Health Innovation East

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Hertfordshire Partnership University Foundation Trust (HPFT) Suicide Prevention Pathway Evaluation of Early-phase Implementation

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From January 2024, Hertfordshire Partnership University NHS Foundation Trust (HPFT) began implementing a newly developed Hertfordshire Suicide Prevention Pathway (HSPP), locally adapted from the nationally recognized Australian Gold Coast Health & Hospital Service Suicide Prevention Pathway (GCSPP).

Health Innovation East was commissioned to conduct an evaluation of the early phase of implementation to provide real-time insights to support ongoing pathway improvement, enhance system-wide learning, and inform future suicide prevention strategies across healthcare systems.

Aim

To understand how the HSPP has been implemented within a complex, multi-agency mental health system and identify key factors influencing the implementation process.

Objectives

- Understand the implementation process and adaptations made
- Explore challenges and enablers to implementation
- Capture staff perspectives, particularly around training experiences
- Apply the findings to identify recommendations for supporting implementation

Methodology

A developmental evaluation approach was used, allowing for iterative feedback and adaptation. Data was collected between April 2024 and February 2025 through workshops, and stakeholder conversations. The Implementation Research Logic Model (IRLM) and Theoretical Domains Framework (TDF) were used to inform the data collection and analysis.

Key Findings

Implementation Strategies

A multi-faceted approach was used, including staff training, promotional activities, system integration, and iterative adaptation. Continuous feedback led to adaptations and improvements in implementation particularly in IT systems and training.

Challenges and Enablers

- Strong leadership and flexibility in approach supported implementation success
- IT system limitations and inconsistent messaging were challenges
- Staff reported varying understanding of the pathway, with concerns around change, adaptability, and consistency, especially in discharge practices

Training

- Training was a cornerstone of implementation, with the simulation hub training widely appreciated for building confidence in handling suicide risk
- Chronological Assessment of Suicide Events (CASE) approach training, originally purchased from USA, was seen as a helpful refresher for some but less engaging for experienced staff. Suggestions included contextualised scenarios and post-training assessments

Mechanisms Supporting Implementation

- Real-time adaptation
- Introduction of peer learning initiatives
- Clearer documentation and communication strategies, aligned with staff roles

Outcomes (desired and achieved)

- There was shared vision, but more varied understanding of the HSPP, its benefits & relevance to specific roles across staff groups and service partners
- Increased number of patients on the pathway
- Increased number of staff who participated in training activities
- Many of the intended outcomes such as embedding HSPP as Business as Usual (BAU), integration of systems to support the HSPP across teams and organisations, multi-level and multi-agency involvement remain in progress reflecting the early-phase of implementation and the challenges of organisational change

Conclusion & Recommendations

- The early implementation of the HSPP has demonstrated promising practices and valuable lessons. Key strengths include strong leadership and effective real-time adaptation. However, consistent communication, improved staff engagement, and ongoing system optimisation are critical to sustained success.
- This evaluation provides valuable insights to inform further implementation of the HSPP and to support broader adoption of suicide prevention models across healthcare services. Continued commitment to shared understanding, adaptive training, and patient-centred care will be vital in achieving long-term impact in HPFT and similar settings.

List of Abbreviations

A&E	Accident and Emergency
BAU	Business as Usual
CASE	Chronological Assessment of Suicide Events
CAMHS	Child and Adolescent Mental Health Services
CPR	Connect, Prevent, Respond
ED	Emergency Department
EPR	Electronic Patient Record
GCSPP	Australian Gold Coast Health & Hospital Service Suicide Prevention Pathway
GP	General Practitioner
HCP	Health Care Professionals
HNA	Health Needs Assessment
HPFT	Hertfordshire Partnership University NHS Foundation Trust
HSPP	Hertfordshire Suicide Prevention Pathway
HWE	Hertfordshire & West Essex
ICB	Integrated Care Board
ICS	Integrated Care Systems
IRLM	Implementation Research Logic Model
MHLDA HCP	Mental Health, Learning Disability and Autism Health Care Partnership
TDF	Theoretical Domains Framework
ZSF	Zero Suicide Framework

1. Introduction

Hertfordshire Partnership University NHS Foundation Trust (HPFT) commissioned Health Innovation East to conduct an evaluation of the early phase implementation of the Hertfordshire Suicide Prevention Pathway (HSPP) via the Integrated Care Board (ICB). The pathway is based on the Australian Gold Coast Health and Hospital Service Suicide Prevention Pathway (GCSPP) (1). This is a system wide project across East and North Hertfordshire NHS Trusts, led by HPFT. The pathway has been implemented in a multi-disciplinary and multi-agency acute mental health programme as part of suicide prevention and management. The evaluation findings were intended to inform the ongoing implementation of the Suicide Prevention Pathway across teams within the system, and to provide insights that would be applicable to similar healthcare settings to support pathway development and implementation.

1.2 The Need for a New Hertfordshire System Wide Suicide Prevention Pathway

Adoption and development of the new pathway in Hertfordshire was a response to:

- Rising suicide rates nationally and locally, alongside the impact of the COVID-19 pandemic on wider determinants of suicide, such as relationship issues, unemployment, debt and housing, particularly for at-risk groups (2).
- An evolving Integrated Care Systems (ICS) landscape.
- The Hertfordshire and West Essex Integrated Care Board (ICB) Health Needs Assessment (HNA) that identified mental health as a clinical focus, with priorities of reducing suicide rates and attendances, admission rates for self-harm, and rates of Accident and Emergency (A&E) attendances involving substance misuse and violence.
- Hertfordshire Public Health data showing:
    - increased numbers in unexpected deaths and deaths by suicide for the period April 2021 to June 2022
    - the need for better understanding and follow up for follow-up attenders in crisis, and for service users who self-harm who were being discharged back to their GP
- Increasing evidence from research showing three key influences on suicide prevention:
    - detection of suicide risk is inadequate;
    - evidence-based, suicide-specific interventions are not deployed; and
    - intensity of care is not increased during high-risk periods (3).
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In January 2025 HPFT published a service evaluation that reported on characteristics and outcomes of people in suicidal crisis at the two local emergency departments (4). Findings support the implementation of the Hertfordshire Suicide Prevention Pathway specifically in relation to several elements:

- the importance of early identification of people with suicidal ideation,
- the focus of standardised suicide-specific screening, assessment and intervention tools for clinicians to use, such as safety planning,
- the need for a structured follow-up to reassess suicidality
- the role increasing knowledge and awareness of risk factors can play.

1.3 The Gold Coast Health & Hospital Service Suicide Prevention Pathway (GCSPP)

HPFT identified the Gold Coast Health and Hospital Service Suicide Prevention Pathway (GCSPP), delivered since 2016 in Australia, as an evidence-based model to address these needs (1, 5, 6). The GCSPP follows from widespread adoption of the Zero Suicide Framework (ZSF) (1, 7), a system-wide approach to care after a suicide attempt with the goal that no suicides should occur when a person is in contact with health services (8, 9).

The ZSF provides a holistic approach to suicide prevention across a healthcare system with a focus on leadership, training and support for staff, inclusion of lived experience, and culture change (6). The framework has seven core elements that have been identified as essential to safe care provision for individuals with suicidal thoughts and urges (1):

i) Leadership: Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors (next of kin/friends & family) in leadership and planning roles.
ii) Train: Develop a competent, confident, and caring workforce.
iii) Identify: Systematically identify and assess suicide risk among people receiving care.
iv) Engage: Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs.
v) Treat: Use effective, evidence-based treatments that directly target suicidality. Include collaborative safety planning and restriction of lethal means.
vi) Transition: Provide continuous contact and support, especially after acute care.
vii) Improve: Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

The evidence base for the ZSF has been building, with evidence suggesting multiple benefits for service users and health care professionals. A cross-sectional analysis demonstrated a reduction in repeated suicide attempts after an index attempt and a longer time to a subsequent attempt for those receiving multilevel care based on the ZSF (10). Another study testing fidelity, reported an association between clinics' use of Zero Suicide organizational best practices and lower suicidal behaviours of patients under their care (11). Improvements have been shown in implementation processes, staff skills and confidence, positive cultural change, and innovations in areas such as the use of machine learning for identification of suicide presentations (1). The implementation of the GCSPP as 'Business as Usual' (BAU) in late 2016 has been associated with reductions in the rates of repeated suicide attempts and deaths by suicide (1).

1.4 The adapted HSPP

The adapted HSPP was developed and co-produced by the Hertfordshire Mental Health, Learning Disability and Neurodiversity Health Care Partnership (MHLDA HCP). Adoption and implementation of the pathway involved an extensive range of stakeholders from across Hertfordshire including NHS trusts, local authorities, voluntary sector partners and experts by experience. The extensive network of collaborators is shown in Figure 1. It aims to provide a structured approach to care and seamless transitions for service users across the system.

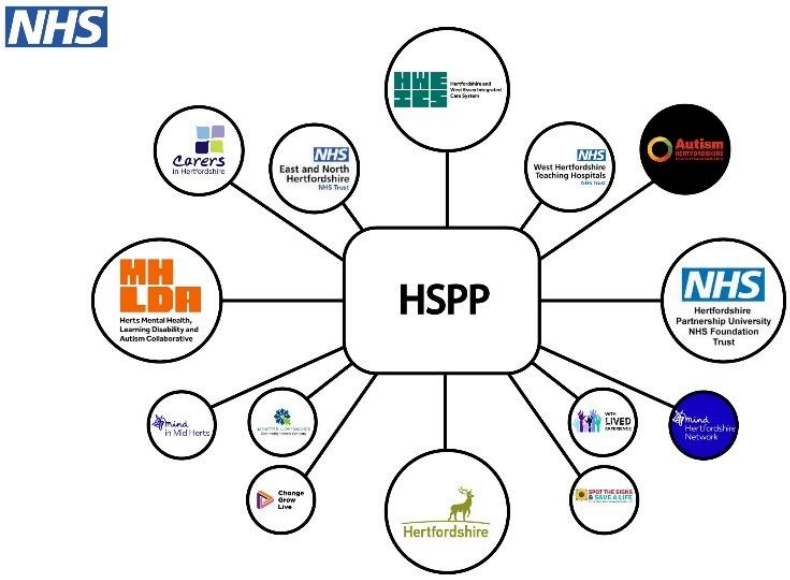


Figure 1 Stakeholders collaborating in the development of the HSPP

The HSPP commenced in February 2024 to be delivered by acute services including A&E at Watford General Hospital and the Lister Hospital in Stevenage, Mental Health Urgent Care Center, Mental Health Liaison team at the Lister Hospital in Stevenage and all Crisis Resolution and Home Treatment (CRHT) Teams in HPFT.

Figure 2 shows the key elements of the HSPP modelled on the Gold Coast approach (1), and adapted to the local setting. Use of the Connect, Prevent, Respond (CPR) framework was incorporated in October 2024 following feedback to improve communication about the pathway and support the messaging around a common approach to suicidality and ensuring every contact counts.

The HSPP incorporates the Chronological Assessment of Suicide Events (CASE) approach (12), to identify suicidal ideation, planning and intent. This is a four-hour training module that is completed online, originally developed in the USA (13).

