

**Conclusion** The diet score was a good approximation of dietary quality and demonstrated a positive relationship between an unhealthy diet and markers of poorer cardiometabolic health. The measure can be used to examine dietary patterns within the UKB and explore their relationship with a range of outcomes.

OP84

#### ADAPTING THE ONLINE DIETARY ASSESSMENT TOOL (MYFOOD24) FOR INDIGENOUS COMMUNITIES IN THE PERUVIAN AMAZON TO RESEARCH FOOD BIODIVERSITY AND CLIMATE CHANGE RESILIENCE

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**Background** Over the past ten years Amazon region has experienced multiple environmental changes including high rates of deforestation, and more frequent 'once in a century' extreme weather events. Despite this it is still not clear how these events effect food biodiversity, local diets and nutrition of Amazon Indigenous people. Information on food consumption is urgently needed, especially to identify key Amazonian Indigenous foods which may increase nutritional resilience to extreme climate events. Technological tools represent a potential feasible solution to measure diet for population studies. We have partnered with International researchers, local nutritionist, Indigenous leaders and community members to adapt a digital tool to support dietary measurement in Amazonian Indigenous communities.

**Methods** The adaptation had three stages. First working with an international multidisciplinary committee, we identified and compiled existing food composition databases to create a database for the Peruvian *myfood24* version to use with communities of Shawi ethnicity. Seven food composition tables were identified, and permission was requested for two cases where information was not public. Six food composition tables, one academic publication and one peruvian report about amazon food species, were used for generating a food composition database. Second, using *myfood24* guidelines, we completed a data base using Access software. This process involved cleaning and removing duplicate food items, including conversion values (from raw to cooked foods) and calculations for potential nutrient losses on cooking. We used a series of six online focus groups meetings with three peruvian nutritionists, including one nutritionist expert on the Shawi diet, to identify portions, and combinations. Finally, during a workshop with five local community members, a list of Shawi foods were validated, and food preparation was characterised to develop recipes and to take pictures for use in the online tool.

**Results** The peruvian food composition database to be used with the Shawi communities included a total of 1042 food items, with information for 14 key nutrients. These foods were split into fourteen food categories. Seventy-six possible options on how food is eaten together, and 43 portion measurements were validated in the focus groups. 114 food items were identified in the workshop as commonly consumed by

Shawi, with five forest animal foods proving the highest level of iron per 100 g: palm larvae (3.6mg), armadillo (3.5mg), deer (3.5mg), paca (3.4mg) and agouti (3.4mg).

**Conclusion** A comprehensive Peruvian Food Composition Database with a focus on Shawi diet has been created. This data has been incorporated within the online dietary assessment tool, *myfood24*. A photo Album and recipes will be completed over the next weeks. The new tool will be useful to understand how food and nutrient intakes in this vulnerable population are affected by climate change events.

Friday 17 September

Primary Care, 13.00 – 15.30

OP85

#### GENERAL PRACTITIONERS WORKING IN OR ALONGSIDE EMERGENCY DEPARTMENTS IN ENGLAND: A QUALITATIVE STUDY OF GENERAL PRACTITIONERS' PERSPECTIVES

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**Background** Up to 40% of Emergency Department attendances could be managed in primary care. In response, policies have led to the introduction of General Practitioner Services in/ alongside Emergency Departments in England. Our aim was to capture General Practitioners' perspectives of the service and their experiences in order to identify factors which may support or hinder General Practitioners working in Emergency Departments.

**Methods** Qualitative study of 10 case sites where GPs were working in/alongside Emergency Departments at NHS sites in England. Data consisted of 186 direct non-participant observations and 226 semi-structured interviews with 191 health professionals, 42 of which were General Practitioners. This paper reports on a thematic analysis of 42 GP interviews and observations relating to GP practice.

**Results** Both system issues and individual characteristics influenced how General Practitioners viewed and experienced working within or alongside Emergency Departments. Themes identified were: A different kind of GP; Disillusionment with primary care; New ways of 'doing' general practice - portfolio working; A reciprocal relationship; Practical barriers and facilitators; Unintended consequences - impact on primary care. General Practitioners working in Emergency Departments saw personal benefits (flexible and portfolio working; less stressful and more supportive environment than traditional general practice; broadening of skills and experience) and systems benefits (sharing their knowledge and skills with secondary care; taking secondary care skills learned into primary care work; prolonging experienced General Practitioners' working life and enthusing younger General Practitioners). They also identified negative aspects. General Practitioners working in Emergency Departments saw themselves as different to 'usual' General Practitioners and were sceptical that a critical mass of General Practitioners willing and able to staff Emergency Departments effectively could be reached and sustained. There were remuneration and practical employment issues such as dysfunctional IT systems and

contract/indemnity/insurance issues. General Practitioners felt that the General Practitioner in/alongside Emergency Department role should be supported professionally e.g. by the Royal Colleges. Finally, General Practitioners were concerned that employing General Practitioners in Emergency Departments may have the unintended consequence of depleting primary care general practice.

