What makes innovations both ‘stick’ and ‘spread’? A multidisciplinary systematic review to understand implementation depth and scale-up of innovations in healthcare

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Background

Often, healthcare innovations are not sustained after adoption and vary in their effectiveness when scaled-up.1 Diverging research strands focus on either implementation or scale-up/diffusion. These strands typically have different analysis levels, focus on different implementation phases and are conducted in different research fields (e.g., health research (implementation), organisation studies (diffusion)). This systematic review aimed at syntheising evidence on implementation depth and innovation diffusion published in these diverging research fields.

Method

We systematically searched eleven health and organisation/management studies databases for theoretical and empirical studies published in English language, including Medline and Business Source Complete. The search strategy combined terms for innovation with terms for implementation depth or diffusion. Further we handsearched key textbooks, references and citations of included studies and relevant journals in the two fields. Two reviewers screened for inclusion and extracted data. Conflicts were resolved in the team. Data are analysed applying qualitative thematic analysis and summarised in a narrative synthesis.

Results

Preliminary results show that conceptualisations of implementation depth and innovation diffusion vary according to the theoretical perspective. They can be conceptualised along dimensions of scale (extensiveness, completeness, prevalence), scope (degree of fit, fidelity and adaptation), process (incremental or continuous or disruptive and episodic) and outcome (decoupling and ephemeral or sustained change).

Conclusion

The review synthesises concepts from different levels of analysis and diverse literatures. It sheds light on the blind spot in our understanding of how to achieve both, the widespread and sustainable implementation of innovations.
place. Provisions within the work place allow for ‘in employment’ education to overcome any disconnect associated with traditional education methods. Using this Participatory Action Research process within an implementation framework created learning and embracing of change in practice from within including the identification of strategies to overcome difficulties and maximise benefits of implementation.

Acknowledgements This study is co-funded by the Irish Health Research Board Applied Partnership Award and the Irish Hospice Foundation O3 Improving European Healthcare Systems through the Development of a Realist Evaluation Framework for a European Public Health Data Analytic Project Andrew Boilson1, Regina Connolly1, Anthony Staines1, Paul Davis2, Justin Connolly1, Dale Weston1
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Background
The multi-national MIDAS (Meaningful Integration of Data Analytics and Services) project is developing a big data platform to facilitate utilisation of a wide range of health and social care data to enable integration of heterogeneous data sources, providing analytics, forecasting tools and bespoke visualisations of actionable epidemiological data.

Method
An evaluation framework starting with a logic model and semi-structured interviews using the principles of realist evaluation was developed working with 6 developers, 5 health service managers, 2 allied health professionals and 3 policy makers. Parallel case studies were used to address the requirements of stakeholders at critical time points during the project.

Results
At this early stage of the MIDAS project's development, the logic model represents an accurate representation of the project's key outputs, outcomes and impacts identified through the logic model transcripts coding process. The logic model was developed through a number of iterations of consultation with the MIDAS consortium as an initial process of evaluating, planning and developing the project. As the project progresses, key indicators (outputs, outcomes and impacts) that were not initially included in the logic model may be identified through interviews with end users of the MIDAS platform tools and the technical development teams.

Conclusion
The objective of this study is to narrow the gap between end user requirements of the platform tools and technical developers' expectations of the end user needs, an ongoing process of refining the logic model is required at critical stages of the project's development. To narrow the gap an ongoing process of refining the logic model is required at critical stages of the project's development. Overall, the early stage interviews indicated the logic model is an effective framework for the evaluation of the project.

O4 Scaling up with structure: Impact, feasibility and theoretical reflections on a practice-informed scale up template to improve patient safety Andrew Sibley, Tracy Broom Wessex Academic Health Science Network, Innovation Centre, Southampton, UK Implementation Science 2019, 14(Suppl 2):O4 Correspondence: Andrew Sibley (andrew.sibley@wessexahsn.net)

Background
In 2017/18 Wessex Patient Safety Collaborative (PSC) led a project to support local NHS teams expand established patient safety initiatives. The aim was to develop a 'scale up template' (SUT) and test its use in practice. The SUT undertook "deliberate efforts to increase the impact of innovation to benefit more people and to foster policy and program development on a lasting basis." [1] The SUT aimed to support "scale up to at least 60% of a target population that could potentially benefit from the program." [2] The SUT developed a 10-stage process to scale up and used pragmatic techniques of engagement, face-to-face, with staff to work through the complexities of scale up.

Method
A mixed methods investigation, of the impact and feasibility of the SUT, collected quantitative scale up data on each initiative and undertook qualitative focus groups with staff.

Results
Quantitative findings indicated all initiatives reached their target of 60% (55 of 92 possible) scaled up units (hospital wards, care homes etc). Sixteen themes from a synthesised thematic analysis of four focus groups were identified. Themes included: Overwhelmingly positive perceptions of SUT; SUT changed the previous scale up approach; Train the trainer potential. Facilitator themes included: Project manager role vital; First meeting with AHSN PSC lead vital; SUT developed staff awareness of implementation science/scale up; Executive sponsorship vital. A key barrier theme was the systemic underestimation, by staff, of scale up complexity and challenges.

Conclusion
The SUT was perceived as a positive force for change as teams pragmatically worked with complexity to scale up their initiatives. The SUT was a catalyst for changing approach after previous failed attempts to scale up had occurred. Active ingredients of its value were identified. Reflections on how the SUT mapped to implementation theories was undertaken to further develop the SUT.

Acknowledgements
On behalf of Wessex AHSN and Wessex Patient Safety Collaborative, we would like to thank the NHS staff who participated in this scale up initiative and evaluation.

References
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O5 The role of knowledge exchange in scaling-up a complex intervention for osteoarthritis (ESCAPE-pain) in England Andrew Walker1,2, Annette Boaz2, Michael V Hurley1,2
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Background
Implementing and scaling-up innovations is a collective social process [1,2]. However, there is limited analysis about how knowledge exchange operates in practice to support scaling-up [3]. ESCAPE-pain is an evidence-based complex intervention for osteoarthritis currently in >100 sites in England. The study investigated the role of knowledge exchange in scaling-up ESCAPE-pain.

Method
A qualitative case study approach was used. Forty clinicians and managers participated in 50 interviews across 14 organisations in England. Four NHS providers were selected as case studies, each comprising 5-7 participants. A fifth case study was undertaken of a clinical-academic network's role in supporting the scale-up of ESCAPE-pain. This used an ethnographic approach comprising multiple interviews with project and senior managers, 8 months of observations and documentation.

Results
Two themes are explored.
1) Creating spaces to exchange formal and tacit knowledge:

a. Physical spaces – large stakeholder knowledge sharing events and partnership working with early adopters were used to share learning about implementing ESCAPE-pain.

b. Digital spaces – a website and app were developed to expand geographical reach and provide practical knowledge about ESCAPE-pain and its implementation.

2) Types of knowledge created and its purpose – the knowledge exchange process developed understanding about:

a. ESCAPE-pain and how to manage osteoarthritis better through manualising it, developing a training course, and creating resources (e.g. return on investment tool).

b. How to implement ESCAPE-pain to expand reach across different settings, widening target populations, and broadening the workforce delivering it (e.g. clinician/non-clinicians).

Conclusion

The study provides empirical evidence that builds on reframing the idea of the evidence-practice gap as one of a “space” of interaction [4]. The clinical-academic network actively facilitated better connectivity across systems to support the exchange and production of knowledge to drive spread. It was a non-linear and emergent process that utilised formal and tacit knowledge. This has implications for planning system-wide scale-up.

Acknowledgements

We would like to thank the participants who took part in the study. Health Innovation Network for funding the study.

References


Figure 1 (abstract P6). Extract of a pathway analysis for one intervention, (+ = reinforcing, - = balancing)

P6

Assessing causal links and potential consequences of implementing innovations in complex systems – A worked example of applying participatory systems thinking methods in a regional emergency medical service system in Oldenburg, Germany

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Background

We assessed the usefulness of systems thinking methods to guide the implementation of interventions reducing demand in a German emergency medical service (EMS) system with the aim of:

a. analysing intended and unintended consequences of implementing innovations in a complex system; and

b. enhancing stakeholder involvement in the implementation process.

Method

Within a stakeholder group (EMS managers, frontline staff, health insurance representatives), causes and consequences of ‘rising EMS demand’ were discussed and incorporated into a causal loop diagram [1]. Potential interventions to reduce demand were identified by the group and incorporated into the diagram. A pathway analysis was conducted identifying intended or unintended consequences of prioritised interventions in the system [2]. Next steps include assessing time delays, a cross-comparison of the interventions’ impact and a stakeholder evaluation of the methodology.

Results

36 variables in four thematic groups were identified as interlinked causes/consequences of demand rise (staff, patients, other services, policy level). Eight feedback loops were identified. Four of 13 interventions were included in the path analysis showing no unintended consequences in the system (Figure 1). Results of the next analysis steps will be presented at the conference.

Conclusion

Applying systems thinking methods helped understanding the complex interactions in the EMS system around the specific problem of demand rise and assess the impact of potential interventions. The methodology allowed for the interactive involvement of the stakeholders from the beginning of the implementation process.

Acknowledgements

Both corresponding authors have contributed equally to this paper and count as first authors. We also thank the Oldenburg-project consortium for their steady input throughout the process of this work.

References


P7

Can a short course increase the skills of early career researchers in initiating and sustaining partnerships with policy? Findings from a pilot evaluation

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Background

Researchers internationally are increasingly motivated to work in partnership with policy agencies on research projects. Such
partnerships can be challenging to initiate and sustain, however, and there are few resources available to guide researchers wishing to build skills in this space. The current study presents pilot data from a short course designed to increase the capacity of early career researchers to initiate and sustain research partnerships with policy agencies. The specific aims of the study are to assess the: a) Uptake and acceptability of the course; b) Impact of the course on intentions to work with policy makers and confidence in doing so; and c) Extent to which the impacts (if any) of the course were sustained six months post attendance.

Method
A pilot evaluation of the first two rounds of this course, developed by the Centre for Informing Policy in Health with Evidence from Research (CIPHER) and the Sax Institute, was conducted. Process measures were collected to assess feasibility, a post-course feedback form was administered to assess acceptability. Participants completed a short questionnaire rating their skills and confidence in working with policy makers, pre, immediately post and six months post course attendance.

