



Report shows abuse of elderly by family

Abuse and neglect of older people is increasingly acknowledged as a social problem in the UK and internationally.

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Around one in 40 adults over the age of 66 and living in a private household reported in 2007 that they had experienced some form of mistreatment in the past year. This equates to 227,000 people aged 66 and over in the UK. The proportion of older adults (aged 65 and over) in the population is expected to increase from its 2008 level of 16%, with recent estimates suggesting by 2033, 23% of the population will be 65 or over. This will have an impact on demand for health and personal care and since the 1990s, such delivery has focused on care in community settings and supporting older people to live independently within their own homes. Set within this context of an ageing population, the importance of elder abuse and neglect (elder mistreatment) is likely to increase.

There was, until 2007, a lack of sound data on the prevalence of elder abuse and neglect in the UK. *The UK Study of Abuse and Neglect of Older People* was the first dedicated study of elder mistreatment in this country.

Commissioned by Comic Relief and the Department of Health, it was designed to establish the prevalence of abuse and neglect among older adults, based on a representative sample of 2011 adults aged 66 and over and living in private accommodation (including sheltered housing).

The World Health Organisation/Action on Elder Abuse definition was used as starting point for this study, defining abuse as: "a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person". Neglect and four types of abuse – financial, psychological, physical and sexual abuse – were covered in this study. These were collectively termed 'mistreatment'.

The study involved several stages, including a consultation period where definitions of mistreatment and its different forms were agreed and tested, and a six month fieldwork period. Interviews were carried out in

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respondents' own homes by experienced interviewers and included face to face interviews as well as self completion elements. The methods and procedures employed reflected the sensitive nature of this study. A detailed qualitative study was also carried out with selected participants and reported separately in *UK Study of Abuse and Neglect of Older People: Qualitative Findings* (2007).

Prevalence of mistreatment

Overall, 2.6% of older people (around one in 40) reported experiencing some form of mistreatment in the past year. A relatively conservative definition was used, including only those who had experienced mistreatment in the past year by a family member, friend or care worker. Neglect was the most common form, reported by 1.1% of older people, followed by financial abuse (0.7%). The prevalence of psychological and physical abuse was similar (both 0.4%) and sexual abuse was the least reported type (0.2%).

Partners (51%) and other family members (49%) were most commonly reported as the perpetrators of mistreatment. Relatively little mistreatment was carried out by care workers (13%) or friends (5%).

Factors associated with mistreatment

Given the small number of individuals in the study who reported mistreatment, it was difficult to examine risk factors in detail, but a number of factors were associated with the likelihood of being mistreated.

For example, women were more likely to have experienced mistreatment than men. Marital status was also significant, with the highest prevalence found among separated or divorced older people and the lowest among those who were widowed. Socio-economic position, based on previous employment, was also significant, with highest levels among those who had last worked in semi-routine or routine occupations. Those in rented accommodation were more likely to say that they had experienced mistreatment than owner occupiers.

Overall, 2.6% of older people (around one in 40) reported experiencing some form of mistreatment in the past year.

Health status featured among risk factors, with increased prevalence of mistreatment being associated with declining health status. Those who reported loneliness or a low quality of life were also more likely to have experienced mistreatment, as were those who had depression and those who regularly used medication.

Definitions of mistreatment

When the definition of mistreatment was expanded to include incidents perpetrated

by neighbours and acquaintances the prevalence was higher, with four percent of older people (around 1 in 25) reporting mistreatment in the past year. This equates to around 342,300 older people aged 66 and over across the UK.

When mistreatment by neighbours and acquaintances was included, there was an increase in the prevalence of different forms of abuse, but not neglect. The prevalence of financial abuse increased from 0.7% to one percent; psychological and physical abuse both increased from 0.4% to 0.7%; and sexual abuse from 0.2% to 0.5%. The salience of risk factors varied with the definition of mistreatment used.

Conclusions

This study provides reliable estimates for the UK prevalence of abuse and neglect among older people living in their own homes. The findings suggest that the problems of mistreatment are comparable to those in other international countries, with a one year prevalence of 2.6% for mistreatment by a family member, friend or care worker, or 4% when neighbours and acquaintances are included.

Individual characteristics, socio-economic factors and health status were all found to be associated with mistreatment.

Melanie Doyle-Francis, Simon Biggs and Bob Erens
National Centre for Social Research & King's College London

from the editor

Some years ago I had tea with my old piano teacher. I had just turned 25 years. "No longer in the springtime of life!" she had quipped. I think that it is quite fitting that this winter issue of *ph.com* is focussed on the winter of life. When this actually begins varies from person to person and indeed there is contention over whether chronological age is a good proxy for biological age. Nevertheless in the UK the term older people is taken to mean those aged 65 years and older. These are people who have entered a new period of life, retirement, grandparenthood and other life changes.

Today's older population cannot be viewed as a homogenous group. Within this group, experience of later life varies with age, gender, ethnicity, social class, wealth and locality. This leads to different needs, aspirations and choices. Due to increased mobility of children, some older people are isolated from their families. Others have childcare demands placed upon them at an age older than previous generations, courtesy of increased age of mother at first birth and working parents. Many have health and care needs while subsequently being a carer for a partner. Moreover, age



can bring social exclusion, dependency on carers and services, fuel poverty, reduced mobility and poorer quality of life. Women aged over 75 are among the poorest in the country. A recent report from the West Midlands Public Health Observatory has shown that winter excess deaths are still of major concern, with 25-30,000 deaths being linked to the cold weather each year.

On the positive side Twitter has seen older generations taking to the medium at a faster rate than any other age group. On Facebook, a large number of long-term condition support groups (stroke, cancer etc) have sprung up, consisting of the older demographic. Department of Health's *Wired for the Third Age* concluded that

there was potential to use social networking sites to promote a sense of community and support carers, particularly those caring for people with dementia.

Meeting the needs of this diverse older population has prompted many varied and innovative ways of delivering services. This edition of *ph.com* reflects some of the excellent new ways of meeting the needs of older people. From intergenerational projects to village agents and targeting elder abuse to helping older women with HIV, these current initiatives show that public health is as forward thinking as ever.

Catherine Heffernan



Cracking the party manifesto health code

As we prepare for the general election, public health is facing interesting times – again. It seems to me that 2010 is shaping up to be a tale of two public healths.

There's the public health basking in the sunny uplands of political recognition. Pandemic flu has been the latest ill wind to blow us quite a bit of good. Add to that the huge interest in lifestyles and health – not a day goes past without a media story on obesity or alcohol or sex, drugs and rock'n'roll. And all the discussion about how to get best value for money from the NHS – quality, innovation, productivity and, yes, prevention. The politicians cannot avoid public health – it is everywhere.

Now is the time to check the various party manifestos for what they're saying about health improvement, health protection and healthcare quality.

Take alcohol, for instance – who is promising a minimum price per unit? Or standardised labelling? Or a mandatory crackdown on marketing and promotion? On obesity – who is going to get tougher over junk food advertising to children? Or force through a compulsory front-of-pack nutrient labelling scheme? Which party is going to introduce a more comprehensive programme for tobacco control? Who will do most to improve sex and relationship education, and improve access to sexual health advice and contraception for young people? Who will implement a sensible, balanced strategy to reduce harm from illegal drugs without causing more harm by criminalising vast numbers of young people?

Who will improve access to NHS dental care? Or improve the standards for health in our prison population? Or extend free healthcare to failed asylum-seekers? Who will provide more educational psychologists? Or speech and language therapists? Who will do most to improve the health and wellbeing of people with long-term conditions and properly integrate health and social care? Who will seriously tackle the social determinants of health?

Now is the time to check the various party manifestos for what they're saying about health improvement, health protection and healthcare quality.

But wait – I'm getting carried away. All this costs money and I'm forgetting the other public health. The public health of hard times. Whichever party wins the election faces a huge challenge – the freeze on public sector budgets from 2011 onwards in an effort to recover some of the billions the government spent on propping up the economy. So we have to ask – what are the various parties' plans for public health in a cold climate?

Budgets will be slashed. Jobs will be frozen. Programmes will be dumped. Which party will do most to sustain and protect all the initiatives outlined above? And, more parochially, which party will do most for public health training programmes and posts? Or introduce minimum standards for public health teams? Or ring-fenced funding? Will there be a bonfire of the quangos? Are the regions safe? Will we be caught up in, wait for it, yet another re-organisation? These and many more questions should be put to the political pugilists.

We need to know what real commitment lies behind all the rhetoric about the importance of healthy living, prevention and improved access to quality health and social care. Let's have a clear and unambiguous promise from all the parties to put their money where their mouth is and ensure that public health is a real priority. I'd like to see a live debate between Andy Burnham, Andrew Lansley and Norman Lamb on where they see the savings being made – and what they would really fight to protect.

At the end of the day, most of the tough decisions will be devolved to local level. How will public health fare in the inevitable blood-bath? Well, I believe that's largely down to us. I'm a glass-half-full person (in my more cheerful moments) and it seems to me the best way we can protect public health from the grim reaper is to make ourselves indispensable. There's no doubt our central role in the pandemic flu response has helped in this respect. So too has the huge contribution we've made to healthcare planning and commissioning, reaching marginalised groups and tackling health inequalities.

We need to play to our strengths, celebrate our successes and provide tangible products. We need to show strong

leadership. We need to demonstrate value for money. We need to foster good news stories. And we need to let our colleagues, bosses, partner organisations and other assorted local deities bask in any reflected glory we create.

Easier said than done, I know – but a necessity if we're to survive in reasonable shape over the next year or two. It's make-or-break time. With the politicians and planners blowing hot and cold over public health, I believe our best defence is to surround ourselves with the insulation of achievement and the warm glow of recognition.

To comment on this editorial email Alan at comments@fph.org.uk

Keep the date in your diary

London will be the base for the UK Faculty of Public Health's 2010 annual conference, possibly for the first time ever.

In this general election year, we felt the UK's capital city would give us the right location for a conference that discusses everything from the big political issues, and the looming economic threats, to the future of public health departments.

Leaders in public health and public life will be asked to debate the big public health questions – from where cash in public health should be spent to tackling public attitudes – from public health policies on children right through to the elderly – before being quizzed by the audience.

The UK FPH conference will be held at Imperial College, London, one of the UK's leading universities, with its many historic links to scientific breakthroughs, on July 7th 2010.

We hope to attract more high-profile speakers than ever before and add more interactivity, with live blogging and Twitter feeds, from the conference.

The conference theme will be **The Next Decade: What is the Future of Public Health?** and sessions and keynote speakers will all explore different aspects of this subject. We will ask what the big challenges are for public health experts, the public and the policy makers in the next decade and beyond.

Let us know what you think the big question for the next decade in public health is by emailing karentidy@fph.org.uk marking your email – the big question.



2009 has presented FPH and its members with a number of new and in some cases unexpected challenges.

