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BARRIERS TO ACCESSING PRIMARY CARE FOR SOCIO-ECONOMICALLY DISADVANTAGED OLDER PEOPLE LIVING IN RURAL AREAS: A QUALITATIVE STUDY

¹RT Turley*, ¹JF Ford, ¹TP Porter, ¹TS Shakespeare, ²GW Wong, ¹AJ Jones, ¹NS Steel.

¹Faculty of medicine and health sciences, University of East Anglia, Norwich, Norfolk;

²Nuffield department of primary care health sciences, University of Oxford, Oxford, Oxfordshire

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Background More healthcare is needed for an ageing population. Within a health care system that has infinite demands and finite resources there is a need to direct those resources available towards those most in need. Previous research has found that older people, those in rural areas, and socio-economically disadvantaged groups are at particular risk of poor access and often have higher health need. We aim to explore the barriers to accessing primary care for socio-economically disadvantaged older people in rural areas.

Methods Semi structured interviews were conducted with fifteen older people over the age of 65 living in a rural area and receiving financial support. Recruitment took place through multiple methods within the community using posters, local radio, hand delivered invitations and invitations dropped in pharmacy bags for home delivery. Participants were purposively sampled for specific characteristics.

Four focus groups were held with rural health professionals from primary care, recruited via the Clinical Research Network.

Thematic analysis was used to identify barriers to primary care access.

Results Multiple barriers were found to impair access to health care of socio-economically disadvantaged older people in rural areas.

From the patient's perspective barriers included attitudes, expectations, experiences and resources. These included engaged telephone lines, availability of appointments, receptionists, transport options, social networks and personal skills. Patients alluded to unwritten rules or a social contract, for example not to bother the doctor in return for additional goodwill when they became unwell. The mismatch between expectations and subsequent experiences led some patients to feel unwelcome or marginalised.

From the health professionals' perspective, barriers included rising demands and expectations, necessitating service reorganisation to overcome significant financial and workforce challenges. Changes included fewer home visits, telephone consultations, triaging calls and appointment system modification.

Conclusion Multiple barriers to accessing primary care exist for this group. As primary care is re-organised to reduce costs, commissioners and practitioners must not lose sight of the perceived social contract and models of care that form the basis of how many older people interact with the service.

Access to services is a key policy area to address inequalities. One-size-fits-all policies may improve access for the

whole population leading to increased pressure on the system and counterproductively worse access for marginalised groups. A targeted approach is needed which appreciates and addresses key barriers.

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THE RELATIONSHIP BETWEEN SOCIO-ECONOMIC CLASS AND WORK-RELATED MENTAL ILL-HEALTH

¹L Hussey*, ¹A Money, ²M Gittins, ¹R Agius. ¹Centre for Occupational and Environmental Health, The University of Manchester, Manchester, UK; ²Centre for Biostatistics, The University of Manchester, Manchester, UK

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Background Inequalities in health are often described showing an inverse relationship with social economic group and mortality and morbidity. However, work-related mental ill-health (WRMIH) reported by GPs show highest rates amongst higher socio-economic groups, particularly 'Lower managerial and professional' and 'Intermediate' occupations. Similar results are shown with the self-reported WRMIH collected by the Self-reported Work-related Illness (SWI) survey as part of the Labour Force Survey (LFS). The Health and Occupation Research network (THOR) collects data on WRMIH from GPs, occupational physicians (OPs) and psychiatrists. This study aimed to analyse the psychosocial factors associated with the WRMIH reported in different socio-economic groups.

Methods With each case of WRMIH, participating physicians report information including occupation and the psychological stressor considered to be associated with the condition. Occupational data were coded using the National Statistics Socio-Economic Classification (NS-SEC). A multi-level logistic regression calculated odds ratios (ORs) (adjusted by age and gender) reporting the likelihood of the stressor occurring within each socio-economic group compared to the highest reference group 'Large employers and higher managerial occupations'.

Results Results showed that the socio-economic groups were exposed to significantly different workplace stressors. Cases reported from the highest group were more likely to be associated with workload and workplace change with ORs falling as socio-economic status decreased, e.g. for workload, ORs in the lowest NS-SEC group were 0.51 (GPs), 0.14 (OPs) and 0.16 (psychiatrists). Lower NS-SEC groups were more likely to have problems associated with bullying and interpersonal relationships, e.g. for bullying, ORs in the lowest group were 2.60 (GPs), 1.76 (OPs) and 1.60 (psychiatrists).

Conclusion WRMIH rates may be greatest amongst higher socio-economic groups as they are more likely to have problems associated with a heavy workload and changes in the workplace such as staff shortages and organisational restructuring. NS-SEC groups with highest rates such as the 'middling' lower managerial and intermediate occupations may find themselves caught in the middle and experience the "worst of both worlds", i.e. they feel responsibility for the success of the workplace, have demands from those in higher managerial positions, but also have to deal with issues surrounding the

maintenance of interpersonal relationships with other workers, clients, patients or pupils. Information from this study may help develop workplace interventions targeted to prevent psychosocial factors affecting different sections of the workforce.

