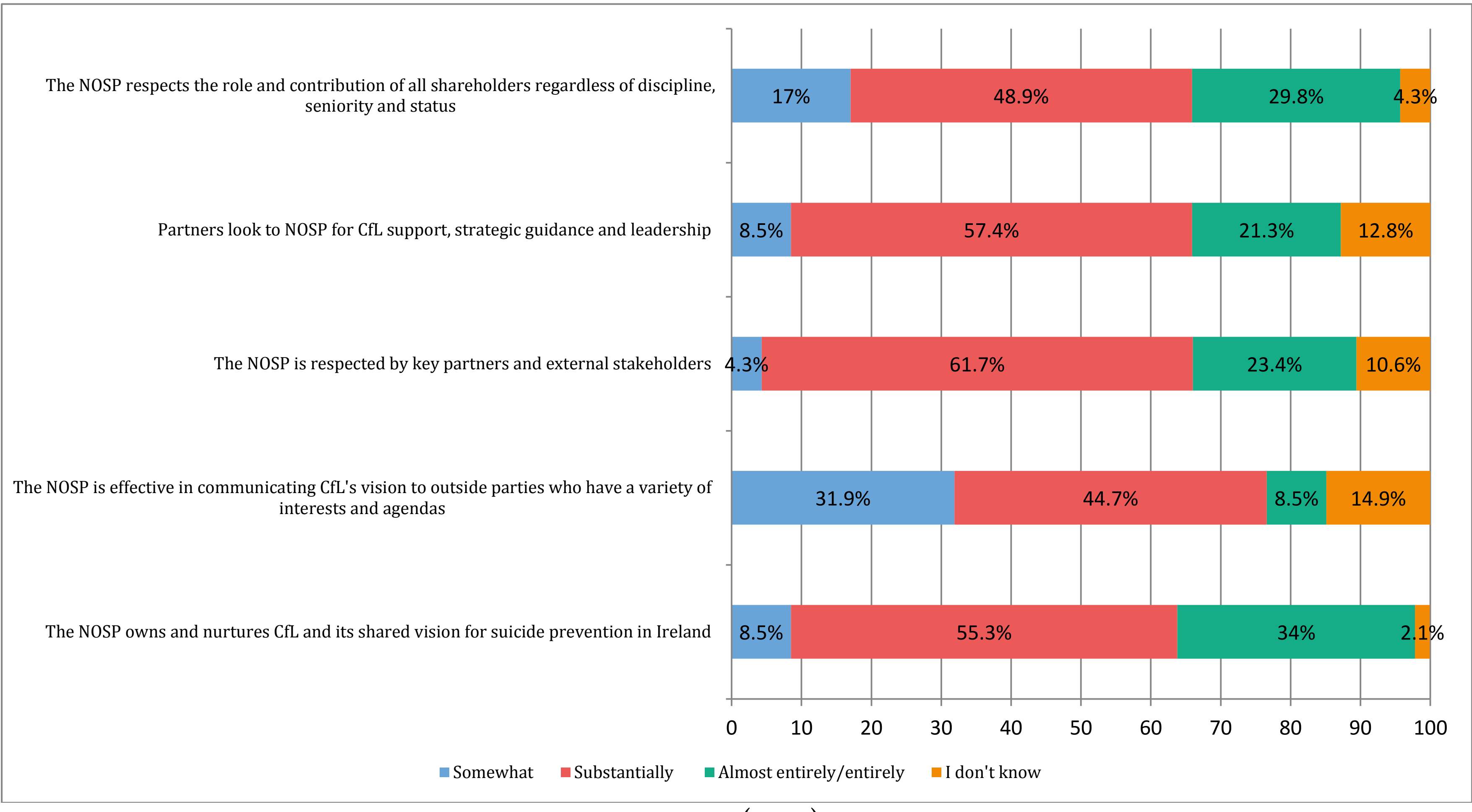


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Figure 4: HSE NOSP Leadership and Capacity

