Implementation of evidence-based health care: the ASPIRE study

Accessibility and Implementation in UK services of Mindfulness-based cognitive therapy (MBCT)

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ASPIRE

Background:

Despite good evidence and NICE guideline recommendations there is variable and patchy access to MBCT across the UK.

Aims:

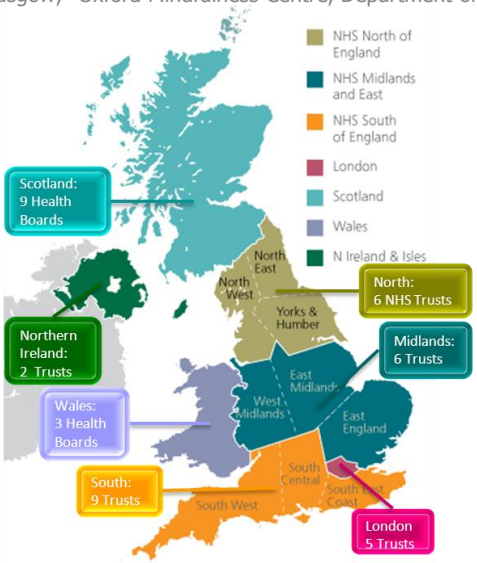
We aim to describe the current state of MBCT accessibility and implementation across the UK, and develop an Implementation Plan, which will be a resource to support the implementation of MBCT within the NHS in the future.

Methods:

This is a two-phase qualitative, exploratory and explanatory research study, using interviews and 10 in-depth case studies. Phase One interviews have been conducted with stakeholders involved in accessing, commissioning, managing and implementing MBCT services in the UK. Whereas Phase 1 focuses on description, Phase2 focuses on more in-depth description, comparing high, low and mixed uptake/implementation sites. Patients have been involved throughout the study e.g. helping in data analysis'

Preliminary Findings Phase 1:

- Provision is patchy: We purposively identified 40 NHS trusts/health boards across all UK regions and interviewed 68 people from different backgrounds.
- Experiential nature of intervention: Given resource and time constraints, implementation is mostly driven by championing mindfulness teachers from the bottom up; 4 sites have a mindfulness clinical lead role
- Apprenticeship Training: Most champions fund themselves, with some partly funded by trusts, supervision is very patchy; Nine of 40 sites are establishing teacher training pathways.



- Evidence-based practice vs practice-based evidence: NICE Depression Guidelines and international research evidence facilitates implementation, but clinicians, managers and commissioners often rely on local, qualitative or experiential evidence.
- Fit with service and population needs: Services are based in both primary and secondary care mental health settings, 18 include IAPT services. Depending on context, and setting, 34 out of 40 sites offer mindfulness-based services to populations outside of NICE remit.
- Adaptation of a complex intervention: Adding to the complexity of implementation in the real world, 16 sites offer MBCT close to the original manual, 10 offer both MBCT and MBSR, and 13 developed hybrid or adapted version of existing manuals (1 site has no service yet).
- Strategies: Implementation often happens organically via committed engagement and raising awareness; examples of strategies employed are staff groups or tasters, piloting and reporting impact, and making a business case.

Status Phase2, May 2015:

We have so far interviewed 128 people and visited 10 of the Phase1 sites, which are at various stages in their implementation journey.

Next steps:

Thematic analysis is in progress, but includes issues about how contexts can facilitate or impede implementation and the role of individuals in championing the intervention.

Conclusion:

A complex and new picture is emerging highlighting issues around access, fit, evidence use, quality and integrity of service provision. Describing and explaining the facilitators to developing MBCT services in the NHS has the potential to support its implementation. The ASPIRE project will report in full in 2016 including dissemination through a series of workshops across the UK.

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Further information available at:
http://medicine.exeter.ac.uk/aspire/

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