Methods 146 metabolites, including dietary-related lipoproteins, fatty acids, cholesterol and amino acids, were included. Partial least squares discriminatory analyses (PLSDA) and sparse PLSDA (sPLSDA) were used to distinguish ethnic-specific metabolite signatures of GDM in 2668 WEs and 2671 PK pregnant women (gestational age ≤196 days) in the BIB cohort. The impact of BMI on the metabolome and GDM risk, along with other known GDM risk factors (age, parity, multiple pregnancy and smoking status), was also examined.
Results Seven metabolites across a panel of metabolic processes (fatty acids, glycolytic, and cholesterol metabolism) were found to be predictive of GDM in both ethnicities, with fatty acids appearing to be more important drivers of GDM within WEs. Additionally, 6 metabolites were predictive of GDM solely within WEs, whilst no distinct metabolite associations were observed in PKs. Following the stratification of women by their BMI, case-status and ethnicity, a distinct metabolite profile was identified within normal-weight PK cases when compared to all other cases, characterised by a panel of amino acids and cholesterols, and glycolytic and unsaturated fatty acid metabolites.
Conclusion Serum-metabolite profiles differ by ethnicity and GDM status, largely driven by differences in fatty acid and cholesterol metabolite levels. However, in normal-weight PK women, a broad range of metabolic processes are uniquely altered and offer insight into the elevated risk of GDM observed in this otherwise healthy population. Future investigations into the determinants of these differences in metabolite profiles may shed light on the aetiology of elevated GDM risk in healthy PK women and direct the development of more efficacious intervention strategies.

P82 REHOUSING OLDER SOCIAL HOUSING TENANTS: HEALTH-RELATED PROCESSES AND OUTCOMES

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Background In the context of a social housing crisis, the UK must meet the housing needs of an ageing population. Rehousing schemes run by social housing providers are important means to support older (aged 55+) social housing tenants to move to appropriate homes. A better understanding of how well these schemes work is needed. This paper is based on a study (01/2020–12/2021) of the health-related processes and outcomes linked to the rehousing of older social housing tenants in Hackney/London through four local authority-supported schemes: Downsizing; Regeneration; Housing Moves; Seaside & Country Homes.
Methods A mixed methods design entailed a scoping review, based on a search of scientific databases (MEDLINE, EMBASE, Scopus, CINAHL, PsychINFO) and the grey literature, and a narrative synthesis of results. Interviews with practice-based stakeholders across sectors (n=11) were conducted. A survey of older social housing tenants who have moved through a rehousing scheme (n=766), analysed in Excel, generated descriptive statistics and themes for qualitative exploration. A Photovoice component with 16 survey participants, currently underway, has been designed to capture the participants' rehousing experience and its effect on their lives. It entails interviews and focus groups. Interviews and a focus group are being conducted with older social housing tenants who were interested in being rehoused, but opted against moving ('non-movers'; n=5). All qualitative data are analysed thematically in NVivo12. All methods have been adjusted to comply with Covid-19 rules.
Results The review yielded three peer-reviewed papers and 13 reports, thus revealing a gap in knowledge around the health-related effects of rehousing older social housing tenants. Interviews with practice-based stakeholders highlighted promising approaches in the rehousing schemes, such as highly personalised support, and challenges, including a lack of suitable homes for tenants to move into. The survey yielded 62 valid responses (8.1%). As well as helpful elements (e.g. being given choices) and challenges (e.g. poor communication) in the rehousing process, it identified welcome (e.g. a warmer home) and unwelcome (e.g. loneliness) health and wellbeing outcomes. The findings will be broken down by rehousing scheme. They will be supplemented by detailed insights from the Photovoice components and data collection with non-movers.
Conclusion The study was designed to generate insights that can inform efforts by Hackney Council and other social housing providers to improve rehousing schemes for older tenants and optimise their health-related effects. Channels through which findings will be shared with decision makers and the public include a national workshop and a photo exhibition.

P83 ABSTRACT WITHDRAWN

P84 ABSTRACT WITHDRAWN

P85 HOW TO TACKLE UNINTENTIONAL DISCRIMINATION IN PRIMARY HEALTH CARE: GENERAL PRACTITIONERS' IMPLICIT BIASES AND CULTURAL COMPETENCE

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Background Reducing ethnic inequalities in health care is a worldwide priority. General practice is no exception to this, as studies pointed to ethnic discrimination in diagnosis, referral and treatment of racial minorities patients by General Practitioners (GPs). However, it is unclear whether these discriminations are due to implicit bias or by the lack of explicit cultural competences, two explanations demanding different intervention. Implicit biases are a human trait which can influence stereotypes and care behaviour whereas cultural competence is 'the ability to work and communicate effectively and appropriately with people from culturally different backgrounds'.
Methods This mixed-method study investigates the existence of implicit biases and the level of cultural competences among GPs trainees. Data collection among GPs trainees (2021) was used and analysed in SAS Enterprise Guide. The 170

respondents took an Implicit Association Test, a validated tool measuring attitudes and beliefs that people are not conscious of. They also completed the Hudelson scale assessing the relative responsibility to adapt to migrants. These quantitative results were then discussed as a group with the respondents.

