

Implementation of Health-Justice Partnerships: A Comparative Case Study of Service Models in England

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Background: Social welfare legal problems are root causes of health inequalities. They are largely associated with deprivation; for example, financial strain and indebtedness, poor housing, living and working conditions. These issues are harmful to physical and mental health and are increasing sharply as a result of the Covid-19 pandemic. Services providing legal assistance with welfare rights can tackle these health-harming social conditions and support the health of the most disadvantaged groups in society. Across the world, partnerships between healthcare and legal services have developed in response to the interconnected challenges of health inequalities and access to justice. In England these occur in diverse settings and take many forms. Success is markedly variable in developing, sustaining and embedding collaborative working, which is critical to the effectiveness and impact of these partnerships.

Method: A comparative case study of health-justice partnerships was undertaken. Services were recruited from different regions across England, representing diverse health settings and service models. Data were collected to describe the service designs, implementation processes and outcomes: i) One-to-one semi-structured interviews were undertaken with staff members of the health and legal services and funding organisations; ii) Service records were collected in the form of quantitative data and written documentation. In-depth qualitative analysis using the process tracing method was applied to each case study individually. Cross-case comparison of the resulting themes identified key patterns and determinants of implementation success.

Results: Nine services participated in the study. Four were based in primary care, four in acute or specialist settings (cancer services, mental health services, a children's hospital and an HIV clinic) and one spanned both primary and secondary care. Thirty-seven interviews were undertaken with staff members in both frontline and management roles. The case studies provided detailed descriptions of how partnership working between health and legal services took place, including: co-location or remote working arrangements, referral methods and routes, communication, data sharing, funding and management. The partnerships had experienced different trajectories: while some were long-lived (more than two decades), others had been discontinued, cut in size or had failed to properly establish. Factors influencing the sustainability of partnerships included funding and resourcing, local commissioning priorities, strategic-level support and issues around leadership and evaluation. The extent of collaborative working was highly variable and influenced by factors such as professional knowledge and attitudes, working relationships, opportunities for learning and interaction. Where close collaborative working between health and legal professionals existed, this resulted in positive impacts for patient care, improved service effectiveness, increased professional knowledge and health service efficiency. All the partnerships indicated improved access to legal assistance for those in need, positive welfare outcomes and benefits relating to improved mental wellbeing among patients.

Implications: With growing concern over the socio-economic impacts on the pandemic, action on health inequalities is more important than ever. Services providing legal assistance for social welfare issues offer a critical safety net for patients facing hardship and can support health services to address the health consequences of deprivation. This study provides detail on how health-justice partnerships can operate in practice and offers insight into the factors affecting successful implementation. Reflections are presented on the relative benefits of the different service models and how they align with other health service priorities and activity. This will assist in the planning and delivery of local partnerships in the near and longer term future.

Exploring Opportunities to Improve Patient Safety When Gps Work in Or Alongside Emergency Departments: Realist Synthesis and Evaluation

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Background: Worldwide, increasing pressure on emergency services has led to the development of different models of care delivery including GPs working in or alongside emergency departments. However, evidence for the effectiveness of this initiative is weak with a lack of evidence for patient safety outcomes. We aimed to explore the nature of patient safety incidents associated with these service models and how the risks may be mitigated.

Method: We used realist methodology to understand the relationship between context, mechanisms and outcomes to develop theories about how and why incidents occurred in different settings and how safe care was perceived to be delivered. Data sources included: a rapid realist literature review (realist synthesis); analysis of a sample of National Reporting and Learning System (NRLS) patient safety incident reports and Coroners' reports; and qualitative data (realist evaluation of 'datix' reports, observations and semi-structured audiotaped interviews) from a purposive sample of 13 selected hospitals with different service models.