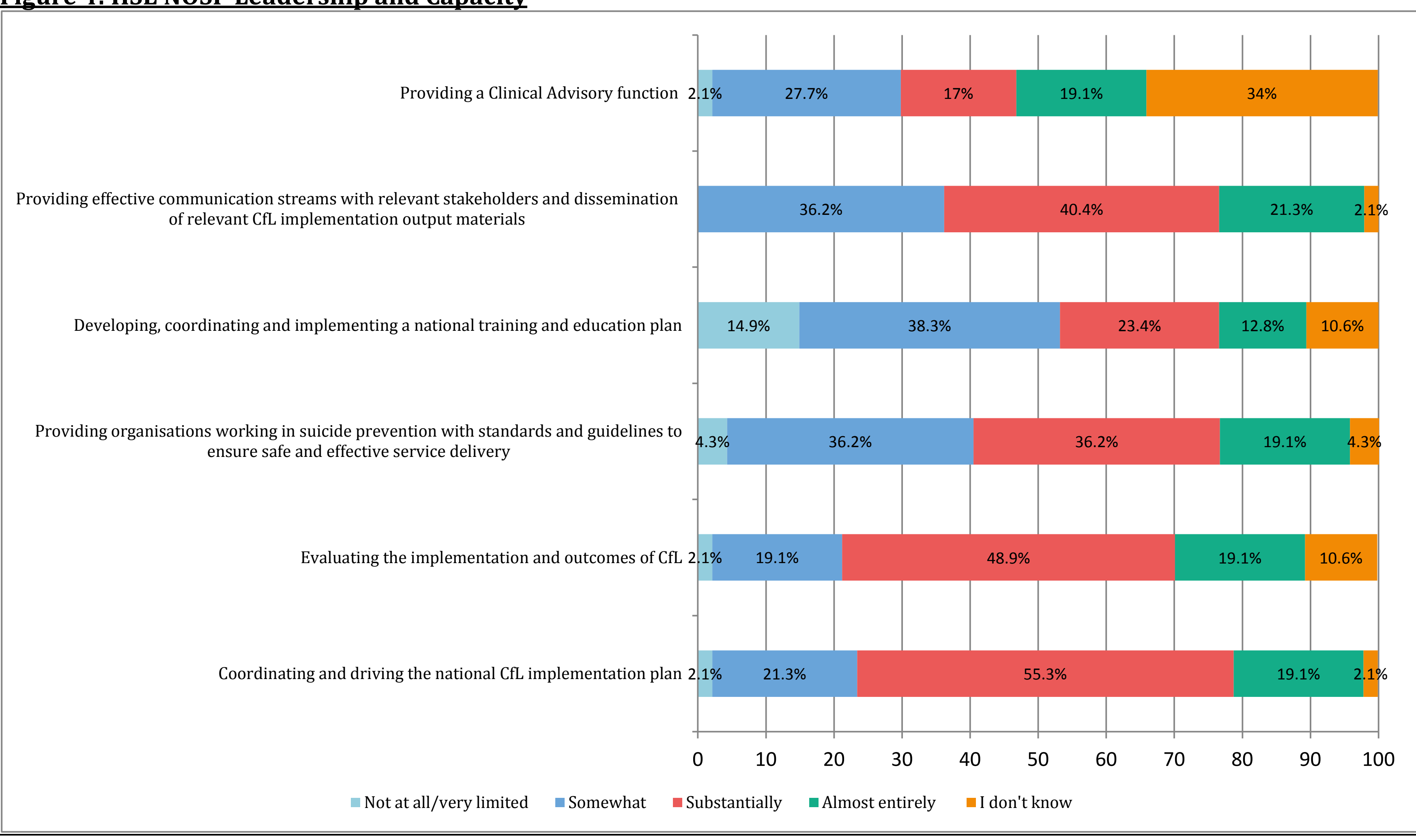

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Figure 5: Feedback on the working of the *Cf*L National Cross Sectoral