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Contextual factors that influence adoption and sustainment of self-management support in cancer survivorship care: a practical application of theory with qualitative interviews

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ABSTRACT

Background Self-management support (SMS) is a recommended component of cancer survivorship care that improves health-related quality of life and reduces healthcare utilisation. However, widespread implementation has been difficult to achieve, with a gap in the literature on system-wide implementation efforts. This study examines contextual factors perceived to influence SMS adoption and sustainment in cancer centres in the Republic of Ireland.

Method Semistructured interviews were conducted with 47 key informants from 20 cancer organisations across community and hospital settings. Participants were asked to report the level of adoption and sustainment of SMS at their organisation. This information was used to categorise organisations as low, medium or high implementers. We conducted cross-case analysis following the principles of Framework Analysis. Using the Consolidated Framework for Implementation Research as a menu of constructs, we examined factors influencing adoption and sustainment and variation in levels of implementation.

Results National policy, external accreditation, external financing opportunities and the presence of champions in organisations are influential early in the implementation process driving adoption. Healthcare provider-led programmes and evidence of SMS improving patient outcomes and aligning with an organisation's priorities are necessary to secure buy-in, particularly among senior leadership. An organisational culture of entrepreneurship enables adoption and sustainment, with resources and a culture supporting staff well-being enabling sustainment.

Conclusion While national policy is a driver, additional factors related to programme attributes and local contextual features such as the presence of champions, organisational readiness and culture influence implementation. The results may be used for future evaluations of SMS implementation in cancer survivorship care and to inform the development of tailored implementation strategies.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Internationally, widespread implementation of self-management support (SMS) programmes for cancer survivors has been difficult to achieve, despite evidence of effectiveness and consensus that such programmes are an essential part of long-term recovery.
⇒ While previous studies have identified barriers and enablers of individual SMS programmes at a local level, few have studied national implementation efforts.
⇒ As a consequence, there is little information on how the roll out of SMS can be optimised across organisations and at a national level and what factors differentiate between organisations with varying levels of implementation.

WHAT THIS STUDY ADDS

⇒ Using the Consolidated Framework for Implementation Research as a foundation menu of constructs, this study presents a framework depicting the contextual factors perceived to be most relevant for adoption and sustainment of SMS in cancer survivorship care.
⇒ Findings provide insight into factors that differentiate between organisations with high and low levels of implementation.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Findings provide a basis to inform the tailoring of implementation strategies at national and local levels to support widespread adoption and sustainment of national cancer survivorship programmes.

INTRODUCTION

With improvements in diagnostics and treatments, more people are living with and beyond cancer.[1] However, many cancer survivors experience long-term physical and psychosocial morbidity after treatment.[2] This has led to the introduction of cancer survivorship programmes in many countries.[3–7] These focus on monitoring and managing symptoms with the aim of reducing morbidity, promoting health and preventing recurrence after the acute phase of treatment.[8 9] International organisations such as the WHO and European Commission recommend the implementation of cancer survivorship care.[10–14] One element of cancer survivorship care is self-management support (SMS),[10–12 15] which is defined as the 'systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support'.[16] SMS programmes aim to enable patients living with a long-term condition to work collaboratively with healthcare providers to manage their own health and well-being to improve health outcomes and reduce health services utilisation.[17–19] Programmes include information provision and online courses, and extend beyond didactic instructional approaches to include behaviour change interventions and coaching by healthcare professionals or trained peers to enhance patients' self-efficacy and self-management skills.[17–19] Despite evidence of effectiveness and international recommendations, widespread implementation of SMS in cancer survivorship care has been difficult to achieve.[15 20–25] One study evaluated the adoption and implementation of a digital SMS programme among 65 hospitals in the Netherlands and the adoption rate was 31%.[25] In adopter hospitals, the programme was offered to 72% of patients by healthcare providers.[25] Studies on SMS implementation have focused on single programmes in local settings,[23 25 26] with a gap in the literature on system-wide initiatives. Few studies have assessed how local organisations react to and act on national policy guidance. There is also limited research on what is needed to implement national policy recommendations in the context of existing local initiatives which may be disrupted. Understanding this is important as there are unique factors surrounding policy implementation that differ from local implementation initiatives.[27]

In Ireland, the 2017–2026 National Cancer Strategy recommended the implementation of survivorship programmes including SMS.[28] Programmes have been adopted across different regions and care settings,[29] and through a multisite qualitative study, we examined the contextual factors influencing adoption and sustainment of survivorship programmes that incorporate SMS in an Irish healthcare setting.[30] Studies of implementation context often generate isolated lists of barriers and enablers without explaining how or why these factors are important and at what stage of implementation.[31] Our study responds to the call for 'theoretically informative' improvement research[32] by presenting a framework of contextual factors perceived to influence service level implementation of SMS programmes and generating potentially testable explanations for variation in implementation.

METHODS

A qualitative study design was used, involving semi-structured interviews with key informants across 20 cancer services including hospitals and community cancer support centres in the Republic of Ireland. Reporting follows the Standards for Reporting Qualitative Research guidelines[33] (online supplemental file 1).

STUDY SETTING

In Ireland, there are two types of public hospitals. One is funded by the state and managed by the Health Service Executive (HSE), and the other type is state funded managed by private bodies or charities known in Ireland as 'voluntary hospitals'. Despite the different management and ownership models, all public hospitals are financed primarily by Government taxation. There are also private hospitals that receive no state funding.

SELECTING CENTRES

Ireland's cancer services are structured around a hub and spoke model featuring eight National Cancer Control Programme designated adult cancer centres located in public hospitals as primary hubs.[28 34] We purposively selected these eight centres because they have sufficient 'case volumes, expertise and concentration of specialist skills, working in multidisciplinary teams to ensure the best outcome for patients' and to ensure geographical representation.[35] Four centres are located in HSE-managed hospitals and four are located in 'voluntary hospitals'. We also included community cancer support centres operated by the charity sector which provide psychosocial care and SMS for cancer survivors and their family.[34] Community cancer support centres are non-profit organisations that provide non-acute care for individuals living with and beyond cancer, their families and caregivers. There are an estimated 35 centres, operating largely on independent funding from donations and grants.[34 36] They

offer services free of charge, including information and education about cancer, psychological support through counselling, and survivorship and SMS programmes. They also offer complementary therapies such as yoga and relaxation classes, facilitate support groups for shared experiences and provide financial advice.[34 36] These centres were identified through our advisory group who provided guidance on where SMS programmes are delivered. We also identified community cancer support centres via listings online which provide information about their services.

Sampling and recruitment

Potential participants were invited via email using both purposive criterion and snowball sampling[37] to select 'information-rich cases'.[38] We interviewed individuals who delivered programmes or care that focused on supporting cancer survivors in developing at least one self-management task (ie, medical management, role management or emotional management)[19] or had a role in referring patients to SMS services. Across organisations, we first contacted management seeking permission to conduct the study and they identified individuals directly involved in delivering SMS. These participants were invited to participate and then asked to suggest other individuals who could contribute to the study. Interested participants contacted NP by email or phone. Participation was voluntary, and all interviewees provided informed consent. Sample size was informed by the principles of information power whereby the more information the sample holds, the lower number of participants required.[39] Information power focuses on the depth and relevance of the data, rather than focusing on a set number of participants or the absence of new themes to guide sample sizes.[39] The research focus was narrow, the interviews and quality of dialogue between the interviewer and participant were in depth and averaged 50 min, the topic guide was informed by pre-existing literature and a theoretical framework. Purposive sampling was also used to ensure participants had in-depth knowledge and experience relevant to the research question.[39]

Expert advisory group

Our expert advisory group reviewed the topic guide, which was refined accordingly. For example, one member of our patient and public advisory group who has experience in healthcare quality improvement in the Irish setting suggested exploring the influence of hospital ownership on implementation. The advisory group also helped frame the research question, provided feedback on data collection procedures and supported recruitment. The group included five individuals with lived experience of cancer and members from the National Cancer Control Programme cancer survivorship team. Our research team included researchers and clinicians with expertise in cancer care and survivorship delivery, quality improvement, implementation science and health services research.

Data collection procedures

From June 2022 to March 2023, interviews were conducted in person, over telephone or online by NP, a radiation therapist with experience of qualitative data collection. Interviews were audio-recorded and transcribed by NP or a professional transcription service and anonymised by NP. Topic guide questions were structured around the updated Consolidated Framework for Implementation Research (CFIR) which sets contextual influences on implementation (n=48 constructs).[40] The topic guide (online supplemental file 2) focused on CFIR constructs that had been identified as potentially relevant to SMS implementation in previous research.[23 25 41–43] The topic guide also elicited descriptions of programme adoption and sustainment.[44]

Analysis

We used a combined inductive-deductive coding approach following the Framework Analysis principles.[45] First, we developed qualitative definitions for non-adoption, adoption, sustainment and non-sustainment based on published definitions (table 1).[44] Based on participant reporting of adoption and sustainment, we classified organisations as low, medium or high implementing sites. Organisations with sustained programmes were classified as high implementing, those with adopted programmes as medium, and those with no programmes as low implementing. This classification of organisations allowed us to compare 'cases' to understand the most relevant factors contributing to these differences. To identify contextual factors, we then coded transcripts inductively and mapped these codes to the CFIR framework.[40] Initially five transcripts were double-coded (independently by NP and SMH). Coders discussed any discrepancies and agreed on the most appropriate CFIR construct to develop an analytical framework to code the remaining transcripts using NVivo. Codes relating to a given contextual factor (eg, champions) were grouped together and summarised in a matrix with contextual factors as rows and organisations (cases) as columns (see online supplemental file 3). In some organisations (n=9), the sample had one participant. While others (n=11) had multiple interviews conducted within the same organisation. For organisations with multiple participants, their perspectives were integrated. Findings were compared iteratively across cases to understand how and under what circumstances factors influence adoption and sustainment.[45] See online supplemental files 3 and 4 for more detail and supporting quotes. Relationships between contextual factors were also explored across and between cases.[46] This enabled us to present a theory-informed framework of contextual factors most relevant for adoption or sustainment or

Table 1 Qualitative definitions of implementation outcomes and participant quotes for perceived adoption and sustainment

Implementation outcome category	Definition of implementation outcome	Published definitions from the literature	Example of participant quotes used to determine perceived extent of adoption and sustainment
Non-adoption	Non-adoption of SMS programme. These organisations had no SMS programme adopted. In these organisations health providers often refer or direct cancer survivors to SMS outside of organisation.	*Adoption is defined as 'the intention, initial decision, or action to try or employ an innovation or evidence-based practice'.*[44]	*Would highlight the resources that are available to them in the community. Would recommend they all touch base with their local cancer support centre, I highlight the Cancer Thrive and Survive programme. I advise them of the nearest two cancer centres.*
Adoption	SMS programme adopted with initial decision, or action to try implement a programme. Or a SMS programme is supported through temporary funding or external financing for adoption but not permanently funded.		*A grant call and we applied for that and that was the catalyst really. So, without that, without us getting that grant this wouldn't be in (organisation).*
Non-sustainment	SMS programme not maintained within a service setting's ongoing, stable operations, including interruptions or gaps in delivery. This includes programme cessation following end of temporary external financing.	*Sustainability is defined as 'the extent to which a newly implemented treatment is maintained or institutionalised within a service setting's ongoing, stable operations'.*[44]	*We're in the process, we haven't done one this year, we delivered two programmes before 2020.*
Sustainment	SMS programme maintained or institutionalised within a service setting's ongoing, routine delivery of care. This includes necessary resource allocation for sustained delivery.		*It's clinical service and continuously being delivered as part of standard of care.*

Qualitative definitions for non-adoption, adoption, sustainment and non-sustainment based on published definitions of implementation outcomes.[44]
SMS, self-management support.

both and the relationship between contextual factors (figure 1).[47] To ensure trustworthiness, interpretations were periodically discussed among the research team and presented to our expert advisory group.

RESULTS

We interviewed 47 key informants (average key informants per site 2.4 (range 1–7)) across 20 organisations. These included 8 hospitals and 12 community cancer support centres. Participants represented local level management, trained peer leaders and healthcare providers. Healthcare providers included nurses, psychiatrists, psychologists, occupational therapists, physiotherapists, dietitians, social workers, surgeons and medical oncologists (table 2). Perceived implementation level varied across organisations, with eight high implementing sites, nine medium and three low implementing sites (table 2). Interviews lasted approximately 50 min (range 30–120 min).

