The British Heart Foundation National Centre (BHFNC) for Physical Activity and Health discusses if anything can be done to prevent the 155,000 deaths each year from cardiovascular disease, especially how to prevent the onset of cardiovascular disease in an ageing population.

Lindsay Smith, an Exercise Physiologist, provides an overview of Cardiac Rehabilitation (CR) for people who have had a range of cardiac events with an aim to improve understanding and reduce the risk of future events, improve quality of life and facilitate health behaviour change in an ageing population.
As we start 2016, I would like to welcome you to another year of Innov-age.

As you reach later life looking after your health is important, and as heart and circulatory diseases are the largest causes of mortality in adults over 65 (Office for National Statistics, 2014), it is especially important to pay attention to your cardiovascular fitness. Indeed 21.4% of people aged over 65 have been diagnosed with coronary heart disease (Age UK, 2015) and the benefits of physical activity for preventing cardiovascular disease in older adults is highlighted in this issue. Even more so in these winter months, as circulatory diseases are particularly affected by winter temperatures (The Marmot Review Team, 2011).

Exercise is also important following a cardiac event and Lindsay Smith, an Exercise Physiologist, discusses how cardiac rehabilitation (CR) has been shown to be both clinically and cost effective in reducing associated morbidity and mortality.

But it’s not just about exercise. In our lead article The British Heart Foundation National Centre (BHFNC) for Physical Activity and Health note that cardiovascular disease is often referred to as a lifestyle disease because some behaviours increase the risk of developing it. Smoking, poor diet and excessive alcohol intake all play a part alongside physical inactivity. They explain that it is particularly important for older people to make healthy lifestyle choices to prevent the onset of cardiovascular disease as these factors are exacerbated as one gets older.

The Innov-age team are writing this Editorial during the end of year festivities and having partaken in too many mince pies, chocolate biscuits and meals out it’s perhaps time to commit to a new year resolution of a better diet and more exercise!

Jackie Oldham
Honorary Director, Edward Centre for Healthcare Management Research
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The (not so) secret to keeping hearts young

British Heart Foundation National Centre for Physical Activity and Health

It’s no secret that the UK has an ageing population. We’re living longer than ever but how are our hearts bearing up? In the UK cardiovascular disease is responsible for around 155,000 deaths each year equating to one every three minutes. Can we do anything about this?

Cardiovascular disease is often referred to as a lifestyle disease because some behaviours increase the risk of developing it. These include smoking, poor diet, excessive alcohol intake and physical inactivity. For older people, making healthy lifestyle choices is particularly important to prevent the onset of cardiovascular disease as age is also a risk factor.

Managing heart disease with physical activity
The benefits of physical activity for preventing cardiovascular disease in all adults are well established, and this does not change once we move into older age. The evidence of the preventative effect of physical activity for cardiovascular disease for older people is at least as strong as that for middle age adults.

Being physically inactive in itself is a risk factor for cardiovascular disease, which increases the chances of having a heart attack or stroke. Increasing physical activity not only helps to reduce this risk, it also helps to avoid developing other major risk factors for cardiovascular disease including high blood pressure, high cholesterol and obesity.

Beyond heart health...
Being physically active in later life has benefits far beyond heart health. These include prolonged life expectancy, prevention of type 2 diabetes and a reduction in the risk of developing many chronic diseases, for example osteoporosis. Being physically active also improves outcomes for people who have existing conditions such as rheumatoid arthritis, chronic obstructive pulmonary disease and low bone density. A natural age-related decline occurs in many physiological functions such as fitness and strength, this decline can be reduced with physical activity.

Considering these benefits it is no wonder that Public Health England said “If physical activity were a pill, we would be rushing to prescribe it” in their latest Physical Activity Strategy. But there is more...

Physical activity is also associated with better mental health as it can alleviate symptoms of depression and anxiety, reduce the risk of
developing dementia and can lead to improvements in day to day cognitive function as well as the quality and quantity of sleep.

**Maintaining independence**

Participation in strength and weight-bearing activities is positively associated with bone mineral content, bone density and helps to maintain muscular strength. These are important components of functional fitness and help older people to perform many activities of daily living, such as walking, standing, carrying shopping, gardening and housework, which help to retain independence.

