Stakeholder interview schedule; Phase 2

Phase 2 – Interview Schedule Guide– Stakeholders

In these interviews we are interested in exploring how MBCT services are delivered locally and the implementation career of them. We will also consider how findings from Phase 1 interview should inform the development of specific questions around these areas:

- How the organisation usually prioritises NICE guideline implementation – approach, strategies, implementation, new commissioning frameworks
- What MBCT services are delivered – including by whom, to whom, how (including referrals) and type and number of sessions
- What are participants views about MBCT and how it fits in with the strategy and values of the organisation
- MBCT implementation processes – the career of implementation (full, partial, failed), facilitators, barriers, champions/leads, resource allocation, who was/is engaged in implementation, identification of any critical success factors (where possible)
- Whether and how existing service delivery had to adapt/change to incorporate MBCT – including costs, changes to roles, training and accreditation requirements
- Views on how embedded MBCT is, and whether any changes to services have been sustained, why and how
- Formal and/or local evaluations of MBCT – what these suggest about impact, cost/benefits etc.
- Any other issues/comments participants would like to add about accessibility and implementation of MBCT locally.

Questions in these areas will be tailored to the particular participant (e.g. commissioner, manager, MBCT teacher)

(Appendix 3 Continued: Stakeholder Interview Schedule, Phase 2)

Version 3 (28/08/14)

1. *How were MBCT services developed?*

Implementation (if implementer):

- Role within service (qualifications, experience, seniority), Interest in Mindfulness
- Cost and benefits (e.g. incentives, relative advantage, cost-effectiveness)
- History of implementation: readiness and development (i.e. since last interview, time, planned vs unplanned/adapted – feedback loops)
- Skills needed for implementation (e.g. communication, leadership, change management)
- Theory around implementation (i.e. in general and specific to MBCT, success of bottom up vs top down; emergent/adaptive vs. negotiated/enabled vs. scientific/managed)

2. *Who was/is engaged in implementation?*

Stakeholders:

- Networks: Peer support, historical development
- Relationships: Communication, Team, Manager support, media and public
- Decision-making (prioritisation, power)
- Cost and benefit (e.g. incentives): Service user, Teacher, Manager, Referrer, HR, Trust, GP/Commissioning, Government perspective (micro/meso/macro)
- Balancing cost and benefit between stakeholders (operationalization)

3. *How were/are MBCT services implemented (critical success factors)?*

Strategies/Implementation Plan:

- Championing (MBCT teacher commitment/embodied, clinical leads, GPs)
- Selling/Marketing: Lobbying, Explaining rationale/evidence base, Advertising, Awareness raising, reporting/demonstrating impact, staff courses (wellbeing, resilience, stress, sickness), tasters
- Costing/planning resources (feasibility study, strategy paper, business case)

- Innovating: University links, Branching out into other departments/sectors/localities
- Private provision, business models (e.g. collaborating with third sector)
- Embeddedness (future, plans); content of Implementation Plan

4. *How are MBCT services delivered?*

Intervention:

- Acceptability/Knowledge (micro - colleagues, meso-management, macro-public, trust wide)
- Accessibility: demand, referral/triage/orientation
- Target Population (Quality: diagnostic inclusions -i.e. caseness/clusters; diagnosis vs appropriateness/commitment; dropouts; follow up)
- Fit: service pathway (eg stepping, trajectory); other therapies/professionals; management (micro/meso/macro)
- Adaptation: population and service needs; delivery and manual (MBCT vs MBSR vs Hybrids), compromising

5. *What audit and evaluation procedures are used to monitor referrals, costs and outcome?*

Intervention: Quality

- Quality: Outcomes, measures, assessment (before, during, after)
- Quality: Audit and evaluation procedures (incl. feedback process)
- Quality: Teaching, training, supervision (minimum/maximum standard); critical elements of training pathway, recruitment/sustainability

6. *What are the challenges?*

Evidence:

- Types: integrity of existing (research) vs practiced-based evidence
- NICE: Credibility/legitimising implementation vs compliance/fit

Resources:

- Financial: funding for staff/teacher training
- Human: Number of teachers, Admin support, implementation skills

- Practical: Time, teaching materials etc.

Context:

- Funding/Contracts/Commissioning
- Primary (including IAPT) vs secondary care and MBCT fit
- NHS policies and re-organisation, culture, implementation climate
- Site specific: e.g. geography, socio-demographic profile etc.

(Appendix 3 Continued: Stakeholder Interview Schedule, Phase 2)

Version 6 (08/09/14)

Time/Implementation Journey

How did you get to where you are now? Based on what we already know what were the milestones/headlines?

Triggers, Starting point/readiness (time and place), timelines/-scales, milestones

Top Down/Bottom up

What bottom-up forces facilitated implementation? What are the top down strategies that have had an impact on implementation activities/service delivery?