Figure 1 depicts the most relevant factors influencing perceived adoption and sustainment, and the relationship between factors. Factors are grouped into three categories: drivers of adoption, factors influencing both adoption and sustainment and factors influencing only sustainment. For example, policy and external financing were influential early in the implementation process driving adoption. Whereas, champions, leadership support, a culture of entrepreneurship within organisations and characteristics of the programme influenced both adoption and sustainment. The arrows illustrate the direction and nature of the relationships between factors, showing how one factor can influence others in the implementation process. For example, some have contingent relationships with adoption and sustainment. For example, the allocation of resources for implementation was perceived to be contingent on leadership buy-in and support. There were also reciprocal relationships between contextual factors, for example organisational culture and leadership interacted with each other to drive adoption and sustainment. An entrepreneurial culture influenced leadership support by fostering positive attitudes among leadership towards implementing new innovations. While leadership actions shaped and reinforced the culture, creating an environment that either supported or impeded the innovation.

Policy is a driver of adoption, but infrastructure and resources in the inner setting are necessary for sustainment

While national policy recommendations created an impetus for implementation, local conditions had

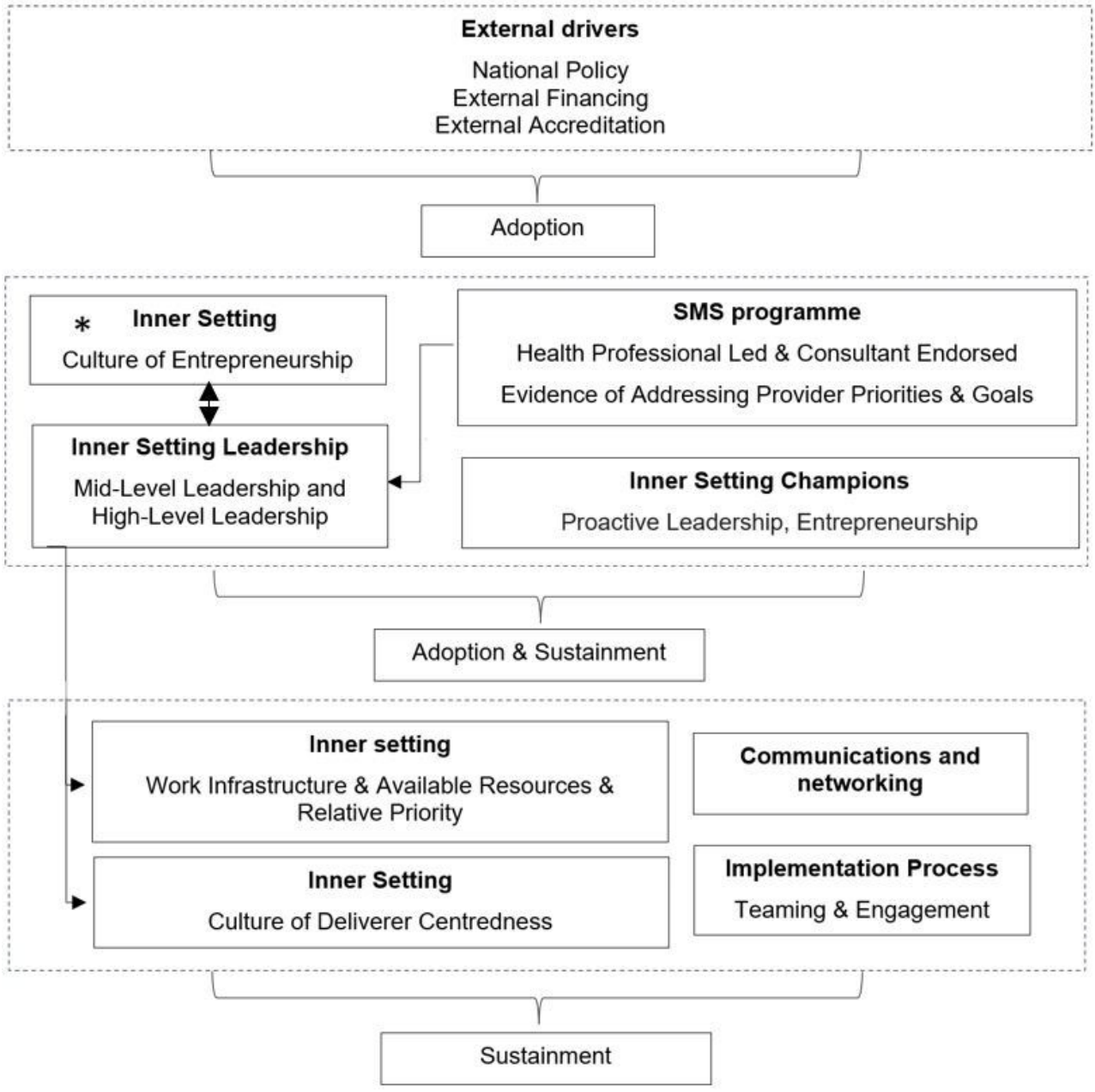

Figure 1 Framework depicting contextual factors influencing implementation. *Strengthen the effects of enabling factors (eg, champions)

to be ripe to act on those recommendations. The Irish National Cancer Strategy recommending the implementation of cancer survivorship care played a key role in legitimising and encouraging the adoption of SMS programmes across organisations. It mobilised external financial support from advocacy groups, such as research charities, and support from senior policy leadership. For example, the National Cancer Control Programme facilitated wide scale adoption of one programme called 'Cancer Thriving and Surviving' through funding and staff and peer-leader training. Some participants who adopted this programme described how they wanted to be part of the national adoption of this programme.

> We wanted to be part of the national run of that programme as everybody else does in the country. (Participant 9, high implementing organisation)

A barrier for many healthcare providers was carrying out administrative tasks to deliver a programme alongside existing responsibilities. In low and some medium implementing organisations, programme delivery was an additional task without alignment to existing roles and duties. Adoption therefore required absorption into the current work infrastructure, without additional resources of funding, protected time and administration support.

> Certainly for me, if there was more organisational support from administration, I would probably

Table 2 Number and role of participants within high, medium and low SMS implementing organisations

	Organisations (n=20)																			
	High								Medium									Low		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Participants																				
Managers (n=5)		1	1	1				1						1						
Nurses (n=13)		1				1	2			1					1	1	2	1	1	2
Psychiatrists (n=2)						1				1										
Psychologists (n=4)							2			1										1
Counsellors (n=2)				1								1								
Occupational therapists (n=1)						1														
Physiotherapists (n=5)						1	1										1	1	1	
Dietitians (n=2)							2													
Social workers (n=2)									1								1			
Surgeons (n=1)						1														
Medical oncologists (n=1)																		1		
Trained peer leaders (n=9)	4			1	1			1			1		1							
Total (n=47)	**4**	**2**	**1**	**3**	**1**	**5**	**7**	**2**	**1**	**3**	**1**	**1**	**1**	**1**	**1**	**1**	**4**	**3**	**2**	**3**

Table displays implementation levels of the 20 organisations. Numbers 1 to 20 refer to each of the 20 organisations. High, medium and low refer to the level of implementation for each of the 20 organisations. Organisations with sustained programmes were high implementing (n=8), those with adopted programmes were medium (n=9) and those with no programmes adopted or sustained were low implementing organisations (n=3).
SMS, self-management support.

be more inclined to do it. (Participant 12, High Implementing Organisation)

Individuals in these settings acted as champions, often delivering programmes beyond their regular working hours, leading to concerns about sustainability. Some organisations developed partnerships with other organisations to acquire resources necessary for sustainment. Higher implementing organisations also had an enabling work infrastructure characterised by having leadership who provided resources to integrate administrative tasks and SMS into core operations rather than treating them as supplementary. Participants' direct line manager also acquired additional necessary resources for sustainment including staffing, funding, protected time and physical space.

> We're so under-resourced across the board, it was a big thing for her to say, 'try it, here's some funding, I'll take you out of your clinical post.' So, someone had to fill my gap when I left, and I got this programme up and running … and her leadership and her support were key. (Participant 02, high implementing organisation)

Accreditation, performance measurement and governance to enable adoption and continued engagement with implementation

Some participants working in hospital settings described how meeting external standards such as Organisation of European Cancer Institutes (OECI) accreditation helped formalise networks and communication between teams to drive innovation and improvements in care delivery, including survivorship care. Participants also described how performance measurement pressure, including key performance indicators and audit and feedback could motivate healthcare providers to engage with implementation and promote standardisation across organisations.

> Whether that needs to be more prescriptive in our care, it needs to be measured by KPIs or through audit. I think something like that would motivate or enable better engagement. You need to see your reward for doing it. (Participant 01, low implementing organisation)

However, there was a concern that setting key performance indicators could lead to the adoption of programmes and actions to meet short-term achievable metrics without putting measures in place to identify areas for improvement and address implementation challenges. Governance frameworks and monitoring systems were therefore deemed important to standardise implementation of policy recommendations and guide monitoring and evaluation of programmes.

> If you've got good quality management and good coordination and there's a feedback loop, that's very sustaining. (Participant 20, high implementing organisation)

Providing evidence of SMS improving patient outcomes and addressing leadership priorities secures organisational buy-in

Prioritising patient needs and reporting on patient-reported outcomes by presenting data and evidence of how SMS improves cancer survivor outcomes were important for securing buy-in during the initial adoption phase. Establishing trust across stakeholder groups and gaining management and healthcare provider buy-in also relied on evidence demonstrating clear benefits in terms of effectiveness and safety.

> It was very much about allowing the organisation to provide programmes that have research done into them, that have a proven track record. (Participant 36, high implementing organisation)

In addition, some interviewees unfamiliar with SMS expressed uncertainty about patient eligibility criteria. There were also concerns that patient involvement in psychosocial programmes could reinforce illness roles. Participants described the significance of patient experience feedback or testimonials to address these initial concerns, but also to motivate implementation leads to continue delivering SMS.

> But once they had a couple of patients go through it, and they got feedback from their patients, they're very happy to refer. Again, because it is safe, because it is evidence based. (Participant 20, high implementing organisation)

In contrast with high implementing organisations, participants in low and medium implementing organisations described SMS and survivorship care as a low priority relative to other services, and therefore difficult to gain buy-in at management level for resource allocation. Management priorities primarily centred on reducing admissions and achieving cost savings. However, within the context of competing priorities and resource limitations, the presentation of evidence illustrating how SMS addresses the organisation's priorities were essential for obtaining high-level management buy-in to secure resources for sustainment.

> Data is everything – if you want something to progress, you need the numbers, because it decreases length of stay, there's more cost savings for the hospital. (Participant 42, medium implementing organisation)

SMS programme credibility and trustworthiness also influenced adoption decisions. For example, health professional-led programmes were essential for securing buy-in across professions. Participants in hospitals also emphasised the importance of endorsement from oncology consultants who are senior medical oncologists in generating high-level management support for SMS.

> You really don't know where to go with hospital management. We have yet without the support of the consultants, and really the badgering from the consultants that they really need this to make their service work. (Participant 01, low implementing organisation)

However, participants expressed how differing priorities among healthcare providers can make it challenging to select appropriate evaluation metrics and present data in a way that secures buy-in.

Continued advertising of programmes including their benefits was also identified as important, as existing programmes may be overshadowed by new priorities.

Champions with proactive leadership and entrepreneurial skills enable adoption and sustainment

Across medium and high implementing sites, there were champions actively driving adoption and sustainment, whereas such champions were not present in the low-implementation sites. Champions were individuals who actively promoted and drove the implementation of SMS across their organisation. Champions varied between those in leadership roles, including senior managers and those in healthcare provider roles such as nurses and psychologists. Across organisations, champions' dedication fostered a bottom-up drive and commitment to implementation. In the absence of national funding opportunities, these champions demonstrated proactive leadership, and entrepreneurial skills to avail of external funding to trial a SMS programme. They also displayed enthusiasm and persuasive communication skills to develop connections and secure buy-in across various levels of influence. One champion who worked in a medium implementing organisation persevered and drove the adoption of SMS despite challenges.

> I'm the driver in the service, I'm the one who keeps pushing … I might be knocked down today and tomorrow, but I'll keep going, there's always solutions. (Participant 41, medium implementing organisation)

In hospitals that lacked a supportive infrastructure, champions in these settings took on additional administrative tasks required to deliver SMS alongside their existing responsibilities, despite the lack of clear directives or defined roles. For example, one champion drove SMS implementation in her setting by taking the initiative to seek leadership support to adopt a programme alongside her existing responsibilities, despite uncertainty regarding responsibility for implementation among healthcare providers.