Despite many benefits for older people, this age group has the lowest levels of physical activity compared to any other age group. **In England, 74% of men and 76% of women over the age of 85 are inactive.**

**Creating an active generation**

The vision of the BHFNC is to create an active nation for people of all ages. Knowing the benefits of physical activity for the heart and wider health of older adults is only a starting point. The BHFNC believes that frontline practitioners working with older people are the key to encouraging this generation to be more active. We work with professionals and provide them with tools to help develop an active older generation. One of our key approaches is to train practitioners to give them the knowledge, skills and practical ideas to promote physical activity to the older adults they work with.

The key focus for the work with older people is maintaining functional fitness - the ability to complete daily living tasks, for example, climbing the stairs or getting out of a chair which are vitally important to maintaining independence in later life.

The ‘Introducing the Functional Fitness MOT’ is a training course developed by the BHFNC in collaboration with Later Life Training and Glasgow Caledonian University to promote the use of the Functional Fitness MOT with health professionals working with older adults.

**Functional Fitness MOT**

The Functional Fitness MOT is a tool that can be tailored to individuals. It includes a number of activities that can be used to measure components of functional fitness. For example, the chair sit and reach, 30 second chair stand, and eight feet up and go test. An individual’s results can then be compared to average scores for someone their age to highlight their strengths and weaknesses. This allows discussion around the person’s needs and preferences to find opportunities for being active.

The Introducing the Functional Fitness MOT course raises awareness of the importance of physical activity and physical function for older people and demonstrates how the MOT can help. For further details please visit [www.bhfactive.org.uk/training-and-events](http://www.bhfactive.org.uk/training-and-events)

The BHFNC provides professionals with information, guidance and support to raise the profile of physical activity. For more information on physical activity for older people visit [www.bhfactive.org.uk/older-adults](http://www.bhfactive.org.uk/older-adults)

**Functional Fitness MOT – case study**

After attending the initial training, the Functional Fitness MOT has been practically applied in a variety of settings for a number of different purposes.

Aberdeen City Council use the Functional Fitness MOT as part of a bi-annual prevention event targeting over 60s who are relatively fit and active and want to remain as independent as possible. Participants get the opportunity to take part in a Functional Fitness MOT conducted by an occupational therapist or personal trainer as part of a full health check. Integrating the Functional Fitness MOT into this event enables health professionals to signpost participants to suitable activities from organisations exhibiting at the event.

Universities have also included the Functional Fitness MOT into their undergraduate teaching. Aberystwyth University trained some of their students to undertake Functional Fitness Assessments who used their skills to host a Functional Fitness Testing workshop for older adults in the local area. This opportunity provided the students with an intergenerational opportunity to practically apply the skills they learnt at University.
Cardiac Rehabilitation in Older Adults

Lindsay Smith is an Exercise Physiologist in the Cardiac Rehabilitation team at the Royal London Hospital. She has been delivering exercise programmes to clinical populations for five years, specialising in cardiac conditions and with an interest in heart disease and cancer patients.

Cardiac rehabilitation – a brief overview
Cardiac rehabilitation (CR) is an evidence based exercise and education programme for people who have had a range of cardiac events including heart attack, revascularisation surgery, percutaneous coronary intervention (PCI) and acute heart failure, along with a number of other cardiac related events that fall within the scope of the cardiac commissioning guidelines (Department of Health, 2010). The aim of CR is to reduce the risk of future cardiac events and hospitalisations, improve quality of life and facilitate health behaviour change. This is usually done by using a multidisciplinary team to tackle lifestyle, medical risk factor management and deliver education and exercise. The team may be made up of Cardiologists, Cardiac Nurse Specialists, Physiotherapists, Exercise Specialists, Psychologists, Dieticians, Pharmacists and Occupational Therapists, although not all services have access to all of these professions (BACPR, 2012; NICE, 2013).

CR has been shown to be clinically and cost effective in reducing morbidity and mortality after a cardiac event across all age groups (Fidan et al., 2007; Heran et al., 2011); an important statistic in an ageing population and when enhanced treatments and pharmaceutical interventions have led to improved survival rates. Currently, there are 2.3 million people in the UK living with coronary heart disease (CHD) and half a million living with heart failure (Bhatnagar et al., 2015).

