

List of abstracts.

Day one – Wednesday 16th November 2022

Title: Tf-CBT implementation project for care-experienced young people.

Author: Dr Rachel Hiller

Co-investigators: G. Bjornstad, T. Clarke, R. Davis, K. Hudson, J. Macleod, H. McLeod, R. Meiser-Stedman, S. Morgan, R. McGovern, P. Smith, P. Stallard

Researchers; R. McGuire, P. Oliveira

Research assistants: D. Schmidt, J. Coombes, R. Bosworth, E. Geijer Simpson

Summary

The ADaPT trial seeks to understand what services and service-providers need to deliver our best-evidenced treatment to care-experienced children and teens with posttraumatic stress disorder (PTSD). Rates of PTSD – a trauma-specific mental health outcome – are 12 times higher in care-experienced young people versus their peers. Yet, this group are rarely assessed for PTSD, and often struggle to access the treatment that we know is most effective – trauma-focused CBT. The primary aim of this project is to understand the barriers and facilitators of the implementation of screening for PTSD and the delivery of tf-CBT, and work with services to address obstacles where possible.

Title: How does Universal Credit affect the mental health of claimants in North East England and Scotland: interim findings from a qualitative study.

Authors: Dr Mandy Cheetham, Dr Steph Morris, M. Gibson, C. Bamba, P. Craig

Summary

The UK social security system is undergoing major transformative changes with the introduction of Universal Credit (UC), which combines six legacy benefits and tax credits into a single payment for unemployed and low-income households. UC is being introduced gradually, with rollout due to be complete in 2024. Despite extensive reports of hardship associated with the introduction of Universal Credit, no previous studies have comprehensively evaluated its impact on mental health. Because UC targets low-income households, impacts on mental health will have important consequences for health inequalities.

Methods

As part of a NIHR funded, mixed methods study, we are conducting longitudinal in-depth interviews with up to 80 UC claimants in England and Scotland to explore reasons for claiming, experiences of the claim process and how people manage on UC. The study is guided by public contributors with experience of UC and policy and practice partners supporting them.

Findings

We report early findings from the first wave of in-depth interviews with UC claimants undertaken between January and August 2022 as the UK emerges from the pandemic. We

describe how the experience of claiming and managing on UC relates to mental health and wellbeing, financial security, employment, family life, housing, service use and other related outcomes, and how this varies between England and Scotland.

Discussion

Building understanding of how Covid-19 and related UC changes have affected claimants' experiences of UC, we discuss the ways in which new and existing claimants' experiences differ in ways that affect health and wellbeing. In addition, we reflect on the challenges and opportunities of involving UC claimants as public partners in the study, the risks they face, and measures undertaken to mitigate these.

Conclusions

The effects of the transition to UC on claimant's health are likely be complex and geographically variable, with some households benefitting from improved living standards and greater financial security, and others facing an increase in hardship, insecurity and debt. We will examine the policy and practice implications of our interim findings for the future transition to UC.

Title: A national evaluation of Project Cautioning And Relationship Abuse ('CARA') awareness raising workshops for first time offenders of domestic violence and abuse.

Author: Dr Sara Morgan

Summary

Domestic violence and abuse (DVA) leads to an adversity package of poor health and social outcomes. Project CARA was developed as a conditional caution offered by the police for first time adult offences of DVA of standard or medium risk. Individuals given CARA are required to undertake two mandatory workshops that increase awareness of their abusive behaviour and the safety of partners and children. Using qualitative and quantitative methods our aim is to evaluate the impact of CARA following its rollout nationally and understand the extent to which it can reduce the impact of DVA at the population level.

Title: A qualitative study into the impact of changes to the primary healthcare system in the UK on marginalised groups.

Author: Ms Ada Humphrey

Summary

There has been a shift in the way in which healthcare services are accessed in the UK with most non-acute healthcare service delivery made remote. A longer-term policy push towards digital first primary care services was accelerated by COVID-19 and has subsequently been normalised into practice. This is against a background of persistent and rising inequities in health outcomes and healthcare access in the UK. Whilst one aim of digital healthcare is to remove barriers to accessing healthcare, it is also possible that this form of service delivery will both create new types of inequities as well as replicate and re-embed existing ones.