Results
The course was feasible to run. Ten participants attended and completed each course (as planned) and feedback data suggested the course was highly acceptable to participants (average ratings of ≥satisfied for all items). Significant improvement in self-reported skills, confidence and intentions regarding working with policy agencies were noted amongst participants post course and almost all were maintained at six month follow up.

Conclusion
Early data suggests that this short course is a feasible and effective way of improving early career researchers self-reported skills, confidence and intentions to work in partnership with policy agencies on research projects.

Acknowledgements
This course was developed as part of the Centre for Informing Policy in Health with Evidence from Research (CIPHER), CIPHER was a National Health and Medical Research Council Centre for Research Excellence (APP1011436). The evaluation of this course was funded by a NSW Health Early-Mid Career Research Fellowship awarded to Dr Anna Williamson.

O8 Implementing the children and young people’s IAPT quality improvement initiative in Cambridgeshire: findings from a process evaluation
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Background
In 2011, the Children and Young People’s Improving Access to Psychological Therapies (CYP-IAPT) programme was introduced nationally to improve outcomes and experience of care for children and young people. The aim was to support services to embed key CYP-IAPT principles into everyday clinical practice so as to deliver evidence-based practice, demonstrate accountability through outcome monitoring, increase access to effective services and engage children and young people to participate in decisions about treatment and services. The current study explored the process of implementation and the experiences of professionals in specialist mental health settings in Cambridgeshire.

Methods
i) An audit and analysis of national and local documents issued between 2011 and 2015 and mapped along a five-year timeline; ii) Thematic analysis of in-depth interviews with 20 staff working in three specialist mental health settings in the Cambridgeshire and Peterborough Foundation Trust, conducted at two time points along the implementation trajectory.

Results
While there was high investment from frontline staff, there was a lack of clarity about the scope and aims of the CYP-IAPT programme during the early implementation phase. Programme developers emphasised some CYP-IAPT principles more than others and there was variation in perceptions of the extent to which principles were embedded. The creation of dedicated staff posts were a key driver to implementing and sustaining the CYP-IAPT model at a local level; specialist training and enhanced supervision facilitated evidence-based practice and outcome monitoring. Barriers to implementation included inadequate and inflexible IT systems, time limited funding and a lack of support from senior management. Organisational differences between partner agencies led to ineffectual collaborative working and high staff turnover prevented knowledge continuity.

Conclusion
This study provides valuable insights into local implementation of a complex national quality improvement programme. Recommendations will inform other local quality improvement initiatives relating to children and young people’s mental health.

P9 Developing an implementation strategy for the use of objective adherence data in routine clinical practice: a case study in cystic fibrosis clinics
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Background
Preventative inhaled treatments preserve lung function and prolong life in Cystic Fibrosis (CF). An online platform (CFHealthHub) has been developed with patients and clinicians to support treatment habits. Self-report adherence to these treatments is over-estimated. CFHealthHub displays real-time objective adherence data from dose-counting nebulisers, so that clinical teams can offer informed treatment support.

In this paper, we used the theoretical domains framework (TDF) to identify implementation barriers to health professionals accessing objective adherence data through CFHealthHub. In 2019, scale up of implementation is required in a further 19 CF centres.

Method
Qualitative data were collected through semi-structured interviews with health professionals in three participating UK CF centres. The participants (n=13) were purposively sampled based on location and professional category. A topic guide was created exploring all theoretical domains. Transcripts were analysed by two researchers using framework analysis.

Results
Interviews demonstrated that participants did not have routine habits for using adherence data in clinical care. Analysis indicated that an implementation strategy should address all 14 domains to successfully support implementation scale up. Participants reported insufficient training and low confidence in using adherence data. As a result, participants reported negative beliefs that adherence data would be used to “tell patients off”. In addition, participants frequently justified lack of engagement because they believed adherence was primarily a physiotherapist responsibility.

Environmental barriers, such as computer access and pressures on staff time were common. Participants thought environmental and social influence barriers could be addressed by dedicated senior management.

Conclusion
The identified barriers supported the development of an implementation strategy using the behaviour change wheel. The strategy includes support for habit formation and other barriers using intervention functions, such as environmental restructuring, enablement, education and modelling. The success of this strategy will be evaluated as the project opens in new CF centres.
Acknowledgements CFHealthHub Data Observatory is funded by NHS England Commissioning for Quality and Innovation
Trial Registration ISRCTN14464661

O10 What are the relationships between contexts, mechanisms and outcomes which underpin the ‘dynamic sustainability’ of a complex health care intervention across a system?
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Background
Whilst there is agreement within the implementation science arena that sustainability is a key outcome, limited attention has been given to understanding how to sustain complex interventions in practice [1]. Historically, the emphasis has been on evaluating and exploring the initial implementation, with time and budgetary constraints often meaning that longer term sustainability has not been a focus. To understand what affects the determinants of sustainability, we need to understand the relationships between determinants. To address this gap, we present a review of the evidence base which aims to contribute to our understanding of these determinants and how they interrelate in different contexts.

Method
A systematic rapid realist review of the literature was undertaken, to examine the relationships between contexts, mechanisms and outcomes which underpin the ‘dynamic sustainability’ of a complex health care intervention across a system. Evidence was submitted to thematic content analysis and synthesised to create a series of Context-Mechanism-Outcome Configurations (CMOCs). Testable hypotheses based on these configurations were derived for further research.

Results
539 studies were screened, of which 17 studies were included in the review. Projects were initiated in a variety of healthcare settings and represented a range of complex interventions. The findings include a series of 17 CMOCs each illustrating how, triggered by specific contextual factors, a combination of programme resource and stakeholder reasoning led to specific outcomes.

Conclusion
The review identified for the first time a set of CMOCs that determine sustainability of complex healthcare interventions. These CMOCs are empirically testable. Our further research focuses on studying how these CMOCs impact on sustainability outcomes.

References

O12 Developing products for knowledge mobilisation of healthcare research
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Background
The current emphasis on demonstrating academic ‘impact’ contributes to the proliferation of knowledge mobilisation (KM) products from healthcare research (e.g. toolkits, guidance etc), which may be referred to as ‘boundary objects’. A research gap exists regarding the motivation for their development, development processes and the factors influencing whether and how they mobilise knowledge.

Methods
Phase 1: Semi-structured interviews (20) + focus group (11) (academics, healthcare managers, funders) focussing on perceptions of toolkits. Phase 2: Four case studies of applied healthcare research projects developing KM products. An ethnographic approach generated data from observations (80+ hours), document analysis (>150) and interviews (40). Thematic analysis was inductive and deductive, building on Phase 1 themes and developing new themes where appropriate.

Results
Phase 1 saw the academic context constraining researchers’ ability to concentrate on developing KM products. Toolkits were perceived as ill-defined, practical resources, helping users put knowledge into practice. Participants reported overwhelming cynicism towards them yet felt obliged to produce them. Phase 1 themes supported Phase 2, where the impact agenda perpetuates KM product development as stand-alone interventions instead of a broader KM strategy. Cross-case analysis revealed themes influencing the potential to move KM products from ‘designated boundary objects’ to ‘boundary objects in use’: need (ranging from unclear to identified gap), audience (ill-defined to clear), team dynamic (dysfunctional to collaborative), leadership (disengaged), project management (chaotic to clear) stakeholder engagement (tokenism to co-production), and product (ill-defined to boundary object-in-use). KM products were characterised as symbolic boundary objects, used as bargaining chips with funders or research subjects.

Conclusion
To optimise the potential application of KM products, researchers and funders should consider the motivation for their development. Where developing such a product is felt, potentially, to make a meaningful impact in practice, carefully planning stakeholder engagement, collaboration and project management might enhance their impact.

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O13
Of distribution and drift, the role of everyday technologies in the implementation of care bundles
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Implementation Science 2019, 14(Suppl 2):O13

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Background
In the NHS there are challenges regarding the implementation, sustainability and spread of quality improvement innovations [1]. Technology in practice offers a useful theoretical perspective to explore the implementation of quality-improvement tools. By applying this perspective, tools are viewed as everyday technologies that play an active part in healthcare as opposed to being inanimate objects in the form of paper-based or computer-based tools [2, 3].

Method
This study sought to systematically and critically examine the role quality-improvement tools play in healthcare organisations. Using sepsis as an example, the study explored two comparative case studies of implementation strategies used to improve the recognition and treatment of sepsis. Ethnographic observation in the Emergency Department (ED), ward settings and relevant meetings (200 hours), semi-structured interviews (60) and documentary analysis were used. The data were analysed using thematic analysis.

Results
The empirical findings showed that when implemented there was a gap between tools and practice which was crossed by a chain of re-representations. Each re-representation contained a multitude of actions and decisions that were; highly distributed across a range of heterogeneous entities such as the tool itself, healthcare workers and equipment. This resulted in workarounds and various elements drifting from the original intention of the tools. For example, using the tool in the ED was different compared to the acute inpatient setting. In the ED work practices were directed towards the recognition and treatment of acute illness. Conversely, in acute inpatient settings work practices were directed towards a multitude of other activities.

Conclusion
This research provides valuable insights into where distribution and drift occur. The findings contribute towards an understanding of the mechanisms by which improvement programmes work. An understanding of the role that tools play when used in practice can lead to more efficient and effective implementation, sustainability and spread of quality improvement innovations.

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References

P14
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Background
The Implementation science Research development (ImpRes) tool and supplementary guide have been developed to provide guidelines on how to design high-quality implementation science research [1]. ImpRes did not include quantitative assessment criteria for evaluating the quality of implementation science protocols; these were developed in this study to identify strengths and weaknesses in implementation science research protocols and make recommendations to address current deficits in implementation research design.

Method
This study developed Implementation science Research development tool Protocol Assessment Criteria (ImpResPAC), a protocol scoring system, to quantitatively evaluate implementation science protocols for information provided on five out of the 10 ImpRes domains: research characteristics, implementation theory frameworks and models, implementation strategies, implementation outcomes, and unintended consequences. ImpResPAC was applied to 16 implementation science protocols, published in Implementation Science, to identify strengths and weaknesses of planned implementation science research.

