EIE 2025: Poster presentations June 5, 2025

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"We need support, now!" Findings of a pragmatic implementation science study to address COVID-19 challenges in the Canadian long-term care and retirement home setting

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Research aim

To describe the creation and impact of a pragmatic support program designed using co-creation methods to address COVID-19 challenges within long-term care homes (LTCH) and retirement homes (RH), while facilitating the advancement of biomedical, clinical, and implementation science.

Setting

LTCH and RH in Ontario, Canada, were one of the groups most affected by COVID-19, yet had little capacity to participate in research in the midst of their pandemic response. We formed a multidisciplinary network to define biomedical, clinical, and implementation science research questions for this population.

Method(s)

We interviewed 91 leaders from 47 LTCH/RH to identify their COVID-19 challenges, and used theoretical mapping to design the Wellness Hub support program. Homes were assigned to a control (self-guided resources) or intervention (facilitator-guided resources with access to community of practice) arm based on capacity and interest to participate in multidisciplinary research. We evaluated homes' rate of challenge resolution (rate/10 challenges, rate-ratio, 95% confidence interval, CI) using a Poisson regression model. By gaining access to homes via Wellness Hub, we were also able to facilitate SARS-CoV-2 biomedical and clinical research in these settings.

Key finding(s)

Wellness Hub addressed infection prevention and control (IPAC), vaccine uptake, and staff well-being challenges. Challenge resolution rate for the intervention arm was 5.23 (CI:4.61-5.94) compared to the control rate of 2.59 (CI:1.99-3.38), resulting in a 2.02 rate-ratio (CI:1.50-2.70,p=<0.0001). The intervention yielded a nearly two-fold (rate-ratio:1.85,CI:1.25-2.73,p=0.002) and four-fold (3.78,CI:1.97-7.25,p=<0.0001) higher resolution of IPAC and vaccine challenges, respectively. No significant differences were observed for well-being challenge resolution. Home type and size were not associated with resolution rate. Wellness Hub facilitated collecting n=1,615 biological samples and surveys, data from 72 LTCH/RH and SARS-CoV-2-wastewater analysis (12 LTCH/RH, 20 neighbourhoods).

Discussion

What do our findings tell us about the feasibility of balancing scientific rigor with immediate pragmatic needs of at-risk populations during a health emergency? What can we learn about how to leverage implementation practice to facilitate rigorous implementation science, biomedical, and clinical research in future health emergencies? How do we sustain implementation of supports post-pandemic, in particular to address the ongoing well-being and mental health needs in LTCH/RH?

Challenges

The urgent need to support homes during the pandemic precluded our ability to conduct a randomized trial. COVID-19 needs evolved throughout the pandemic, requiring our team to be nimble and responsive in our delivery of Wellness Hub interventions, which demonstrated significant impact.

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Co-creating climate services for behaviour change in the climate change-health-energy nexus: Insights from Germany and Taiwan

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Research aim

CoCareSociety aims to explore the interconnected factors linking climate change, long-term care and health of older society members and their energy efficiency in the living environment. Our work employs co-creation to develop tailored climate services that encourage both immediate and long-term behaviour change through incentives and personal motivation.

Setting

We examine implementation within an interconnected nexus that brings together three sectors: climate change, health and care, and energy. Our focus is on addressing specific needs and considerations of older adults and aging populations within these sectors.

Method(s)

Co-creation of narratives and semi-structured interviews are employed to develop tailored climate services. Workshops were held in Germany and Taiwan with older adults and stakeholders working with them to gain insight into current practices and possible motivators for behaviour change. Interviews based on the COM-B model for behaviour change were conducted with stakeholders from several levels of Bronfenbrenner's Social Ecological Model (SEM) to examine how several layers of influence (e.g. public policy, community, organisational, interpersonal and individual) affect an individual's capacity to change their behaviour (e.g. capability, opportunity, and motivation). Climate services will be co-developed and tested in living labs.

Key finding(s)

Several factors across various levels of influence impact an older adults' ability to make climate-friendly and sustainable decisions. Incentives must leverage the motivations and priority of older adults within the parameters in which they currently live. Both short and long-term desired behaviour changes must be considered relevant, doable, and appealing for the action to be implemented.

Discussion

How can available support systems within existing networks, such as community organisations, family, and friends, be leveraged to influence how older adults access and trust information? How might one's health status, income, language spoken, ethnicity, perception of risk, and financial resources impact the implementation of desired behaviours and what can be done to overcome this?

Challenges

In working with older adults and diverse stakeholders we had several lessons learned. The concept of interactive workshops was new to some and thus, instructions should be kept as simple as possible. Several mediums must be utilized including both digital and paper-based materials.

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Implementing the Multi-Disciplinary Expertise Team method to reduce involuntary care in intellectual disability care: Multi-methods study evaluating adaptations and effectiveness

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Research aim

Intellectual disability care organisations need to reduce involuntary care. The Multi-Disciplinary Expertise Team (MDET) method proved effective in a previous trial with 20% more reduction of involuntary care compared to CAU. The current study examined how four organisations adapted MDET during implementation, and tested whether these versions were also effective.

Setting

In the Netherlands, the new Care and Coercion Act in 2020 required intellectual disability care organisations to implement new methods that aim to increase clients' self-determination and reduce involuntary care practices. Involuntary care is defined as care provided without clients' consent.

Method(s)

To describe adaptations made to MDET during implementation in four organisations semi-structured interviews with MDET-coordinators were analysed using the Framework Reporting Adaptions and Modifications-Expanded. A quasi-experimental interrupted time-series design tested change in weekly counts of digital involuntary care recordings from before to during MDET implementation, in care homes that implemented MDET (n = 22) compared to care homes providing care-as-usual (CAU).

Key finding(s)

All organisations adapted the MDET method to fit into their work structure and to comply with care professionals' needs. Adaptations varied per organisation. These included implementing MDET without an independent MDET-team, reducing the number of care team professionals involved in discussions, and loosening recordings of involuntary care. No differential changes in recordings were found before and after implementing MDET, nor between the implementation- and CAU-groups.

Discussion

Scaling-out MDET led to adaptations that may have undermined its effects on reducing involuntary care. The plasticity of multi-component methods was theorized as beneficial in implementation processes, as this would allow organisations to tailor these methods to specific contexts. However, the current study suggested that efforts of care professionals concerning the change work routines, structures and relations within organisations, may be necessary to contribute to the expected objectives and outcomes. Question to discuss with the audience: What are experiences of researchers concerning this topic? How can researchers invite care organisations to put in the effort to change work routines?

Challenges

In response to Covid-19 care organisations suspended MDET. Discussions led to the insight that there might be an opportunity to attend to the adverse effects of involuntary care on clients' well-being, given that COVID-19 restrictions made everyone aware of these effects. All organisations resumed MDET, with adaptations to simplify implementation.

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Improving guideline-based care for suicide prevention in mental healthcare: an implementation science approach

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Research aim

To enhance adherence to clinical practice guidelines for suicide prevention in mental healthcare by employing an implementation science approach. We evaluate determinants and implementation strategies, and the effect of the implementation on quality of care and professionals' self-efficacy.

Setting

The study takes place in five diverse Dutch mental healthcare institutions, which collectively treat approximately 100,000 patients annually. These institutions offer a mix of inpatient, outpatient, and long-term residential care. The project builds on prior efforts in suicide prevention, targeting systematic improvement across multiple care levels and contexts.

Method(s)

The study adopts the KTA framework, focusing on its action cycle, and integrates CFIR to assess implementation determinants and RE-AIM for evaluating outcomes. Initial activities included institution-specific baseline assessments and identification of project goals within each MHI based on these assessments. Tailored strategies, ranging from leadership engagement to a suicide prevention Toolkit, were offered to each MHI. The evaluation approach incorporates pseudonymized patient data, surveys on professional self-efficacy and knowledge, and interviews with healthcare staff to explore contextual influences on implementation success. Feedback loops enable iterative adjustments, fostering alignment between institutional goals and effective guideline-based care.

Key finding(s)

Baseline assessments revealed that most healthcare professionals consider themselves confident in dealing with suicidality, though guideline adherence remained low on several elements, including targeted treatment for suicide prevention. Midway evaluation of the project reveals that MHIs have largely been too ambitious when formulating initial goals, and progress is often slower than imagined. Large-scale activities targeting the organisation as a whole seem less effective than smaller team-based approaches, which improved motivation and readiness to change. Through regular meetings, project leaders of all participating MHIs have been encouraged to share materials and processes, which has led to several between-MHI collaborations.

Discussion

This study aims to improve guideline implementation while addressing the underutilization of appropriate implementation science frameworks within the mental health field. This research represents a step towards bridging the gap between guideline development and practical application in mental healthcare, striving to make a meaningful impact on suicide prevention efforts. The integration of comprehensive implementation science frameworks provides a systematic and evidence-based foundation for fostering sustainable improvements in guideline adherence, ultimately contributing to a more effective and responsive mental healthcare system. This work

highlights the potential of implementation science to drive meaningful, sustainable improvements in mental healthcare practices.

Challenges

Communication with and within the MHIs has been challenging. The researchers engage mostly with the project leaders. Before steps toward implementation are taken, activities often have to be discussed internally at various levels in the organisation. This makes it difficult to keep the momentum going and keep track of progress.

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Evaluating the Long-Term Impact and Cost-Effectiveness of Antenatal Magnesium Sulphate Implementation for Neonatal Neuroprotection in the UK

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Research aim

Evaluate the long-term impact of the national PReCePT Quality Improvement (QI) to increase magnesium sulphate ($MgSO_4$) uptake for preventing cerebral palsy in preterm births. Compare use in England, Scotland, and Wales. Demonstrate the value of implementing $MgSO_4$ using health economics. Explore knowledge mobilisation to improve adherence to clinical guidance.

Setting

$MgSO_4$ in preterm labour is an evidence-based intervention to prevent neurological damage to the infant. However, uptake has varied across UK maternity units since then. In 2018, NHS England rolled-out the National PReCePT programme as QI implemented in maternity units, providing clinical guidance, training, learning resources, backfill funding, and support.

Method(s)

Data from the National Neonatal Research Database on preterm babies admitted to NHS neonatal units were used to assess the impact of PReCePT on MgSO4. Long-term impact was evaluated through interrupted time series analysis. We valued MgSO4 implementation for babies under 32 weeks' gestation from 2014-2022 in England, Scotland, and Wales, estimating its societal lifetime INMB and the cost-effectiveness of a hypothetical future QI programme. Data collected via semi-structured interviews for the PReCePT National Programme, PReCePT study, and a study in Scotland and Wales, were analysed using Normalisation Process Theory and the framework method.

Key finding(s)

$MgSO_4$ administration rose from 32% in 2014 to 85% in 2022 in the three nations. In England, PReCePT was associated with a 5.8 percentage points improvement (95%CI 2.69 to 8.86, $p<0.001$), mainly within the first two years. PReCePT had an INMB of £597,000 with 89% probability of being cost-effective. The onset of the pandemic coincided with a decline in $MgSO_4$ use. Interviews with 68 strategic and clinical leads and implementers from the three nations suggested that cross-organisational communities of practice enhanced success. $MgSO_4$ is still under optimal uptake (calculated as 95%), and future implementation initiatives are likely to be cost-effective.

Discussion

- What factors contributed and will contribute to the variation in the implementation of $MgSO_4$ across different maternity units, and how can these challenges be addressed to ensure more consistent adherence to clinical guidelines?
- Would 'incremental net monetary benefit' (INMB) provide a useful and comprehensible approach to guide the allocation of resources to support improved implementation of guidelines, and what future steps can be more systematically conducted economic evaluation of such initiatives?

Challenges

Variations in $MgSO_4$ implementation, the COVID-19 pandemic, data collection and analysis, interdisciplinary coordination, and communication between professionals. We addressed these through rigorous methodological approaches, QI support and implementation investment, which facilitated cross-organisational learning leading to effective knowledge mobilisation. These key factors improved $MgSO_4$ implementation and ensured its cost-effectiveness and sustainability.

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Applying implementation at the micro level in animal health through empowerment of non-specialists in implementation

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Research aim

This research aims to adapt and apply the principles of implementation to encourage uptake of evidence-based practices (EBPs) on ruminant (beef, sheep, dairy) farms. We aim to address the complexity of implementation across variable settings by empowering non-specialists in implementation to apply implementation science principles on an individual farm level.

Setting

This work is in the field of animal health – specifically working on individual ruminant (beef, sheep, dairy) farms involving the farmer, farm workers, and their usual veterinarian. Ruminant farms are highly variable settings, with each involving a small number of actors, and having different modes of operation and challenges.

Method(s)

To overcome the challenge posed by diverse settings with limited resources, we are seeking to adapt implementation principles to be applied directly by veterinarian-farmer partnerships on an individual farm level through development of a novel process model (NPM). Veterinarians and farmers will utilise the NPM themselves to guide implementation and sustainment of EBPs, independent of support from implementation specialists. Development of the NPM involved incorporating existing theory to create a draft NPM, then adapting and tailoring this for farm settings through a process of expert and stakeholder consultations. A feasibility trial exploring the use of this NPM is currently underway.

Key finding(s)

Successful implementation can be achieved on an individual farm level through empowerment of non-specialists with pre-existing involvement. Specifically, the NPM and approach developed facilitates this through:

- A co-productive approach using existing actors in the setting who are, respectively, experts in animal health and in the setting.
- Clear guidance of key areas for discussion/ decision-making. This allows the key facets necessary for implementation to be explored and met in conversation without the need for in depth, resource hungry, formal approaches.
- Giving scope for variable focus on components depending on what is relevant to the individual setting, allowing adaptability to different settings.

Discussion

- To the best of our knowledge, there is a paucity of research and approaches that empower the very individuals involved to apply implementation science approaches themselves - is this a missed opportunity? Where could this approach be applied?
- Implementation science principles have rarely been applied in animal health, and therefore this presents an opportunity to approach the discipline with a clean perspective - If you could start anew with the application of implementation into your discipline, what would you keep? What would you avoid?

Challenges

The researchers undertook a series of expert and stakeholder consultations that proved a valuable approach to overcome the challenge of simplifying existing time and resource heavy implementation approaches, as well as enabling identification of core and variable components of the NPM.

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Act in Time: Experiences related to the outcome of a 12-month implementation intervention to achieve a more health-promoting practise in primary healthcare

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Project aim

The Act in Time project supported staff and managers in five primary health care centres (PHCC) to adopt a more health-promoting clinical practice through a 12-months multi-faceted, tailored implementation intervention. The intervention strategies were based on implementation research literature and the Astrakan leading change model, and were further refined by using the expectations, barriers and facilitating factors identified in interviews and focus group discussions with PHCC managers and staff at a pre-implementation stage. The present study aims to explore staff and internal facilitators experiences of embedding a more health- promotion practice in everyday routine work.

Setting

The study was conducted in Region Örebro county, situated in the middle of Sweden, with 28 PHCCs serving approximately 307,000 inhabitants. In Sweden, PHCCs are the first port of call for all kinds of diseases and health-related problems, except for emergency care, and for all ages.

