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The Better Start Bradford approach to Fidelity & Implementation

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Better Start BRADFORD

Implementation

- Understanding **how** and **why**
  - So we know what happened in an intervention (high fidelity?)
  - Establish internal validity and strengthen conclusions about the intervention's role in changing outcomes
  - Better understand the intervention and how the different elements fit together
  - Provide ongoing feedback to enhance service delivery
  - Replication in other settings

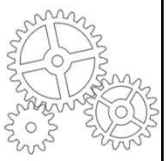
However…

Interventions are rarely implemented as designed

- Variability in implementation has been consistently shown to predict variability in outcomes
- Risk of dismissing a good intervention due to poor implementation
- Risk of misattributing success of a wobbly intervention when actually due to locally reinvented components

Mechanisms and context

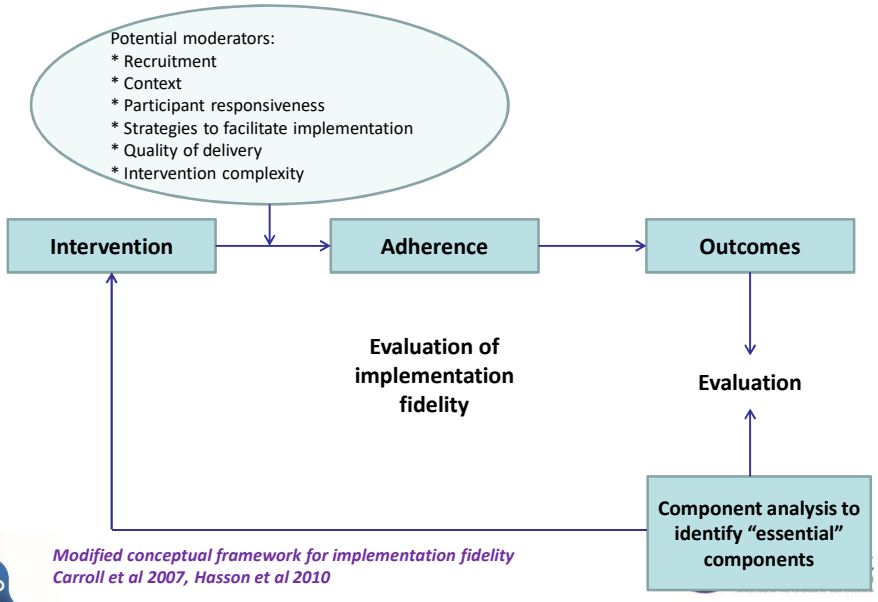
- Understanding how intervention activities, and participants' interactions with them, trigger change
- Factors that are mediating the effects of the intervention
- Any unanticipated pathways
- Context: what works **here** might not work **elsewhere**, what works **now** might not work **in 10 years from now.**



Evaluation framework in Better Start Bradford

- Development of an overall evaluation protocol for over 22 interventions
- Based on the Conceptual Framework for Implementation Fidelity (Carrol et al 2007, Hasson 2010)
- Adapted protocol based on potential reach, existing evidence base, complexity of intervention & involvement of stakeholders and commissioners
- Using mixed methods to assess implementation, fidelity and mechanisms of impact at both individual (micro) and wider community (macro) levels
- Pragmatic and consistent approach – building up evaluability of local services

Implementation evaluation framework



Modified conceptual framework for implementation fidelity
Carroll et al 2007, Hasson et al 2010

Key elements

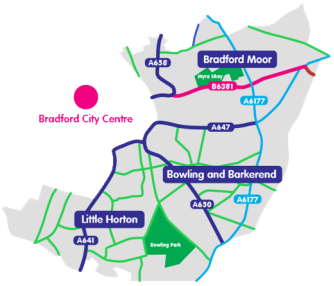
Adherence
- Content: was the intervention implemented as planned?
- Frequency/duration (dose): whether the active ingredients of the intervention have been received by the participants as often and for as long as was planned
- Coverage (reach): what proportion of the intended target population received the intervention

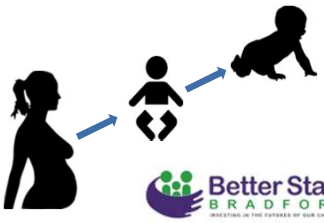
Potential moderating factors
- What recruitment and engagement activities took place
- What contextual factors affected implementation
- Participants' responsiveness including parents' satisfaction of intervention, facilitators' views
- Strategies to facilitate implementation, barriers and facilitators

Evaluation of a Continuity of Care Pilot: The Personalised Midwifery Project

Personalised Midwifery Pilot

- The Personalised Midwifery pilot is an adapted model of continuity of care from community midwives throughout the antenatal and postnatal period, ***without*** *an intrapartum (labour & birth) element.*
- Provides women with one midwife or a 'buddy' throughout the antenatal and postnatal period.
- The pilot aims to:
  - Improve satisfaction and sense of empowerment during pregnancy and birth,
  - improve antenatal nutrition,
  - reduce harmful behaviours
  - increase engagement with antenatal care and early detection of problems.





