Pathways to impact

Gene Feder

School for Primary Care Research

The National Institute for Health Research School for Primary Care Research (NIHR SPCR) is a partnership between the Universities of Birmingham, Bristol, Keele, Manchester, Nottingham, Oxford, Southampton and University College London.

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What is impact?

REF definition

facilitators of impact

- research questions that matter
- downstream results
- positive findings
- strategy (and budget) for knowledge mobilisation/commissioning
- engagement of stakeholders from conception onwards

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questions that matter?

- What are the health care needs of Traveller Gypsies?
- Can clinical guidelines improve quality of care?
- Can patients with moderate COPD withdraw from inhaled steroids?
- Is access to cardiac care inequitable by ethnicity, age, gender or socioeconomic status?
- Can we improve the response of general practice to domestic violence?

Traveller Gypsies and childhood immunization: a study in east London

GENE S FEDER

TERESA VACLAVIK

ALLISON STREETLY

This study was part of a larger project to assess the health care of Traveller Gypsies in Hackney, east London. As one measure of preventive health care provision the immunization status of Traveller Gypsy children presenting to primary care services was assessed and compared with that of a control group.

Traveller Gypsies have stopped in Hackney for at least 150 years.[7] There are no official caravan sites in the borough but

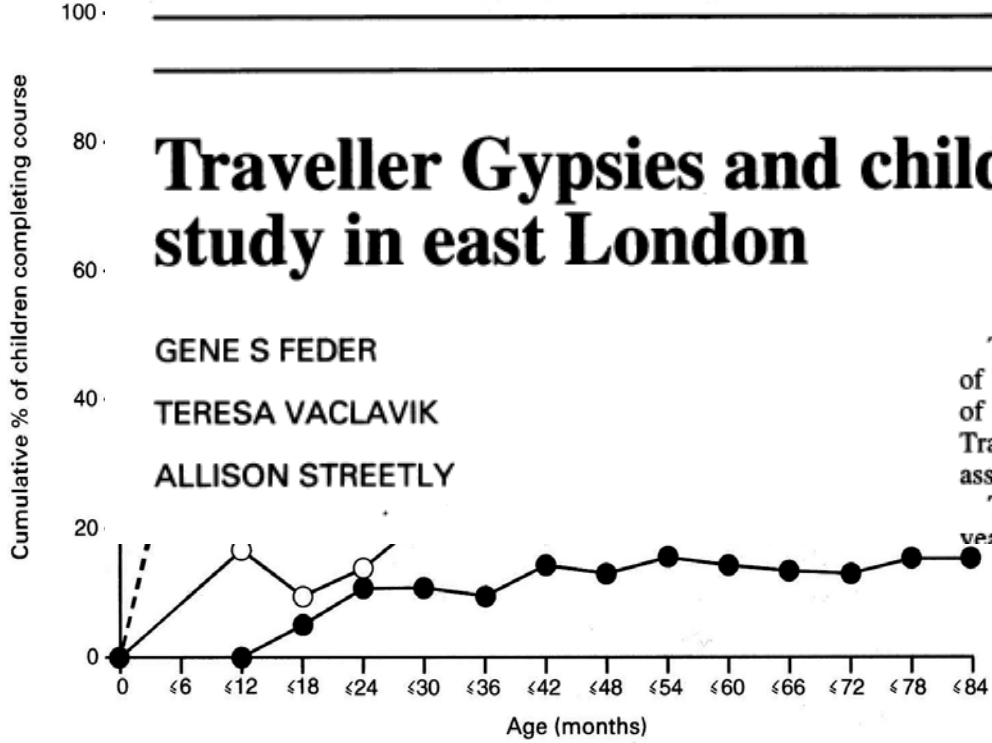

Figure 1. *Completion of primary tetanus (and diphtheria) and pertussis immunizations for the Traveller Gypsy and control children.*