Aims and objectives

This PhD study explores the experiences of changes to GP services amongst marginalised groups in the UK. The research focuses on the different ways in which healthcare work is being created and reallocated in Primary Care and the implications of this for already marginalised people. The research utilises the ideas of responsabilisation, work, and candidacy to explore how processes of marginalisation shape experiences of digital provision of primary care services in the UK.

Methods

This study took an ethnographic approach over the course of six months (November 2021-April 2022) involving observations and interviews (n=15), conducted across a range of field sites in London. Interviews were conducted with participants recruited from services catering to different forms of marginalisation. These included a foodbank, an advice centre for refugees and asylum seekers, and a charity offering digital support. The research also includes in-depth interviews with GPs (n=6) from London's lowest ranking IMD boroughs, members of staff at Digital Health Hubs (n=4) across the UK, and staff members at the fieldwork site services (n=3).

Results

The results of this study indicate that the digitalisation of GP services, specifically remote consultations, are creating new forms of 'monitoring and noticing', 'articulation' and 'place-making' work for patients. These forms of work are introduced as patients are tasked with making themselves comprehensible to their GPs and creating effective working spaces for them to practice in remotely. Patients' capacities to engage in these forms of work are dependent on their access to a range of material and cognitive resources, which are not equitably distributed. Further, new normative expectations placed on patients may be creating clinical and safeguarding risk for patient groups who can't fulfil these roles.

Conclusion

The results suggest that digitalisation of GP services can create added barriers for marginalised groups which may result in lower levels of access and engagement with primary healthcare services. These barriers extend beyond simply access to digital devices to include softer barriers such as the ability to communicate without visual cues. The rapid digitalisation of General Practice during COVID-19 risks further marginalising already marginalised groups and widening longer term healthcare inequalities within the UK.

Title: Mixed-methods evaluation of a Population Health Management system to reduce inequalities in update of COVID-19 vaccinations - to ask if they mind altering title to remove 'Covid-19'.

Author: Dr Jessica Sheringham, G. Watson, C. Moore, F. Aspinall, A. Hutchings

Summary

Population health management (PHM) is an emerging technique to join and analyse patient data across organisations to identify population needs, deliver care and address health inequalities. PHM is considered a key enabler of integration across health and care organisations but little is understood about how (or whether) PHM achieves its aims.

North Central London's PHM system includes a dashboard reporting uptake of COVID-19 vaccinations (the Dashboard). The Dashboard, first deployed from December 2020, enables staff in North Central London to view variations in uptake by population characteristics in near real-time.

Aim

To understand how health and care staff in North Central London used the Dashboard to address inequalities in vaccine delivery and uptake.

Methods

A mixed-methods evaluation, codesigned and delivery in partnership with staff in North Central London, comprised descriptive quantitative analysis of staff Dashboard usage and individual semi-structured interviews with nineteen health and care professionals in North Central London. Interview schedules were informed by Normalisation Process Theory; data were analysed using the Framework Method.

Results

Quantitative data indicated the Dashboard was used differently over time and by distinct staff groups. Usage was highest in February 2021 when approaching deadlines for vaccinating vulnerable populations and new cohorts became eligible for vaccination. Interviews also indicated different types of Dashboard user; while some used the Dashboard intensively every day, other highly influential indirect users accessed outputs from the tool rather than the Dashboard itself.

Most participants reported that the Dashboard helped them to answer key questions about vaccine uptake, with some recommendations for improving design and functionality. Participants described how the Dashboard influenced decisions about the delivery of vaccinations to reduce inequalities in uptake. In particular, by helping users to identify variation in uptake, it enabled them to target supportive interventions responsively to groups with low uptake, and work together as one system to deliver the programme.

Certain qualities of the Dashboard were described as crucial in supporting users to take action. Participants trusted the data because it was local, consistent and shared across the system. The Dashboard provided information which was otherwise unavailable to them. Much of this information was 'targetable' and was combined with an ability to layer and combine characteristics, such as ethnicity and language spoken. This enabled staff in North Central London to reach specific populations in a tangible way, for example via an identified location, by communicating in specific languages or through particular media.