Key questions

- Was the pilot delivered as planned?
- What are the barriers and facilitators of implementing the personalised care model?
- How satisfied are women with their care?
- Do the benefits of continuity of care remain when there is not a known midwife in labour?
- How feasible is the wider roll-out model? What levels of continuity of care are achieved?
- Do midwives providing personalised model experience more or less burnout and stress than midwives providing standard care?
- How do contextual factors affect the implementation and fidelity of the project?

Data sources

1. Routinely collected monitoring data from the Personalised Midwifery team
2. Satisfaction questionnaires self-completed by women
3. Qualitative interviews with women and midwives

Areas to measure	Potential questions	Data source and collection method
1. Content	Was the intervention implemented as planned? (fidelity)	From monitoring data: Midwives available to deliver service Average caseload per midwife Percentage of women who had 90% of their appointments with their named midwife/buddy Percentage of appointments with named midwife/buddy antenatally & postnatally Interviews with women and midwives exploring their expectations and experiences of continuity of care
2. Coverage (reach)	What proportion of the target group participated in the project?	From monitoring data: Socio-demographics of women No. women eligible for referral to PM BSB women booked by PM team BSB women booked before week 34 BSB women under specialist care No. women refused consent

Areas to measure	Potential questions	Data source and collection method
3. Strategies to facilitate implementation	What strategies were used to support implementation? How were these strategies perceived by staff involved within project	Interviews with midwives to explore their experiences of delivering a personalised care model
4. Participant responsiveness	How satisfied were women with the intervention?	Satisfaction survey with women who received Personalised Midwifery and women who received standard care
	How did women perceive the outcomes and relevance of the project?	Interviews with women exploring their expectations and experiences of continuity of care
	How satisfied were midwives with the personalised model compared to the standard care model?	Interviews with midwives to explore their expectations and experiences of delivering a personalised care model.
	Do midwives providing personalised model experience more or less burnout and stress than midwives providing standard care?	Interviews with standard care midwives

Areas to measure	Potential questions	Data source and collection method
5. Quality of delivery	How was the quality of delivery of intervention sessions?	Interviews with women exploring their expectations and experiences of continuity of care antenatally and postnatally.
6. Context	Which contextual factors affected the implementation? What are the wider implementation and contextual factors to consider in the rolling out of a personalised care model as perceived by midwife team leaders and other BSB community midwives currently working in a standard care model?	Additional data collection from midwives and team leaders Document analysis of quarterly and annual review reports

Qualitative Study Overview

- 15 semi-structured interviews with midwives across the BSB area including:
  - Personalised Midwifery team
  - Midwives from two other teams in the area
  - Midwifery team leaders
- 15 semi-structured interviews with women from the BiBBS cohort who received their care through the Personalised Midwifery team
  - 13 SA origin, 1 African, 1 White & Asian Mixed
  - Aged between 23-40 years
  - 9 mums with other children, 6 first time mums
  - Interviewed in English (n=11), Arabic (n=1), Hindi (n=1), Urdu (n=2)
- Interview schedules based on the Theoretical Domains Framework (Michie et al 2005).
- Interviews all recorded and transcribed. Analysed using Thematic analysis

Preliminary findings

Facilitators of implementation

- ✓ Volume of women: manageable caseload of 60 in personalised team compared to 120-140 in standard care teams
- ✓ Time: extra 10 mins allows time to address women's concerns, answer questions, seek/signpost to support
- ✓ Increased trust and acceptance of support from women
- ✓ Flexibility of working pattern and autonomous diary management
- ✓ Stability of the team: fixed team vs rotational patterns in standard community midwifery

Barriers to implementation

- ➢ Complexity of women's needs, mobile population, cultural beliefs about maternity care, language barriers
- ➢ Increased time pressures due to less admin and midwifery support staff, low I.T connectivity in the community
- ➢ Work-life balance: stress/burnout and workforce retention
- ➢ Staffing levels and covering sickness and leave across the city
- ➢ On-calls for home births and impact on continuity
- ➢ Less integration and communication with hospital midwives

Next steps

- Complete analysis of qualitative data including additional comparisons of midwives and women's satisfaction with standard care
- Combine all strands of the evaluation and compile evaluation report and publications for our partners including Better Start Bradford, Midwifery, Clinical Commissioning Groups (local and national)
- Preliminary evaluation of effectiveness. Primary outcome: women's mental health

Acknowledgements

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Thank you! Any questions?

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www.borninbradford.nhs.uk/about-the-project/better-start-bradford-innovation-hub

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