

awareness and/or availability of targeted support services to aid patients with their recovery.

Doctors are knowledgeable to varying degrees about the impact of the recovery process on patients. When managing patient's expectations of recovery, it is evident that doctors provide general advice based on their clinical experience, rather than evidence. Many also noted that patients with CAP seek reassurance, often afraid of recurrence upon hospital discharge.

Conclusion Doctors have mixed views on the current management of patients with CAP following discharge. Many concurred that patients experience anxiety and morbidity associated with recovery from CAP. Also, a perceived deficiency in the support infrastructure for affected patients was noted. Thus, further research could consider post-discharge management and recovery, in order to improve existing clinical recommendations and resources.

P34 PARAMEDIC TRAIL BLAZERS – WHY DO PARAMEDICS TAKE PART IN PREHOSPITAL RESEARCH?

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Background Research to improve prehospital treatment and care requires the participation of clinical and managerial staff from ambulance services to test interventions and collect research data. Researchers work closely with individuals and organisations with prehospital clinical, managerial and policy expertise to plan, deliver and disseminate research evidence. A recent trial involved assessing feasibility of paramedics administering Fascia Iliaca Compartment Block (FICB) in place of morphine to patients with suspected hip fracture. Participation in the trial was voluntary. We explored paramedics' motivation for participating in research through the RAPID (Rapid Analgesia for Prehospital Hip Disruption) trial.

Methods We held three focus groups with 11 RAPID trial paramedics serving one district hospital, audio-recorded with participants' consent. We conducted thematic analysis of interview transcripts. Two researchers, one paramedic and one lay member were in the analysis team.

Results Paramedics believed their participation in research had benefits for patients, for them individually and for the paramedic profession. Respondents said that being part of a research project provided an opportunity to increase their skills and provide improved patient care. In the RAPID trial, they understood the potential risks and benefits of different medications and management for patients with suspected hip fracture and welcomed the chance to identify improved pain management for a vulnerable population. They felt proud to be learning and using a procedure usually administered by clinical staff: *'This is quite specialised, like, hang on, I'm doing a really top job here, dealing with anaesthetics...blunt needles... it's like 'up there'. It's not our everyday thing.'*

More generally, respondents identified how research potentially contributed towards widening the scope of paramedic practice by extending their role into clinically specialist areas. They suggested that many paramedics were unwilling to undertake tasks perceived to exceed their pay-grades and shunned the opportunity to learn new techniques which were

not routine care. In comparison, these paramedics saw themselves as trail-blazers for the profession, proud to be acquiring extra clinical responsibilities and skills. They also valued the chance to contribute to the evidence base, providing knowledge about using alternative medication which they instinctively felt would cause fewer complications and benefit patient mortality and morbidity.

Conclusion Paramedics who take part in research believe they contribute to personal and professional development and potentially improve patient care. Future research with paramedics refusing research participation could explore barriers and different views on skills development, which may also inform implementation of new evidence-based interventions.

P35 IS THE STORY ABOUT WORRYING WOMEN AND STOICAL MEN TRUE? GENDER DIFFERENCES IN SUBJECTIVE HEALTH AFTER ADJUSTMENT FOR REPORTING STYLES

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Background Although women are less healthy than men with respect to physical health and depression, gender differences in morbidity and self-rated health (SRH) are less consistent. Female disadvantage in SRH has been partially explained by women's preponderance to report poor health. Although more recent studies challenge gender stereotypical treatment-seeking behavior and reporting of specific health conditions, we know relatively little about gender differences in reporting of SRH. The present study investigates to which extent adjusting for differences in reporting styles modifies gender differences in SRH, whether these changes are due to gender-specific over- and/or under-reporting patterns, and whether these changes are consistent for reporting of poor and good health.

Methods We utilize the data collected in the wave 1 (2004) of the Survey of Health, Ageing and Retirement in Europe, a multidisciplinary panel survey of community-dwelling individuals aged 50+ in 12 countries. The analysis follows the method proposed by Jürges (2007) and Rebelo and Pereira (2014). Our dependent variable is a global evaluation of health 5 possible responses: excellent, very good, good, fair, and poor. SRH is our dependent variable and is modelled with a generalized ordered probit model. There are two types of independent variables: latent health (e.g. chronic conditions, physical limitations, and smoking) variables and threshold variables (gender, education level and country). Once the appropriate model is selected and fitted, health indexes and disability weights are calculated. They, in turn, are used to calculate SRH adjusted for reporting styles.

Results Our preliminary analyses suggest that when SRH is adjusted for differences in reporting styles, the gender gaps in the percentage of persons with both poor and good widen. Except the oldest age group, more men have reported poor health than they have, whereas less women have reported poor SRH than they have except the youngest women. These findings suggest that men over-report and women under-report poor health. At all ages less men have reported very good

health than they have, whereas the fraction of women in very good health is higher on the original than on the adjusted scale. In other words, these findings suggest that men under-report and women over-report good health.