Method(s) / Approach

This is a qualitative study with an exploratory purpose. Individual interviews with internal facilitators (n=10) and five focus group discussions with staff representing a variety of professions were conducted using semi-structured interview guides. Data were collected 4 to 6 months after ending the implementation intervention. To avoid circular reasoning during the data analysis when using a theory as a guiding matrix, data were first coded inductively. The codes were thereafter deductively mapped to the Normalisation Process Theory (NPT) domains.

Key insights

We present preliminary findings for the NPT domain Outcome. The implementation intervention was described to simplify health-promotion practice by providing structure. Existing but unknown individual expertise in health promotion became evident. The PHCCs were able to benefit from this expertise when moving forward to increase their health-promotive practice. The staff described the patients they asked about lifestyle and gave advice to as positive and grateful, and that they expressed that they felt acknowledged. The staff also described that simple advice was sometimes sufficient to help a patient reconsider a lifestyle habit, for example, when an overuse of alcohol was identified.

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One fracture is enough! - Support for implementation of a new care process

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Project aim

In the "One fracture is enough!" project, we want to reduce recurrent fractures by implementing a tailored care process for elderly people with hip fractures. We will study both the implementation process and the effect of the clinical intervention (the care process). The overall project aim is to evaluate the uptake and effects of an implementation strategy for the introduction of a tailored care process based on degree of frailty for elderly people with fragility fractures. The specific aim of this study is to describe the internal facilitators' experiences of taking part in the implementation strategy.

Setting

This study is performed in the orthopaedic units at one university and one local hospital in the same Swedish county. Both units are providing care for older people with hip fractures.

Method(s) / Approach

Each included unit appointed a multi-professional internal facilitator team to lead the implementation. The teams received a 1-year support programme including five workshops on frailty, osteoporosis and implementation, followed by monthly support from external facilitators. A qualitative descriptive approach was chosen, and data will be collected by means of focus group discussions with the internal facilitator teams at the two units, internal facilitator logbooks and notes made by the researchers during the study period. Data will be analysed with qualitative content analysis.

Key insights

This study will reveal:

- Insights on barriers and facilitating factors for the implementation of the tailored care process experienced by the internal facilitators.
- Insights into whether using a tailored care process will be found feasible for the caregivers in clinical practice and perceived as relevant and as a quality improvement for the patients.

Insights into whether the 1-year support programme for implementation was found valuable.

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Bibliometric analysis of research trends in Implementation and Physiotherapy

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Project aim

Physiotherapists treat multiple health condition and work in various clinical setting across the patient pathway. The utilisation of research is integral for physiotherapists to support clinical decision-making and plan effective evidence-based management programmes. Implementation Research and Practice is essential for advancing the Physiotherapy profession and support improvement in patient outcomes. Implementation helps bridge the gap between research and clinical practice, and reduce the time for new technologies and interventions to become routine practice. We aimed to explore characteristics of research trends in Implementation and Physiotherapy to understand research needs and inform future research priorities in this area.

Setting

Any healthcare setting that physiotherapists currently practice. This includes primary care, secondary care and community settings.

Method(s) / Approach

We searched Web of Science Core Collection (20/12/2024) using keywords such as “Implementation”, “Implementation science”, “Physiotherapy” and “Physical Therapy” and limited to papers published between 2006-2024; 2006 was selected as one of the main journals in the area (Implementation Science) was established on that year. We included peer-reviewed articles of any study design. Editorials, abstracts and commentaries were excluded. We analysed the frequency and relationship of terms, and the evolution of terms used based on the publication year using VOSviewer (version 1.6.20, Universiteit Leiden). We included relevant terms used at least 30 times; generic terms such as ‘improvement’ were excluded.

Key insights

We analysed 22,772 records from 30,673. The top five Research Areas were ‘Rehabilitation’, ‘Orthopaedics’, ‘General Internal Medicine’ ‘Neurosciences Neurology’ and ‘Sports Science’. We identified 304.414 terms and included 1009. The term ‘Implementation’ had stronger relationships with ‘Education’, ‘Practice’ and ‘Physical Therapist/Physiotherapist’. For health conditions, ‘Implementation’ showed stronger links with ‘Stroke’ and ‘Knee’. Terms such as ‘Barrier’, ‘Facilitator’ and ‘Implementation Strategy’ were more common after 2019. Current research trends suggest weaker links between ‘Implementation’ and ‘Guidelines’ and study designs such as randomised controlled trials. The Physiotherapy profession may benefit from further research addressing these topics. Further analyses are ongoing.

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Enhancing emotional intelligence and interactional awareness in intellectual disability care: A multi-methods implementation study

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Research aim

This study evaluates the implementation and effects of *Begeleiders-in-Beeld*, an intervention designed to enhance support staff's emotional intelligence and awareness of their interactional behaviour with people with intellectual disabilities and challenging behaviour. By adapting the intervention to organisational contexts, we systematically assess its impact, implementation, and integration into practice.

Setting

The study is conducted within two Dutch-organisations specializing in the care for people with intellectual disabilities. Teams of support staff in each organisation implement Begeleiders in Beeld, an intervention carefully tailored to reflect each organisation's unique vision, culture, and local context. This customisation ensures the intervention's relevance and practical applicability.

Method(s)

This study employs a hybrid effectiveness-implementation design to evaluate *Begeleiders in Beeld*, integrating effect and process evaluation methods. Emotional intelligence in support staff is measured with the Bar-On EQ-i, interactional awareness with the bond subscale of the Working Alliance Inventory-12, and client behaviour with the ABCL. Implementation processes are evaluated through the NoMAD-NL questionnaire, focus groups, structured logs, and surveys. Challenges, such as managing video recordings and balancing workloads, are addressed. Triangulated data from clients (n=8), support staff (n=18), senior staff/managers (n=6), and behavioural scientists (n=3) reveal factors critical for successful adaptation and delivery.

Key finding(s)

Preliminary findings highlight that the success of *Begeleiders in Beeld* relies on intrinsically motivated participants with a clear understanding of the training's purpose and structure. Online sessions with trainers and stakeholders effectively prepared participants, while continuous engagement from senior staff and managers through discussions and feedback supported implementation. Clear policies and strong organisational backing for managing video recordings enhanced feasibility. Addressing barriers such as workload constraints and technology-related challenges requires sustained organisational commitment. Detailed effectiveness data for *Begeleiders in Beeld* will be presented at the congress.

Discussion

The study underscores the importance of aligning training interventions with the organisational contexts for healthcare organisations specialising in the care for people with intellectual disabilities to ensure relevance and sustainability. Early stakeholder engagement and consistent communication significantly improve implementation outcomes. Structured organisational support is crucial for success. Practical challenges, such as workload management and video recording logistics, highlight the need for strategic resource allocation. The findings emphasise the value of hybrid evaluation designs in assessing both intervention outcomes and the processes that drive successful integration into care practices for people with intellectual disabilities.

Challenges

Implementation challenges include identifying participants who are intrinsically motivated, balancing workloads, and addressing technical and ethical concerns regarding video recordings. Organisational

support and clear communication strategies mitigate these barriers, but sustained commitment is required to integrate the training into routine practices effectively.

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From Evidence to Action: Our learning from implementation and non-implementation of an integrated care model for people with severe mental ill-health (UCLP-PRIMROSE) in three regions of England.

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Research aim

We explored the implementation of UCLP-PRIMROSE, an integrated innovation to improve physical health in patients with Severe Mental Ill-Health (SMIH) across three regions of England, as part of normal service transformation. We investigated pre-implementation context and readiness, implementation and non-implementation, and the associated barriers, facilitators and processes.

Setting

Our research covered the North East and North Cumbria (NENC), Yorkshire and London, and included rural, remote, coastal and urban populations. These regions have high rates of premature mortality for adults with SMIH. Our research focused on primary, secondary and voluntary care, plus local authorities and Integrated Care Systems (ICS).

Method(s)

Our multi-disciplinary implementation research used complementary methods of data collection with inductive and deductive analysis, underpinned by patient and public involvement. Research teams conducted interviews, Ripple Effects Mapping workshops, focus groups and ethnographic site visits, and collected uptake data on core model elements, and recordings and notes of implementation meetings. Throughout the project, we fed back to implementation teams using Lightning Reports. Data were analysed using the Consolidated Framework for Implementation Research. The Yorkshire and London team also used Reflexive Thematic Analysis for qualitative data, calculated frequencies for quantitative data and triangulated findings using Normalisation Process Theory.

Key finding(s)

There were different levels of engagement in implementation of UCLP-Primrose. Iterative implementation was achieved across 24 GP practices with variation and adaptation based on local context and resources. Components of the model compatible with existing practices were easier to implement and prioritised. Facilitating factors included belief that UCLP-PRIMROSE demonstrated value to care, staff buy-in across the system including leadership, skilled champions and project management, and a culture of learning and reflection. Key barriers were a strong focus on financially incentivised health screening over holistic intervention or prevention, stretched resources, and poor digital infrastructure between care teams.

Discussion

Nationally, there remains a strong policy focus for holistic SMIH integrated care within ICS transformation. However, systems are not yet functioning in ways that facilitate this. We found unintended consequences of promoting incentivised health screening and ongoing challenges of siloed care sectors. In addition, residual impact from COVID-19, ongoing workforce challenges and industrial action were influencing factors. We identified enablers and barriers (including localised contextual factors) within implementation processes to offer insight for future iterative implementation efforts. UCLP-Primrose implementation was variable, yet teams commonly

prototyped (instead of piloting) the model, demonstrating its agility and allowing contextual adaptation aligned to local needs.

Challenges

We found challenge in navigating between our dual roles of researcher and implementation facilitator. Regular reflexivity helped us delineate our roles and influence, addressed with openness of reporting. Additionally, we navigated local contextual and implementation differences across Sites through tailored innovation packages.

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Implementability of post-hospital interventions for intensive care survivors

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Research aim

To explore if and how 'implementability' (acceptability, fidelity and feasibility) and efficacy have been considered in the development and evaluation of complex post-hospital interventions for intensive care survivors.

Setting

Intensive care survivors can experience physical, mental and cognitive impairments, limiting activities and ability to participate in society. This is known as post-intensive care syndrome. Limited evidence supports the effectiveness of post-hospital interventions for survivors. The primary setting of the interventions is the hospital sector (including outpatient rehabilitation/clinic settings).

Method(s)

A systematic review was conducted. Studies were included if they developed and/or evaluated a complex, structured post-hospital intervention aimed at improving recovery outcomes for intensive care survivors. MEDLINE, Embase, PsycINFO, CINAHL and PEDro were searched in June 2024. Extracted data included: intervention development processes; intervention description; if/how acceptability/satisfaction, fidelity, feasibility and efficacy were evaluated. Synthesis methods included deductive analysis and scoring using the 12 items from the Template for Intervention Description and Reporting (TIDieR), and the National Institute of Health's Treatment Fidelity Framework which includes 21 components across the domains of development, training, delivery, receipt and enactment.

Key finding(s)

Seventy-one publications were included involving 62 unique patient cohorts. Twelve studies (19%) used intervention development frameworks, while 24 (39%) engaged stakeholders in development processes. The median[IQR] TIDieR score was 16[14-20]/24. Twenty-two studies (35%) evaluated patient acceptability, of which two also evaluated clinician acceptability. Median[IQR] treatment fidelity score was 6[6-8.5]/21 with training, delivery, receipt and enactment domains poorly described. Median[IQR] consent rate was 48%[34-68%]. Twelve (57%) of the 21 studies designed to test efficacy achieved their sample size. Eight studies (13%) evaluated cost and 20 (34% of studies delivering interventions) reported safety.

Discussion

- What are the important priorities for implementation scientists to enhance the evaluation of implementability (acceptability, fidelity and feasibility) of complex interventions?
- What are the hypothesised relationships between stakeholder perceptions, fidelity, feasibility, and other important implementation outcomes such as sustainability and scalability?

Challenges

Applying an implementation lens to a field traditionally focused on efficacy. This required attention to the breadth of applied methodologies and heterogeneity during data extraction and analyses. Framing this research required consideration of the research context, including the intensive care field's stage of readiness to consider implementation science approaches.

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Measuring stakeholders' perceptions of acceptability, appropriateness, and feasibility. Are the constructs empirically interrelated? And what does this mean for implementation practice?

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Research aim

Our study aimed to i) empirically examine stakeholders' perceptions of acceptability, appropriateness, and feasibility about providing a complex health intervention, ii) determine if the outcomes are correlated and if so, iii) to characterise the nature of the interrelationships

Setting

Our study looked at the field of implementation science and how evidence around established implementation outcomes is generated and synthesised, and what this means for future practice. We used the example of genetic health professionals providing additional genomic results to families following genomic sequencing as the study context.

Method(s)

We used an exploratory, sequential, mixed-methods approach (quant + qual) to determine correlations among outcomes (quant) and characterise the nature of the interrelationships (qual). Genetic healthcare professionals involved in a national study that investigated providing additional genomic analysis to families were invited to complete pre- and post-implementation surveys using validated instruments for implementation outcomes acceptability, appropriateness, and feasibility. Data were analysed descriptively, and correlation analysis was performed. Follow-up semi-structured interviews were conducted using a guide that was developed to specifically target each of the three outcomes. Following deductive and inductive content analysis approaches, interrelationships were interpreted alongside the survey data.

Key finding(s)

Rather than existing separately, we found interrelationships among stakeholders' perceptions of acceptability, appropriateness, and feasibility. Survey results showed little differences among the three outcomes and statistically significant strong to moderate correlation scores. Five interrelationships were characterised from the interview data. Our results explain how perceptions, positive or negative, are determined by interrelating factors of acceptability, appropriateness, and feasibility and that in different scenarios, the function and emphasis can switch among outcomes. Our findings suggest that instruments may need to take a holistic approach to measurement, or the outcomes could be proxies for each other.

Discussion

- Given acceptability, appropriateness, and feasibility may predict behaviours such as adoption, what does the audience see as important to be better equipped at measuring the outcomes and intervening, when needed, to improve implementation?
- Which of the implementation outcome(s) would you consider ripe to serve as a proxy for each other and what enhancements would you think may be necessary to support this?

Challenges

The direction of the study began with a challenge. Despite repeated and deliberate efforts to discretely measure clinician perceptions of the three outcomes, we failed. This challenge led us to

empirically examine, as suggested in the literature, that the three outcomes may be less distinguishable in the real world.

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Identifying implementation facilitators and barriers in the field of profound intellectual and multiple disabilities: introducing the Behavioural Appraisal Scales- Revised in practice

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Project aim

The recently developed Behavioural Appraisal Scales– Revised (BAS-R) is an instrument that can be used by assessment specialists to assess functional abilities in people with profound intellectual and multiple disabilities (PIMD). The BAS-R involves observations of elicited and spontaneous functional behaviour and interviewing a proxy of the person with PIMD. Implementation of the BAS-R started recently, using various implementation strategies including a user training. Our aims are to develop a version of the Measurement Instrument for Determinants of Innovations (MIDI) tailored to the support for people with PIMD in order to identify facilitators and barriers for implementation of the BAS-R.

