OP80 GUIDANCE FOR ADAPTING EVIDENCE-INFORMED POPULATION HEALTH INTERVENTIONS FOR NEW CONTEXTS: THE ADAPT STUDY

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Background Adaptation of evidence-informed population health interventions for new contexts may be more efficient than de-novo intervention development, where well developed and tested interventions exist. There is however currently no consensus-based guidance for decision-making on adapting interventions for implementation and/or deciding on the need for re-evaluation in new contexts. We are developing guidance, with funding from MRC-NIHR. This presentation will describe the underpinning research used to develop this guidance, and draft content of the guidance, which will be completed by the end of 2020.

Methods We used a phased approach to develop guidance. This began with a systematic review of existing guidance, including papers published between January 2000 and October 2018 identified through searches of 7 databases. This was followed by a scoping review focused on a purposive sample of cases of intervention adaptation identified through this search. Semi-structured qualitative interviews with researchers (N=23), practitioners (N=3), journal editors (N=5) and funders (N=6), were conducted, and analysed using framework analysis. Finally, a three round modified Delphi consensus process was undertaken (N=66).

Results The systematic review identified and synthesised 35 sources of guidance to develop a draft framework, which was refined in subsequent phases. Reviews and qualitative interviews identified several ongoing debates in adapting interventions for new contexts, and areas of consensus. Informed by the review, we defined adaptation as 'intentional modification(s) of an evidence-informed intervention, in order to achieve better fit between an intervention and a new context'. Consensus processes suggested this definition was useful, but emphasised the importance of including guidance for both pro-active and re-active adaptation. Different conceptualisations of fidelity were identified within the reviews and interviews which shaped approaches to adapting interventions. Further, while we initially defined 'evidence-informed' interventions as those with prior evidence of effects, qualitative interviews and DELPHI processes suggested a wider framing of 'evidence-informed', with interventions often adapted from elsewhere based on evidence of feasibility, but with no prior robust evaluation of effects. Draft recommendations for adapting interventions for new contexts include considerations in relation to what interventions to select, when and how to adapt these, the level of re-evaluation required in the new context, and reporting of adaptation processes and outcomes.

Discussion Producers and users of population health evidence face significant uncertainties over whether and how to adapt and re-evaluate interventions in new contexts. This guidance should improve the commissioning, conduct and reporting of studies involving intervention adaptation for new contexts.

OP81 DEVELOPMENT OF BEHAVIOUR CHANGE INTERVENTION TO PROMOTE PHYSICAL ACTIVITY FOR CANCER SURVIVORS: A MIXED METHOD APPROACH USING MRC FRAMEWORK

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Background Although beneficial effects of physical activity in adult cancer survivors are well-established, patients are often not active enough to reap such benefits. The aim of this project was to develop a theory-based physical activity behaviour change intervention to promote physical activity in cancer survivors.

Methods Development stage of the MRC framework was completed conducting systematic review with meta-analysis, focus groups of adult survivors of any type of cancer and an online survey of primary, secondary and allied healthcare professionals in oncology. A separate literature review was conducted to identify the relevant theory to underpin the proposed physical activity promotional intervention.

Results Education materials in various formats are effective to increase physical activity in cancer survivors. Reminders based on behaviour change theories complements readiness to initiate or increase exercise. Focus group participants in general revealed receiving inconsistent physical activity advice, and preferred this to be tailored and face-to-face as part of their standard care, with a component of reminders at the end of their active cancer treatment. The survey findings reiterated focus group participants' experiences highlighting such inconsistency, partly because of health professionals' lack of knowledge or confidence to offer optimum physical activity advice.

Findings from the above three phases were integrated into a weekly text message based intervention that can easily be integrated into existing health services with minimal structural or financial implications.

Conclusion Physical inactivity in cancer survivors needs addressing to improve their quality of life. Behaviour change interventions need to be theory-driven and low-maintenance. The proposed intervention to promote physical activity in cancer survivors comprising of 12 weekly text messages may be beneficial when integrated into existing health services.

OP82 HEALTH, SOCIAL CARE AND TECHNOLOGICAL INTERVENTIONS TO IMPROVE FUNCTIONAL ABILITY AMONG OLDER ADULTS: A CAMPBELL EVIDENCE AND GAP MAP

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Background By 2030, adults over 60 years are expected to be higher than the number of children under 10 years globally. Currently, over two thirds of people over 65 years of age are living with multi-morbidities. With increasing disparities in health care and determinants of health, there are major health

and social care system implications worldwide. Evidence and Gap Maps are used to highlight gaps in research and inform strategic health and social policy, program and research priorities. The objective of this Campbell Evidence and Gap Map is to identify health and social support services as well as mobility devices that support functional ability among older adults in the home.