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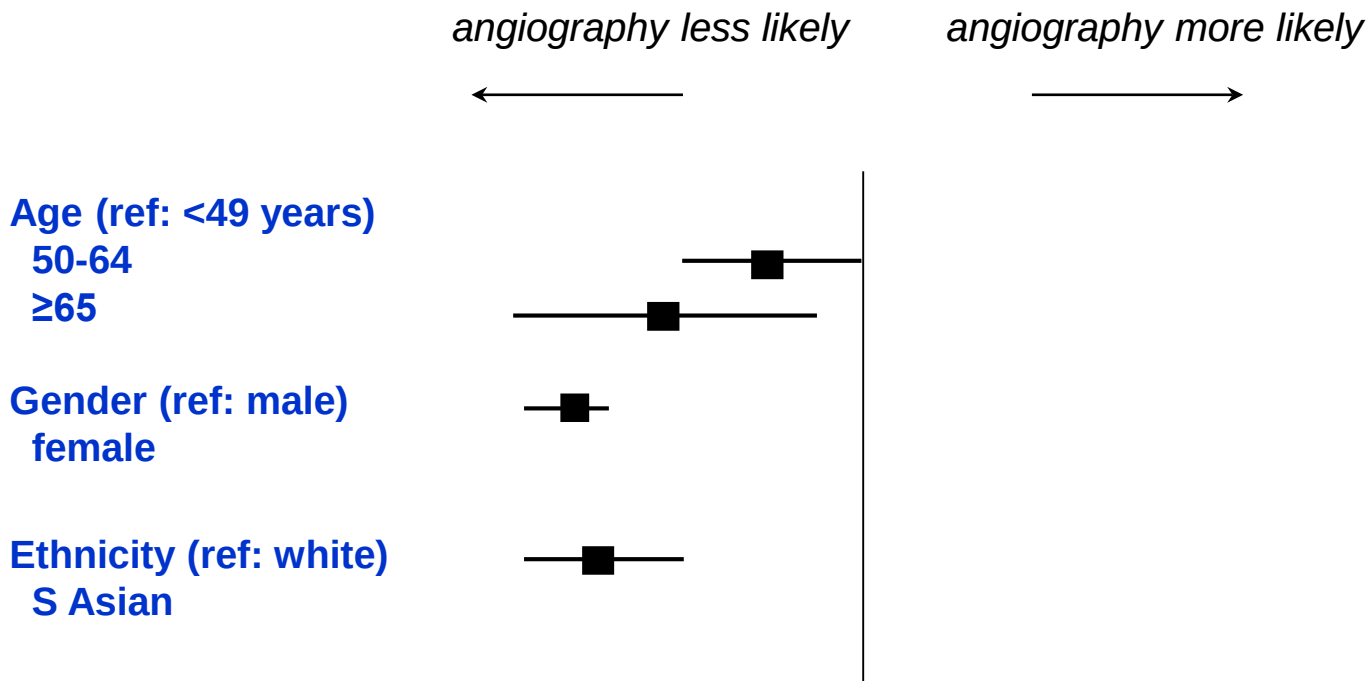
Older people, women, south Asians and poorer people less likely to get appropriate angiography



BMJ

RESEARCH

Inequity of access to investigation and effect on clinical outcomes: prognostic study of coronary angiography for suspected stable angina pectoris

Neha Sekhri, clinical research fellow,[1] Adam Timmis, professor of clinical cardiology,[1] Ruoling Chen, senior lecturer in epidemiology,[2] Cornelia Junghans, research fellow in epidemiology,[2] Niamh Walsh, statistician,[3] Justin Zaman, clinical research fellow in epidemiology,[2] Sandra Eldridge, professor of biostatistics,[3] Harry Hemingway, professor of clinical epidemiology,[2] Gene Feder, professor of primary health care[4]