- ◆ Global financial crises resulting in an economic recession
- ◆ Political uncertainty as UK heads towards a national election in 2010
- ◆ Rise of a global public health threat (swine flu)
- ◆ Cuts in public sector spending
- ◆ Changes in policy and personnel within the Department of Health

FPH has been affected by these challenges, which have had a significant impact on many of the activities planned for 2009.

Special measures have been taken during 2009 to address these challenges in the short term, for 2010 and beyond. By modifying and adjusting our 2009 Business Plan, we have managed to bring this financial year to a close with only a small deficit – whilst continuing to meet the commitments planned for 2009. My thanks to the Senior Management Team (SMT) and Officers who have worked very hard to achieve this.

During 2009 Trustees, Officers and Staff

of FPH have participated in a process to assess how FPH can best work towards achieving its strategic objectives and to safeguard FPH against the impact of these challenges moving forward.

This process has taken place via a series of away days between the Trustees, Officers and SMT, the SMT and the FPH staff. Key to this process has been the presentation of the President's vision for 2010 and analysis undertaken by the SMT on the public health environment, FPH's financial status, FPH's standard-setting role and the FPH's UK and international membership base. The process has also included the revision and refreshment of the FPH organisational values.

The evidence uncovered and conclusions drawn from the research has formed the basis of business planning for FPH for 2010. The following principles have been used as the basis for business planning:

- ◆ Maintain and strengthen the FPH leadership role in public health
- ◆ Actively engage with FPH members
- ◆ Review and refresh how we deliver our core areas of business
- ◆ Diversify FPH income base through new sources of income and investment in the organisation.

President's vision for 2010

The President's vision has provided the organisation with a framework for business planning in 2010. The key elements of the vision are that by the end of 2010, FPH will become:

1. More widely recognised and highly regarded as the standard-setting body and professional home for public health specialists in the UK.

2. More widely recognised as an authoritative voice for public health
3. Expanding and more engaged membership
4. Well on track to being granted our Royal Charter as a College.

FPH organisational values

The FPH values of service, cooperation and respect were developed in 2007 as part of FPH organisational development programme. The values were reviewed and refreshed in 2009 as part of a FPH organisational development programme.

The new values will guide the organisation on how to operate to achieve its objectives.

Work to embed the values with the organisation will take place during 2010.

◆ Member focused:

FPH provides excellent service to members based on a firm understanding of their needs

◆ Leading voice:

FPH is committed to driving and setting the public health agenda

◆ Professional commitment:

FPH develops and delivers with excellence, expertise and integrity

◆ Innovative:

FPH embraces fresh challenges and creates new opportunities to improve the way it operates

We hope that this work will prepare us for another challenging year ahead and call on all members to support the FPH through these difficult times. It only remains for me to wish all our members the warmest of seasonal greetings and a healthy and happy 2010.

Paul Scourfield
CEO

In Memoriam

The public health world has recently lost two great pioneering heroes. Here are a few reflections on their lives.

Jerry Morris (1910-2009), Emeritus Professor of Public Health, London School of Hygiene & Tropical Medicine

Anne Mills, Head of the Department of Public Health and Policy at LSHTM writes:

Jerry Morris was a member of many significant post-war health committees, from the RCP committee on smoking and air pollution to the Black Committee on health inequalities. He recently worked on the minimum income required for healthy living. The architect of the new 'community physician', he was responsible for community diagnosis intended to be the lynchpin of the NHS. He also played a central role in the formation of the Faculty of Community Medicine (now FPH).

Alan Maryon-Davis, FPH President writes:

I met Jerry 35 years ago on the Social Medicine MSc at the LSHTM. He welcomed us with a wonderfully motivating

talk and rounded it off with a stirring call to always strive to turn evidence into action. Jerry was a groundbreaking cardiovascular epidemiologist, ardent champion of the postwar welfare state and passionate campaigner against health inequalities. He was a giant of the public health world and a huge inspiration to so many of us.

Sir John Crofton (1912-2009), Emeritus Professor of Respiratory Diseases, University of Edinburgh

Joy Townsend, Professor of Economics at LSHTM writes:

John Crofton's pioneering work on the pharmaceutical treatment of tuberculosis in the 1950s saved many thousands of lives worldwide. He later turned his attention to smoking and became an impassioned anti-tobacco campaigner. He was a co-founder of ASH and worked tirelessly against tobacco use in this country and overseas.

Noel Olsen, public health physician writes:

I worked for John Crofton in Edinburgh in the 70s where he was a truly inspirational leader, medical school dean and role model. As well as his TB work, he and his wife contributed massively to tobacco control and to alcohol policy. John Crofton, Jerry Morris, George Godber, Richard Doll, Geoffrey Rose and Douglas Black were a fantastic group of epidemiologist-clinicians who grew enormously out of their wartime experiences – all now sadly gone.

Sir Sandy Macara, President of the National Heart Forum writes:

He was still campaigning right up to the end – just like Jerry Morris. And he was such a gracious, gentlemanly chap and so hospitable to colleagues visiting his beloved Edinburgh. I shall miss him – almost the last and arguably, everything considered, the finest of a magnificent breed.

FPH announces educational public health competitions

Notice of entry deadlines for 2010 awards

Cochrane prize

- Awarded to an undergraduate student to support educational activity in public health. Applicants must be bona-fide students at a higher education school in the UK at the time of application.
- The application must provide clear statements of the aim(s) and/or expected benefits of the project, methods by which these will be achieved and the precise, intended use of the funds.
- The winner will receive a certificate and an award of up to £250 at the Annual FPH Award Ceremony.

Deadline for entries: 1 February 2010

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McEwen award

- Awarded in March each year to the candidate with the highest score in the Part B MFPH (OSPHE) examination at their first attempt.
 - All candidates must be recognised as SpR/SpT/StR members of the FPH on the date of the application for Part B MFPH (OSPHE) examination. Consideration is automatic (candidates need not apply)
 - The winner will receive a medal and a cheque of £100 presented at the Annual FPH Award Ceremony
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Michael O'Brien prize

- Awarded to a candidate at each exam sitting, for gaining the highest marks in the Part A MFPH Examination.
 - All candidates who have passed the Part A MFPH Examination and are sitting the exam at the first attempt will be eligible for consideration. Consideration is automatic, candidates need not apply
 - The winner will receive a medal and a cheque of £100 at the Annual FPH Award Ceremony.
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June and Sidney Crown award

- Open to all FPH members in good standing and under the age of 35 at the time of application; to support the cost of travelling undertaken for the gain of experience or further training outside the UK. Preference will be given to those working within the National Health Service.
- Applications to comprise a full CV of the applicant and a travel plan specifying further experience or training to be gained, the place(s) to be visited and an outline of the expected benefits.
- The winner will receive a certificate and award of up to £150 at the Annual FPH Award Ceremony.

Deadline for entries: 1 February 2010

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Sian Griffiths international award

- Awarded to FPH members with the aim of promoting the development of public health capacity by helping them working within the specialty, to gain international public health experience, either whilst in training or as a part of continuing professional development. An emphasis will be on public health work in middle and low income countries.
- Applications to comprise a full curriculum vitae of the applicant and a travel plan, specifying the details of their proposed overseas placement or secondment, further experience or training to be gained, place(s) to be visited and an outline of the expected benefits.
- The prize will consist of a FPH certificate and a cheque up to a maximum of £500, which will be awarded at the Annual FPH Award Ceremony.

Deadline for entries: 1 February 2010

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Ann Thomas prize

- Awarded in March each year, on the recommendation of the Welsh Affairs Committee of Public Health, to the Welsh candidate who attains the highest mark in the Part B MFPH (OSPHE) examination at their first attempt.
 - Applicants must be recognised as SpR/SpT/StR members of the FPH on the date of the application for Part B MFPH (OSPHE) examination. Consideration is automatic (candidates need not apply)
 - The prize will consist of a certificate and a cheque of £100 and shall be awarded at the Annual FPH Award Ceremony.
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BACP travelling fellowship

- Awarded biennially to assist FPH members in training to undertake educational travel, normally outside the UK.
- Applications to comprise of a full curriculum vitae of the applicant, a travel plan specifying the detailed educational aims of the travel, the place(s) to be visited with reasons for the choice, and an outline of the visit programme with expected benefits.
- The winner will receive a letter and cheque by post and the decision will be announced at the Annual FPH Award Ceremony.

Deadline for entries: 1 March 2010

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To view the regulations for these prizes, please refer to the FPH website at <http://tinyurl.com/y8l1xmb> or contact Marijana Curic in the Education and Training Department on 020 7224 0642 or by email educ@fph.org.uk

You must read and follow the regulations closely and adhere to the closing date carefully when applying for any prize.

Dr Anthony Golding

The UK Public Health Register was saddened to learn of the death of Dr Anthony Golding. Dr Golding was a great supporter of the Public Health Register and indeed chaired the Tripartite Group (comprising of representatives from the Royal Institute of Public Health, the Faculty of Public Health and the Multidisciplinary Public Health Forum) which was responsible for the development and launch of the Register.

He remained as a member of the interim Board and his help and advice were always valuable and informative.

Our sincere condolences and our thoughts are with his widow and his family.

UKPHR
Public Health Register

National Treasures

'National Treasures' are training placements which offer opportunities to acquire specific additional or contextual experience which may not be available in all programmes.

We are pleased to inform you that the National Treasures section on FPH website has been updated.

For further information please visit: <http://tinyurl.com/yc6555z>

Should we be using standard measures of deprivation when targeting health inequalities in older people?

Deprivation indicators are typically used to identify communities for targeting health or social care interventions. Although there is substantial evidence examining the relationship between different deprivation indicators and health in the working age populations, it is not clear whether the same relationships apply to older people.

For example, many primary care trusts in England use indicators, such as the proportion of households in a neighbourhood receiving income support benefits to target programmes aimed at reducing health inequalities. Although housing tenure, car access and receipt of income support, have been linked to mortality in older people, there is little to suggest that such economic indicators predict ill health or morbidity at older age.

We examined the relationship between different area measures of deprivation and the health of older people in Sheffield. At neighbourhood level, we correlated both

self-rated health from the 2001 census and emergency admission rates with commonly used deprivation indicators through an ecological study design.

A measure of educational attainment expressed by the percentage of people aged 65+ years in a neighbourhood with no or unknown qualifications showed the strongest correlation with self-reported poor health. This relationship was stronger than the one using poverty postcodes (more than 30% of households claiming income support benefits in a neighbourhood), which was the measure used by Sheffield City Council and the Health Informatics Service to inform targeting of health initiatives. Educational attainment also seemed to be a better predictor of subjective ill-health than property ownership. The relationship got weaker with advanced age (75+ years) for all measures.

However, it remained relatively strong for educational attainment in this age group. Emergency admission rates for people

aged 65 years and over were also strongly correlated with educational attainment.

Using education as a deprivation measure has many advantages. It has the benefit of being relatively stable over time. It avoids the problems of reverse causation (bad health leading to deprivation rather than the opposite) that accompany the use of other measures, such as income and occupation. It is also available in the UK from routine census data. A disadvantage of using educational level is the limited differentiation that exists between groups, perhaps allowing the most advantaged to be differentiated from the rest of the population. However, this pattern may change in the future with more people gaining educational qualifications than ever before. This measure should at least be considered for use as a deprivation indicator at area level when targeting programmes to improve the health of older people.