Results
The majority of protocols scored highly on describing the research gap, but few differentiated between the implementation
activities associated with each implementation stage. Although most protocols provided strong rationale for the choice of theory, framework and model underpinning the research, many lacked thorough application throughout the implementation research. In most cases, the implementation strategy was explicitly described and justified. Many protocols described the intention to measure fidelity, but few intended to measure appropriateness, acceptability, penetration and sustainability. Only two of the protocols intended to measure unintended consequences. The reliability of ImpResPAC was evaluated by conducting intra-class correlation coefficient (ICC) tests on a subset of protocols and demonstrated agreement of 0.85 (ICC).

Conclusion
The application of ImpResPAC to 16 protocols identified strengths and weaknesses in research design. Furthermore, ImpResPAC presents a reliable scoring system that researchers, funders and decision-makers can use as a learning tool to self-assess implementation science research protocol quality.

Reference

P15 Scaling up a polypharmacy Action Learning Sets tool: interim findings and methodological insights
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Background
In line with national policy, to address the issues associated with inappropriate polypharmacy, the Centre for Implementation Science are evaluating the implementation of a Wessex Academic Health Science Network led Action Learning Sets (ALS) tool, to improve healthcare practitioners’ confidence, perceptions and experiences of stopping inappropriate medicines safely.

Methods
Up to 125 healthcare practitioners attending ALS across three localities in the South of England are being invited to participate in the study. A mixed method approach involving pre-post ALS questionnaire, evaluation forms and observational methods, will be used to evaluate the study.

To date, interim findings have been analysed from one locality (n=33), and methodological insights recorded which relate to the prospective scale up and evaluation of the ALS across two further localities. Quantitative paired pre-post ALS questionnaire responses were analysed using the Wilcoxon signed-rank test, whilst qualitative data were analysed using thematic analysis and ethnographic methods. Overall impact of the ALS will be evaluated using Kirkpatrick’s evaluation model.

Results
Interim findings show the ALS has contributed to improving perceptions, confidence and experiences in addressing polypharmacy and more specifically perceptions of; stopping inappropriate medicines, use of knowledge, information and tools, shared decision making with patients/clinicians and the role of institutional factors. Methodological insights relating to the scale-up of the ALS across two further localities include the impact of locality upon participation, as well as the process of engagement of participants in the evaluation.

Conclusion
Interim findings and methodological insights in scaling up the study may be of relevance to national policy to understand how to address polypharmacy issues in different localities.

P16 The Life Link Clinic: Meeting the socio-economic needs of patients and families within complex rehabilitation in-patient services
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Background
Feedback from patients and families in complex rehabilitation services highlighted that socio-economic issues increased their stress and anxiety levels. In response, an integrated provision is being piloted within complex rehabilitation inpatient settings under the umbrella of the Cheshire and Merseyside rehabilitation network. This service aims to offer a multi-agency approach to support patients with any socio-economic issues, to help reduce stress and anxiety, to promote integrated accessible support.

Method
We conducted sixteen Semi-structured interviews with staff and service users to evaluate the existing three services and improve the implementation of the two new sites. Using the DASS 21 and the NHS family and friends test, service users are asked to provide feedback on the service and rate their stress and anxiety before and after accessing the service. Staff and service users’ perception of the service is also collected through semi-structured interviews. Using a mixed method analysis, the semi-structured interviews were thematically analysed and paired t-test utilised to compare changes in pre- and post-data.

Results
Interviews indicated that this support was considered essential, which helped to improve the two new sites implemented since December 2018. The service evaluation is on-going. Preliminary analysis suggests that stress levels in families are above the ranges which we see in patients on admission to the acute rehabilitation setting. Using information from the staff questionnaire, socio-economic issues encountered by patients, carers, and families were mapping across the main themes raised when accessing the service. This reflected that the service was meeting the needs of patients and families.

Conclusion
Findings from the evaluation of this implementation of two new sites and five in total across the North West Coast region can help to identify the benefits of this service to people with complex brain injuries and their families in terms of their social needs.

O17 Evaluation of implementation of high-throughput Non-Invasive Prenatal Testing (NIPT) for foetal RHD genotype testing: results of a survey of maternity units in England, supplemented by expert elicitation findings
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Background
An Rhd-negative mother carrying an Rhd-positive foetus is at high risk of sensitisation which can be reduced by administration of Routine Antenatal Anti-D Prophylaxis (RAADP). However, approximately 33% of women carry an Rhd-negative baby and do not need RAADP [1]. In 2016, The National Institute for Health and Care Excellence
recommended Non-Invasive Prenatal Testing (NIPT) for foetal RHD genotype as a cost-effective option to guide RAADP in the United Kingdom and established research recommendations investigated in this study. The aim of the study was to evaluate the implementation of high-throughput NIPT for foetal RHD genotype in maternity units in England, the United Kingdom.

**Method**

A survey evaluating the implementation, antenatal care, uptake of the new test, RAADP adherence and postpartum care was sent to 39 Hospital Trusts in England. Topics which required further investigation were explored during qualitative interviews with seven clinicians chosen based on their geographical location. Test results from all hospitals in the United Kingdom which offer the new testing strategy are included.

**Results**

Nurses and midwives were most likely to have received training organised internally within a Trust. The new service is not expected to incur extra costs. Cost savings include reduction in Anti-D use, Anti-D quantification, and samples testing (cord blood typing, the Kleihauer test). RAADP appointments are shorter or not required which balances the extra time needed during the initial appointments. The frequency of positive, negative and inconclusive results is 55.9%, 34.5% and 4.3%, respectively. Neither the uptake of NIPT for foetal RHD genotype nor adherence to RAADP is routinely monitored. Trusts described using four different postpartum testing strategies.

**Conclusion**

NIPT for foetal RHD genotype fits well within the existing patient pathway. The success of implementation of the new testing was associated with good working relationship between staff and organisation of work within the department.

**Acknowledgements**

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**References**


**O18 Developing a scaling up plan for quality improvement training in urological surgery**

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Implementation Science 2019, 14(Suppl 2):O18

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**Background**

The education in quality improvement programme (EQUIP) for urology aims to address the need for an evidence-based curriculum in quality improvement (QI) methods training in surgery. Key goal of EQUIP is to be nationally scalable in the UK. Here we present the development of the EQUIP scale-up strategy.

**Methods**

The strategy was developed using evidence triangulation from mixed-methods studies: evidence-based curriculum development (evidence reviews), national gap analysis (qualitative data), and programme piloting at two UK sites for feasibility and effectiveness (quantitative data). The collected data involved a range of stakeholders: training programme directors and trainers as well urology trainees, and a steering group which included educational practitioners, patient representatives, trainees and consultant urologists. Further, we framed the implementation model of the scale up plan based on the Exploration, Preparation, Implementation, Sustainment (EPIS) framework (Fig 1).

**Results**

We identified prioritization challenges, Trust resources, and time commitments as the greatest barriers towards the scale-up of EQUIP, while structured approaches to QI work as the drivers towards developing an educational platform in QI techniques, a network to support undertaking QI work and creating a QI infrastructure.

**Conclusion**

This study offers an empirical and theoretical understanding of how to scale-up the EQUIP programme nationally in the UK. Based on the study, the scale-up strategy involves national stakeholder support; an IT platform; nationally shared training materials; and a train-the-trainers programme. The scale-up strategy will be evaluated further in the coming 2 years of EQUIP implementation and will be used to guide potential diffusion across other specialties.

**Acknowledgements**

The authors would like to thank the Training Programme Directors of each region, the trainers on the course and the Urology Surgery trainees who took part in the study.

**Funding**

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**Figure 1 (abstract O18).** Empirical model of the scale-up plan using the EPIS framework and the conceptual phases and factors affecting implementation in QI training for urological surgery

**O19 The development and application of a logic model to translate an established Perioperative medicine for Older People undergoing Surgery (POPS) service to a novel setting**

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Implementation Science 2019, 14(Suppl 2):O19

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**Background**

Older people are at higher risk of adverse perioperative outcome in comparison to younger patients and the need for geriatrician involvement in surgical pathways is advocated. An evidenced-based method of improving care for older surgical patients has been developed and embedded at Guy’s & St Thomas Trust (GSTT) and is being
replicated nationally [1-5]. There is a call for scale up of Perioperative medicine for Older People undergoing Surgery (POPS) services but this requires a systematic approach [6]. A logic model is a critical initiating step to begin the scale up process with fidelity [7,8].

**Method**

Thirteen clinical and safety implementation experts were recruited to participate in three sessions to develop the POPS logic model. Guided by literature review and consensus, the model was constructed through mapping themes against core components of the Kellogg Logic Model Guide [8]. The model was applied and evaluated at Darent Valley Hospital (POPS@DVH).

**Results**

The logic model was used to design, develop, iterate and embed POPS@DVH. Over 18 months the new service resulted in improvements in process measures reductions in length of stay (-2.58 days) and readmission rates (-12%). Other key outcomes included improved documentation of medical complications (eg. improved delirium diagnosis from 0 to 21%) and comorbidities, translating to improved patient care and hospital coding. Stakeholder engagement was actively sought throughout this process, with high satisfaction noted from surgical teams, junior doctors and patients. The overall success of POPS@DVH was reflected in substantive surgical directorate funding allowing sustainability.

**Conclusion**

This study demonstrates the clinical utility of a logic model in facilitating successful scale up of an established POPS service into a novel setting.

Further work would involve refinement of this logic model to establish a relevant and sustainable framework for a wider POPS scale up.

**References**


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7. Medical Research Council. Developing and evaluating complex care for women in labour and birth are decisions about the appropriate use of clinical interventions. Interventions for example caesarean-sections or instrumental births are necessary when problems arise, however routine use increases mortality and morbidity. We undertook a systematic review of studies to explore facilitators and barriers to the implementation of evidence-based practices to support physiological labour and birth, an important initiative, to reduce routine intervention use. We reviewed studies that explored practices in obstetric setting where routine intervention use is higher compared to midwife-led settings.

**Method**

Using PRISMA guidelines [1], databases was searched from 1990 to September 2018 and 31 original studies were included for thematic synthesis [2]. Analytic themes that were theoretically informed enabled us to explore facilitators and barrier at a micro level (obstetricians, midwives and women) and meso level (organisation) to implementing EBPs to support physiological labour and birth.

