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. Informing 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.
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 poor housing, 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.

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.