Nisreen Alwin
Specialty Registrar in Public Health
University of Leeds

Irish heritage linked to poorer health

Weighing up the challenges of tackling the issue

A recent Health Needs Assessment (HNA) of the over-50 Irish population in Calderdale, West Yorkshire, has shown that they do have poorer health than the wider population. It describes how the migration experience of local older Irish people shaped and influenced where they subsequently worked, lived and their lifestyle behaviours. One of the most important findings was reluctance among some older Irish people, to engage in health and social services, and critically, a complex range of historical, cultural and psychosocial reasons underpinning this were identified.

In addition to raising awareness of the needs of older Irish people throughout the PCT and the council, some of the quick-wins have included ensuring that Irish health is incorporated within equality and diversity training and is specifically addressed by the local Equality Impact Assessments process. Longer-term gains are hoped to be achieved through improved and closer relationships between the PCT and the Irish community, and through the findings being incorporated into the Joint Strategic Needs Assessment and local strategies.

Some of the more specific challenges that this particular HNA brought up however, were related to the use of ethnicity, in this case Irish, to identify and categorise people:

- 1. How complete/representative are the results?**
 - ◆ Why do some people of Irish heritage identify themselves as Irish while other choose not to?
 - ◆ Are these reasons confounding factors in relation to health needs. Do those that identify themselves as Irish, have systematically different health needs to those that choose not to identify themselves as Irish?
 - ◆ Do those that identify themselves as Irish, do so consistently e.g. in the Census, on hospital forms, in response to a local survey?
- 2. Quality and completeness of ethnicity data**
 - ◆ A lack of ethnicity data regarding access to primary care/GP services.
 - ◆ Inconsistencies in the categories of ethnicity used by different services/agencies.
 - ◆ Poor collection of ethnicity data in some areas e.g. mental health services in this HNA.

- ◆ Insufficient ethnicity data to be able to control for potential confounding factors such as deprivation or lifestyle factors e.g. smoking.

- 3. The difficulty with making inferences from small numbers of individuals regarding patterns of illness and service use.**

This HNA raised broader issues about using HNA's effectively as a tool to better understand the health needs of different ethnic populations. In particular, and fundamental to the concept of a HNA, it highlights some of the factors which need addressing at an early stage, if any action is to be taken as result of the findings. In addition to its intended aims, the HNA process has also triggered useful discussions locally (with both the community and professionals) about how to use the vast amount of health-related ethnicity data routinely collected and the crucial role of HNA's within the 'commissioning cycle'.

Tim Fielding
Specialty Registrar in Public Health
Calderdale PCT

Leeds scheme aims to increase eye tests

The Leeds 'Save Your Sight' Campaign (SYS) is a novel health promotion and case detection programme aiming to prevent visual impairment, loss of independence and falls by promoting healthy living and regular free NHS sight tests for those most at risk. The programme targets the 150,000 most socio-economically deprived inner urban population through partnership working across the NHS, social care and community groups.

Population-based data which provides estimates of prevalence of visual impairment and blindness in the elderly UK population show that the majority of patients with potentially serious eye disease and visual impairment are not known to eye care services. The principal pathway is by referral from community optometrists. This is particularly true for those with chronic, slowly progressing conditions which lack any acute symptoms e.g. cataract or glaucoma. Case detection, therefore, is heavily dependant on the uptake of optometrist eye tests by members of high risk groups, notably the elderly population.

Whilst there is evidence that interventions targeting optometrists can increase the capacity to identify and refer cases to ophthalmic services, such interventions can only increase timely case detection

amongst individuals in regular attendance at optometrists. A survey of 5,000 people over the age of 60 across the UK conducted on behalf of Royal National Institute of Blind People (2007) found that half of respondents were not getting their eyes tested annually.

The problem is particularly acute amongst the elderly. Despite the clear need, therefore, to address issues of access to eye care services, little has been published regarding ocular health promotion interventions in the UK. This campaign aims to assess whether the uptake of the optometrist sight test amongst an urban population of those over 60 years old in northern England can be increased by distribution of a health promotion leaflet with or without assistance from non-traditional eye care workers.

The SYS campaign developed a health promotion/case detection leaflet and trained non-traditional eye care workers to promote uptake of free NHS optometrist sight tests for the over 60s. The aim was to reduce visual impairment, falls and retain independence. Project evaluation, including university research trials, have shown the 'Vision Testing' leaflet can be used effectively by non-eyecare workers/volunteers to detect visual

impairment and promote referral but self-testing, including mail out methods are possibly counter productive.

Since 2004, the SYS campaign has systematically developed a novel health promotion/case detection/referral programme in conjunction with cross-sector working with a robust evaluation/research framework of peer-reviewed scientific publication quality. This has contributed to Leeds and the recent Leeds Vision Strategy being highlighted as the leading national programme in line with the UK Vision Strategy and DH guidelines on best practice in tackling health and visual inequalities. This project has inspired increasing community group ownership including new groups requesting involvement without being solicited (eg social workers). This has been widely recognized and rewarded by joint health/social care sustainable funding for programme extension for 2009-11, including attracting £50k external pharmaceutical industry funding despite no immediate linkage to increased pharmaceutical revenue.

Amanda Douglas
Leeds Older People's Strategic Partnerships
NHS Leeds

Plan to grow services for older people

Leeds City Council (LCC) and NHS Leeds are procuring community support for older people across the city. The aim is to commission services which are evidence-based and outcome focussed. There has been a rigorous exercise undertaken to procure services providing equality of access and consistent core services to enable people to live at home independently. It supports the self care and personalisation agendas.

The Neighbourhood Network Schemes (NNS) were created in the early 1990s by LCC to improve the lives of older people in Leeds. They were formed from existing local voluntary organisations; new schemes have been supported to develop over the years, latterly jointly with the NHS Leeds. There are now 36 schemes covering specific geographical areas across the city and run by local management committees.

As the schemes evolved disparities become apparent with considerable variations in:

- ◆ The way organisations are funded
- ◆ Levels of funding by LCC and NHS Leeds
- ◆ The services provided
- ◆ Management and supervision of workers
- ◆ Performance and monitoring information provided

- ◆ Size and type of geographical area covered
- ◆ Population demographics.

A joint project team was established to lead the process commencing with a broad-based review comprising of:

- ◆ Baseline assessment of NNS
- ◆ Analysis of current and future needs of older people in Leeds
- ◆ Consultation with NNS managers, trustees, older people's reference group, lunch clubs, and survey of NNS members and referrers
- ◆ An independent report on NNS infrastructure, capacity, review and support issues
- ◆ Survey of people aged 55 and over who are part of the Leeds City Council Citizens Panel

The collated evidence was presented to key commissioners from both organisations as an option appraisal to support decisions required for the procurement process.

The core purpose of NNS was agreed as:

- ◆ Reduction of isolation
- ◆ Increased participation and involvement in the NNS and community in which they live
- ◆ Choice and control over their own lives

- ◆ Enhanced wellbeing and healthier life choices

The specification would focus on these "core" services for all older people in Leeds. Additional services, for instance, transport or handyperson services could be commissioned, subject to local needs.

Maintaining the community focus was viewed as an important success factor, therefore, funding would be allocated using established NNS boundaries but collaboration would be encouraged. The funding formula developed took account of the demographics including the numbers of older people and the deprivation ranking of the area.

Contracts will be awarded following a tendering process under way, up to a possible eight years. The benefits of this approach are to provide the schemes with a stable base on which to grow services with and for the benefit of older people in local communities, and contributing to all age all cause mortality and healthy life expectancy targets.

Elaine O'Brien
Senior Strategic Partnership and Development Manager (Older People and Disabled People)
NHS Leeds PCT/Leeds City Council

Village agents reach out to elderly

Services provide face-to-face information and advice for older people living in rural Essex

Village Agents is a pilot project operating in 12 village locations across Mid-Essex. The primary aim of the Village Agents project is to establish contact with older people in rural areas who experience difficulty in accessing health advice and services they need. These are people either not aware of the range of local service providers that exist or not confident enough to seek support without assistance.

The Village Agents project will operate as a pilot in the Mid-Essex area – Braintree, Chelmsford and Maldon districts – for the next two years. It is based on an original idea from Gloucestershire, where a very similar project, originally funded by the Department of Work and Pensions, has now developed into a mainstream countywide service. The project has been developed and funded using a partnership approach involving NHS Mid-Essex, Essex County Council and Braintree Local Strategic Partnership. The Rural Communities Council for Essex was selected as the delivery partner.

The project uses locally recruited community champions (Village Agents) who

have received specific training to enable them to work proactively with older people in isolated rural communities to improve access to appropriate services. The Village Agents are in constant contact with local organisations and service providers to enable them to provide the most up-to-date advice to their customers. They also work alongside county, borough and parish councillors, as well as parish clerks and other key people in the community, to ensure that they can point people in the right direction for help and support.

Each Village Agent is working part-time in their area, meeting residents face-to-face in their home or at local community facilities. An on-line system is used to refer people on to services and to manage the information process, as well as monitor performance. Local stakeholder groups have also been set up to support the agents', meeting every six months to share local knowledge, advice and discuss ways in which to raise awareness of the project.

The long term objectives are in line with the principles of Quality, Innovation, Productivity

and Prevention (QIPP) for the following reasons

- ◆ Intelligence from Village Agent referrals should have a positive effect on the quality of services received by clients ensuring they are timely and appropriate
- ◆ More appropriate referrals to services will increase productivity by screening out inappropriate clients
- ◆ The strong link to the prevention agenda will focus on increasing the number of older people who are able to live independently
- ◆ The development of innovative systems to support data collection and analysis that will provide robust evaluation of impact on targets

It is envisaged that ongoing evaluation of the project will provide evidence to support the return on investment in terms of both impact on reducing inappropriate use of services and improved outcomes for older people in respect of quality of life.

Jane Richards
Head of Health Improvement & Health Inequalities, NHS Mid-Essex

A view from abroad – Eye care in India

I have just returned from the October Summit 'Making it happen, through sharing – So that more may see', which happens every year in Madurai, India. It is part of the celebrations for the founding father of the Aravind Hospital and Eye Care System, Dr V. The guiding principle is the belief in delivering quality services within a compassionate spiritual awareness. Dr V's vision was to develop a state-of-the-art eye care system which incorporated hospital services, outreach, education and training programmes.

The summit this year consisted of a series of workshops, one of which was on *Global Consultation on Patient Empowerment Strategies*. There were people from Philippines, Nepal, Guatemala, Bangladesh, Pakistan, Egypt, and of course, India. The workshop was part of a World Health Organisation consultation focussed on the need to engage and empower patients. The interesting observation from a UK perspective is that we were all encountering the same issues whether it was in a small village in rural Nepal or a big city such as Leeds. We were not engaging with the people who needed eye care, especially those from poorer communities. Even more crucially, those people we did have contact with were still not attending services and that compliance issues, especially around diabetic retinopathy and glaucoma, was a problem.