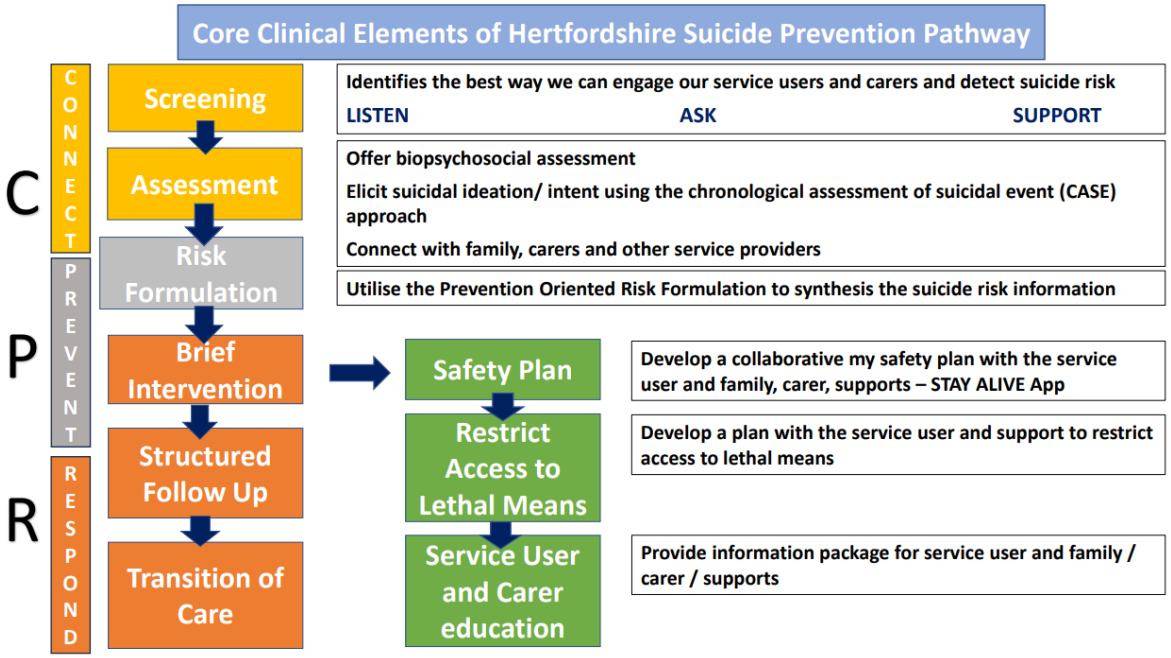


Figure 2 The 'Connect, Prevent, Respond' framework (Magon et al, 2024 (14))

The HSPP is being implemented in a range of teams within HPFT, including Mental Health Liaison, Crisis, Mental Health Urgent Care Centre and Crisis Resolution and Home Treatment Teams (acute assessment), as well as Lister Emergency Department. It also offered a referral pathway to the Mind Befriending service funded by Hertfordshire County Council Public Health.

2. Aim of the evaluation

To understand how the Hertfordshire Suicide Prevention Pathway (HSPP), an adapted Gold Coast Suicide Prevention Programme (GCSPP), has been implemented in a multi-disciplinary and multi-agency acute mental health setting in Hertfordshire, and to explore the factors influencing implementation.

2.1 Objectives

1. To identify and map the planned pathway for implementing the HSPP to better understand the rationale and context for adoption and adaptations in the pathway.
2. To explore challenges and enablers to implementation, including readiness for implementation.
3. To explore staff experiences and views on the training required and received as part of implementing the Suicide Prevention Pathway.
4. To apply the findings to identify recommendations to facilitate implementation within this and similar settings.

3 Method

3.1 Evaluation approach

We undertook a developmental evaluation (15) approach to allow us to share interim findings, so these could inform both ongoing implementation and adaptations to the evaluation. This allowed an iterative approach to continually check and challenge emerging findings and our methodology and was intended to ensure we fully addressed the objectives, the evidence required, and priorities of partners involved.

To describe the pathway development, we held regular meetings with the program lead. Through these we documented key activities, identified key implementation milestones and timelines, and tracked progress. This collaborative process allowed us to develop a shared understanding of the implementation of the HSPP; to produce visual representations to map the pathway and its implementation; and facilitated adaptive planning and data collection.

3.2 Implementation frameworks

We combined the use of two complementary implementation frameworks to guide data collection, analysis and reporting. The Implementation Research Logic Model Framework (IRLM) was used to build a map of the HSPP implementation process, and the Theoretical Domains Framework was used to specifically describe determinants to implementation (e.g. challenges and enablers), as described below. These frameworks provided a structured approach to develop semi-structured topic guides and workshop materials, to agree our sampling framework and to develop an appropriate coding framework for analysis.

The Implementation Research Logic Model Framework (IRLM)

The IRLM (16) provided high level components to appraise implementation processes and outcomes, and to provide a visual tool to summarise and share findings. We used this at three time points (April, July and December 2024) to enable the visual representations to be used to share findings and as a tool to capture insights and changes made to the implementation process and outcomes over time.

The Theoretical Domains Framework (TDF)

The TDF (17) provided a more detailed set of 14 domains to identify factors influencing behaviours of health professionals implementing evidence-based interventions. It identifies key constructs that influence behaviour, such as knowledge, motivation and skills. We used the TDF as a structured approach to develop data collection tools (Appendix 1) and to code and identify challenges and enablers to implementation.

3.2 Data collection

We collected qualitative data through a series of workshops and stakeholder conversations to gather the experiences and views of staff involved in relevant services and pathways across sites. Data was collected between April 2024 and December 2024.

We adapted our data collection iteratively to optimise the time available from participants and recruitment across staff teams. A pragmatic approach sought to minimise burden on health professional participants whilst ensuring a diverse and robust sample that would be representative of a range of experiences and perceptions. This included flexibility in mode of delivery (in-person or online), timing and length of sessions, use of existing meetings, and communicating via multiple channels. Figure 3 provides an overview of the data collection, including time frames, activities and participants.

We also gathered information through informal discussions with staff members; for example, in at least one occasion we were invited to attend a multidisciplinary team to talk to staff. These engagements facilitated the identification of key themes which subsequently were further explored and guided data collection.

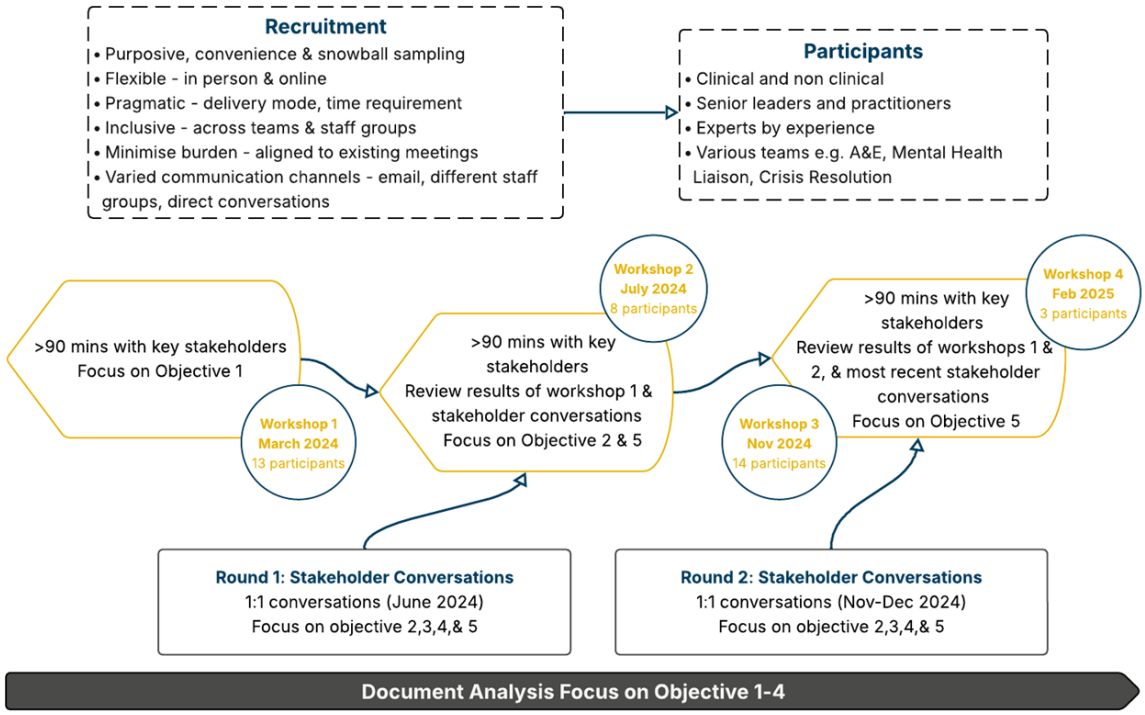


Figure 3 Overview of data collection conducted to address each objective

3.2.1 Recruitment

Relevant stakeholders were identified by the staff leading the HSPP and were sent an invitation to participate in the evaluation by email. We also recruited via meetings we attended and via a snowball approach, asking staff to invite other appropriate colleagues. The invitations provided information about the HSPP evaluation, topics for the relevant workshop or conversation, and a consent form.

Dates for the workshops were agreed with the programme leads and circulated to potential participants. Those who were invited to participate in a 1:1 conversation were asked to provide their contact details when signing the consent form so a member of the evaluation team could schedule a mutually convenient time for the conversation.

3.2.2 Workshops

Workshops were facilitated at three different stages of the implementation process (March 2024, July 2024, November 2024) with key stakeholders and, where possible 'experts by experience' to include the patients' and carers' voice. These workshops were a mixture of in person facilitated at HPFT sites and hybrid with optional on-line participation, depending on staff preference and availability at those sites. Each workshop was led by at least two members of the evaluation team.

Workshops had an approximate duration of 90 minutes. These sessions began with an introduction from the evaluation team, followed by a discussion guided by a semi-structured topic guide. Detailed notes were taken, and on three occasions the workshop was audio-recorded for the purposes of analysis. After each workshop, the evaluation team met to compare, combine and transcribe notes for analysis.

The first three rounds of workshops were for data collection purposes, where a formal topic guide shaped the session, data was analysed and synthesised within this report. The fourth

workshop (February 2025) was used as an opportunity to share our findings and encourage any final reflections from staff that may differ from what was presented from the first three workshops.

3.2.3 Stakeholder Conversations

We held semi-structured stakeholder conversations with staff at two timepoints, one towards the start (June 2024) and one approximately six months after implementation started (November-December 2024). The participants included staff responsible for programme implementation and clinicians delivering the pathway. All stakeholder conversations were conducted on Microsoft Teams and lasted between 30 and 40 minutes.

At the beginning of each conversation, researchers introduced themselves and provided an overview of the evaluation aims and procedures. A semi-structured topic guide was used to facilitate the discussion. With participants' consent, conversations were video recorded, converted into an audio file, and later transcribed by the evaluation team for analysis.

To facilitate engagement in the second round of data collection, some stakeholder conversations were conducted in small groups. The evaluation team was invited to join existing team meetings, where a 30-minute slot was allocated for the discussion. Three meetings were attended via MS teams and one meeting was attended face to face.

3.4 Data Analysis

Transcripts and notes from the workshops and stakeholder conversations were analysed using thematic analysis (18). Through familiarisation, a coding framework was developed and agreed; this was based on codes identified deductively from the two evaluation frameworks and the data collection topic guides and an inductive approach to identify new themes emerging from the data.

Through repeated rounds of coding, the data was mapped onto the four components of the IRLM framework: implementation context and determinants; strategies; mechanisms; and outcomes. Within these higher-level themes, where there was relevant data, the TDF was applied selectively to identify context-specific challenges and enablers related to the implementation of the HSPP.

Coding and analysis were agreed through duplicate coding by evaluation team members, cross-checking for consistency of interpretation, and discussions and feedback meetings with the evaluation team and key staff leading programme implementation. Where necessary, additional codes and refinement of the coding framework was agreed.