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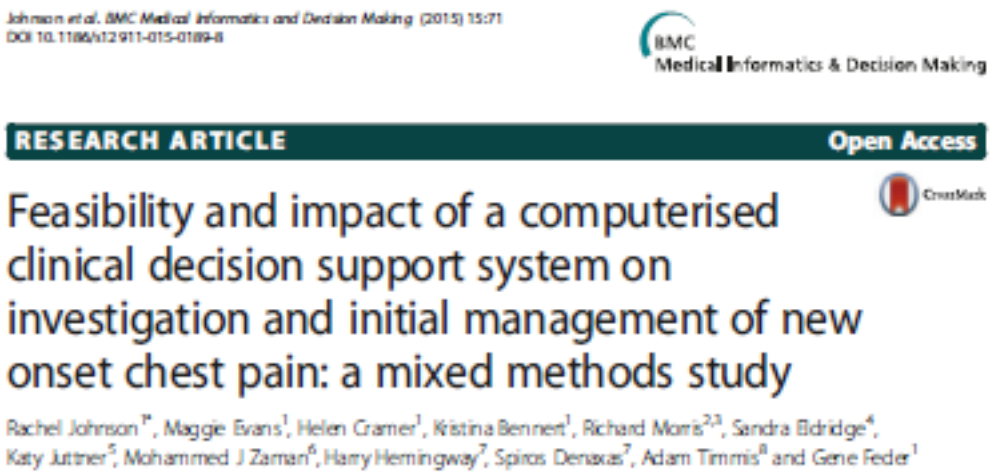
positive findings (not)



Johnson et al. BMC Medical Informatics and Decision Making (2015) 15:71
DOI 10.1186/s12911-015-0189-8

BMC Medical Informatics & Decision Making

RESEARCH ARTICLE Open Access

Feasibility and impact of a computerised clinical decision support system on investigation and initial management of new onset chest pain: a mixed methods study

Rachel Johnson[*], Maggie Evans[1], Helen Cramer[1], Kristina Bennett[1], Richard Morris[2,3], Sandra Eldridge[4], Katy Juttner[5], Mohammed J Zaman[6], Harry Hemingway[7], Spiros Denaxas[7], Adam Timmis[8] and Gene Feder[1]

negative findings can have an impact

positive findings (bigger is better)

Open Access Research

BMJ open accessible medical research

Cost-effectiveness of Identification and Referral to Improve Safety (IRIS), a domestic violence training and support programme for primary care: a modelling study based on a randomised controlled trial

Angela Devine,[1] Anne Spencer,[2] Sandra Eldridge,[1] Richard Norman,[3] Gene Feder[4]

To cite: Devine A, Spencer A, Eldridge S, *et al*. Cost-effectiveness of identification and referral to improve safety (IRIS), a domestic violence training and support programme for primary care: a modelling study based on a randomised controlled trial. *BMJ Open* 2012;**2**:e001008. doi:10.1136/bmjopen-2012-001008

► Prepublication history for this paper is available online. To view this file please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2012-001008).

Received 10 February 2012
Accepted 14 May 2012

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ABSTRACT

Objective: The Identification and Referral to Improve Safety (IRIS) cluster randomised controlled trial tested the effectiveness of a training and support intervention to improve the response of primary care to women experiencing domestic violence (DV). The aim of this study is to estimate the cost-effectiveness of this intervention.

Design: Markov model-based cost-effectiveness analysis.

Setting: General practices in two urban areas in the UK.

Participants: Simulated female individuals from the general UK population who were registered at general practices, aged 16 years and older.

Intervention: General practices received staff training, prompts to ask women about DV embedded in the electronic medical record, a care pathway including referral to a specialist DV agency and continuing contact from that agency. The trial compared the rate of referrals of women with specialist DV agencies from 24 general practices that received the IRIS programme with 24 general practices not receiving the programme. The trial did not measure outcomes for women beyond the intermediate outcome of referral to specialist agencies. The Markov model extrapolated the trial results to estimate the long-term healthcare and societal costs and benefits using data from other trials and epidemiological studies.

Results: The intervention would produce societal cost savings per woman registered in the general practice of UK£37 (95% CI £178 saved to a cost of £136) over 1 year. The incremental quality-adjusted life-year was estimated to be 0.0010 (95% CI −0.0157 to 0.0101) per woman. Probabilistic sensitivity analysis found 78% of model replications under a willingness to pay threshold of £20 000 per quality-adjusted life-year.

