

**Reflections on an Academic Implementation Network:  
Contributions from the (real world) Implementation Team**

Lelliott, Z., Kelsall, A. and Robinson, S.

**Introduction**

The Mental Health Implementation Network (MHIN) is one of seven National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC) national priority areas in applied health and care research, funded to deliver ‘*real world*’ impact.

The aim of these networks is to “*develop evidence to inform decision making, enable effective implementation and change practice*”. Therefore, the MHIN has “real world” implementation at its core, which enables the study of effective implementation and scaling of evidence-based interventions. As the priority networks have been conceived of and funded by the NIHR they are designed as academic programmes focused on the facilitation and study of implementation, rather than programmes that directly support the implementation itself.

The MHIN leadership comprised applied health researchers and implementation science experts. During the planning stage the programme leadership recognised that the programme would need to draw on broader expertise and knowledge in order to advise and support the implementing teams across the country, and hence an Implementation Workstream was established. The implementation workstream team brought practical, hands-on expertise into the MHIN with regard to leading national implementation projects, but not academics working in implementation science. The team consisted of the authors of this paper: a joint Deputy Director of ARC South London, the Implementation Lead for ARC East of England and a Senior Advisor from Health Innovation East (hereafter referred to as ‘we’.) The following represents some of our collective learning from our involvement in this programme and is written from our unique perspective as real-world implementers.

There is a fundamental difference between implementation science expertise and implementation expertise<sup>1</sup>: one reflects knowledge of the theory and concepts, one reflects

experience of practical implementation itself, and the learning and insights gained from that experience. “Lived experience” of real-world implementation projects is critical for understanding; implementation science seeks to codify that knowledge, enabling it to be shared and built upon. Both have value, and the different perspectives can help us better understand the complex (and frankly downright messy) process of implementation, with the aim of getting research evidence into practice more effectively.

During the course of the MHIN programme, we found that our knowledge and experience enabled us to contribute much more broadly across many aspects of the design and delivery of the programme. For example, we have a detailed understanding of the changing health and care landscape and of operational issues and commissioning models, as well as experience of leading and managing highly complex and rapidly evolving national programmes. One of the MHIN projects created a guide for commissioners and researchers to provide them with tips about how best to engage with one another<sup>iv</sup>.

We believe that insights from a practical implementation perspective, considered alongside the academic outputs from the programme, will help to build the body of knowledge, and inform the design of future programmes, supporting the effective implementation of research evidence.

### **MHIN - Design of Implementation Phase**

A comprehensive prioritisation process was initially carried out, leading to the selection of three priority areas / projects. The MHIN team partnered with two local ARCs/sites within each area:

1. Improving access to Mental Health services for **minoritised ethnic communities** (Patient and Carer Race Equality Framework (PCREF)) – Greater Manchester and Yorkshire and Humber (Sheffield)
2. **Children and young people’s mental health** (parent-led Cognitive Behavioural Therapy (CBT)) – East of England and North West Coast
3. Integrated care protocols for **substance use issues, mental and physical health problems** (Alcohol Assertive Outreach Teams, AAOT) – Greater Manchester (Bolton and Salford) and Yorkshire and Humber (Hull)

There are key differences in the approach to research design and the design of a successful implementation programme. The former tends to be “protocolised” and planned in a structured way over the duration of the research funding. In our experience, real world

implementation is unpredictable and messy, and requires an evolving and adaptive approach to programme management and design. As part of this more agile approach, rapid decision making and ongoing re-design are needed, and leaders of such programmes require a comfortableness with uncertainty and ambiguity.