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RELATIONSHIP BETWEEN SOCIOECONOMIC STATUS AND GASTROINTESTINAL INFECTIONS IN DEVELOPED COUNTRIES: A SYSTEMATIC REVIEW AND META-ANALYSIS

^{1,2,3}NL Adams*, ^{1,2}TC Rose, ^{1,3}J Hawker, ^{1,4}M Violato, ^{1,2}SJ O'Brien, ^{1,2}B Barr, ²VJK Howard, ^{1,2}M Whitehead, ³R Harris, ^{1,2}DC Taylor-Robinson. ¹NIHR Health Protection Research Unit in Gastrointestinal Infections, Health Protection Research Unit, Liverpool, UK; ²Department of Public Health and Policy, University of Liverpool, Liverpool, UK; ³National Infection Service, Public Health England, London, UK; ⁴Health Economics Research Centre, University of Oxford, Oxford, UK

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Background The public health impact of gastrointestinal (GI) infections is substantial, with around a quarter of individuals experiencing an episode of infectious gastroenteritis each year. Yet relatively little is known about the social patterning of these infections. Studies investigating the association between socioeconomic status (SES) and risk of GI infections have produced conflicting results, with some reporting greater risk amongst lower SES and other observing the opposite effect. This systematic review and meta-analysis aimed to assess the association between SES and risk of GI infections, and explore possible sources of heterogeneity in effect estimates reported in the literature.

Methods MEDLINE, Scopus, Web of Science and grey literature were searched from 1980 to October 2015 for studies reporting a quantitative association between GI infections and SES in a representative population sample from a member-country of the Organisation for Economic Co-operation and Development. Quality assessment was conducted using the Liverpool University Quality Assessment Tool. Harvest plots were created for comparison where heterogeneity between studies was high, stratified by age, SES measurement, GI infection measurement and pathogen type. Meta-analysis was conducted on a subset of data. To explore sources of heterogeneity, meta-regression and stratified meta-analyses were performed on the basis of country, age, pathogen type, GI infection measurement and SES measurement. The protocol was registered on PROSPERO: CRD42015027231.

Results In total, 6021 studies were identified; 102 met the inclusion criteria. Overall risk of GI infection for low versus high SES was 1.06 (95%CI 0.95–1.19). For children, risk was higher for those of low SES versus high (RR 1.51, 95% CI 1.26–1.83), but there was no association for adults (RR 0.83, 95% CI 0.61–1.14). Results were similar when sensitivity analyses were performed on the basis of study quality. Age explained a small proportion of the overall heterogeneity.

Discussion We quantify, for the first time, the association between SES and risk of GI infection in developed countries and show that disadvantaged children, but not adults, appear to be at greater risk of GI infection compared to their more advantaged counterparts. Increased risk may relate to differential exposures, vulnerability or healthcare-seeking behaviours by SES. It is possible that factors that could not be adjusted for may explain the high residual heterogeneity. Strategies to

improve childhood socioeconomic conditions are likely to reduce the burden of GI illness. Gaining greater insight into this relationship will help to inform policies to reduce the health inequalities identified.

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EXAMINING STRATEGIES TO INCREASE KNOWLEDGE MOBILISATION BETWEEN PUBLIC HEALTH ENGLAND AND KEY STAKEHOLDERS: A MIXED METHODS STUDY

¹R Johnson, ¹GJ Melendez-Torres, ²G Currie, ³P Bradley, ¹O Oyebode*. ¹Warwick Medical School, University of Warwick, Coventry, UK; ²Warwick Business School, University of Warwick, Coventry, UK; ³Chief Knowledge Officer's Directorate, Public Health England, Cambridge, UK

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Background Public Health England (PHE) is an executive agency, sponsored by the Department of Health, which aims to protect and improve the nation's health and wellbeing, and reduce health inequalities. PHE has a number of responsibilities relating to the collection, curation and sharing of research, data and other knowledge relevant to public health. The organisations key stakeholders include local authorities and clinical commissioning groups. PHE requested that an academic partner support the organisation to develop the organisation's knowledge mobilisation function.

Methods We conducted a sequential mixed methods study. 1. We performed a rapid evidence review to identify strategies which improve knowledge mobilisation; 2. We held a workshop for PHE staff during which we prioritised identified strategies using Delphi methods; 3. We conducted semi-structured interviews and a focus group with a range of PHE staff to discuss the relevance of identified strategies in context; 4. We integrated findings from all three sources using the Pillar Integration Process, a technique for analytical integration of mixed data.

Results We identified 13 relevant reviews/meta-reviews. 16 PHE staff attended the workshop. 18 PHE staff were involved in indepth qualitative work (8 semi-structured interviews, 1 focus group of 10 people). Of strategies identified in the literature, workshop participants agreed that some were already working well at PHE, and this was echoed in the qualitative findings. Existing strengths of the organisation are that it is large and trusted, with established local networks. Short term priorities included gaining better understanding of stakeholder needs and future challenges in order make best use of social marketing, tailoring and targeting, and also to reflect narratives that are of particular interest to both immediate and downstream users of PHE evidence (e.g. the Director of Public Health who directly accesses PHE evidence, but also the councillor who ultimately makes decisions based on this). A longer term priority was to develop methods of measuring and evaluating the use of PHE knowledge products. The importance of flexibility in approaches, harmonising rather than homogenising, was a strong theme arising from the qualitative work. Integrated findings highlight the legacy of multiple previous entities having come together to form PHE and the burgeoning identity of PHE as a knowledge brokering organisation.

Conclusion We have identified some priority actions for both the short and long-term to improve mobilisation of knowledge