How does it work?
Patients follow a seven-stage pathway outlined in the National Institute for Health and Care Excellence guidelines (NICE, 2013):

- **Stage 0** Identify and refer patient
- **Stage 1** Manage referral and recruit patient to cardiac rehabilitation programme
- **Stage 2** Assess patient for cardiac rehabilitation
- **Stage 3** Develop patient care plan
- **Stage 4** Deliver comprehensive cardiac rehabilitation programme
- **Stage 5** Conduct final assessment
- **Stage 6** Discharge and transition to long-term management

Individual rehabilitation programmes vary in how they deliver these guidelines but usually the patient is assessed for their suitability for exercise and offered a range of delivery methods, for example group exercise classes, gym based programmes or a home programme. Once a plan has been established, patients are risk stratified and have their functional capacity assessed. This will give an indication of their current fitness, anxiety levels and highlight potential activities that may need modification. Education is also offered in combination with the exercise to help empower patients to take control of their condition and make necessary lifestyle changes (BACPR, 2012).

Most programmes are twice per week and should be for a minimum of 8 weeks (Heran et al., 2011). On completion the patient will be reassessed, have their functional capacity re-tested and be facilitated with long term management of their condition and maintenance of a healthy lifestyle.

Individual exercise prescription
Where possible, CR should be tailored to the individual, however, differences occur in age, gender, fitness and motivation levels and exercise experience. Patients present with a range of limitations including comorbidities, injuries, disabilities, balance, sight, hearing and memory issues, particularly in the over 65 age group. It would be time consuming and costly to have every patient doing something completely different, therefore, generally all patients follow the same programme but at a prescribed intensity and with adaptations where necessary.

Most issues can be addressed with minor adaptations, for example, a circuit can be made safer for those with reduced balance by placing equipment near a chair or wall to hold onto or making the exercise predominantly chair based. If capacity allows, smaller groups with a larger staff to patient ratio allow for more support and one to one contact. If available, specialist equipment may be used in those with severely reduced function, for example a motorised arm or leg ergometer. Patients who need a lot of modifications or have very low functional capacity may do better with a personalised gym programme or a home programme where it may be easier to go at their own pace and less overwhelming.
Benefits and barriers
The 2014 National Audit of Cardiac Rehabilitation (NACR) reported that the average age of male and female CR patients was 65 and 70 respectively. The risk of cardiovascular disease (CVD) increases with age and multiple benefits can be gained from CR in patients over 65 years (Lavie et al., 1993; Menezes et al., 2012) including reduced mortality and morbidity and improved modifiable risk factor profile. Additionally, exercise serves not just to try and improve disease status but also quality of life (Flynn et al., 2009; Ades et al., 2013), which is important for irreversible conditions like heart failure. It can help to maintain independence and activities of daily living by optimising activities such as the ability to get up from a chair unaided. Enhancing independence can further impact on mental health and well-being, and can prevent isolation and falls which, in turn, leads to fewer hospital admissions. Therefore, regular exercise in older adults with heart disease can have a huge impact cascading into many benefits.

Despite this evidence, older adults, particularly women, are an underrepresented group in CR (Beswick et al., 2004). Barriers include lack of referral from primary healthcare workers, expectation of pain and discomfort during exercise, lack of knowledge about what rehabilitation offers and its benefits, and wanting to self-manage the condition (Grace et al., 2009).

Recommendations
The UK guidelines issued by the Department of Health (2011) for the amount of physical activity for health gains in adults over 65 years are largely the same as for younger adults and to some extent the guidance issued to cardiac patients: 150 minutes of moderate or 75 minutes of vigorous activity per week or a combination of the two.

It is also recommended that strength training is performed twice a week and to be active every day, restricting sedentary activities. It is advisable that only older adults who are already engaging in the recommended level of physical activity perform vigorously intense activity. The weekly exercise amount should be spread across the week, most commonly quoted is 30 minutes five times per week, but an accumulation of a minimum of 10 minute bouts is sufficient (Glazer et al., 2013), and advisable to start with, in currently inactive or low functioning individuals.

Strength training for over 65s should include all major muscle groups and use body weight or resistance. This could be done via everyday activities, for instance carrying shopping or other activities that involve stepping and jumping, for example dancing. Weights or resistance bands can also be used, such as in chair aerobics.

In addition, older adults are advised to perform activities that improve and maintain balance and coordination such as tai chi and a warm up and cool down should always be included. For cardiac patients it is recommended that an extended warm up of 15 minutes and an extended cool down of 10 minutes is done to avoid adverse effects such as dizziness and arrhythmias. It is also good practice for anyone to fully warm up and cool down to also avoid muscle or joint injuries and particularly older adults who are much more likely to have other comorbidities (Global Burden of Disease study, 2013).

In summary, CR has been shown to be very beneficial in older adults and statistics show that more people reach the recommended activity guidelines after attending a rehabilitation programme than those who do not (BHF, 2015).