Conclusion

This evaluation highlighted some key success factors for local population health management. Data were trusted and reached users with the power to shape service delivery. It suggested that depth of usage may, in some cases, be more important than breadth across a system. These findings are already influencing North Central London PHM system design, programme planning and delivery. The COVID-19 vaccination dashboard, however, was applied in an urgent policy context, so further evaluation of PHM is required in other contexts to understand the extent to which these findings are transferable.

Title: Implementing effective primary care responses to poverty-related mental distress (DeStress-II).

Author: Dr Felicity Thomas

Summary

Current primary care options to support patients experiencing poverty-related mental distress can be experienced as unsatisfactory by both patients and GPs. The RCGP-accredited DeStress training package has been generated by researchers, community partners and GPs to better support consultations for poverty-related mental distress. It incorporates a framework for best practice techniques and topic guides that can be used within a ten-minute consultation. This study examines how best to deliver this GP training and understand its impact on consultation practice for low-income patients and for GPs. The research will also capture the barriers and facilitators to intervention delivery across diverse practice/place-based settings.

Title: Evaluation of the Mental Health Navigator Scheme.

Authors: Dr Sarah Blower, Dr Sarah Masefield, Dr Steph Bramley, Wakefield District Housing, NHS Wakefield Clinical Commissioning Group, South West Yorkshire Partnership NHS Foundation Trust, Gravelly Hill Borough Council

Summary

Wakefield District Housing (a registered social housing provider) operate a Mental Health Navigator scheme to support tenants with mental health problems at risk of losing their housing to maintain their tenancies. The navigators are specialist practitioners (e.g. mental health nurses and occupational therapists) employed by the NHS but embedded within Wakefield District Housing. They provide early intervention and support tenants access appropriate existing health and wellbeing services in their area. Our research aims to document what the scheme involves, what works well, what could be improved and how a best practice tool kit can be applied across the UK.

Title: Social deprivation and public attitudes in North East England and North Cumbria towards bystander cardio pulmonary resuscitation (BCPR).

Author: Mr Karl Charlton

Summary

Out of hospital cardiac arrest (OHCA) is a time critical event. Bystander cardiopulmonary resuscitation (BCPR) is a critical link in the 'Chain of Survival' for OHCA. For every 30 patients who receive BCPR, 1 additional life will be saved.[1]

Across England significant variation exists in the proportion of patients who receive BCPR; this has been associated with social deprivation. North East England and North Cumbria (NENC) is one of the most socially deprived regions in England, comprising a large concentration of high-risk neighbourhoods (high incidence of OHCA and low BCPR

provision[2]). Initiatives aimed at improving the rates of BCPR training have yet to make an impact in high-risk neighbourhoods, leading to significant health inequality.[3]

Methods

A cross-sectional mixed methods study conducted in postcode districts of varying social deprivation (identified using Indices of Multiple Deprivation (IMD)) across NENC between July and December 2021. Members of the public aged ≥ 18 years with mental capacity were approached in busy commercial areas, to participate in a survey exploring knowledge of, and willingness to perform, BCPR/defibrillation. Participants left contact details if they were willing to be recontacted regarding participating in an interview to explore their survey answers further. Study participation was voluntary.

Results

Of the 601 survey participants, 52.2% (n=313) were female and the mean age was 51.9 years. Men were more comfortable performing BCPR compared to women, $p < 0.01$; increased age was associated with being less willing to help, $p < 0.01$. Participants from least deprived areas were less likely to be comfortable performing BCPR compared to those in most deprived areas, $p = 0.01$, and were less likely to know what a defibrillator is for, $p = 0.02$. Higher education, income and occupation level resulted in improved willingness to follow advice, competency in recognising OHCA and desire for more information about BCPR. 20 survey participants, 10 female and 10 male, aged between 21-73 years, from postcode districts of varying IMD, were interviewed. Irrespective of IMD, a general lack of knowledge regarding BCPR and defibrillators existed, participants were fearful of causing harm to the patient and aware of personal risk, which were heightened when the patient was unfamiliar to them, and during the Coronavirus pandemic

Conclusion

Factors influencing willingness or ability to deliver BCPR existed at individual rather than population level. A general lack of knowledge existed in all communities. A nuanced approach is required when developing policies to improve rates of BCPR.

