

one comprised focus groups/semi-structured interviews and cognitive interviews to evaluate content validity, comprehensibility and acceptability; and refinements to IPOS-Dem made. Phase two employed an embedded mixed methods design to evaluate MOA, feasibility and implementation requirements. Residents received IPOS-Dem as part of routine care for 12 weeks. Qualitative data included focus groups, semi-structured interviews and observations. Quantitative data comprised IPOS-Dem scores. Directed content analysis and descriptive statistics was used for qualitative and quantitative data analysis respectively, analysed separately and then integrated on key areas to inform a final theoretical model.

**Results** Phase one: 26 family, care staff and health professionals participated in focus groups/interviews, and 10 care staff in cognitive interviews. Five additional items were identified as important for content validity. Refinements to improve acceptability and comprehensibility included use of lay terms and item descriptors. Phase two: 32 residents received IPOS-Dem and 18 family, care staff and health professionals participated in focus groups, interviews and observations. Key MOA were improved collaborative assessment resulting in improved detection of symptoms and concerns; comprehensive 'picture of the person' which supported systematic record-keeping and monitoring, and facilitated communication between care staff, family, and health professionals. IPOS-Dem was perceived as easy to use and providing value to care, with the proportion of missing data decreasing from 2.1% at baseline to 1.1% at 12 weeks.

**Conclusion** IPOS-Dem is an acceptable and feasible measure to improve comprehensive assessment and management of symptoms and concerns in residents with dementia. A theoretical model of likely MOA and implementation requirements is presented. Further psychometric testing and effectiveness trial is required.

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## Health services research

### OP30 #INTEGRATED CARE AT THE FRONTLINE: A PARTICIPATORY EVALUATION OF LOCALITY LEVEL MULTI-PROFESSIONAL TEAMS IN EAST LONDON

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**Background** NHS England's new models of care (NCM) offer a platform for local partnerships between health and social care providers to reduce fragmentation of services and to support an integrated approach to care provision that is patient-centred and coordinated. The rationale behind these partnerships is to promote multi-professional working and integrated care, e.g. locality level multi-professional teams. These teams provide care coordination and case management for patients whose needs are most appropriately met by different health

and social care professionals. The aim of the evaluation is to assess the enablers and barriers of implementing a multi-professional care model in primary care.

**Methods** The model of care presented here is being evaluated using a participatory approach to research: the Researcher in Residence (RiR). The researchers are embedded at the locality level and are using a formative, process-orientated approach employing primarily qualitative methods to gather data including participant observation, interviews, focus groups and documentary analysis. The RiR model places the researcher as a key member of the delivery team and enables co-creation of knowledge between researchers and practitioners, with the aim to increase opportunities for evidence to influence programme development. Furthermore, we have developed a maturity matrix tool which will enable the organisations participating in the evaluation to assess the extent of the development of the locality level teams over time.

**Results** Preliminary findings have revealed that a series of system enablers to promote integrated working have been introduced including efforts to co-locate health and social care staff. Whereas co-location might contribute to team building as evidenced by effective working between health professionals, it is not a panacea, and organisational development needs are evident in terms of organisational, cultural and professional issues, i.e. different management lines and organisational pressures, professional identity, trust, and accountability, compounded by rapid staff turnover and high numbers of locum staff.

**Conclusion** Frontline staff from both health and social care have demonstrated a desire to ensure delivery of joined up patient-centred care; interdisciplinary teams can potentially play a crucial role in driving greater care coordination. However, a plethora of policy initiatives resulting in continual reconfiguration of community health services while overlooking the same stumbling blocks that have continued to hamper previous efforts at strengthening integrated care may weaken outcomes once again. Better understanding of patterns of collaborations and integrated care pathways is crucial to identify frontline staff's organisational development needs and provide adequate support.

### OP31 TOWARDS UNDERSTANDING THE 'PARTNER' IN PARTNER NOTIFICATION FOR SEXUALLY TRANSMITTED INFECTION HEALTHCARE: MOVING BEYOND THE DICHOTOMY OF 'REGULAR' AND 'CASUAL' PARTNERS

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**Background** Partner notification (PN) is a key strategy for sexually transmitted infection (STI) management to reduce transmission and improve population health. It involves contacting sexual partners of people diagnosed with an STI and encouraging testing and treatment to prevent onward transmission, and re-infection. Current UK PN practice tends to conceptualise sexual partner types as 'regular' or 'casual'. However these terms do not sufficiently capture diverse sexual behavioural