Results: There was little evidence in the literature about patient safety outcomes. We identified few incident reports describing diagnostic error associated with these service models: nine Coroners' reports (9/1347; 2013-2018) and 217 NRLS reports (217/13,074,550; 2005-2015). These were largely due to: inadequate streaming processes; errors in clinical decision-making and inadequate skillset; and inadequate referral pathways and communication between services. Strategies perceived to facilitate the delivery of safe patient care at selected hospitals included: an experienced streaming nurse using local guidance and early warning scores; support for GPs' clinical decision-making relevant to the intended role (a traditional GP approach or an emergency medicine approach); strong clinical leadership and clear governance processes.

Implications: There are few evidence-based interventions to improve patient safety for these service models. Priority areas to focus upon include: appropriate streaming processes; supporting GPs' clinical decision-making with clear governance processes; and improving communication between services.

Trauma-Informed Primary and Community Mental Health Care: Analysis of Policy and Professional Perspectives

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Background: Patients can experience psychological trauma as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. The impact of trauma on individuals and healthcare systems are well documented, accounting for significant morbidity in both primary and secondary care. There is strong public health rationale for service design which optimises and supports recovery of trauma survivors. However, existing healthcare services fail to meet the needs of this patient group and can re-traumatise through invasive procedures and coercive practices. Trauma-informed care (TIC) is a novel service delivery framework involving organisational change which creates environments and relationships with clinicians that promote recovery and prevent re-traumatisation. Our systematic review of TIC in primary and community mental healthcare identified limited evidence for its effectiveness in the UK, despite endorsement in various policies. This study aims to explore the reasons for this disconnect by analysing how and why TIC is represented in UK health policies.

Method: A qualitative study using a framework analysis of UK health policies on TIC, with documents identified from manual and electronic searches, as well as snowballing, ii) semi-structured interviews with a purposive sample of professionals involved in the development and implementation of TIC health policies, iii) synthesis of document and interview findings into an account of how and why TIC is being presented in UK health policy. We present findings from the policy review sub-study.

Results: We analysed 20 UK policy documents across a range of categories including strategic plans, guidelines, general evaluations and reports of formative research. We developed seven key themes. In the theme 'What is trauma?' policy documents provide a range of presentations of trauma, with certain documents taking a more specific focus for example on Adverse Childhood Experiences or Domestic Violence. In the theme 'Why TIC?' policy documents provide reasoning for TIC which acknowledges the widespread experience of trauma within the population. It also considers the issue of re-traumatisation within health services. In the theme 'What is TIC?' few policies explain what TIC is in practice, although some cite foundation principles of TIC from published documents. Other documents consider TIC in the context of integrated care and novel models of care provision. In the theme 'TIC for whom?' policies predominantly target mental health and women's health services. Other policies focus on services for rough sleepers and homelessness. There is limited reference to primary care. In the theme 'How to practice TIC' policy documents cite foundation principles of TIC but do not explain how it should be implemented. The theme 'Piecemeal adoption of TIC' recognises the patchy and disjointed adoption of TIC across countries and sectors, as well as in funding commitments. There is variation in breadth of TI care adoption in the UK. For example, some policy documents recommend single sector application such as in mental health whereas others recommend a whole system approach which may include the entire public sector, as well as consideration of police and judiciary systems. There are also geographical differences in adoption for example within a devolved nation compared with nationwide. The theme 'Evidence-policy gap' identifies limited reporting and exploration of evidence for TIC in the UK, despite endorsement in policy documents.

Implications: These findings will support the development of a UK-specific model of TIC in primary health care and community mental health care.

Presenting Author: Jessica Gates

Background: Primary Care Networks (PCNs) are groups of GP practices within a local area with responsibility for 30-50,000 patients. They are a mechanism which encourages collaboration and resource sharing between practices, and they are required to deliver a set of national service specifications. PCNs will focus on areas where they can have an impact against the 'triple aim': improving health and saving lives; improving quality of care for those with multiple health problems; and helping to make the NHS more sustainable. PCNs are a new initiative as of 2019, therefore there is a lack of research in this area and the goals of PCNs are not currently evidence based. This PhD project, which is funded by North Tyneside Clinical Commissioning Group (North East, England), will develop an evidence base and will be fundamental to understanding PCNs and advancing this field of knowledge.