Place of top-down vs bottom-up strategies and examples, suitability of distinction

Stakeholders (Value, Awareness/Knowledge, Expectations, Champions)

Who was/is engaged in implementation? Who have been the key players?

Awareness/Knowledge, Expectations Proposition: "Different stakeholders access (or not) different types of knowledge depending on stakeholder role, expectation and aims/motivations; each has to be catered to in the context of successful implementation"

Values, including Cost and benefits (e.g. Personal Interest in Mindfulness, incentives, relative advantage, cost-effectiveness); Proposition: "Having a personal stake/having experienced or observed the benefits of mindfulness positively is critical [and more important than other empirical data, theory or logic] to successful implementation, across all stakeholder group"

Champions: Role within service (qualifications, experience, seniority)

Proposition: Champions can be found in all stakeholder groups (but will in most cases either practice mindfulness or would have observed the benefits), the more champions hold seniority/gravity and standing within organisations the more singular impact they generate.

Skills needed for implementation, Proposition: The more implementers develop or excel in communication, leadership, change management skills the better.

Networks: Peer support, Proposition: micro, meso, macro levels; Proposition: Implementation rarely succeeds where people are working in total isolation from a community of like-minded peers or networks either within organisations or outside of them.

Decision-making (prioritisation, power) Proposition: Several stakeholders are likely to be key players in implementation, providing facilitation / barriers in particular ways

Strategies and Fit

If you reflect on the implementation journey so far, what strategies have been helpful?

Selling/Marketing: Lobbying, Explaining rationale/evidence base, Reporting/demonstrating impact,

Staff courses (wellbeing, resilience, stress, sickness), tasters

Costing/planning resources (feasibility study, strategy paper, business case)

Innovating: University links, Branching out into other departments/sectors/localities

What are the challenges and how were they overcome?

Fit: service pathway (eg stepping, trajectory); other therapies/professionals; management (micro/meso/macro)

Fit with other therapies/professionals; management (micro/meso/macro

Intervention: Accessibility/demand; fit in service pathway (eg referral/triage/orientation, stepping, trajectory

Adaptation: population and service needs (e.g. Quality: diagnostic inclusions -i.e. caseness/clusters; diagnosis vs appropriateness/commitment; dropouts; follow up); delivery and manual (MBCT vs MBSR vs Hybrids), compromising

Evidence + Evaluation, Feedback, Quality

What kind of evidence was considered in getting the service up and running?

How does the service / the teachers get feedback on the service?

What audit and evaluation procedures are used to monitor referrals and outcomes?

Are costs monitored in any way?

Is teacher quality, supervision and competence monitored in any way?

Evidence Types: integrity of existing (research) vs practiced-based evidence

NICE: Credibility/legitimising implementation vs compliance/fit

Quality: Outcomes, measures, assessment (before, during, after)

Quality: Audit and evaluation procedures (incl. feedback process)

Quality: Teaching, training, supervision (minimum/maximum standard); critical elements of training pathway, recruitment/sustainability

Context (Resources)

What are the challenges?

Funding/Contracts/Commissioning; funding for staff/teacher training

Primary (including IAPT) vs secondary care and MBCT fit

NHS policies and re-organisation, culture, implementation climate

Site specific: e.g. geography, socio-demographic profile etc.

(Appendix 3 Continued: Stakeholder Interview Schedule, Phase 2)

Version 11 (16.09.14)

Please could you briefly describe your role and a little bit about how you are involved with MBCT in your area?

Time/Implementation Journey

Can you think back along the journey you've taken to get to where you are now (being in a well embedded MBCT service or not); What were some of the key milestones?

Starting Point

Key events / triggers (Planned / Unplanned) (eg funding, person, re-organisation, any milestone that brought along some changes +ive / –ive)

What were the changes, how did they come about and how were they dealt with?

Top Down/Bottom up

From what we've seen in some of our data, for a service to become well embedded and sustainable, there need to be a top down and bottom up drive. To what extent is this true at your trust?

What are some of the bottom up / top down drivers that have had an impact on MCBT being delivered (or not)

What's the balance at your trust? (more bottom up/more top down)

Stakeholders (Value, Awareness/Knowledge, Expectations, Champions)

If you think about different stakeholders involved in making MBCT available (or not) at your trust. Who have been the key players and how?

Who has been involved and how have they been involved in making MBCT available (or not)

WHO: Teachers; Managers; Service Users; Referrers; Commissioners;

HOW:

- *Awareness / Knowledge (Stakeholder's awareness and knowledge of MBCT in general and how that is a barrier/facilitator)*

- *What are the key skills and characteristic of a Champion?*
  Champions; Role within service (qualifications, experience, seniority)
- *What do you think about the cost and benefits of mindfulness (esp. cost-effectiveness)? Values; including Cost and benefits (e.g. Personal Interest in Mindfulness, incentives, relative advantage, cost-effectiveness);*
- *With whom and how do you communicate about implementation?*
  Networks; *What networks have they been involved in, Peer support (micro, meso, macro levels)?*

Strategies and Fit

What have been the key challenges and how were they overcome?