Steering and Implementation Group

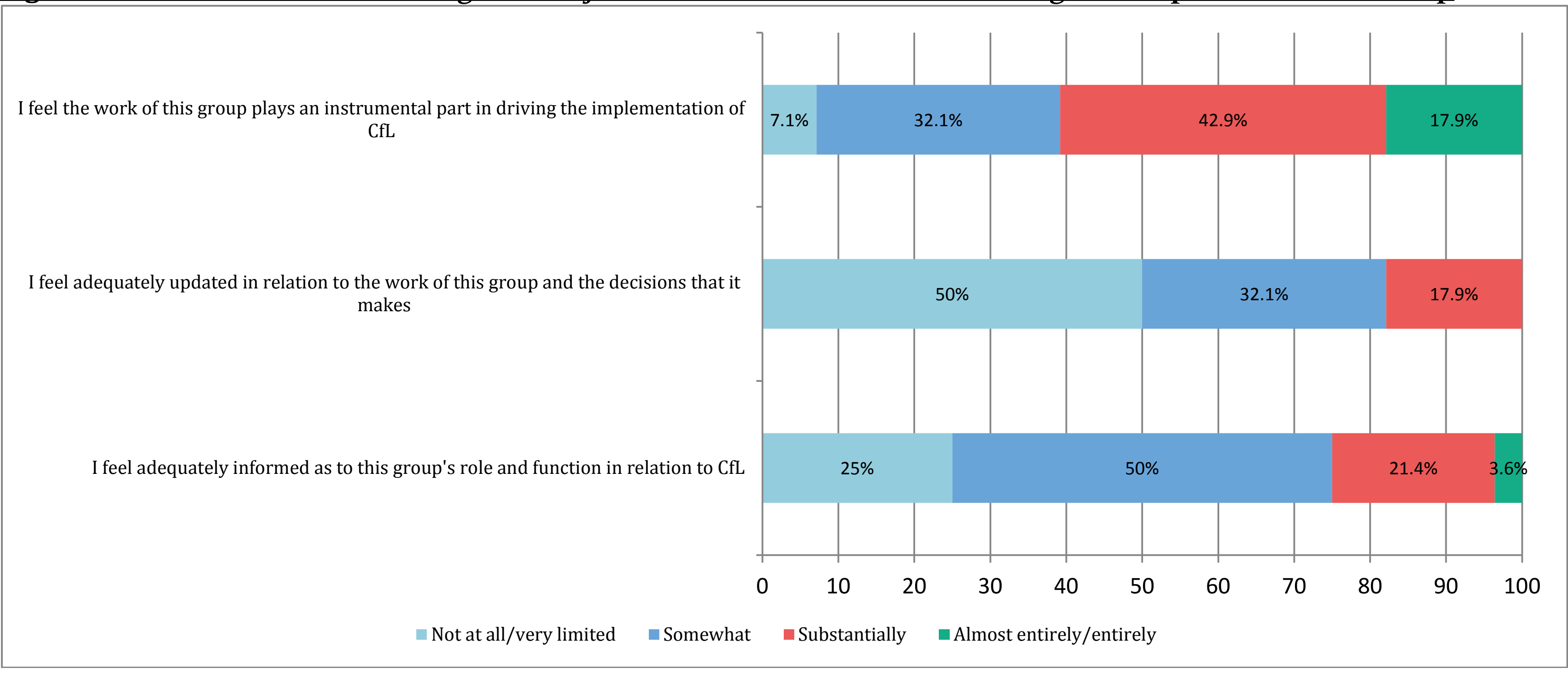

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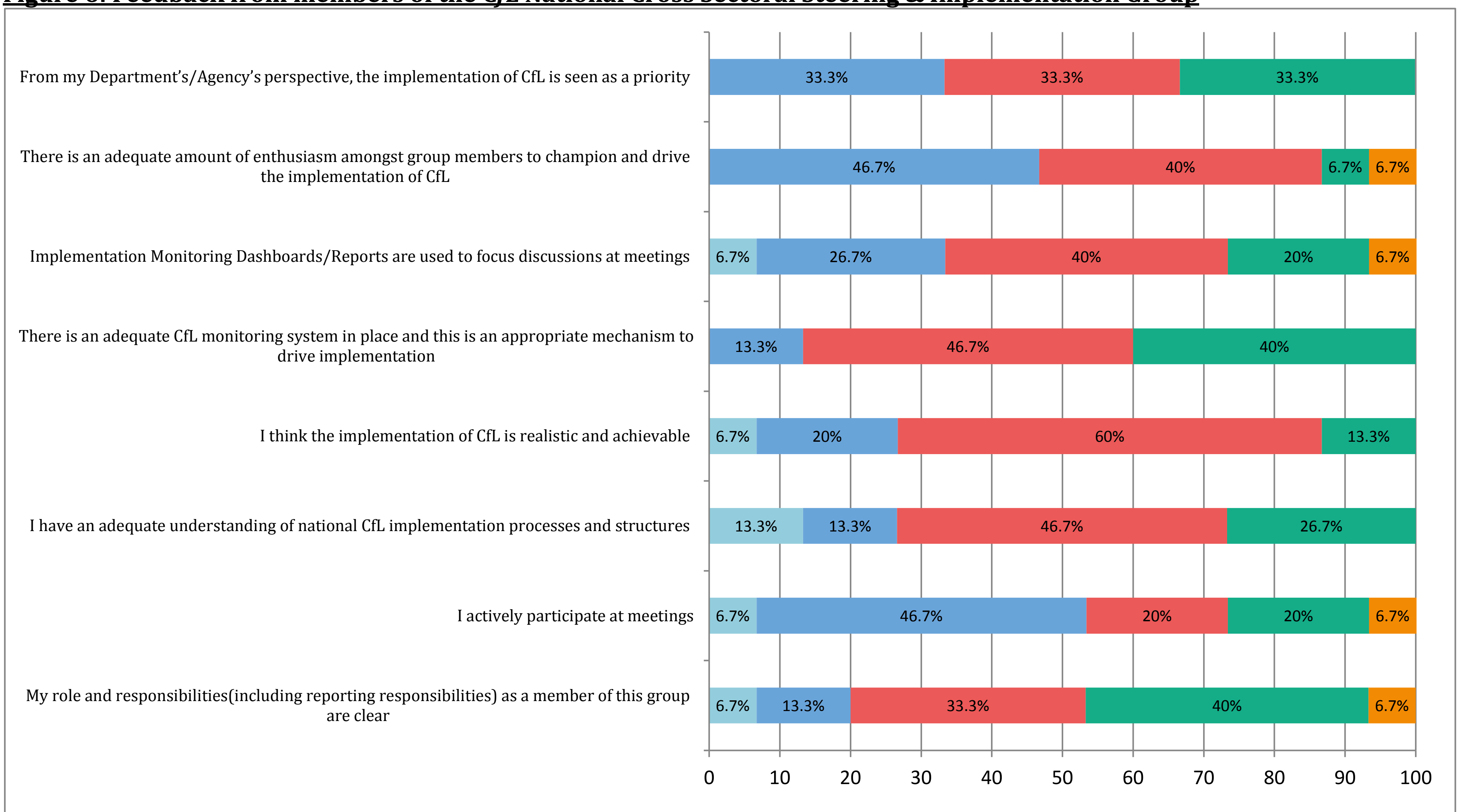