Referral bias in this age range is high and appropriate information and encouragement is needed at all stages of the rehabilitation pathway to ensure everyone who would benefit from rehabilitation has access.

References
Department of Health (2011) Start Active, Stay Active, A report on physical activity for health from the four home countries’ Chief Medical Officers.
Health and Alcohol

David Brough, Cognitive Behavioural Psychotherapist, Compassion Focused Therapist MSc, Master Practitioner and Trainer of Trainers (N.L.P.), Diploma Systemic Counselling, Clinical Director of Alcohol Treatment Solutions and Doctoral Researcher.

David began his career in Occupational Psychology, specialising in Psychometrics and co-developed the first automated psychometric test in the UK. After working in consultancy David became a Director of a Training and Enterprise Council and developed innovative measures to assess the impact and effectiveness of counselling process control and evaluation. David went on to specialise in substance misuse and mental health, researching the effectiveness and efficacy of alcohol treatment programmes in the western world.

Alcohol dependence has a significant disease burden and financial cost for individuals and society. According to the World Health Organisation 2.5 million deaths occur each year from alcohol related complications. In the UK, it is estimated that 24% of adults drink in a hazardous or harmful way.

The World Health Organisation has identified alcohol as the third largest health risk factor in developed countries.

In 2012/2013 there was an estimated 1,008,850 alcohol related hospital admissions:
- 651,010 of the admissions were due to alcohol related conditions categorised as chronic conditions,
- 60,830 were conditions categorised as partly attributable to acute alcohol conditions,
- 198,600 were for mental and behavioural disorders due to alcohol
- 50,510 admissions were for alcoholic liver disease. (Health and Social Care Information Centre, 2014).

This is not just a problem of the young. According to The Royal College of Psychiatrists one in five people over 65 who drink are consuming an unsafe level of alcohol. Approximately a third of older people with drinking problems develop them for the first time in later life, the majority of these are women.

One in five older men and one in ten older women are drinking enough to harm themselves and these figures have increased by 40 per cent in men and 100 per cent in women over the past 20 years.

Nobody plans to have an alcohol problem and it can present as a maladapted coping strategy to regulate mood and emotions. As such, there are a number of reasons why someone over 65 may start to develop drinking problems later in life. There is more chance they will have experienced bereavement, physical ill-health, mobility problems and social isolation, All of which can lead to despondency, boredom and depression. A number of older people may be using alcohol to help them manage pain and stress originating from a physical illness. With fewer family and work responsibilities, once alcohol is part of their daily routine all these combine to make it difficult to give up. Health professionals should be aware of heavy drinking in older people as it could be difficult to recognise. The effects of alcohol may be mistaken for another physical or mental health problem (The Royal College of Psychiatrists, 2015).

Evidence shows in 2010 there were almost half a million alcohol-related hospital admissions for people aged 65 and over (Drugscope, 2014). People aged 55 to 74 have the highest rate of alcohol related deaths of all age groups (Office for National Statistics, 2014).

There is evidence to show that this is getting worse. Between 2002 and 2012 there was an increase in hospital admissions related to alcohol across all ages, but the biggest increase was among older people: admissions rose by 136% for men aged 65 and over and 132% for women aged 65 and over. During the last decade there has been an 87% increase in alcohol related death rates in men aged 55-74, and a 53% increase for women (Drugscope, 2014).

Why is alcohol abuse a mental health issue and what help is available?

Drinking is defined as harmful when it leads to physical and mental health problems. Drinking that risks interpersonal relationships and dependence is harmful. Sustained alcohol use often leads to alcohol tolerance and in the longer term discontinuation of alcohol can lead to withdrawal problems.

If alcoholism is viewed through the lens of a medical model and consequently as a disease it implies the person can't do anything and pharmacological intervention is often the only treatment of option choice. Research demonstrates alcohol problems are often the result of trying to manage emotional pain and psychological distress. Alcoholics need to be understood and desperately need well researched and powerful therapy to enable better ways to manage emotional problems.

Indeed the latter is recognised by the National Institute of Clinical Excellence (NICE) current recommendations that psychosocial interventions (PSI) for alcohol dependence should be used in addition to, or in conjunction with, pharmacological treatments.
After reviewing the literature from 2008 - 2014 on psychosocial treatments (PSI) for alcohol dependence it could be concluded, that although effective for many people, PSI does not offer an approach which is an effective treatment solution for everyone.