One of the interesting sessions included talking to four patients who had undergone cataract surgery in the last few days. The discussion was on how long it had taken people to seek help once they noticed that their vision was deteriorating. For the three men present, all of them said it was once it started to affect their work and thus stopping them earning an income. There was a delay of a few months between diagnosis and actually coming for surgery. This was generally due to financial pressures and the need to travel with a family member. The fourth patient was a widow and she waited a whole year before being seen. This was due to the fact that no one from her family would bring her. Widows in India do not have very high status and are often considered a burden to families. While this may not be an issue for widows in Leeds we have anecdotal evidence to suggest that some communities are accessing services late and in some case have actually lost some of their sight.

From a Leeds Public Health perspective we are currently engaging with the African



Caribbean community to increase awareness around glaucoma and eye health using similar techniques to the Avarind Model. This includes taking services directly to where people live (in this case Chapeltown Library) and offering health education advice from community health educators. In addition we are looking at producing a theatre production, Bollywood style, targeting the Asian community especially in relation to diabetic retinopathy. We are also exploring the idea of a mobile eye-testing service.

Bernadette Murphy
Regeneration and Development Manager
NHS Leeds

Dignity in care demanded for older people

Dudley PCT has embarked on a significant programme to improve the quality and dignity of care. The *Dudley Dignity in Care Programme* led by the PCT, commenced in 2008, and was developed to have a cross sector approach to implementing dignity in care in Dudley. This has the national dignity challenge at its centre and also the *Dudley Value Base for Older People Services*.

There are two elements to the *Dudley Dignity in Care Programme*: a monthly rolling programme and Dignity Champions.

Monthly Dignity Rolling Programme

The dignity programme has a set theme each month, with a series of education sessions in a variety of venues across the borough to make it as accessible as possible. These are open to all employees across the health economy. It is acknowledged that there will be overlap with previous training and courses and thus there will be different levels of participation. However, a baseline proforma was undertaken in consultation with managers and the 'Dignity in Care Group' which found a need to address the following themes:

- ◆ Privacy, dignity and person-centred care
- ◆ Medicines management
- ◆ Falls
- ◆ Tele-care and tele-health
- ◆ Mental health

- ◆ End of life care
- ◆ Elder abuse/protection of vulnerable adults
- ◆ Fluid balance and nutrition
- ◆ Continence and elimination
- ◆ Supporting and working with carers
- ◆ Pain management
- ◆ Hearing loss
- ◆ Sight loss
- ◆ Loneliness and social isolation

Dignity Champions

Health care workers/professionals can be trained to become Dignity Champions, aiming to change attitudes, raise the profile of dignity in older people's care and provide person-centred care with optimal outcomes. Champions attend two day workshops, which include the themes outlined above. They then cascade the themes from the workshops, to their colleagues and undertake evaluation of their care environments.

The Champions are provided with support via resource packs, website, CEO commitment, network meetings with co-ordinators and access to the monthly rolling programme to support their cascading objective and enable them to signpost to their colleagues.

Long term implications of the Programme

- ◆ Improved care and support (prevents hospital admissions)

- ◆ Reassurance and confidence in the care provided for older people/adults
- ◆ To have a proactive workforce that is fit for purpose and provides care for all adults and for a rising ageing population
- ◆ Part of national agenda (Chief Nursing Officer and National Dignity Campaign)

Benefits for people

- ◆ Receive personalised care. Treated with dignity and respect

Benefits for organization and partnerships

- ◆ Skilled and competent staff that work together across the continuum of care, focus on the service user and an improved service of care

The *Dudley Dignity in Care Programme* is monitored and there is input into 'Dignity in Care' tools, sharing of examples of good practice, development of standards and an end of year conference.

There is also a dedicated website for Dudley Dignity Champions, www.dudley.nhs.uk/dignitychampions

Andrew Hindle
Commissioning Lead for Older People, Dudley PCT

Down but not out

Age Concern and Help the Aged's *Down but Not Out* campaign is working to improve the diagnosis and treatment of older people with depression.

The campaign calls for increased support for older people with depression to seek treatment, and a range of measures to improve diagnosis of depression by GPs. This also includes a depression indicator in the Quality and Outcomes Framework as part of the General Medical Services Contract.

Only one third of older people with depression discuss it with their GP, and only half of them are diagnosed and receive treatment.

This campaign follows research in 2007 from the *UK Inquiry into Mental Health and Well-Being in Later Life*, which found that despite being the most common mental illness in later life, depression continues to be under-diagnosed. Only one third of older people with depression discuss it with their GP, and only half of them are diagnosed and receive treatment.

A key barrier for many older people with depression is the reluctance to discuss mental health issues with GPs and other healthcare professionals. For many older people, and the wider public, depression remains a taboo subject and many people feel uncomfortable talking about sadness, stress and anxiety. When depressed, older people may present with somatic symptoms or the depression may be masked by long-standing physical or mental illness. Older people themselves may think that depression is a normal or inevitable part of ageing and do not recognise that depression is a manageable health condition. GPs themselves sometimes reinforce this attitude by focusing purely on the treatment of physical symptoms. Many of these problems are exacerbated by a lack of investment in psychological therapies for older people, which limits the range of effective treatment options available to the patient.

Age Concern and Help the Aged is working to break down these barriers by producing information leaflets and factsheets which

feature simple information about depression, and making them readily available to older people. These resources will make it easier for older people with depression to have the confidence and vocabulary to discuss depression and to access the treatment and support they need.

In partnership with the Royal College of General Practitioners, the campaign is also working to improve GPs' awareness of depression in older patients. Take the Challenge, an online interactive programme designed for GPs, follows an older patient on a visit to the GP. It highlights the multiple conditions and complications which can prevent diagnosis and treatment.

The free information leaflets about depression are available, along with more information about *Take the Challenge* and the *Down but Not Out* campaign can be found at: www.ageconcern.org.uk/downbutnotout

Samantha Nicklin
Senior Campaigns Officer
Age Concern and Help the Aged

Infected, affected and overlooked: Older people and HIV in Swaziland

Taboos about sexual behaviour mean Swazi elders fail to reveal risk factors, reports Susan Elden after a visit to the country.

Each year, when UNAIDS produces the update of global HIV prevalence figures, an “adult” is defined as those aged between 15-49 years – even though HIV infection does not stop at age 49.

Almost all routinely collected statistics on the HIV pandemic stop at age 49. From a policy and research standpoint, the age group beyond 49 years is under-represented and potentially neglected.

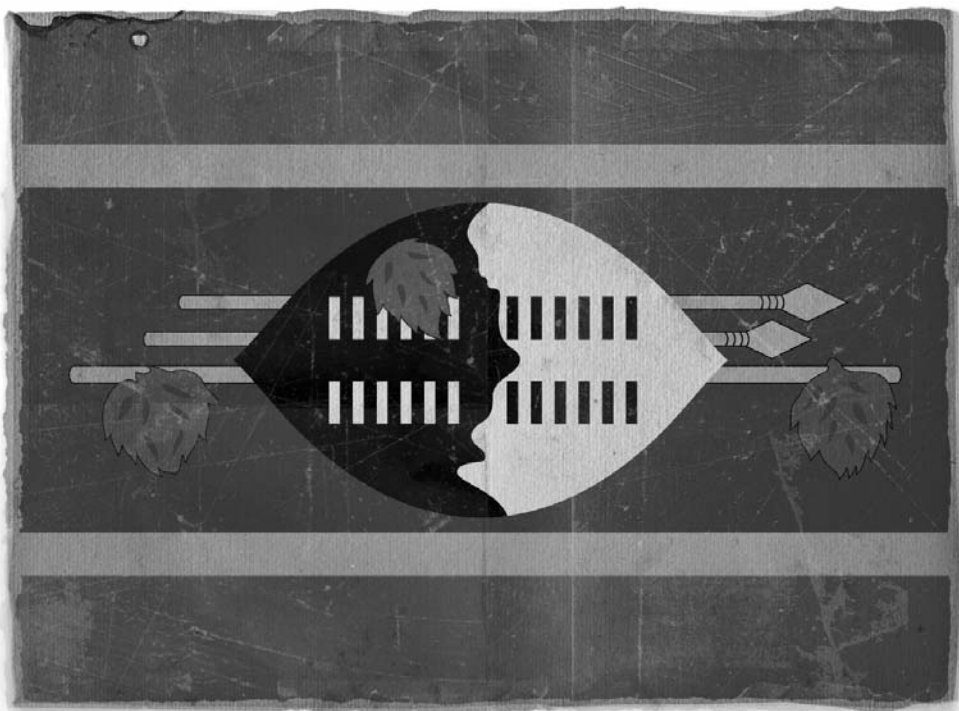
Swaziland has the highest HIV prevalence in the world and just as in wealthier countries, there are increasing numbers of older people newly diagnosed and living with HIV. This is a hidden population, rarely reached by programmes or identified as a vulnerable group by service providers.

During 2008, I was part of a HIV team that tested 14,376 adults in the Lubombo region of Swaziland. The official UNAIDS' indicators would have excluded 17% of this population – as 2,476 people who tested were aged between 50 and 89; and 37% (938) of those older people tested as HIV positive.

Our programme then discussed with government, why it was that so many older people were coming to test for HIV and over a third of them were testing positive. We worked together to look at the public health implications for this overlooked group, and their sexual contacts, even though they are not recorded in official figures.

When presenting for testing, most older people did not refer to risk behaviours or sexual practices, but simply indicated, “the nurse sent me” or “I don't feel well”. If receiving results showing they were HIV positive, many talked about caring for adult children who had died of AIDS and frequent contact with blood or bodily fluids. As a risk factor, sex was rarely mentioned. Occasionally women said their husband had died, or that a younger wife (in a polygamous marriage) had been brought into the home. Coerced sex was rarely reported, but selling sex can be a choice, or survival strategy, even if not always reported.

Counsellors suggested that sex with older women was seen by younger men as less “risky” in terms of pregnancy and disease, or that older women used sex in order to get food or money, if they were left unsupported. However, one counsellor laughed at me saying, “Why are you making



it so complicated with so many assumptions? Maybe some older people like having sex just as much as we younger ones do and they just don't think about the consequences?”

One factor in the high infection rate may relate to taboos around sex and HIV, shared by old and young alike. People were especially reluctant to discuss sexual practices or reproductive health conditions with medical professionals. One solution was training HIV-positive community members. These “Basiti” (meaning “helpers” in the si-Swati language), offered HIV counselling on prevention, testing, and treatment. I remember one respected, well-informed community elder, who had lost family members to AIDS and was HIV positive herself. She stood in front of the crowd and began showing her “education materials” (including a plastic penis and vagina) to demonstrate the proper use of male and female condoms. The crowd was silenced. She politely referred to the penis as “Babe Zwane” and the vagina as “Make Zwane” (the si-Swati equivalent of “Father” and “Mother Smith”). The respectful crowd asked no questions. Clearly this was the first time they had heard sex discussed openly – including visual aids.