Conclusions: The IRIS programme is likely to be cost-effective and possibly cost saving from a societal perspective. Better data on the trajectory of abuse and the effect of advocacy are needed for a more robust model.

Trial registration: Current Controlled Trials, ISRCTN74012786.

ARTICLE SUMMARY

Article focus

- The aim of this study was to assess the cost-effectiveness of the IRIS training and support intervention for primary care clinicians from the UK societal and NHS perspectives.

Key messages

- The intervention is likely to be cost saving from a societal perspective with a high likelihood of being under a £20 000 per quality-adjusted life-year willingness to pay threshold.

Strengths and limitations of this study

- We have minimised bias in estimating the effect size of the IRIS programme by basing it on a randomised controlled trial.
- By using epidemiological and cost data external to the trial, we were able to extrapolate from directly measured trial outcomes (DV disclosure and referral rates) to quality of life, health and economic outcomes.
- The uncertainty of the transition probabilities based on assumptions was addressed by probabilistic sensitivity analysis, contributing to the robustness of the model.
- Important limitations of that data are the paucity of longitudinal studies measuring the trajectory of abuse and uncertainty about the effect of DV advocacy for women not living in a refuge or shelter.

ortion of referrals
ortion of identifications

fety (IRIS) of
vith a primary care
er randomised

Alison Gregory, Annie Howell, Medina Johnson

Lancet 2011; 378: 1788–95

facilitators of impact

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knowledge mobilisation

‘Herding cats’: the experiences of domestic violence advocates engaging with primary care providers

Medina Johnson from Next Link in Bristol revea
recent Identification and Referral to Improve Sa
general practices with domestic violence specia

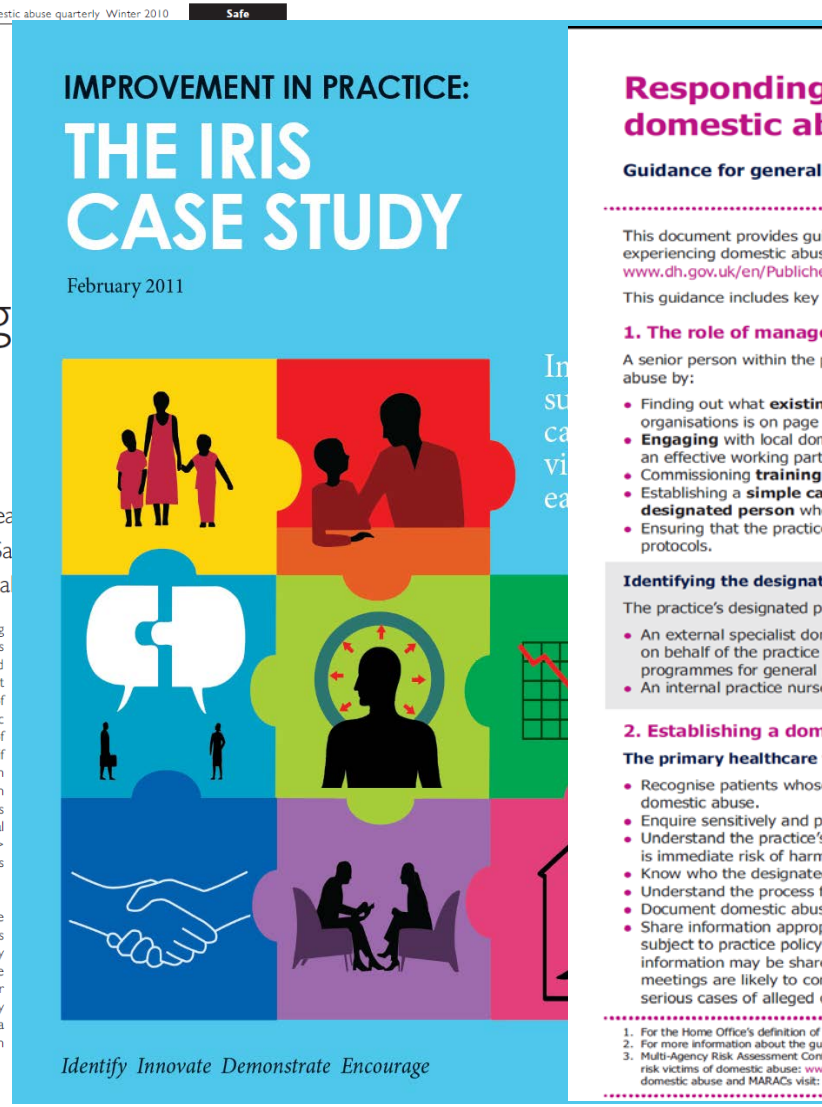
Engaging health care services in supporting women experiencing domestic violence has been a challenge for domestic violence fora and specialist agencies. Reluctance to talk about domestic violence may be for a variety of reasons: clinicians may feel that domestic violence is not their remit; are not aware of related health issues; fear offending women if they ask about abuse; do not want to open Pandora's Box and then not be able to deal with what comes out of it; domestic violence does not fit with what many see as the traditional medical model of symptom > diagnosis > treatment > cure (even if much of what GPs and nurses do lies outside that model)[1,2].