> Nobody has come to me and said you need to do this, and this is what we have chosen, and this needs to be part what you're delivering if you're delivering a survivorship service. (Participant 21, high implementing organisation)

Champions were also important for information sharing and increasing awareness of SMS among staff in their organisation. Participants described how

one-off education sessions can appear formal, and ongoing working together and frequent communications from champions are more likely to build awareness of SMS and secure buy-in among healthcare staff.

> You can deliver education, but I think that tends to be perceived as being formal and can be difficult to get the tone right. Whereas I think ongoing working together is what helps make things work better. (Participant 28, high implementing organisation)

Organisational culture of entrepreneurship and addressing employee well-being affects the capacity of champions and staff to adopt and sustain programmes

A culture of entrepreneurship and innovation within organisations enabled champions to adopt and sustain SMS. This entrepreneurial culture was characterised by a set of shared attitudes, goals and practices that support entrepreneurialism. These organisations encouraged staff to take initiatives in adopting new programmes. For example, high implementing hospitals had a culture where there was freedom to initiate change and an implicit expectation to innovate and shape care delivery methods, with leadership support and less administrative pushback. Participants also described having more autonomy to shape service delivery and being able implement things quicker. In contrast, individuals in low and some medium hospitals described an unenterprising culture.

> They don't want to know what we're doing as long as we're showing up for work, as long as we're practising safely, as long as there isn't a complaint about us … it would be great if we had these performance meetings to say look, this is where I want to see, this is what I want to do. There's none of that, it's a pity that culture isn't there. (Participant 41, medium implementing organisation)

In hospitals, this culture appeared to be shaped by governance and ownership, as some participants described differences between non-voluntary-led hospitals (ie, Health Service Executive (HSE) led) and 'voluntary hospitals'.

> I've worked in HSE run hospitals which are different but the (hospital) has its own board of management and it tends to prioritise innovation over a lot of other things. So, we have a certain amount of freedom in terms of how we design things. (Participant 38, medium implementing organisation)

Participants working in non-voluntary-led hospitals described processes for approval and resource allocation as slow and arduous due to administrative structures and 'layers of management' leading to a loss of motivation among healthcare providers to drive implementation. Strategies to support employee well-being were also important to sustain the motivation and capacity of staff to deliver programmes. Recognising the potential emotional toll associated with delivering psychosocial support and SMS, there was an emphasis on the importance of peer supervision and debriefing sessions.

> Supervision has always been part of our practice, but I don't know if it is for a lot of the other professions in this area … there's a lot of an emotional load that comes with working in oncology, and I think if people are to be sustained in the work, and if people are also to keep their warmth and care towards patients, they have to be supported themselves as well. (Participant 15, medium implementing organisation)

Line management in high implementing organisations also fostered an environment with high staff morale by providing non-monetary incentives such as praise and recognition and bringing team members together to collaborate on tasks to implement the programme.

DISCUSSION

By analysing the implementation of various SMS programmes across different settings with different levels of implementation, we contribute to the understanding of the contextual factors influencing adoption and sustainment of SMS in cancer survivorship care. National policy is a driver of SMS adoption; however, it is insufficient on its own. Our findings suggest that organisations need the right internal conditions to respond, including the presence of enterprising champions, leadership buy-in, entrepreneurial culture, teamwork, networks and communications, work infrastructures and resources. In addition, enabling SMS programme attributes include healthcare provider led programmes, consultant endorsement, evidence of effectiveness in improving cancer survivor outcomes and alignment with organisational priorities. Our findings also highlight the importance of addressing multiple factors rather than isolated barriers when trying to improve SMS implementation.

We also describe potential strategies that could improve SMS implementation (table 3).[48 49] Introducing new SMS programmes requires a shift in existing workflows, and healthcare providers spoke about conflicting priorities such as patient care and administrative responsibilities, along with limited resources as barriers. Meeting external standards was described as enabling leadership-buy-in and subsequent resource allocation and formalisation of structures and workflows. Therefore, one possible strategy to drive adoption is building SMS into the external accreditation of cancer services. Another possible strategy is the measurement of performance indicators such as number of patients who participate in SMS or number of programmes delivered within specified timeframes, with audit and feedback.[50]

Collecting patient-reported data and demonstrating that SMS improves cancer survivor outcomes helped to secure buy-in among leadership and healthcare

Table 3 Strategies to address contextual factors influencing implementation of SMS

Strategy		Description
1	Mandate change	Develop policies and guidelines that prioritise SMS and outline the responsibilities of healthcare providers for implementation.
2	Change accreditation	Integrate SMS into external accreditation standards so that those who want to meet external accreditation standards are required to implement SMS.
3	Audit and feedback	Implement performance measurement using key performance indicators or audit and feedback to monitor, evaluate and modify behaviour.
4	Identify and prepare champions	Identify and support champions within the organisation who can advocate for and lead SMS implementation.
5	Recruit, designate and train for leadership	Engage health services' leadership buy-in for resource allocation and to foster a culture of entrepreneurship and continuous quality improvement to drive innovation and enhance SMS implementation.
6	Develop and organise quality monitoring systems	Develop processes for ongoing monitoring and evaluation to identify areas for the purpose of quality assurance and improvement in SMS implementation.
7	Develop resource sharing agreements	Develop partnerships with organisations that have resources needed to implement the innovation, such as administrative support or physical space.
8	Alter incentive structures	Provide incentives to motivate staff to implement SMS.
9	Obtain and use patients/consumers and family feedback	Develop strategies to increase patient feedback on their experience of SMS.
10	Communicate with stakeholders the continued impact of the evidence-based intervention	Advertise and communicate data to external stakeholders, end-users and consumers to demonstrate the ongoing benefits, cost-effectiveness or return of investment of the innovation with continued implementation to sustain buy-in from healthcare providers and patients.

Strategies 1–9 are derived from the Expert Recommendations for Implementing Change (ERIC) compilation,[49] while strategy 10 is derived from Nathan *et al*.[48]
SMS, self-management support.

providers for adoption and sustainment.[26 51] We also found that continued advertising and promotion of SMS was important to maintain buy-in at the healthcare provider level and to stop existing programmes from being overshadowed by newer priorities. Our findings also highlight the need for champions to drive adoption and sustainment of SMS. Identifying and developing champions may be difficult in contexts that lack engaged leadership or a culture of entrepreneurship and innovation. In their study, Howell *et al*[23] highlighted that leadership support and a culture of quality improvement enabled organisations to be more receptive to implementing SMS in Canada. A realist review found that managers who endorse and communicate their expectation for SMS motivates staff to prioritise SMS delivery.[50] While there is limited evidence on the effectiveness of strategies for sustaining evidence-based interventions, a review identified leadership support as a commonly used strategy for public health interventions.[52] Therefore, future efforts should consider strategies that enhance leadership buy-in for SMS implementation. This could be achieved by presenting evidence of how SMS implementation aligns with an organisation's priorities such as reducing admissions and achieving cost savings.[52] Strategies are also needed to cultivate an organisational culture that focuses on innovation and continuous improvement in cancer survivorship care.[53] There is limited evidence on how to do this,[54] but engaged leadership[54] and a commitment to accreditation can have positive impacts on culture, performance and leadership support.[55] Engaging clinicians from the outset may also foster a sense of ownership.[51 56] When implementing the UK National Cancer Survivorship Initiative, national level commitment provided impetus and financial backing, but engagement of clinicians at local level was key to bringing about a cultural change. For example, ministerial approval was obtained to secure the support of senior stakeholders and clinicians were brought together to address and resolve implementation challenges.[56]

Recognising and rewarding staff efforts may also incentivise motivation and engagement.[57] This should be supplemented with administrative support so that clinical staff have the time to focus on SMS programme implementation. Prioritising administrative efficiency may also boost staff morale and productivity as our findings highlight how a culture addressing employee well-being enables sustainment. This aligns with the 'Quadruple Aim' which recognises the importance of addressing the well-being of staff.[58] In addition, it is possible that peer supervision and debriefing sessions will sustain motivation and capacity among individuals delivering SMS and reduce the emotional toll of delivering these programmes.

Although our participants did not discuss the impact of digital solutions, there is evidence that technology may enhance SMS programme delivery and patient engagement.[59] For example, online or app-based delivery of SMS can help a programme to scale up

and accommodate a growing number of users without requiring substantial resources. Digital solutions also reduce geographical and time constraints.[59–61] The findings from this study can be applied to other similar contexts but strategy adaptations may be necessary to address specific local conditions, such as different organisational cultures or resource availability. For example, external accreditation and performance measurement may be influential drivers in Ireland but may not work as well elsewhere depending on local practices and regulatory frameworks. Further comparative studies are required to deepen our understanding of which contextual factors and implementation strategies have broad applicability.

Strengths and limitations

The integration of multiple perspectives from key informants across different organisations enhances the generalisability of our findings.[30] Our focus on identifying only the most relevant factors for implementation[30 62] is another strength, as is our provision of testable hypotheses about implementation strategies. A limitation of our study is the lack of routinely available quantitative data on implementation outcomes. This meant we were not able to identify combinations of factors that are minimally necessary or sufficient for achieving particular targets.[63] Implementation outcomes were reported qualitatively which lacks precision.[44] In addition, while Ireland's National Cancer Strategy has been supported by government funding, a limitation is the lack of specific information on national level funding and financial support for SMS, as neither public reports or interviews provided detail on the funding amounts. This leaves uncertainty about the weight of funding influence on programme adoption. In addition, while we included a large number of organisations, we had relatively few interviewees per site. However, the study was guided by the principles of information power,[39] and key individuals who were directly involved in the implementation of SMS were purposively selected within each organisation. Therefore, even with fewer informants these participants provided in depth insights. Finally, this study did not explore the perspectives of patients and their families. Including their views could have offered greater insight into how SMS programmes align with their needs and preferences, as well as patient-level drivers of adoption and sustainment. For example, their perspective could have given more insight into ways to monitor and evaluate the effectiveness of SMS.

CONCLUSION

National policy, programme attributes and local contextual features are key drivers of SMS implementation. When tailoring strategies to local contexts, multiple factors have to be addressed to improve implementation outcomes.

Correction notice This article has been corrected since it was first published online. Changes have been made to the Selecting Centres section.

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Supplementary file 1: Standards for Reporting Qualitative Research guidelines

Standards for Reporting Qualitative Research (SRQR)*
http://www.equator-network.org/reporting-guidelines/srqr/

	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Page 1/ Lines 1-2
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Page 1/Lines 6-27
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Pages 3-4/Lines 51-87
Purpose or research question - Purpose of the study and specific objectives or questions	Pages 3/Lines 80-86
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Page 4 /Lines 90-94 Page 6 169-193
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Page 5/Lines 145-155 Page 6 169-193
Context - Setting/site and salient contextual factors; rationale**	Page 4-5 /Lines 96-122
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Pages 4-5 /Lines 104-143
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Page 5 /Line 133-134
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Pages 5-6/Lines 158 – 167

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Pages 6-7/Lines 158 – 167
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Pages 6-7/Lines 195-208
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Page 5 /Lines 156-160
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Page 6 /Lines 169-193
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Page 6/Lines 191193

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Pages 6-18 /Lines 195-493
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Pages 6-18 /Lines 195-493

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Pages 18-22/Lines 495-591
Limitations - Trustworthiness and limitations of findings	Page 23

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Page 23
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Page 23

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388

Supplementary file 2: Topic guide

Background
As you know self-management support is provision of education and supportive interventions increase patients' skills and confidence in managing their health problems.

Rationale
- We want to identify the factors influencing the approach taken to support patients to self-manage, such as intervention/programme selection and implementation approaches.
- We want to understand any barriers or facilitators to the implementation of self-management support.
- We hope that our results will inform the development of an intervention to improve the implementation, sustainability and uptake of self-management support services for cancer patients in Ireland.

Just some **general housekeeping** before we start.

- Confirm consent verbally and confirm participant has read the information leaflet.
- The interview should last approximately 40 minutes.
- If it is ok with you I will audio record the interview.
- Anything we discuss will be confidential and your identity will remain anonymous on any reports or publications. We may use direct quotes from this interview but again I stress that your name will **not** appear anywhere and neither will that of your organisation.
- Finally, you can stop the interview at any point, if you wish.
- Do you have any questions for me before we get started?

