

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

patterns or STI transmission risk. Given this context, we explored the social relevance, understandings and meanings of contemporary sexual partner types, as a first step in aligning lived realities with clinical practice to improve PN outcomes.

Methods We conducted eleven semi-structured focus groups (November 2016–August 2017), with members of the public (n=38) and sexual health clinic attendees diagnosed with an STI in the past six months (n=19) in England and Scotland. We recruited participants aged 18–65 years who identified as heterosexual or men who have sex with men (MSM), using purposive and convenience sampling. Data were digitally recorded, transcribed and analysed using thematic analysis in NVivo V10.

Results Findings from the 57 participants (male n=34; female n=23), suggested two key themes in understanding sexual partner types: 1) nature of emotional involvement with the partner(s) and 2) time/continuity of the relationship. Both tapped into participants' relationship perspectives and shaped their understandings and use of partner terms. Interrelated subthemes involved: the different contexts, such as clinical consultations or everyday social interactions, which shaped the use of the terms 'regular' and 'casual' and associated interpretations; and the polysemy and ambiguity of the terms when they were used in combination with other words (e.g. casual sex; casual partner; casual regular) and alternate terms (e.g. random, one-off, serious relationship). There were no differences in the understandings of the terms between heterosexual and MSM participants.

Conclusion This is the first empirical evidence that challenges and provides insight into the dichotomy of sexual partner types in contemporary clinical practice. There is a need for a new socially informed, interdisciplinary classification of sexual partner types to enable better recording and communication between patients, sex partners and healthcare professionals. Improved understanding of partner types will help healthcare professionals develop and tailor PN approaches which address social and cultural influences on the way people form sexual relationships and talk about sex. This will enable targeting of resources to achieve greatest benefit to individual and population health by detecting and preventing STI transmission.

OP32 TRENDS IN USE OF PRESCRIBED MEDICINES BY BODY MASS INDEX AND AGE: EVIDENCE FROM THE LAST TWO DECADES USING HEALTH SURVEYS FOR ENGLAND DATA

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Background Prescribing is the most common clinical intervention in the NHS, with annual costs exceeding £9 billion. Understanding differences in patterns of prescribed medicine use over time informs clinical practice and epidemiological research. We compare trends in prescribed medicine use by body mass index (BMI) and age to better understand the factors associated with increased prescribing.

Methods Repeated cross-sectional analysis of nationally-representative Health Surveys for England 1994–2015 (n=42 216 participants aged 20+ years with measured BMI and medicine use data). Sex-specific logistic regression models with main effects and interactions between BMI (reference: normal-

weight; obese: BMI ≥ 30 kg/m²), age, and survey year on taking any prescribed medicine in the last week (excluding smoking cessation products and contraception) were assessed adjusting for smoking and education. Analyses were repeated for polypharmacy (3+ medicines), and for cardiovascular and non-cardiovascular medicines. Results are presented as fully-adjusted Odds Ratios (OR) with 95% Confidence Intervals (95% CIs).

Results Overall, the age-standardised prevalence of prescribed medicine use between 1994 and 2015 increased from 37.8% (95% CI 36.7% to 39.0%) to 46.7% (45.2%–48.2%) in men and from 45.7% (44.6%–46.8%) to 53.2% (51.8%–54.6%) in women. By 2015, use of 3+ medicines had doubled to 24.6% (23.4%–25.8%) in men and to 27.2% (26.1%–28.3%) in women. Among those taking any medicine, polypharmacy rose by 1.7 times to 42.8% (39.9%–45.6%) and 45.1% (42.9%–47.2%) respectively.

Prescribed medicine use increased over time more sharply with age. However, after age-adjustment, the increase in prevalence over time was greatest in obese women (BMI-by-year interaction: p=0.003). The odds of obese women taking any prescribed medicine in the last week were 1.5 times higher than those for normal-weight women in 1994 (OR: 1.49; 95% CI 1.28 to 1.73), but had increased to 2.1 in 2015 (2.14; 1.82–2.53). Increased medicine use over time was greatest in obese men for cardiovascular medicines (BMI-by-year interaction: p=0.036). The odds of obese men aged 50–59 years taking any prescribed cardiovascular medicine in the last week were 2.1 times higher than those for normal-weight men of the same age in 1994 (2.08; 1.46–2.95). The equivalent odds had increased to 3.0 in 2015 (2.98; 2.10–4.21).

Conclusion Higher BMI is associated with increased prescribing over the last 20 years regardless of age, reflecting secular rises in levels of awareness and of treatment of obesity and other co-morbid conditions, such as hypertension and diabetes, increased availability of effective secondary prevention medicines (e.g. statins, ACE inhibitors), lower thresholds for their use, and greater adherence to guidelines for their prescription.

OP33 PERMANENT CHILDHOOD HEARING IMPAIRMENT DETECTED THROUGH UNIVERSAL NEWBORN HEARING SCREENING: SYSTEMATIC REVIEW AND META-ANALYSIS OF PREVALENCE AND SCREENING PROGRAMME PERFORMANCE IN 1.8 MILLION INFANTS

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Background Systematic appraisal of universal newborn hearing screening (UNHS) programme performance and the prevalence of permanent childhood hearing impairment (PCHI) detected is lacking, including for those admitted to Neonatal Intensive Care Units (NICU). We carried out a systematic review and meta-analysis of studies reporting PCHI prevalence (defined as bilateral loss ≥ 26 dB HL) detected through UNHS (defined as universal screening using otoacoustic emissions and/or auditory brainstem response testing by age 6 months) in very-highly developed countries (PROSPERO:CRD42016051267). We