Methods We developed our intervention-outcome framework and defined the scope by adapting the WHO International Classification of Functioning, Disability and Health framework and consulting with our stakeholders. We systematically searched MEDLINE, EMBASE, Cochrane Database of Systematic Reviews, PsycINFO, AgeLine, Campbell Library and other databases. We conducted a focused search for grey literature and protocols of studies. Studies were selected for inclusion based on study design, setting and population. We assessed methodological quality of systematic reviews using the AMSTAR II. To assess health inequalities, we coded whether studies measured effects of interventions across the PROGRESS framework (i.e. place of residence, race/ethnicity, occupation, gender/sex, religion, education, socioeconomic status, and social capital).

Results We retrieved 16,083 records and included 548 studies, (120 reviews and 428 randomized trials) in this map. Most studies (56%, n=310) were focused on health services. Only 23 studies focused on general social support services. Nine studies focused on personal indoor and outdoor mobility and transportation, and 15 studies focused on design, construction and building products and technology. Most studies were from high income countries (n=532 out of 548). Of the 120 included systematic reviews, 46% of reviews were critically low quality (n=55), and only 11% of reviews were high quality. No studies assessed effects of interventions on health inequalities.

Conclusion There is a gap in the evidence-base on studies of effectiveness focused on general social support services and design, construction and building products and technology. The lack of evidence from low and lower-middle income countries points to the need for more high-quality reviews and trials in these settings. This is particularly important since these regions are experiencing a quicker growth in population ageing compared to high income countries.

Friday 11 September
Health Policy II

OP83   SOCIAL PRESCRIBING AND CLASSED INEQUALITIES IN HEALTH: EXPLORING A COMPLEX RELATIONSHIP USING ETHNOGRAPHIC METHODS

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Background Social prescribing involves non-medical link workers addressing patients' personalised support needs, largely by connecting them with relevant voluntary and community sector services. Such schemes are particularly aimed at people with long-term health conditions, mental health issues, and other social needs which affect their health and wellbeing.

Recently identified in the NHS Long Term Plan (2019) as a means by which to address health inequalities, social prescribing is currently being implemented on a large scale in the UK. Yet evidence of its effectiveness, how it is delivered and how it is received is scant. The qualitative study reported here is part of a larger mixed methods study, funded by the National Institute of Health Research (PHR Project: 16/122/33 https://research.ncl.ac.uk/nuspe/), evaluating the impact of link worker social prescribing on people with type 2 diabetes living in an area of high socio-economic deprivation.

Methods Ethnographic methods comprising observation of 19 services-users, two waves of semi-structured interviews at the start and end of fieldwork (n=33), photo-elicitation interviews (n=9), and interviews with family members (n=7) were undertaken. The ethnography was conducted over 16 months (November 2018-March 2020) in a range of contexts enabling access to the daily practices of participants. Purposive sampling was used to ensure a sample of maximal variation. Data were thematically coded.

Results The research illuminates the nuanced ways in which broader inequalities shape participants experience of both type 2 diabetes and social prescribing. Some participants responded to the intervention as anticipated, changed their behaviours and engaged in health-generating practices with positive results. In contrast, participants most affected by inequalities and the effects of factors such as changes to the benefits system, other long term health conditions, and poor housing, experienced multiple setbacks. Their very challenging immediate social circumstances took priority over the intervention. Importantly, while inequalities shaped participants' *capacity* to engage with the intervention, all participants recognised the value of the health capital offered by the intervention.

Conclusion In a socio-political climate where significant 'upstream' changes continue to increase inequalities, our detailed observations reveal how such inequalities shape participants' priorities to engage with health and how social class features in this process. Our findings suggest that, despite aiming to address the effects of the wide range of social and economic factors that influence health, social prescribing operates as a 'downstream' intervention and, as such, has a limited impact on the health of the most disadvantaged.

OP84   STRENGTHENING THE INFERENCE FROM AN INTERRUPTED TIME SERIES ANALYSIS: EVALUATION OF THE EFFECTIVENESS OF HEALTH IN PREGNANCY GRANTS IN SCOTLAND USING ROUTINE DATA

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Background Natural experiments are used to evaluate population health interventions when exposure to the intervention has not been manipulated by the researchers. As an example, the interrupted time series (ITS) is a strong natural experimental design. However, the weakness of ITS is the inability to determine whether effects are attributable to something other than the intervention which affects the outcome and occurs at the same time. We used the ITS technique to evaluate the effectiveness of the Health in Pregnancy (HiP) grant, a universal unconditional cash transfer of £190 It was introduced in the UK in April 2009 and withdrawn in April 2011. We