**Results**

The synthesis showed that prevent risk perceptions of birth are an important barrier. This informed an approach based on risk surveillance and active management of labour. Obstetricians who hold strong risk perceptions of birth exert control over other professionals to apply a risk-based approach. An important barrier is their reluctance to relinquish this power. Approaches cognisant with EBPs to support physiological labour and birth is muted. Midwifery acquiesces, obstetric and midwifery preoccupation with risk surveillance and rationalisation of intervention use are important barriers. Women expect interventions to shape birth experiences. Centralisation of labour care sustains a risk-based approach. Facilitators included collaborative working by obstetricians and midwives to implement evidence-based practices, midwifery involvement in decision-making and organisational efforts to enhance midwifery autonomy.

**Conclusion**

Future research should explore obstetrician’s reluctance to relinquish power, factors that facilitate collaborative working between professional groups, organisational influences and women’s experiences in obstetric settings.

**Registration:** International Prospective Register of Systematic Reviews (Ref: CRD42017081891)

**References**


**P21**

**Evaluation of a Physical Health Plan for people with psychosis: Protocol for a Quality Improvement study**

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**Implementation Science 2019, 14(Suppl 2):P21**

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**Background**

People with serious mental illness (SMI) have poorer physical health compared to the general population. Reasons for this are complex but include the identification and treatment of physical health conditions. Creating tools to support people with SMI to assume more control of their physical health may help to ameliorate some of these problems. This study evaluates the use of a service user-held Physical...
health plan (PHP) for service users to determine whether its use increases uptake of physical health services.

**Method**

We have undertaken a pilot quality improvement study to test the use of the PHP [1]. This included testing a Theory of Change using focus groups with service users and staff and evaluating the use of the PHP in two community mental health teams using the RE-AIM implementation framework to guide the evaluation using qualitative and quantitative measures to do this (eg collecting data on how many people used the PHP, if they required support, if there was a change to uptake in physical health services, measuring Patient Activation).

**Results**

Focus groups were run with staff and service users before the pilot started which led to some change to the PHP and how it was used. 27 service users have completed the PHP. Participants have found it easy to use and were able to identify physical health needs. These were shared with clinical staff. Follow-up is ongoing which will include interviews with service users and clinical staff to elicit their views on using the PHP. Analysis of the implementation outcomes using the RE-aim framework is ongoing.

**Conclusion**

This study used an implementation framework to test a novel intervention for people with SMI. Participants found the PHP easy to use and analysis will help us to evaluate the success of the intervention and whether a larger-scale definitive RCT is warranted.

**Acknowledgements**

Thank you to all the service users, carers and academic and clinical staff who took part in the initial stages of the development of the PHP. Special thanks to the two service users who ran the focus groups.

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**Trial Registration**

ClinicalTrials.gov Identifier: NCT03178279. Registered date: 05/06/2017

**Reference**


**P22**

**Measuring success of quality improvement in a mental health NHS Foundation Trust**

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Implementation Science 2019, 14(Suppl 2):P22

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**Background**

Quality Improvement (QI) in healthcare is widespread [1] with diverse projects and target outcomes [2]. Success rates are highly variable, often with disappointing results [3]. Existing guidance on QI evaluation [4] does not aid organisational reporting on the impact of QI [5]. We aim to develop a framework for measuring success of QI to aid organisational learning and shed light on capacity building needs and resource allocation priorities in South London and Maudsley (SLaM) NHS Foundation Trust.

**Method**

A scoping exercise was conducted by an academic faculty (KC) who is embedded as a researcher-in-residence in SLaM. With combined inputs from QI team in SLaM and academic colleagues in Centre for Implementation Science as well as a rapid evidence scan, we designed a survey for retrospective summative assessment. A generic input-process-output framework was used for the survey to overcome the difficulty of making comparisons when project-specific aims and outcomes were heterogeneous and highly localised. Each QI team member then identified 3-5 “successful” and “unsuccessful” QI projects to create a gradient of contrast for small but rapid gains in learning about pertinent factors of QI success. We did not formally operationalise the definition of success in the survey so as to understand “work-as-done” rather than imposing a “work-as-imagined” criteria in the absence of an established definition of QI success [6]. Logistic regression was used to compare the impact of contextual, input and process factors on whether projects achieved their aims.

**Results**

Among 52 QI projects across five boroughs of London, 12 achieved their aims. Contextual and input factors showed very little impact. In contrast, process factors like stakeholder engagement and measurement plan showed sizable impact on whether projects achieved their aims.

**Conclusion**

Measurement plan and data quality matters more than contextual and input factors in determining success of QI.

**References**


**P23**

**Provider training and implementation of newborn care interventions at facilities in Malawi: a secondary analysis of Service Provision Assessment survey data**

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**Implementation Science 2019, 14(suppl 2):P23**

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**Background**

In Malawi, most newborns have contact with health service in the first days of life, however, coverage of comprehensive newborn care remains low. National efforts have been made to improve and scale up provider training in newborn care. We aimed to evaluate the associations between provider training in newborn care and interventions implemented in practice at facilities in Malawi.

**Methods**

Using data from the 2013-14 Service Provision Assessment survey in Malawi, we employed ordinal and logistic regression models to evaluate the associations between training and observed newborn interventions, adjusting for facility and provider factors. Data included 1294 providers, 527 facilities and 474 observed births.

**Results**

Newborn care providers reported attending trainings covering on average 4.7 (95% CI: 4.5, 5.0) themes in their career and 2.6 (95% CI: 2.4, 2.8) themes in the past two years out of 14 training themes.

**Conclusion**

Malawian newborn care services have largely aligned to the international new care recommendations, however, evidence for improvements in the practice of newborn care is lacking.
included in the survey (Figure 1). Following births observed at facilities, providers implemented on 6.9 (95% CI = 6.6, 7.2) of 12 recommended interventions. Preliminary analyses did not show an association between number of recent training themes attended by a provider and the number of interventions implemented after birth (AOR = 1.08, 95% CI = 1.02, 1.16) however for every additional recent training theme attended, providers were 8% (AOR = 1.08, 95% CI = 1.02, 1.16) more likely to implement more than the mean number of interventions.

**Conclusions**
While newborn care providers in Malawi reported attending recent trainings on newborn care, the relationship between recent training and improved practice is not clear. More research is required to understand drivers of improved newborn care following provider training and scale-up coverage of comprehensive newborn care.

**O24**
Knowledge brokering in a public mental health program: does sharing knowledge derived from implementation science help to improve outcomes?
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**Background**
Schools need mental health interventions that are deliverable, scalable and effective. However, rates of successful implementation of evidence-based practices in schools is low. An underpinning factor is lack of understanding, and attention, by commissioners, providers and schools, to evidence about what works to bolster effective and sustained implementation. Knowledge brokering is one way to improve use of implementation science in program delivery in complex settings. To date, evidence for the use of KBs in public health settings is scarce, and their use for brokering implementation related knowledge is non-existent.

The aim of this study was to examine whether it was feasible and acceptable for knowledge about implementation to be brokered to a steering group responsible for a wide scale, public mental health, school-based intervention, and what impact this might have on their implementation decisions.

**Methods**
The primary researcher attended 13 (3 hrs each) monthly steering group meetings during the initial implementation phase of the public mental health program and shared implementation knowledge with them.

With consent, meeting notes were taken by the primary researcher, and a journal kept of 12 meetings; 5 meetings were also audio recorded and SG minutes referred to. All data were amalgamated and ordered into month-by-month summaries. The analysis attempted to identify when implementation knowledge was shared with the group (coded a ‘key moment’) and what the steering group did with this knowledge (coded a ‘key outcome’).

**Results**
Over the 13 meetings, 15 key moments led to 14 key outcomes, 10 of which involved implementation decisions being made based on brokered knowledge about implementation science (Figure 1). Some brokered knowledge was not acted upon.

**Conclusions**
Knowledge brokering on implementation science to a group responsible for public mental health is feasible and acceptable, although this may have been promoted by the strong research culture amongst steering group members.

**O25**
Withdrawn

**P26**
Withdrawn

**P27**
Rapid testing of service innovations in general practice: an evaluation of the Primary Care Home model in Newham
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*Implementation Science* 2019, 14(Suppl 2):P27

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**Background**
In Autumn 2018, Newham Clinical Commissioning (CCG) group piloted two service enhancements to groups of six general practices under the national Primary Care Home (PCH) programme: 1) managing in-hours demand for doctors’ appointments through online triage, care navigation, and additional GP hours shared between practices, and 2) a complex case (CC) management team for patients with multiple co-morbidities. The evaluation aimed to assess the feasibility and acceptability of the PCH model and identify factors that could affect the roll-out of services across the Borough.

**Method**
A mixed-methods, formative process evaluation was carried out between December 2018 and May 2019: 1) routinely collected data, 2)
involvement in the Centre for Implementation Science and King’s College London, Denmark Hill, London, UK; 2Centre for Implementation Science, King’s College London, Denmark Hill, London, UK; 3Centre for Implementation Science & King’s College London, Denmark Hill, London, UK

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Background
The Centre for Implementation Science (CIS) and King’s Improvement Science (KIS) carried out patient and public involvement (PPI) activities separately until 2017 when both teams identified the need for more consistent models of PPI, so merged efforts to develop an overarching PPI strategy for the Centre that would be co-produced with members of the public living and/or using health services in South London.

The first workshop in September 2017 brought together 17 members of the public and 17 Centre staff to answer the question ‘How can we best include and involve people in the work of the CIS and KIS?’ This poster describes how we have scaled-up our PPI strategy, what we have achieved, and lessons learnt.

Method
Ideas from the initial workshop were developed and scaled up using several methods to co-produce our PPI strategy.

These include:
Consensus building methodology (used to facilitate the first workshop)
Focus groups and consultation meetings to action and develop ideas collaboratively

Ensuring we strive to include diverse members of the public throughout all stages

Results
Our achievements showcase how we have implemented our PPI strategy from ‘ideas’ to actionable achievable results.