Table 1 Coding Framework and application of IRLM framework components and TDF domains

IRLM COMPONENTS	TDF DOMAINS	THEMES
Characteristics of HSPP intervention	Knowledge	Evidence-based model underpinning HSPP Understanding, awareness of HSPP Novelty of HSPP Relevance of CASE approach training
Inner setting	Social Influences	Culture and shared understanding Leadership (executive and clinical/managerial) engagement and encouragement Peer learning
	Environmental context and resources	Capacity at team level IT and documentation Resource availability
Wider context (Outer Setting)	Social Influences	Connections with external groups and service
Individual Characteristics	Professional role and identity	Established professionals vs junior staff Key role of senior leaders Teams' different priorities
	Beliefs about capabilities and skills	Feeling competent in current role CASE Approach validates existing skills CASE Approach useful to build skills in junior staff Move away from risk stratification
	Emotional reactions	Positive (hope, pride, enthusiasm) Negative (anxiety, frustration, dismissive, pessimistic)
Implementation Process	Engagement	Use of HSPP implementation groups Early coproduction and engagement with Patients and Public Involvement and staff groups Context specific training
	Impact	Implementation strategies tailored to groups Meeting patients' needs
	Goals/Intentions	Need for clear plans and actions
	Reinforcement	Training assessment and attendance

4 Findings

The findings are presented below aligned to each objective. Within each section the themes are grouped following the structure of the IRLM framework to clearly set out the strategies that were adopted and implemented, the mechanisms of actions, and outcomes.

4.1 The HSPP pathway implementation and adaptations

4.1.1. From the Gold Coast Suicide Prevention programme (Australia) to an acute setting in England

Figure 4 presents a simplified version of the HSPP implementation process adopted by HPFT (a detailed version is available on request from the evaluation team). The strategies have been colour-coded to reflect the type of resources employed by HPFT to facilitate the implementation and are categorised as: (i) staff training and resources, (ii) promotional activities, (iii) HSPP implementation activities, iv) evaluation activities.

4.1.2 Implementation Strategies

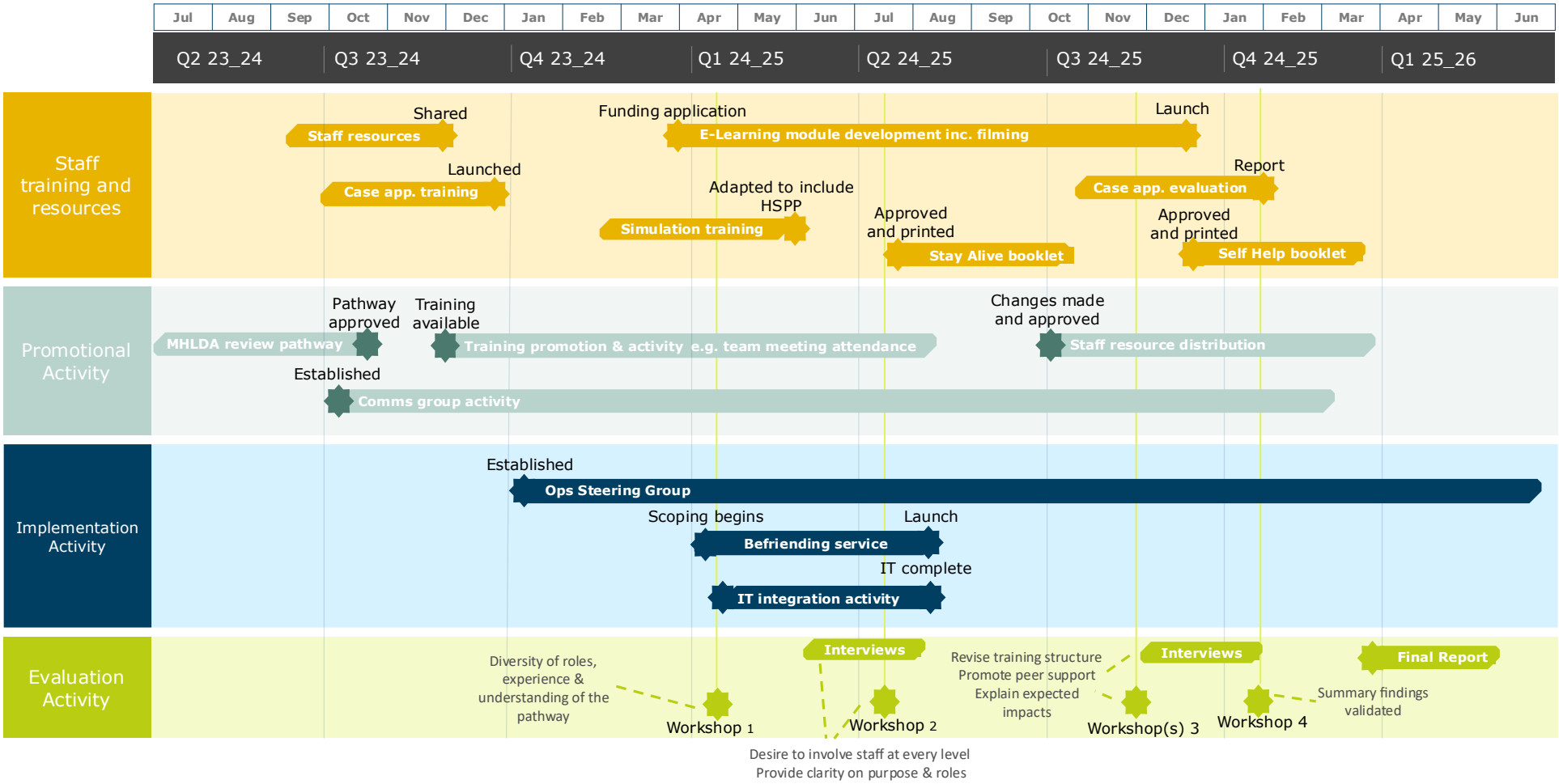
1. **Staff training and resources** included the development and dissemination of materials such as the Suicide Prevention Stay Alive Booklet for service users and carers and suicide prevention resources for clinicians and professionals (shared with staff via the Hertfordshire and West Essex (HWE) Learning Hub), regular face-to-face and simulation-based training, the creation of an animated e-learning module, and the CASE Approach on-line training.

2. **Promotional and communication activities** focused on the development of materials to popularise the pathway (e.g., HSPP screensaver, suicide prevention blogs) and promotion through presentations delivered by senior leaders at key meetings, including the East and North Hertfordshire NHS Trust Clinical Matrons Team Meeting, East and North Hertfordshire NHS Trusts Executive Board, West Herst NHS Trust (A&E at Watford General Hospital), the Hertfordshire Mental Health and Neurodiversity Health Care Partnership (MHLDN HCP) Clinical Professional Advisory Committee, MHLDN HCP Board, HPFT Mental Health Liaison Team and CRHT away days, the MHLDA Co-Production Group.

3. **HSPP implementation activities** to build the infrastructure for implementation, including: the establishment of a monthly IT Infrastructure Task and Finish Group; a fortnightly Operational Steering Group; integration of team records via Paris EPR and the local Spike dashboards; exploration of ED/A&E information sharing; and the launch of the Befriending Discharge Service.

4. **Evaluation activities** are explained throughout this report and included to outline the phase of implementation at each data collection time point.

Figure 4 Timeline of the HSPP implementation strategies by quarter 2023-2026



4.1.3. Iterative adaptation of implementation: Evaluation – Implementation feedback loop

Regular meetings between the leadership team took place to discuss implementation progress, challenges and enablers, and to facilitate adaptation and improvement of implementation.

Emerging findings from the evaluation informed both ongoing discussions and subsequent changes to the pathway. Later stages of data collection provided further insight into the impact of these adaptations, and is reflected in the findings. In particular, feedback highlighted inconsistencies in staff awareness and understanding of the pathway, as well as challenges related to integrating the current IT system.

In response, several key adaptations were implemented.

Targeted staff training and the development of supportive resources played a key role in the initiative. These included the creation of materials such as the *Stay Alive* suicide prevention booklet, suicide prevention resources for clinicians and professionals (shared with staff via the Hertfordshire and West Essex (HWE) Learning Hub), and a dedicated resource publication for carers. Training offer was diversified, and staff encouraged to attend training in short stages.

Promotional activities were also integral to raising awareness and engagement. Updates were made to existing staff resources, including the safety plan, and the leadership team initiated several awareness-raising initiatives. Notably, these included the promotion of the pathway during Suicide Prevention Day, presentations at the Lister Mental Health Liaison Team Away Day, and the implementation of an A&E engagement strategy, spearheaded by the communications team.

In response to concerns regarding the effectiveness of traditional communication channels—such as emails and newsletters—especially for A&E staff with limited time, more direct and visible methods were employed. These included the use of laminated information sheets and posters, strategically placed in high-traffic areas such as triage and waiting rooms. Additionally, fortnightly meetings with Team Leaders were instituted, and opportunities to integrate information into other existing meeting agendas were explored. The organization's social media platforms and internal communications website were also enhanced. Modifications were also made to the electronic patient record (EPR) system (Paris) to ensure smoother documentation processes.

Specific improvements to the IT system were made to facilitate a more efficient and user-centred approach to promoting knowledge and understanding of the pathway. Adaptations are summarised in Figure 5.

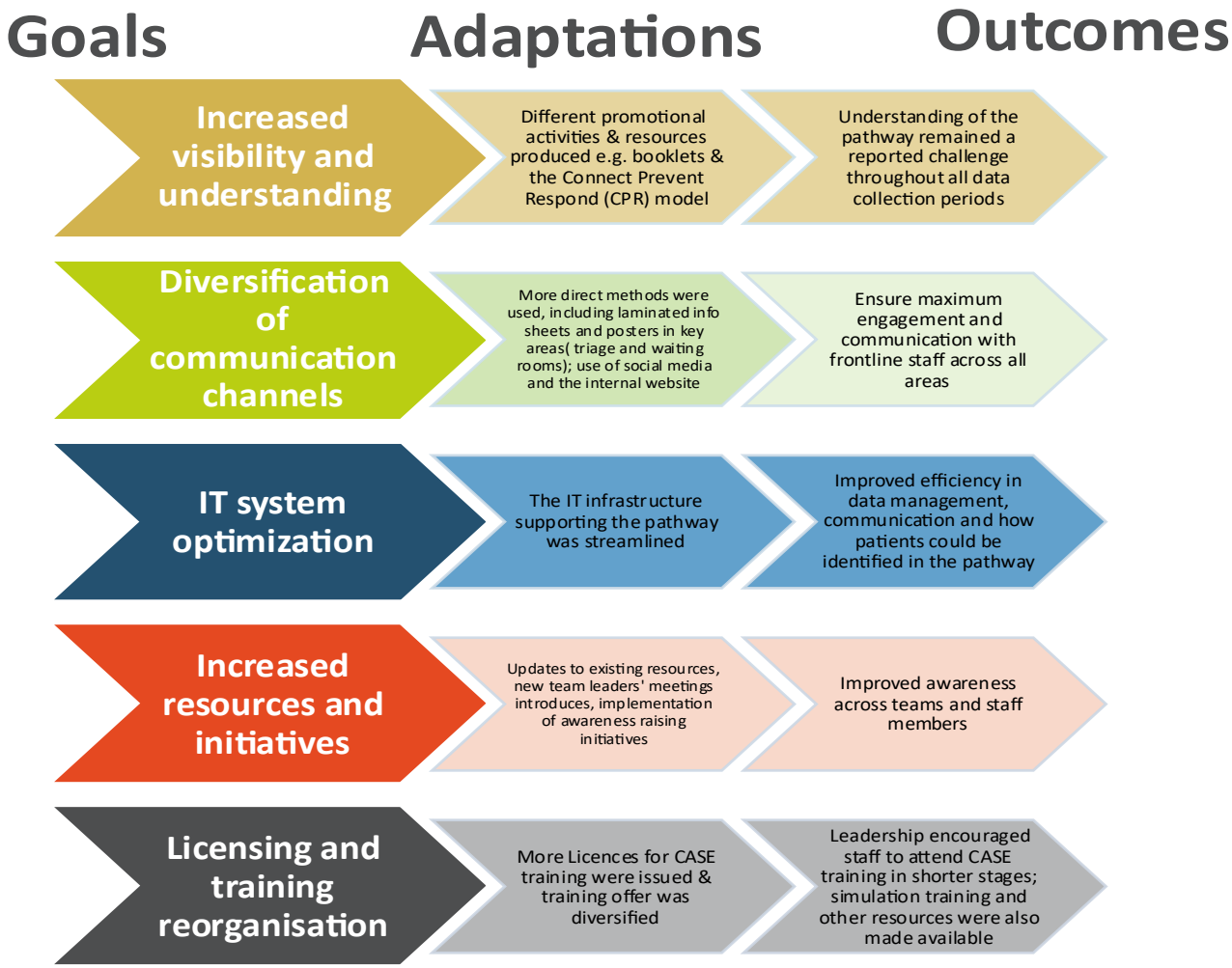


Figure 5 Adaptations following stakeholder feedback and ongoing refinement of implementation