*Some questions are only applicable for those involved in implementing a programme **Question**	**CFIR Domain**
Can you tell me a little about your role(s)?	Individuals
How is SMS delivered in your setting? • Who delivers the SMS/SMS programme? • How often is it run? • How long has it been running?	Individuals Innovation Implementation Process

• How do you coordinate with other team members? • What kind of space is used for the programme?	
How did you first hear about this SMS programme? How did you get involved? • Were there any events that triggered plans for the delivery of SMS? • Who is the driving force behind implementing this SMS programme in your setting? *Probes: Policy, individual health professionals, University research group, Health professional group, patient group, governmental agencies, funders.*	Outer Setting Inner Setting
What kind of resources have you received to deliver SMS? *Probes: Training, Financial support*	Inner Setting Implementation Process
How does SMS fit in with your role, other priorities and daily work?	Inner setting Individuals
How is SMS/SMS programme communicated/advertised in your setting?	Inner Setting
Is the programme continuously being used and embedded within practice delivery? • Is it part of standard of care for all patients? • How do those involved make sure the programme is delivered?	Inner Setting Implementation Process
Does the infrastructure (e.g. staffing) of your setting affect the implementation of SMS? • Are there any infrastructure changes needed to accommodate the delivery of SMS? • What needs to be considered to ensure the programme remains in place?	Intervention Characteristics Inner Setting
What kind of information or evidence are you aware of that shows whether this SMS programme works/improves patients' outcomes? *Probes: Practice guidelines/ Published literature/ Co-workers/Participant evaluation of the SMS* programme	Innovation
Now that SMS is adopted how much time and effort is required to run SMS programme? • Do you think it's sustainable? • Are there any changes needed to continuously deliver it? • Do you have sufficient resources to continue to deliver the programme? What would be needed to keep SMS going on a long-term basis?	Outer Setting Inner Setting Implementation Process
Are there other high priority cancer survivorship initiatives or activities are already happening in your setting?	Innovation

• How does this SMS programme fit with your other programmes? • Does SMS take a back seat to other high-priority initiatives going on? • Do you think there is a shared understanding among the professional groups and leadership about the purpose of SMS and its value?	Inner Setting
Do you think the people you work with influence implementation? • How would you describe the culture of your organisation in relation to implementing SMS? • Do you think this/culture influences the implementation of the intervention? *Probe: Hospital ownership & governance*	Inner Setting Individuals
Recap Is there anything that I haven't touched on that you think is important? Can you suggest other people who might be useful for us to contact? **Summarise and thank participant**	

Supplementary file 3: Example of mapping data into matrix

	Level of Implementation						
	High			**Medium**		**Low**	
	Organisations						
Codes	**Organisation 7**	**Organisation 4**	**Organisation 6**	**Organisation 11**	**Organisation 14**	**Organisation 17**	**Organisation 18**
Partnerships & connections	*We're able to do it with our local community and they can help us with admin. So that works really well. Couldn't do it without that because they set up the calls, they do the admin.* (Participant 20)	*Yes, it's through our own connections. I'd be a big believer in connecting with other organisations within our community settings, I think we're all trying to do our best and there's lots of really good spaces.* (Participant 36)	*There's no meeting space to deliver the group, so we have close links with (University). So, the last time it was run, we ran it in a room over in the (University) building).* (Participant 03,	*People are still very parochial. So, I think we have to take that global approach.* (Participant 13)	*We work very closely together; we have a good working relationship with them. So that's where it came from.* (Participant 34)		*Because we're divided by geography, so we work autonomously. It's great to see things like the NCCP who are so active and really trying to amalgamate services. I think that's definitely something I see as a bit lacking.* (Participant 06)
Communications	*You can deliver education, but I think that tends to be perceived as being formal and can be difficult to get the tone right. Whereas I*		*We talk a lot at the chemo education talks... and then I do a lot of work outside, meeting with teams, encouraging referrals, education, training staff member. We try and attend in-*			*A barrier is sharing of information, of what's going on. I think everyone has their own information, but sometimes maybe we don't share it amongst the professionals. I think the sharing*	

	think ongoing working together is what helps make things work better. (Participant 28)		*services, meetings, we did a grand rounds presentation. We have internal communications through newsletters and our internal hospital magazine, so trying to include the information in that as well, and then we have shared notes online.* (Participant 02)			*of information and knowledge between staff working in the same clinical area is vital.* (Participant 42) *I think promotion of your service, I think information sharing, that's what changes culture.* (Participant 41)	
	Level of Implementation						
	High			**Medium**		**Low**	
	Organisations						
	Organisation 4		**Organisation 6**	**Organisation 17**		**Organisation 19**	
Line management buy-in and support.	*The manager is very much around the whole survivorship programme. She really believes in it, and she believes in the benefit of it, but it does require you to have the time to send the staff off to be trained like we had to do.* (Participant 23)		*It comes from the CEO down and from our director of nursing down. I have gone to my director of nursing with things that are completely aside from survivorship and said to her 'I really want to do this, what do you think?' She'd be absolutely, tell me exactly what you need me to do, and I will 100% support you.* (Participant 04)	*It is such a pity, when I was looking, as part of the research I had to get the go-ahead from my director of nursing, she wouldn't even meet me about it, and she wouldn't sign the go-ahead for me.* (Participant 41)		*Suppose that's why you'll have your line manager and my line manager support. And that's as much as I need at the moment regarding it.* (Participant 05)	

		I had built up a relationship with the Manager, but we're so under-resourced across the board, it was a big thing for her to say, 'Try it'. Here's some funding. I'll take you out of your clinical post.' So, someone had to fill my gap when I left, and I got this programme up and running. … and her leadership and her support were key. (Participant 02)		
	Level of Implementation			
	High		**Medium**	**Low**
	Organisations			
Codes	**Organisation 7**	**Organisation 2**	**Organisation 17**	**Organisation 19**
Health provider and organisation priorities	*One of the biggest things that would have been said to me from very early on starting was that they want to develop something to help enhance cancer survivorship. So, it would have been from the get-go here. Overall, here, it would be positive and encouraging to create something to help with survivorship*. (Participant 14) *So, trying to have patients able to manage themselves at home, mainly for their quality of life...There's more of an emphasis*	*It's a natural extension of the work here.* (Participant 18)	*In the acute setting we're putting out fires all the time, management aren't seeing the bigger picture, and the time and effort isn't going into that. If we keep these people well, know how to access things if they need them, the acute problems won't happen.* (Participant 10)	*It's just the way we are set up. Survivorship is not number one, it's definitely down the list of priorities…higher management, their goals are more keeping clinic numbers down and keeping people out of A&E.* (Participant 05)

	on admission avoidance first of all, well it is a hospital priority. (Participant 44)			
	Level of Implementation			
	High			**Medium**
Organisations				
Codes	**Organisation 4**	**Organisation 6**	**Organisation 2**	**Organisation 17**
SMS addressing organisation's goals	*How do we help people move on from the cancer centre, because it's not just about them coming into us, it's great to be able to support them. But we also have a responsibility to help them get on with their lives and move on from this and that's where the survivorship programme is very good.* (Participant 23)	*Because it decreases length of stay, there's more cost savings for the hospital, it was a neater business case, it was a nicer business case.* (Participant 02)	*It's a good way to help move patients on and out of the service. That's what you want. You want them to be able to self-manage.* (Participant 17)	*Management responds to data and numbers, that's how they work and function, so they want numbers in, numbers out, they don't want waiting lists. When you look for more resources, you have to come around to their language to explain to them and say, look this will ultimately reduce people coming into ED, that's where you have to sell it to them, but because you don't have strong data on immediate numbers they're not really interested or they don't understand it.*

				(Participant 41)
	Level of Implementation			
	High		**Medium**	**Low**
Organisations				
Codes	**Organisation 4**	**Organisation 7**	**Organisation 15**	**Organisation 19**
Incentives	*It's really important to acknowledge their contribution.* (Participant 36)	*I was part of the movement to make sure that there was an embedded payment process for leaders*. (Participant 20)	*She's highly acknowledged as well within our centre, and we'd always give her a donation, or a present, or a gift, a significant one to cover costs of coming every week, or a voucher, or something for herself.* (Participant 31)	*And there would be no extra, obviously no money for extra money for it (delivering programme) or anything like that. So that's definitely a barrier as well.* (Participant 05)

	Level of Implementation		
	High	**Medium**	
Organisations			
Codes	**Organisation 6**	**Organisation 10**	**Organisation 17**
Culture: Entrepreneurship	*There's a lot of very genuinely interested and motivated people who want (hospital) to be a centre of excellence and who are therefore very invested in providing and improving really good care. It feels like a very positive culture in that way. Often throughout the hospital, there'd be different innovation programs and things like that. So, I think the hospital culture is progressive, and it encourages development and innovation. There's an implied pressure to be doing more and to be delivering good care as possible. So it's a positive peer pressure element. And I think that's because the clinical governance, I think*	*The (hospital) is very supportive of things like this and kind of let you do what you want if it looks like a good idea. In other areas you might have to make a case for things a little bit more. (*Participant 38)	*We don't have performance meetings or anything like that, they don't want to know what we're doing as long as we're showing up for work, as long as we're practising safely, as long as there isn't a complaint about us...and it would be great if we had these performance meetings to say look, this is where I want to see, this is what I want to do. There's none of that, it's a pity that culture isn't there". (Participant 41)*

	*the governance is quite good. And for most people doing more, there's not too much, or at least I haven't experienced yet, too much bureaucratic pushback. If there is something that potentially could be developed, I think once people have a clear idea and want to do something, they're usually facilitated and supported in doing that. That's my experience. I think it is true that the culture promotes innovation. (*Participant 07*)* *I do think it is a clinical environment that is motivated for change. (*Participant 04*)*		
	Level of Implementation			
	High	**Medium**	**Low**	
Codes	**Organisation 6**	**Organisation 10**	**Organisation 18**	**Organisation 20**
Hospital governance & ownership	*I've seen that throughout my training, I've worked in HSE direct funded hospitals, and in a couple of the voluntary hospitals, and I see a difference, to be honest. My impression, which is only an impression, I have absolutely no data on this, but my impression is that there's much more of a sense of ownership, and a sense of kind of responsibility and interest in making things as good as they can be, versus a sense of kind of executing*	*I've worked in HSE run hospitals which are quite different but the (hospital) has its own board of management and it tends to prioritise innovation over a lot of other things. So, we do have a certain amount of freedom in terms of how we design things, and the directorate is really, really supportive. Which really helps as well….I worked for four years in (hospital) which is the HSE directly run hospital and when I came to this (hospital) the difference is*	*Because most of them are voluntary, and they're not true HSE. So, you definitely can see the difference between voluntary hospitals and the HSE.* (Participant 06)	*I'm here a while now and things are just slower*. (Participant 40)

	what you were told to do, you know, kind of doing the requirements and having very little scope necessarily to push beyond that. Because I think in the HSE direct funded hospitals, you're working in a machine and you don't feel like you've got power, the capacities to even see that you could make change. Whereas when you're working in a hospital or a system that feels small and efficient, like that feels like you could try and make a change tomorrow and you'd be a step closer to it the day after you. You know, you might achieve it by the end of the year, that is much more motivating. So, I think there is a difference. (Participant 07)	*actually mind-blowing. We got a new nurse appointed and we had her in post within two weeks. In a HSE run hospital that would have taken two years. So, it just allows you to move that a little bit faster which is why we have our team up and running here.* (Participant 38)		

Supplementary file 4: Themes explaining the contextual factors influencing implementation with examples of supporting qualitative quotes.