Method: This study will take a mixed methods approach, primarily utilising data from a series of semi-structured interviews which will be conducted with a range of staff members (GPs, nurses) working within North Tyneside PCNs, to explore staff perceptions of the PCNs. This research will also analyse routinely collected metric data from each PCN, to understand whether the intended contract outcomes are being delivered. Detailed case studies will be created for each of these PCNs, pulling together this data, in addition to data from a systematic narrative review conducted by the author and documentary evidence (NHS documents, policy documents). These case studies will illuminate both the perceptions and realities of how the PCNs are evolving in North Tyneside.

Results & Implications: This presentation will focus on overall agenda of the PhD project. In particular it will explore the importance of PCNs, the planned methodological approach, contextual factors associated with the region of North Tyneside, as well as touch upon any initial findings.

Developing A Taxonomy of Care Coordination for Rare Conditions

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Presenting Author: Holly Walton

Background: Coordinating care for people with rare conditions may help to improve care and reduce treatment burden associated with patients attending multiple healthcare appointments on different days, in different locations. Previous research has shown that there are many elements of care coordination. To fully understand care coordination for rare conditions, it is necessary to develop a method for organising different ways of coordinating care. Taxonomies are systems, used to organise complex phenomena into domains. To the authors' knowledge, no studies have previously developed a taxonomy of care coordination for rare conditions. This research aimed to develop and refine a care coordination taxonomy for people with rare conditions.

Method: This research had two stages: a) development of the taxonomy and b) refinement of the taxonomy. To develop the taxonomy, we conducted 30 interviews with healthcare professionals, charity representatives and commissioners, and four focus groups with patients (with rare, ultra-rare and undiagnosed conditions) and parents/carers (n=22). Interviews and focus groups were audio-recorded and professionally transcribed. During the interviews and focus groups, we asked participants about how care is currently coordinated, their preferences for coordination, benefits and challenges of models of coordination, and factors influencing coordination. Findings were analysed using thematic analysis. Themes were used to develop a taxonomy, and to identify which types of coordination may work best in which situations. To refine the taxonomy, we held two workshops: one with patients and carers (n=12), and one with healthcare professionals, commissioners, and charity representatives (n=15). Workshop participants were asked to watch a short video prior to the workshop. This video summarised the taxonomy domains and key findings. During the workshop, participants were split into groups and asked for feedback on each taxonomy domain. Feedback was requested on: whether anything was missing, whether findings seemed appropriate based on participant experiences, appropriateness of options in light of COVID-19 and recommendations to improve the taxonomy domains.

Results: We developed a taxonomy of care coordination for rare conditions. Our taxonomy has six domains, each with different options for coordinating care. The six domains are: 1) Ways of organising care (local, hybrid, national), 2) Ways of organising the team (high, some and low collaboration), 3) Responsibility for coordination (administrative support, formal roles and responsibilities, supportive roles and no responsibility), 4) How often appointments and coordination take place (regular, on demand or hybrid), 5) Access (full or filtered access to records), and 6) Mode of information sharing, care coordination/delivery and communication. Our findings highlighted stakeholder preferences, benefits/challenges, and factors influencing coordination for different options within each of the six domains. For example, for ways of organising care, participants reported preferences for nationally commissioned services or hybrid models (including hub and spokes, networks and outreach models). Hybrid models of organising care had associated benefits (e.g. reducing travel) and challenges (e.g. requiring resources). Factors influencing the way care is organised included patient factors (e.g. condition complexity and severity), healthcare environment factors (e.g. resources) and societal factors (e.g. availability of funding). We will discuss these qualifying factors in relation to our taxonomy domains during the presentation.