The Implementation Workstream members brought experience of national implementation programmes and played a significant role supporting MHIN colleagues in shaping and steering the overall MHIN programme, utilising our collective expertise. Contributions included:

- **Prioritisation and selection process** – Although the implementation team were not centrally involved in the prioritisation of areas of mental health needs, we did play an important role in the selection of evidence-based interventions within each priority area. Due to our understanding of the health and care landscape, we were able to advise on a number of issues, including feasibility of implementation, fit with NHS national policy, and with commissioning models. For further detail, see our discussion.
- **Design & delivery of kick-off workshops.** We provided additional knowledge of communications routes and had existing networks and contacts within health and care, which helped to widely distribute invitations, increasing engagement in the programme. Understanding how to maximise impact for busy practitioners helped with planning the content, timing and duration of workshops.
- Shaping the **expression of interest** process for sites/ARCs, ensuring this was rapid and engaging, not too onerous, but detailed enough to elicit necessary information. Having obtained initial bids, we then helped to adapt the process to include detailed discussions with sites prior to selection, testing implementation readiness, etc. This enabled us to make more informed decisions about selection of implementing sites.
- **Programme management expertise;** facilitating rapid problem-solving, supporting the team with re-design of programme structures and functioning following ARC selection, helping to enable the pivot to a more distributed model of leadership and decision-making, working with our partner teams in ARCs and implementing sites.
- **Advising on health and care commissioning and delivery landscape,** for example, highlighting and explaining the introduction of integrated care boards and partnerships. This included a spotlight session for the MHIN capacity building programme.
- Supported **stakeholder mapping activities** with the provision of advice and tools, helped with networking and engagement.

- **Dissemination planning** (in partnership with the ARC South London communications team) helped to identify non-academic routes for communicating MHIN lessons and experiences, for example, through clinical networks, Health Innovation Networks, the Health Foundation's quality improvement Q community, etc.
- **Evaluation** throughout the programme, we have worked closely with the evaluation workstream, given the close connection between implementation approaches and strategies, and the evaluation of implementation. For example, for our pragmatic analysis of implementation strategies we have utilised the ERIC framework, which has also been used to inform the formal evaluation, which will enable us to combine learning for greater insight.

### Delivering implementation support

Initial planning of implementation support activities had been made with a number of ongoing assumptions regarding the level of existing implementation expertise (and hence support required) and level of consistency of approach to implementation across the MHIN sites. For example, we had planned interactive workshops/seminars on implementation, including application of implementation science frameworks. The extent and type of implementation support we could provide was limited to an extent by NIHR's requirements which explicitly precluded using any of the funding for implementation. The implementation workstream therefore worked closely with the local site implementation teams, providing them with support and advice.

Once ARC partners were selected, the implementation workstream held online meetings with the ARC/implementation leads and teams from each participating site individually, in order to determine support needs. It very soon became clear there was much greater sophistication of implementation knowledge across the sites than we had anticipated, based on our experience from other real-world implementation programmes. This had perhaps been developed through previous experience of close working with local ARCs and/or Academic Health Science Networks (AHSNs), now known as Health Innovation Networks. In addition, there was considerable variety in terms of implementation stages and approaches to implementation. All these factors meant that we needed to rapidly re-define our implementation support offer, providing individually tailored advice, with a much more responsive approach.

The process conducted by MHIN to select ARCs/sites used “development of implementation plans” as a selection criterion. This meant in practice that implementing teams in these sites had already begun to plan their implementation approaches and strategies, and already had some momentum or “system-pull” towards implementation.

In this context, the implementing sites already had initial plans outlined, and may have been unclear what support and advice was available to them from the central MHIN team, or they were used to receiving the support they needed from local partners, such as their ARCs. The physical distances and number of sites involved meant that close, trusting relationships took time to develop between the sites and the MHIN central team, which may have reduced the likelihood of the implementing teams seeking advice and support from MHIN colleagues. This was also perhaps influenced by the programme design, whereby MHIN could be seen as a “funder” or “commissioner” to which the ARCs/sites (or “delivery sites”) had bid for funding.

For future programmes flexible funding may be beneficial, for example, local Health Innovation Networks being enlisted to provide on-the-ground support. We believe that these kinds of approaches could utilise the existing relationships and knowledge of the context to see desired outcomes achieved more effectively and rapidly. We suggest that this is a consideration for future national programmes, that programmes could be jointly funded between NIHR and NHSE (as with the National Insights Prioritisation Programmes, NIPP).