Traditionally, Swazi families are large and polygamous and it is not uncommon to

find women who have given birth to seven or eight children. Prior to the HIV pandemic, these children would have been expected to care for their parents into old age. The impact of HIV has changed these traditional roles entirely. Having lost almost an entire generation to AIDS, Swazi society now relies upon grandmothers to hold the remaining family together; to care for their own sick and dying children and to raise their orphaned grandchildren. It is common to have frail elderly people caring for HIV positive adult children in the hospital and community. As one said, “I never thought that I would see my own children die before me.” With no one left to plant the crops, or tend them, many older people depend solely upon food aid to feed themselves and their sick children and grandchildren.

In Swazi culture, older people are the respected elders of the community, the heads of the homesteads. They are revered and form the backbone of society. As they pass down their important stories and traditions, it would only compound the tragedy if their experience of HIV was left unspoken.

Susan Elden
Specialist Trainee in Public Health,
Nuffield Centre for International
Health and Development

One child policy adds to Chinese ageing crisis

Walk into any park in China on an early morning and you will see elderly people practicing Tai Chi. Stroll through municipal parks at any time of day and there will be groups of older people chatting, dancing, making music.

China's population is aging. One in ten (128 million) are aged over 60 and by 2050 it is estimated that 30% of the population, over 400 million people, will be over 60. Life expectancy increased dramatically between 1949 and 1980 from 36 to 63 years. The total fertility rate fell from 5.8 to 2.4 between 1970 and 1980, a direct result of the one child policy introduced to control population growth.

The other major contributing factor has been the modernization of China and its rapid economic growth. This growth has not, however, come without cost.

The one-child policy has meant that a growing number of younger people face what is known as 4-2-1 – the need for a single working person to provide for his or her parents and grandparents despite a busy job.

By 2030 it is estimated that 300 million older people will consume 10% of national income. Many older people do not have a pension and the problem of providing care falls on families. It is estimated that 80% of those over 85 are dependent on children or relatives. Seventy percent of 60 year olds live with children or relatives. Only 0.8 % are institutionalized, reflecting the societal values of filial piety and veneration of the elderly. However, these patterns are changing. In cities many older people now live alone. The one-child policy has meant that a growing number of younger people face what is known as 4-2-1 – the need for a single working person to provide for his or her parents and grandparents despite a busy job. Add to this the impact of migration by younger working age people from rural to urban areas where jobs and pay are better. This leaves many older people in the countryside where they are less likely to have pensions, medical insurance and formal support for health and social care.

As the ratio of working population to retiree shifts from 3:1 in 2003 to 2:1 in 2050,



a common saying is China will become old before it becomes rich. With the changing family structure and greying of the population there are national and local initiatives to develop home-based care, elderly centres and more residential care. Pension schemes which were previously mainly in the bigger cities are now being extended to rural areas, but there is a long way to go.

The China National Committee on Ageing recognizes the need "to establish a support system for senior citizens that provides medicare, helps them avoid loneliness through study and entertainment and encourages them to continue serving society after retirement using their knowledge". The Chinese leadership are also highly cognizant of the

challenge and this year Vice Premier Hui Liangyu used Senior Citizen's Day, or Double Ninth (the ninth day of the ninth month of the lunar calendar), to emphasise the importance of paying attention to the challenges of an ageing population, particularly the imbalance between rural and urban areas.

For those concerned with healthcare reform, helping older people stay healthy as well as providing affordable and equitable health services must be the biggest challenge for the future.

Sian Griffiths
Professor of Public Health/Director
Chinese University of Hong Kong

Demographic change hits the health service

The numbers and proportion of older people in our population is changing. One third of the population is aged 50 or over and hundredth birthdays are no longer a great rarity. That is a cause for celebration and a tribute to improved conditions of living (with a little help from medical care). However, this development has consequences for most aspects of life including the pension system and the health service.

One third of the population is aged 50 or over and hundredth birthdays are no longer be a great rarity.

Although chronological age is an unreliable proxy for individual physical and mental ability, the risk of most disease states increases with age, and the probability of ill health is greater in a group of eighty year olds than in a group of sixty year olds.

Healthy life expectancy increases with total life expectancy and while one can debate whether the period of life

expectancy in poor health is increasing or unchanged, there is little evidence that a compression of morbidity is occurring. We may experience the disease of old age at a later age but we will still experience them. Older patients will still occupy the majority of hospital beds. Geriatric medicine has vastly raised the standards of care for older patients, but the time may have come when all doctors should have the skills of specialists in medicine of older age.

Legislation will soon forbid discrimination on grounds of age and age defined admission criteria for services will only be permissible, when they can be shown to be in the interests of the patients. On the sad occasions when standards of patient care fall below acceptable limits or the duty to respect patient dignity is forgotten, it is all too often older patients, who are affected.

Not only do older people vary widely in their physical state, their social and economic circumstances also differ. Some are very comfortable with large occupational pensions and accumulated savings. Others have been poor all their life and will be poor in old age. It is wrong to think of older people solely as service users, they are also major contributors to

society. Older people are frequently better at civic engagement than younger citizens, whether in formal roles as councillors, in voluntary organisations, in informal caring for other older people, or in helping younger generations by looking after grandchildren and in other ways.

Public health specialists have a greater part to play than by simply describing the demographic trends. We must inform commissioning to ensure services for older patients have sufficient capacity, maintain high quality and are effective. The drive to shift delivery of care from secondary to primary care, closer to patients' homes and away from residential care will continue and as new care-pathways are introduced they must be closely monitored to ensure effective and quality care.

Public health must watch and interpret the statistics to tell the full story of how older people are being treated in our society and health service and where necessary, advocate for improvement.

John Kemm
Director
West Midlands Public Health
Observatory

Call to treat more people at home

In Autumn 2009, NHS Bradford & Airedale and Bradford Metropolitan Borough Council Adult and Community Services, jointly commenced a new intermediate care programme for adults and older people.

Reviews of current intermediate care services for older people in the area highlighted a focus on 'step down' arrangements (i.e. discharges) and not enough on 'step up' (i.e. admissions).

There hasn't been enough emphasis on preventing admissions to A&E. About 75% of falls amongst the over 65s are seen in A&E in Bradford compared to 40% in nearby Leeds. Addressing this will take a joint approach from the ambulance service and community-based intermediate care teams, providing a rapid response to assessment and treatment at home, followed by specialist out-patient falls clinics. For example, the Airedale Care Collaborative Team has developed intermediate care services in Airedale. More people are treated in their own homes and in specially commissioned nursing home beds. They are supported by a team including a Community Geriatrician. This enabled the closure of the intermediate care ward in the local general hospital. It is early days, but the team appear to be having a positive impact on admissions to acute care beds on the patch.

There hasn't been enough emphasis on preventing admissions to A&E. About 75% of falls amongst the over 65s are seen in A&E in Bradford compared to 40% in nearby Leeds.

At the other end of the spectrum, older people with mental health problems such as dementia tend to stay in hospital for too long. Their needs are clearly not understood and services are not oriented towards meeting them. We are working with HM Treasury on a 'Total Place' approach to address this problem. This involves working with agencies with an interest in improving acute care for people with dementia. In particular, we are trying to facilitate a more successful discharge process by encouraging closer working relationships and re-evaluating how the total investment can be used to better effect. The Treasury will also assist in unblocking unhelpful national perverse incentives to improving co-operation and care in this area.

A programme board consisting of commissioners and providers has been set

up to develop an evidence-based care pathway to help ease the patient journey, achieve better outcomes and deliver efficiencies in the whole system.

Four projects will feed into this work:

- ◆ Community hospitals and local authority care home step-up services development to prevent avoidable admissions
- ◆ Total Place and discharge processes both from an A&E attendance and after an in-patient stay
- ◆ Improving multi-agency community-based rapid response to prevent avoidable admissions to hospitals and care homes
- ◆ Integrated falls and bone health services, implementing the Department of Health 'systematic approach to falls and fracture care and prevention'

The Board will also address workforce development issues such as new types of worker including: merged roles, process redesign and the development of integrated systems, to ease properly integrated working across health and social care in particular. It is maintained that this work will result in improved health and wellbeing outcomes.

Catherine Heffernan
Locum Consultant in Public Health

Cath Doman
Head of Older People's Commissioning
NHS Bradford and Airedale

Wired for the third age

Older people have long been seen as constituting a 'problem' for those advocating the benefits of the 'network society'.

'Typically, they have been regarded as occupying the wrong side of the digital divide. I was part of a DOH funded project – which resulted in the book: *Digital Welfare for the Third Age: Health and social care informatics for older people*. This project attempted to see beyond such generalisations by bringing together a range of studies exploring how digital services are provided to older users and how they engage with information technologies.

Since the 1980s, policy makers and politicians of all political hues have greeted the networked computer as both a valuable organisational tool and as a way of delivering more effective services. However, the reality of providing robust information from and to diverse sources as proved something of a challenge.

The desire to provide a seamless inter-agency service built around the needs of individual older people (and more broadly clients and patients of national health and welfare services) is a common aspiration in most countries with a centralised welfare system.

The Single-Assessment Process (SAP), initially developed for older people reflects

this agenda. Related developments in telecare have seen the development of 'smart homes' that enable people to live safely at home through various monitoring and intervention systems. In other words information technology has become both directly and indirectly part of everyday life for many older people, and those who play a part in their lives.

Policy makers and politicians, of all political hues, have since the 1980s greeted the networked computer as both a valuable organisational tool and as a way of delivering more effective services.

Reflecting this diversity of resources, our book is divided into three sections:

- ◆ Towards Integrated Service Provision?
 - ◆ User-centred assessment and autonomy
 - ◆ Integrated user design.
- Individual chapters explore, SAP, telecare,

smart homes, dementia and older peoples' online support groups.

In a chapter about user-centred devices, Andrew Webster begins with the following quote from a Royal Society (2006) report that argues: "the design and implementation of new ICTs should be seen as an iterative process where the users are central." The general failure to meet this expectation is a running theme in the book, seeking to offer a critique, grounded in empirical research, of the role for older people in an increasingly technologically shaped health and welfare landscape.

Despite many good intentions, the complexity and desire for the fast and 'economic' implementation of technologies, ranging from SAP to a bodily sensor, have conspired to marginalise the end user and the older person in particular. The term 'end user' is used deliberately as it is commonly found in policy and technology reports and because it also relates to the way that front line staff may also feel marginalised as SAP and other systems are introduced into their work.

Michael Hardey
Reader in Sociology
Hull/York Medical School

How older people define wellbeing

The term 'wellbeing' is both widely used and has multiple connotations within the context of health, social care and research with older people. Theoretical formulations of wellbeing have been grounded within a wide variety of frameworks, models and perspectives of human existence with arguably insufficient attention having been given towards an understanding of wellbeing that is informed from the perspectives and opinions of older people themselves.