Policy is a driver of adoption, but infrastructure and resources in the inner setting are necessary for sustainment		
CFIR Construct	**Codes**	**Sample quote(s)**
Policies & Laws	National policy	*I think the national strategy is definitely the main driver, that publishing of standards and requirements to roll out the survivorship care.* (Participant 01, Low Implementing Organisation). *Broadly speaking if we look at policies and procedures and everything, there's been this paradigm shift that we're moving beyond this. It's not just about treating the cancer but now that we've got such an increase in survivorship, we're now starting to look at, OK, well what are the survivorship issues? (Participant 07,* High Implementing Organisation).
	National Programme	*And it's a national programme, so we wanted to be part of the national run of that programme as everybody else does in the country.* (Participant 09, High Implementing Organisation).
Financing	External financial support	*Initially through pilot funding and now the funding is secured. We applied for the feasibility funding, from the (Grant funder). That allowed us to test an intervention here.* (Participant 02, High Implementing Organisation).
Work infrastructure	Staffing arrangement and alignments with team responsibilities	*Now we have staffing confirmed and permanent moving forward. So that's been a really positive development.* (Participant 02, High Implementing Organisation)

	Competing Priorities	*I'm back late every time I do it, which doesn't work from a home point of view.* (Participant 24, Medium Implementing Organisation)
	Bureaucratic administrative tasks	*If there was more organisational support, certainly for me, if there was more organisational support from administration, I would probably be more inclined to do it.* (Participant 12, High Implementing Organisation) *And they can help us with admin. So that works really well.* (Participant 20, High Implementing Organisation)
Available Resources	Funding at local level	*The money to resource is not there, that comes at a local level, and I think that's what would be needed to push this onto the next stage.* (Participant 01, Low Implementing Organisation). *She had autonomy to be able to use her funding for something like this, which then obviously has led to the programme being developed further.* (Participant 02, High Implementing Organisation) *There isn't equal access across the country because some places are very small, with very little funding behind them.* (Participant 23, High Implementing Organisation)
	Funding staff positions	*Usually, we have to have done some kind of pilot or shown the effectiveness of it but no matter how good that is, if we don't have a funding source, we can't get a post.* (*Participant 44,* High Implementing Organisation) *So, we had that feasibility funding and then we had pilot funding from the hospital very short-term, and now there's been a post in cancer survivorship.* (Participant 02, High Implementing Organisation)
	Physical space	*We have the space, that's a big thing in the delivery of it, that's a huge thing.* (Participant 17, High Implementing Organisation)
	Time	*I have the time to do it*. (Participant 22, , High Implementing Organisation) *It's so time consuming. There's a lot of work goes in behind organising it.* (Participant 17, High Implementing Organisation)

	Partnerships & connections	*We're able to do it with our local community and they can help us with admin. So that works really well.* (Participant 20, High Implementing Organisation) *I'd be a big believer in connecting with other organisations within our community settings.* (Participant 36, High Implementing Organisation) *There's no meeting space to deliver the group, so we have close links with (University), so the last time it was ran, we ran it in a room over in their building.* (Participant 03, High Implementing Organisation)
Mid-Level Leaders	Line management buy-in and support.	*The manager, she really believes in it. And she believes in the benefit of it, but it does require you to have the time to send the staff off to be trained like we had to do". (Participant 23, High Implementing Organisation)* *I had built up a relationship with the Manager, but we're so under-resourced across the board, it was a big thing for her to say, 'Try it'. Here's some funding. I'll take you out of your clinical post.' So, someone had to fill my gap when I left, and I got this programme up and running. … and her leadership and her support were really key.* (Participant 02, High Implementing Organisation) *It is such a pity, when I was looking, as part of the research I had to look for the go-ahead from my director of nursing, she wouldn't even meet me about it and she wouldn't sign the go-ahead for me, but I didn't let it stop me because there's a bigger picture to look at here.* (Participant 41, Medium Implementing Organisation)

Accreditation, performance measurement and governance to enable adoption and continued engagement with implementation.		
CFIR Construct	**Codes**	**Sample quote(s)**
Performance-Measurement Pressure	Accreditation	*We went for OECI accreditation and as part of that we had to formalise our structures and it's really come on from that then when we got the OECI accreditation.* W*hen we got that accreditation there was a Quality Improvement plan that went into place. (*Participant 44, High Implementing Organisation*)*

		The cancer services here have been realigned, so we got accreditation, to be a Cancer Centre. (Participant 11, High Implementing Organisation)
	Key performance indicators	*And whether that needs to be more prescriptive in our care, it needs to be measured by KPIs or through audit. I think something like that would motivate or enable better engagement. You need to see your reward for doing it.* (Participant 01, Low Implementing Organisation) *So "KPI ticked", now we have this programme up and running and there is no way of feeding back into where it's going wrong.* (Participant 30, High Implementing Organisation)
Policies	Governance to guide monitoring and evaluation	*If you've got good quality management and good coordination and there's a feedback loop, that's very sustaining.* (Participant 20, High Implementing Organisation) *I don't know where the governance lies of the course and who oversees the course evaluations, work improvement, quality management, all that stuff.* (Participant 30, High Implementing Organisation)

Providing evidence of SMS improving patient outcomes and addressing leadership priorities secures organisational buy-in			
CFIR Construct	**Codes**	**Sample quote(s)**	
Relative Priority	Health provider and organisation priorities	*It's just the way we are set up. Survivorship is not number one, it's definitely down the list of priorities…higher management, their goals are more keeping clinic numbers down and keeping people out of A&E.* (Participant 05, Low Implementing Organisation) *It's fluffy and it seems like that it's a luxury to be able to deliver that as opposed to a necessity, it's an absolute necessity for patients.* (Participant 41, Medium Implementing Organisation) *One of the biggest things that would have been said to me from very early on starting was that they want to develop something to help enhance cancer survivorship. So, it would have been from the get-go here. Overall, here, it would be quite positive to encouraging to create something to help with survivorship*. (Participant 14, High Implementing Organisation) *In the acute setting we're putting out fires all the time, management aren't seeing the bigger picture, and the time and effort isn't going into that. If we keep these people well, know how to access things if they need them, the acute problems won't happen.* (Participant 10, Medium Implementing Organisation) *There's more of an emphasis on admission avoidance first of all, well it is a hospital priority.* (Participant 44, High Implementing Organisation)	
Mission Alignment	SMS addressing organisation's goals	*Because it decreases length of stay, there's more cost savings for the hospital, it was almost a neater business case, it was a nicer business case.* (Participant 02, High Implementing Organisation)	

		How do we help people move on from the cancer centre, because it's not just about them coming into us, it's great to be able to support them. But we also have a responsibility to help them get on with their lives and move on from this and that's where the survivorship programme is very good. (Participant 23, High Implementing Organisation) *The director definitely is a big fan. So, we see the benefit of it to patients and it's a good way to help move patients on and out of the service. That's what you want. You want them to be able to self-manage.* (Participant 13, Medium Implementing Organisation) *Management responds to data and numbers, that's how they work and function, so they want numbers in, numbers out, they don't want waiting lists. When you look for more resources, you have to come around to their language to explain to them and say, look this will ultimately reduce people coming into ED, that's where you have to sell it to them, but because you don't have strong data on immediate numbers they're not really interested, or they don't really understand it.* (Participant 41, Medium Implementing Organisation)	
	Individual healthcare provider goals and priorities	*If you're surgical you're going to look at your post op complications and your length of stay, if you are an oncologist, you're going to look at the survival rates and the quality of life. Whereas if you're like me or social workers you're looking at quality of life and function.* (Participant 06, Low Implementing Organisation)	
Innovation Source	Health professional led	*You won't get medical buy in unless there are medical people doing it*. (Participant 16, High Implementing Organisation)	
	Consultant endorsed	*You really don't know where to go with hospital management. We have yet without the support of the consultants, and really the badgering from the consultants that they really need this to make their service work. Unless the consultant is leading it out for a patient and really recommending and supporting it, it becomes a challenge, then you're on an uphill battle to try and engage people.* (Participant 01, Low Implementing Organisation).	
Innovation Evidence-Base	Evidence of effectiveness	*From all the research that's been done behind the programme that has been proven to work in that way.* (Participant 29, High Implementing Organisation) *It was very much about allowing the organisation to provide programmes that have research done into them, that have a proven track record. I felt for an organisation that was so small, I was really conscious of ensuring*	

		I pointed the organisation towards what I felt were sustainable deliverable types of programmes that had a proven benefit to patients. (Participant 36, High Implementing Organisation)	
	Testimonials	*But once they had a couple of patients go through it, and they got feedback from their patients, they're very happy to refer. Again, because it's safe, because it's evidence based.* (Participant 20, High Implementing Organisation) *The feedback from clients There was very little, very little negative, there was nothing really negative about the contents of the programme.* (Participant 19, High Implementing organisation) *I wasn't sure about the programme, but after delivering it's powerful…I took a look at the summaries of evaluations and it's so consistent.* (Participant 13, High Implementing organisation)	
	Local data	*Data is everything – if you want something to progress, you need the numbers, because it decreases length of stay, there's more cost savings for the hospital.* (Participant 42, Medium Implementing Organisation) *It's the local data that motivates higher management to do it. Having local data, that has an impact where you can show what is happening on the ground. That is worthwhile and hard to argue with.* (Participant 47, High Implementing Organisation)	
Reflecting & evaluating: innovation	Information about the success of the program.	*I'd love to see a national review of what we've done so far. And how that has impacted people because we don't really know, we do our own review, you know, and they're always really well evaluated I think. We really need to know, nationally, how are we doing here? How well we've done or what impact these programs have.* (Participant 09, High Implementing Organisation). *To see the validity in the program, they have to see it running within the community and get feedback.* (Participant 36, High Implementing Organisations) *To keep it going they need to see the statistics that people are taking part.* (Participant 24, Medium Implementing Organisations)	
Relative advantage	Overshadowed by new priorities	*The (SMS programme). There's still a lot of work to be done to promote it. You know, I follow all these groups on Twitter and it's as if then they kind of pick a thing that they're going to promote. At the minute, it's all the children and young adults coming through on my timeline, absolutely, that has to be promoted. But I haven't seen much of the (SMS programme) coming through. I think there's a lot of work to be done there to promote it.* (Participant 21, High Implementing Organisation)	

	Advertising of the programme	*When it comes to sustainment, you need to continue marketing it and you need to continue advertising it. I think if you want a program like this to continue, you need to continue advertising it to people. You need to bring in people that have done it and for them to say it 'I got this benefit out of it'.* (Participant 26, Medium Implementing Organisation)	

Champions with proactive leadership and entrepreneurial skills enable adoption and sustainment		
CFIR Construct	**Codes**	**Sample quote(s)**
Implementation leads	Bottom-up drive and commitment	*Now we have staffing confirmed and permanent moving forward. So that's been a really positive development, but that came from ourselves in the social work department, as opposed from a higher management point of view who pushed it.* (Participant 15, Medium Implementing Organisation) *I'm the driver in the service, I'm the one who keeps pushing, pushing, pushing, pushing, because I've been in the service so long, I understand the way it works, but I have a vision, I might not get it done today or tomorrow and I might be knocked down today and tomorrow, but I'll keep going, there's always solutions. So, you're forced to work within the structures that you have but I'll keep asking so it's not going to stop me that I'm getting 'no'. I'll keep asking and I'll keep putting forward my business case.* (Participant 41, Medium Implementing Organisation)
	Respected	*Because (champion in another high implementing organisation) was there from the very start pushing. And she's so good at what she does, she was so highly respected, that she could literally walk into a meeting with anyone and sell them ice. Just brilliant, which is the way we need to be. But it's a shame that we need to be like that to get….and shaping the way things are.* (Participant 06, Low Implementing Organisation) *I really think she's a doer, and she likes to do things well, and she likes to think properly. And because she has such a wealth of experience, people come to her, she's a known figure. She is keen to continue to improve and develop things.* (Participant 07, High Implementing Organisation).