These include:
Setting up the Public Involvement Advisory Panel to offer expertise and advise from public members to staff on projects within the Centre
Two public members recruited to our working group which oversees the operational running of the strategy
A monthly Involvement Bulletin to keep in contact with public members, build positive working relationships and offer opportunities to get involved
A guidance document being co-developed to offer advice and information for staff in the Centre on how best to carry out PPI activities

Conclusion
We have developed multiple ways to include public voices throughout the work of the Centre, striving for parity between academic and public members and we continue to move forward with public involvement that is not tokenistic, but trying to reach ‘beyond the usual suspects’ [1].

Acknowledgements
We would like to thank everyone, past and present, who have been involved in developing the strategy. We are especially grateful to all our public members for their time, invaluable expertise and contributions and for sharing their experiences and knowledge with us.

Reference

P29
Theoretical Domains Framework (TDF) and COM-B model based implementation study of a school-based, toothbrushing complex intervention
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Background
The school-based supervised toothbrushing program with fluoride toothpaste twice a day medical demand in the most deprived cohort of children. Health inequalities were decreased as well [1]. However, the implementation of a school-based brushing program is not merely based on oral hygiene instructions. Knowledge transfer has shown little effect on behaviour change. Changing behaviour requires an understanding of the context which behaviours occur [2]. The multifactorial nature of human behaviour made it difficult to evaluate this program through traditional randomized controlled trials. Therefore, we used a qualitative study design to analyse the potential facilitators and barriers in this complex intervention program [3].

Method
Focus groups and semi-structure interviews were used to collect the ideas from the elementary school students, teachers, and staff in this program. The topic guides were developed according to the Theoretical domains framework combined with COM-B Model. Data were analyzed with a content analysis approach.

Results
A sustainable environment which could encourage brushing behaviour was important. Toothbrush and toothpaste need to be supplied, and a set brushing schedule should be arranged. Brushing became a daily routine. Students may supervise each other brushing without the teachers’ help. Opportunity in COM-B model, instead of motivation or capability, was the key theme to implement the school-based brushing program.
Conclusion
Future studies will re-evaluate the program and develop a logic model in order to transfer the toothbrushing program to other schools.

Acknowledgements
This publication is independent research. The school-based toothbrushing program is funded and supported by Taiwan Academy of Pediatric Dentistry, and the Give2Asia organization.

References

O30
Use of the World Health Organisation Surgical Safety Checklist in Low and Middle Income Countries: A Systematic Review of Implementation Strategies Used and Outcomes Reported
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Implementation Science 2019, 14(Suppl 2):O30

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Background
The WHO Surgical Safety Checklist (SSC) reduces surgical morbidity and mortality by 50% but is not widely used in low and middle income countries (LMICs). Evidence of the effectiveness of SSC implementation in LMICs is lacking. Therefore, we aimed to systematically identify all SSC implementation studies in LMICs, the implementation strategies used, and critically evaluate success based on implementation outcomes.

Method
We used the PICO framework to design a systematic review of SSC implementation strategies and reported outcomes in LMICs, registering the study on PROSPERO. 73 strategies and 8 outcomes were predefined according to the Expert Recommendations for Implementing Change and Proctor’s implementation outcome framework respectively.

Results
We identified 1562 articles and included 45 in analysis. In preliminary analysis: mean number of strategies employed was 6 (range:0-24); most commonly from the “train and educate stakeholders” cluster (n=29) and least commonly from the “engage consumers” cluster (n=0) (Figure 1). Most commonly reported implementation outcomes were fidelity and penetration. Average penetration was 85% (95%CI=77%,90%) and average fidelity (adherence to basic safety measures) was 82%(95%CI=76%,86%); SSC use was associated with reduced mortality (RR=0.72,95%CI=0.63,0.82) and morbidity (RR=0.58,95%CI=0.47,0.72). Mean implementation strategy importance ratings were associated with increased fidelity and penetration but this was not statistically significant.

Conclusion
This systematic review identified wide variation in implementation strategies used and outcomes reported in LMICs. Successful implementation showed a non-statistically significant association with mean strategy importance rating, as well as an association with improved clinical outcomes.

O31
Scaling up the Obstetric Anal Sphincter Injury Care Bundle – Evaluation of clinical and implementation effectiveness of a national quality improvement project to reduce severe perineal trauma sustained during childbirth
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Implementation Science 2019, 14(Suppl 2):O31

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Background
Obstetric anal sphincter injuries (OASI) can severely affect quality of life. In England OASI rates amongst primiparous women tripled from 1.8% in 2000 to 5.9% in 2011 [1]. Aetiology is multifactorial, however, contributing factors are training inconsistencies, lack of awareness and variation in practice [1-3]. To address this, the OASI Care Bundle was developed and supported by the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM).

Method
Using a stepped-wedge trial design the intervention was sequentially rolled out every three months to four regions across England, Scotland and Wales [4]. Each region comprised of four maternity units of various sizes and types. Local clinical champions (midwives and obstetricians) cascaded training and educational materials within their units. Implementation was evaluated using mixed methods. A Theory of Change was developed to map how the desired reduction in OASI rates was expected to occur. Patient-level data (October 2016–April 2018) was collected to determine OASI rates pre- and post-intervention. A qualitative process evaluation examined acceptability, feasibility and sustainability for clinicians and women.
Results
The OASI rate was 3.3% pre- and 3.0% post-intervention (adjusted OR 0.79 (0.65-0.97), p=0.03). Most barriers to adoption of the intervention had corresponding enablers. Data capabilities varied, affecting ability to measure compliance. A heavy training burden was placed on champions, who had little or no dedicated time for this. Challenging autonomy and perceptions of women’s wishes created resistance amongst some clinicians. Success drove further uptake.

Conclusion
Change takes time. Complex topics require good communication and good feedback mechanisms. Appetite for change and senior buy-in facilitate engagement. Service-user support is a powerful enabler and women’s involvement is key. Our project increased team cohesion, which was strengthened by top-level support from the two Royal Colleges. This project offers a blueprint for effective scale-up of improvement interventions within maternity.

Acknowledgements
Local champions were key to success of the OASI Care Bundle and we are grateful to them for all their hard work and dedication to improving outcomes for women. The OASI Care Bundle was fully funded by the Health Foundation.

Trial Registration
The OASI Care Bundle is registered on the ISRCTN registry https://doi.org/10.1186/SRCTN2143325

References

O32 Evaluating the uptake of evidence-based guidance and associated determinants to inform implementation strategies that reduce maternal and perinatal morbidity in pregnant women with chronic hypertension: a mixed-method multi-centre study
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Implementation Science 2019, 14(Suppl 2):O32

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Background
Mortality from hypertensive disorders is reducing [1] but morbidity is prevalent [2]. Uptake of evidence-based guidelines and the associated determinants is unknown.

Method

Results
Survey (n=97)
Self-reported compliance with guidelines was high. Absence of anti-hypertensive prescribing guidance was mimicked by variance in reported practice.

Case-notes (n=55)
100% cessation of teratogenic medication thereafter variance in first-line anti-hypertensive prescribing existed. Target setting documentation occurred infrequently (56.4%) however action was taken when blood-pressure exceeded 150/100mmHg (76.5%) resulting in personalised setting (20%) and absent setting (23.5%). 45.5% of women developed severe hypertension.

Observations (n=23)
Provision of correct amount and type of information to support shared decision-making (52%). Women’s involvement in decisions (43%) and offered choice of anti-hypertensive (19%).

Women’s interviews (n=18)
14/18 experienced conflict about hypertension management, conflict resulted in 8/18 non-adhering (fig 1a). Facilitators to concordant adherence were found to be determined by ‘trust’ mediated by management of side effects, information and professional’s approach to women (fig 1b).

Clinician’s interviews (n=13)
Sub-optimal information was attributed to strength of anti-hypertensive evidence and lack of guidance. Clinicians also lacked SDM skills and tools. Optimal pathways and schedules of care are unknown.

Conclusion
Severe hypertension is prevalent. Strategies to reduce associated morbidity should engender ‘trust’ and improve target setting. Standardised pathways and schedules of care are required, accompanied by research into safety and effectiveness of anti-hypertensive.

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Trial Registration
South London Ethics Committee 17/LO/2041

References
O33
Scale-up of SmartVA, an electronic decision support tool to improve cause of death certification in The Philippines
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Implementation Science 2019, 14(Suppl 2):O33

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Background
The majority of deaths in Philippines occur out-of-hospital and require a medical certificate of cause of death (MCCD) by Municipal Health Officers (MHOs). In order to improve the quality of MCCD of home deaths, SmartVA auto-analyse, an electronic decision support tool for physicians was introduced to assist MHOs in the certification process.

Method
SmartVA Auto-analyse was implemented in a phased manner. A stakeholder consultation was followed by site visits and workshops with MHOs. A pre-test was conducted to assess feasibility and acceptability by MHOs in 13 municipalities. The intervention included training MHOs in SmartVA Auto-analyse, and MCCD (Fig 1). Next, the intervention was scaled-up to 50 municipalities across 6 regions. A mixed-methods evaluation was performed using cause of death data and group discussions with the MHOs and policy meeting with the Department of Health.

Results
During the pilot 5649 home deaths were registered (54% male). SmartVA used to certify 81% of all deaths (4333), for the remaining 19%, doctors could assign a cause of death based on the availability of medical records. Physicians agreed with the SmartVA diagnosis in 65% cases. Group discussions identified two key themes: 1) SmartVA was acceptable to MHOs, and 2) It standardised certification for home deaths and improved the quality of death certification. The Government plans to roll out the intervention in a phased manner over the next 2 years.

Conclusion
SmartVA can be implemented by MHOs and improve the quality of death certification of home deaths in Philippines.

Acknowledgements
The project was funded by Bloomberg Philanthropies and the Department of Foreign Affairs, Australia. We acknowledge the Country Coordinator, the Staff from the Department of Health, the implementing partners, all the participating Municipal Health Officers, and the respondents.

Figure 1 (abstract O33). Standard operating procedure for use of SmartVA Auto-analyse by physicians

O34
A systematic review of the implementation outcome instruments used in healthcare settings and their measurement properties
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Implementation Science 2019, 14(Suppl 2):O34

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Background
The use of validated instruments is needed to measure the implementation of evidence-based interventions and services [1]. To help researchers and practitioners identify relevant tools to measure implementation outcomes in physical healthcare settings, we conducted a systematic review aiming to identify quantitative implementation outcome measures, and critically appraise their psychometric properties [2].