In addition, research clearly shows that ethnicity and mental health have important contributions to our understanding of wellbeing, but have rarely been considered together in wellbeing research. If the term is to be used both as a basis for informing policy and provision to older people and as a criteria for evaluating intervention outcomes, there is an ethical imperative to ensure the term is evident as a construct, in the perspectives of older people themselves.

As part of a PHD, qualitative research was undertaken to investigate wellbeing from the personal perspectives of older people drawn from clinical, non-clinical and ethnic minority populations in the UK.

Six overarching themes emerged from the data namely:

- ◆ Integrity of Self – One's sense of self as valued, accomplished and resilient
- ◆ Integrity of Other – The welfare of one's valued friends and family and that one is able to contribute to their welfare
- ◆ Belonging – The extent to which one feels a sense of belonging to valued others
- ◆ Agency – The extent to which one is able to exert choice, influence and control over one's life
- ◆ Enrichment – The extent to which one is leading a purposeful life in terms of interests, goals or activities
- ◆ Security – Feeling secure financially, personally and environmentally

How older people experience wellbeing (and indeed ill being) is essentially grounded in the nature of one's relationships. The extent to which illness, disability or inadequate resources (financial social and environmental) precludes one from living a chosen lifestyle, and the opportunities available to experience one's valued interests.

Integrity of self is perhaps the most important property of wellbeing. This appears to be managed largely through the

level of reciprocity one engages through one's relationships with valued others. People who have a poor sense of self are therefore likely to have either dependent relationships with others or martyr themselves to others (or a combination of both). Those experiencing positive wellbeing are those who achieve a balance between giving and receiving in their relationships.

This model offers a broader theoretical (eco-systemic) framework for understanding well being in older people. Policies and interventions based upon this framework are likely to have a greater impact upon health and quality of life for older people, than those which are solely grounded within a bio-medical framework.

Research has shown that indices reflecting self-esteem, having purposeful goals, optimism, and supportive relationships (particularly those involving reciprocity of support) are stronger predictors of mental health and recovery from physical illness, than diagnostic indices alone.

Andrew Papadopoulos
Consultant Clinical Psychologist
Birmingham and Solihull Mental Health
NHS Foundation Trust

Submission of specialist standards and supporting information

FPH has now submitted the draft specialist standards for public health to the General Medical Council (GMC). The GMC will approve these draft standards in the next few months. After this, all specialist standards developed (including the standards for public health) will form part of the GMC's UK-wide consultation on revalidation.

The FPH has developed a series of standards for all senior professionals practising within public health and related disciplines and identified a range of supporting information for revalidation. The specialty standards are required to be in line with the generic standards and criteria outlined in the GMC's *Framework for Appraisal and Assessment*, which is an adaptation of Good Medical Practice. The Specialist Standards Frameworks are designed to support all professionals in the positive demonstration of their specialist practice.

Their purpose is to:

- ◆ Help public health professionals understand and prepare for their appraisal and revalidation.
- ◆ Provide guidance for appraisers to discuss and consider the specialist practice of appraisees.
- ◆ Assist the Responsible Officer and/or the FPH representative(s) in determining the revalidation recommendation of an individual doctor.

The FPH has developed the *Public Health Standards Framework for Revalidation* using the GMC's *Framework for Appraisal and Assessment*. The *Public Health Standards Framework for Revalidation* links closely with *Good Public Health Practice and Revalidation and Public Health*, a guidance booklet produced by the FPH.

It has proved immensely challenging to identify and distil any common or central elements of practice in public health, due to the breadth of public health activity and the range of roles in which public health professionals practice. The FPH has therefore identified seven areas of supporting information, which will assist individual public health professionals to demonstrate compliance with the FPH specialty framework. These areas of supporting information are divided into 'Core' items of supporting information and additional suggested 'Options'. All public health professionals will be required to provide the information listed in the checklist as 'Core' over a five year period wherever possible. It is recognised that in some areas of public health practice or in certain settings, some items may be unobtainable or inappropriate. The additional suggested sources of supporting information listed under 'Options', may help to demonstrate the quality of particular areas of specialist practice.

- ◆ The proposed areas of supporting information include:
- ◆ General
- ◆ Peer Feedback
- ◆ Patient Feedback
- ◆ Practice
- ◆ Audit
- ◆ Education, Training and Development
- ◆ Governance

Work is currently underway to collect 'baskets of evidence' of best practice in each of these areas of supporting information. These examples of supporting information will be incorporated into the guidance on revalidation for public health professionals. This will provide much greater clarity on how to incorporate different pieces of specialised supporting information into a coherent portfolio for appraisal and revalidation. It will also bring together very disparate areas of public health practice into similar models for revalidation, for example the 'basket of evidence' for 'publications/reports' could include annual Director of Public Health reports, Health Protection Unit surveillance reports, demographic profiling, joint strategic needs assessments or academic research.

FPH membership consultation on revalidation and specialist standards

The FPH ran a comprehensive consultation on the full draft specialist standards contained in the *Public Health Standards Framework for Revalidation* between August and October 2009. This had a very good participation rate with 531 responses.

As with the first membership consultation on revalidation in 2008, we requested information on specialist registration and employment, together with more detailed information on place of practice and role.

Overall, the principles and standards proposed were well received. Over 85% of respondents supported the FPH's proposed role in revalidation, with over 75% agreeing that the principles of revalidation are appropriate and reasonable. However, considerable levels of uncertainty remain about how the system will apply to public health professionals practising outside NHS-managed environments, and the amount of time and resources the process will consume. Other significant concerns related to linking to responsible officers – less than 40% of respondents felt it would be straightforward for them to identify and link to a responsible officer.

A more detailed report will be published on the FPH website as soon as possible.

Pilot projects

The FPH is involved in numerous projects and pilots, both as an independent faculty and in collaboration with other medical royal colleges, to test and refine aspects of revalidation processes for public health.

Multi-source feedback tool

In this project the FPH aims to develop and validate an instrument specifically for use by those professionals where individual patient feedback and colleague feedback on patient relationships are not possible. In public health relationships are all important, but rather than being with individual patients they may be with colleagues from within the same and different organisations, or with community groups.

This work has been scoped and FPH is currently investigating funding opportunities and research partners to carry it out.

CPD

The FPH has commissioned the Public Health Resource Unit (PHRU) to review the FPH process for CPD in the light of forthcoming requirements for revalidation, including the link between consultant appraisal and CPD. PHRU also looked at whether CPD processes could be enhanced to better assess impact on practice/effectiveness of practice.

This work has now been carried out and the final report was presented to the FPH CPD Co-ordinators Committee on 7 October 2009.

E-portfolio

The FPH, in a cohort of ten Colleges and Faculties co-ordinated by the Royal College of Physicians, London, is working to develop an e-system which would be capable of storing and organising the essential supporting information required for the specialty specific component of revalidation.

Further information

If you would like further information, please visit the FPH website (www.fph.org.uk) or email Elin Sandberg (elinsandberg@fph.org.uk) or Laura Webb (laurawebb@fpg.org.uk)

Continuous Professional Development – Q&A

Over the summer months, FPH carried out its annual 10% audit of CPD submissions.

This was the first year for this process after piloting the scheme in 2008. With revalidation coming, the audit process is growing in importance and is a compulsory element of each of the College's CPD schemes.

Throughout 2010, the CPD co-ordinators will be reviewing the process and working to increase the audit sample to at least 20%, with each CPD participant being audited at least once in the five year cycle.

In total 133 FPH members were selected for inclusion in the audit of the 2008 CPD returns. 93% of those not granted exemption due to extenuating circumstances, returned their audit materials by the deadline and FPH CPD co-ordinators assessed during July. 84% of auditees were given a satisfactory audit. Since CPD is still a formative process, for those small number deemed unsatisfactory, no sanction applies in year one and they will automatically be included in the 2010 audit. Full feedback has been given by the co-ordinators to ensure that those finding the process difficult this year will gain a satisfactory audit next year.

FPH is committed to supporting its members through CPD, audit and ultimately revalidation, so will be building on its communication in 2010 to ensure public

health specialists know what is required. As we know, the vast majority of public health professionals are operating at a high level and committed to their CPD. In fact, for the most part, failure to pass the audit is not a reflection on whether the CPD has been completed, rather that the information supplied did not evidence it effectively.

The CPD coordinators have created a brief Q and A of common issues to help members with their audit. If you would like specific advice, please do contact your regional CPD co-ordinator.

Q. My personal development plan (PDP) year and the CPD year do not coincide. What should I do?

A. FPH is currently exploring the possibility of changing its CPD year, but for the moment it may be that two PDPs will have to be presented.

Q. My PDP is very specific and relates to a couple of specialised areas, making it difficult for me to find 25 credits directly related to the PDP. How should I address this?

A. This can easily be addressed by including a line in the PDP showing commitment to 'maintaining public health competencies' or similar.

Q. What should I submit for the audit?

A. The audit calls for sections one, two, three and four plus five (in the form of a reflective

note) from the portfolio. Members are advised to use forms in the FPH CPD booklet or the electronic version on the FPH website.

Q. How can I ensure my reflective note is robust?

A. The FPH CPD audit policy lists five prompting questions for reflective notes. A fair reflective note addresses two or three of these questions, while a good one addresses at least four. Members should ensure they address at least two of these prompting questions in their reflective notes or, preferably, use the FPH's online diary.

Q. Should I declare everything I consider CPD?

A. Members are required to complete a minimum of 50 credits per year (up to a maximum of 100). Only the first 100 hours of CPD will be assessed in the CPD audit.

Q. Can I aggregate activities?

A. This does not allow members to reflect learning sufficiently. Members are required to write a reflective note for each activity in the log. This means each piece of learning. Therefore, a single reflective note covering 50 hours of journal reading spread throughout the year is not acceptable. Whereas a series of individual reflective notes covering one or two hours spent reading journals that day or week would be.

Dr Anne Mackie
CPD Director

Call for members to submit workforce survey

Workforce planning is about making sure we have the right number of public health consultants and specialists for the future. Robust data can inform the process, and can help us plan and make the case for an appropriate number of public health trainees.

This is the fourth workforce census undertaken by FPH, the previous ones being done in 2003, 2005 and 2007. As many of you have been aware, FPH ran an online survey to collect this information earlier in the year. We are now sending out copies with *ph.com* to ensure that all members who have not yet responded are given the opportunity to do so.

It is very important that we get this information as:

- ◆ This data informs the allocation of training numbers and new trainees to public health
- ◆ Public health consultants work in a multiplicity of different settings and are employed by a number of different bodies including the NHS, universities,

the Health Protection Agency and the Department of Health

- ◆ Evidence from advisory appointments committees continues to show that there are few or even no suitable applicants for some posts
- ◆ The age at which individuals choose to retire has a profound effect on workforce figures
- ◆ Comparative data between regions can provide a powerful argument for increasing resources for public health.

Please help the FPH reduce its carbon footprint by completing enclosed survey, filling in the census online via the FPH website or downloading the survey from the same page and emailing it to elinsandberg@fph.org.uk.