4.2 Challenges and enablers to implementation

Various challenges and enablers were identified by staff throughout the evaluation. Many of these acted as both challenges and enablers and are therefore presented together as the key themes. Figures 5 to 9 provide details of these themes, aligned to the TDF domains and grouped according to the IRLM framework to show where these occur in the system: Intervention characteristics (Figure 6), Setting - Inner and Wider Setting (Figures 7 and 8), Characteristics of Individuals (Figure 9) and Process (Figure 10).

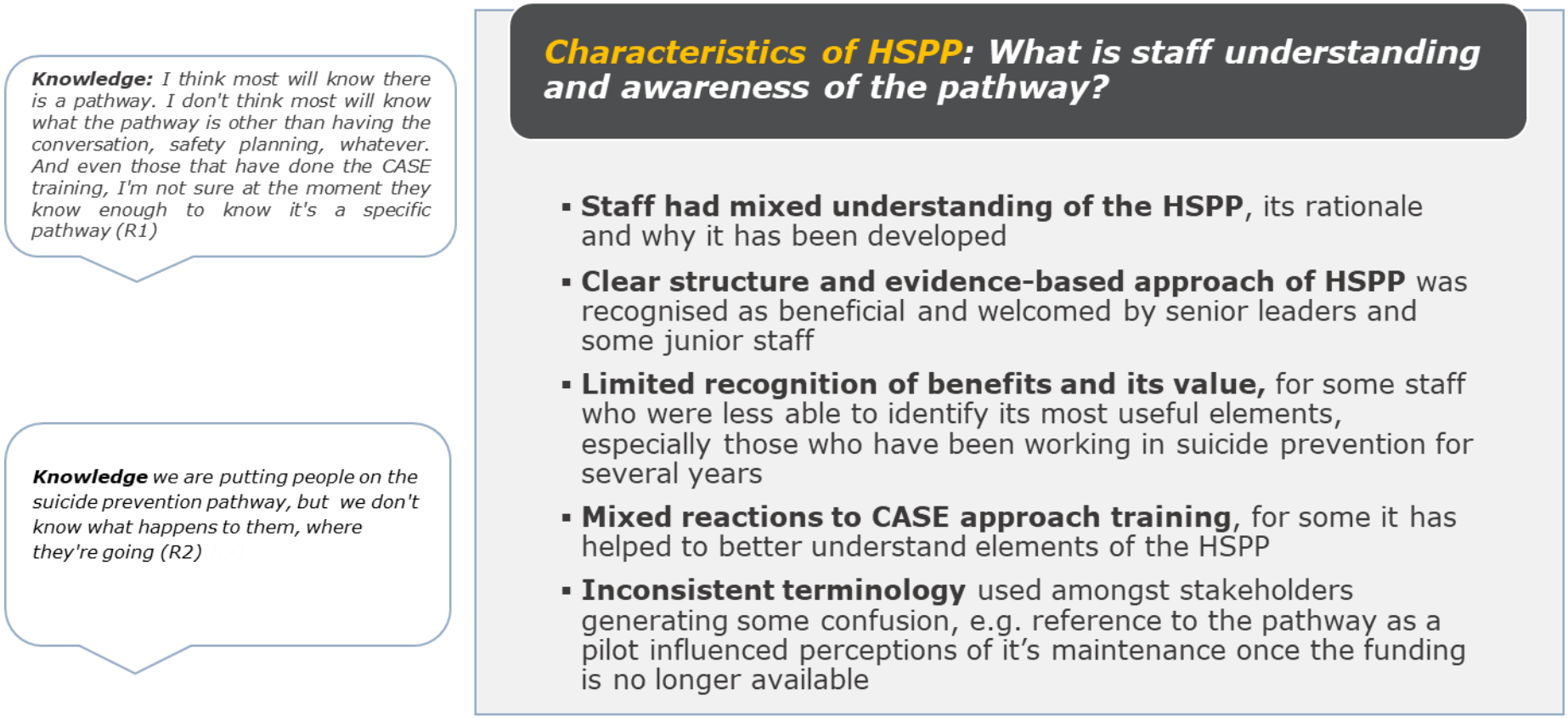


Figure 6 Intervention Characteristics: Challenges and Enablers

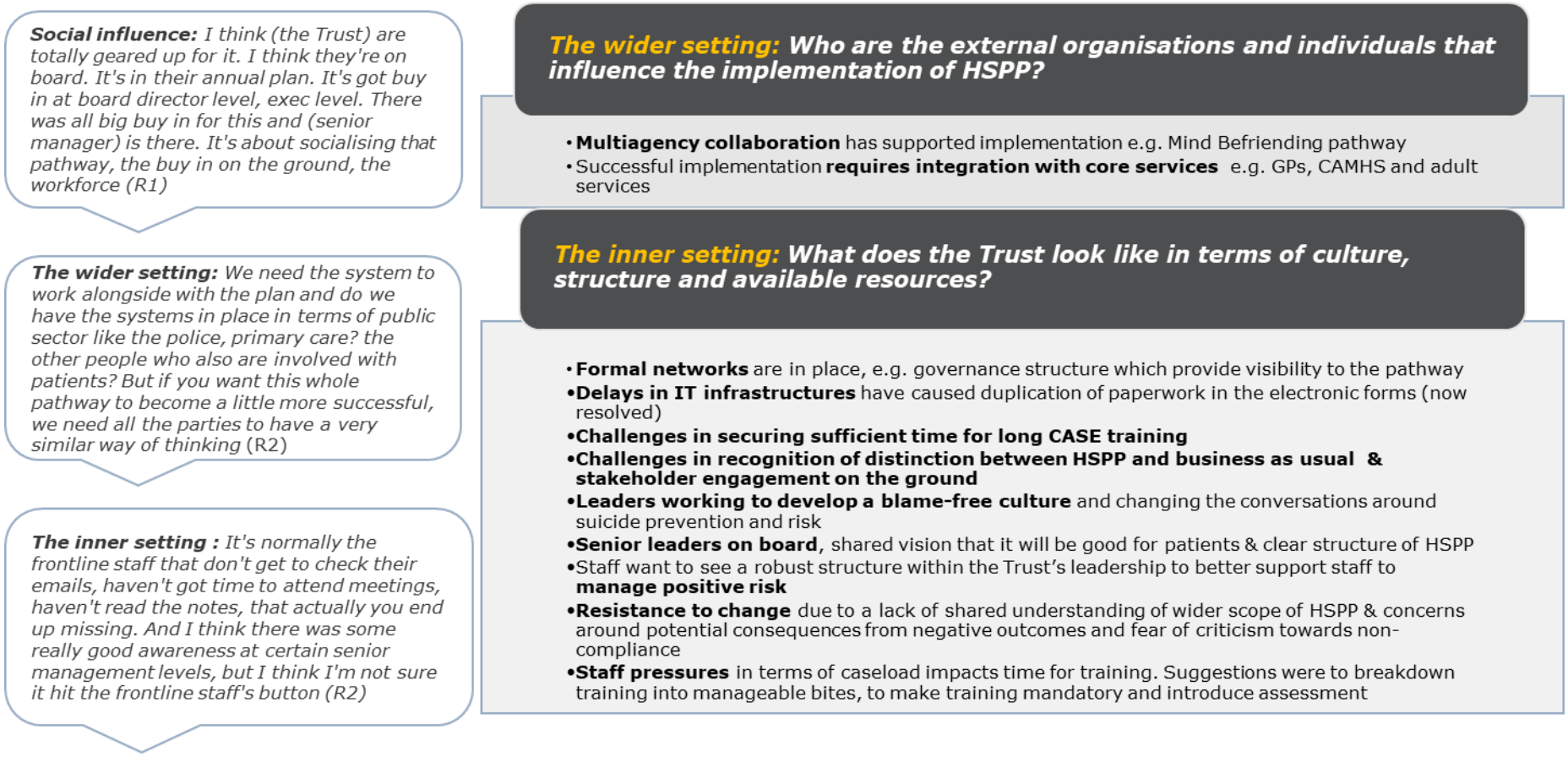


Figure 7 The Inner and Wider Setting: Challenges and Enablers

***Skills**: But I think the early parts and the later parts of the pathway just need to be about that communication and that listening to the service user and that level of empathy (R1)*

***Role & identity**: I wouldn't imagine that it's going to be too different given that, as I said this is our bread and butter (R1)*

***Role and identity**: I've been a senior clinician for 25 to 30 years and I didn't find anything new, but what I did find is, it gave words to the things that I was doing. So, like validation and that kind of thing. So, I think it's useful for the trainees and for the students, but I personally didn't learn anything (R2)*

***Skills:** What skills have staff developed, need to develop or already have?*

- **Good communication skills and work with family and friends to coproduce** is critical
- **Training has helped to develop consistency** in eliciting stories. Clinicians each have their own style e.g. personal instincts & empathy; CASE training can help to enrich skills and find new and consistent ways to approach patients and do risk assessment
- **Need to learn a new language away from risk stratification**
- **Lack of IT skills**
- **CASE approach is more relevant to junior staff to learn new skills**
- **Established staff members used HSPP to validate their knowledge**

***Professional role and identity:** What roles do people, teams and the Trust play in the implementation of the Suicide Prevention Pathway?*

- **Senior leaders** are proactive and enthusiastic in promoting HSPP
- **Team Leaders support** staff to take positive risks and build confidence when doing risk assessment
- **Team leaders** are key to encourage staff to attend training
- **Senior clinicians** suggested suicide prevention is an **established** part of the role, with less new to learn from training (crisis teams)
- Staff would benefit from **supervision** around HSPP and **peer learning**
- Teams across the Trust have different **identities and priorities**: big culture shift for some more than others (A&E)
- Some teams identified they believe they are **already following the pathway** (A&E)