Setting

The support of people with profound intellectual and multiple disabilities

Method(s) / Approach

The first step in our project is to adapt the Measurement Instrument for the Determinants of Innovation (MIDI) to our specific context (the support for people with PIMD) with a select team of experts. The adapted version of the MIDI will then be administered to the participants of BAS-R user trainings. The MIDI consists of a set of determinants for implementation, which have to be rated using a 5-point Likert scale. Items which ≤ 20% of the respondents rate most negatively are categorized as barriers, and items which ≥ 80% or more of the participants rate most positively as facilitators.

Key insights

At the moment of presenting, we will have developed a version of the MIDI tailored to our context (the support for people with PIMD), and we will have collected data from our first training group. We want to (i) find out how and where the MIDI needs to be adapted to our setting (PIMD) and (ii) what the initial data suggest about the potential barriers and facilitators for the implementation of the BAS-R. In our presentation, we also want to address issues we encountered in adapting and administering the MIDI for our implementation setting.

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Real word data and implementation of guidelines; how does it work and is it doable?

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Research aim

By using micro data trying to determine if and to what level certain recommendations of the trans gender care guideline were implemented in daily practice, next to using other methods to determine this.

Setting

Transgender care (somatic) in hospital care (transgender care centres, multidisciplinaire teams including mental health care) and primary care

Method(s)

Mixed methods; next to questionnaires among medical specialist associations, trans organisaties and expertise centres, a nationwide study using anonymized datasets from Statistics Netherlands on transgender status, prescription reimbursement data, national health surveys, and hospital procedure data, covering the total Dutch transgender population who received primary, secondary and tertiary-care between 2016 and 2021.

Key finding(s)

Eight (out of 45) recommendations were translated into research questions, of which six could be evaluated with nationwide registry-data. Based on the nationwide registry-data, recommendations were fairly well adhered to in daily practice, except perhaps one recommendation; this could be due to preferences of the trans persons receiving this treatment. Primary care data are recorded differently and elsewhere, but for hospital care nationwide registry-data can be used for evaluation of CPG implementation.

Discussion

- What are other (positive and negative) experiences with using real world/nationwide registry data are there and how did you circumvent the limitations and challenges?
- Taking into account the strengths but also limitations and challenges, and required expertise two work with these data, is it worthwhile (to explore further) to use real world data for implementation evaluation?

Challenges

- Definitions of (gender and seks in registry) data - clarify and explain
- Amount of data - writing a program to select data
- Required skills - hire an expert
- Access to registry data - set up statistical department
- Validity of data - cross reference and triangulation, between group comparison

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Application of MODIFI to Adapt a Complex, Multilevel Intervention to Improve Care Quality in Rural United States Cancer Hospitals

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Research aim

To adapt a complex, multi-level evidence-based intervention (EBI) for improving cancer care in community hospitals from one setting (Kentucky) to another (Iowa) while addressing systematic differences that could limit the intervention's implementation and effectiveness in the new context.

Setting

The University of Kentucky Markey Cancer Center Affiliate Network (MCCAN) improved cancer care in community hospitals in Kentucky. Iowa, also a rural US state, was an ideal setting in which to scale-up MCCAN; however, differences between Kentucky and Iowa necessitated adapting MCCAN to enhance its implementation and effectiveness in Iowa.

Method(s)

We used Making Optimal Decisions for Intervention Flexibility during Implementation (MODIFI), a method for EBI adaptation, to adapt MCCAN, (1) identifying key EBI information and learning about the local context and users; (2) adapting the EBI while leaving its functions intact; and (3) evaluating whether the adapted EBI was effective in the new context. Notably, we refined MODIFI to better adhere to the Model for Adaptation Design and Impact (MADI), the method on which MODIFI was based, by identifying differences between original and new contexts to determine what adaptations, if any, might be needed.

Key finding(s)

We leveraged the 18 core functions identified in preliminary studies and the study team's extensive knowledge of Kentucky and Iowa contexts and users to identify differences between Kentucky and Iowa to be addressed in MCCAN's adaptation. Delivering MCCAN core functions required tailoring forms to individual Iowa hospitals. Tailoring forms to each hospital enhanced fidelity to MCCAN's core functions but required substantial effort on the part of the investigative team. Practical constraints (e.g., scheduling interviews with busy practitioners) limited rigor; however, by limiting interviews to key informants, we were able to evaluate MCCAN's effectiveness in Iowa.

Discussion

MADI, the method on which MODIFI was based, recommends identifying differences between original and new contexts to determine what adaptations, if any, might be needed. In contrast, MODIFI recommends basing adaptations on the new context only. Key questions include: Does MODIFI risk compromising EBI features that diminish implementation and effectiveness? How can MODIFI be amended to better align with MADI principles? How might our application of MODIFI enhance its alignment with MADI principles?

Challenges

Our adaptation efforts extended beyond the patients, caregivers, and providers whose perspectives MODIFI recommends incorporating; adapting other multilevel, complex EBPs may require similarly expansive approaches. Further, adapting MCCAN required investigators' nuanced understanding of MCCAN, its original context, and the new Iowa context, which may not be feasible for practitioners.

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Strengthening local cooperation between formal and informal welfare and care organisations for people in the last stage of life and their loved ones: assessing experienced barriers and possible facilitators for cooperation and ways to improve it before the start of living labs

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Research aim

This project aims to realise better cooperation between formal and informal welfare and care organisations. In the preparatory phase, before starting 3 living labs to realise better cooperation, we want to gain information about the current situation regarding experienced barriers and possible facilitators through exploratory interviews with professionals and volunteers.

Setting

In Amsterdam, good cooperation in palliative care is limited by the fact that many organisations such as healthcare, social care and informal care do not find each other sufficiently. In this action research, researchers work together with organisations and initiatives by organizing living labs in three parts of the city.

Method(s)

For approximately two years, in three living labs, professionals from different fields are working on joint activities to improve collaboration. This process is accompanied and evaluated by action research that also looks at the impact on people in the last phase of life and their loved ones. Research is done by observations, interviews, and joining relevant meetings where fieldnotes are written. For the first phase of the project, 16 exploratory interviews were conducted with 14 professionals and three volunteers, and six relevant meetings were attended. For data-analysis, we used open coding with a focus on experienced barriers and possible facilitators.

Key finding(s)

Preliminary data suggests that there is (indeed) a need for more cooperation in this field of palliative care. Among experienced barriers, we found that firstly, there is a need for more awareness of what palliative care exactly entails (e.g. confusion with the terminal phase). Secondly, role confusion is present between volunteers and professionals, more clarity as well as collaboration is needed. Thirdly, professionals don't always know where to go or how to find each other. Subsequently, among facilitators, we found the need for an overview of organisations and/or services that can be of help or offer support.

Discussion

In our research project, we work together with a lot of different groups of people. This poses several challenges and discussions.

- How do we go from recognising barriers and facilitators and organising living labs to (developing) concrete action points for the corporation and thereafter structural implementation? How can we ensure that these action points are about cooperation and not about individual ways of doing things from their own discipline/domain?
- How do we ensure a balance between completeness of representation disciplines and space for their daily agenda? How do you keep participants long-term actively involved?

Challenges

Among challenges that participants experience is working with professionals from different fields and disciplines who speak a different 'language' (e.g. same words, different meaning). Next to that, not everyone who is interested has the time and/or capacity to participate in this project (busy schedule, understaffed, finances play a role).

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Determinants for the implementation of a lifestyle coaching application in individuals with metabolic syndrome: a literature review

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Research aim

Individuals with metabolic syndrome are at higher risk of developing cardiovascular diseases and diabetes. This risk can be reversed by making improvements in lifestyle using digital interventions. The current literature review aims to identify determinants that influence the implementation of a digital lifestyle coaching application in individuals with metabolic syndrome.

Setting

This review is part of the Healthbox project which aims to develop a tailored and personalized lifestyle application combined with self-measurement devices for individuals with metabolic syndrome living in The Netherlands. Within this project, particular attention is given to individuals with low health literacy.

Method(s)

A literature search was conducted across five databases to identify studies examining barriers and facilitators for implementing a lifestyle coaching application for individuals with metabolic syndrome. Studies were included if they targeted adults meeting at least one criterium for metabolic syndrome, involved a telemonitoring intervention with lifestyle coaching, and described implementation determinants. Title and abstract screening was performed using ASReview, an AI-aided open-source systematic review software program, followed by manual full-text screening by two independent reviewers. Data were analyzed inductively in Atlas.ti, next codes were categorized according to the CFIR domains, resulting in a list of identified barriers and facilitators.

Key finding(s)

The literature search identified 26.880 studies, of which 218 were relevant after title and abstract screening using ASReview. Following full-text screening, twenty-five studies were eligible for inclusion. Barriers and facilitators experienced by individuals with metabolic syndrome that emerged were costs of the application, lacking trust in own ability and technology, need for tailoring and personalization of application, and support from their healthcare provider. For the healthcare providers themes that emerged were integration with their software programs, insight into health data of patients, time and resources to monitor their patients' progress, and preference for an evidence-based intervention.

Discussion

- The theme “trust” emerged as barrier to implementation. Trust can mean trust in one's own ability to work with technology for health goals and trust in health technology in general. Which strategies will improve such a broad construct as ‘trust’ from your experiences?
- In the Healthbox project, individuals with metabolic syndrome and low health literacy are given particular attention. Only few studies address this group specifically, so we will conduct interviews with this specific population to interpret our literature review results. How can we inclusively integrate different knowledge sources like literature and experiential knowledge?

Challenges

Our literature search resulted in over 25.000 studies to be screened, owing to the various definitions used for different search terms like barriers and facilitators. We chose to work with an AI-tool,

ASReview, which enabled us to screen this large number of studies without excluding potentially relevant search terms.

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Approaching the complexity of implementing and assessing a community-centred violence initiative through diverse data collection methods: lessons learned from the Milwaukee Blueprint for Peace

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Research aim

The aim of this research is to describe the context in which the Milwaukee Blueprint for Peace (MBPP) was implemented. Additionally, assess the barriers and facilitators to implementing a community organizing training (Resident Leadership Training) as an implementation strategy for the community violence prevention intervention (the MBPP).

Setting

This project took place in Milwaukee, a semi-urban city. Our partners included the Office of Violence Prevention (OVP) and 414 Life, an OVP-supported hospital-based violence interruption team. The Prevention Institute, a nonprofit who works in building prevention and health equity into policy, supported development of the Resident Leadership training.

Method(s)

The parent hybrid trial evaluated the community strength-based violence prevention initiative MBPP and a community organizing training developed to complement the MBPP in furthering the violence prevention activities. The MBPP involved recommendations that were a combination of community healing, resilience approaches, and mitigation-focused violence interrupter efforts. Data sources include interviews with community representatives, focus groups with residents, meeting minutes, and training process evaluation data. We used the Practical Robust Implementation and Sustainability Model (PRISM) integrated with the RE-AIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance) framework and the Consolidated Framework for Implementation Research to guide data collection and analysis.

Key finding(s)

Six Resident Leadership Training sessions were completed between 2021-2023 with 41 persons participating. Three key areas impacted implementation. First, the External Environment was such that Milwaukee community residents were witnessing a rise in violence and demanding a new community-centered approach (the MBPP). Second, Characteristics of the Organisation (specifically OVP) included staff with strong roots in community practices whose perspectives informed a public health approach to violence. This resulted in a complimentary relationship between governmental and community organisational partners. Third, Implementation and Sustainability Infrastructure included a strong program champion who departed OVP, weakening the MBPP and the Resident Leadership training.

Discussion

The COVID-19 pandemic disrupted development and implementation of the Resident Leadership Training as a key component of the MBPP. Leadership of the Milwaukee city's office directing violence prevention policy changed twice within the study period and shifted MBPP priorities. Our research team engaged with multiple persons, not only from government but community partners as well throughout the life of the study as turnover occurred. How do we elevate the value of community knowledge as a facilitator to implementation when organisational leadership changes? How do we maintain rigorous implementation science methods when the necessary data to understand community is complex?

Challenges

- Government Leadership Changes - shifting priorities in violence prevention impacted communication and support for the program
- COVID-19 - Stay-at-home orders impacted data collection, analysis, communication, and engagement. Resident Leadership Training centered community connection; we adapted the training for the virtual environment and altered recruitment strategies with limited success.

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Exploring the best strategies to improve the implementation of the combined lifestyle intervention for overweight patients with knee osteoarthritis in primary care

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Research aim

This study explores barriers and facilitators in implementing a reimbursed combined lifestyle intervention (CLI) for people with overweight and knee osteoarthritis (kneeOA) within primary care. By examining participants' and healthcare professionals' (HCP) perspectives, this study aims to identify tailored strategies to optimize CLI delivery.

Setting

Primary care HCPs (general practitioners (GPs), lifestyle coaches (dieticians and exercise professionals)) and participants with overweight and kneeOA of the CLI.

Method(s)

Qualitative semi-structured interviews were conducted with 23 CLI participants with kneeOA and 16 HCPs (GPs (n=7), lifestyle coaches (n=9)) between December 2023 and May 2024. The interviews were transcribed verbatim and coded independently by two researchers based on predetermined themes of the Consolidation Framework for Implementation Research (CFIR). The results of the interviews were discussed in separate discussion sessions with different participants (n=15), GPs (n=6) and lifestyle coaches (n=6) to explore the best strategies to improve the implementation of the CLI.

Key finding(s)

Barriers and facilitators were identified across four CFIR domains: intervention characteristics, outer setting, inner setting, and individual characteristics. Key barriers included lifestyle coaches' limited OA-specific expertise, absence of an exercise component in the CLI, GP skepticism about CLI effectiveness, and challenges adapting to participants' diverse knowledge and health literacy. Strategies to enhance understanding of OA and exercise importance were discussed. Additionally, GPs' lack of awareness about referring patients with OA and overweight to the CLI emerged as a barrier in the discussion session. Increasing GP awareness was identified as a promising strategy to improve referral and enhance program implementation.

Discussion

Despite reimbursement policies and nationwide promotion, implementing the CLI for patients with overweight and kneeOA remains challenging. Many GPs are unaware of the referral option or hesitate due to high dropout rates. Dissatisfaction of participants often results from the absence of an exercise component, which is difficult for providers to include in de CLI. Enhancing CLI providers' and participants' knowledge about the importance of exercise for OA, may help address this barrier and improve program adherence. Awareness strategies among GPs can address an important barrier for GPs.

Challenges

Implemented reimbursed programs are more difficult to change in order to improve the effectiveness for specific subgroups. Developing strategies to improve implementation of a program that GPs are sceptical about is challenging.

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Sometimes it can be like an icebreaker - evaluation of the Refugee Health Screener-13 in the health assessment for newly arrived migrants in Sweden

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Research aim

To evaluate the barriers, facilitators, and level of implementation of the Refugee Health Screener-13 (RHS-13) used for mental health detection during health assessments (HAs) for forced migrants, and to explore migrants' perceptions of the mental health assessment and the screening tool.

Setting

Eight primary health care centers (PHCC) in Stockholm, Sweden, assigned to offer HAs to newly arrived forced migrants including asylum seekers, UNHCR resettled refugees, and undocumented migrants.

