2018-05

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Lloyd, Helen

10.5334/ijic.s2032

Iloyd, H et al 2018 Patient Experiences of Care from Multi-Speciality Community Providers: Findings from a Realist Synthesis of International Evidence. *International Journal of Integrated Care*, 18(S2): A32, pp. 1-8, DOI: dx.doi.org/10.5334/ijic.s2032

CONFERENCE ABSTRACT

Patient Experiences of Care from Multi-Speciality Community Providers: Findings from a Realist Synthesis of International Evidence

18th International Conference on Integrated Care, Utrecht, 23-25 May 2018

Helen Mary Iloyd[1], Rod Sheaff[3], Sarah Brand[4], Amanda Wanner[1], Richard Byng[1], Jose Valderas[2], Mark Pearson[2]

1: Community and Primary Care Research Group, Plymouth University, United Kingdom;
2: Exeter Medical School, Exeter University, United Kingdom;
3: School of Law, Criminology and Government, Plymouth University, United Kingdom;
4: Cardiff University, United Kingdom

Introduction: Multispecialty Community Providers (MCPS) aim to provide horizontal coordination of care via networks of primary care providers (general practice, community health services, mental health, ambulance, etc.) and non-health services (e.g. voluntary sector, social services etc.). MCPs are also expected to improve the quality, continuity and coordination of care for people with chronic health problems. Our Realist Synthesis identified policy assumptions about how MCPs are thought to achieve outcomes and the extent to which these were supported by evidence. Improvements to patient experiences of care was also an expected outcome of MCP care. We explored the evidence for this outcome.

Theory/Methods: Three stage synthesis:

1) Review of policy material to identify the underlying programme theory (PT) for MCPs. This work surfaced policy makers assumptions about how MCPs would achieve their outcomes. These were elicited from policy documents and 'think-tanks' with stakeholders. We searched Health Management Information Consortium (HMIC) database, and the King's Fund database. The elaboration of the policy-makers' assumptions about MCPs provided search terms for the second stage.

2) A systematic literature review and synthesis of secondary evidence mapped to the initial PT. We searched for evidence of the 'causal links' in the initial PT by searching databases: MEDLINE, PsycINFO, CINAHL, and ASSIA. 1319 titles/abstracts reviewed in two rounds, and 116 selected for full-text data extraction. Secondary data were extracted and synthesised into a framework reflecting causal links in the initial PT. We used the Mixed Methods Appraisal (MMAT) and the Assessment of Multiple Systematic Reviews (AMSTAR) tools to assess quality and validity.

3) Comparison (and reformulation) of original PT based on secondary evidence and identification and focus on all studies measuring patient experience as an outcome (e.g. goal setting, care planning at a patient level etc.).

Results: We found supporting evidence that if MCPs implement care planning at a patient level then patient experiences of care improve. The evidence was less strong for improvements in patient experience as a consequence of diversion from in-patient care. MDTs and boundary spanning roles helped improve patient experience. There was emerging evidence that MDTs and boundary spanning roles facilitated the delivery of person centred care by improvements in care planning and access to services.

Discussion: Individuals with complex needs or those with long term conditions commonly report poor experiences of care (5, 6), particularly care from multiple organisations (7). Our review suggests that MCPs can improve patient experiences of care by providing tailored and accessible coordinated care.

Conclusions: Patients' experiences of care have the potential to improve if care planning at a patient level becomes prevalent and delivered through MDTs and/or professionals with boundary spanning roles.

Lessons learned: MDTs and boundary spanning roles are potential mechanisms to improve the experiences of care.

Limitations: Due to the large volume of material we only included studies published 2014-2016; reviews covered earlier periods.

Suggestions for future research: Changes in organisational culture was a potential mechanism associated with improvements in patient experience. Primary research that explore how this works would help unpack this newly identified mechanism.

Keywords: horizontal integration; multidisciplinary working; patient experience; person centred care; realist methods