Have you had any challenges with the following, how were those challenges addressed, (rational behind their choices, decisions);

Fit: Accessibility/demand, fit in service pathway (eg referral/triage/orientation, stepping, trajectory)
Adaptation: population and service needs (e.g. Quality: diagnostic inclusions -i.e. caseness/clusters; diagnosis vs appropriateness/commitment; dropouts; follow up); delivery and manual (MBCT vs MBSR vs Hybrids), compromising
Fit with other therapies/professionals; management (micro/meso/macro)
Resources

If you reflect on the implementation journey so far, what strategies or (planned) actions have been helpful?

What do you think of the strategies that others have used below?

Selling/Marketing: Lobbying, Explaining rationale/evidence base, Reporting/demonstrating impact,
Staff courses (wellbeing, resilience, stress, sickness), tasters
Costing/planning resources (feasibility study, strategy paper, business case)
Innovating: University links, Branching out into other departments/sectors/localities

Context

What are some of the contextual challenges you have faced or are currently facing?

Funding/Contracts/Commissioning; funding for staff/teacher training

Primary (including IAPT) vs secondary care and MBCT fit

NHS policies and re-organisation, culture, implementation climate

Evidence + Evaluation, Feedback, Quality:

What are the different types of evidence you've used in getting the service up and running and how have you used them?

Evidence Types: integrity of existing (research) vs practiced-based evidence

NICE: Credibility/legitimising implementation vs compliance/fit

How are different elements of the services monitored and evaluated?

Quality: Outcomes, measures, assessment (before, during, after)

How does the service / the teachers get feedback on the service?

What audit and evaluation procedures are used to monitor referrals and outcomes?

Are costs, teacher quality, supervision and competence monitored?

Quality: Teaching, training, supervision (minimum/maximum standard); critical elements of training pathway, recruitment/sustainability

(Appendix 3 Continued: Stakeholder Interview Schedule, Phase 2)

Version 17 (17.04.15)

What's your role in implementing MBCT in your service?

What is your reach in terms of geography of service/trust, as well as implementation?

We have seen that champions are investing considerable personal resources, and that they are using any autonomy they have depending on their level to push things.

In your experience, what skills do you need to be an implementer? What personal/material resources, what support?

The Implementation Journey

Can you think back along the journey you've taken to get to where you are now? Where did the journey start and what were some of the key milestones?

Starting Point

What is currently happening? How does it fit? ***What plans? What still needs to be done?***

What investment in terms of money and other resources was made?

Top Down/Bottom up – Balance:

From what we've seen in some of our data, for an MBCT service to become well embedded there needs to be a top down and bottom up investment and drive. What do you think the balance is at your trust?

Manager: What's been the balance from your experience of implementing new interventions? (If can't relate to MBCT in particular)

We have seen from other sites that things coming together, organic growth as well as planned/strategic implementation might be elements of success. In your opinion, what does it take to get an MBCT service set up?

Investment?

Non-embedded sites: What do you think you would need to do? What would be some of the challenges you would face?

Networks

The data is showing us that having at least one peer, or being linked to local or national Network is a key facilitator in implementing MBCT. How developed are those networks in your service or area?

With whom and how do you communicate about implementation?

Perception

How is the intervention perceived within your service?

Awareness / Knowledge of different Stakeholders

Cost and Benefit;

What are the cost and benefits in your view? What do you think you're manager's view is on the cost and benefit?

What are your training and supervision needs and how are they met?

Context and Fit:

With regards to fitting into local context, from what we have seen some flexibility and adaptation is needed, depending on how people are referred, who delivers the service how, to whom, and when in the pathway (e.g. primary vs secondary care). What are some of the contextual challenges you have faced or are currently facing?

Funding/Contracts/Commissioning; funding for staff/teacher training

Primary (including IAPT) vs secondary care and MBCT fit

NHS policies and re-organisation

Culture; Openness to Innovation

Readiness and Need to Change

Evidence + Evaluation, Feedback, Quality (Practice-based evidence, NICE guidelines and Local Information):

We have seen different types of evidence (for example the NICE guidelines, national or local research, local service outcome data, or patient/staff feedback) may play different roles in implementation depending on context and stakeholder group. What part does evidence play in your service?

Evidence Types: integrity of existing (research) vs practiced-based evidence and local information

What Evidence is collected? What happens to that evidence?

NICE: What role does NICE play? How are the implementation of NICE guidance prioritised?

Implementation Plan

What would be most helpful in your current situation?

Some suggestions from others have been; how best to evaluate their service and put together a business case to convince stakeholders, how best to access relevant evidence etc.

What are your thoughts?