Figure 8 Individual characteristics: skills and professional Identity

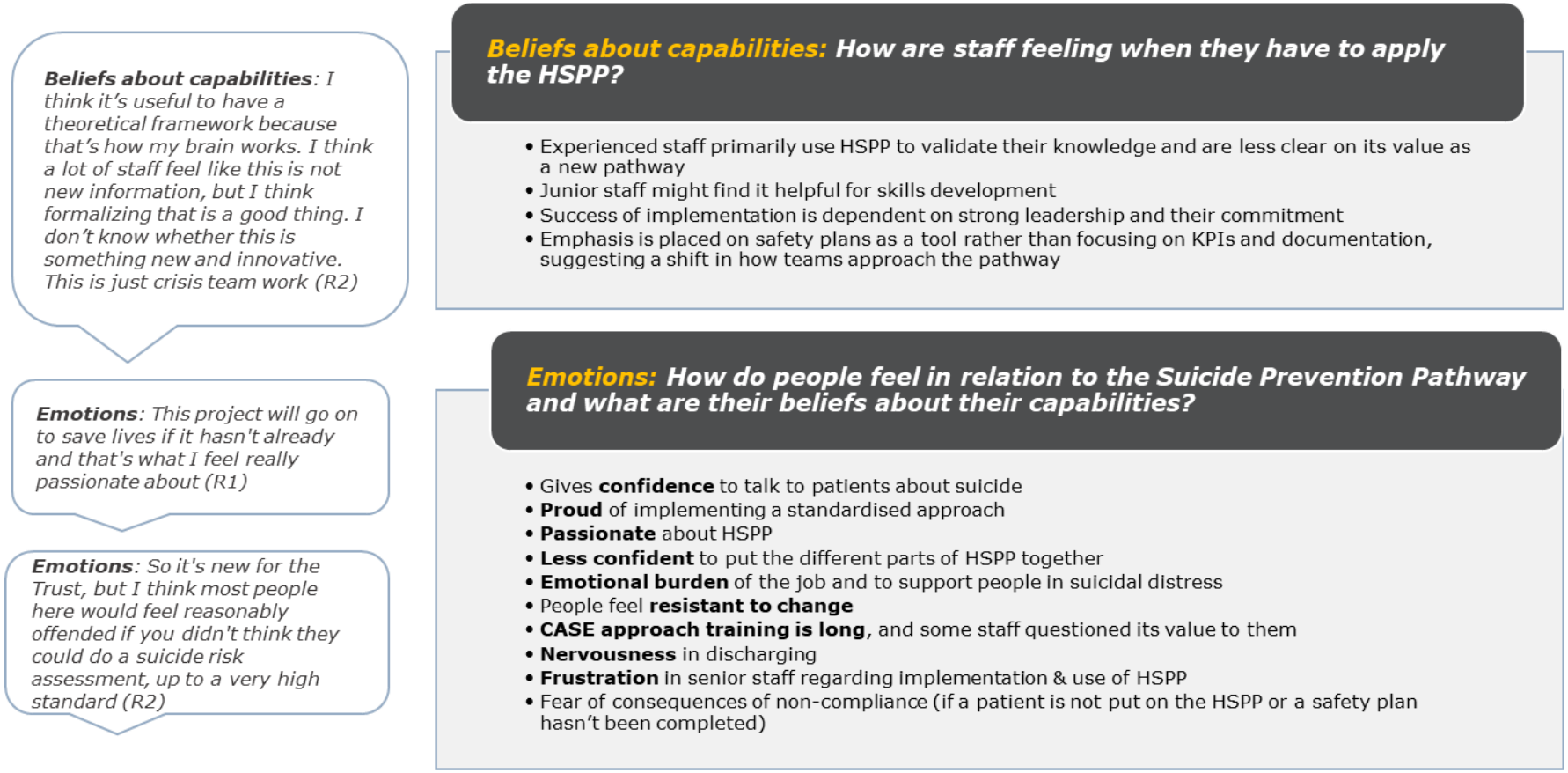


Figure 9 Individual characteristics: beliefs about capabilities and emotions

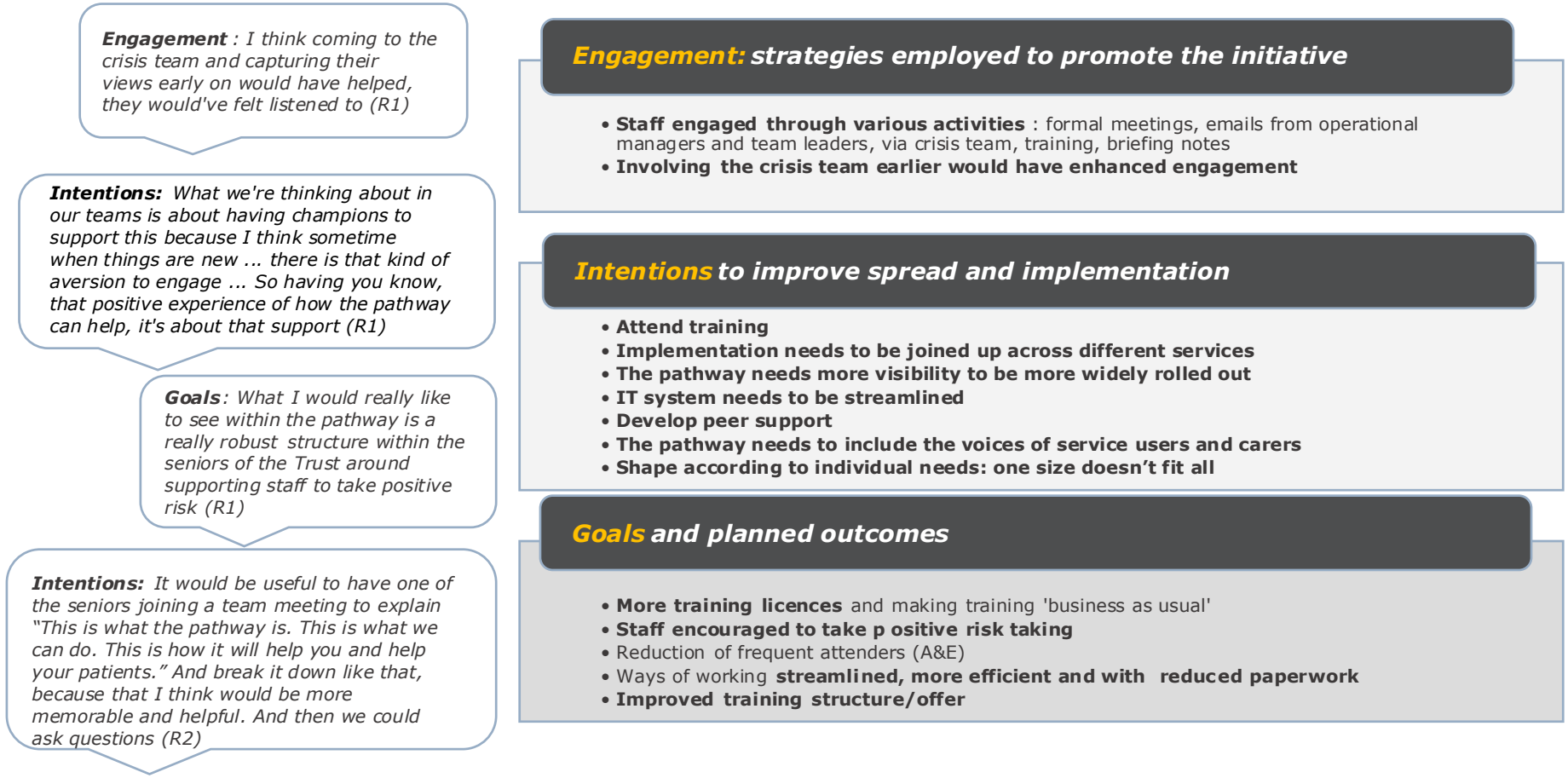


Figure 10 Process of implementation: Engagement, Intentions and Goals

Figure 11 provides a summary of the challenges and enablers. Key themes included: varying staff understanding and resistance to change; concerns over non-compliance and the pathway's long-term sustainability; inconsistency in terminology; effective communication strategies; IT infrastructure to reduce administrative burdens and improve operational efficiency and broader implementation; and engaging frontline staff. Training was a recurrent theme and is explored in detail in section 4.3.

Engagement of staff was an ongoing challenge to implementation. Staff pressures, high caseloads and insufficient training were all factors. The crisis team staff suggested that involving them earlier at the planning stage would have helped with engagement and buy-in.

Strong leadership and senior leaders' proactive and enthusiastic engagement in promoting the initiative was vital, as was the team leaders' role in supporting staff to take positive risks, instilling confidence in their risk assessments, and in encouraging staff participation in training programs. The flexible approach to development and improvement was also a key enabler.

Generally, senior leaders and junior staff welcomed the HPSS, appreciating its clear structure and evidence-based approach. Formal networks and a governance structure were established to provide increased visibility for the pathway. However, there was varied understanding of aspects of the pathway, such as the rationale for development, purpose and specific benefits. Staff agreed that successful scaled implementation requires integration with key services, including GPs, CAMHS, and adult services, to ensure a comprehensive and coordinated approach.

Beliefs about capabilities revealed differing perspectives on the implementation of the HSPP among staff, often related to their clinical role and experience. For example, more experienced staff who have worked in acute mental health settings for a long time felt more than capable of delivering the pathway and individual elements, whereas less experienced described feeling less confident. The training and the clear structure of the pathway were perceived as supporting staff belief in their capability to implement the pathway. Those who didn't have a strong understanding of the pathway, its expected outcomes, or importantly, how the pathway relates to their role specifically had less confidence to implement.

Emotions related to the HSPP also varied and reflected a mix of confidence, passion, and anxiety. Some staff suggested they felt empowered and confident in discussing suicide with patients, and others described their pride in implementing an evidence-based approach. There was a strong sense of passion for the pathway among some staff. However, staff described concerns about integrating the various components of the HSPP, with some feeling less confident in bringing these elements together. Some staff from ED suggested that suicide prevention has already been adequately addressed. The emotional burden of the role, particularly in supporting individuals in suicidal distress, was felt deeply. Staff also expressed a sense of nervousness around patient discharges, for example, if a safety plan had not been developed. Some more experienced staff described frustration regarding the implementation of the pathway, primarily due to a lack of clarity of its aims and additional benefits.

Differing experiences and roles of individual staff and teams influenced perceptions and engagement. Some senior clinicians and established staff suggested that they thought suicide prevention was already established as part of their role, and that the new pathway and training was more of a validation tool than a new initiative to engage with. Linked to this, resistance to change was identified as a challenge. This seemed to stem from a lack of clarity of the scope of the HSPP, different staff teams having different identities and priorities, as well as some of the negative emotions staff shared. These factors led to some resistance to implementing the pathway uniformly, and concerns over consequences of non-compliance.