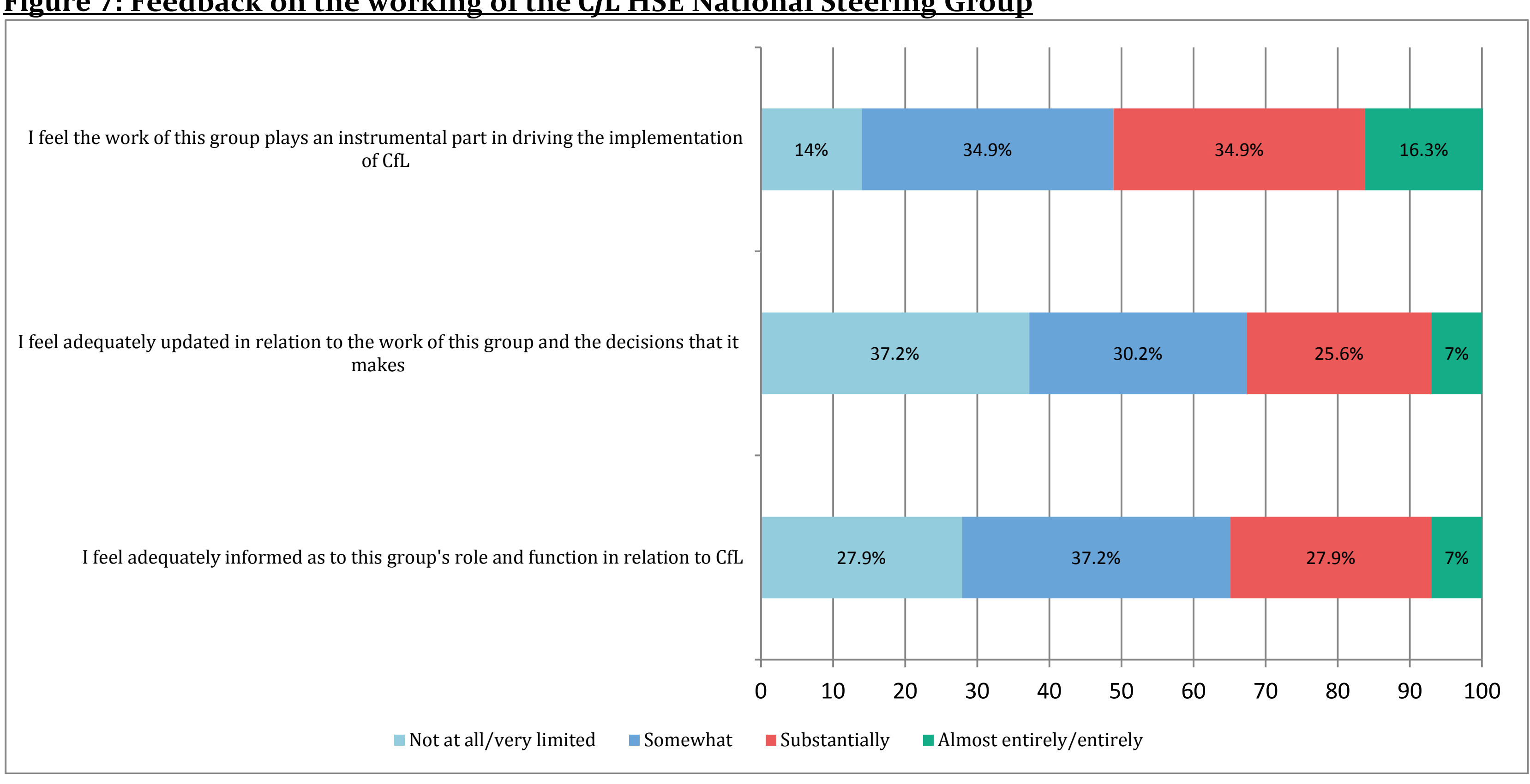
Figure 6: Feedback from members of the *Cf*L National Cross Sectoral Steering & Implementation Group