Conclusion Our preliminary findings challenge the prevailing assumption of women over-reporting and men under-reporting health problems and highlight the importance to attend to health problems reported by women and men equally carefully.

P36 **CANCER PREVENTION IN VULNERABLE WOMEN: AN EXPLORATORY QUALITATIVE STUDY WITH WOMEN WHO HAVE EXPERIENCED DOMESTIC VIOLENCE AND OFFENDING BEHAVIOURS**

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Background Cancer is more common among disadvantaged communities. Women who have experienced domestic violence or offending behaviours are at higher risk of cancer through multiple risk factors: addictive behaviours, low levels of activity and poor screening uptake. Such women are also likely to come from socially marginalised backgrounds where persistent health inequity remains. Addressing their needs is an important factor in cancer prevention and early diagnosis. This exploratory study aimed to explore women's health behaviours in terms of excessive alcohol consumption, tobacco use, physical activity, diet, weight and cancer screening within their context and experiences of vulnerability. We also aimed to assess perceptions of risk to cancer and barriers to health promoting activities.

Methods We conducted 14 semi-structured interviews and two focus groups with vulnerable women attending support groups in a Housing Association women's centre, and seven interviews with the staff who support them. Verbatim transcripts were analysed thematically.

Results We identified three themes: risk factors as markers of distress, inhibiting views of self, and navigating the healthcare system. Risk factors of alcohol use, smoking, physical inactivity and unhealthy eating were common but reported in context of distressing experiences of mental ill-health, poverty, addition and abuse. Walking, for example, was reported as the result of lost driving licences or a symptom of anxiety; smoking was reported as part of other additive behaviour such as alcohol abuse and drug taking. Women's views of themselves such as self-worth were often negative, shaped by experiences of neglect and abuse, or of perceived negative treatment by social and mental health services. This shaped their trust in health services, as well as low perception of risk for cancer susceptibility and potential for delay in presenting with cancer symptoms. Women frequently reported fatalistic attitudes to cancer, chronic diseases and early death but paradoxically also reported high levels of screening uptake. Despite narratives of distress, women showed self-reliance and resilience, and this might have helped navigating the health systems to some degree, for example using screening services. Women and staff were receptive to health promotion in cancer prevention.

Conclusion Women in this study were at high risk of chronic diseases, including cancer. Their experiences of social disadvantage and personal and structural violence profoundly shaped their practices, aspirations and attitudes towards risk, health and healthcare. Our findings will inform the design of a feasibility study to test a cancer prevention strategy co-designed by and tailored to vulnerable women.

P37 **RELATIONSHIP BETWEEN PHYSICAL ACTIVITY AND BLOOD GLUCOSE MARKERS DURING PREGNANCY AMONGST A MULTI-ETHNIC MATERNAL COHORT: RESULTS FROM THE BORN IN BRADFORD COHORT STUDY**

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Background Physical activity is associated with positive health biomarker profiles during pregnancy and resultant birth outcomes. Furthermore, there is some evidence to suggest that physical activity both prior to and during pregnancy may reduce the risk of gestational diabetes. In this study we aim to investigate the relationship between physical activity and biomarkers associated with gestational diabetes (GDM) risk and clinical diagnoses of GDM.

Methods Participants were pregnant women recruited to the Born in Bradford cohort study who completed phase 1 or 2 of the baseline questionnaire and provided a fasting blood sample between approx. 26–28 weeks of gestation, and had a singleton birth. Where mothers had two births during the study period, only the first was included in the present analyses. Physical activity level was measured using the General Practice Physical Activity Questionnaire (GPPAQ) and questions about usual walking speed. The relationship of self-reported physical activity, using both of the two definitions above, with levels of fasting blood glucose was evaluated using multivariate linear regression. GDM risk was assessed using logistic regression analyses. Models were adjusted for other key covariables including age, ethnicity, body mass index and parity.

Results Data were available for 6119 maternal participants. White British women reported higher levels of physical activity and physical function (i.e. higher self-reported average walking speed) relative to their Pakistani and Other ethnic group peers. Despite the higher GPPAQ scores in the White British group, over 67 per cent still fell into the inactive or moderately inactive category.

Higher levels of activity as measured by GPPAQ scores was not associated with fasting blood glucose or odds of gestational diabetes. Walking speeds were associated with lower levels of fasting glucose, and remained so after adjustment for other relevant covariables (−0.04 (−0.08, −0.05). Adjusted odds of gestational diabetes diagnosis were also lower in those reporting the highest self-reported walking speeds OR 0.49 (0.27–0.87).

Conclusion Faster self-reported walking speeds, which may result from greater residual fitness prior to pregnancy, were shown to be associated with lower fasting blood glucose levels and lower odds of a gestational diabetes diagnosis. These