Characteristics of HSPP

Challenges

Mixed understanding of the HSPP & it's benefits

Inconsistent terminology relating to pathway as a pilot and its sustainability

Enablers

Clear structure of HSPP

Evidence-based approach (GCSPP)

Training to improve staff understanding of elements of the HSPP

The Setting

Challenges

Greater integration with related key services is critical for successful implementation

Delays in IT infrastructure impacted duplication of work initially

Lack of recognition between the HSPP & established care pathways (BAU) hindered engagement

High caseload volumes

Different team identities and priorities

Resistance to change and to implementing the pathway uniformly across the Trust

Enablers

Senior leadership support for HSPP

Multiagency collaboration, e.g., the Befriending pathway, Mind

Governance structures that increased pathway visibility

Leadership & actions to foster a blame-free culture & shift the discourse on suicide prevention & risk

A shared vision that it will benefit patients

Individual Characteristics

Challenges

Differing staff experiences and roles influenced perceptions of HSPP as a tool to validate existing knowledge versus an opportunity to learn new approaches

Varied emotions around the HSPP, including a sense of anxiety in ED where staff feel suicide prevention has already been addressed

Emotional burden & resistance to change

Some staff dissatisfaction with CASE training

Limitations in IT skills among some staff

Balance of focus on KPIs & documentation versus safety plans as primary tool

Enablers

CASE training supported development of staff skills and methods particularly risk management

A shift away from traditional risk stratification language beneficial for improving clinical practice

Strong leadership and commitment to the initiative was critical to success

Some staff felt empowered & confident in discussing suicide with patients

Strong sense of passion for HSPP among individual

The Process

Challenges

Limited engagement from some staff & a need for **earlier involvement**

Difficulty in achieving broad visibility & implementation across services

Difficulty in determining numbers of patients within the pathway

Streamlining the IT system to improve efficiency is a significant challenge

More efficient workflows would support engagement

Training structure could be more effective

Tailoring the pathway to individual needs rather than relying on a standardized approach is needed

Enablers

Effective engagement strategies, e.g., meetings, emails, and training were vital to promote the HSPP

Peer support mechanisms and the inclusion of service users and carers' perspectives were key

Coordinated training across different groups and greater visibility of the pathway will support implementation & spread

Figure 11 Summary of Challenges and Enablers

4.2.1 Readiness for implementation

Readiness for implementation at a team and individual level was varied. Senior leaders were proactive in their encouragement and willingness to support implementation of the HSPP, suggesting a readiness within the leadership teams at both Trust and team level. Staff pressures such as high caseloads and limited time available impacted staff's readiness to implement new processes. Readiness to implement appeared to be dependent on staff's team identity and practices, and how these may have differed from the expectations of the pathway. Readiness was also dependent on individual experiences and confidence, for example, some staff felt less confident about having these conversations with patients, whereas other staff felt well equipped and motivated to implement an evidence-based approach. Staff were less ready to implement the pathway if they did not have a full understanding of how the pathway related to their own specific job role or of the benefits and potential impacts of the pathway.

At a system level in the early phase of implementation, the IT infrastructure was not in place to effectively support integration of key elements such as identifying patients on the pathway in Paris EPR or completing and uploading safety plans efficiently. Improvement in IT integration was evident across the data collection period and was key to the organisational readiness for change.

4.3 Staff experiences and views of training

Training was a recurrent theme. Many staff found the CASE approach training valuable as a refresher or useful for new staff members. However, more experienced clinicians felt that suicide prevention is their '*bread and butter'* and suggested they felt the training was less worthwhile. Time constraints to complete the online CASE approach training was a challenge, while some suggested that an assessment at the end of the training could motivate staff to attend and test their knowledge. Some staff perceived the terminology and context as not culturally relevant and 'Americanised'. Staff were encouraged to complete CASE Approach training by their managers. Suggested approaches to this included; attending a short weekly session and applying learning in clinical practice where appropriate.

From May 2024 the pre-existing HPFT simulation hub training was adapted to include an overview and understanding of HSPP (Figure 4). Most staff suggested that they found the experience helpful for building confidence in real-life situations and that it helped with communication and handling patients in crisis, particularly regarding suicidal ideation, as illustrated by the following quote:

> *"I feel like I've definitely gained a bit more confidence with the simulation hub. And I think any training we do, if it can be done in, in like simulation style, I feel like that's really a useful way of training" (stakeholder R2)*

Between January 2024 and November 2024 the implementation team collected feedback via survey to evaluate initial perceptions and experience of the CASE approach training. Responses from 13 out of the 48 staff members who had completed the training suggested their experiences were generally positive. See Appendix 2 for extra details.

4.4 Mechanisms supporting implementation

Several mechanisms were identified as facilitating implementation strategies (Figure 12); these were often developed following evaluation feedback:

- Increased co-production and collaboration with staff delivering services, patients and carers
- Implementing peer to peer learning via champions
- Ongoing development and adaptation of training
- Targeted communication resources to different stakeholders
- Effective communication strategies across staff groups
- Appropriate, context specific, and consistent language (CASE Approach training)
- Clarity of scope and aims of HSPP, including role and responsibilities for staff, expectations for patients and carers, and patients' journey
- Identifying a clear pathway and adapting documentation processes & systems (e.g., Paris EPR)
- Using iterative evaluation and feedback to inform development of the pathway and implementation

Many of the mechanisms for implementation of the HSPP contain an element of coproduction with staff. The Trust actively sought staff feedback and made adjustments, for example there were adaptations to the training throughout the period of implementation considered in the evaluation. It is important to note, that many of these mechanisms are ongoing (in progress) and this links to the early stage of pathway implementation. There was strong evidence of ongoing development, with some differences in the experiences and perceptions described between the initial data collection and the third data collection workshop. In Round 2 one of the stakeholders described the impacts of staff feedback and ongoing development:

> *"One of our senior managers has done kind of a little bit more focused work with the teams as well as everything that's happened already with the training implementation of the pathway and there's been some good feedback in that teams are kind of, you know, not seeing it as a tick box, but actually there's discussions around it as a service user document so how do we make it meaningful? So I think that's been a positive impact." (stakeholder R2)*

Additionally, to ensure the effective communication strategies across staff groups and the use of a consistent, context-specific language the messaging around HSPP among clinicians was reframed. In response to some staff having perceived the pathway as "*a new and shiny*" technique (Round 2), it is now positioned and referred to as a tool to "*enhance learning*". Related to this, further work has also been undertaken to support staff to engage with the scope and aim of the HSPP. This was in response to some of the findings from Round 1, suggesting that clinicians were sometimes unclear about the purpose and impact the pathway was going to make on patients. The HSPP has since been communicated as a "*mental health CPR*" to make its purpose clear to clinical staff and provide the prompts for them to consider when and how to use the elements of the pathway, recognising that a safety plan would not be needed for every service user.

Developments have also been made in identifying a clear pathway and adapting documentation on the electronic patient record (EPR) system (Paris). This followed the challenges with the system, raised in Round 1 and 2, such as screening information not being visible to all teams and having to duplicate information unnecessarily when putting a service user on the HSPP. Furthermore, adjustments were made so that the EPR no longer requires safety planning to be created for all patients. The risk formulation documentation was also

adapted at a team level to better integrate with previous documentation the teams were utilising.

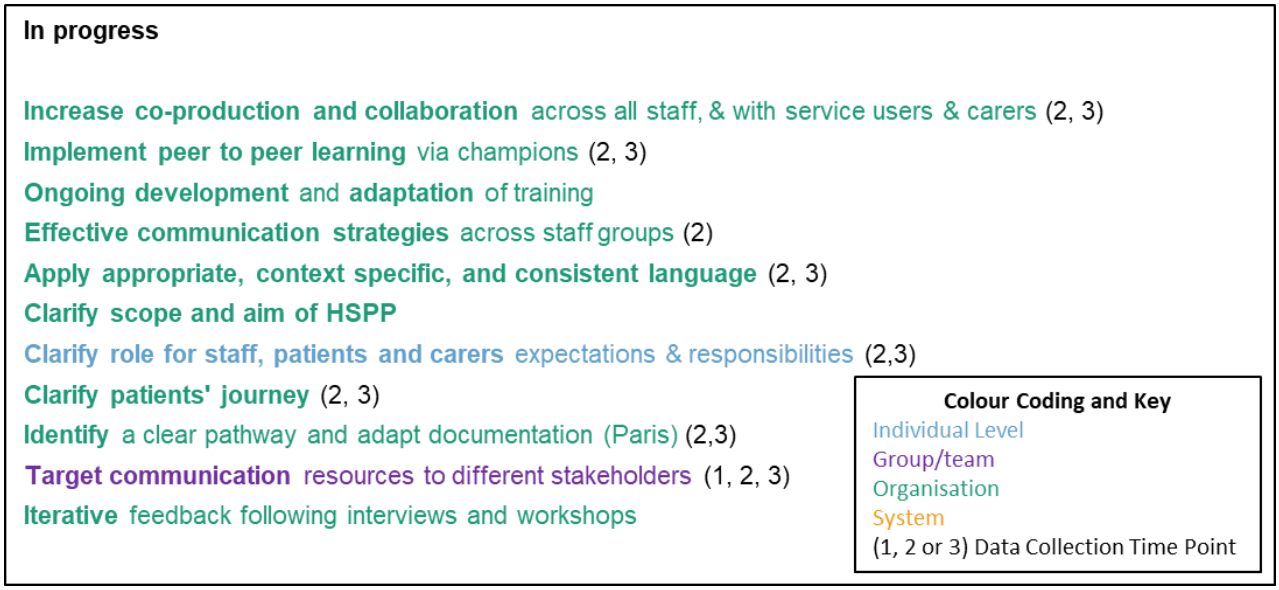


Figure 12 Mechanisms supporting implementation aligned to IRLM developed for HSPP (Figure 13)

4.5 Outcomes

Outcomes identified from the data are presented in Figure 13. Outcomes are grouped in line with the components of the IRLM framework: Implementation outcomes, service outcomes and individual (clinician and patient) outcomes. These have been coded as 'Desired' (encompassing both outcomes the Trust is working towards and what clinicians would like to see in the future) and 'Achieved' (outcomes described by staff as having been attained), and reference to the data collection rounds (1,2, or 3) used to indicate where changes were observed across the different rounds of data collection (implementation journey).

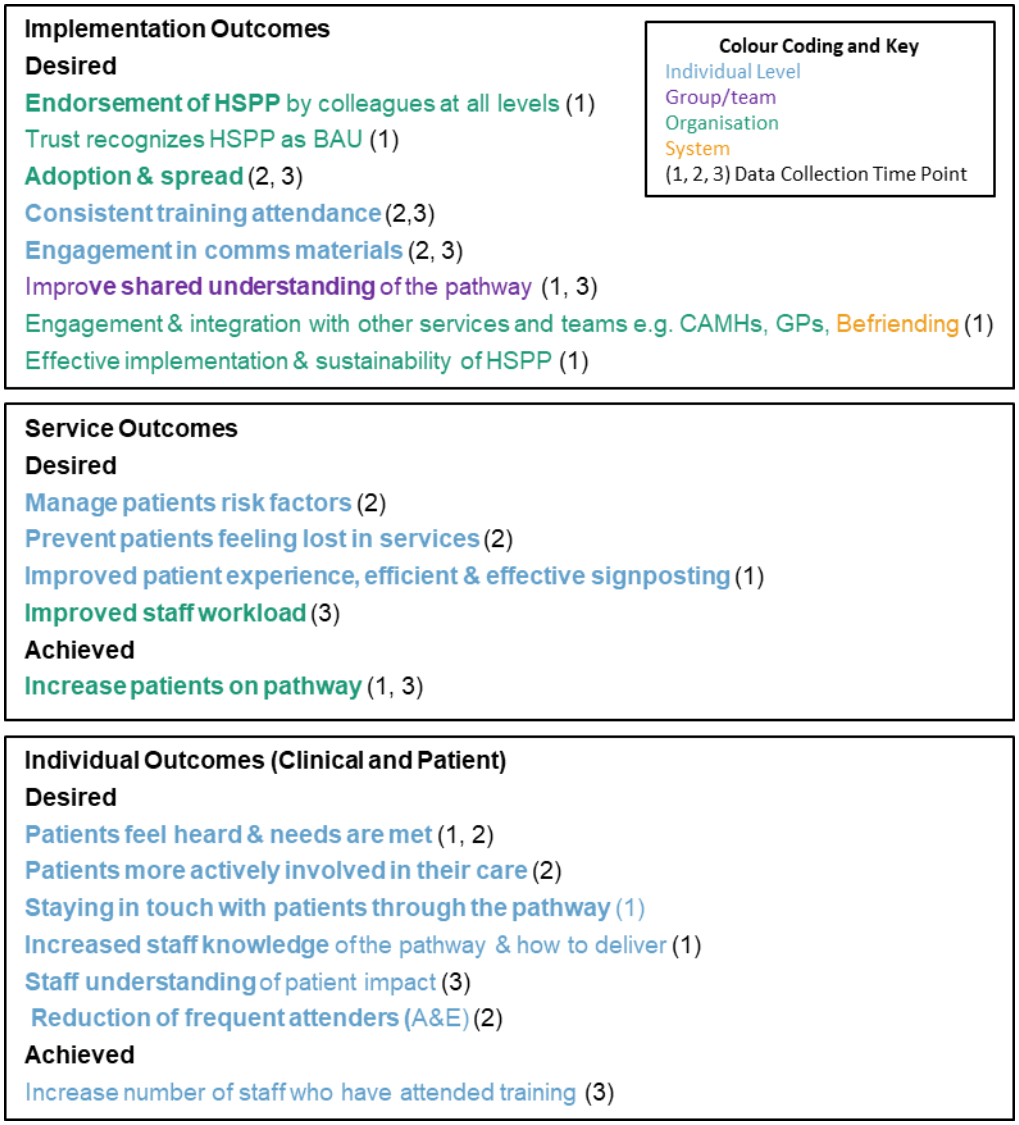


Figure 13 Desired and achieved outcomes aligned to IRLM developed for HSPP (Figure 13)

