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

compared outcomes before the introduction of HiP in Scotland and immediately after its withdrawal with those during the period for which it existed, and by varying the timing of the intervention period, ascertain if observed effects could be attributed to HiP or other co-existing policies.

Methods All singleton births with a gestational age 26–44 weeks were extracted from routinely collected birth data between January 2004 and December 2013. The outcomes of interest were birthweight and contacting midwife before 25 weeks. Interrupted time series models, adjusting for maternal, birth characteristics, seasonality and temporal trends, were used. The intervention period (April 2009 to April 2011) and post-intervention period (May 2011 to December 2013) were compared to the pre-intervention period (January 2004 to March 2009). Four different start dates (6 & 12 months before and after April 2009) and three duration periods (18, 24, 30 months) were chosen.

Results There were 272,935 births pre-intervention, 109,775 during the intervention and 144,663 post-intervention. Compared to pre-intervention, birthweight remained unchanged in both the intervention period -2.6 g (95% CI -6.9; 1.7) and post-intervention -5.0 g (-11.1; 1.0). During the intervention period women were more likely to contact the midwife OR 1.10 95%CI (1.02; 1.18). For birthweight, the duration of the intervention did not alter the effect of HiP. The effect on contacting a midwife was similar across start dates and duration periods.

Conclusion The strongest intervention effects did not coincide with the dates during which the HiP grant was in place, and there was little dilution of the effects, meaning any effects found could be due to policies and events other than the HiP grant. The lack of random allocation to intervention means the groups were exposed to different macro-level environments, which may impact on birth outcomes during the intervention period.

OP85 | **PATIENT AND STAFF PERCEPTIONS OF SAFETY AND RISK: TRIANGULATING PATIENT COMPLAINTS AND STAFF INCIDENT REPORTS TOWARDS A DUAL PERSPECTIVE ON ADVERSE EVENTS**

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Background Incident reporting systems in healthcare are historically based on staff descriptions of adverse events. An increasing body of literature suggests patients provide critical insights to risk and error, but their potential has not sufficiently been investigated at the incident level. This study aims to examine to what extent patient complaints and staff incident reports discuss identical incidents, and how their perspectives could be integrated for more comprehensive safety analysis.

Methods Deterministic data linkage was performed on all complaints (n=5,265) and staff incident reports ('PSIs') (n=81,077) between April 2014 and March 2019 at a multisite hospital in London. A total of 402 complaints covered at least one incident also identified in the PSIs, and were included in the study. All incidents reported in complaints and staff incident reports were codified based on problem domain; problem severity; stage of care; staff group implicated; reported harm; and descriptive level (eg, description of human

factors and root causes); adapted from the Healthcare Complaints Analysis Tool (HCAT) and the National Reporting and Learning System (NRLS). Aggregated coding outputs informed targeted qualitative analysis of free text incident reports for an in-depth exploration of key overlap and discrepancies in patient and staff descriptions of unsafe care.

Results Our preliminary results indicate staff and patients reported similar problem themes for 81.1% of overlapping incidents (of which 66.5% clinical, followed by 27.1% institutional, and 6.4% relational), but commonly differed in their description of contributing factors and root causes (eg, different time points in patient journey). Alongside overlapping incidents, patients reported an average of 1.4 additional incidents in their complaint, of which 23.6% were high severity. Additional patient-reported incidents included blind spot clinical issues (36.7%; eg care continuity; care omissions) or relationship issues pre- or post mutually identified incidents (39.1%; eg failure to listen to patient concerns; breach of candour).

Conclusion Our study suggests that traditional, clinician-based models of safety and risk are likely to omit critical dimensions of root causes to adverse events. Patients and public are able to contribute to safety monitoring and evaluation in two ways: by highlighting overlooked or undervalued aspects of unsafe care (eg failure to listen; absent communication) and by revealing latent causes of incidents across time (eg failed continuity of care; systemic care omissions).

OP86 | **LOW ECONOMIC GROWTH, HEALTH, HEALTH INEQUALITIES AND SUSTAINABLE DEVELOPMENT GOALS IN A RICH COUNTRY: 27-YEAR JAPANESE TIME SERIES**

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Background Sustainable Development Goal #8 refers to decent work and economic growth. In the context of climate change and global resource depletion, it is important to understand whether low economic growth is compatible with positive population health in rich countries, particularly because the past decade of austerity in the UK and USA is associated with stagnating life expectancy. Japan provides a natural experiment in that it has experienced low economic growth since 1992, and life expectancy continued to improve. However, the trend in health inequality in good self-rated health is unknown.

Methods We examined trends in health and health inequalities using ten triennial waves of a nationally representative survey in Japan, 1986–2013 (n=731,647). Change in age-standardized self-rated good health was calculated, and health inequalities and their time trends were calculated using Slope and Relative Indices of Inequality (SII and RII respectively) in relation to net household income. Analyses were stratified by sex and age, for children (6–18 years), working-age adults (20–59 years), younger old (60–69 years) and older old (70–79 years), given age differences in relation to the economy