The Identification and Referral to Improve Safety (IRIS) randomised control trial has been working to engage general practices by providing primary care teams with the information, confidence and skills to ask their female patients about domestic abuse and by creating an easy and clear referral route to a named advocate who is able to meet with

Notes

1 Gremillion DH, Kanof EP. *Overcoming barriers to physician involvement in identifying and referring victims of domestic violence.* Ann Emerg Med. 1996;27:769–773.

2 Sugg NK, Thompson RS, Thompson DC, Maiuro R, Rivara FP. *Domestic violence and primary care. Attitudes, practices, and beliefs.* Arch Fam Med. 1999;8:301–306.



Responding to domestic abuse:

Guidance for general practices

Royal College of General Practitioners

IRIS Identification & Referral to Improve Safety

caada

This document provides guidance to general practices to help them respond effectively to patients experiencing domestic abuse,[1] a Department of Health strategic priority: www.dh.gov.uk/en/Publichealth/ViolenceagainstWomenandChildren/index.htm

This guidance includes key principles to help you develop your domestic abuse policy.[2]

1. The role of management

A senior person within the practice should be identified to clarify the practice's response to domestic abuse by:

- Finding out what **existing domestic violence services** are available (a list of national organisations is on page 4).
- **Engaging** with local domestic abuse services – and the Domestic Violence Co-ordinator – to develop an effective working partnership.
- Commissioning **training** for the practice team.
- Establishing a **simple care pathway** for patients disclosing domestic abuse by identifying a local **designated person** who will be responsible for the initial assessment of victims.
- Ensuring that the practice's response to disclosure always adheres to its **information sharing** protocols.

Identifying the designated person

The practice's designated person can either be:

- An external specialist domestic abuse service practitioner who undertakes the initial assessment on behalf of the practice and liaises with the GP. Specific evidence based training and support programmes for general practice are available: www.irisdomesticviolence.org.uk
- An internal practice nurse or other health professional who is trained to carry out this work.

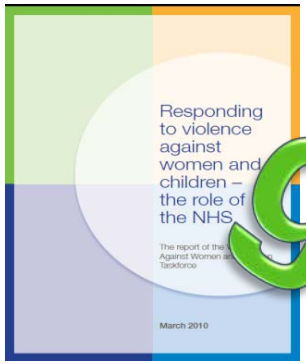
2. Establishing a domestic abuse care pathway