The findings of the articles reviewed are in line with NICE’s (2011) findings that although psychosocial interventions work, they are not more effective than each other. Treatment of alcohol dependence however, is based on a disease model and prioritises symptom reduction over addressing psychological factors involved in the causes of alcohol misuse as maladapted coping behaviour. Although symptom reduction and medical stability are central to recovery, indicators highlight that not addressing underlying causal mechanisms in treatment can undermine efforts to recover. Recent advances in Cognitive Behavioural Therapy (CBT) focusing on co-morbidity with depression and anxiety (Kushner et al., 2013, Kessler et al., 1997) indicate the dynamic interaction between these disorders and alcohol misuse, and the role CBT has to play to address emotional regulation in conjunction with targeting alcohol reduction.

Third wave CBT, such as dialectical behaviour therapy (DBT) (Linehan, 1993), acceptance and commitment therapy (ACT) (Hayes, Strosahl & Wilson, 2011) and compassion focused therapy (CFT) (Gilbert, 2014) advocates that no one therapy is appropriate for every client and social context plays a significant role in psychological wellbeing. For example, Northern European and U.S. social norms that underpin alcohol use are likely to be a contributing factor but the role of stigma and socially induced shame and guilt, have received relatively little attention.

Despite some research exploring the relationship of alcohol dependence with shame and guilt there remains a lack of evidence to ensure reference to these factors in NICE recommended therapies. As early as 1989, Potter-Effron suggested that individuals who abuse alcohol are more shame prone than most, even before they become dependent on alcohol. However, he did not offer any evidence to support this claim at the time. More recently Carpenter and Hasin (1999) observed shame was associated with high alcohol consumption and guilt was associated with resistance to drinking. These authors also noted that there is no research to clarify whether proneness to either guilt or shame is related to these emotions being experienced in the context of alcohol related transgressions.

Alcohol abuse can be understood as a safety behaviour aimed at preventing the experience of shame and guilt or other negative emotions. However, like most safety behaviours, drinking can be seen to create a vicious cycle (Beck, 1993) where failing to stop activates the feelings of shame and guilt that the behaviour was originally designed to suppress. Worthington et al., (2005) argued that individuals who become dependent on alcohol suffer from an inflated sense or responsibility, much like those who are diagnosed with anxiety or depression and may experience negative affect related to poor emotional regulation. By addressing chronic feelings of shame and guilt, as well as the emergence of these feelings when clients attempt to discontinue alcohol, it is possible to help address the problem. Indeed, 12 step Alcohol Programs utilise emotional regulation by directing clients to address the real harm caused by individuals under the influence of alcohol. This is presented as an opportunity to ask for forgiveness and make reparations for emotional transgressions.

12 step Alcohol Programmes undoubtedly have some role to play for some people, but alcohol abuse associated with adverse health outcomes and alcohol use disorder remains a public health problem in the UK with little systematic research and a lack of creativity leaving a void in an evidential basis for what are important treatment strategies.

To address similar challenges in the US, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has identified a need for Addiction Research Centres to nurture an attitude of creativity to address alcohol problems. Such centres should have the freedom to pursue new unorthodox, creative ideas which may seem to be high risk, but may prove to be high gain and thereby stimulate creativity in this field of research.

In the UK, Alcohol Treatment Solutions is a Community Interest Company (CIC) (www.alcohol-treatment-solutions.com) and is one example of an initiative designed to advance alcohol treatment putting emotional regulation at the heart of treatment approaches. The alcohol Fortitude and Resilience programmes are proving to be highly effective treatments with excellent success rates and there are plans to offer training programmes based upon evidence based practice to enable other providers to deliver similar better treatment outcomes.

References
Older people jumping into daily activities

Older people would be willing to increase their bone strength in later life by doing exercises including jumping and hopping.

A Bristol University study, funded by the Medical Research Council, found that if older people overcome the barriers to undertaking exercises, they would be willing to undertake the type of exercises that are likely to increase their bone density and strength, which in turn could reduce their risk of falls or bone fractures.

Published in Osteoporosis, International Lead Researcher Dr Bethany Simmonds, from the School of Social and Community Medicine, said: ‘Fracturing bones are painful for the individual and costly for the economy. Moreover, having a fracture or fall can be a turning point in an older person’s life. It can lead to a loss of confidence, and a shift from being independent into being far more reliant on others and less able to do things for themselves.