Please complete all census forms (electronic or hardcopy) by 31st December 2009.

Faculty must play a part in election countdown

The clock is ticking down towards a general election – only six months, or possibly less, to go.

In the run-up to the election – which must happen before the end of June – the FPH will be studying how each of the political parties sets out its stall on its approach to public health issues, and their budget.

So far interestingly, both Labour and the Conservatives have spoken about their commitment to health, but we would like to press them further on specifics.

As the campaigns get under way, we will see more flying of kites via the media to see how the public and the health profession react to announcements of health policies and health spending.

The policy and advocacy team will be holding meetings with politicians from all parties and talking to them about the FPH and its background.

We have already met with MPs, MSPs and with Secretary of State Hilary Benn's special advisor, to talk about policy ideas.

Rachael Jolley
Head of Policy, Advocacy and Communications

Top Tips for Sexual Health published

New report focuses on sex and relationships

This report focuses on positive influences for sexual health in the community and how they can be promoted.

The tips reflect a lifelong approach from childhood through adolescence into adulthood and on to old age. The promotion of positive sexual health is also considered in various settings and among different population groups.

The emphasis of the report is on sex and relationships as a social issue. Background information, national policy and evidence, and examples of good practice can be found in the full report.

These top tips provide common sense practical suggestions to approaching sexual health issues that will make a positive difference at home and in the workplace to you and those around you.

The 'Top Tips for Sexual Health Promotion'

report is the fourth in a series of reports aimed at promoting public health in a variety of settings. Previous guides were Top Tips for Healthier Hospitals (November 2006), Top Tips for Health in Local Authorities (January 2008), and Top Tips for Healthier Workplaces (September 2008).

The guides were commissioned by the Merseyside directors of public health from Liverpool Public Health Observatory, and were supported by ChaMPs, the Cheshire and Merseyside public health network.

Top Tips for Sexual Health Promotion was produced in partnership with the Cheshire and Merseyside Sexual Health Network.

Copies of each of the reports both in their easy-to-use executive summary format, and as full reports, can be found at www.nwph.net/champs/publications



FPH opening times over Christmas

The Faculty of Public Health will be closed from 12 noon on Thursday 24 December 2009 and will reopen on Monday 4 January 2010.

We wish all our members a a joyful and peaceful holiday season.



Call for radical training re-organisation

John Ashton reflects on the future for public health

Yet another new government is on the horizon and no matter who wins the day, the future is bleak, as all public services (including the NHS) will be in dire financial straits. In order to survive and help those in need, we need to look to our communities and invest with what we already have, people. This and the creation of a county-level, integrated public health service is the way forward to address inequalities and indeed survive the financial storm.

In 1976 the publication of *Prevention and Health – Everybody's Business* was a beacon for those of us who had recently begun to work in public health. The full impact of the wanton destruction of Local Authority public health departments in 1974 had yet to be realised. Jerry Morris' concept of the health authority-based community physician was felt to re-invent the twentieth-century public health infrastructure. Yet since then the domestic public health landscape lies littered with green and white papers, many short-lived and not infrequently half-baked whims, not to mention NHS re-organisations.

The new Labour government in 1997 has also proved to be a disappointment. The opportunity was there to create a dynamic and robust public health system fit for the 21st century. Instead, we have fragmentation compounded by central meddling and accountancy-dominated, top-down performance management.

Occasionally, as in the aftermath of the attacks on the World Trade Centre, the imperative of national security held the promise of proper funding, but once the immediate threat passed, resources were diverted yet again away from public health.

In the early days of the 1840's, the country's first Medical Officer of Health, William Henry Duncan and others around the country, were able to mobilise resources to intervene decisively in the public health threats of the day. This was often through environmental measures on sanitation, involving significant expenditure from public and private sources, voluntarism and the Church.

There are lessons to be learned from this. We need public mobilisation and full engagement rather than narrow programmes of intervention and targets.

So how could things be different? A wonderful breath of fresh air was experienced in the North West recently by the visit of Professor John McKnight from Chicago. McKnight's Asset-Based Community Development Institute (ABCDI) has spent the past 35 years approaching communities to identify and mobilise their assets, rather than becoming ever more refined at defining their needs. In a nutshell, that is it – communities are half full, not half empty. Once exposed to this way of thinking, as with the works of Freud, Darwin and Marx, it is impossible to see

things the same way again. President Obama, who trained as a Community Organiser with John McKnight in a disadvantaged area of Chicago, says he learned more from John McKnight than he learned in his years at Harvard Law School.

So let us consider the way ahead. Our education and training needs a radical makeover, and where and how practitioners are educated for public health need to be radically reviewed. Asset mapping in support of active citizenship needs to take its proper place alongside needs assessment and *Investment for Health*.

When it comes to the organisational arrangements, my prejudice – based on my current experience in Cumbria – is for the county footprint. A fully integrated public health service is needed, based on a county observatory and a joint health unit. Bringing together health protection, environmental health, health and safety and evidence-based local health policy informed by the WHO's *Investment for Health* principles and links to local universities. This should be funded from a local precept and accountable to the local population through an elected board. The death of the quango is nigh, let us embrace a new era of democracy in health.

**Professor John R Ashton, CBE
Joint Director of Public Health for NHS
Cumbria and Cumbria County Council**

Policy, Advocacy and Communications update

Health Bill puts tobacco out of sight and out of reach

The recent Health Bill, which contained tobacco control measures to limit point of sale advertising, passed successfully through the House of Commons after MPs voted overwhelmingly in favour. A new clause, banning cigarette vending machines, was also carried, and also approved by the House of Lords. FPH supported partner charity ASH to achieve this historic result, and President Professor Alan Maryon-Davis, said: "We are delighted. This is the biggest step forward for the nation's health since the smoking ban. The ban will ensure that fewer children will develop a lethal addiction to cigarettes."

No Smoking Day saved

In other smoking news FPH was pleased to learn that No Smoking Day is to continue, after expressing concern in a joint letter to the Department of Health over threats to withdraw funding. Professor Alan Maryon-Davis commented: "The service is pushing smoking down the agenda even though it's the biggest avoidable killer and has a huge impact on health inequalities. It almost says we don't think smoking is as important as it was. That's very wrong and would be an own goal."

Health Practitioner's Guide to Climate Change

October saw the launch of FPH Fellow Jenny Griffith's book *Health Practitioner's Guide to Climate Change* at the Chartered Institute of Environmental Health. FPH was on hand to film the event and vox pops with some of the high-profile authors and guests can now be watched at www.betterhealthforall.org.

Media update

The US healthcare system vs. the NHS debate was still raging on both sides of the Atlantic during the autumn months. An open letter from leading UK doctors exposing the "lies" about the NHS was published in *The British Medical Journal* and added more fuel to the discussion. One of the signatories was FPH President, Professor Alan Maryon-Davis, who was widely quoted in the media from *The Daily Telegraph* and *The Daily Mail* to the online health news website www.onmedica.com.

FPH President's comments featured in press pieces about topics as varied as life expectancy, alcohol marketing and smoking during pregnancy. In September he could also be heard on the BBC Radio 2's *Jeremy Vine show*, discussing the availability of cheap alcohol and drunken behaviour in the streets of UK cities.

Finally, *The British Journal on Healthcare Management* commissioned a commentary from FPH on the financial, environmental and health benefits of greening up the NHS healthcare estates.

Revamped FPH Blog

FPH blog has had a complete overhaul. Thought-provoking posts range from climate change to food policy, and offer insights into emerging public health debates at conferences in the UK and further afield.

Tune in at www.betterhealthforall.org.

FPH on Twitter

Keep up with FPH's work, views on breaking news, comments, thoughts and questions – and take part in the conversation.

Follow us at www.twitter.com/fph

FPH joins the 10:10 climate change campaign

FPH has risen to the challenge and committed to cutting its carbon emissions by 10% in 2010.

Any individual, business or organisation can sign up at www.1010uk.org/

Journalism as a second career

My experience as a British Science Association media fellow

Public health is all about communication with the public. So what could be more interesting than a placement with the most powerful public communicator of all: the mass media.

Each year, the British Science Association awards ten media fellowships for scientists from all disciplines to spend time working with science journalists in national press and broadcast media. The aim of the fellowships is to create awareness amongst scientists of the needs, pressures, and constraints of science journalism.

Doctors have previously been on the scheme, and with a sideline in public health research, I thought I had as good a chance as any other scientist. After a few late nights on the application, I found out that I had been lucky enough to win a fellowship with the Science Editor of the Times newspaper, Mark Henderson.

Walking into *The Times* newsroom was a fantastic experience. It is a very lively atmosphere and you can feel the tension of getting the paper out on time.

I started gently by attending the daily news conferences, where the editors choose

which items will go into the next morning's paper. These meetings really opened my eyes to the process of news creation. News is not news just because it is newsworthy. As public health practitioners, we need to get our issues past several editors before they will reach the attention of the public. It was certainly a valuable lesson seeing what kind of items made it through.

I also attended press conferences as a journalist – covering everything from epigenetics to artificial trees. These left me really impressed with UK science journalists. For example, my host Mark, frequently pushed scientists for clarity on methodological rigour, rather than simply accepting their results.

The power of the sub-editors was quite eye-opening. For someone to be able to change text that will appear under your name, without checking back with you, was quite disconcerting. I am used to revising journal papers many times before submission to exclude any errors. However, the sub-editing process can create new errors or opinions which are then attributed to you. This probably contributes to the mistrust of journalists

and it was a revelation that journalists themselves have little control over this process.

Writing my own articles under deadlines also brought home what the media needed from public health spokespeople. For example, if I called a scientist to clarify some details on their paper, I would usually only have a couple of hours left to finish the story. If they didn't get back to me before this, then the story would get published without their clarification – or not published at all.

Overall, this was a fascinating and unusual placement allowing direct access to a key public health ally. A similar scheme in the future consisting of placements with health journalists would be very beneficial for public health trainees.

Acknowledgements

The British Science Association and sponsors of the Media Fellowships.

Kate Mandeville
NIHR Academic Clinical Fellow in Public Health
University College London

Working at the sharp end of public health – health protection in the 21st century

Challenging public attitudes on MMR is still a major health protection challenge, argues Dr Meirion Evans, the Chair of FPH's new Health Protection Committee, in an interview covering issues as varied as changing public health regulations, gaining public confidence and preparing for climate change with *ph.com*.

What's your vision for the Health Protection Committee during your time as chair?

Health protection is integral to public health and I see it as an important step forward that FPH now has a specific health protection committee in place.

I'm conscious of the fact that health protection teams often have individuals from a variety of professional backgrounds. So the committee will need to look at training and accreditation issues, particularly accreditation for non-medical staff who are daily involved in health protection. We also want to identify what the key competencies are for colleagues who aren't involved in health protection on a daily basis, but are required to be on on-call rotas.

I think there are new opportunities for advocacy work, and we will also be advising the Faculty in regards to consultations on both communicable disease control and environmental hazards, including logistic preparedness for climate change.

