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Conference Abstract

# A new causal model of access and continuity for marginalised groups

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## Abstract

**Background:** Problem statement: Care for individuals who are marginalised and have complex needs is poor due to both reduced access and poor continuity. Improved access to treatment requires to improvement to both. Previously access has usually been measured quantitatively while there has been a trend to seeing continuity as an 'experience' encompassing relationship, flexibility and organisation of care.
Purpose: To develop a causal model for barriers and facilitators of access to and continuity of healthcare care for individuals with complex needs using data from offenders as an exemplary group.

**Methods:** Design: Mixed-method, exploratory synthesis utilising a Realistic Evaluation framework to describe outcomes of interest (access and continuity)and then examine data streams to identify causal influences.

**Data:** Three related data and analysis streams: quantitative analysis of data about care from structured interviews with 200 offenders ; qualitative (pre-coded and thematic) analysis of 25 offender interviews and three focus groups; and two whole-organisation case studies and six mini 'best-practice' case studies from England.

**Setting:** Health and criminal justice systems covering two local authorities in the south west and south east of England and six additional case study sites.
Participants: 200 offenders and 35 practitioners and managers.

**Results:** Healthcare was reported as disrupted, with barriers to access and ongoing care; there was quantitative evidence of continuity for those with substance misuse but not for those with mental health problems. In the new model developed from the data, continuity was conceptualised as a continuation of access with the same practitioner, a different practitioner in the same team, or a different team. In contrast we described how organisational and practitioner factors contribute to both initial and ongoing continuity of access. Services needed well engineered access arrangements as well as to demonstrate they have treatments worth receiving to sceptical clients; initial distrust needed to be overcome with skilful practitioner interactions in order to promote

continuity; and organisational integrating functions such as liaison, pathways, data sharing and co-location could all play a part in creating continuity but practitioners need to be empowered to be flexible.

**Conclusions:** Access and continuity are best seen as a continuum. By considering organisational and interpersonal factors that contribute to ongoing access, those who provide and commission care for people with complex conditions and from marginalised communities can use the model to specify practitioner behaviours and service configurations which are likely to be helpful in different contexts.

## Keywords

**continuity, access, primary care, continuity of care, hard to reach groups**