WHAT FACTORS DRIVE UNHEALTHY DIET? NOVEL CHALLENGES IN MANAGING MULTIMORBID PATIENTS: 

Two main axes emerged from the FFQ data, describing demographic variable. Results can be displayed graphically using scatter plots, frequencies exist. Should investigate why urban-rural differences in consumption fruit consumption were greater in rural areas. Future research consumed fruit on approximately 1 day less a week than those living in 4 Cities of equivalent deprivation. However, among the most affluent (SIMD = 3.03), Remote Rural residents ate fruit on average on 0.6 days more than their urban counterparts. Sharing a family meal, dieting behaviour, food poverty and breakfast consumption did not differ by rurality. Variance at the school level was significant for fruit and vegetable consumption frequencies and for irregular breakfast consumption.

Conclusion Young people from rural areas have a healthier diet than those living in urban areas. The eating behaviours examined did not explain these differences. Socioeconomic inequalities in fruit consumption were greater in rural areas. Future research should investigate why urban-rural differences in consumption frequencies exist.

Managing morbidity

Background Multimorbidity refers to the co-existence of two or more long-term conditions in an individual patient, and is the norm amongst patients attending primary care for chronic disease management. Qualitative research shows that GP’s experience challenges in the management of patients with multimorbidity, which are not experienced in the management of single chronic diseases. However, it is unclear how the challenges revealed by individual studies relate to each other and the overall problem of managing multimorbidity. The aim of this study was to establish the overarching challenges faced by GPs in the management of multimorbid patients, by systematically reviewing and synthesising the published literature in this field.

Methods A systematic literature search and synthesis was performed using the meta-ethnographic approach described by Noblit and Hare. This 7 step model involves a process of comparison and cross-interpretation between studies but allows the context of the primary data to be preserved.

Results The initial search yielded 1805 potential papers. Following screening, 10 papers were included in the review. Four overarching concepts emerged from these papers: 1) Organisation & Fragmentation of Health Care, 2) Conflict with evidence based medicine 3) Delivering patient centred care 4) Challenges in Shared Decision Making. Subthemes developed within the core concepts, and many cases of contradictory opinions were seen. By translating individual studies to the key concepts higher order interpretations were developed and a ‘line of argument’ was drawn. The line of argument pointed to GP’s sense of isolation in decision making for patients with multimorbidity.

Discussion This systematic review and qualitative synthesis has generated a fuller understanding of the difficulties in managing highly processed food items generally scoring low and raw ingredients scoring high. The second axis related to a Mediterranean diet; relevant items (e.g. pasta, rice, fruits and vegetables, cheese, yoghurt and wine) scored high, whereas those related to a traditional British diet (i.e. ‘meat and two veg’) scored low. Food consumption is highly individual but by constraining the ordination with reported age, dietary knowledge, educational attainment, socio-economic status and receipt of welfare benefits, it was possible to show their relationship to eating habits. These correlates accounted for 5.8% of variation, age exerting the strongest influence. Older people showed a strong preference for a British, low-processed food diet. University education was associated with consumption of a low-processed Mediterranean diet, whereas those living in deprived areas were associated with a highly-processed traditional British diet.

CCCA provides a robust, descriptive and conceptually superior method for dietary pattern analysis using FFQ data. Results confirm findings of qualitative research, suggesting that diet is strongly culturally patterned among specific, identifiable population subgroups. Such work is limited by cross-sectional data, but CCA may enable better tailoring and targeting of interventions for those at greatest risk from an unhealthy diet.

Abstracts