	Entrepreneurialism	*She has been great for grants and funding. So, without that, without us getting that grant there still would be no survivorship.* (Participant 10, Medium Implementing Organisation)
	Personal interest	*From a personal level is that I had a personal interest in oncology, and I had previously completed self-management research. It came nationally, internationally, and then personally with my own drive to develop the intervention.* (Participant 03, High Implementing Organisation) *Nobody has come to me and said you need to do this; this is what we have chosen, and this needs to be part what you're delivering if you're delivering a survivorship service.* (Participant 21, High Implementing Organisation)
	Communication to develop connections, leverage networks and secure buy-in	*I think part of the reason is because of how I did it. I'm one of those people who you can tell talks a lot. So, I brought everybody on the journey with me. The admin people knew all about this before they ever knew what their role was going to be. My colleagues, my nursing colleagues knew all about it before they even knew where they were going to fit into this.* (Participant 04, High Implementing Organisation) *My strategy really was to keep talking about it to every single person.* (Participant 20, High Implementing Organisation)
	Championing qualities	*Health professionals who are already overstretched try to do this as well. And I think that's when it's dropped. It's only those of us that really stick it out have continued with it.* (Participant 12, High Implementing Organisation) *I choose to do it outside of my working day. So that's a personal choice for me, one really good thing about the programme from my perspective, is that it's a really good adjunct to the work that I do.* (Participant 20, High Implementing Organisation) *I think individuals can do things if they're motivated enough and can manage their time…but that's then at a cost to other members of the team picking up some of your work.* (Participant 42, Medium Implementing Organisation)

Organisational culture of entrepreneurship and addressing employee well-being affects the capacity of champions and staff to adopt and sustain programmes		
CFIR Construct	**Codes**	**Sample quote(s)**

Culture: Learning-Centeredness	Culture of innovation & entrepreneurship	*There's a lot of very interested and motivated people who want (hospital) to be a centre of excellence and providing and improving really good care. It feels like a very positive culture in that way. So, I think the hospital culture is progressive and it encourages development and innovation. There's an implied pressure to be doing more and to be delivering good care as possible. And I think that's because the clinical governance is quite good. And for most people doing more, there's not too much, or at least I haven't experienced yet, too much bureaucratic pushback if there is something that potentially could be developed. I think once people have a clear idea and want to do something, they're usually facilitated and supported in doing that. I think it is true that the culture promotes innovation.* (Participant 07, High Implementing Organisation) *We don't have performance meetings or anything like that, they don't want to know what we're doing as long as we're showing up for work, as long as we're practising safely, as long as there isn't a complaint about us...and it would be great if we had these performance meetings to say look, this is where I want to see, this is what I want to do. There's none of that, it's a pity that culture isn't there.* (Participant 41, Medium Implementing Organisation)
	Administrative organisational structures	*The dynamic, so it's very hard, there's layers of management, so it's very hard to get an actual appointment with our director of nursing, it's very hard –we're supposed to go through the proper channels to try and agree anything, so if I am to ask my director of nursing to request on my behalf that I get clerical support, well she's going to business managers, but any motion you put through to speak directly to the director of nursing about it, it could take a year for anything to happen, it is so arduous, all these executive council meetings, they bring up different topics and nothing, nothing is done .. you can only have these meetings every three months, came back again, right and then nothing.* (Participant 41, Medium Implementing Organisation) *That's where you lose the motivation to push things forward, because it takes so long, you're motivated but that motivation starts to wear off, as time passes and there's no progress. You could be chasing emails, like what are we doing next, are we meeting again....you're putting energy onto something that's not progressing". (Participant 42, Medium Implementing Organisation).*

	Hospital governance and ownership	*They're supportive of things. If it looks like a good idea, in other areas you might have to make a case for things a little bit more and I've worked in HSE run hospitals which are quite different but the (hospital) has its own board of management and it tends to prioritise innovation over a lot of other things.* (Participant 38, Medium Implementing Organisation) *I've worked in HSE direct funded hospitals, and in a couple of the voluntary hospitals, and I see a difference, it's my impression, which is only an impression, I have absolutely no data on this, but my impression is that there's much more of a sense of ownership, and a sense of responsibility and interest in making things as good as they can be, versus a sense of executing what you were told to do, doing the requirements and having very little scope necessarily to push beyond that. .* (Participant 07, High Implementing Organisation)
Culture: Deliverer-Centeredness	Non-monetary incentives	*It's really important to acknowledge their contribution. So, we nominated our peer leader here for an award last year. One of the things was her work on the SMS programme. So, it's important to acknowledge it.* (Participant 36, High Implementing Organisation) *It doesn't have to be monetary, but some appreciation of the time and all that.* (Participant 22, High Implementing Organisation)
	Supervision	*We started supervision. So that was very important, and our director of services recognised that and how much you could be holding. So, for managing our boundaries that helped greatly. That we could go somewhere with that after the programme, because it brings up a lot of emotional issues for clients. That was a very good strategy on the on our director of services part.* (Participant 19, High Implementing Organisation) *Supervision has always been part of our practice, but I don't know if it is for a lot of the other professions in this area….there's a lot of an emotional load that comes with working in oncology, and I think if people are to be sustained in the work, and if people are also to keep their warmth and care towards patients, they have to be supported themselves as well.* (Participant 15, Medium Implementing Organisation)
	Debriefing	*I realised it was good just after the session that you can debrief and talk directly about the session.* (Participant 32, High Implementing Organisation) *I think the debriefing is really important, because if you're not a trained psychologist, I'm really lucky in that sense I'm trained, and I know how to manage it. And I think it's a lot to hear everybody's story, the sadness around that is really hard to hold if you're not trained in that way.* (Participant 33, High Implementing Organisation).

	Continuous professional development certifications	*In terms of the professionals could this stand to their professional development, continuing development credits.* (Participant 28, High Implementing Organisation).
Teaming	Bringing team members together	*Really for the centre to take it on and to do it effectively, this requires a lot of training around each session. So, for example, before I do each session, I would meet with my volunteer the day before, or a number of days before, and we go through each session, we practice that. You have to make sure the volunteers are comfortable of course. I have a new volunteer just trained this year so that can take up a lot of time that maybe isn't captured.* (Participant 19, High Implementing Organisation)
Engaging Deliverers	Engaging	*I'm a volunteer with them, but I'm very much part of the team there, and I feel connected and that's to do with the management of the centre and the way they hold their volunteers. So, it's just the way the centre holds us and keeps engaging with us and checking in with us and so forth. So, I feel very much part of the team there.* (Participant 29, High Implementing Organisation)

Supplementary file 1: Standards for Reporting Qualitative Research guidelines

Standards for Reporting Qualitative Research (SRQR)*
http://www.equator-network.org/reporting-guidelines/srqr/

	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Page 1/ Lines 1-2
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Page 1/Lines 6-27
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Pages 3-4/Lines 51-87
Purpose or research question - Purpose of the study and specific objectives or questions	Pages 3/Lines 80-86
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Page 4 /Lines 90-94 Page 6 169-193
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Page 5/Lines 145-155 Page 6 169-193
Context - Setting/site and salient contextual factors; rationale**	Page 4-5 /Lines 96-122
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Pages 4-5 /Lines 104-143
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Page 5 /Line 133-134
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Pages 5-6/Lines 158 – 167

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Pages 6-7/Lines 158 – 167
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Pages 6-7/Lines 195-208
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Page 5 /Lines 156-160
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Page 6 /Lines 169-193
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Page 6/Lines 191193

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Pages 6-18 /Lines 195-493
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Pages 6-18 /Lines 195-493

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Pages 18-22/Lines 495-591
Limitations - Trustworthiness and limitations of findings	Page 23

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Page 23
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Page 23

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388

Supplementary file 2: Topic guide

Background
As you know self-management support is provision of education and supportive interventions increase patients' skills and confidence in managing their health problems.

Rationale
- We want to identify the factors influencing the approach taken to support patients to self-manage, such as intervention/programme selection and implementation approaches.
- We want to understand any barriers or facilitators to the implementation of self-management support.
- We hope that our results will inform the development of an intervention to improve the implementation, sustainability and uptake of self-management support services for cancer patients in Ireland.

Just some **general housekeeping** before we start.

- Confirm consent verbally and confirm participant has read the information leaflet.
- The interview should last approximately 40 minutes.
- If it is ok with you I will audio record the interview.
- Anything we discuss will be confidential and your identity will remain anonymous on any reports or publications. We may use direct quotes from this interview but again I stress that your name will **not** appear anywhere and neither will that of your organisation.
- Finally, you can stop the interview at any point, if you wish.
- Do you have any questions for me before we get started?

*Some questions are only applicable for those involved in implementing a programme **Question**	**CFIR Domain**
Can you tell me a little about your role(s)?	Individuals
How is SMS delivered in your setting? • Who delivers the SMS/SMS programme? • How often is it run? • How long has it been running?	Individuals Innovation Implementation Process

• How do you coordinate with other team members? • What kind of space is used for the programme?	
How did you first hear about this SMS programme? How did you get involved? • Were there any events that triggered plans for the delivery of SMS? • Who is the driving force behind implementing this SMS programme in your setting? *Probes: Policy, individual health professionals, University research group, Health professional group, patient group, governmental agencies, funders.*	Outer Setting Inner Setting
What kind of resources have you received to deliver SMS? *Probes: Training, Financial support*	Inner Setting Implementation Process
How does SMS fit in with your role, other priorities and daily work?	Inner setting Individuals
How is SMS/SMS programme communicated/advertised in your setting?	Inner Setting
Is the programme continuously being used and embedded within practice delivery? • Is it part of standard of care for all patients? • How do those involved make sure the programme is delivered?	Inner Setting Implementation Process
Does the infrastructure (e.g. staffing) of your setting affect the implementation of SMS? • Are there any infrastructure changes needed to accommodate the delivery of SMS? • What needs to be considered to ensure the programme remains in place?	Intervention Characteristics Inner Setting
What kind of information or evidence are you aware of that shows whether this SMS programme works/improves patients' outcomes? *Probes: Practice guidelines/ Published literature/ Co-workers/Participant evaluation of the SMS* programme	Innovation
Now that SMS is adopted how much time and effort is required to run SMS programme? • Do you think it's sustainable? • Are there any changes needed to continuously deliver it? • Do you have sufficient resources to continue to deliver the programme? What would be needed to keep SMS going on a long-term basis?	Outer Setting Inner Setting Implementation Process
Are there other high priority cancer survivorship initiatives or activities are already happening in your setting?	Innovation

• How does this SMS programme fit with your other programmes? • Does SMS take a back seat to other high-priority initiatives going on? • Do you think there is a shared understanding among the professional groups and leadership about the purpose of SMS and its value?	Inner Setting
Do you think the people you work with influence implementation? • How would you describe the culture of your organisation in relation to implementing SMS? • Do you think this/culture influences the implementation of the intervention? *Probe: Hospital ownership & governance*	Inner Setting Individuals
Recap Is there anything that I haven't touched on that you think is important? Can you suggest other people who might be useful for us to contact? **Summarise and thank participant**	

Supplementary file 3: Example of mapping data into matrix

	Level of Implementation						
	High			**Medium**		**Low**	
	Organisations						
Codes	**Organisation 7**	**Organisation 4**	**Organisation 6**	**Organisation 11**	**Organisation 14**	**Organisation 17**	**Organisation 18**
Partnerships & connections	*We're able to do it with our local community and they can help us with admin. So that works really well. Couldn't do it without that because they set up the calls, they do the admin.* (Participant 20)	*Yes, it's through our own connections. I'd be a big believer in connecting with other organisations within our community settings, I think we're all trying to do our best and there's lots of really good spaces.* (Participant 36)	*There's no meeting space to deliver the group, so we have close links with (University). So, the last time it was run, we ran it in a room over in the (University) building).* (Participant 03,	*People are still very parochial. So, I think we have to take that global approach.* (Participant 13)	*We work very closely together; we have a good working relationship with them. So that's where it came from.* (Participant 34)		*Because we're divided by geography, so we work autonomously. It's great to see things like the NCCP who are so active and really trying to amalgamate services. I think that's definitely something I see as a bit lacking.* (Participant 06)
Communications	*You can deliver education, but I think that tends to be perceived as being formal and can be difficult to get the tone right. Whereas I*		*We talk a lot at the chemo education talks... and then I do a lot of work outside, meeting with teams, encouraging referrals, education, training staff member. We try and attend in-*			*A barrier is sharing of information, of what's going on. I think everyone has their own information, but sometimes maybe we don't share it amongst the professionals. I think the sharing*	

	think ongoing working together is what helps make things work better. (Participant 28)		*services, meetings, we did a grand rounds presentation. We have internal communications through newsletters and our internal hospital magazine, so trying to include the information in that as well, and then we have shared notes online.* (Participant 02)			*of information and knowledge between staff working in the same clinical area is vital.* (Participant 42) *I think promotion of your service, I think information sharing, that's what changes culture.* (Participant 41)	
	Level of Implementation						
	High			**Medium**		**Low**	
	Organisations						
	Organisation 4		**Organisation 6**	**Organisation 17**		**Organisation 19**	
Line management buy-in and support.	*The manager is very much around the whole survivorship programme. She really believes in it, and she believes in the benefit of it, but it does require you to have the time to send the staff off to be trained like we had to do.* (Participant 23)		*It comes from the CEO down and from our director of nursing down. I have gone to my director of nursing with things that are completely aside from survivorship and said to her 'I really want to do this, what do you think?' She'd be absolutely, tell me exactly what you need me to do, and I will 100% support you.* (Participant 04)	*It is such a pity, when I was looking, as part of the research I had to get the go-ahead from my director of nursing, she wouldn't even meet me about it, and she wouldn't sign the go-ahead for me.* (Participant 41)		*Suppose that's why you'll have your line manager and my line manager support. And that's as much as I need at the moment regarding it.* (Participant 05)	