Method
We searched seven databases (MEDLINE, EMBASE, PsycINFO, HMIC, CINAHL and the Cochrane Library), from inception to March 2017. A search update (March 2017-18) is currently ongoing. Eligible studies assessed measurement properties of implementation outcomes in physical healthcare settings. Proctor et al.’s framework [2] was used to select the implementation outcomes: acceptability, appropriateness, feasibility, adoption, penetration, implementation cost and sustainability. We used the CONSensus-Based Standards for the selection of health Measurement INstruments (COSMIN) checklist to assess their methodological quality [3] and a newly developed Contemporary Psychometrics (ConPsy) checklist to assess their robustness.

Results
Two reviewers independently screened 6,586 titles and abstracts, and 313 full papers. More than 50 publications were included, among which over half measured acceptability. Less than 10 studies measured each of the other implementation outcomes (figures pending update). Most studies reported some measurement properties. Content and structural validity were the most reported properties for the validity domain; and internal consistency for the reliability domain. Studies had overall poor or fair methodological quality, and the ConPsy checklist indicated poor instruments’ robustness. However, some acceptability measures, like the Ottawa acceptability of decision rules instrument [4], or the Impact of Health Information Technology Scale [3], had excellent methodological quality.

Conclusion
This review provides a much-needed repository of appraised implementation outcome instruments for physical healthcare settings. It highlights the efforts to quantify implementation outcomes, and the need for further psychometric testing of existing measures. It also encourages researchers to consider how to best measure feasibility, penetration, implementation cost and sustainability.

Acknowledgements
The research is supported by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care South London (CLAHRC South London) at King’s College Hospital NHS Foundation Trust.
Sabah Boufked and Zarnie Khadjesari received funding from the King’s Improvement Science (KIS), which is a part of the NIHR CLAHRC South London. KIS is funded by King’s Health Partners, Guy’s and St Thomas’ Charity, the Maudsley Charity and the Health Foundation.

References


P35
The role of Principal Investigators of research studies in the adoption and scaling up of healthcare interventions
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Implementation Science 2019, 14(Suppl 2):P35

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Background
The importance of assessing the impact of universities’ research is gaining importance with an increase in impact weighting in case studies from the 2014 to 2021 REF exercises. Similarly funders require Principal Investigators (PIs) to describe impact pathways and strategies for grant applications to demonstrate how research may be expected to inform policy or practice, and ultimately provide benefit to society. Historically the primary role of the academic has been to carry out rigorous and original research to add to disciplinary knowledge. This study aims to examine the role of the PI to describe the role of PIs in driving the adoption and uptake of their own research findings in the healthcare setting.

Method
Purposive sampling of the 163 REF 2014 impact case studies in Unit of Assessment 2 (Public Health, Health Services and Primary Care) was used to identify case studies, which cited a definitive effectiveness trial in the impact summary. Trial PIs will be emailed a questionnaire to describe the roles and work in driving the uptake of their research findings (or intervention). They will also be asked about what perceived freedoms/enablers or disincentives/barriers meant they have been able to do more/less impact generation than they would have liked, the role of serendipity/luck, how their role in enabling implementation has changed over time, and whether they made use of specific tools or frameworks to guide their evidence implementation efforts.

Results
Data will be analysed and presented using descriptive statistics.

Conclusion
The study will characterise the variety of roles that lead researchers can play in promoting the successful uptake or application of their research findings in health policy and practice, together with outlining the perceived contextual factors that have enabled (or constrained) them to adopt such roles.

P36
Assessment of involvement and perspective towards involvement of people with mental illness and their caregiver in the Indian mental health system: results from systematic review and the qualitative exploratory study
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Implementation Science 2019, 14(Suppl 2):P36

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Background
The National Mental Health Policy launched in India in 2014 encourages service user and caregiver involvement in the mental health system and the Mental Health Act passed in 2017 stipulates clear guidelines for service user and caregiver involvement. Yet there is no specific operational plan to encourage and improve service user and caregiver involvement in the revised National Mental Health Programme.

Methods
Two studies are conducted in a step-wise manner starting with a systematic review followed by the qualitative research study exploring the concepts of mental health service users and caregiver involvement and to assess barriers and facilitators affecting this involvement in the mental health service domain in India.

Results
Service user and caregiver involvement is a process that progresses parallel to the development and delivery of mental health care. Understanding perspectives of both service providers and service users for a common cause of user involvement, addressing stigma, testing strategies for greater involvement and engaging an external facilitator emerged as necessary interventions for effective user involvement to strengthen the mental health service in India.

Conclusions
People with mental health problems in India are in a serious need of basic mental health care which is accessible, acceptable and feasible to them and their families. Lack of a trained human resource is a major challenge to scaling up quality mental health care in India. Since emergence of ASHA as a community health worker, a notion of community based human resource supporting public health system has evolved as a prominent success story in the Indian public health domain. Therefore, the discourse on the involvement mental health service users and caregiver in the mental health service is most relevant and synonymous with community involvement and lay health worker participation to strengthen the Indian mental health service.

P37
Implementation of an online healthy weight toolkit to support practitioners working with pre-school children
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Implementation Science 2019, 14(Suppl 2):P37

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Background
Recent data shows Blackburn with Darwen (BwD) has a higher than average prevalence of both over- and under-weight in children starting school. Following local concern for the lack of pre-school child weight management provision, an 8-module online health weight toolkit was co-produced in partnership between local stakeholders and academic partners. All modules include guidance from the Royal College of Paediatrics and Child Health (RCPCH), National Institute for
Method
The implementation strategy draws on the Consolidated Framework for Implementation Research (CFIR) and involves multidisciplinary collaboration between academics, healthcare professionals, local authority commissioners and four public members. This presentation will reflect on the CFIR process and milestones in the implementation of the online tool. The shared learning will offer insight into how stakeholder engagement enhances the process of implementation.

Results
The process in engaging different stakeholders in the development of an implementation strategy consolidates the acknowledgment of local expertise. However, this process can be challenging when considering the inner and outer context in creating a strong partnership for implementation. For example it required ensuring shared vision, addressing team dynamics, alignment with local pathways, exploring individual role restrictions, and alignment with national policy/guidance.

Conclusion
The CFIR provided a structured framework that enabled exploration of different factors to support the process of engaging different stakeholders and public members in the development of an implementation strategy.

Acknowledgments
We would like to acknowledge the tremendous work of Dr Ruth Young in supporting the implementation of this project. We would also like to show gratitude to Shirley Goodhew for supporting the internship process of this project.

O38
Embedding implementation science in practice: learning from the Partner Priority programme
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Implementation Science 2019, 14(Suppl 2):O38

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Background
Increasingly, practitioners and other professionals are expected to be involved in research and evaluations not only as advisers but also as researchers. The Collaboration for Leadership in Applied Health Research and Care North West Coast (CLAHRC NWC) Partner Priority Programme (PPP) has undertaken an approach of work that facilitated this type of co-working, which in its third iteration set out to build capacity in Implementation Science. This offered a Consolidated Framework for Implementation Research (CFIR) through which practitioners could consider the drivers associated with the implementation of their projects.

Method
Four reflective narratives explore the journey travelled by practitioners new to the framework, reflecting the inside and outside setting, characteristics of the intervention and the individuals involved. Offering guidance as to how in the future their fellow professional could be engaged and enabled to deliver Implementation Science in their institutions.

Results
Being at the forefront of change is not easy, however, the CFIR offered the practitioners a means to discuss and understand the challenges they were facing in the implementation of their projects. No longer was it seen as a case of individually named people appearing to be obstructive. It became apparent that changes were challenging their knowledge and beliefs about the intervention as the new project did not sit easily with their understanding of the wider organisation. The characteristics of one project was found to be a major challenge not only in terms of delivery but also as a concept and practice within mainstream health care.

Conclusion
Practitioners need support to enable them to apply Implementation Science frameworks such as the CFIR. In particular, they need a learning environment in which to apply the methodology, reflect on the outcome, and assess the impact whilst continuing with the ‘day job’.

O39
Experience of using mental health indicators in six low and middle-income countries where mental health is integrated in primary care: a qualitative study
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Implementation Science 2019, 14(Suppl 2):O39

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Background
Efforts to scale up integrated mental health care in low and middle-income countries are underway. Some of these initiatives are focusing on strengthening information systems for mental health. In the previous publications, we described the need and the process of implementing key indicators covering mental health service delivery in lower and middle-income countries. These measures were introduced by a multi-country consortium Emerald (Emerging Mental Health System) at a district level in six LMICs (Ethiopia, India, Nepal, Nigeria, South Africa and Uganda).

Methods
In this paper, through a qualitative study with 128 in depth interviews, we assessed the feasibility, acceptability and utility of a set of indicators for routine monitoring of mental health care and evaluated the performance of a set of indicators for routine monitoring of mental health care.

Results
Most mental health indicators were deemed relevant and potentially useful for improving care, and therefore acceptable to end users. Exceptions were indicators on functionality, cost and severity. The simplicity of the data capturing formats contributed to the feasibility of using forms to generate data on mental health indicators. Health workers reported increasing confidence in their capacity to record the mental health data and minimal additional cost to initiate mental health reporting. However, over stretched primary care staff and the time-consuming reporting process affected perceived sustainability.
Conclusion
This qualitative study provides a potential model for evaluating the use of mental health information systems across low and middle-income countries and recommends key feasible indicators to be adapted for similar settings.

O40
Amalgamating theoretical frameworks to understand individual and organisational level implementation
Stephanie Best1,2, Janet C Long1, Melissa Martyn3,4, Clara Gaff3,4, Jeffrey Braithwaite1, Natalie Taylor6
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Implementation Science 2019, 14(Suppl 2):O40

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Background
Despite the rapid advances in genomic medicine, few studies incorporate implementation science theoretical frameworks.1 When exploring implementation on multiple levels, for example the use of clinical genomics in Australia, it can be challenging to identify a single appropriate approach and amalgamating frameworks may be advantageous. We used two frameworks to learn from early adopters to design interventions to support initial implementation and sustainability of genomics in wider and less genetically specialised healthcare settings.