‘Our study found older people were worried about damaging their joints and falling over. However, if they were given the right information, and helped to understand how doing this type of physical activity could enable them to be independent for longer, most of the participants in this study said they would be willing to incorporate jumping activities into their daily lives.’

Previous research has already found that higher-impact physical activity, such as jumping or hopping, can increase bone density and strength in later life. Dr Simmonds said: ‘We were interested in discovering the concerns older people had about this kind of exercise, and how those concerns could be overcome. It became apparent that older people were worried about damaging their joints and falling, but they also had difficulty conceptualising their bones.

‘These findings showed the importance of providing clear, easy to follow information and guidance for older people when it comes to this sort of exercise. Our results also suggest that if the activity is fun and interactive, they will be more likely to try it.’

The researchers also found that participants were interested in how participating in higher impact physical activity could maintain their mobility, independence and social relationships.

To find out more please visit: http://link.springer.com/article/10.1007/s00198-015-3376-7

Tai chi may be able to help older patients with age-related diseases

The martial art may help relieve some symptoms of four age-related diseases: cancer, heart failure, osteoarthritis and chronic obstructive pulmonary disease (COPD).

A study published in the British Journal of Sports Medicine noted significant improvements in walking for those who had heart failure, improved strength of the big quadriceps muscles for those with heart failure and COPD, and pain and stiffness for people with osteoarthritis in those who participated in Tai chi. There were also trends for effects on depression and quality of life for those with heart failure and COPD.

Remaining active and exercising within your limits is positive in all stages of life, even for those who have a chronic disease. If older people find tai chi is improving their physical or mental wellbeing, it is a good outcome.

The results demonstrated a favourable effect or tendency of tai chi to improve physical performance, and showed that this type of exercise could be performed by individuals with different chronic conditions, including COPD, heart failure and osteoarthritis.

To find out more please visit: http://bjsm.bmj.com/
Harmful alcoholic drinking in over-50s

This study showed that higher-risk drinking was linked to a number of factors the researchers described as "middle-class", like higher educational attainment, being socially active and good ratings of health.

A study carried out by Professor José Iparraguirre from the Research Department of Age UK has estimated what risk factors might be linked to harmful alcoholic drinking in over-50s.

Alcohol consumption is growing among older people in England and people who have better health, higher income, with higher educational attainment and are socially more active are more likely to drink at harmful levels. The results reported that, generally speaking, people aged 50 or over ageing ‘successfully’ in England are more at risk of drinking at harmful levels or of developing harmful drinking consumption patterns than those who fit less well into the paradigm of ageing ‘successfully’, such as non-smoking, greater physical activity, more social contacts, better self-rated health and absence of depression.

To find out more please visit: http://bmjopen.bmj.com/

Upcoming Events...

Ageing 2016  9th – 11th February 2016
EuroSciCon are hosting an international summit looking at research into ageing, with discussions ranging from the discovery of biomarkers and assay development to effects of loneliness on older people.
www.euroscicon.com

Intermediate Care for Older People  9th February 2016
The King’s Fund are hosting a workshop for clinicians and managers leading the delivery, co-ordination and commissioning of intermediate care for older people with frailty, within and across health care, social care and the voluntary sector, as part of a series on improving the experience for and care of older people.
www.eventbrite.co.uk/e/intermediate-care-for-older-people-registration

Modern Care of Older People  16th March 2016
The programme at this Royal College of Physicians of Edinburgh event looks at the changing picture of how older people should be cared for in modern healthcare by drawing upon experts in geriatric medicine and from a variety of other specialties. This event is open to all grades of medical, health care and scientific staff and to students and is approved for Continuing Professional Development (CPD).
http://events.rcpe.ac.uk/

RCN Older People’s Forum & British Geriatrics Society Joint Conference Multidisciplinary team working in community settings  14th April 2016
This second joint conference between the RCN and BGS takes place in Birmingham and focuses on multidisciplinary team working in community settings. The agenda shares best practice and examine the barriers and solutions to multidisciplinary working in out of hospital health care settings. The programme offers UK leaders in older people’s care as keynote speakers and a wide variety of concurrent sessions covering major issues for all levels of professionals and staff working with older people.
https://www.rcn.org.uk/news-and-events/events
Older patients get round-the-clock care on screen thanks to new technology

Justin Tuggey, Respiratory Consultant with responsibility for lung cancer, is clinical director for digital care at Airedale NHS Foundation Trust, in West Yorkshire. He has been employed by this hospital for 10 years and is clinical champion for the role out of an integrated electronic health record across the Airedale health economy. Dr Tuggey is supporting the uptake of telemedicine technology into mainstream operational and clinical practice both within the hospital and to other parts of the country through the Trust’s work in prisons and care homes. He is part of the National Vanguard for Technology Enabled Health in Care Homes.