Method(s)

We used a convergent mixed methods design to evaluate the implementation level of RHS-13 and identify barriers and facilitators in health centres conducting HA. We assessed the implementation levels as the percentages of HA that used RHS-13 for each PHCC. Nurses delivering the HAs were interviewed (semi-structured) to assess barriers and facilitators for implementation of RHS-13 and the interviews were analyzed using the CFIR 2.0. Semi-structured interviews were conducted with patients to explore their perception of mental health screening including their acceptance and relevance of the screening tool RHS-13.

Key finding(s)

Three centers achieved high levels and five reported low levels. A common barrier was lack of time, however, this was less of a barrier in centers where nurses could manage their schedules. Nurses' perceived RHS-13 as a complement to the HA but not as a standardized tool for referral, partly due to lack of established pathways for follow-up care. Preliminary findings indicate that patients appreciate RHS-13's focus on mental health but stress the importance of discussing mental health concerns with nurses, rather than relying solely on screening. Patients highlighted the need to address migration-related issues alongside mental health.

Discussion

- RHS-13 was used as a complementary tool to the HA but was not consistently utilized for referral due to the lack of fully established pathways for follow-up care. What is the responsibility of the researcher when follow-up care falls outside their mandate?
- How can we meaningfully involve under-served populations in implementation research, particularly when addressing niche topics like screening during one-time health assessment?

Challenges

Patient recruitment was challenging due to their unique living situations, such as not being registered as residents, compounded by Sweden's adoption of repressive laws. Close collaboration with the PHCCs, combined with prior experience in immigration settings and flexibility in time and location, facilitated both recruitment and the conduction of interviews.

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Exploring implementation of a shared decision-making intervention for patients following an Anterior Cruciate Ligament Rupture: A Qualitative Investigation

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Research aim

This research aimed to understand factors associated with implementing a shared decision-making (SDM) intervention in an orthopaedic and musculoskeletal pathway to support treatment decision-making with patients following an anterior cruciate ligament (ACL) rupture. Implementation factors were explored through the lens of the Extended Normalisation Process Theory (ENPT).

Setting

Two orthopaedic and physiotherapy services at an acute National Health Service teaching hospital in the Midlands, UK. Patients and key stakeholders with experience of having, treating or managing departments treating ACL injuries were involved in the study design and/or set up.

Method(s)

Individual interviews were conducted as part of a non-randomised feasibility study exploring implementation of a shared decision-making intervention for patients following an ACL rupture. Five patients with a first time ACL rupture and five physiotherapists with experience of using the SDM intervention were interviewed in person or virtually according to preference. Interviews were audio recorded and transcribed verbatim. Interview data sought to explore how the intervention was operationalised and to understand considerations for future implementation in practice. Data were analysed using a framework approach underpinned by ENPT, with findings mapped to the theory's four constructs: potential, capacity, capability and contribution.

Key finding(s)

The SDM intervention was successfully operationalised across the ACL pathway with barriers and enablers to implementation/normalisation identified. Patients and physiotherapists demonstrated a clear understanding of the intervention's purpose (coherence). It supported interactional work between patients and clinicians and physiotherapists were positive about its workability and adaptability to meet individual patients' needs (capability). Physiotherapists described the intervention's function in altering social roles of both themselves and patients, which supported the set-up and action of SDM conversations (capacity). The intervention was described as non-burdensome, patients reported they would recommend its use and physiotherapists described utilising it in usual practice (contribution, capability).

Discussion

The communication of equipoise and context created for intervention delivery was identified to be critical to engagement (potential). Where several healthcare professionals are involved in a patients care at different time-points across a healthcare pathway, how do we create shared ownership for implementation that's pragmatic and sustainable? How do clinicians create the 'optimum' context to enact SDM and thus interact with the SDM intervention and what role does equipoise play?

Challenges

The interviews were conducted by a researcher who is also a clinician at the hospital where the study took place. Thus, they have tacit knowledge of the complex treatment pathways and potential implementation challenges. Reflexive practices supported the researcher to explore barriers that may have been overlooked and considered ‘normal’.

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Scaling community mental health interventions for men and boys: Real-world learnings for funders, program developers and evaluators from the evaluation of Movember's Scaling What Works grant funding initiative

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Research aim

The evaluation of Movember's Scaling What Works fund provides a real-world example of balancing pragmatism and theoretical complexity in the context of scaling. We present lessons from seventeen grant-funded mental health interventions regarding their scaling experience and describe practical implementation considerations from the perspectives of funders, funded organisations, and evaluators.

Setting

SWW is a grant funding program which supports mental health and wellbeing initiatives with demonstrated promise for men and boys to be implemented at greater scale. Seventeen community-based interventions have been funded in various settings (including schools, family services, sport/recreation, and justice) across Australia, Canada and the United Kingdom.

Method(s)

The evaluation involves individual assessments of the implementation, effectiveness, scalability and cost-effectiveness of the seventeen funded interventions, with data collected from program teams and participants. The presentation focuses on implementation and scalability learnings to date. Scalability was evaluated by administering a tailored assessment tool designed for community-led interventions, applied by evaluators in collaboration with program personnel. The tool interrogates practical insights into key focus areas for scaling consideration and action, including specifically within community-based initiatives. Implementation insights were drawn from semi-structured interviews with designers and facilitators from all funded intervention teams, and from pre-post surveys of participants from all interventions.

Key finding(s)

Initial scalability findings have identified strengths and capability gaps among individual interventions. When extrapolated, these demonstrate valuable patterns and themes for funders, e.g. informing how to support funded interventions throughout delivery. Moreover, assessing scalability collaboratively identifies actionable implementation support strategies in real time, enhancing both program delivery and alignment with strategic goals of funded organisations and Movember/SWW. Initial implementation insights highlight recommendations for funded organisations around resource allocation, planning and processes, addressing scaling pressures, and adapting interventions to fit community contexts and engaging men and boys. Findings will continue to be integrated with other methods throughout the SWW evaluation.

Discussion

As with implementation, 'context counts' in scaling. However, as the emerging knowledge base of scaling relies heavily on shared learnings from a patchwork of different interventions and experiences, this poses two nuance-related risks:

- Findings are too contextually specific or 'fragmented' and lose their applicability, or
- Scaling findings become 'overgeneralised', such that important contextual nuance is lost during analysis.

Our evaluation approach attempts to balance both considerations- how have we gone? What scaling learnings specifically within health and wellbeing interventions for men and boys are relevant to other settings, and how could these be translated (e.g. into implementation strategies)?

Challenges

Developing and executing an evaluation which focused on the overall SWW program while involving seventeen individual, varied interventions: Navigated by evaluation design with clearly defined questions/methodology. We also invested heavily during in evaluation planning to thoroughly understand each intervention (e.g. delivery context/setting, mechanism of action and scaling approach).

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Streamlining Implementation: Feasibility and Usability of the Implementation Playbook (TIP) Software for Service Settings

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Research aim

Evidence-based innovations drive effective outcomes. Despite empirical advancements, their implementation remains challenging. We developed *The Implementation Playbook* (TIP), a first-of-its-kind, interactive software that provides simplified, empirically based, user-friendly guidance paired with project management functionality. TIP was designed for service organisations implementing EBIs in diverse real-world settings without costly in-person facilitation.

Setting

We recruited nine healthcare organisations in Canada (n=7) and the USA (n=2) through professional networks and social media to pilot TIP while implementing various sufficiently complex EBIs of interest to them. The organisations include hospitals, mental health service organisations (child and adult), and public health authorities.

Method(s)

Implementation teams complete baseline surveys on readiness and usual implementation approaches. Teams access TIP via its online platform, onboard team members, utilize TIP independently of other facilitation and provide verbal (check-in meetings) and usability feedback (System Usability Scale, SUS) at three-month intervals. TIP software captures user data, including usage patterns, progress pathways, timelines, and content input. Quarterly check-in meetings elicit what's working or not and what needs not be adequately addressed by the software. Field notes are captured in real-time using a meeting protocol and audio recorded to support rigour. A retrospective CFIR-based interview will follow with each team.

Key finding(s)

Preliminary findings from early users indicate satisfactory usability at three months. Thus far, users report that TIP clarifies the implementation pathway, enhances understanding of the target EBI core components, and increases confidence in identifying implementation barriers. Baseline readiness scores show moderate organisational readiness for TIP use. Up-to-date findings and a live TIP software demonstration will inform the presentation.

Discussion

We created novel implementation facilitation software and are assessing its' feasibility, usability, and impact on implementation across diverse EBIs and healthcare settings. Findings will inform software revision and a commercialized product for dissemination and global accessibility. In time, TIP data will provide valuable insights into how service-based organisations implement EBIs "in the wild" outside research-controlled settings. These insights can inform strategies for more equitable, efficient, effective, and scalable implementation facilitation. TIP version 2.0 will be the basis for effectiveness and feasibility studies in other evidence-based domains (e.g., education, climate studies) and geography (e.g., majority world/global south).

Challenges

- Due to concept novelty, I wrote 14 grant applications (2015 to 2021) before the project was ranked first and funded by CIHR.
- Several organisations experienced upheavals that warranted early withdrawal from the study. With many shifting priorities, implementation is often put on the back burner more than anticipated.

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Successful transfer and adoption of Good Practices on digitally enabled integrated care across Europe, a scaling-out methodology

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Research aim

Facilitate the translation of evidence-based public health interventions into practice by developing methods to transfer best practices in digitally-enabled integrated care across different European contexts, transforming health systems into sustainable organisations that improve population health and deliver high quality care.

Setting

JADECARE, EU funded Joint Action (JA), assisted Member States in undertaking health system reforms by supporting the transfer of four "original Good Practices" (primary care centres, hospitals and community settings) to 21 "Next Adopters" of 14 different EU countries. It started in October 2020 and ended in October 2023.

Method(s)

The JADECARE scaling-out methodology guided Next Adopters in transferring and adopting practices, whereas increasing their implementation capacity and providing an evaluation framework to assess impact and success. It includes four steps: (1) local needs assessment and context analysis; (2) definition of adapted local good practice; (3) local good practice implementation and monitoring; and (4) process and outcome evaluation. Key stakeholders in the new implementation sites formed local working groups that actively participated in the transfer process. Capacity-building activities facilitated dissemination and up-scaling of the practice, while sustainability considerations ensured long-term implementation.

Key finding(s)

The JADECARE scaling-out methodology guided the transfer and adoption of complex evidence-based interventions across diverse contexts, addressing challenges of adaptation, stakeholder empowerment and outcome evaluation. Drawing on implementation science, it translates theory into pragmatic steps for sustainable, context-appropriate interventions that have benefited over 4 million people in Europe. Combining scientific rigour with usability, the approach balances thorough evaluation and scientific fundamentals with practical applicability through learning cycles, ensuring that interventions fit into real-world systems. 77% of implementers found it useful and usable, supporting the development of interventions that are both evidence-based and operationally effective in diverse settings.

Discussion

- When an evidence-based intervention is implemented with fidelity in a setting that is very similar to the context wherein it was previously found to be effective, it is reasonable to anticipate similar benefits of original intervention. Do you think this statement is true? If not, why? Do you have any experiences?
- How do you consider the necessity of enhancing individual, organisation or system capabilities to conduct and implement high-quality research and practice?

Challenges

- Emerging systems perspectives highlight that interventions are inextricably linked to their contexts and need to be adapted to new settings.

- Large-scale implementation of data-driven, people-centred approaches requires a shift from one-size-fits-all programmes to targeted, tailored interventions for effective implementation and impact.

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From news to everyday use, an implementation support package aimed at the public health sector in Sweden - based on the Quality Implementation Framework

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Research aim

Implementing new interventions and work practices in public health often entails challenges, but successful implementation is crucial for achieving equitable health outcomes. The aim of this project was to develop, disseminate and evaluate an implementation support package for the public health sector, based on the Quality Implementation Framework.

Setting

The implementation support package is provided within the public health sector in Sweden in order to assist decision-makers, managers, strategists, and practitioners responsible for conducting activities across various public health domains. These domains include health care, social services, communicable disease control, and health promotion.

Method(s)

The Public Health Agency of Sweden has developed an implementation support package based on the Quality Implementation Framework. This package includes a report, a hands-on checklist, an interactive e-guide for support and inspiration, and five short videos illustrating examples from various public health contexts. The report is based on a scoping review which initially identified 4 222 publications, with 16 articles finally included in the analysis. The checklist and the e-guide were created through close collaboration with target groups. The collaborative efforts involved in the development of the package emphasizes the multidisciplinary approach taken to ensure its relevance and usability.

Key finding(s)

This project has yielded some insights into how the implementation support package might be used in public health settings in Sweden. Preliminary feedback from target groups suggests that the package could be helpful in supporting the implementation of public health initiatives, such as efforts to promote physical activity and healthy eating among children and youth in school settings across Swedish municipalities. Dissemination efforts, including publications on the Public Health Agency`s website, engagements through social media platforms, and outward-facing promotional activities have contributed to a positive trajectory in the diffusion of the implementation support package.

Discussion

- Is the process model Quality Implementation Framework useful in real-world implementation compared to other implementation frameworks?
- Our intention was to provide concrete support for people who occasionally face the challenge of implementing new knowledge and interventions to promote public health. How could such support be provided from national level to local and regional levels with reasonable resources?

Challenges

A big challenge was limited knowledge among practitioners in applying implementation frameworks. We tried to meet this by offering presentations and workshops. Another challenge is to ensure that

implemented interventions remain in routine practice over time, especially when funding or external support end. This is emphasized in the support package.

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Participation as the Missing Link: Understanding Implementation Gaps in the Energy Transition

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Project aim

The aim of this project is to paint a comprehensive picture of the gaps in implementing energy policies designed to engage citizens in the energy transition across Europe. It also seeks to advance the theory of implementation gaps by introducing a missing dimension: the "reality gap." This concept highlights the disparity between the institutional perception of the landscape and the actual reality on the ground, revealing how this mismatch contributes to the unfulfillment of policy goals.

Setting

Energy transition and policy implementation in Europe.

Method(s) / Approach

Reflexive, theory-informed thematic analysis of gray literature produced by four H2020 projects.

Key insights

The barriers to citizen participation in the energy transition are rooted in the complexity of both the transition itself and the policies designed to support it. These policies often reflect an idealised reality where all citizens are equal and have the same opportunities. However, to be effective and just, policies must account for the complexities of the systems they operate within, acknowledging and addressing existing socio-economic inequalities rather than exacerbating them.

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Integrating participatory research and implementation science in a randomised controlled trial of intravenous iron for pregnant women with anaemia in Malawi

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Research aim

We aimed to 1) identify barriers and enablers to implementing IV iron in the RCT using local infrastructure, 2) co-design culturally appropriate implementation strategies to support IV iron uptake and delivery in the RCT, and 3) evaluate the acceptability, feasibility and fidelity of implementing IV iron in routine antenatal care.

Setting

The research program was conducted in Zomba district, Malawi. The RCT involved screening pregnant women in the third trimester for moderate or severe anaemia using capillary haemoglobin across eight health facilities providing primary health care. Eligible pregnant women were randomised to receive IV or oral iron.

Method(s)

We conducted a multiphase implementation research program using a participatory approach embedded within an RCT. In Phase 1, we conducted a health system review, 82 stakeholder interviews (policymakers, district managers, healthcare workers, pregnant women), and eight health facilities readiness assessments. In Phase 2, we organised two co-design workshops with 20 community members (pregnant women, parents/in-laws, married men, and local leaders) and 20 healthcare workers to develop implementation strategies. In phase 3, we conducted three focus groups (pregnant women, partners/guardians) and interviewed 16 pregnant women and 23 healthcare workers. We observed 10 anaemia screening and seven IV iron administration.