Method
Working with Australian Genomics and Melbourne Genomics, we interviewed 37 people with experience of clinical genomic testing. i) non-genetic medical specialists, using the Theoretical Domains Framework (TDF) to understand determinants of practice along the patient journey ii) service-level decision makers, using the Translation Science to Impact framework (TSci) to understand organisational and external factors affecting translation phases. Individual and organisational barriers and enablers were coded to the TDF and the TSci, respectively. Areas for overlapping themes across frameworks were explored.

Results
Clinician level barriers and enablers were identified across four key target areas (patient identification, test selection, communicating results, and mainstreaming) along the genomics pathway and represented all of the TDF domains. Service-level factors were identified to represent all the TSci Key Issues across the pre-adoption, adoption, implementation and sustainability phases relating to ‘Needed Practice Supports’. Overlap between frameworks was found across all target areas, but predominantly for clinician-identified barriers and enablers to mainstreaming of genomics which covered all TSci phases.

Conclusion
Our study highlights the potential to combine different theoretical frameworks to maximise the value of theoretical approaches in highly complex settings. The next steps will be to explore the extent to which a theory driven approach to intervention design (e.g., behaviour change techniques) can be applied to address both individual and organisational level barriers.

P41
Implementing rapid genomic testing in acute paediatric care in Australia
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Implementation Science 2019, 14(Suppl 2):P41

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Background
Genomic testing, reading the entire genetic information, provides an opportunity to end the diagnostic journey for many patients with rare disease. Typically, return of results takes around six months – a timeline too slow for the management of acutely-unwell children. Whilst faster turnaround times can deliver more clinically useful results, it demands a restructure of the whole genomics pathway and causes disruption to traditional practices.

Melbourne Genomics led a rapid-genomic testing (<21days) real-world project in two hospitals. We used implementation science principles to learn from this project and apply them in an Australian Genomics multi-centre project for ultra-rapid genomic testing (<5days) in acutely-unwell children.

Method
Data on the barriers and enablers to implementation were gathered (observations at multidisciplinary team meetings, research journals (February 2016-September 2017) from the project leads and participating genetic clinical and laboratory staff. The multi-centre project data collection also included interviews with laboratory scientists, genetic clinicians and paediatric intensivists (April-June 2019). Analysis was undertaken using the Consolidated Framework for Implementation Research (CFIR).

Results
Several CFIR constructs were prominent (see table 1) across both hospitals. Enablers were identified, and outcomes noted.

Conclusion
Accounting for organisational culture and tailoring implementation science principles to real-world problems are key to success. Using implementation science theory has enabled structured learning from one project and facilitated the initiation of a multi-centre project that will inform the next steps of delivering genomic testing in the acute paediatric setting.

Reference
1. Stark et al, Meeting the challenges of implementing rapid genomic testing in acute pediatric care Genetics in Medicine, 2018, 20(12), 1554-1563.
## Table 1 (abstract P41). Example CFIR construct, barriers, solutions, and outcome (adapted from Stark et al.)

<table>
<thead>
<tr>
<th>CFIR construct</th>
<th>Barrier</th>
<th>Enabler identified</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Networks &amp; Communications</td>
<td>Delay in referral to clinical genetics</td>
<td>Clearly communicate availability of rapid genomic testing and indications for referral</td>
<td>Easier referrals to clinical genetics</td>
</tr>
<tr>
<td>Relative advantage</td>
<td></td>
<td>Ensure referrers get feedback on diagnostic and clinical impact of rapid genomic testing, e.g. at monthly NICU meetings</td>
<td>Increased number of referrals to clinical genetics</td>
</tr>
<tr>
<td>Implementation climate</td>
<td>Parental difficulty processing complex information in a stressful environment</td>
<td>Increased genetic counselling support in the acute setting</td>
<td>Higher rate of rapid genomic testing acceptance by families</td>
</tr>
<tr>
<td>Adaptability</td>
<td>Results batched ready for weekly dedicated MDT meeting</td>
<td>Initiate multidisciplinary team meetings for single cases, with minimum quorum defined</td>
<td>Reduction in time to report</td>
</tr>
<tr>
<td>Formal implementation leaders</td>
<td>Absence of an established rapid genomic testing pathway</td>
<td>Clinical and laboratory champions identified</td>
<td>Formal rapid genomic testing operating procedure established</td>
</tr>
</tbody>
</table>

Interviews for the multi-state trial are ongoing. Early findings indicate the importance of relationships between genetic and paediatric intensivist staff.

### P42

**Social prescribing for people with motor neurone disease in Liverpool: enabling access to local well-being activities to prevent social isolation and mental ill health**

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**Implementation Science** 2019, 14(Suppl 2):P42

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**Background**

Motor neurone disease (MND) affects around 5,000 people in the UK. This project aims to identify potential services and activities provided by the third sector in the Sefton and Liverpool area that can support psychological wellbeing in people living with MND (plwMND).

**Method**

This project is part of the NIHR CLAHRC NWC Partner Priority Programme, enabling partner organisations to implement services collaboratively with academics and the public. The project team includes three public advisors, two with experience of caring for someone with MND, and one working for a third sector organisation providing information and advice services for individuals with neurological conditions. Recruitment is carried out by MND association visitors, outpatient and community therapists. To ensure the occupation is based on the person’s interests, the Modified Interest Checklist is used [1]. Once suitable activities are identified, the project lead attends the activities with the plwMND, acting as a support for the plwMND and the activity provider for a total of six weeks.

Referrers complete questionnaires prior to recruitment to establish their current use of wellbeing services, and quality of life measures are administered to the plwMND and their family carer pre and post intervention. Interviews will be carried out post intervention with plwMND and their family carer, the referrers, and community providers.

**Results**

Starting in February, two plwMND have utilised the service so far. Both have recently finished working and expressed concern that they had no structure or purpose. They have chosen varied activities including reading and history groups, art classes, bird watching, and accessible exercise.

**Conclusion**

Currently, we are at the beginning of this implementation project. Findings will have important implications on how a social prescribing service can be provided to plwMND, and if successful, how this service can be rolled out wider across the region and nationally.

**Acknowledgements**

This study was part-funded by The National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care North West Coast (NIHR CLAHRC NWC). The views expressed here are those of the author(s) and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care.

**Reference**


### P43

**Stakeholder-driven, mixed-methods implementation evaluation of two psychoeducational programmes to reduce the incidence of severe hypoglycaemia in type 1 diabetes**

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**Implementation Science** 2019, 14(Suppl 2):P43

**Correspondence:** Tayana Soukup (tayana.soukup@kcl.ac.uk)

**Background**

In line with the Medical Research Council’s (MRC) recommendations for evaluating complex interventions [1-3], we have set out to evaluate implementation of two novel psychoeducational courses for people with type 1 diabetes (T1D) and problematic hypoglycaemia. The courses are delivered within a hybrid type 2 effectiveness-implementation cluster randomised trial (4; NCT02940873). Here we report co-design of the implementation arm of the trial.

**Method**

This was an international, multisite study conducted October-December 2017 across 5 diabetes centres in England, UK, and Massachusetts, US. We conducted 11 focus groups with overall 28 intervention stakeholders, including, individuals with lived experience of T1D and hypoglycaemia unawareness (n=6 attending 2x1.5hrs focus groups), and healthcare professionals (HCPs; n=22; physicians, nurses, dietitians, psychologists and support staff attending 9x1hr focus groups). We were guided by the tool for designing implementation research [5-6], including also:

- MRC framework [1-3],
- Reach Effectiveness Adoption Implementation Maintenance [7],
- Consolidated Framework for Implementation Research [8-9],
- Implementation outcomes by Proctor et al [10], and

In a qualitative manner, the stakeholders reviewed for relevance, feasibility and clarity a selection of outcomes, tools [12], approaches, measurement time-points and participant groups. Following each
meeting, stakeholders’ feedback was incorporated in an iterative manner – until the final versions of the materials were produced for implementation within the trial.

**Results**

Stakeholder input has enabled relevant, feasible, and appropriate implementation outcomes, validated surveys, interview questions, participant groups, and measurement time-points to be identified. The final outcomes included acceptability, feasibility, appropriateness, fidelity, context, unintended consequences and implementation cost. Mixed-methods approach was deemed most acceptable.

**Conclusion**

Our study offers a stakeholder-driven methodological approach to co-designing an evaluation of complex intervention implementation within a hybrid trial. Input from HCPs and people with lived experience, who co-authored this work, continues to be instrumental in maximising relevance of this research.

**Acknowledgements**

We would like to thank the representatives of the people with type 1 diabetes, as well as the health care professionals involved, for their time and commitment in the design of this study protocol.

**References**


**Table 1 (abstract O43). Stakeholder-driven data collection plan for the implementation study: assessment objectives, data, instruments, timeline and participants**

<table>
<thead>
<tr>
<th>Study outcomes</th>
<th>Definition of the study outcome</th>
<th>Data type</th>
<th>Data collection method</th>
<th>Measurement time-point</th>
<th>Stakeholder groups*</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPLEMENTATION OUTCOMES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Acceptability [8]</td>
<td>Extent to which programme is perceived to be acceptable and acceptable for hypoglycaemia and diabetes management.</td>
<td>Quantitative</td>
<td>AIME survey</td>
<td>Post-intervention</td>
<td>HCPs, people with T1D and their relatives</td>
</tr>
<tr>
<td>2. Appropriateness [8]</td>
<td>Extent to which programme is perceived to be fit and relevant for hypoglycaemia and diabetes management.</td>
<td>Quantitative</td>
<td>IAIM survey</td>
<td>Post-intervention</td>
<td>HCPs, people with T1D and their relatives</td>
</tr>
<tr>
<td>3. Feasibility [8]</td>
<td>Extent to which programme can be successfully used or carried out to reduce incidents of severe hypoglycaemia.</td>
<td>Quantitative</td>
<td>FIM survey</td>
<td>Post-intervention</td>
<td>HCPs, people with T1D and their relatives</td>
</tr>
<tr>
<td>4. Fidelity of delivery [8]</td>
<td>Extent to which programme is delivered as intended.</td>
<td>Qualitative</td>
<td>Checklist</td>
<td>Post-intervention</td>
<td>Diabetes educators and psychologists</td>
</tr>
<tr>
<td>5. Fidelity of receipt [8]</td>
<td>Extent to which programme is received as intended.</td>
<td>Qualitative</td>
<td>Interview</td>
<td>Post-intervention</td>
<td>People with T1D</td>
</tr>
<tr>
<td>6. Adoption [8]</td>
<td>Intention to adopt and use the knowledge and skills learned in the programme in everyday hypoglycaemia and diabetes management.</td>
<td>Qualitative</td>
<td>Interview</td>
<td>Post-intervention</td>
<td>HCPs, people with T1D and their relatives</td>
</tr>
<tr>
<td>7. Sustainability [8,12]</td>
<td>Facilitators and barriers to sustained use of the programme</td>
<td>Qualitative</td>
<td>Interview</td>
<td>Post-intervention</td>
<td>HCPs, people with T1D and their relatives</td>
</tr>
<tr>
<td>8. Implementation costs [8,12]</td>
<td>Costs associated with prospective implementation of the programme</td>
<td>Qualitative</td>
<td>Interview</td>
<td>Post-intervention</td>
<td>HCPs, people with T1D and their relatives</td>
</tr>
</tbody>
</table>