Given the predicted growth in healthcare demand from an increasing number of elderly residents and those with long-term conditions future healthcare delivery mechanisms will need to change. Recognising this need, Airedale NHS Foundation Trust has altered its hospital dominated delivery model to one based on diversified, integrated services, delivered at the most appropriate point for patients, enabled by technology.

The Trust is now leading a team that have been selected by NHS England to transform care for patients nationally. The team comprises partners from the NHS, local authorities, care homes, technology developers and academia with responsibility for developing a new technology based model of care. This builds on their experience of providing telemedicine services to care homes to improve patient experience and quality of care. Their aim is to integrate services and provide immediate access to expert opinion and diagnosis where appropriate, whilst supporting residents to be more independent and have better quality of life, by focusing on proactive rather than responsive care and delivering more specialist services into care homes.

Telemedicine is an innovative service which offers patients a face-to-face consultation with health professionals via a secure video link, from the comfort of their own home, care home or in a GP surgery. Airedale Hospital has established a Telehealth Hub on site, staffed 24 hours a day, seven days a week, by a central team of highly skilled senior nurses who specialise in acute care providing remote triage and advice to patients. A consultant is also on hand if needed. The team provides clinical consultation and referral to the most appropriate setting of care where necessary.

Evidence suggests that many patients are admitted into hospital when this is not always the best or most appropriate environment. The service reduces unnecessary patient admissions and time-consuming, costly trips to the Emergency Department whilst improving the lives of patients. A typical hospital admission can cost upwards of £2,500 (covering transport by ambulance, A&E care, tests, medical equipment food, bedding and care on a ward).

Airedale NHS Foundation Trust teamed up with technical partners ‘Involve’ in a partnership called ‘Immedicare’ to provide its telemedicine service to around 300 care homes nationwide helping to relieve pressures on urgent care services. Telemedicine is also used to support patients with long term conditions such as COPD, heart failure and complex diabetes in their own homes resulting in over 6000 patients being linked to the Telehealth Hub at the Trust.

Phil Parkinson is the new managing director for Immedicare and first employee solely recruited by the joint venture which provides an end-to-end service - clinical expertise and the technology.

Immedicare provides a remote consultant-led service including full trauma, orthopaedic and dermatology clinics, to 16 prisons nationwide, using the 24-hr Telehealth Hub, based at Airedale Hospital.

Speaking about the service, Phil said: “High quality and reliable video connections are vital to this service so that nurses can visually assess patients who could be having a stroke or look closely at wounds or rashes. The system uses an encrypted video link to maintain confidentiality.

Effective training of staff in care homes is important to make sure they are knowledgeable and enthusiastic.
about the service. They assist patients to contact the Hub and can get advice from our nurses about providing support and treatment.

Immedicare is an exciting, ground-breaking venture and our telemedicine service delivers high quality patient care using the latest technologies and clinical skills.”

‘Gold Line’, a round-the-clock telephone advice service for patients thought to be in the last 12 months of life, is also run from the Hub. Some patients have a secure video link to clinicians via an ipad.

Teledmedicine proved to be a success with staff and residents alike at Heatherstones Court - a unique housing scheme in Calderdale providing care, housing support and the chance for residents to rebuild independence, with the aim of returning to live in the community. It was created by Calderdale Council, NHS Calderdale Clinical Commissioning Group, Connect Housing and Calderdale and Huddersfield NHS Foundation Trust.

The self-contained apartments in Halifax, are now linked up to Airedale Hospital’s Telehealth Hub providing round-the-clock care on screen.

Tanya Smith, reablement support assistant at Heatherstones, has used the telemecine service to get medical help for a resident with Alzheimers, who was having a stroke and spoke very little English. On another occasion Tanya sought advice about a male resident who had been given his maximum amount of medication but was still in a lot of pain.

Tanya said the service was used to check whether residents needed to be taken to hospital urgently as staff at Heatherstones are not medically trained.

She said: “It’s really simple to use and you can quickly have a friendly face on screen on the laptop in your bedroom or living room.”

Justin Tuggey, Respiratory Consultant at Airedale NHS Foundation Trust, said: "The message we get from residents is that they feel assured just by having easy access to telemecine knowing that if they need to see a nurse they can, at the touch of a button.