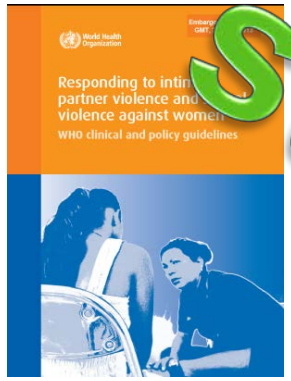
The primary healthcare team's role

- Recognise patients whose symptoms mean they might be more likely to be experiencing domestic abuse.
- Enquire sensitively and provide a safe and empathetic first response.
- Understand the practice's process for responding to disclosure, and know what to do when there is immediate risk of harm to patients and their children.
- Know who the designated person is for their practice.
- Understand the process for arranging the patient's initial assessment with the designated person.
- Document domestic abuse within patient records safely and keep records for evidence purposes.
- Share information appropriately. Information will be shared **only with the consent** of the patient, subject to practice policy on child protection and adult safeguarding. In exceptional circumstances information may be shared without the patient's consent. Some cases considered at MARAC[3] meetings are likely to constitute exceptional circumstances because MARACs discuss the most serious cases of alleged or suspected domestic abuse.

1. For the Home Office's definition of domestic abuse visit: www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-violence/
2. For more information about the guidance contact iris@nextlinkhousing.co.uk or info@caada.org.uk
3. Multi-Agency Risk Assessment Conference – where information is shared and a coordinated safety plan implemented to protect the highest risk victims of domestic abuse: www.caada.org.uk/aboutus/faqs.html For guidance about the application of Caldicott Guardian Principles to domestic abuse and MARACs visit: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133589

knowledge mobilisation



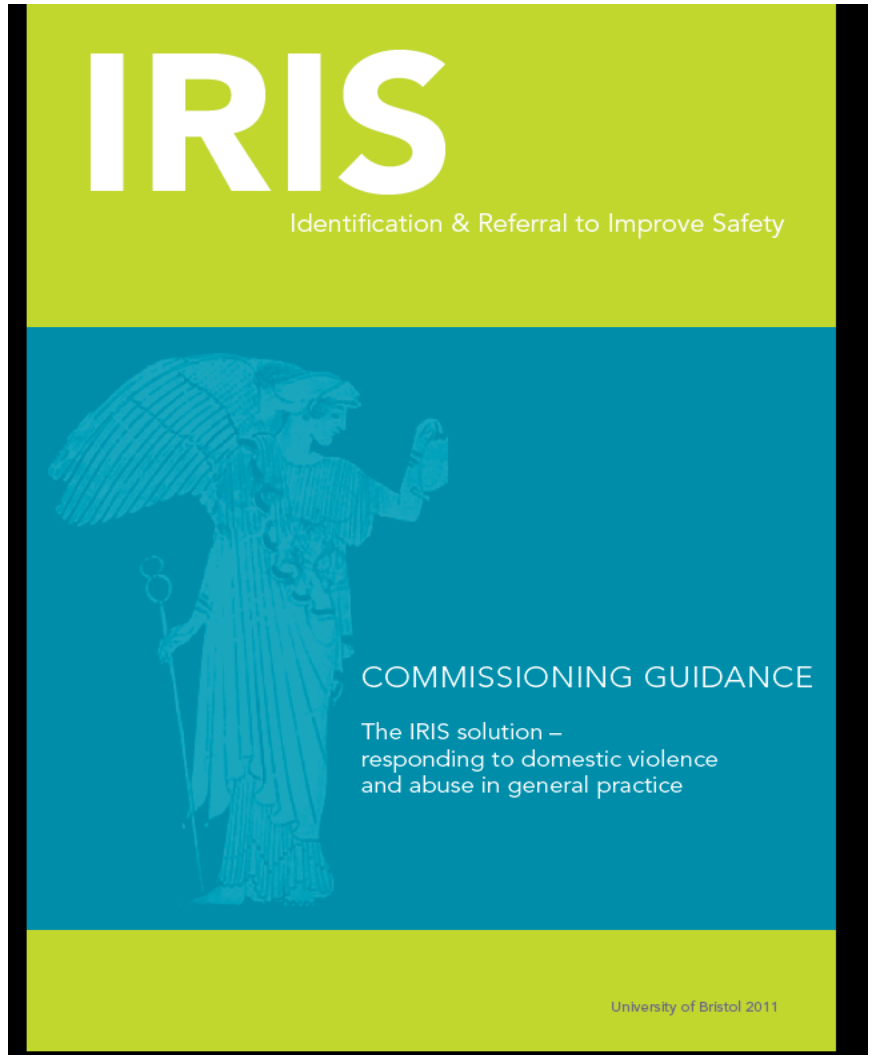


- cited in Department of Health Violence Against Women and Children taskforce report as an exemplar programme
- cited in WHO partner violence guidelines as evidence for recommendation on training interventions
- part of NICE domestic violence guidelines evidence review
- cited as a "particularly effective remedy" by the Task and Finish Group for the Welsh Government's proposed 'Ending Violence Against Women and Domestic Abuse (Wales) Bill'