**OTHER OUTCOMES:**

9. Unintended consequences of programmes [8] | Positive or negative consequences that are not anticipated at the time of programme implementation. | Qualitative | Interview | Post-intervention | HCPs, people with T1D and their relatives |
10. Contextual factors [8] | Facilitators and barriers to the implementation of the programme. | Qualitative | Interview | Post-intervention | HCPs, people with T1D and their relatives |
11. Implementation strategies [8,11] | Strategies used to deliver and implement the programme; they refer to methods or techniques to enhance and promote adoption, implementation and sustainability of the programme. | Qualitative | Interview | Post-intervention | HCPs, people with T1D and their relatives |

**Note:** *HCPs = Health Care Professionals incl. diabetes educator, physician, psychologist, and administrative support; IAM = Intervention Appropriateness Measure [12]; IMR = Implementation Measurement Research [11]; FIM = Feasibility of Intervention Measure [12]; §FIM = Feasibility of Intervention Measure [12]

**O44**

Looking into determinants and mechanisms related to the implementation of a pain management guideline in nursing homes

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Implementation Science 2019, 14(Suppl 2):O44

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**Background**

Underutilization of evidence-based pain management in nursing homes is common. Evidence towards effective approaches to improve adoption of evidence-based practices in nursing homes is limited. Furthermore, little is known about the mechanisms of how implementation strategies affect
practice change [1]. This study uses a mixed-methods approach to explore the mechanisms and determinants related to the implementation of a pain management guideline in Swiss nursing homes.

Method
We conducted a process evaluation alongside an effectiveness-implementation study in four nursing homes. Based on an a priori contextual analysis in the participating homes, we developed a conceptual framework describing the hypothesized interactions of implementation strategy, contextual factors, mechanisms, and implementation outcomes. With a care worker questionnaire survey at baseline (n=136), after three (n=99) and six months (n=83) we assessed our hypothesized central mechanism, self-efficacy in pain management, and self-reported guideline adoption. We computed linear mixed-effect models to assess changes over time in self-efficacy and logistic regressions to assess associations between self-efficacy and guideline adoption. Concurrently, we conducted focus groups with care workers (n=16) to gain a deeper understanding of the implementation process, interactions between potential mechanisms, determinants and outcomes of the implementation. Qualitative data was analysed using a deductive thematic analysis approach.

Results
Overall, there was a significant increase in self-efficacy after three and six months (p<0.001). Self-reported adoption of guideline components ranged between 44% and 73%. We found significant associations between self-efficacy and adoption of some guideline components, e.g., performing a comprehensive pain assessment. Qualitative findings indicate a different response to implementation strategies by registered nurses and nursing aides, e.g., in role empowerment. Training workshops increased awareness towards pain, stimulating changes in pain assessment behaviour.

Conclusion
Understanding implementation processes in a multilevel context is challenging. Developing a conceptual framework can facilitate the exploration of potential mechanisms and influences of contextual factors.

Reference

P45
Impact of evidence-based healthcare education for Chinese medicine practitioners: A pre-post evaluation
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Method
We conducted a process evaluation alongside an effectiveness-implementation study in four nursing homes. Based on an a priori contextual analysis in the participating homes, we developed a conceptual framework describing the hypothesized interactions of implementation strategy, contextual factors, mechanisms, and implementation outcomes. With a care worker questionnaire survey at baseline (n=136), after three (n=99) and six months (n=83) we assessed our hypothesized central mechanism, self-efficacy in pain management, and self-reported guideline adoption. We computed linear mixed-effect models to assess changes over time in self-efficacy and logistic regressions to assess associations between self-efficacy and guideline adoption. Concurrently, we conducted focus groups with care workers (n=16) to gain a deeper understanding of the implementation process, interactions between potential mechanisms, determinants and outcomes of the implementation. Qualitative data was analysed using a deductive thematic analysis approach.

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Background
The WHO Traditional Medicine Strategy 2014-23 has been promoting the development of complementary medicine using evidence-based healthcare (EBHC) approach. The Hong Kong government has adopted this approach to ensure safety, quality and efficacy of Chinese medicines. However, little is known about the perspectives of Hong Kong Chinese medicine practitioners (CMPs) on EBHC. We aimed to examine key facilitators and barriers of applying results from evidence-based synopses in routine practice among Hong Kong CMPs.

Method
Four synopses with the summary of systematic reviews and randomized controlled trials on Chinese medicine interventions were presented to CMPs (n=15). Qualitative face-to-face interviews on their views on these synopses were then conducted. A semi-structured interview guide was designed based on the Consolidated Framework for Implementation Research (CFIR). CFIR was also used as a framework to guide the analysis by means of categorizing barriers and facilitators of applying results from evidence-based synopses in CMPs’ routine practice.

Results
Analysis of the interview identified seventeen constructs in four CFIR domains: intervention characteristics, outer setting, inner setting and characteristics of individuals. Facilitators which promoted the application of evidence-based synopses in CMPs’ routine practice included adaptability, cost, patient needs and resources, external policy and incentives. Barriers of the intervention included complexity and available resources. Constructs that acted as both facilitators and barriers included interventional source, evidence strength and quality, relative advantage, peer pressure, structural characteristics, compatibility, access to knowledge and information, knowledge and beliefs about the intervention, self-efficacy, individual identification with organization and culture.

Conclusion
This study distinguished a number of CFIR constructs and illustrated how they influenced the application of results from evidence-based synopses in routine practice among Hong Kong CMPs. Findings have
indicated the importance of providing continuing education on EBHC for CMPs which may facilitate the integration of clinical research evidence into their routine practice.

P47
Bridging communication gap in HIV treatment programs through Closed user group (CUG) mobile technology: Approach to HIV patient monitoring and referrals services on the Strengthening integrated delivery of HIV/AIDS services project

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Background
Timely and complete referrals for HIV clients in need of care within health facilities, facility-community and inter facility is crucial in closing the gaps for HIV care. Monitoring, tracking and routine interaction with HIV clients by health workers and case managers has been proven to reduce leakage in treatment cascades and improve retention in care. However, most health facilities in Nigeria are challenged by the non-existence of communication infrastructure or resources required to facilitate timely tracking and completion of referrals for HIV positive clients. The USAID-funded Strengthening integrated delivery of HIV/AIDS services (SIDHAS) project implemented the provision of closed user group (CUG) mobile technology as a strategy to closing the gap.

Description
SIDHAS procured 2,606 mobile phones and lines, distributed to 785 health facilities, laboratories and 28 community-based organizations across 13 states in Nigeria. Mobile networks were distributed according to the strength of network available in the locale. The CUG allowed health workers providing HIV care and treatment services to call each other within the network with zero charges and to follow up HIV clients referred within service delivery points and those referred to other health facilities to ensure complete referrals. A desk review was conducted on the CUG directory and communication logs for 4 states between June – December 2017.

Lessons learned
Review of the phone directory and call logs shows evidence of inter and intra facility communications, therefore contributing to improved referral and linkage rate from 39% to 74% within the period for some states. Data collected from 4 states also showed about 2240 defaulter returned within the period compared to 785 that returned to care before the CUG implementation. Overall, Improvement in completion rates for referrals and tracking and provision of adherence support to HIV clients was recorded.

Conclusions/Next steps
Given the results demonstrated by removing communication barriers and bridging the gap through CUG innovation, expanding CUG distribution to support groups in communities can be explored to reduc-

P49
Lessons learnt from a novel HIV care & treatment funding model for health facilities in Nigeria, a resource constrained country: The reimbursement for incidentals (RFI) funding model

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Background
Partnership between the governments of Nigeria (GoN) and the United States (USG) through PEPFAR aims to strengthen the capacity to scale up HIV prevention, care and treatment services in Nigeria. While PEPFAR streamlined operational health facility costs in 2014, the GoN was unable to adequately fund operational HIV/AIDS related services. As a result, health workers were using their personal funds to pay for operational costs, and when they could not, services were not administered. In response to these gaps in care, the SIDHAS project developed the RFI funding model to better cover health facility operational costs. The RFI model reimburses health facilities through service providers, for operational cost incurred during service delivery. This abstract describes lessons learnt using the RFI funding model.

Description
The RFI funding model for 13 SIDHAS-supported states in Nigeria was developed to cover operational health facility costs such as telephone cards and home visits for HIV clients, internet costs for data entry, transport for sample logging to hub laboratories, and quality improvement measures. Funds reimbursed for operation costs to each health facility were calculated at 110 naira ($0.31 US) per client currently on ART in comprehensive treatment facilities and 300 naira ($0.83 US) per pregnant woman tested for HIV in PMTCT standalone facilities. The model reimbursed health workers monthly using standardized verifiable activity request and report forms.
Lessons learned
The RFI funding model was adopted in 100% of health facilities across 13 SIDHAS supported states in Nigeria. Health workers were motivated because of the RFI model directly reimburses cost incurred during service delivery. Improvement in service delivery was recorded, resulting in more clients visiting health facilities. Monthly pay out to health facilities improved from an average of 57% in 2015, to 66% in 2016 and 84% in 2017.

Conclusions
The RFI model has proven to be a motivational tool for health workers and a means to fund and improve HIV care treatment related operational costs in a resource-constrained country such as Nigeria.

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