		I had built up a relationship with the Manager, but we're so under-resourced across the board, it was a big thing for her to say, 'Try it'. Here's some funding. I'll take you out of your clinical post.' So, someone had to fill my gap when I left, and I got this programme up and running. … and her leadership and her support were key. (Participant 02)		
	Level of Implementation			
	High		**Medium**	**Low**
	Organisations			
Codes	**Organisation 7**	**Organisation 2**	**Organisation 17**	**Organisation 19**
Health provider and organisation priorities	*One of the biggest things that would have been said to me from very early on starting was that they want to develop something to help enhance cancer survivorship. So, it would have been from the get-go here. Overall, here, it would be positive and encouraging to create something to help with survivorship*. (Participant 14) *So, trying to have patients able to manage themselves at home, mainly for their quality of life...There's more of an emphasis*	*It's a natural extension of the work here.* (Participant 18)	*In the acute setting we're putting out fires all the time, management aren't seeing the bigger picture, and the time and effort isn't going into that. If we keep these people well, know how to access things if they need them, the acute problems won't happen.* (Participant 10)	*It's just the way we are set up. Survivorship is not number one, it's definitely down the list of priorities…higher management, their goals are more keeping clinic numbers down and keeping people out of A&E.* (Participant 05)

	on admission avoidance first of all, well it is a hospital priority. (Participant 44)			
	Level of Implementation			
	High			**Medium**
Organisations				
Codes	**Organisation 4**	**Organisation 6**	**Organisation 2**	**Organisation 17**
SMS addressing organisation's goals	*How do we help people move on from the cancer centre, because it's not just about them coming into us, it's great to be able to support them. But we also have a responsibility to help them get on with their lives and move on from this and that's where the survivorship programme is very good.* (Participant 23)	*Because it decreases length of stay, there's more cost savings for the hospital, it was a neater business case, it was a nicer business case.* (Participant 02)	*It's a good way to help move patients on and out of the service. That's what you want. You want them to be able to self-manage.* (Participant 17)	*Management responds to data and numbers, that's how they work and function, so they want numbers in, numbers out, they don't want waiting lists. When you look for more resources, you have to come around to their language to explain to them and say, look this will ultimately reduce people coming into ED, that's where you have to sell it to them, but because you don't have strong data on immediate numbers they're not really interested or they don't understand it.*

				(Participant 41)
	Level of Implementation			
	High		**Medium**	**Low**
Organisations				
Codes	**Organisation 4**	**Organisation 7**	**Organisation 15**	**Organisation 19**
Incentives	*It's really important to acknowledge their contribution.* (Participant 36)	*I was part of the movement to make sure that there was an embedded payment process for leaders*. (Participant 20)	*She's highly acknowledged as well within our centre, and we'd always give her a donation, or a present, or a gift, a significant one to cover costs of coming every week, or a voucher, or something for herself.* (Participant 31)	*And there would be no extra, obviously no money for extra money for it (delivering programme) or anything like that. So that's definitely a barrier as well.* (Participant 05)

	Level of Implementation		
	High	**Medium**	
Organisations			
Codes	**Organisation 6**	**Organisation 10**	**Organisation 17**
Culture: Entrepreneurship	*There's a lot of very genuinely interested and motivated people who want (hospital) to be a centre of excellence and who are therefore very invested in providing and improving really good care. It feels like a very positive culture in that way. Often throughout the hospital, there'd be different innovation programs and things like that. So, I think the hospital culture is progressive, and it encourages development and innovation. There's an implied pressure to be doing more and to be delivering good care as possible. So it's a positive peer pressure element. And I think that's because the clinical governance, I think*	*The (hospital) is very supportive of things like this and kind of let you do what you want if it looks like a good idea. In other areas you might have to make a case for things a little bit more. (*Participant 38)	*We don't have performance meetings or anything like that, they don't want to know what we're doing as long as we're showing up for work, as long as we're practising safely, as long as there isn't a complaint about us...and it would be great if we had these performance meetings to say look, this is where I want to see, this is what I want to do. There's none of that, it's a pity that culture isn't there". (Participant 41)*

	*the governance is quite good. And for most people doing more, there's not too much, or at least I haven't experienced yet, too much bureaucratic pushback. If there is something that potentially could be developed, I think once people have a clear idea and want to do something, they're usually facilitated and supported in doing that. That's my experience. I think it is true that the culture promotes innovation. (*Participant 07*)* *I do think it is a clinical environment that is motivated for change. (*Participant 04*)*		
	Level of Implementation			
	High	**Medium**	**Low**	
Codes	**Organisation 6**	**Organisation 10**	**Organisation 18**	**Organisation 20**
Hospital governance & ownership	*I've seen that throughout my training, I've worked in HSE direct funded hospitals, and in a couple of the voluntary hospitals, and I see a difference, to be honest. My impression, which is only an impression, I have absolutely no data on this, but my impression is that there's much more of a sense of ownership, and a sense of kind of responsibility and interest in making things as good as they can be, versus a sense of kind of executing*	*I've worked in HSE run hospitals which are quite different but the (hospital) has its own board of management and it tends to prioritise innovation over a lot of other things. So, we do have a certain amount of freedom in terms of how we design things, and the directorate is really, really supportive. Which really helps as well….I worked for four years in (hospital) which is the HSE directly run hospital and when I came to this (hospital) the difference is*	*Because most of them are voluntary, and they're not true HSE. So, you definitely can see the difference between voluntary hospitals and the HSE.* (Participant 06)	*I'm here a while now and things are just slower*. (Participant 40)

	what you were told to do, you know, kind of doing the requirements and having very little scope necessarily to push beyond that. Because I think in the HSE direct funded hospitals, you're working in a machine and you don't feel like you've got power, the capacities to even see that you could make change. Whereas when you're working in a hospital or a system that feels small and efficient, like that feels like you could try and make a change tomorrow and you'd be a step closer to it the day after you. You know, you might achieve it by the end of the year, that is much more motivating. So, I think there is a difference. (Participant 07)	*actually mind-blowing. We got a new nurse appointed and we had her in post within two weeks. In a HSE run hospital that would have taken two years. So, it just allows you to move that a little bit faster which is why we have our team up and running here.* (Participant 38)		

Supplementary file 4: Themes explaining the contextual factors influencing implementation with examples of supporting qualitative quotes.

Policy is a driver of adoption, but infrastructure and resources in the inner setting are necessary for sustainment		
CFIR Construct	**Codes**	**Sample quote(s)**
Policies & Laws	National policy	*I think the national strategy is definitely the main driver, that publishing of standards and requirements to roll out the survivorship care.* (Participant 01, Low Implementing Organisation). *Broadly speaking if we look at policies and procedures and everything, there's been this paradigm shift that we're moving beyond this. It's not just about treating the cancer but now that we've got such an increase in survivorship, we're now starting to look at, OK, well what are the survivorship issues? (Participant 07,* High Implementing Organisation).
	National Programme	*And it's a national programme, so we wanted to be part of the national run of that programme as everybody else does in the country.* (Participant 09, High Implementing Organisation).
Financing	External financial support	*Initially through pilot funding and now the funding is secured. We applied for the feasibility funding, from the (Grant funder). That allowed us to test an intervention here.* (Participant 02, High Implementing Organisation).
Work infrastructure	Staffing arrangement and alignments with team responsibilities	*Now we have staffing confirmed and permanent moving forward. So that's been a really positive development.* (Participant 02, High Implementing Organisation)

	Competing Priorities	*I'm back late every time I do it, which doesn't work from a home point of view.* (Participant 24, Medium Implementing Organisation)
	Bureaucratic administrative tasks	*If there was more organisational support, certainly for me, if there was more organisational support from administration, I would probably be more inclined to do it.* (Participant 12, High Implementing Organisation) *And they can help us with admin. So that works really well.* (Participant 20, High Implementing Organisation)
Available Resources	Funding at local level	*The money to resource is not there, that comes at a local level, and I think that's what would be needed to push this onto the next stage.* (Participant 01, Low Implementing Organisation). *She had autonomy to be able to use her funding for something like this, which then obviously has led to the programme being developed further.* (Participant 02, High Implementing Organisation) *There isn't equal access across the country because some places are very small, with very little funding behind them.* (Participant 23, High Implementing Organisation)
	Funding staff positions	*Usually, we have to have done some kind of pilot or shown the effectiveness of it but no matter how good that is, if we don't have a funding source, we can't get a post.* (*Participant 44,* High Implementing Organisation) *So, we had that feasibility funding and then we had pilot funding from the hospital very short-term, and now there's been a post in cancer survivorship.* (Participant 02, High Implementing Organisation)
	Physical space	*We have the space, that's a big thing in the delivery of it, that's a huge thing.* (Participant 17, High Implementing Organisation)
	Time	*I have the time to do it*. (Participant 22, , High Implementing Organisation) *It's so time consuming. There's a lot of work goes in behind organising it.* (Participant 17, High Implementing Organisation)

	Partnerships & connections	*We're able to do it with our local community and they can help us with admin. So that works really well.* (Participant 20, High Implementing Organisation) *I'd be a big believer in connecting with other organisations within our community settings.* (Participant 36, High Implementing Organisation) *There's no meeting space to deliver the group, so we have close links with (University), so the last time it was ran, we ran it in a room over in their building.* (Participant 03, High Implementing Organisation)
Mid-Level Leaders	Line management buy-in and support.	*The manager, she really believes in it. And she believes in the benefit of it, but it does require you to have the time to send the staff off to be trained like we had to do". (Participant 23, High Implementing Organisation)* *I had built up a relationship with the Manager, but we're so under-resourced across the board, it was a big thing for her to say, 'Try it'. Here's some funding. I'll take you out of your clinical post.' So, someone had to fill my gap when I left, and I got this programme up and running. … and her leadership and her support were really key.* (Participant 02, High Implementing Organisation) *It is such a pity, when I was looking, as part of the research I had to look for the go-ahead from my director of nursing, she wouldn't even meet me about it and she wouldn't sign the go-ahead for me, but I didn't let it stop me because there's a bigger picture to look at here.* (Participant 41, Medium Implementing Organisation)

Accreditation, performance measurement and governance to enable adoption and continued engagement with implementation.		
CFIR Construct	**Codes**	**Sample quote(s)**
Performance-Measurement Pressure	Accreditation	*We went for OECI accreditation and as part of that we had to formalise our structures and it's really come on from that then when we got the OECI accreditation.* W*hen we got that accreditation there was a Quality Improvement plan that went into place. (*Participant 44, High Implementing Organisation*)*

		The cancer services here have been realigned, so we got accreditation, to be a Cancer Centre. (Participant 11, High Implementing Organisation)
	Key performance indicators	*And whether that needs to be more prescriptive in our care, it needs to be measured by KPIs or through audit. I think something like that would motivate or enable better engagement. You need to see your reward for doing it.* (Participant 01, Low Implementing Organisation) *So "KPI ticked", now we have this programme up and running and there is no way of feeding back into where it's going wrong.* (Participant 30, High Implementing Organisation)
Policies	Governance to guide monitoring and evaluation	*If you've got good quality management and good coordination and there's a feedback loop, that's very sustaining.* (Participant 20, High Implementing Organisation) *I don't know where the governance lies of the course and who oversees the course evaluations, work improvement, quality management, all that stuff.* (Participant 30, High Implementing Organisation)

Providing evidence of SMS improving patient outcomes and addressing leadership priorities secures organisational buy-in			
CFIR Construct	**Codes**	**Sample quote(s)**	
Relative Priority	Health provider and organisation priorities	*It's just the way we are set up. Survivorship is not number one, it's definitely down the list of priorities…higher management, their goals are more keeping clinic numbers down and keeping people out of A&E.* (Participant 05, Low Implementing Organisation) *It's fluffy and it seems like that it's a luxury to be able to deliver that as opposed to a necessity, it's an absolute necessity for patients.* (Participant 41, Medium Implementing Organisation) *One of the biggest things that would have been said to me from very early on starting was that they want to develop something to help enhance cancer survivorship. So, it would have been from the get-go here. Overall, here, it would be quite positive to encouraging to create something to help with survivorship*. (Participant 14, High Implementing Organisation) *In the acute setting we're putting out fires all the time, management aren't seeing the bigger picture, and the time and effort isn't going into that. If we keep these people well, know how to access things if they need them, the acute problems won't happen.* (Participant 10, Medium Implementing Organisation) *There's more of an emphasis on admission avoidance first of all, well it is a hospital priority.* (Participant 44, High Implementing Organisation)	
Mission Alignment	SMS addressing organisation's goals	*Because it decreases length of stay, there's more cost savings for the hospital, it was almost a neater business case, it was a nicer business case.* (Participant 02, High Implementing Organisation)	