Key finding(s)

In phase 1, we identified community, health facility and health system level barriers likely to impact the uptake and delivery of IV iron in the RCT. These included myths and misconceptions about vampirism/satanism, healthcare worker shortages, limited resources and lack of political will. In phase 2, we addressed these barriers by creating anaemia in pregnancy educational materials and providing additional equipment. In phase 3, we found high acceptability amongst healthcare workers and pregnant women. Healthcare workers demonstrated high fidelity in anaemia screening and administrating IV iron. IV iron intervention was deemed feasible in the Malawian primary health care setting.

Discussion

The RCT was conducted within existing local infrastructure and resources to reflect real-world conditions. Healthcare workers received training for anaemia screening and IV iron administration. However, they were not always available to provide these services due to competing work demands, with a research nurse stepping in to administer the IV iron. How can we balance the need for scientifically rigorous data collection with the pragmatism and flexibility required for effective real-world implementation? Additional equipment/consumables for anaemia screening and IV iron were

supplied to the sites. How can we ensure the scalability and sustainability of the intervention beyond the RCT?

Challenges

Integrating participatory research, implementation science and RCT required careful alignment of methodologies. The implementation science and RCT teams collaborated closely to ensure the findings from phases 1 and 2 informed the RCT process. However, a planned second evaluation was not conducted because the RCT sample size was reached earlier.

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Implementing core outcome sets (COS) in the neurological physiotherapy department: facilitators and barriers, implementation indicators and sustainability

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Project aim

Neurological physiotherapy aims to improve the patient's mobility, independence and quality of life. Core outcome sets group essential assessments for the evaluation of the neurological patient according to the therapeutic goal. They are used in research and clinical practice. The aim of the study is to develop and implement neurological COS, standardizing both assessment and measurement time points, at a rehabilitation clinic.

Setting

This project is conducted in a neurological in-patient rehabilitation clinic in Basel, Switzerland. The setting includes multidisciplinary teams (physiotherapists, occupational therapists, physicians, nurses, and neuropsychologists) providing comprehensive care to patients with various neurological conditions (e.g., stroke, traumatic brain injury, multiple sclerosis).

Method(s) / Approach

This study project follows the EPIS Framework. In the exploration and preparation phases (Jan-2022-June-2023), the context was evaluated via questionnaires and focus groups within the team. An expert-group of neurological physiotherapists designed a digital tool for the documentation and interpretation of the assessments. The implementation started on July-2023: a series of ad hoc trainings were realised for the dissemination and learning of the new tool. Before (T1-June-2023), during implementation (T2-January-2024), and sustainability (T3-January-2025) phases, the following measurements were recorded: number of therapists trained, and percentage of patients assessed with 1. the correct COS and 2. within the standard time frame.

Key insights

Six COS were created depending on patient’s goal. Four additional COS were available for specific treatments (e.g. sports or respiratory physiotherapy). Lack of time and adequate training are thus far the main barriers for use, whilst the requirement to assess the patient every 2 weeks for a ward visit as well as a standardised procedure over time and between departments are reported as facilitators. The measurements concerning the implementation (T2) and sustainability (T3) phases are in analyses process. Its findings can lead to a more efficient utilisation of resources and facilitate patient-centred treatment.

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Scaling uptake of ChEETAh trial evidence into practice: Mixed-methods development of an implementation research logic model

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Research aim

Implementation of best clinical evidence to practice is often slow. The ChEETAh trial demonstrated changing gloves and instruments before closing the abdominal wound reduces SSI rates and is cost-effective. This study aimed to co-design an implementation research logic model (IRLM) with stakeholders across low- and middle-income countries (LMICs).

Setting

This study was developed and delivered across 88 hospitals in seven low and middle income countries (Benin, Ghana, India, South Africa, Mexico, Nigeria, Rwanda)

Method(s)

This mixed-methods study was delivered in three phases. In phase 1, we completed a multicentre cohort study across seven LMICs to determine post-trial implementation rates. In phase 2, to explore reasons for incomplete implementation, we undertook a survey of key stakeholders (surgeons, principal investigators, research staff) to identify barriers and facilitators. In phase 3, we conducted a workshop with the Study Management Group (SMG) to develop and refine the IRLM with key stakeholders in two subsequent workshops.

Key finding(s)

Overall implementation was 27.0%, higher in hospitals that had participated in the ChEETAh trial compared to those who did not (38.9% vs 14.4%). In phase 2, commonest barriers were limited available resources such as procurement costs and equipment (46.7%, n=14/30) and executing intervention complex emergency settings (26.7%, n=8/30). In phase 3, local strategies included (i) identifying local champions to monitor and feedback on performance; (ii) developing training protocols for simulation; and (iii) developing a toolkit which includes business cases. National strategies included (i) embedding intervention into national guidelines; and (ii) regional and national-level systems to regularly monitor performance.

Discussion

While implementation of the ChEETAh intervention has improved from baseline, it remains inconsistent, especially in hospitals that did not participate in the trial. The gaps in implementation suggest a need for targeted efforts, particularly in non-trial settings. Future initiatives should prioritise stakeholder engagement to co-develop tailored strategies that address local barriers and promote sustainable, system-wide adoption

Challenges

Delivering research across seven countries is challenging due to language barriers. However, we have a long-standing relationship and infrastructure funded by the NIHR Global Health Research Unit, which have allowed translators to help overcome this.

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Evaluation of the implementation and outcomes of the Québec (Canada) Observatory on Student Mental Health in Higher Education

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Project aim

Knowledge Translation Infrastructures (KTI) are emerging organisations in the health sector aimed at bridging the gap between research and practice. Understanding how they operate to achieve their intended outcomes is essential, especially since their development requires significant resources. The Observatory on Student Mental Health in Higher Education (OSMHHE) is a KTI established in 2023 in Quebec. Its mission is to contribute to the advancement and mobilization of scientific knowledge on student mental health. This project aims to document its innovative model of collaborative governance, and to better understand whether this KTI is effective, how it operates, and in what contexts.

Setting

OSMHHE's implementation is an opportunity to study a large-scale KTI in depth. Its gathered 275 stakeholders, including students and researchers, around 25 thematic. The OSMHHE has an organized structure with an innovative collaborative governance and a participatory approach to foster the development of co-constructed knowledge and student engagement.

Method(s) / Approach

To better understand the conditions for OSMHEE effectiveness, a three-phase longitudinal realist evaluation using mixed methods will be conducted. First, an initial middle range theory will be developed to identify the potential mechanisms through which OSMHHE can achieve potentials outcomes. It will be developed based on a literature review, interviews, and document analysis. Next, this theory will be tested through multiple rounds of data collection, including interviews, a questionnaire, and observations. Finally, an interpretation workshop will be organized with OSMHHE members to confirm and refine the program theory and propose an organisational model. A multidisciplinary team will be formed.

Key insights

This project will not only identify the success conditions of an innovative KTI initiative like the OSMHHE but also contribute to the development and improvement of other KTI initiatives. The recommendations will enable the continuous improvement of the OSMHHE, thereby optimizing its processes to benefit the mental health of students. In addition, solid theoretical and methodological knowledge for evaluating KTI initiatives will be developed.

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Individual pathways of changing (de)motivating styles: Qualitative process evaluation of a training intervention with a complex systems lens

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Research aim

Interaction systems are complex – unpredictable and messy. This paper conceptualises interaction style change as an adaptive dynamic process and present a process evaluation within a feasibility study of a newly developed interaction training intervention. It explores, how training participants make sense of their individual complex pathways of adopting interaction styles.

Setting

The use of motivating interaction styles in physical activity (PA) promotion has several advantages. (De)motivating styles can be changed, but achieving sustainable change is difficult. However, little is known about the pathways through which motivating styles are adopted, or how suboptimal or even demotivating styles are reduced.

Method(s)

Process evaluations often describe static systems and fail to analyse how change occurs. To tackle this challenge we conducted a process evaluation of a training intervention with a complex systems lens. The training intervention for PA and sport professionals (based on Self-Determination Theory, SDT) taught participants interaction behaviour-change strategies, including habit formation/breaking strategies. We conducted longitudinal interviews with 15 participants (three interviews per participant) to explore the participants' accounts of their interaction system undergoing change. This approach allowed us to investigate changing (de)motivating style as a process with stops and starts, detours and sometimes small and gradual shifts.

Key finding(s)

We aimed to explore meanings people attach to change, and the lived experiences associated with processes that lead people to move in to different directions. The analysis led to us to explore the dynamics that interviewees described in their pathways of changing (de)motivating styles – awakening self-awareness, progression, relapse/slide and stagnation. Each participant had unique (idiographic) triggers behind the transition, but we interpreted common patterns of how participants made sense of self-managing these triggers: (1) regulating emotions, (2) reflecting on the root causes of the triggers, and (3) using triggers to overcome and form interactional habits.

Discussion

The findings allow us to understand the interplay between temporal development, dynamics between people's agency and contextual determinants. Participants described awakening self-awareness, progression, relapse/slide and stagnation that occurred on their journeys of changing (de)motivating styles. Each participant had unique triggers behind the phase transition between motivating and (de)motivating styles. Participants described how they could self-manage these triggers by reflecting on their root causes, regulating emotions and forming interactional habits. We discuss the practical implications of these findings for motivating style trainings.

Challenges

There are no fixed rules to do longitudinal qualitative analysis. Our analysis drew on modes of case and thematic analysis, which are nested within an overarching temporal framework. The process was iterative and multidimensional, involving multiple readings of the data and requiring a constant shift of analytical gaze.

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Facilitating access to precision-guided treatments: Insights from beta testing an online paediatric oncology medicines database in preparation for a hybrid type 3 implementation trial

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Research aim

ProCure is an online, interactive paediatric oncology medicines database co-designed with health professionals to streamline the application process for accessing targeted therapies. ProCure was beta tested to identify functionality improvements and explore anticipated implementation barriers, informing the co-design of an implementation support package for a hybrid type 3 implementation trial.

Setting

This research relates to the delivery of precision medicine programs within the paediatric oncology sector. Findings are applicable to clinical service settings, including oncologists and pharmacists within the healthcare system, as well as research service settings involved in the recommendation process for precision-guided treatment.

Method(s)

Intended end-users (n=12, paediatric oncologists, pharmacists, scientists) beta tested ProCure for eight weeks. Follow-up interviews adopted a mixed-methods approach, collecting quantitative data (Acceptability of Intervention Measure (AIM), Intervention Appropriateness Measure (IAM)) to assess satisfaction and qualitative data using an interview schedule guided by the Consolidated Framework for Implementation Research (CFIR) to explore factors that might influence ProCure implementation. CFIR-coded barriers and the Expert Recommendations for Implementing Change tool informed an implementation support package (ISP), which is being co-refined through consultation with clinicians across paediatric centres prior to a hybrid type 3 implementation trial.

Key finding(s)

Beta testers found ProCure acceptable (AIM=4.67) and appropriate (IAM=4.48) for streamlining access to recommended targeted therapies. All beta testers indicated support for ProCure's intuitive design and simple user interface, and provided suggestions for improving functionality. Anticipated implementation barriers included: complexity of the advanced search function, end-users' awareness of ProCure, accuracy of information and ability to keep ProCure updated. These barriers informed the development of the ISP to be delivered alongside ProCure in a hybrid type 3 trial. Next steps include the co-refinement of the ISP through consultation with clinicians across nine paediatric centres.

Discussion

- How can hybrid trial designs effectively balance scientific rigour with pragmatism to achieve both meaningful real-world impact and robust implementation science?
- Should the development of a service level intervention (e.g., ProCure) to support a clinical intervention (e.g., precision medicine) require an effectiveness trial? What if clinicians want the tool/service intervention immediately?

Challenges

Our study was originally designed as a hybrid type 1 stepped wedge trial, however following clear clinical demand from invested-parties, we designed a new approach. This included a beta testing phase and a two-arm, parallel, randomised cluster hybrid type 3 trial to navigate the trade-off between pragmatism and scientific rigour.

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Using Proctor's Implementation Outcomes Framework to measure the impact of an advocacy online learning course on knowledge, understanding & changes in work practice among health and social care staff: a mixed methods study

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Research aim

Advocacy is about giving voice to those without voice or whose voices are not heard. We aimed to use Proctor's Implementation Outcomes Framework to evaluate the impact of an advocacy OLC on knowledge and understanding and reported changes in work practice pertaining to advocacy among health and social care staff.

Setting

This study relates to all health and social care settings for adults in Ireland. We focused on public acute hospitals, services for older people and services for people with disabilities in particular.

Method(s)

We employed a convergent parallel design. Informed by meetings with health and social care representatives and a review of relevant national reports, we developed and conducted an online survey with 155 course completers (response rate 21%) six months after course launch. Descriptive statistics and content analysis were conducted. We facilitated three online focus groups (participants n=15) one year following course launch with a purposive sample of participants with oversight of advocacy practices. Transcriptions were analysed using coding reliability thematic analysis. Quantitative and qualitative results were then integrated by combining and mapping the findings to four of Proctor's implementation outcomes.

Key finding(s)

The OLC was completed 15,356 times from April 2023 to May 2024 (adoption). Focus group findings complemented the survey responses. Participants reported that the OLC increased knowledge and understanding of advocacy; 99% of survey respondents stated that online learning courses were effective in helping them to improve the way they work (acceptability). 90% of survey respondents were encouraged by their employer or manager to complete the OLC, but workload made undertaking the OLC challenging (appropriateness). Participants reported that they had a greater awareness of human rights and 82% of survey respondents had made changes to the way they work (penetration).

Discussion

Study participants reported that the OLC contributed to improved knowledge and awareness of advocacy, and improved work practice. They said it was accessible and easy to understand. Participants shared stories that staff were supporting people to advocate for themselves, communicating better, and focusing more on people's needs. Further recommendations for practice should consider mandatory advocacy training, and support for continuing professional development. The Proctor Implementation Outcomes Framework offered a structured and flexible approach to articulating and measuring the impact of the OLC. The study design enabled us to define and measure impact, in terms of adoption, acceptability, appropriateness, and penetration.

Challenges

There has been little focus in the literature on the quality of techniques and methodologies used in the evaluation of OLCs. We addressed this by using Proctor's Implementation Outcomes Framework to structure the evaluation. The survey and focus group questions were designed by translating the relevant outcomes into measurable criteria.

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Development of an evidence-based implementation plan for a gatekeeper intervention in schools

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Project aim

This mixed method study investigates how to use the Implementation Stages science tool, the Implementation drivers and the Behaviour Change Wheel framework to develop an evidence-based implementation plan for a gatekeeper intervention in schools attended by youth.

Setting

The Preparatory Basic Education and Training schools in Denmark, called FGU schools are state funded schools for youth that either have personal, academic or psychological problems. The FGU schools prepare young people aged 15-25 years to start and continue secondary school education or to get into employment.