4.5.1 Implementation Outcomes

Improved shared understanding of the pathway emerged as a fundamental outcome, highlighted during all rounds of data collection. In the round 1 workshop staff described evidence that clear strategies had been put in place to support this:

> *"There is one introduction to the pathway, to the … people on the ground. So essentially, it is more of an operational training, helping people to understand what the pathway is about and what they're supposed to do as part of the pathway, and what they're supposed to document on the EPR, and what are the outcomes we are looking for." (stakeholder R1)*

However, findings from round 2 indicated that staff understanding of the HSPP remained inconsistent and varied between teams. By round 3 there had been a change in approach in order to facilitate this. The revised approach sought to ensure clinical staff possess a good practical understanding of the HSPP *"to have fuller conversations with patients about their care" (stakeholder R2)* and facilitate more effective signposting to other services.

4.5.2 Service Outcomes

One of the desired outcomes that emerged was to prevent patients from feeling lost in services. Respondents in Round 2 spoke of this as still being an ongoing issue:

> *"They've waited for hours, then they come to us the next day, we call them up then we go in and we might go with the doctor, and he might go through exactly the same kind of questions, and it gets a bit too much. Then we might send them to a day centre and they sit with them and go through some of the, it is a bit difficult."* (stakeholder R2)

Some improvements to the referral process were reported in Round 3 which have resulted in a reduction in the number of inappropriate referrals to the pathway according to stakeholders. Staff described their hopes that in the long-term this might contribute to improvements in patient experience and might help mitigate service user's sense of being lost between services. Optimising the process of signposting patients to external services (e.g., the Befriending service) was another target the Trust was working towards during this implementation phase. This aligns with the desired outcome of reducing patient readmissions and referrals to services, together with more effective signposting to services.

4.5.3 Clinical and Patient Outcomes

Two related desired outcomes were that patients feel heard and have their needs met in a timely manner and that patients and their families feel more actively involved in their care. While empowering service users and their carers, and timely follow-up was mentioned during round 1, in round 2 it emerged that clinicians were unsure how placing a patient on the HSPP would benefit them as opposed to following another pathway. Following from this, the latter seems likely to depend on clinicians' improved shared understanding of the pathway to encourage them to put patients on the HSPP and thus be able to measure the improvement in clinical/patients outcomes.

5 Summary of findings

The Implementation Research Logic Model (IRLM) guided the evaluation; figure 14 provides the final IRLM which retrospectively combines the findings from each of the three rounds of data collection and provides an overview of the enablers and challenges identified as determinants influencing implementation of the HSPP, the strategies and mechanisms of implementation and the outcomes.

Staff reflections and feedback suggested increased patients on the pathway and increased numbers of staff completing the training for the HSPP across the data collection period. Many of the mechanisms and intended outcomes were ongoing. However, staff described a clear shared vision and how feedback was being used to adapt and improve the pathway and implementation. Staff and organisational readiness for implementation was influenced by staff's understanding of the HSPP and its potential benefits, as well as aspects of the setting such as IT infrastructure, integration and training that were highlighted as enablers and barriers, summarised in figure 14 under determinants.

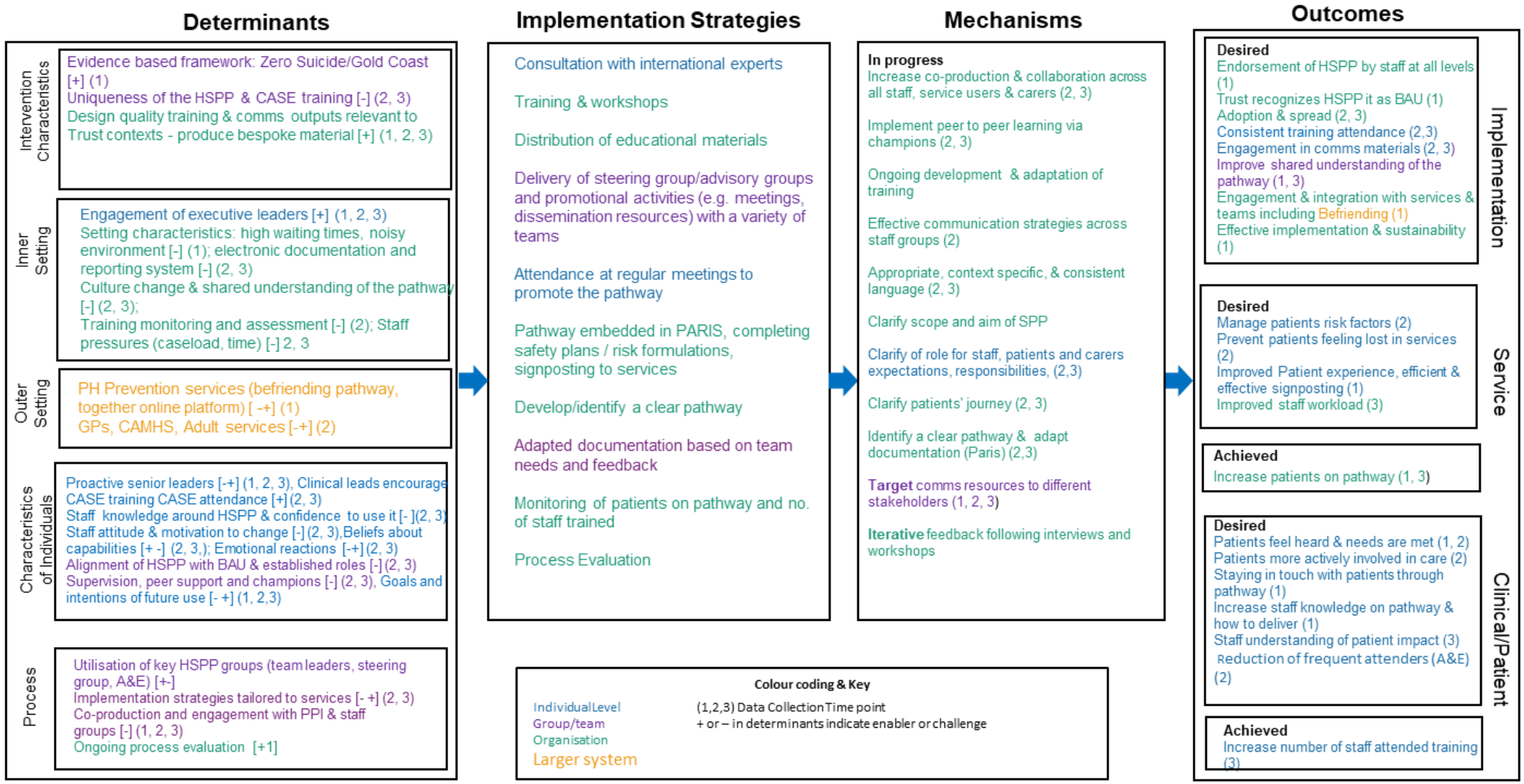


Figure 14 Implementation Logic Model Framework (IRLM) developed for HSPP

5.1 Discussion

The findings highlight that early-phase implementation of the HSPP has been an iterative process with increasing engagement from staff and teams during this period, increasing numbers of patients on the pathway mentioned and ongoing adaptation and improvement of implementation strategies and mechanisms. The developmental evaluation approach (15) adopted enabled emerging findings to feed into ongoing pathway discussions and decisions across the staff teams and leadership.

The use of the TDF (17) enabled identification of factors influencing staff behaviours in implementing the HSPP, such as their understanding of the pathway and confidence and motivations to engage with the pathway and training. Reflecting on the key elements of the ZSF (7) in relation to the findings suggest that there has been a strong focus on leadership, with training, engagement and improve also being addressed and adapted throughout the data collection period. There was more limited data to draw conclusions about the effectiveness of implementation in relation to other elements of the ZSF (identify, treat and transition).

Successful sustainable implementation requires multi-level and multi-faceted change at individual, team, organisational and system levels (19, 20), often including system redesign and alignment, changes in staff behaviours, workflows, and effective communication to support change. The findings showed a readiness for implementation across HPFT staff and staff teams, a shared vision and motivation towards the pathway and intended outcomes, and a keenness to adapt and improve the pathway.

Greater integration of systems and processes across teams and organisations is key to system level change and to improving efficiencies for staff as part of embedding the HSPP. This would also enable greater use of data to support elements of the pathway such as earlier identification of people with suicidal behaviours, and for data-driven improvement, in line with the ZSF components. These areas for consideration support the findings of previous service evaluation conducted by the HPFT team that explored data to understand demographic differences in patients (4).

Strength and Limitations

The flexible approach adopted by the evaluation team facilitated engagement with a broad range of healthcare staff, enabling the collection of in-depth and nuanced insights. Informal insights also played a critical role in shaping both the data collection and the subsequent analytical framework. Ongoing feedback loops with the implementation team were integral to the process, allowing for continuous adaptation and refinement of implementation strategies to ensure they were contextually appropriate and responsive to emerging needs.

Recruiting participants for interviews and workshops presented several challenges, prompting the need to adapt to align with staff availability, preferences, and working patterns. Although the qualitative approach generated valuable and in-depth insights into staff experiences and perceptions, the potential for self-selection bias should be acknowledged. Those with particularly strong views, either highly positive or critical, may have been more motivated to participate, which could influence the breadth and balance of perspectives represented in the findings.

5.1.1 Recommendations for implementation

The findings have also highlighted aspects for consideration to support further development of the pathway implementation, its visibility and staff understanding and engagement.

Recommendations focus on enhancing training delivery, embedding the pathway into existing systems and promoting collaboration across services. Building on the adaptive approach to further engage staff, and include feedback from service users and carers where appropriate, through co-production to identify areas for improvement that will further streamline integration, reduce burden on staff, reduce duplication, and improve service user outcomes is critical. Key considerations include:

1. Furthering knowledge and understanding of HSPP across staff and system, including clearly communicating pathway evidence and impacts and relevance to specific teams and staff roles
2. Continue to tailor training to address specific staff training needs and contextual relevance, including aligning delivery to staff capacity and service demands
3. Continue to embed the pathway within current systems and structures, including integrating HSPP processes into existing workflows, IT systems and EPR
4. Promote multiagency collaboration and integration with core services
5. Enhance stakeholders' engagement through peer champions and identify and empower clinical staff as implementation facilitators and role models

For other trusts or similar settings it is recommended to adopt a co-produced approach from the outset, involving all key stakeholders throughout pathway development and adaptation. Senior leadership buy-in at both trust and team levels is critical. Engagement is likely to be enhanced through tailoring implementation to team-specific contexts, clearly defining roles and expectations early across teams and staff levels, and communicating pathway benefits to both staff and patients.