**Conclusion** General Practitioners' perspectives of General Practice Services in or alongside Emergency Departments identify systems and individual benefits and issues which may be used by policy makers and managers when planning and implementing General Practitioner Services in/alongside Emergency Departments.

OP86

# USING NORMALISATION PROCESS THEORY TO EXPLORE THE IMPACT OF GENERAL PRACTITIONERS WORKING IN OR ALONGSIDE EMERGENCY DEPARTMENTS IN ENGLAND: QUALITATIVE FINDINGS FROM A NATIONAL MIXED METHODS EVALUATION

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**Background** It is estimated between 15% and 40% of patients attending emergency departments could be treated in General Practice (GP). Hospitals throughout England have introduced GP services in or alongside emergency departments (GPED) to try to reduce demand. Our aim was to explore the impact of GPED and the extent to which it has become a part of routine practice.

**Methods** Qualitative study consisting of: non-participant observation of 142 individual clinical encounters and 413 semi-structured interviews with key stakeholders (policymakers, service leaders, ED staff, GPs, patients and carers). This was distributed across 64 NHS emergency departments in England, including 10 case sites. A coding framework was formed with patient collaborators and used with the pen portrait method for case sites. Findings were mapped onto the four main constructs of NPT: coherence, cognitive participation, collective action and reflexive monitoring.

**Results** There was widespread disagreement at individual, stakeholder and organisational levels regarding the purpose and potential impact of GPED (Coherence). Participants criticised policy development and implementation and viewed it as a rushed, top-down generalised solution to local problems. The amount of 'work' staff were willing to invest into GPED was hindered by tensions between ED and GP staff; often stemming from different attitudes to risk, perceptions of the GPED GP role and of what should be considered a GPED appropriate patient (Cognitive participation). Streaming and implementation issues (e.g. inter-professional relationships and structural support) and staffing and resource constraints affected how staff used GPED and the extent that it was embedded into routine practice. Concerns that GPED may encourage patients to attend ED and strong views around 'appropriate' ED attendance also influenced how staff and patients viewed GPED (Collective action). There was a lack of consensus as to whether GPED could be considered a success, due to variations in GPED

model, site-specific patient mix and governance arrangements (Reflexive monitoring).

**Conclusion** Translating policy into practice is complex. Our findings highlight challenges of applying a national policy locally. We identified a series of success factors (e.g. inter-professional working, leadership, staffing) for introducing GPED, a number of which are commonly cited as barriers/enablers for introducing health policy in the wider literature.

OP87

# CO-DESIGNING A DEEP END GP NETWORK FOR THE NORTH EAST AND NORTH CUMBRIA (NENC)

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**Background** From their Scottish origins in 2009, Deep End GP networks are being established all over the UK and further afield in Ireland and Australia. Formed of primary care practitioners in areas of high blanket socioeconomic deprivation, their common goal is to mitigate health inequalities and champion the cause of primary care. As the North East is the most deprived region in England, it was important to set up a network that was sustainable and reflected the priorities of those who worked in it. The network currently consists of the 34 most deprived practices in the region. Deep End NENC is affiliated with the Newcastle University Applied Research Collaboration's (ARC) 'inequalities and marginalised communities' strand and this work will also be used to direct the ARC research priorities. This project aims to use co-design methodology to gather information from practitioners in the region that could be used to guide the initial steps of the Deep End NENC network. Co-design interviews would also serve to improve engagement and disseminate information about the network.

**Methods** Participants were recruited using purposive and snowball sampling, as well as a blanket communication to all Deep End practices. Fifteen semi-structured interviews were carried out with health professionals (11 GPs, 2 social prescribing link workers, 1 nurse practitioner and 1 district nurse) from Deep End practices in the NENC. Due to Covid-19 these were carried out over Zoom before transcription and thematic analysis. Findings from the interviews were communicated to the members of Deep End NENC via webinars and they also formed the part of the Deep End Steering Group spending prioritisation protocol.

**Results** A coding framework was used to consider findings at patient level, practice/network level and 'upstream' political level. Themes identified were the specific clinical and social challenges in the Deep End; barriers to patient care and access to services; training and recruitment; the need to connect with others who worked in these communities to share best practice; and the need to advocate for the Deep End. The COVID-19 pandemic itself brought challenges that were felt more acutely by Deep End patients and those who cared for them.

**Discussion** These interviews were successful at identifying priority areas that will form the basis of the work that Deep End NENC will focus on over the coming years. They also add to the literature around challenges facing staff who work in deprived communities.