Title: Investigating health inequalities in the access to, experience of, and outcomes from treatment for lung cancer: A mixed methods approach.

Authors: Dr Laura Lennox, K. Lambe, C. Hindocha, S. Coronini-Cronberg

Summary

In England, there are persistent inequalities across the life-course, resulting in unfair and avoidable differences in health across and between populations(1). Critical to reducing health inequalities (HIs), is identifying how they manifest within care pathways. Lung cancer (LC) remains the leading cause of cancer-related deaths(2,3); while there have been significant improvements in survival this is not equally distributed among all groups(4).

A tri-partite partnership (local hospital; Cancer Alliance; ARC Northwest London) facilitated a one-year Research Fellowship to review HIs in access to, outcomes from, and experience of LC care to inform an overarching HI-reduction strategy for the acute trust.

Methods

A systematic scoping review of global literature was conducted to ascertain existing evidence on HIs in LC care (databases interrogated: EMBASE, HMIC, Medline, PsycINFO, and PubMed).

The acute trust's LC pathway was studied in detail for HIs. Data from patients with suspected (n=6,414) and confirmed LC (n=975) were analysed. Using univariate and multivariate logistic regressions, key HI variables (e.g., age, sex, ethnicity, deprivation) were examined in relation to diagnosis, treatment, outcomes.

Finally, semi-structured interviews (staff, n=12; LC patients/carers, n=8) were undertaken to gain insight into their lived-experiences of HIs. Thematic content analysis was conducted using NVivo software.

Findings

Scoping review: 41 HI papers were identified, among which: n=31 considered outcomes (mortality, survival); n=29 considered access (treatment, diagnosis, supportive care); n=3 considered experience (unmet need, mental health).

Quantitative analysis: Older patients, White British, or those referred via the Emergency Department(ED), were significantly more likely to receive a LC diagnosis. For patients with confirmed LC, being older or referred via ED significantly increased the likelihood of death. Patients identifying as Asian were more likely to miss diagnostic test appointments. Data quality was assessed: almost one in four (23%) suspected LC patients' ethnicity was recorded as 'unknown' or 'not stated'.

Title: In at the Deep End: co-creating a primary care network with practitioners serving communities living in areas of blanket socioeconomic deprivation.

Authors: Dr Sarah Sowden, J. Wildman, C. Norman, S. Hassan, M. Weatherhead, R. I. Henwood, D. Julien

Summary

England's primary care crisis threatens the ability of general practice to play its role in the latest attempts to address the nation's stubbornly persistent health inequalities. Deep End networks of general practitioners (GPs) serving communities living in areas of blanket socioeconomic deprivation are being established in the UK, and internationally, in response to the challenges of delivering primary care in deprived areas – challenges that have been further intensified by the COVID-19 pandemic. Established by primary care practitioners in July 2020, the Deep End network North East and North Cumbria (NENC) is the latest network in the growing Deep End movement. The Deep End NENC is being developed through a process of co-creation, supported by the National Institute for Health Research (NIHR) Applied Research Academy (ARC) NENC, which provides researcher time to support the development and evaluation of the network.

Aims

This study aimed to 1) generate an in depth understanding of the specific challenges of delivering primary care in areas of severe blanket socioeconomic deprivation, including experiences through the Covid-19 pandemic 2) co-create with primary care practitioners a Deep End network for the North East and North Cumbria region.

Methods

Semi-structured interviews with practitioners working in primary care practices in NENC identified as 'Deep End' (as defined by IMD applying methodology developed by Scotland Deep End). Participants were recruited via purposive and snowball sampling. Interviews were conducted using video-conferencing software. Data were analysed using thematic content analysis through a social determinants of health lens.