As indicated above, the support provided by MHIN’s implementation workstream was more responsive than proactive and tailored to the nuanced needs of each project or each of the implementing sites. Examples of implementation support given include:

- **Ad hoc advice and support** - a team member regularly attended local site project meetings and advised, for example on strategies for recruiting participants using their knowledge of the NHS landscape and providing support to practitioners delivering new interventions.
- **Connections / networking** - each of the team members brought a variety of existing working relationships to the collaboration, enabling them to link local sites, for example, to their local Health Innovation Networks, NHS England clinical networks, relevant national charities and voluntary sector organisations and government departments such as the Office for Health Improvement and Disparities.
- **Community of Practice (CoP)** concept and facilitation – we launched a new Community of Practice, establishing support from senior sponsors, gathering

members and leading the design and convening of a launch and initial sessions<sup>ii</sup>. See the report, [\*\*'If you want to go fast, go alone, if you want to go far, go together.'\*\*](#) – a practical example of setting up and convening a new community of practice.

This CoP was effective in providing a safe space for those involved to share experiences and challenges/learning regarding implementation of alcohol assertive outreach teams. In addition, we introduced the concept of Communities of Practice to the wider network through formal capacity building sessions and more informal updates at project meetings.

- **Translation** (between implementation practice and implementation science) – experiential knowledge and approach to implementation science, for example, explaining the process of using implementation science to stakeholders at local project meetings, providing a glossary of terminology at initial workshops and sharing resources to specific implementation science frameworks and tools.
- Formal **capacity-building** presentations, including an introduction to the history and development of the NHS and social care landscape, project management theory and practice, Communities of Practice and using Liberating Structures.
- **Stakeholder mapping tools** – providing templates and examples of completed maps as well as meeting with individual researchers to advise and guide on the use of the tools and interpretation/analysis for their specific projects and research questions.
- **Project management** - tools such as Gantt charts and RAID (risks, assumptions, issues and dependencies) logs – provision of templates (e.g. “support log”) and completed examples. Use in MHIN project meetings to model their use and value.
- **Identification of cross-project themes / learning** – for example challenges relating to involvement of people with lived experience, how to use research evidence to influence commissioners and how commissioners should use research to guide decisions and planning, reflected in MHIN’s other publications.

## Conclusions

The Mental Health Implementation Network is a highly complex programme with multiple national contextual factors impacting over the lifespan of the programme, as well as different

contexts and approaches across the six implementing sites. We found that the skills and experience we had developed whilst leading other complex projects and national programmes were particularly valuable in supporting the MHIN, in addition to our implementation expertise. At times, we were able to assist with our approach to agile problem solving and direct implementation experience, helping to maintain pace and focus on delivery of milestones and timelines. Despite some early tensions due to our very different backgrounds and approaches, we developed as an effective team and found that the different perspectives helped us to better understand the complex (and messy) process of implementation, with the shared aim of more effectively getting research evidence into practice.

We therefore strongly recommend the MHIN model of integrating experts in implementation practice alongside experts in academic implementation science, within an academic programme. We believe that an effective way to enable and incentivise this approach could be for NIHR and NHSE to work together as commissioners, and ARCs to partner with Health Innovation Networks for effective programme delivery (as we have seen in the National Insights Prioritisation Programme<sup>iii</sup>).

Whilst we have drawn our conclusions from reflections on our role in the programme and our informal observations of cultures and working practices, the more formal data-driven MHIN evaluation will provide additional insights from an academic perspective.

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<sup>i</sup> Metz, A., Jensen, T., Farley, A., & Boaz, A. (2022). Is implementation research out of step with implementation practice? Pathways to effective implementation support over the last decade. *Implementation Research and Practice*, 3. <https://doi.org/10.1177/26334895221105585>

<sup>ii</sup> Link to CoP blog

<sup>iv</sup>2024. Tips for Researchers on How to Engage with Planning and Commissioning to Maximise Knowledge Transfer and the Impact of your Research and Evaluation.

<sup>v</sup>Ahuja, S., Phillips, L., Smartt, C., Khalid, S., et.al (2023). What interventions should we implement in England's mental health services? The mental health implementation network (MHIN) mixed methods approach to rapid prioritisation. *Frontiers in health services*, 3, 1204207.

<sup>iii</sup> <https://thehealthinnovationnetwork.co.uk/about-us/supported-initiatives/nhs-insights-prioritisation-programme-nipp/>