6 . Conclusion

Strong leadership and a proactive approach to adoption and improvement were key influences on successful implementation. Readiness for implementation at individual, organisational and system level were also key determinants, influenced by organisational infrastructure; staff roles, experience and work-loads; communication strategies to promote visibility and understanding of the HSPP; and training. Additionally, multiagency collaboration and integration, and a shift toward a blame-free culture were identified as crucial in promoting the pathway’s success. Application of the TDF and ILRM to understand how the determinants have influenced individual staff, teams, and the organisation implement the HSPP have highlighted several recommendations for consideration to further develop implementation, visibility and sustainability of the HSPP.

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Appendix 1

Data collection tools

Interview topic guide for HSPP Evaluation (R1)

1. Please can you describe your job role?

Pathway Implementation

2. What is your involvement in the Suicide Prevention Pathway?

When/How/What did you/have you heard about the Suicide Prevention Pathway?

3. What are the activities that you have been involved with in implementing or delivering the pathway?
4. Please can you describe the Suicide Prevention Pathway?
5. Can you describe the intentions (goals) of the pathway?

<u>Social influences, support, organisational and environmental influences and resources, culture and attitudes</u>

6. What are the key steps or activities/actions involved in the pathway?

What do you expect them to be?

7. What, if any, have been the key enablers to implementation?
8. What, if any, have been the key challenges to implementation?
9. What, if any, adaptations of the proposed pathway have been required?

   What caused you to make these adaptations or why were these adaptations needed??

10. How did you find the CASE approach training?
    Have you found it useful in your role?

<u>System Readiness</u>

11. How confident do you feel in carrying out your role in the pathway?

In what ways do you feel confident/ in what ways don't you?

12. What knowledge and skills do you feel you have or need to deliver the pathway?

    Do you feel sufficiently informed/knowledgeable about the pathway to deliver it? Do you feel the training has prepared you sufficiently to equip you with the knowledge and skills needed?

13. How well prepared do you think colleagues are to implement the pathway?

14. How prepared do you feel the trust is for implementation of the pathway?

15. How prepared do you feel the service is for implementation of the pathway?

    how well prepared do you feel different teams or departments are?

Pathway impacts

16. Can you describe what impacts you feel the Suicide Prevention Pathway has on patient care?
    How do you think this might differ across roles/ teams and for different patients?

Future considerations

17. Do you have any suggestions for how the Suicide Prevention Pathway implementation could be improved?

Anything to increase likelihood of success (staff and patients)

Anything that would help future development

18. Do you have any other reflections you have about your experiences of the Suicide Prevention Pathway?

19. Do you have any questions or anything else that you would like to add?

Interview topic guide for HSPP Evaluation (R2)

1. Please, can you briefly describe your job role?

Which team do you sit in?

Pathway Implementation

2. What is your involvement in the Suicide Prevention Pathway?

if unsure or have not been involved then: When/How/What did you/have you heard about the Suicide Prevention Pathway

3. Have you been involved in any activities to implement/deliver the pathway?

Acceptability and feasibility of the Pathway

7. How acceptable do you / your colleagues find the pathway?
8. How feasible (/realistic) do you find the pathway is to implement?
9. Is the pathway easy to understand?
10. Do you feel that information and communication around the pathway has been delivered to you/ your team appropriately?
11. Have you received sufficient information to understand how it is being implemented?
12. Has the information about the pathway and expectations of you/your team been communicated clearly? Do you feel you know enough about the pathway to deliver it as part of your role?

Training

13. Have the training activities been appropriate/ the right level for you/team?

If not mentioned before:

13.a What training, activities have you been involved with? e.g. CASE approach training etc

14. Have you been able to apply the training you have received?

Barriers and facilitators

15. What, if any, have been the key enablers to implementation of the pathway in your day to day clinical practice?
16. What, if any, have been the key challenges to implementation?

17. What, if any, adaptations of the proposed pathway have been required?

What caused you to make these adaptations or why were these adaptations needed??

Pathway impacts

18. Can you describe any impacts you feel the Suicide Prevention Pathway has had on patient care so far? How do you think this might differ across roles/ teams and for different patients?

Future considerations

19. Do you have any suggestions for how the Suicide Prevention Pathway implementation could be improved?

Anything to increase likelihood of success (staff and patients)

Anything that would help future development / adoption

20. Do you have any other reflections you have about your experiences of the Suicide Prevention Pathway?
21. Do you have any questions or anything else that you would like to add?

Workshop 1 Logic Model session

Define Implementation strategies

•What equipment is required?
•What workforce is required and what training will they need?
•What changes need to be made to existing pathway(s) to implement the new pathway?
•What will different staff, teams, organisations need to do?
•How will patients be introduced, on-boarded and how will that be recorded?

Define Implementation outcomes

- Clinical and patients outcomes
- Service outcomes

What does success look like? E.g. improved health outcomes, improved patient or staff experience, improved efficiencies etc.

•For individuals e.g. patients, staff, commissioners?
•For organisations
•For systems

What changes could be measured

- Primary outcome (the thing you are most interested in and will affect other outcomes – e.g. patient or staff uptake)
- Secondary outcomes (that flow from the first)

How should it be measured?

•Patient or staff survey
•Routine hospital data etc.

Defining Mechanisms

- What are the processes through which implementation strategy affects outcomes?
- What are the assumptions about how the activities and implementation strategies will work?
- Any external factors that could affect implementation?

Workshop 2 discussion guide

Thinking about your experience and understanding of the pathway to this point, what is your broad reflection of the pathway?

1. What potential advantage does the SPP have over other existing pathways?
2. How can existing services adapt to the new pathway?
3. Are there any staff groups that are more ready than others?
a. If so, which groups, and what characteristics impact on their readiness?

4. What would acceptable pathway implementation look like?
5. What changes, if any, have you made, or planning to make, to implement the pathway?
a. How quickly was the pathway adopted into the service?
6. What elements of the pathway have been incorporated through the trust?
7. What, if any, potential outcomes do you see from the pathway?

Efficiency, patient safety, enhanced effectiveness, better ways of working, levels of satisfaction (patients/staff)

i. How might these be achieved?
ii. How does the pathway impact the service efficiency?

8. What is the role of different staff groups in delivering the pathway?
9. What steps will be taken to implement the pathway?
a. what further support might you/teams need?

Workshop 3 discussion guide

Implementation

1. Thinking about the Suicide Prevention Pathway, what has gone well for the implementation?

Prompts: integration with current services, training, delivery of certain elements of the pathway, relevance (for staff and patients), clarity of aims, right individuals being involved.

What has not gone well for the pathway implementation?

Prompts; integration with current services, training, delivery of certain elements of the pathway, relevance (for staff and patients), clarity of aims, right individuals being involved

3. Have implementation strategies been adequate?

Prompt: Training, role modeling, promotion of activities, identified and prep champions, educational meetings

How do you feel the pathway has been integrated with current ways of working: e.g. record systems, need to revise roles?

How has quality management been assessed?

Prompt: clinical supervision, staff feedback

Outcomes

6. Can you describe the impacts you think the pathway has on your service?

Prompt – efficiencies, process, staff time, collaborative working

7. Can you describe the impacts you think the pathway has on patient care?

e.g. any feedback from patients, admission rates, presentations in A&E, lengths of stay

Future implementation, spread and adoption

8. Do you have any suggestions for how the Suicide Prevention Pathway implementation could be improved?

Prompt; adoption across teams, spread of engagement

9. If you could go back and do things differently, what changes or improvements would you make to the implementation process?

Appendix 2

CASE Approach Training - Evaluation

- 48 staff members have completed the CASE approach training between August 2022 and November 2024
- Between January 2024 and November 2024, 13 respondents completed the post-CASE approach training questionnaire (27.08% completion rate)
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Figure 1. Occupational group of respondents (*N* = 13)

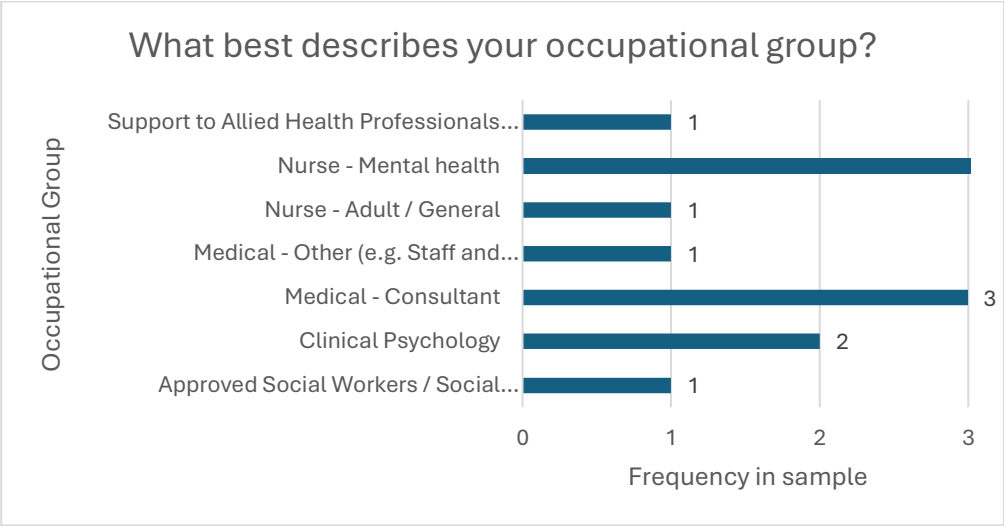
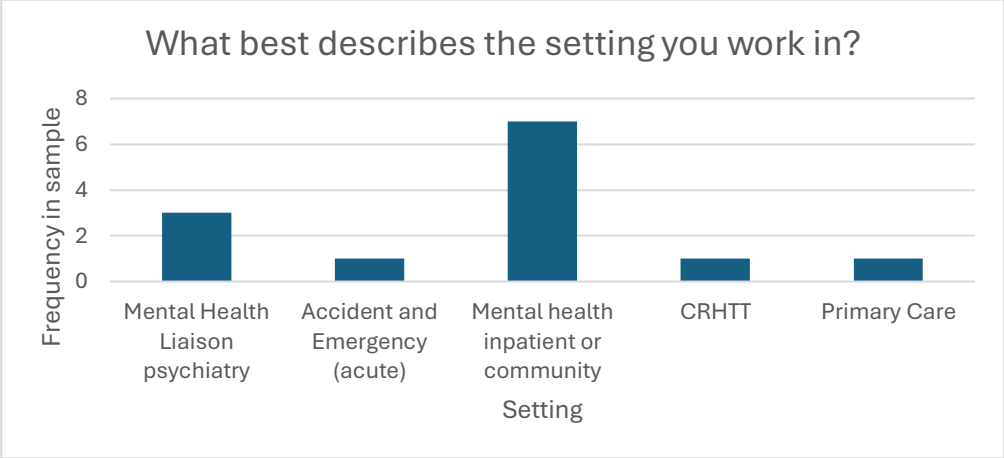


Figure 2. Work setting of respondents (*N* = 13)



Our Values
Welcoming Kind Positive Respectful Professional

Figure 3. Years experience working in health and social care (*N* =13)

- 12 out of 13 (92.31%) respondents provided routinely patient facing care
- 12 out of 13 (92.31%) of respondents had not heard of the CASE approach training prior to this e-learning. The respondent who had heard of CASE approach training heard of it through a book, lecture and undergraduate/post graduate training.
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Figure 4. Respondents perceptions of CASE approach training (*N* = 13)