Method(s) / Approach

The implementation stages and Implementation drivers as well as the Behaviour Change Wheel are applied to systematically design the implementation plan and implementation strategies for a gatekeeper intervention.

To investigate components and effectiveness of a gatekeeper intervention a scoping review is performed. Secondary analyses are done on a survey about barriers and facilitators at teaching staff level and furthermore analysis is performed on single and group interviews at the organisation level for the implementation of a gatekeeper intervention.

Key insights

How to use of implementation science tools in suicide prevention. How difficult it can be to work with external partners.

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Virtual darkness as treatment for agitation in people with dementia: Complex interplays between intervention, socio-cultural context and implementation

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Project aim

The project aims to explore the interplay between the intervention in an ongoing RCT-study, the implementation and the socio-cultural context it's implemented in. The intervention applies virtual darkness as treatment for agitation in people with dementia. Virtual darkness involves reducing blue light and light intensity in nighttime. While darkness affects us biologically, it also has socio-cultural dimensions. How we experience darkness depends on i.e. knowledge, values and conceptions. These elements affect, and are affected by, the intervention and the implementation. The project pursues increasing our knowledge about how the complex relations between the three domains can play out.

Setting

The virtual darkness treatment is implemented in a specialized psychiatric geriatric hospital in Norway. The care worker to patient ratio is relatively high. The ward is newly renovated with new technology to facilitate and control the light.

Method(s) / Approach

Data is collected through focus group interviews with employees and leaders in the ward. This enables exploring socio-cultural dynamics and the implementation process. The interviews are conducted over time throughout the project period, allowing us to continuously explore how changes in our own, and participants prejudices and understanding evolve. A hermeneutic approach is chosen as methodology. The open attitude in hermeneutics can reveal contextual factors and interactions not yet studied and is a well-suited interpretation strategy to study complex interactions.

Key insights

A part of the project is exploring how much complexity it's possible to include in one study. The socio-cultural dimensions of darkness are not well known. So far it seems like the confidence in darkness as therapy is high, and that this has a positive impact on the implementation. The interviews done so far have revealed that the virtual darkness (intervention) together with values and knowledge (context and implementation) changes the participants' behaviour (implementation and intervention), which affects the intervention mechanisms in a non-linear fashion. It's yet to figure out what model(s) or framework will best show the interactions.

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Evaluating the implementation of trauma-focused Cognitive Behavioural Therapy to care-experienced young people

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Research aim

Trauma-focused Cognitive Behavioural Therapy (tf-CBT) is the best-evidenced treatment for Post-traumatic Stress Disorder, yet in practice, young people with experience of out-of-home care often struggle to access this treatment. We aimed to work alongside services to understand barriers and facilitators of the implementation of tf-CBT to care-experienced youth with PTSD.

Setting

We worked with 28 mental health teams across England. At recruitment, 16 teams were based in Child and Adolescent Mental Health Services (CAMHS; general or specialist outpatient, and 1 inpatient team), nine targeted youth in care CAMHS (formally NHS but often embedded in social care), and three social care-based teams.

Method(s)

We recruited 243 mental health professionals from a wide variety of professional backgrounds, and provided initial training in the intervention (tf-CBT). Teams participated in rolling 3-monthly focus groups and individual interviews, to develop an understanding of what helped and hindered implementation of tf-CBT within their service. As this was an active implementation trial, the research team developed and provided additional trainings and resources in response to the needs identified by services in their discussion of barriers to implementation. Data were analysed using a framework analysis conducted using the CFIR 2.0 to better understand the key factors affecting implementation.

Key finding(s)

Almost half of the teams were able to implement tf-CBT, but only approximately one-quarter with care-experienced youth, specifically. Universal barriers discussed by almost all teams particularly highlighted service-structures and commissioning as a major barrier to delivering tf-CBT to care-experienced youth, as well as the complexities of the young person and their network. Unique factors that differentiated teams who did and did not implement included the culture of the team, leadership engagement and style, and the development of in-house supervision structures. Overall, findings highlighted vast differences between regions in terms of service structure, referral gate-keeping, and assessment and treatment offers.

Discussion

Findings offer key considerations for mental health teams, service leads, commissioners and policy-makers to enhance delivery of best-evidenced mental health treatments like tf-CBT for care-experienced youth. Particularly as it appears these young people face additional barriers which vastly vary between regions, potentially as a result of biases at various stages within the system.

- How can we ensure that mental health services are better set-up so that care-experienced young people nation-wide have a universal experience of easily navigating them and accessing best-evidenced treatments?
- How can we change the culture within a team to enable successful implementation of best-evidenced treatments?

Challenges

I hope to discuss the many challenges in detail, as these were central to the project – developing our understanding of ever-changing service structures, accessing service data, retention of mental health professionals, recruitment of care-experienced young people receiving treatment. We consulted our professional and care-experienced advisory boards to overcome these difficulties.

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Fidelity and adaptation – so what is a core step?

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Research aim

Our study aimed to make implicit decision-making about implementation fidelity, explicit. Specifically, the aim of this study was to co-design a 'plug-in' tool, as an adjunct to enhance existing fidelity/adaptation theories, models or frameworks, to facilitate identification of 'core steps' when scaling up equitable cancer care

Setting

This study took place in the healthcare sector with a focus on cancer service delivery.

Method(s)

We undertook a sequential, exploratory, multi-phase qualitative study. Consecutive workshops (n=6) were held with consumer advocates, cancer clinicians and then implementation researchers (n=32). We used a deliberative approach, first sharing information about fidelity and adaptation before capturing participants views on what made a step in a cancer care intervention either 'core' or 'open to adaptation'. We undertook content analysis of the workshop findings to generate a 'plug-in' tool to determine how amenable to adaptation each step in an intervention is. The tool was shared with all workshop participants for review and revised in response to comments, captured through online feedback.

Key finding(s)

Two steps were generated from the workshops to inform the 'plug-in' tool.

- Step 1: *Understanding the implementation context in which the scaling up was due to occur* through stakeholder engagement, context identification and process mapping.
- Step 2: *Interrogating each step in the process map by asking ten questions related to three features*: (1) the characteristics of the intervention e.g., Does the adaptation impact the active ingredient of the intervention?; (2) the context e.g., Does the adaptation impact local workforce capacity?; and (3) population e.g., Does the adaptation impact equity of access?

Discussion

- How does the audience see a 'plug-in' being incorporated into existing fidelity/adaptation theories, models and frameworks working?
- How applicable could the use of a 'plug-in' be for theories, models and frameworks in other areas of implementation science.

Challenges

- Identifying consumers with strategic knowledge and/or experience. We overcame this by working closely with a consumer engagement group
- Communicating fidelity and adaptation simply. We overcame this by using graphics, discussions and real-life scenarios that were taken through, as a thread, to build knowledge throughout using the same contextual examples

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Implementing evidence-based core components of rehabilitation into practice

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Project aim

Rehabilitation organised by the Finnish Social Insurance Institution (Kela) is guided by service descriptions that aim to promote the quality of rehabilitation and the provision of services in a reasonably uniform manner. The core elements are the essential elements of a rehabilitation service, which should be evidence-based. Our assumption is that carrying out rehabilitation in accordance with the core elements will produce the intended effects. However, the core elements are not sufficiently specified in the descriptions of rehabilitation services. The aim of the study is to strengthen evidence-based rehabilitation practice by implementing service descriptions that include the core elements.

Setting

Kela organises various rehabilitation services on the basis of legislation. These services, carried out by local rehabilitation service providers, are guided by service descriptions. These descriptions are regularly updated using research and feedback from users and providers, and also guide the audit of rehabilitation services conducted by Kela.

Method(s) / Approach

The study will be conducted in two phases (2025-2028). The first phase will focus on understanding service descriptions that integrate the core elements of rehabilitation interventions and their role in the procurement, design, management, and auditing of rehabilitation services. This will be informed by the perspectives of Kela's rehabilitation specialists. In the second phase, two rehabilitation services will be selected as cases, and service descriptions will be developed based on the findings from the first phase. Data will be collected from Kela's experts, service providers, and clients to examine the implementation determinants and strategies for implementing the evidence-based service descriptions.

Key insights

We expect that the information and experience created by the study will promote the evidence-based, high-quality and person-centred nature of rehabilitation organised by Kela. We want to gain a deeper understanding and experience of how to appropriately integrate the core elements of rehabilitation intervention into service descriptions. We recognise that simply defining core elements in rehabilitation service descriptions is unlikely to strengthen evidence-based practice. Effective implementation strategies are also needed. Our focus is now on building knowledge about implementation determinants and successful implementation strategies and the contexts in which they are used.

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Comparative effectiveness of de-implementation strategies to reduce low-value pharmacological prescription in cardiovascular disease primary prevention in Primary Care

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Research aim

The DE-imFAR study aims to compare the effectiveness of several de-implementation strategies targeting clinicians' reflective and non-reflective decision-making processes to reduce potentially inappropriate prescribing (PIP) of statins in CVD primary prevention.

Setting

Thirteen Integrated Healthcare Organisations (IHOs) of the Basque Health Service-Osakidetza

Method(s)

A cluster randomized implementation trial with an additional control group, involving family physicians (FPs) with non-zero incidence rates of PIP of statins in 2021. All eligible FPs (n=621) were exposed to a strategy based on reminders and decision support tools. Of those, 118 FPs were randomized to additionally receive a knowledge dissemination strategy, or a knowledge dissemination plus an Audit/Feedback strategy. Target population comprises 45- to 74-year-old patients with elevated cholesterol, no diagnosed CVD and low cardiovascular risk, who attended between May 2022 and May 2023 (n=30,672).

Key finding(s)

All three strategies significantly reduced the pre-to-post incidence of PIP of statins in low risk patients ($p<0.001$). There were no statistical differences when comparing all three strategies ($p=0.07$). Reduction was higher in the decision information strategy that adds a dissemination campaign to the decision support tools (adjusted OR: 0.46; CI95%: 0.35-0.60), while the Audit/Feedback strategy did not have an additional effect ($p=0.32$). A significant reduction was observed when comparing both reflective strategies with the non-reflective strategy (adjORs: 0.51 vs. 0.63; $p=0.038$).

Discussion

De-implementation strategies targeting FPs clinical decision-making are effective on reducing PIP of statins in CVD primary prevention. An organisational culture promoting, prioritizing and increasing awareness to reduce low-value care is associated with better results.

Challenges

We have not been able to evaluate the potential of the Audit/Feedback based strategy, as only 40% of the FPs have been exposed to the Audit/Feedback reports. This may explain why Audit/Feedback did not exerted all the potential effect that it was expected to attain.

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Implementation of a conditional cash transfer programme for families living on low incomes

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Project aim

The study aims to evaluate the pilot implementation of a nation-wide conditional cash transfer (CCT) programme in Singapore, intended for low-income families who work with family coaches towards short-term outcomes of preschool enrolment and attendance, stable employment, household debt clearance, and savings for homeownership. More specifically, the study seeks to examine (1) how families work with their respective family coach to develop action plans and take steps to achieve the intended outcomes and (2) how family coaches work with families through outreach befriending, action planning, case co-ordination, and progress tracking.

Setting

The CCT programme is implemented in the social service setting in Singapore. CCT programmes have been adopted in many countries. What differentiates this from the other programmes is the integration of cash transfer with social service intervention, specifically, the family coach assigned to each family to facilitate behavioural change.

Method(s) / Approach

This qualitative study adopts the Capability, Opportunity and Motivation (COM-B) model of behaviour change as its theoretical framework (Michie et al. 2014). The study comprises face-to-face in-depth interviews with 75 families over 2 time points (an interview 6 months after the introduction of the programme and a follow-up interview 12 months later) and focus group discussions and interviews with 120 family coaches and other key programme staff.

Key insights

While most evaluation studies on CCT programmes focus on outcomes, this study will deep dive into its implementation, which has implications on the design, implementation and impact of future programmes. COM-B has been primarily used in behaviour change interventions in health services. This study will demonstrate its application in social services. The use of COM-B will provide a systematic method of understanding how and why families achieve (or not) the behavioural outcomes by examining their capabilities, opportunities, and motivation and how family coaches facilitate these outcomes, through the intervention functions that they adopt.

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Adapting implementation strategies for improving early identification of palliative care needs that were developed in nursing home care for use in homecare: a bottleneck analysis

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Research aim

The SigMa-methodology contributes to early identification of palliative care needs by healthcare professionals. Originally developed for nursing homes, it will be adapted for homecare, ultimately enhancing the quality of palliative care for homecare clients. As homecare is organised differently, we conducted a bottleneck-analysis, in order to adapt implementation strategies.

Setting

Dutch homecare is organised in various ways, and provided by different disciplines. Therefore, timely identifying palliative care needs can be done by different disciplines. The disciplines involved in SigMa Home include household assistants, social care or welfare workers, and nurses or nurse assistants.

Method(s)

Eleven individual interviews and eight homogeneous focus groups were conducted with household assistants, social care/welfare workers, and nurses/nurse assistants from different Dutch homecare organisations. These disciplines all have direct contact with clients and therefore potentially can recognize changes in clients' situations. They were asked about the barriers and facilitators they experience in identifying and discussing changes in clients situations and possible related palliative care needs. The interviews were conducted using semi-structured topic lists and took place both in person and online. We analysed the transcripts with thematic analyses. The input will be used to adapt implementation strategies.

Key finding(s)

Household assistants and welfare workers mentioned that they feel they lack knowledge of the clients' medical conditions. Household assistants found it difficult to discuss their observations about palliative care needs since they have no clear communication channels with other disciplines, while welfare workers and healthcare workers report in patient records. Whereas household assistants and welfare workers have much time with clients and have in-depth conversations, care workers face time pressure and are often only able to quickly ask questions about symptoms rather than overall well-being, hampering early identification of palliative care needs.

Discussion

- Should we focus more on possibilities within organisations, or should we try to also improve communication with external organisations and disciplines like general practitioners? The first might be more feasible, the second might be more impactful. How do we weigh the feasibility against impact?
- How can we adapt the implementation strategies that align with the diverse practices and organisation of homecare organisations and homecare disciplines? Is it possible to have general implementation strategies, or is it necessary to differentiate between all different practices?

Challenges

In homecare, there are various organisations, from small ones only providing nursing care, to larger, multidisciplinary organisations also providing housekeeping and welfare. Adapting implementation strategies that are adequate for all these organisations and disciplines is a challenge due to their diverse approaches and needs.

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Identifying the current support infrastructure and best practices for supporting workplace learning: Developing a realist theory of change

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Project aim

This project is part of the of Dutch Doing What Works for Children research programme. Part of this programme is to develop implementation strategies for a support infrastructure that fosters workplace learning. The first step involves uncovering the mechanisms driving the current support infrastructure in three youth care organisations and developing a tentative theory of action. This will be complemented by a review of existing research on key elements of this theory. The project will result in an overview of the current support infrastructure and an initial theory of change on the infrastructure of workplace learning.

Setting

The Doing What Works programme operates in the fragmented, dynamic field of the Dutch youth care. Supporting workplace learning empowers youth care professionals to apply up-to-date knowledge and work effectively and thus, organisations will be able to meet the changing demands, such as new legislation, technologies and interventions.