Results The results suggested that more than 80% (95% CI: 0.71–0.85) of GPs in training have implicit preferences for their ingroup to the detriment of the exogroup of migrants. Also, 60% (95% IC: 0.52–0.67) of respondents placed the responsibility to adapt on migrant patients when their values and habits differ from those of the host country.Qualitative data indicate trainees were not aware of these biases.

Conclusion This study shows that GPs trainees have implicit and explicit bias detrimental to ethnic minority groups, of which they are not aware of.

P86 A COMPARATIVE CASE STUDY OF HEALTH-JUSTICE PARTNERSHIPS IN ENGLAND: SERVICE MODELS AND IMPLEMENTATION SUCCESS

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Background Social welfare legal problems are root causes of health inequality. Legal advice services can improve socio-economic circumstances and mitigate the financial and social costs of illness. With these aims, partnerships between healthcare and legal services exist across England to support patients with welfare needs. They occur in diverse health settings and take many forms. Success is markedly variable in developing collaborative working and sustaining cross-sector partnerships. This study investigates how such partnerships are implemented and what factors determine differences in implementation outcomes.

Methods A comparative case study of health-justice partnerships across England was undertaken. Services were recruited from different regions, representing diverse health settings and service models. Data were collected through: i) One-to-one semi-structured interviews with staff members and funding organisations; ii) Service records and documentation. In-depth qualitative analysis using the process tracing method was applied to each case study individually. Cross-case comparison of the resulting themes identified key patterns and determinants of implementation success.

Results Nine services participated in the study. Four were based in primary care, four in acute or specialist care (cancer services, mental health services, a children's hospital and an HIV clinic) and one spanned both primary and secondary care. Thirty-eight interviews were undertaken with staff members in frontline and management roles. The case studies provide detailed descriptions of service models, including: co-location or remote working arrangements, referral methods and routes, cross-sector communication and data sharing, funding and management arrangements. The partnerships had experienced different trajectories: while some were long-lived (up to two decades), others had been discontinued, cut in size or had failed to properly establish. Factors influencing sustainability included decision-making processes around funding, strategic-level support and leadership characteristics. The extent of collaborative working was highly variable and influenced by: i) willingness to engage; ii) confidence to engage; iii) ability to engage. These factors were amenable to change. All the partnerships indicated benefits for patient access to legal assistance, positive welfare outcomes, improvements in mental wellbeing and patient experience. Benefits were strengthened where health and legal teams collaborated closely, with improved identification of need, professional skills and service efficiency.

Discussion Health-justice partnerships have a critical role to play in supporting the NHS Covid-19 recovery and tackling health inequalities. Opportunities for cross-sector working are growing with the movements towards Integrated Care Systems and social prescribing. This study provides information to support the successful implementation of heath-justice partnerships in the near and longer term future.

P87 TRENDS IN INEQUALITIES IN LOCAL AUTHORITY SPENDING ON CULTURAL, ENVIRONMENTAL AND PLANNING SERVICES: A LONGITUDINAL STUDY IN ENGLAND, SCOTLAND, AND WALES

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Background Local authorities (LAs) provide Cultural, Environmental, and Planning (CEP) services, such as parks, libraries, and waste collection, that are vital in supporting the health of the communities they serve. There have been significant changes to LA funding recently, most notably due to the UK government's austerity programme. These changes have not affected all places equally. To understand potential impacts on health inequalities, we investigated the extent to which areas have been differentially affected by declines in CEP services spending based on local characteristics.

Methods We conducted a longitudinal ecological study using routinely available data on LA expenditure, as collated in the Place-Based Longitudinal Data Resource. We used generalised estimating equations to determine how expenditure trends varied across 378 LAs in Great Britain between 2009 and 2018 on the basis of country, deprivation, rurality, and local government structure. We investigated the gross expenditure per capita on CEP services, and the CEP expenditure as a proportion of total LA budgets. We conducted analysis using R v4.0.2.

Results Expenditure per capita for CEP services reduced by 36% between 2009 and 2018. In England, the reduction in per capita spending was steepest in the most deprived quintile of areas, falling by 5.9% [95% CI: 4.7; 7.0] per year, compared to 3.3% [95% CI: 2.5; 4.1] in the least deprived quintile. Budget cuts in Scotland and Wales have been more equitable, showing little differentiation between most and least deprived areas. Welsh LAs have reduced the proportion of total LA budget spent on CEP services more than any other country (-2.9% per year [95% CI: -4.0; -1.8]), followed by Scotland (-1.5% [95% CI: -2.8; -0.3]) then England (-0.5% [95% CI: -1.0; 0.1). In England, rural LAs have reduced their CEP spending share more than those in urban areas, and unitary authorities have reduced their share more than those in a two-tier structure.