

Knowledge Exchange and Dissemination plan was to reengage with key stakeholders to present and request their feedback on trial findings, and to inform the design of a future definitive effectiveness trial.

Methods Stakeholders who supported recruitment of women and/or trial planning, representatives of the Irish Cancer Society, the Ireland's Health Service Executive, community organisations and pharmacies, GPs and primary care staff were invited to participate in an online interactive workshop. A Policy Brief which summarised trial findings was disseminated beforehand. Specific workshop objectives were to capture stakeholders' views on improvements to community engagement, strategies to enhance recruitment and retention, and policy and practice priorities arising from the research. Workshop participants were invited to fill in an anonymous, open-ended questionnaire after the workshop to register any further views on the previously discussed topics. Field notes taken during the workshop and questionnaire responses were combined to obtain a final list of challenges, barriers and recommendations for policy development and future research from a community perspective.

Results Forty-one stakeholders attended the workshop. The need for additional time to build relationships with local stakeholders for participant referral was identified. Further development of the social prescribing model in primary care was recommended as a vehicle to enhance recruitment. Low literacy was identified as a barrier to recruitment and retention, to be addressed by simplifying trial-related information, and by greater assistance with data completion. Other recommendations included provision of an intervention boost after trial completion to facilitate retention, and to maintain the established group support by encouraging participants to join other healthy community programmes. Key policy priorities were to remove cost and administrative barriers to access NRT, prioritise smoking cessation support tailored to disadvantaged groups, and to recognise and fund the peer-support model for smoking cessation.

Conclusion These results yielded important strategies to optimise the design of a future trial to assess WCQ effectiveness on smoking cessation for women smokers living in disadvantaged districts in Ireland. The findings may be generalisable to other community-based health interventions.

P46 EVOLUTION OF GEOGRAPHICAL INEQUALITIES IN COVID-19 MORTALITY OVER THE FIRST WAVE OF THE PANDEMIC IN ENGLAND

¹Claire Welsh*, ^{1,2}Viviana Albani, ^{1,2}Fiona Matthews, ^{1,2}Clare Bamba. ¹Population Health Sciences Institute, Newcastle University, Newcastle, UK; ²Applied Research Collaboration North East and North Cumbria, Newcastle University, Newcastle, UK

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Background Early in the COVID-19 pandemic it was clear that inequalities were emerging in the distribution of deaths, with more deprived areas harder hit than less deprived ones. How these inequalities began, evolved, and changed with the implementation of the first national lockdown did not receive as much attention. We used COVID-19 death counts per local authority (LA) over the first wave (up to 4th July, 2020) to understand how COVID-19 impacted different areas, and to shed light on the equity effects of a strict national lockdown.

Methods Weekly COVID-19 death counts per LA were provided by the Office for National Statistics, along with population estimates for mid-2019 and data on the index of multiple deprivation (IMD) and median age per LA. Mortality rates for each area were calculated as deaths per 100,000 persons. Characteristics of the evolution of mortality rate per LA and decile of IMD were calculated, for example the speed of increase to each LA's peak rate. Simple linear models and descriptive statistics were used to compare areas.

Results More deprived LAs tended to begin recording COVID-19 deaths earlier than less deprived areas. Mortality rates in more deprived LAs rose at a faster rate to their peak, which was also higher than in less deprived LAs. All LA death rates peaked between 3 and 9 weeks following the implementation of the first lockdown. The time between the lockdown announcement and the peak death rate was significantly negatively associated with the speed of increase, adjusted for the median age of the population (95% CI -0.33 to -0.31 deaths per 100,000 per week). Total cumulative mortality varied from 10.79 to 170.61 deaths per 100,000 persons per LA. Cumulative death rates were significantly higher in the most deprived 10% of LAs compared to others ($p < 0.001$). Until lockdown, the most deprived 20% of LA's recorded 64% more deaths than the most deprived 20%. By 4th July, this gap had narrowed to 16%.

Conclusion Variation in the timing and speed of increase of local mortality rate curves occurred in the first wave and led to large inequalities across deprivation quintiles. This inequality was reduced but not completely abolished by the strict national lockdown imposed in March 2020. Timings of future national lockdowns should consider differences in local epidemic evolution, with extra support offered to those areas hardest hit.

P47 INTERROGATING STRUCTURAL INEQUALITIES IN COVID-19 MORTALITY IN ENGLAND AND WALES

^{1,2}Gareth Griffith*, ^{1,2}George Davey Smith, ⁴David Manley, ^{1,2}Laura Howe, ³Gwilym Owen. ¹Medical Research Council Integrative Epidemiology Unit, University of Bristol, Bristol, UK; ²Population Health Sciences, Bristol Medical School, Bristol, UK; ³Department of Public Health and Policy, University of Liverpool, Liverpool, UK; ⁴School of Geographical Sciences, University of Bristol, Bristol, UK

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Background Numerous observational studies have highlighted structural inequalities in COVID-19 mortality in the UK. Such studies often fail to consider the complex spatial nature of such inequalities in their analysis, leading to the potential for bias and an inability to reach conclusions about the most appropriate structural levels for policy intervention.

Methods We use publicly available population data on COVID-19 related- and all-cause mortality between March and July 2020 in England and Wales to investigate the spatial scale of such inequalities. We propose a multiscale approach to simultaneously consider four spatial scales at which processes driving inequality may act and apportion inequality between these.

Results Adjusting for population age structure, number of care homes and residing in the North we find highest regional inequality in March and June/July. We find finer-grained within-region increased steadily from March until July. The