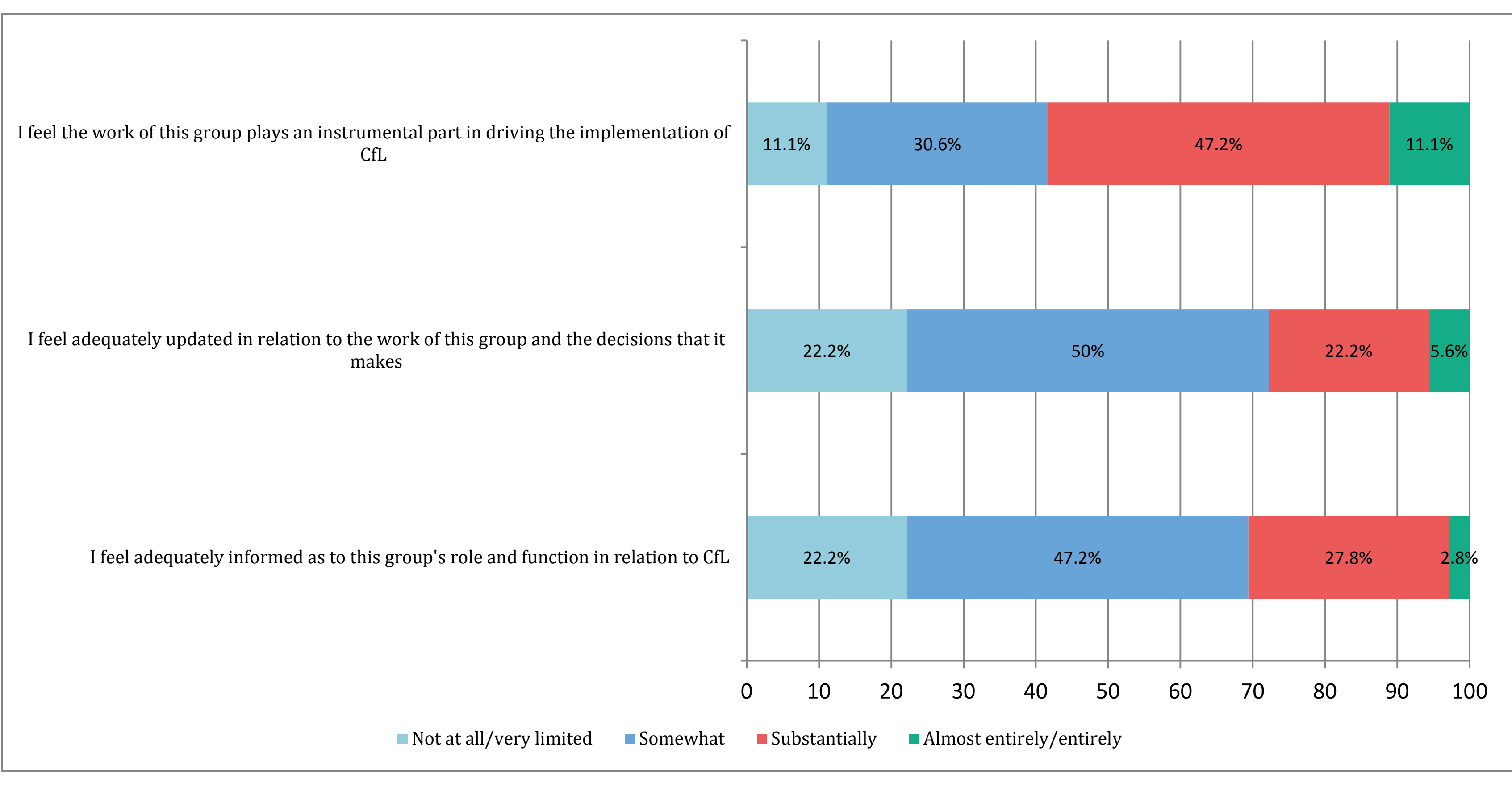
(n=15)

Figure 7: Feedback on the working of the C*f*L HSE National Steering Group



(n=43)