You mention advocacy work – what areas would you like FPH to lead in?

It's still early days for the committee, but one area that we'd definitely like to look at is promoting MMR immunisation. There have been a number of measles outbreaks over the last few years and yet we have an effective preventive measure in immunisation. The issue is still primarily the loss of public confidence in the MMR vaccine and I think a clear viewpoint from the Faculty would be helpful.

What about current consultations?

There's an important consultation underway at the moment on the public health (control of disease) legislation – long due an overhaul.

The new regulations on infectious disease control that are being proposed should reflect the creation of country-specific health protection services. The law should also reflect the societal changes that have come about in the last 20 years. We've seen numerous outbreaks, for example in relation to increasing leisure activities and

tourism such as visiting farms or waterparks, none of which are fully reflected in the existing public health legislation. Legionnaire's Disease has also emerged as a significant issue since the original public health act was enacted.

It's still early days for the committee, but one area that we'd definitely like to look at is promoting MMR immunisation. There have been a number of measles outbreaks over the last few years and yet we have an effective preventive measure in immunisation.

What challenges do you think the committee will face?

In terms of FPH's public profile, a big challenge will be for it to convey what it stands for and at the same time earn the trust of the public when it speaks on matters like the safety of vaccines.

Training and accreditation are always thorny issues, not least because health protection arrangements are very different for all the UK countries.

What are the big issues in health protection today?

HIV and AIDS, Sexually Transmitted Infections, hospital-acquired infections, food-borne illnesses and vaccines for preventable diseases such as influenza and measles.

Health protection issues such as the recent E. coli 0157 outbreak usually make the headlines, and although these are real concerns they aren't necessarily the biggest threats. HIV and AIDS now have much lower profiles due to advances in treatments, and yet, new HIV infections are on the increase and it's still very much a threat. Also, most members of the public



wouldn't see the seasonal flu as a serious threat, even though it is one of the major causes of death from infectious disease.

What does the future hold for health protection?

Health protection is at the sharp end of public health so it is the area that chief executives and health ministers feel the most vulnerable about. When you get an outbreak like E. coli 0157 or meningitis and people are dying, you want to be able to call on the expertise of health protection professionals and be confident that they will deal with the situation effectively. This is why I think there'll always be a need for health protection.

Specifically, we must ensure that any future organisational changes will provide an effective basis for dealing with health protection issues. We also have a responsibility for ensuring that the profession is trained to a high standard and equipped with the scientific knowledge and the managerial expertise to deal with emerging and on-going issues.

What is your health protection career highlight?

Working as a Consultant in Communicable Disease Control (CCDC) at a time when colleagues and I were trying to get coverage levels up to 95% for most routine childhood immunisation.

And finally, your biggest personal achievement?

Getting to the top of Mount Kilimanjaro this year!

Dr Meirion Evans is a regional epidemiologist based at the Communicable Disease Surveillance Centre of the National Public Health Service of Wales, as well as Senior Lecturer in the Primary Care and Public Health Department at Cardiff University.

Interview: Suvi Kingsley

Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to the Faculty between 21 August and 17 November 2009.

New diplomate members

Benjamin ANDERSON
Rubinder BAINS
Charles BECK
Jane BEENSTOCK
Araceli BUSBY
Daniel CARTER
Charlotte CHAMBERLAIN
Alisha DAVIES
Lucy DENVIR
Delanjathan DEVAKUMAR
Anna DHAR
Tom FOWLER
Anupam GARRIB
Rosalind Mary-Jayne GRIFFITHS
Jennifer HALL
Anna RICHARDS
Lucinda SAUNDERS
Sarah SOWDEN
Janine THOULASS
Philip Geoffrey VEAL

New trainee members

Mike AHERN
Rachel MCCABE
Rosemary Elizabeth MILLAR
Mary O'BRIEN
Susanna ROUGHTON
Sonya SCOTT
Graeme SNELL

New members

Sumina AZAM
Joanne BROADBENT
Elizabeth BRUTUS
Jennifer CHAMPION
James CHIPWETE
Darrell GALE
Irfan GHANI
Edward KUNONGA
Iain LANG
Sarah LAWSON
Andrew LEE

Lynne MCNIVEN
Anna MIDDLEMISS
Brian O'NEILL
Babafemi SHIN
Kriel RAMCHARITAR
Sucharita YARLAGADDA
Christopher ZISHIRI

New fellowships

Neil ADAMS
Kirsteen ALEXANDER
Adenike AROWOBUSOYE
Sabina ASIF
Alison CHALLENGER
Addi CHAN
Ka CHAU
Fiona CRAWFORD
Blanaid DALY
Julian ELSTON
Caryn HALL
Jo HARCOMBE
Catherine HEFFERNAN
Geraint LEWIS
Marie MCLOUGHLIN
Catherine MORRIS
John O'DOWD
Teresa OWEN
Robert PEARS
Teresa ROCHE
Peter SANDIFORD
David SPENCE
Marie-Noelle VIEU
James WILLIAMS

UK Public Health Register

The following have been admitted to the UK Public Health Register through portfolio assessment or training.

Through Defined Specialist portfolio assessment

John HAMPSON
Jennifer MUSSARD

Through Generalist Specialist portfolio assessment

Velena GILFILLIAN
Madeleine JOHNSON
Elizabeth SHASSERE
David SUGDEN
Lynda WEARN
Louise WOODFINE

Through the standard FPH Generalist Specialist training route

Adenike AROWOBUSOYE
Alison CHALLENGER
Julian ELSTON
Andrea FALLON
Jonathan GRIBBIN
Carl GRIFFIN
John MOONEY
Puja MYLES

Deceased members

The following members have sadly passed away:

Keith BALL
Alun DAVIES
Geoffrey DEAN
Michael FFRENCH-O'CARROLL

John GRANT
Agnes MACPHERSON
Gerard REYNOLDS
John RICHMOND
John SEXTON
Peter SHAVE
John TOLLAND
Thomas WELLER

UK Public Health Register

Call for Fitness to Practise panellists

UKPHR is seeking applications from PH Consultants or Specialists (from any background) to join our pool of Fitness to Practise professional and lay panellists.

You will need:

- ◆ The ability to sift through and comprehend large amounts of written material
- ◆ to listen carefully to evidence from any party and to listen to fellow panel members
- ◆ To remain focussed on the task in hand
- ◆ To be impartial and fair at all times

- ◆ To respect the confidentiality of all panel deliberations that are not in the public domain – e.g. health matters
- ◆ To be able to articulate questions succinctly and sensitively to both parties and to witnesses
- ◆ To analyse and weight, all the evidence of any type in order to reach decisions as to fitness to practise and appropriate sanction
- ◆ To be able to contribute to the composition of determinations, including giving reasons for the decisions being reached.

Relevant experience is valuable, but not essential: e.g. member of tribunals of other regulators, magistrate, NCAS work, handling complaints or disciplinary matters. The role is not paid, but reasonable expenses will be reimbursed.

If interested in becoming a panellist, please send your CV to Sarah North, Manager, UKPHR, at S.North@cieh.org. Should you have any questions or wish to discuss the role further, please contact Sarah, or Fiona Sim, UKPHR Registrar, at fiona.sim@ishtm.ac.uk

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Amanda Killoran
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Sam Ramaiah
Premila Webster
Jan Yates

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Alison Hill

In-house Editor:

Iain Brown

In the next edition

The theme for the March edition will be Health Protection. If you would like to submit an article on this or a public health related topic, please contact news@fph.org.uk with a proposal including your full contact details.

Please send all communications regarding *ph.com* to:

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The views expressed in this publication do not necessarily reflect those of either the editors or the Faculty of Public Health.

Moving?

If you have recently moved, please notify the Faculty of your new contact details to ensure you will still receive FPH communications.



PRINTED ON PAPER FROM SUSTAINABLE RESOURCES

Intergenerational relationships: Linking lives or age divide?

Social isolation is one of the main issues faced by the increasing numbers of older people in society. They have a wealth of experience and skills developed throughout their lives which may be lost if not shared with others.

Young people have skills in areas such as technology which could allow older people to keep in touch with their families and shop online if they can no longer get out and about. So how do we go about transferring skills from one generation to another?

In 2005, Derbyshire County Council (DCC) developed an Intergenerational Strategy. Over a period of 18 months projects linking the generations were devised in conjunction with local communities. These were evaluated and developed into a resource pack which was launched along with the strategy in September 2007. Two years on we are still the only local authority in England to have a dedicated strategy.

Since then Derbyshire has launched projects linking the lives of different generations, reducing the fear of crime and helping to create a more tolerant society. Older people have come to realise that perhaps today's teenagers are not so different after all and the younger ones have commented that just because you're older doesn't mean you're boring.

Gardening projects, such as designing allotments, are a firm favourite. One of Derbyshire's recent projects received national acclaim when it was put forward as a model of best practice in 2008 on National Older People's Day. Pupils from Grassmoor Primary School and members of the local allotment society collaborated on a pilot scheme which proved so successful it was embedded into the school curriculum during the subsequent term. The project was filmed and ran 'live' on BBC Breakfast bringing an air of excitement to the whole community. It recently received international acclaim and was selected as one of seven projects throughout Europe to showcase intergenerational work, being translated into all European languages.

During 2009 DCC has been collaborating with the Drop Inn Youth Project at Belper, working on knife crime and the negative stereotypical images of young people. Initiated by the younger generation who felt they were getting a raw deal and being unfairly judged, they developed and distributed 700 surveys to find out what other members of the community thought. Too much 'negative press' was considered to be responsible and that good news rarely made headlines. Our Project Manager, Gill Clarke, secured the backing of the National Youth Agency and this



became one of their pilot projects focussing on taking intergenerational work forward from a young person's perspective.

Over the summer the Drop Inn had a chance to work on a film project so a series of workshops were devised and delivered in order to utilise this opportunity and the 'role reversal' theme was created. The group got to know each other better through fun sessions which took place in the evening but the main aim was to get them to think about how they would like to take the project forward. Acting is enjoyed by all ages as we found out when the older people donned their hoodies and formed a gang and the young ones showed them all the moves and gestures. These scenes were filmed at Chatsworth House and everyone had a wonderful day visiting the house and gardens together and sharing a picnic lunch. Not to be defeated, the young ladies put on their make up, rollers and hair nets and the young men found suits and walking sticks to be the order of the day as they went to film at one of their local cafés. The final production 'premiered' on National Older People's Day 2009 as the generations came together along with invited guests over tea and cakes at the Drop Inn. The outtakes and photographs were also presented as a slide show and gave an insight into the groups' journey. Some of the comments we received after the sessions were: "It makes us oldies feel young again to work with teenagers" and "the older people rock". This group will continue to meet in other activities planned to brighten up the long winter days.

With the rise in intergenerational work across the country, should we refer to our future in terms of 'linking lives' rather than the 'age divide'? Inclusion, enjoyment and creativity are what it's all about and these ingredients support the wellbeing of all ages.

Gill Clarke
Intergenerational Project Manager
www.derbyshire.gov.uk/intergenerational