Method(s) / Approach

A mixed-method approach will guide the first step in Realist Evaluation: developing a theory of change for five different parts of youth care organisations. Qualitative data will be gathered through interviews, document analyses of organisational policies, and a review of literature on elements of the initial theory of action. These insights will be complemented by quantitative data collected using validated surveys. By triangulating these methods, the study will offer a comprehensive understanding of the mechanisms driving the support infrastructure for workplace learning across various organisational contexts.

Key insights

We aim to get a deeper understanding of the current infrastructure for workplace learning in five different parts of youth care organisations and the beliefs about the relations between the mechanisms and outcomes. We will also review mechanisms and outcomes of workplace learning in other contexts. This will allow us to determine a theory of action for workplace learning and the support infrastructure that is needed. Ultimately, these insights will provide a solid baseline for designing additional strategies to enhance workplace learning and will serve as the foundation for testing and refining our theory in future research.

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Assessing the effect of job demands on implementation climate in outpatient mental health clinics in Norway

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Project aim

The study aims were to examine if perceived quantitative job demands (QJD; e.g., workload, overtime, work speed)predicts Implementation climate (IC) in mental health clinics. Second, the study aimed at assessing whether an intervention that has demonstrated beneficiary effects on IC (the Leadership and Organizational Change for Implementation; LOCI), moderates the plausible effect of QJD on IC. Specifically, higher QJD was hypothesized to predict poor IC, and LOCI was hypothesized to negatively moderate this effect due to LOCI's effect on IC.

Setting

The study takes place in specialized mental health outpatient clinics in Norway.

Method(s)/ Approach

387 therapists completed surveys assessing IC and QJD pre and post LOCI intervention. Therapists participated in a project where LOCI was applied as an implementation strategy in 25 mental health outpatient clinics implementing evidence-based trauma treatments. IC was measured using implementation climate scale and QJD was measured using the General Nordic Questionnaire for Psychological and Social Factors at Work. Multilevel modelling with QJD as predictor and IC as outcome was applied. As clinic leaders received LOCI during the implementation, data measurement time (i.e., pre and post LOCI) was included as an interaction effect, to investigate the moderating effects of LOCI.

Key insights

The results revealed significantly higher implementation climate when job demands were lower. There was no significant interactional effect of LOCI. These findings suggest that reducing therapists' perceived QJD might lead to improved IC, and, thus, favourable implementation outcomes. Alternatively, better IC could lead to lower QJD, which accentuates the necessity of further longitudinal research. Nonetheless, this study demonstrates an important relationship between QJD and IC. The effect of QJD on IC remained regardless of the LOCI intervention, indicating that high therapist QJD could have detrimental effects on IC despite tailored implementation interventions at the leadership level.

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Cultural adaptation of a digital intervention for mental health promotion in Southeast Asia within the MentalHigh project

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Research aim

This study aims to describe the process of cultural adaptation of a digital intervention developed and tested in Spain (Smiling is Fun) for promoting mental health in higher education institutions in Vietnam and Cambodia within the Erasmus + Capacity Building project MentalHigh: https://mentalhigh.net/

Setting

Higher education setting: Seven universities (five from Vietnam and two from Cambodia) participated in the cultural adaptation. Representatives from each university (managers, faculty) were nominated to participate in the process. A student board with students from the different universities participated too.

Method(s)

MentalHigh adopts a culturally adapted psychotherapy approach defined as a systematic change of an intervention where consideration of culture and context modifies the intervention in accordance with the individuals' values, contexts, and cultural relevance. Following the work by Derek Richards, we integrate several approaches: cultural sensitivity framework (CSF), cross cultural principles from Helms (2015) and ecological validity framework (EVF). Representatives had access to the program and measured the cultural sensitivity with interviews and focus group and the ecological validity using the Cultural Relevance Questionnaire (CRQ). The student board validated the changes proposed in the program.

Key finding(s)

Adapting an intervention for students in Vietnam and Cambodia required careful consideration of cultural factors and the specific needs of the students. Most of the changes included using culturally appropriate examples that are culturally sensitive to the values, beliefs and norms of Vietnam and Cambodia. Also, including characters addressing issues that are common for students in these countries (economic, academic and family pressure; difficulties with peers; etc.). In addition, in terms of psychological content, an effort was made to simplify technical language and make the exercises easier so that students can practice in each of the program modules.

Discussion

- How do we implement mental health promotion in different contexts beyond high-income countries?
- How can we sustain mental health promotion programs in lower-income countries?

Challenges

One of the main challenges was the effort to convert the audiovisual material (videos and illustrations) because it entailed changing the characters and examples. Another challenge was the translation into Vietnamese and Khmer. Working groups within the consortium were formed to conduct those tasks.

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Effectiveness of interventions to de-implement low-value healthcare practices: An overview of reviews

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Research aim

Low-value care (LVC) practices, which cause more harm than benefit to the patients, continue to be used in healthcare. Reducing these practices can improve care quality, and support sustainable development goals by promoting good health. This study aimed to systematically investigate the effectiveness of de-implementation strategies across various healthcare practices.

Setting

We considered all healthcare sector settings.

Method(s)

A comprehensive search was conducted in MEDLINE (Ovid), Epistemonikos.org, and Scopus (Elsevier) for systematic reviews (SR) published between January 1, 2010, and April 17, 2023. Two reviewers independently screened abstracts and full texts against predefined criteria, assessed the quality of SRs using AMSTAR 2, and extracted specified data. The de-implementation strategies were mapped against the ERIC (Expert Recommendation for Implementing Change) compilation and synthesized narratively. Harvest plots were used to visually present the findings.

Key finding(s)

From 46 SRs included, the majority focused on reducing drug treatments, such as antibiotics and opioids (n=27), and on laboratory tests or diagnostic imaging (n=12). Fifteen SRs reported effective reductions in antibiotic and opioid usage, while evidence for reducing antipsychotics, benzodiazepines, laboratory tests, and diagnostic imaging was mixed. Strategies involving adaptation to context, stakeholder engagement, and changes to infrastructure and workflow consistently achieved reductions in LVC. However, details about applied theories, the duration, and the intensity of de-implementation initiatives were often missing. The Cochrane EPOC taxonomy was the most commonly used framework for categorizing strategies (n=6).

Discussion

This overview underscores the effectiveness of specific de-implementation strategies that can be extended to other LVC practices. The study highlights a critical need for detailed, standardized reporting of de-implementation initiatives to enhance the utility of synthesized evidence for decision-makers.

- Would the development of standardized templates for describing de-implementation strategies enhance their clarity and usability in publications?
- Conducting systematic reviews rigorously is highly time-consuming and should ideally include a GRADE assessment to synthesise the body of evidence comprehensively, thereby guiding decisions effectively. However, under what circumstances might other forms of evidence synthesis prove more efficient or appropriate?

Challenges

We faced challenges synthesizing numerous systematic review results and ultimately presented findings using harvest plots to prepare a better overview of the results. Another challenge was, that due to limited reporting in the systematic reviews, we could only utilize the cluster level of ERIC strategies.

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Evidence is not enough: health technology reassessment to de-implement low-value care

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Research aim

To investigate how Health Technology Reassessment (HTR) is conducted to facilitate de-implementation of Low-value care (LVC) and to investigate how the results of HTR are received and acted on in healthcare settings.

Setting

Health technology assessment agencies and health care organisations in Sweden

Method(s)

This study is a qualitative interview study with representatives from health technology assessment agencies (n=16) that support the regional health care organisations in Sweden and with representatives from the healthcare organisations (n=7). Interviews were analysed with qualitative content analysis

Key finding(s)

We identified three overarching categories: (1) involving key stakeholders to facilitate de-implementation of LVC in identifying potential LVC practices, having criteria for accepting HTR targets, ascertaining high quality reports and disseminating the reports; (2) actions taken by health care organisation to de-implement LVC by priority setting and decision-making, networking between health care organisations and monitoring changes in the use of LVC practices; and (3) sustaining use of LVC by not questioning continued use, continued funding of LVC and by creating opinion against de-implementation.

Discussion

- How can the HTR process be improved to further support de-implementation of LVC?
- What other activities would you suggest to prevent sustained use of LVC?

Challenges

Presenting the findings without revealing which specific HTR reports our interviews were based on since that would had revealed the identity of our research subjects. This was handled by presenting types of practices (i.e. surgical procedures, nonsurgical procedures and behavioural health interventions) that were studied but not the specific practices.

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Bridging research and practice for dementia care: strategies and challenges of public and private funders in dissemination and implementation of research

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Research aim

This study's aim is to identify research dissemination and implementation (D&I) strategies and challenges of public and private dementia research funders in the Netherlands to inform implementation theory-building for implementation science. The results may also be used to help determine roles of actors (researchers, funders) in the research ecosystem.

Setting

This study is based in The Netherlands. The participants are professionals in the public and private sector and are employed by organisations that are responsible for financing academic dementia research.

Method(s)

This study conducted semi-structured in-person and virtual interviews with 20 individuals with professional experience with dissemination and implementation in dementia research funding agency in The Netherlands. Respondents were recruited from 3 public and 4 private dementia research funding agencies. Data extraction and data analysis were conducted using an iterative abductive thematic coding approach, based on the methodology of Timmermans and Tavory. Final results revealed strategy clusters that reflect the key contributions of dementia research funders in the dissemination and implementation process.

Key finding(s)

The strategies, and related challenges, of public and private funders were clustered into three themes: 'dissemination', 'implementation support', and 'research ecosystem capacity-building'. 'Dissemination' and 'implementation support' strategies enabled funders to achieve the intended outcome by guiding, incentivizing, or mandating action from an intermediary body (e.g., research teams). 'Research ecosystem capacity-building' strategies impacted change at the systems level, strengthening infrastructure (workforce competencies) and processes that support the entire dementia research D&I process. These results contribute to the fundamental development of a research ecosystem meta-conceptual approach to frame and structure the contributions and interdependent IKT activities of research D&I stakeholders.

Discussion

- What is your context's experience with assessing and advancing non-clinical implementation workforce competencies?
- How has your context employed transdisciplinary knowledge, tools, and infrastructure to determine and bridge these implementation systems gaps (specifically involving intermediary implementation workforce)?

Challenges

Research funders are not traditionally trained to consider the implementation of the research outputs. This shift toward 'normalizing' implementation science in their role is recent. They were often confused about their role in the implementation process. We had to adapt the jargon in our interviews to elicit relevant information.

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Harnessing Nudge Strategies for the Implementation of Transitional Care Innovations: A Qualitative Interview Study

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Research aim

This research aims to explore the use of nudge strategies in facilitating the implementation of transitional care innovations (TCIs). It focuses on their potential role, applications, and behavioural influence as promising tools to address the challenges associated with implementing TCIs in practice and ultimately improving care continuity for patients.

Setting

Transitional care involves at least two care settings or more, since it refers to the coordination of care for patients when they move between multiple settings. This project relates to long-term care and it involves settings such as geriatric care settings, acute hospital care, rehabilitation centers, and residential care.

Method(s)

A qualitative interview study design was utilized. Building on findings from a previous study conducted by the research team, 36 implementation strategies for TCIs were mapped to the MINDSPACE framework for nudge strategies to identify those with a nudging nature. This mapping process informed the development of narrative-style interview questions guide. Subsequently, narrative interviews were conducted with healthcare professionals who had experience working in organisations where TCIs had been implemented, aiming to capture their perspectives on the use and application of nudge strategies in this context. The collected data were analyzed using deductive thematic analysis.

Key finding(s)

Preliminary results: A total of 16 implementation strategies for TCIs were determined as incorporating nudging elements (e.g.; the implementation strategy "facilitation" encompasses the nudges "defaults, priming, incentives"; "audit and feedback" includes nudges "salience and norms"). Fifteen participants from five countries were interviewed. Participants reported that while most of the 16 strategies are used within their respective organisations, strategies incorporating communication and messenger nudge elements were widely applied and perceived as most beneficial to implement TCIs successfully. However, some participants expressed differing views regarding the role of strategies such as facilitation and scenario-based risk information (linked to priming and defaults nudges).

Discussion

- What challenges do healthcare professionals face when implementing transitional care innovations, and how might nudge strategies (being a novel approach) address these obstacles?
- How can nudge strategies be better integrated into the design of implementation strategies, and which ones are potentially the most promising to enhance implementing healthcare innovations in practice?

Challenges

The key challenge in this project was the development of a narrative-interview style questions. This required multiple rounds of creating a short story around each strategy and to formulate it into a question. This was needed in order to ensure the participants understand "what we are talking about".

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Adapting a complex intervention of integrated care to improve early diagnosis of cancer in 3 Latin American countries: Lessons learnt from the EquityCancer-LA project

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Project aim

EquityCancer-LA project seeks to evaluate the contextual effectiveness of scaling-up an integrated care intervention to improve early diagnosis of cancer in 3 Latin American countries – Chile, Colombia, Ecuador. The intervention comprises primary care training, fast-track referral pathway, and a patient information strategy. After analysis of diagnostic delays and contextual factors, the multicomponent intervention was adapted to each implementation site through a participatory approach. Currently, the implementation process, effectiveness and costs of the intervention are being evaluated, and sustainable tools for large-scale implementation will be developed. We aim to describe the adaption process of the intervention across diverse Latin American contexts.

Setting

The 3-component cancer care intervention is being implemented in public healthcare networks (primary care units and hospitals) in Chile, Colombia and Ecuador, which are responsible for diagnosis and treatment of cancer and providing care to urban low and middle-low socioeconomic areas.

Method(s) / Approach

The evaluation study adopts a quasi-experimental design, using a mixed-methods and participatory approach. Intervention's effectiveness is assessed pre and post intervention via surveys to doctors and patients, and medical records in two public networks (intervention and control) in each country. The implementation process is evaluated through monitoring indicators (uptake, acceptability, costs) and qualitative evaluation (focus groups) with key actors. Intervention's adaptation to each implementation site involved literature reviews, meetings with local steering committees (healthcare professionals, users and policy makers) to ensure acceptability, feasibility, and appropriateness. The meetings also explored sustainability, transferability, and contextual factors influencing early diagnosis and implementation effectiveness.

Key insights

Adapting interventions to specific contexts ensures relevance, validity and optimal effectiveness by addressing unique health systems, socioeconomic and cultural factors. Participatory approaches and systematic monitoring enable early identification of barriers, enhancing improvement and successful implementation across diverse settings. Nevertheless, adaptation of such a complex intervention poses challenges to evaluation. A major challenge is how to assure a common conceptual framework across countries and identify indicators that allow cross-country comparison, while capturing contextual factors of implementation. Also, the elements of the participatory approach affecting the processes of intervention adaptation and scale-up are yet to be uncovered.

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Implementation of a new model of care for supporting adherence in people starting a new medication for a long-term condition (myCare Start-I project) – a Hybrid Type 2 effectiveness-implementation study – study protocol

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Project aim

The myCare Start-Implementation Project (myCare Start-I) is a biphasic, interprofessional pharmacist-physician initiative based on the UK's New Medicine Service (NMS), designed to improve patient adherence to newly prescribed long-term medications. Phase A adapted the NMS to the Swiss primary care context and developed a multifaceted implementation strategy via in-depth contextual analysis and iterative co-creation focus groups with stakeholders and the investigative group. Phase B aims to evaluate the myCare Start service in Switzerland in terms of clinical (improvement in adherence) and economic (cost-effectiveness) impact and implementation (acceptability, adoption, appropriateness, fidelity, feasibility, reach, and implementation cost), and implementation.

