contribute to enhancing understanding of local food consumption and health. The findings indicate important avenues for further research, such as the role that food borrowing may play in ensuring dietary diversity in these regions.

On behalf of the CFaH Team.

Thursday 10 September

Health Policy I

OP59 STAKEHOLDER NARRATIVES OF 'PROBLEMS' AND 'SOLUTIONS': ANALYSING THE 2018 HEALTH AND SOCIAL CARE COMMITTEE ANTIMICROBIAL RESISTANCE SUBMISSIONS IN THE UNITED KINGDOM

¹RE Glover*, ¹NB Mays, ¹MP Petticrew, ²C Thompson. ¹Faculty of Public Health Policy, LSHTM, London, UK; ²Health and Social Care, University of Hertfordshire, Hatfield, UK

10.1136/jech-2020-SSMabstracts.58

Background Antimicrobial resistance (AMR) is an area of global policy attention. Antibiotic resistance is often characterised as a 'wicked problem', because it (i) affects, and requires simultaneous action by, public, private, and third sector stakeholders, (ii) requires local, regional, national, and supranational buy-in (and implementation of strategic change) across low, middle, and high-income countries, and (iii) spans human, animal, and environmental health. The corollary to AMR being described as a wicked problem is that 'crisis' narratives have been adopted by public health policymakers and practitioners to marshal resources, attention, and public engagement. This AMR narrative has been co-opted at times, in order to privilege solutions promoted by and involving the private sector; with the co-optation of these solutions comes the risk of sequestering public sector funds to subsidise private sector work – in particular, in the pharmaceutical and medical diagnostics industries.

Methods There were 72 written submissions made to the 2018 'Antimicrobial resistance' House of Commons Health and Social Care Committee. The sectors represented in these submissions were industry, trade associations, non-governmental organisations, professional associations, academia, government, public private partnerships, and homeopathy proponents. We accessed these documents and extracted relevant data according to the theoretically-informed critical discourse analysis (CDA) framework that we developed. Once this was complete, two researchers collaboratively coded the findings. A third researcher randomly coded a sample of the documents in order to determine reliability.

We identified the dominant and biosecurity narratives that were used by the various actors who submitted evidence. We then compared the narratives, framing, and language used by the private sector with public and third sectors, and academia. We subsequently analysed the three main promoted 'remedies' to the AMR problem and categorised them within a 'market paradox' framework.

Discussion We found that, irrespective of sector, the submissions presented the problem of AMR similarly. The solutions, however, diverged dramatically. The relevant industries use particular discursive strategies to achieve their aims, including the development of market paradoxical positions; on the one hand, asking for subsidies and incentives, but on the other

hand explaining that regulation would be detrimental to 'innovation'. We expand on these paradoxes, and catalogue the tactics used to achieve them discursively, including: obfuscating funding sources, stake inoculation, and lobbying for influence. Learnings from the unhealthy commodities industry allowed us to critically appraise the framing of industries involved in AMR.

Conclusion Overall, our CDA demonstrates that commercial interests deploying the crisis narratives do so in order to lobby heavily for self-serving solutions, namely deregulation and public subsidies. Discursive choices shaped by a technocratic-industry complex are redefining the pathways to success, monitoring, and decision-making in the global AMR arena.

OP60 NATIONAL IMPLEMENTATION OF AN INTEGRATED DIABETES PROGRAMME IN IRELAND: REALIST EVALUATION

¹KN O'Neill, ¹FM Riordan*, ¹E Racine, ²ML Tracey, ³C Papoutsis, ¹PM Kearney, ¹SM McHugh. ¹School of Public Health, University College Cork, Cork, Ireland; ²Axis Consulting Limited, Hemel Hempstead, UK; ³Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford, UK

10.1136/jech-2020-SSMabstracts.59

Background 'Integrated care' for chronic conditions is considered central to international health system reform. However, models of integrated care work differently in different circumstances. In Ireland, the National Diabetes Programme aimed to integrate diabetes care across primary, secondary and tertiary settings based on patient complexity through the introduction of new clinical posts and guidance for diabetes care. We conducted a realist evaluation to determine *how and why* the implementation of the programme worked (or not) across the country.

Methods Through documentary analysis and qualitative interviews (n=19) with a purposive sample of national stakeholders, we developed an initial theory on how the programme was expected to work. We then refined this theory in semi-structured interviews (n=39) with professionals purposively sampled to represent different clinical disciplines involved in implementation. We applied a realist logic of analysis and synthesis to iteratively build CMO configurations.

Results National stakeholders assumed that: 1) introducing guidance would formalise and standardise how care was provided, 2) that professionals would 'buy in' and align their work with new ways of working, and 3) that the new clinical posts would become catalysts for service changes at local level. At a national level, important contexts included varying levels of awareness about the programme, no plan for communicating service changes, and no established approach to implementation or professional oversight. Locally, experience delivering diabetes care, resource demands and familiarity with the intended purpose of the new clinical posts were important contextual factors. The extent to which integrated care was adopted and implemented depended on judgements made by health professionals (GPs, nurses, specialists and podiatrists) working in these contexts, specifically; judging the relative advantage of the programme and whether to engage in negotiations to legitimize their roles in diabetes care.