Implications: The development of a care coordination taxonomy may help key stakeholders (e.g. commissioners/service planners) to make decisions about how care for rare diseases is organised. It may also inform patients about the types of coordination that may be possible. Our findings on preferences, benefits and challenges, and factors influencing coordination help to identify which types of coordination may work best in different situations. If different ways to coordinate care are piloted, evaluated and eventually implemented within the NHS, findings could potentially improve care and reduce burden for people living with rare conditions.

The Types and Effects of Feedback Received by Emergency Ambulance Staff: A Systematic Mixed Studies Review with Narrative Synthesis

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Background: The phenomenon of feedback is well-researched within the wider healthcare context, where it is suggested that feedback can improve patient care and patient safety by enhancing clinical performance and staff mental health (Ivers et al., 2012). Within the rapidly changing urgent and emergency care landscape, ambulance staff navigate complex patient care pathways and patient safety concerns, whilst reporting low levels of staff engagement and wellbeing. Enhancing prehospital feedback may have considerable benefit to clinical decision-making, professional practice and staff mental health by providing closure. Systematic reviews have been conducted for automated feedback from defibrillators and debrief after simulation, but not on the wider concept of prehospital feedback. The aim of this systematic review was to identify, describe and synthesize the published literature on the types and effects of feedback received by emergency ambulance staff.

Methods: A systematic mixed studies review was conducted to synthesise existing primary empirical evidence and support a review of current practice in prehospital feedback in the United Kingdom. Studies were included if they explored the concept of feedback as defined in this review: “the systematised provision of information to emergency ambulance staff regarding their performance within prehospital practice and/or patient outcomes”. Databases searched on 11th June 2020 from inception were MEDLINE, EMBASE, AMED, PsycInfo, HMIC, CINAHL and Web of Science. Study quality was appraised using the Mixed Methods Appraisal Tool (Hong et al., 2018) and data analysed using narrative synthesis guided by Popay et al. (2006) following a parallel-results convergent synthesis design. PROSPERO ID CRD42020162600.

Results: The search strategy yielded 2424 articles excluding duplicates. 78 studies met the inclusion criteria after full-text review, of which 37 only mentioned feedback briefly as a solution to improving specific circumstances being studied (e.g. decision-making, burnout). The remaining 41 studies had prehospital feedback as a main focus and consisted of 34 interventional prehospital feedback studies, 4 non-interventional feedback studies and 3 preparatory studies. The source, content, mode, format and frequency of prehospital feedback in the interventional studies varied greatly and encompassed both feedback on behaviour and/or feedback on outcomes of behaviour. 7 of the 34 interventional studies encompassed feedback on all patients, with the remaining interventional studies focusing on specific patient conditions such as cardiac arrest (n=13), myocardial infarction (n=8), cerebrovascular accidents (n=3), trauma (n=2) and non-conveyance (n=1). The main outcome measure of included interventional studies was quality of care (e.g. quality of cardiopulmonary resuscitation, adherence to guidelines) but softer measures such as staff wellbeing, professional development and clinical decision-making were also represented. 27 of the interventional studies reported a statistically significant positive effect on their primary outcome measure, with the remaining studies either not testing for significance (n=4) or reporting non-significance (n=3). Overall, the methodological quality of the evidence base in this area is poor with no randomised controlled trials being retrieved and many of the quantitative non-randomised studies not reporting to have accounted for confounding in their design or analysis.

Implications: The lack of reported use of underlying theory in the interventional studies suggests that many prehospital feedback developments in practice are isolated initiatives with no clear intervention model or evaluative framework, which highlights the need for a firmer evidence base. Building upon the review findings, the research team is conducting further empirical research using a realist approach, which will explore whether the published literature reflects current prehospital practice in the United Kingdom and facilitate the development of programme theory for prehospital feedback. It is anticipated that findings from the systematic review will be useful to guide the development of future prehospital feedback interventions, for which there is growing interest in the national and international prehospital setting.