Results

15 participants were interviewed (11 General Practitioners (GPs), 2 social prescribing link workers and 2 nurses) with Deep End careers ranging from 3 months to 31 years. We find that the Deep End metaphor is apposite: it is the volume of clinical and social patient need that creates burdens for Deep End practitioners. We also find a severe mismatch between the demands of caring for Deep End communities and the 'fantastical thinking' that expects GPs to address health inequalities while failing to redistribute resources to areas of greatest need. We identify practitioners' hopes for a Deep End network that delivers initiatives tailored to patients' needs, gives a name to their struggles, and advocates for wider healthcare system recognition of deprivation, and a funding formula that recognises need. Further, we find that the COVID-19 pandemic, and particularly, the move to 'digital first' primary care, was increasing existing inequalities for Deep End patients.

Conclusion

To date, policies and initiatives aimed at addressing health inequalities have failed to make an impact. It will take courage to address the problems in primary care that threaten the latest attempts to reduce socioeconomic inequalities in healthcare access and outcomes. However, the task must not be shirked as currently, the burden falls on primary care practitioners who struggle to meet their patients' needs with inadequate resources. This is unfair and unsustainable.

Title: How can the NHS maximise its role as an anchor institution to boost local economies and reduce socioeconomic and health inequalities?

Authors: Dr Ruth Watkinson, Mr Sam Khavandi, and Dr Luke Munford

Academic co-investigators: M. Sutton, P. Wilson, C. Bamba, Jo Wildman, John Wildman, H. Brown, K. Pickett, B. Barr, J. Ford, L. Forbes, P. Lorgelly

Policy and practice partner co-investigators: NHS Confederation – M. Wood, H. Davies, B. Ahmad, T. Lloyd Goodwin

Summary

The NHS represents a substantial part of the economic activity in most areas by being a large employer and providing a source of local economic activity: an 'anchor institution'. We are exploring historical data to examine the strength of association between anchor related

activities and economic and health outcomes of places. In particular, we are examining inequalities and place-based factors that affect the strength of these associations. We will also undertake qualitative work in three or four areas to understand barriers and facilitators. We will combine the results into a 'model anchor hospital' to be used by local and national policy makers.

Title: Co-producing understanding around access to mental health and substance use services during the pandemic for people experiencing homelessness.

Author: Ms Emma Adams

Summary

People facing homelessness often experience challenges around mental health, drugs, and alcohol use. Despite this, they can often have poorer access to health and care services compared to the general population. During the COVID-19 pandemic service delivery changed across health and social care, with some services closing while others adopted virtual or telephone support. Existing evidence has highlighted a gap in our understanding of access to mental health and substance use support for people facing homelessness during the pandemic, with an even greater gap in evidence that is co-produced (developed with people experiencing homelessness).

To better understand access to community-based mental health, drug, and alcohol use services, we conducted a qualitative study with people who experienced homelessness in Newcastle and Gateshead during the pandemic. Telephone interviews were conducted between February and May 2021 with 10 women and 16 men who self-identified as facing homelessness within Newcastle and Gateshead during the pandemic. Through a combination of online (via Zoom) and in-person workshops, transcripts were analysed using inductive reflexive thematic analysis with people who have lived experience of homelessness.

Three themes were developed: a) inadvertent exclusion (reactive changes to support provision often led to people being unable to access services); b) barriers to recovery (including physical locations, repetition of recovery stories, individual readiness, and limited availability); and c) building a system responsive to needs (suggestions to create services reflective of the needs of people experiencing homelessness and provide them with an active role in their care).

The local geographical focus and involvement of individuals with lived experience has strengthened the study's implications for policy and practice in the region. Additionally, both regional and national conversations with commissioners, practitioners, and policy makers, has led to suggestions for changes to mental health, drug, and alcohol use policy and practice across England. As part of wider impact, the findings have been presented in a peer-reviewed journal article, conference presentation, blog posts, a policy and practice workshop, as well as the production of low literacy visuals.

All these dissemination activities have been co-authored and co-produced with those with lived experience of homelessness and the visuals (an idea suggested by those with lived experience) are displayed within housing, inclusion health, substance use, and mental health services across the region.