		How do we help people move on from the cancer centre, because it's not just about them coming into us, it's great to be able to support them. But we also have a responsibility to help them get on with their lives and move on from this and that's where the survivorship programme is very good. (Participant 23, High Implementing Organisation) *The director definitely is a big fan. So, we see the benefit of it to patients and it's a good way to help move patients on and out of the service. That's what you want. You want them to be able to self-manage.* (Participant 13, Medium Implementing Organisation) *Management responds to data and numbers, that's how they work and function, so they want numbers in, numbers out, they don't want waiting lists. When you look for more resources, you have to come around to their language to explain to them and say, look this will ultimately reduce people coming into ED, that's where you have to sell it to them, but because you don't have strong data on immediate numbers they're not really interested, or they don't really understand it.* (Participant 41, Medium Implementing Organisation)	
	Individual healthcare provider goals and priorities	*If you're surgical you're going to look at your post op complications and your length of stay, if you are an oncologist, you're going to look at the survival rates and the quality of life. Whereas if you're like me or social workers you're looking at quality of life and function.* (Participant 06, Low Implementing Organisation)	
Innovation Source	Health professional led	*You won't get medical buy in unless there are medical people doing it*. (Participant 16, High Implementing Organisation)	
	Consultant endorsed	*You really don't know where to go with hospital management. We have yet without the support of the consultants, and really the badgering from the consultants that they really need this to make their service work. Unless the consultant is leading it out for a patient and really recommending and supporting it, it becomes a challenge, then you're on an uphill battle to try and engage people.* (Participant 01, Low Implementing Organisation).	
Innovation Evidence-Base	Evidence of effectiveness	*From all the research that's been done behind the programme that has been proven to work in that way.* (Participant 29, High Implementing Organisation) *It was very much about allowing the organisation to provide programmes that have research done into them, that have a proven track record. I felt for an organisation that was so small, I was really conscious of ensuring*	

		I pointed the organisation towards what I felt were sustainable deliverable types of programmes that had a proven benefit to patients. (Participant 36, High Implementing Organisation)	
	Testimonials	*But once they had a couple of patients go through it, and they got feedback from their patients, they're very happy to refer. Again, because it's safe, because it's evidence based.* (Participant 20, High Implementing Organisation) *The feedback from clients There was very little, very little negative, there was nothing really negative about the contents of the programme.* (Participant 19, High Implementing organisation) *I wasn't sure about the programme, but after delivering it's powerful…I took a look at the summaries of evaluations and it's so consistent.* (Participant 13, High Implementing organisation)	
	Local data	*Data is everything – if you want something to progress, you need the numbers, because it decreases length of stay, there's more cost savings for the hospital.* (Participant 42, Medium Implementing Organisation) *It's the local data that motivates higher management to do it. Having local data, that has an impact where you can show what is happening on the ground. That is worthwhile and hard to argue with.* (Participant 47, High Implementing Organisation)	
Reflecting & evaluating: innovation	Information about the success of the program.	*I'd love to see a national review of what we've done so far. And how that has impacted people because we don't really know, we do our own review, you know, and they're always really well evaluated I think. We really need to know, nationally, how are we doing here? How well we've done or what impact these programs have.* (Participant 09, High Implementing Organisation). *To see the validity in the program, they have to see it running within the community and get feedback.* (Participant 36, High Implementing Organisations) *To keep it going they need to see the statistics that people are taking part.* (Participant 24, Medium Implementing Organisations)	
Relative advantage	Overshadowed by new priorities	*The (SMS programme). There's still a lot of work to be done to promote it. You know, I follow all these groups on Twitter and it's as if then they kind of pick a thing that they're going to promote. At the minute, it's all the children and young adults coming through on my timeline, absolutely, that has to be promoted. But I haven't seen much of the (SMS programme) coming through. I think there's a lot of work to be done there to promote it.* (Participant 21, High Implementing Organisation)	

	Advertising of the programme	*When it comes to sustainment, you need to continue marketing it and you need to continue advertising it. I think if you want a program like this to continue, you need to continue advertising it to people. You need to bring in people that have done it and for them to say it 'I got this benefit out of it'.* (Participant 26, Medium Implementing Organisation)	

Champions with proactive leadership and entrepreneurial skills enable adoption and sustainment		
CFIR Construct	**Codes**	**Sample quote(s)**
Implementation leads	Bottom-up drive and commitment	*Now we have staffing confirmed and permanent moving forward. So that's been a really positive development, but that came from ourselves in the social work department, as opposed from a higher management point of view who pushed it.* (Participant 15, Medium Implementing Organisation) *I'm the driver in the service, I'm the one who keeps pushing, pushing, pushing, pushing, because I've been in the service so long, I understand the way it works, but I have a vision, I might not get it done today or tomorrow and I might be knocked down today and tomorrow, but I'll keep going, there's always solutions. So, you're forced to work within the structures that you have but I'll keep asking so it's not going to stop me that I'm getting 'no'. I'll keep asking and I'll keep putting forward my business case.* (Participant 41, Medium Implementing Organisation)
	Respected	*Because (champion in another high implementing organisation) was there from the very start pushing. And she's so good at what she does, she was so highly respected, that she could literally walk into a meeting with anyone and sell them ice. Just brilliant, which is the way we need to be. But it's a shame that we need to be like that to get….and shaping the way things are.* (Participant 06, Low Implementing Organisation) *I really think she's a doer, and she likes to do things well, and she likes to think properly. And because she has such a wealth of experience, people come to her, she's a known figure. She is keen to continue to improve and develop things.* (Participant 07, High Implementing Organisation).

	Entrepreneurialism	*She has been great for grants and funding. So, without that, without us getting that grant there still would be no survivorship.* (Participant 10, Medium Implementing Organisation)
	Personal interest	*From a personal level is that I had a personal interest in oncology, and I had previously completed self-management research. It came nationally, internationally, and then personally with my own drive to develop the intervention.* (Participant 03, High Implementing Organisation) *Nobody has come to me and said you need to do this; this is what we have chosen, and this needs to be part what you're delivering if you're delivering a survivorship service.* (Participant 21, High Implementing Organisation)
	Communication to develop connections, leverage networks and secure buy-in	*I think part of the reason is because of how I did it. I'm one of those people who you can tell talks a lot. So, I brought everybody on the journey with me. The admin people knew all about this before they ever knew what their role was going to be. My colleagues, my nursing colleagues knew all about it before they even knew where they were going to fit into this.* (Participant 04, High Implementing Organisation) *My strategy really was to keep talking about it to every single person.* (Participant 20, High Implementing Organisation)
	Championing qualities	*Health professionals who are already overstretched try to do this as well. And I think that's when it's dropped. It's only those of us that really stick it out have continued with it.* (Participant 12, High Implementing Organisation) *I choose to do it outside of my working day. So that's a personal choice for me, one really good thing about the programme from my perspective, is that it's a really good adjunct to the work that I do.* (Participant 20, High Implementing Organisation) *I think individuals can do things if they're motivated enough and can manage their time…but that's then at a cost to other members of the team picking up some of your work.* (Participant 42, Medium Implementing Organisation)

Organisational culture of entrepreneurship and addressing employee well-being affects the capacity of champions and staff to adopt and sustain programmes		
CFIR Construct	**Codes**	**Sample quote(s)**

Culture: Learning-Centeredness	Culture of innovation & entrepreneurship	*There's a lot of very interested and motivated people who want (hospital) to be a centre of excellence and providing and improving really good care. It feels like a very positive culture in that way. So, I think the hospital culture is progressive and it encourages development and innovation. There's an implied pressure to be doing more and to be delivering good care as possible. And I think that's because the clinical governance is quite good. And for most people doing more, there's not too much, or at least I haven't experienced yet, too much bureaucratic pushback if there is something that potentially could be developed. I think once people have a clear idea and want to do something, they're usually facilitated and supported in doing that. I think it is true that the culture promotes innovation.* (Participant 07, High Implementing Organisation) *We don't have performance meetings or anything like that, they don't want to know what we're doing as long as we're showing up for work, as long as we're practising safely, as long as there isn't a complaint about us...and it would be great if we had these performance meetings to say look, this is where I want to see, this is what I want to do. There's none of that, it's a pity that culture isn't there.* (Participant 41, Medium Implementing Organisation)
	Administrative organisational structures	*The dynamic, so it's very hard, there's layers of management, so it's very hard to get an actual appointment with our director of nursing, it's very hard –we're supposed to go through the proper channels to try and agree anything, so if I am to ask my director of nursing to request on my behalf that I get clerical support, well she's going to business managers, but any motion you put through to speak directly to the director of nursing about it, it could take a year for anything to happen, it is so arduous, all these executive council meetings, they bring up different topics and nothing, nothing is done .. you can only have these meetings every three months, came back again, right and then nothing.* (Participant 41, Medium Implementing Organisation) *That's where you lose the motivation to push things forward, because it takes so long, you're motivated but that motivation starts to wear off, as time passes and there's no progress. You could be chasing emails, like what are we doing next, are we meeting again....you're putting energy onto something that's not progressing". (Participant 42, Medium Implementing Organisation).*

	Hospital governance and ownership	*They're supportive of things. If it looks like a good idea, in other areas you might have to make a case for things a little bit more and I've worked in HSE run hospitals which are quite different but the (hospital) has its own board of management and it tends to prioritise innovation over a lot of other things.* (Participant 38, Medium Implementing Organisation) *I've worked in HSE direct funded hospitals, and in a couple of the voluntary hospitals, and I see a difference, it's my impression, which is only an impression, I have absolutely no data on this, but my impression is that there's much more of a sense of ownership, and a sense of responsibility and interest in making things as good as they can be, versus a sense of executing what you were told to do, doing the requirements and having very little scope necessarily to push beyond that. .* (Participant 07, High Implementing Organisation)
Culture: Deliverer-Centeredness	Non-monetary incentives	*It's really important to acknowledge their contribution. So, we nominated our peer leader here for an award last year. One of the things was her work on the SMS programme. So, it's important to acknowledge it.* (Participant 36, High Implementing Organisation) *It doesn't have to be monetary, but some appreciation of the time and all that.* (Participant 22, High Implementing Organisation)
	Supervision	*We started supervision. So that was very important, and our director of services recognised that and how much you could be holding. So, for managing our boundaries that helped greatly. That we could go somewhere with that after the programme, because it brings up a lot of emotional issues for clients. That was a very good strategy on the on our director of services part.* (Participant 19, High Implementing Organisation) *Supervision has always been part of our practice, but I don't know if it is for a lot of the other professions in this area….there's a lot of an emotional load that comes with working in oncology, and I think if people are to be sustained in the work, and if people are also to keep their warmth and care towards patients, they have to be supported themselves as well.* (Participant 15, Medium Implementing Organisation)
	Debriefing	*I realised it was good just after the session that you can debrief and talk directly about the session.* (Participant 32, High Implementing Organisation) *I think the debriefing is really important, because if you're not a trained psychologist, I'm really lucky in that sense I'm trained, and I know how to manage it. And I think it's a lot to hear everybody's story, the sadness around that is really hard to hold if you're not trained in that way.* (Participant 33, High Implementing Organisation).

	Continuous professional development certifications	*In terms of the professionals could this stand to their professional development, continuing development credits.* (Participant 28, High Implementing Organisation).
Teaming	Bringing team members together	*Really for the centre to take it on and to do it effectively, this requires a lot of training around each session. So, for example, before I do each session, I would meet with my volunteer the day before, or a number of days before, and we go through each session, we practice that. You have to make sure the volunteers are comfortable of course. I have a new volunteer just trained this year so that can take up a lot of time that maybe isn't captured.* (Participant 19, High Implementing Organisation)
Engaging Deliverers	Engaging	*I'm a volunteer with them, but I'm very much part of the team there, and I feel connected and that's to do with the management of the centre and the way they hold their volunteers. So, it's just the way the centre holds us and keeps engaging with us and checking in with us and so forth. So, I feel very much part of the team there.* (Participant 29, High Implementing Organisation)