Figure 8: Feedback on the working of the HSE Mental Health and NOSP National Steering Group



(n=36)

Figure 9: Feedback on the working of the HSE Resource Officer for Suicide Prevention (ROSP) Business Learning Community of Practice Group

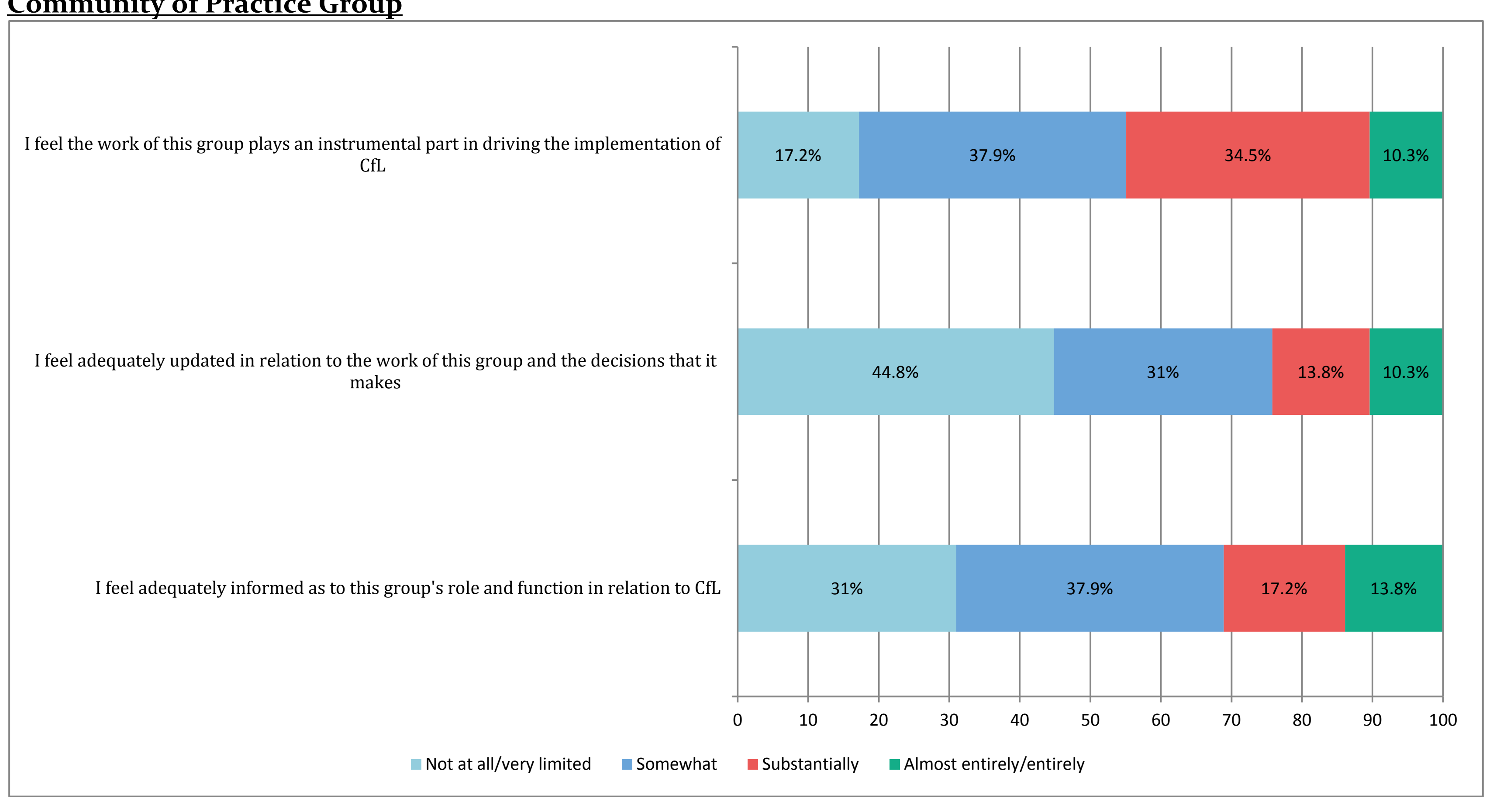


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