Setting

myCare Start will be implemented within Swiss community pharmacies and ambulatory primary care settings, in the French- and German-speaking regions of Switzerland. It will target adult patients with a newly prescribed long-term medication indicated for a cardiovascular or respiratory (asthma, COPD) conditions, depression, diabetes or hyperlipidemia.

Method(s) / Approach

Using a stepped-wedge cluster randomized Hybrid Type 2 effectiveness-implementation study design myCare Start will be trialed in 30-40 early adopter community pharmacy and primary care clusters. Medication adherence will be assessed using health insurance data applying the software AdhereR and patient self-report (BAASIS® questionnaire). Cost effectiveness will be measured in the short term (total healthcare utilisation and costs per quality-adjusted life years) and long term (Markov modeling). Implementation outcomes will be assessed using a mixed methods approach including study specific surveys, qualitative interviews, and validated measures such as the time-driven activity-based costing (TDBAC).

Key insights

myCare Start is the first nationwide interprofessional model between pharmacists and physicians in Switzerland. Our evaluation will determine if patients receiving myCare Start demonstrate improved adherence, leading to reduced overall healthcare utilization and healthcare costs in Switzerland.

Further, the trial will assess the implementation of this service in Swiss primary care settings to identify implementation challenges and inform future scale up. Implementation science is still emerging in pharmacy practice research in Switzerland; this project serves as an example of integrating implementation science from inception to rollout, offering insights for future studies.

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Nature-based Social Prescribing: Applying Implementation Science to Improve Children's Mental Health

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Project aim

The "Connect" project aims to adapt blue and green social prescribing to address children's growing mental health needs. This intervention integrates nature-based (green) and water-based (blue) activities, including art with natural materials, walking schemes, community gardening, conservation volunteering, green gyms, and surfing, to improve well-being. Healthcare professionals will refer children to link workers, who will co-create personalized plans tailored to each child's and family's needs and preferences. The project seeks to reduce anxiety, social isolation, and promote healthy lifestyles, while fostering mutual benefits for individuals and the environment. It will assess the feasibility and acceptability of this approach.

Setting

The intervention will be implemented in four community deprived settings across Portugal. It will engage children and families in nature-rich environments, adapting activities to local contexts while fostering collaboration among stakeholders to support children's mental health and well-being.

Method(s) / Approach

Using implementation science frameworks, including RE-AIM, MRC, and INNATE (INgredients iN ArTs in hEalth), the project will assess the intervention's acceptability, feasibility, effectiveness and potential scalability in multi-site contexts. These frameworks will help address questions such as 'What works, for whom, in what circumstances, and why?' and ensure the adaptation of the intervention to meet diverse local needs and resources. Data will be collected through surveys, interviews, and observations, with ongoing input from genuine public and patient involvement groups ensuring the intervention remains responsive and equitable.

Key insights

This project explores how nature-based social prescribing can improve children's mental health and well-being while fostering community connections. It emphasizes the importance of addressing equity in the adaptation and implementation of the intervention, ensuring it meets the needs and preferences of children, particularly those in underserved communities. The project will use implementation science to understand how to reduce inequalities and prevent unintended consequences from exacerbating disparities. Through rapid assessments and public and patient involvement, the project will refine the intervention to effectively address children's and families mental health challenges in real-world community settings.

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Integrating Positive Health in Primary Care: a small scale implementation project in Belgium

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Project aim

Positive Health focuses on people's ability to manage physical, emotional, and social challenges in life while maintaining control over their own choices. Our primary healthcare practice strives to operate from this broad perspective on health. So we set out to implement and evaluate ‘Café Santé’, a preventive health activity for older people in in partnership with primary care professionals and socio-cultural organisations. This project outlines a structured approach to implementing Positive Health principles within a practice and its neighborhood, with a focus on collaboration, patient-centered care, and actionable insights for broader community health initiatives.

Setting

The project was initiated by a multidisciplinary primary care practice in a district of the city of Antwerp in Belgium. Key participants include the primary care practice team, medical professionals in the neighbourhood, socio-cultural organisations, and senior patients from two primary care practices.

Method(s) / Approach

The project adopts an action research approach, emphasising iterative cycles of planning, action, evaluation, reflection, and adjustment (PDCA model). Two cycles are conducted, targeting the practice team, primary care professionals, socio-cultural organisations, and senior patients from primary care practices. The evaluation utilises the RE-AIM QuEST model, focusing on: Reach: Participation rates and demographic profiling of participants; Adoption: Engagement and motivation of professionals and organisations. Implementation: Experiences of professionals and patients, including strengths, improvement areas, and impacts on collaboration and health. This information will serve as the basis for refining the activity and re-implementing it on a larger scale.

Key insights

A half day activity was organised where 30 senior patients from 2 primary care practices came together to work on their "broad" health (e.g., completing and discussing the Positive Health spider web, medication review with a pharmacist, frailty assessment, addressing existential questions, healthy nutrition). The specific content and approach were co-designed with the involved local stakeholders (GPs, nurses, pharmacists, physiotherapist, organisation working with elderly people in the district, developer of a social prescribing platform). Interviews with a purposive sample of the participants have been done and are currently being analysed. A focus group discussion with the stakeholders is planned.

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The CRADLE Vital Signs Alert intervention to improve maternity triage in Sierra Leone: developing and evaluating implementation outcomes of a new device repair and replacement system

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Research aim

The CRADLE is a vital signs monitoring device designed to aid in early recognition of complications in pregnant women. Clinical evidence shows it reduces mortality, but a new device repair and replacement system was required to ensure sustainability. We evaluate the implementation outcomes of the original and new system.

Setting

Sector - Healthcare
Service - Maternity triage in Sierra Leone

Method(s)

A mixed methods evaluation of the original repair and replace system was undertaken from a sample of five of the eight scale-up districts in Sierra Leone (SL) between January to March 2023. Non-functioning devices were collected and evaluated across five districts. Semi-structured interviews conducted with staff explored barriers and facilitators to maintenance and sustainability. The new repair and replacement system and its implementation was based on the findings of this evaluation. The implementation of the original and new system were evaluated and compared using the implementation outcomes defined by Proctor et al.

Key finding(s)

Problems with the original repair and replace system included poor fidelity, adoption, appropriateness, penetration and sustainability. Users were taught to report any broken devices to their local Medical Equipment Technician (MET) who were were trained medical equipment technicians and engineers already working in the area. However healthcare workers in SL are used to communicating all issues through their District Health Sister. Transport and communication were also barriers. There were also issues with feasibility. The heat and humidity of SL meant that certain components of the device were damaged faster than expected. These issues were addressed in the new system.

Discussion

- Do you think implementation frameworks prepare for the environmental impact on materials when implementing new technological innovations?
- How important do you think it is to adjust your initial plan for implementation based on feedback from local stakeholders?

Challenges

As for the CRADLE project itself, the most significant challenges were communication and transport. There was limited electricity and phone signal, so arranging meetings with healthcare staff and travelling to remote areas was difficult. We worked with a local Sierra Leonean researcher who helped us navigate these problems.

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Exploring Global Challenges to Healthcare Delivery Commissioning: A Scoping Review

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Research Aim

Healthcare commissioning entails the planning and procurement of health services tailored to local population needs. However, implementation has been met with various challenges. This scoping review investigates the key barriers affecting the effective implementation of healthcare delivery commissioning on a global scale. Guided by the EPIS (Exploration, Preparation, Implementation, Sustainment) framework, the review systematically examines challenges across three contexts: outer (external influences), inner (organisational and operational factors), and bridging (coordination and interactions between inner and outer contexts).

Setting

This review analyzed studies exploring healthcare commissioning practices across diverse settings globally. Eligibility criteria included studies focusing on healthcare delivery through commissioning in various contexts, such as primary care, public health, specialized care, and integrated healthcare systems. No limitations were imposed on geographical region, cultural context, or healthcare system type.

Methods

Methods: A scoping review was conducted following the JBI methodology. Comprehensive searches were performed in Scopus, PsycINFO, MEDLINE, and Web of Science. This review included studies examining healthcare commissioning processes across various settings. To ensure methodological rigor, only peer-reviewed articles were selected. Study selection involved a two-stage screening process: initial title and abstract screening, followed by full-text review. Two independent reviewers conducted the screening, with a third reviewer resolving any conflicts to maintain consensus and adherence to predefined inclusion criteria. Data extraction focused on the stages of the commissioning cycle, stakeholder roles, and contextual challenges and facilitators, categorized using the EPIS framework.

Key Insights

This review underscores the significant role of healthcare commissioning in improving service coordination, optimizing resource utilization, and promoting equity. While external challenges such as political, economic, and policy constraints may be difficult to modify in the short term, addressing internal and bridging factors presents viable opportunities for progress. Strengthening governance, fostering integration, enhancing inclusivity, and leveraging technology can help healthcare systems navigate implementation barriers and achieve more effective and equitable service delivery.

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Sustainability of an interprofessional communication approach for patients with advanced lung cancer

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Research Aim

Investigation of the sustainability of the implementation of the milestone communication approach (MCA) (> 5 years) and of quality indicators for end-of-life care; development of recommendations for adaption and dissemination of MCA.

Setting

Department of Thoracic Oncology at the University Hospital Heidelberg, Germany. This hospital is a certified (German Cancer Society) comprehensive lung cancer centre and one of the largest thoracic oncology clinics in Germany (600 patients newly diagnosed with metastatic lung cancer per year).

Methods

A convergent mixed-methods design is planned. The quantitative part comprises a retrospective analysis of hospital documentation of the deceased concerning e.g. administration of chemotherapy in the last 14 days before death, inpatient admissions and/or admissions to intensive care units in the last 30 days. The qualitative part includes semi-structured interviews conducted with employees from medicine, nursing, psycho-oncology, social work, etc. in order to identify adjustments in the current implementation compared to the original concept, to identify the benefits and any changes in the daily routines. Also the results of the retrospective analyses will be addressed.

Key Insights

We would like to learn what kind of adjustments to the original intervention were made and what the influence of these adjustments on long term sustainability over the period of five years was. Further we would like to investigate long term quality indicators of palliative care for patients with advanced lung cancer receiving MCA such as, support of patients and informal care in the last weeks and place of death. Based on the results, recommendations for transferability with regard to the adoption of the intervention in an organisation, implementation strategies, facilitation and adaptability are drawn up.

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Making decisions and taking actions: Embracing the complexity of implementation to reduce health inequalities

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Research Aim

This 6-year research program sheds light on the implementation challenges involved in changing health determinants to achieve improvements in public health. The aim is to explore challenges related to political and administrative decision-making as well as practical implementation of public health interventions. The program combines expertise in public health and implementation science with the goal of identifying ways to close the gaps in health among societal groups.

Setting

The contribution of this program lies in its ambition to cover different parts of a society comprising of local authorities (i.e., municipalities and regions) and civil organisations that impact public health. In this, the program will, in addition to studying each part, also address the interactions and relations between the parts.

Methods

This multidisciplinary program will be performed in three phases:

- Decision-making: Interviews with local politicians and administrators to understand how they make decisions about public health initiatives, including how different needs and conflicting societal goals are prioritized.
- Practical implementation: A participatory approach, in which local actors implement initiatives and participate in collecting data (e.g. to investigate barriers and facilitators, perform local adaptations, evaluate outcomes). Cross-case comparisons using both quantitative and qualitative methods.
- Capacity-building: Interventions for decision-makers and implementers (e.g. practical tools, training) will be tested and evaluated for feasibility and proximal impact through a multi-method design.

Key Insights

With the overarching goal to identify ways to close the gaps in health among societal groups, we will: (1) get deeper insights into local decision-making around initiatives to reduce health inequities, (2) understand how and to what effect public health programs are implemented in routine practice, and (3) learn which interventions, when their goals, content and format are being guided by the interest-holders' needs, that could lead to reduced health gaps within the population.

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Pushing the boundaries of Implementation Science. Can we improve care as usual?

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Research Aim

So far, Implementation Science has mainly focused on implementing and de-implementing specific evidence-based interventions. However, this is not always feasible. Implementation science has not yet formulated a response to this. We believe that implementation science can provide an opportunity to improve care as usual without focussing on evidence-based interventions. Our poster will discuss a major research and development programme in the Netherlands that aims to improve care as usual in Dutch Youth Care, by implementing effective key components that are common to most forms of youth care, independent of the specific intervention or method being used.

Setting

This programme is set in Dutch Youth Care. We collaborate intensively with three youth care organisations providing a diverse array of specialised youth care, for example to children in residential care or foster care, families in high conflict divorce, or children and families struggling with a variety of psychiatric problems.

Methods

The programme consists of multiple steps, based on the Active Implementation Framework. The first step is to turn the effective key components (e.g., shared decision making) into usable interventions, using practice profiles. Using a design-oriented approach, the next steps are to develop learning interventions for professionals to learn these key components, and to develop implementation strategies to ensure sustainability of the learning interventions. We use a mixed-method approach to monitor changes in the organisations over time, and a single-case study design to evaluate effectiveness of the learning interventions. We are currently working on step 1.

Key Insights

- We believe our approach can be a promising solution to the current limitations of implementation science, which focusses on implementation of interventions only.
- We will show how common components can be developed into usable interventions, thereby framing care as usual into terminology and formats that are usable within implementation science.

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Implementation of an online intervention (MINDxYOU) to reduce stress and promote mental health among healthcare professionals in Spain

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Research aim

The aim of this project is to evaluate the effectiveness and implementation of MINDxYOU, an online programme based on mindfulness, compassion and acceptance, specifically designed to reduce stress in healthcare professionals. Through a hybrid type 2 study with Stepped Wedge design, we analyse not only the impact of the programme on perceived stress levels, but also the factors that influence its adoption, use and sustainability in real-world contexts. The research applies implementation science to bridge the gap between scientific evidence and clinical practice in hospital, primary care and nursing home settings.

Setting

The research concerns the healthcare sector, specifically professionals in hospitals, primary care centres and nursing homes. The scope of services is mental health and well-being at work, addressing the implementation of digital interventions to reduce psychological distress through mindfulness, compassion and acceptance in clinical care settings.

Methods

A hybrid type 2 effectiveness-implementation study was conducted. A cluster randomized, Stepped Wedge trial design was used. A total of 180 participants were recruited from hospitals, primary care centres and nursing homes in two Spanish regions. The efficacy of the intervention was studied, with perceived stress as the main outcome. The implementation study is guided by the CFIR theoretical framework. It includes passive data collected by the platform, qualitative study of implementation strategies and analysis of quantitative implementation variables.

Key insights

Preliminary implementation results show that, on average, the 229 participants who started the program spent 4.3 days per session. After the intervention, participants (n =148) reported performing formal practices 3.3 days per week on average, with an average duration of 18.8 minutes per practice. Informal exercises were practiced, on average, 3.5 days per week. Implementation strategies were defined through individual interviews and focus groups with participants and health centre managers and analysis of quantitative implementation variables. Implementation costs were measured using cost-utility variables.

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