encourage screening for established cerebrovascular risk factors in this high-risk, vulnerable group.

Conclusion Current NHS Health Checks implementation appears neither equitable nor cost-effective. The addition of structural policies proved equitable and cost saving. Future research might now seek to identify the optimal combination of structural policies at local level.

SSM annual scientific meeting 2017
Plenary (PL) presentations

PLD1 THE IMPACT OF CO-LOCATED WELFARE ADVICE IN PRIMARY HEALTHCARE SETTINGS ON MENTAL HEALTH AND HEALTH SERVICE USE: A MIXED METHODS EVALUATION

Background Co-locating welfare advice services in primary healthcare settings has been one approach to tackling health inequalities by increasing income among socially deprived individuals. It is also hoped to relieve pressure on general practitioners in supporting patients with ‘non-clinical’ needs. Previous evaluations have been methodologically limited and lack theoretical underpinning. We aimed to examine the impact of co-located welfare benefits and debt advice on mental health and primary care service use, and to develop theory linked to pathways of effect.

Methods A prospective, controlled quasi-experimental study with an embedded qualitative component was carried out (December 2015-December 2016) in eight intervention and nine comparator sites across North Thames, London. Before and after quantitative data were collected via self-report questionnaires. Comparison group members were propensity score weighted for analyses. Outcomes included change in symptoms of common mental disorder (CMD) (12-item General Health Questionnaire), well-being (Shortened Warwick and Edinburgh Mental Well-being Scale), three-month GP consultation rate and financial strain. Data from qualitative interviews with 24 primary care staff, funders and advice providers were analysed using a modified realist evaluation approach to understand how co-located welfare advice could influence practice outcomes.

Results For the quantitative study, n=285 and n=633 individuals were recruited into advice and comparison groups respectively at baseline. 72% and 84% were retained at 3 month follow-up. Relative to controls, CMD caseness reduced significantly among female and Black/Black British advice recipients. Individuals whose advice resulted in positive outcomes demonstrated significantly improved well-being scores. Significant reduction in financial strain overall but no change in three-month consultation rate was found. Per capita, advice recipients received £15 per £1 of funder investment. Qualitative findings were used to inform underlying theory linking service activity to general practice outcomes. These were reduced GP consultations for ‘non-clinical’ issues and reduced practice staff time supporting patients with such issues. The findings revealed key implementation, context and agency factors that facilitated or hindered the potential for co-located advice to influence these outcomes.
Conclusion Recipients of co-located welfare benefits and debt advice experience reduced financial strain and for sub-groups short term mental health is improved. Co-located advice services have the potential to support general practice work but not if co-location is limited to a physical sharing of space. Suggestions are made to facilitate joint working.

Both scenarios could reduce socioeconomic health inequalities in cardiovascular disease and lung cancer morbidity and mortality.

Conclusion Strengthening existing English tobacco control policies through limiting access could substantially improve effectiveness and equity. Further research is now needed to explore the political and legal feasibility issues.

Background In 2015, almost one-fifth of English adults continued to smoke. Tobacco control policies in the UK are amongst the strongest in Europe, yet smoking prevalence remains stubbornly high, especially in deprived groups. Novel and radical approaches may be needed to control tobacco effectively. The British Medical Association backs a tobacco ban for those born after 2000, and a population-wide tobacco ban has already been implemented in Bhutan. We use microsimulation modelling to quantify the effectiveness and equity of these two radical tobacco policies.

Methods IMPACTncd is a previously validated dynamic stochastic microsimulation developed in R. It simulates the life course and smoking histories of synthetic individuals under alternative scenarios. We used IMPACTncd to estimate the potential impact of two proposed changes to tobacco control policy in England – a sales ban restricted to those born in or after 2000 and a total sales ban – on a simulated English population over a 30 year time frame. Extrapolating from Bhutan’s implementation, we assumed 50% reductions in smoking initiation rate, active to ex-smoking ratio, and cigarette consumption. We compared both scenarios with a counterfactual that assumed current declining trends in smoking prevalence.

Results The model suggested that under the tobacco-free generation caps scenario, smoking prevalence would fall to 12.4% (12.1% to 12.6%) for men and 7.9% (7.7% to 8.1%) for women, by 2045. This could prevent or postpone approximately 3500 (4,200 to 11,000) cardiovascular disease cases and some 230 (3,100 to 3,600) lung cancer cases; resulting in approximately 190 (-2,900 to 3,400) fewer cardiovascular disease deaths, and 220 (-2,700 to 3,200) fewer lung cancer deaths.

Under the total caps scenario, the English smoking prevalence would fall to 7.2% (7.0% to 7.4%) for men and 4.3% (4.1% to 4.5%) for women, by 2045. This could prevent or postpone approximately 90,000 (70,000 to 120,000) cases of cardiovascular disease, some 79,000 (55,000 to 120,000) cases of lung cancer, approximately 14,000 (3,000 to 25,000) fewer cardiovascular disease deaths and some 54,000 (38,000 to 73,000) fewer lung cancer deaths.