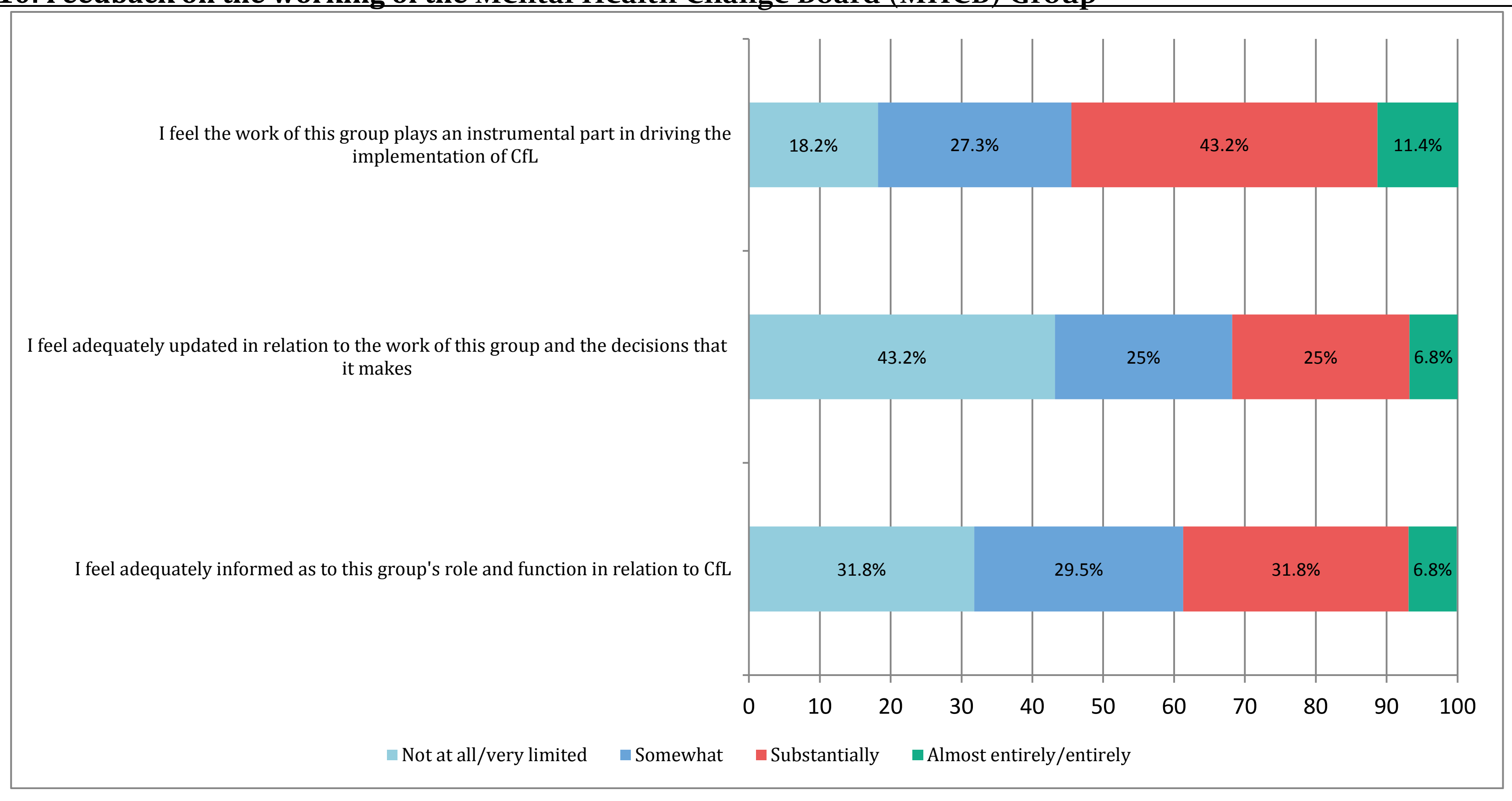
Figure 10: Feedback on the working of the Mental Health Change Board (MHCB) Group



(n=44)