guidelines are a stepping stone

commissioning

- IRISimp
- 2-year grant from Health Foundation
- commissioning guidance



- website

http://www.irisdomesticviolence.org.uk/iris/

impact

- commissioned by CCGs and local authorities in 32 English localities
- current annual rate of referral of DVA survivors from IRIS practices in England to specialist agencies is > 1000/year
- the programme started implementation in Scotland in June 2013 and implemented in south Wales in 2015.

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engagement of stakeholders

- CCGs
- national patient/lobbying organisations
- pilot implementation sites
- potential implementation funders

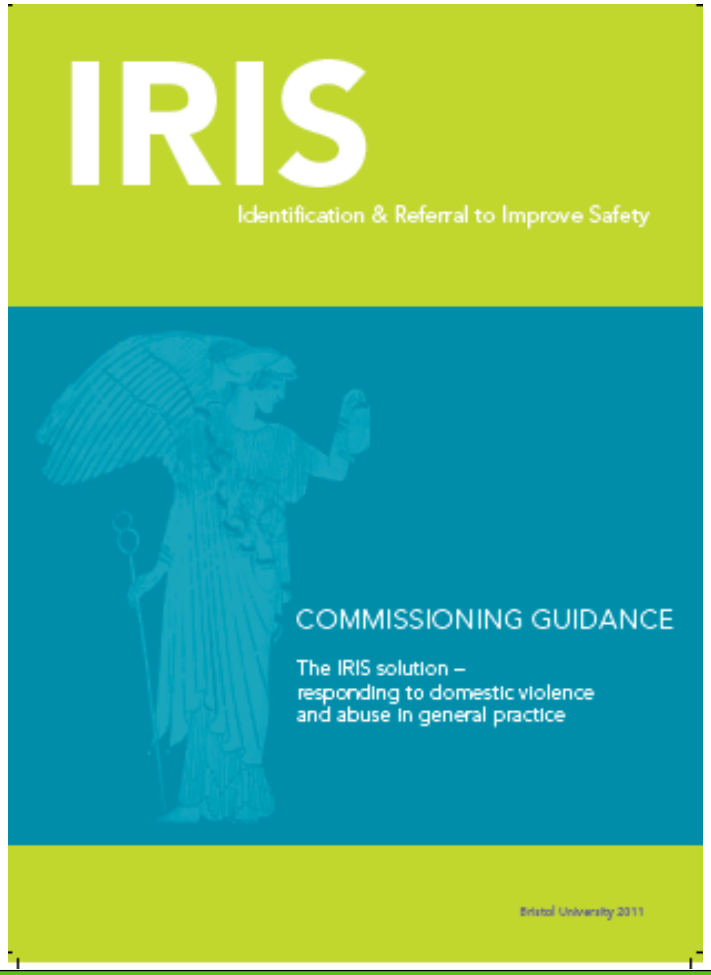
AUSTERITY

lessons

- think about pathways to impact at conception of study
- include a cost-effectiveness analysis for evaluative studies
- get funding for knowledge mobilisation
- produce non-academic outputs
- form strategic partnerships
- be lucky

guidelines are a stepping stone

translation into practice



- **IRISimp**: ongoing project to facilitate commissioning of the programme, train advocate educators and monitor outcomes
- commissioned in 11 English PCTs/localities

REF definition

Include on last page of presentation

The [name of project] is funded by the National Institute for Health Research School for Primary Care Research (NIHR SPCR). The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.

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