It’s so disruptive for elderly residents to be taken into hospital. They have told us that they prefer to be cared for at home - so it’s been down to us to change the way we work.”

Impact of the service
Independent analysis has been carried out by Yorkshire Health Economics Consortium, between 2012 – 2014, looking at the impact of the telemecine service in care homes on the use of acute hospital resources.

The study was an uncontrolled retrospective observational review of data on emergency hospital admissions and emergency department visits for care home residents in Airedale, Wharfedale and Craven. Acute hospital activity for residents was observed before and after the installation of telemecine in 27 care homes. Data from a further 21 care homes that did not use telemecine were used as a control group.

Both the care homes with telemecine and the control group showed a reduction in the costs of emergency admissions and in emergency department attendances, however the reduction was greater in the care homes after telemecine installation. The incremental difference in costs between the two groups of care homes was almost £1.2 million. The cost of telemecine to care commissioners was £177,000, giving a return on investment over a 20 month period of £6.75 per £1 spent.

Justin Tuggey recently told delegates at an event hosted by the Kings Fund that the use of telemecine in these care homes was cost-effective and that these reductions represented significant savings in resources and staffing.

For more information visit the links below:
http://www.airdale-trust.nhs.uk/services/telemecine/
http://immedicare.co.uk/
ERAS +
Supported by the NHS England Regional Innovation Fund

Dr John Moore has been a Consultant in Anaesthesia and Critical Care at Manchester Royal Infirmary, Central Manchester University Hospitals NHS Foundation Trust since 2008. He is currently the Clinical Director for Adult Critical Care Services. Over the last 3 years he has been working on the Enhanced Recovery After Surgery + project. This has attracted national funding and has been adopted by Manchester Academic Health Science Centre (MAHSC) as one of its key Quality Improvement projects. He is currently working with the transformation team to help further improve surgical pathways particularly for patients with cancer.

Nearly two thirds of cancer diagnoses occur in the over 65s and one third in people aged 75 and over. By 2020 there will be nearly two million people aged 65 and over alive following a diagnosis of cancer (National Cancer Intelligence Network, 2015). Survival from cancer needs to be improved and the World Health Organisation has set an ambitious target of improving worldwide 5 year cancer survival by 25% by the year 2025. Unfortunately, the UK still lags behind the rest of Europe in terms of cancer survival and with more than 330,000 new diagnoses of cancer every year in the UK this is obviously concerning. Greater Manchester with its poor socioeconomic demographic has an even further survival disadvantage and this has been recognised by the Manchester Academic Health Science Centre, with an important aim to improve 5 year survival to 70% for all cancer patients by 2020. One of the possible ways is to help improve recovery from major cancer surgery.

Major surgery, particularly in the context of cancer, poses a massive physiological and emotional challenge for patients and their families. We know that patients spend weeks to months recovering from their surgical event. If they have complications after surgery, this period of recovery is significantly extended, with consequent functional restriction and can lead to both a short and long-term mortality disadvantage. This challenge of recovery is even more complicated if patients have to undergo other cancer therapies such as chemotherapy and radiotherapy.

Central Manchester University NHS Foundation Trust (CMFT) is recognised nationally as a leading centre in the innovation of Enhanced Recovery After Surgery (ERAS) pathways. A multi-disciplinary team incorporating the trust’s key ERAS innovators, including surgical, anaesthetic and critical care medical, nursing, allied health professionals developed a new cancer surgery pathway, ERAS+. This new pathway aimed to reduce complications following major cancer surgery with a particular focus on reducing respiratory complications. By reducing complications the ERAS+ team sought to reduce the period of time patients spent in hospital, and also improve both short and long-term survival.

ERAS+ aimed to equip patients and their families with the tools to help optimise patient preparation and recovery from surgery built on state of the art hospital service. Patient and family involvement was supported by talking to patients and their relatives through patient and family listening sessions both before and after their surgery seeking to understand patient and family needs in an updated major surgery pathway, particularly in the context of cancer.

Key aims of ERAS+

- Improve short and long term (5 year) patient survival following cancer surgery
- View patients and their families as partners in their surgery and recovery
- Aim to help patients improve their general fitness before and after surgery and so reduce their risk from complications
- Improve psychological well-being for patients and families
- Enable them to return to their previous level of function as quickly as possible

ERAS + incorporates multiple new innovations aimed at improving patient recovery from cancer surgery:

ERAS+ is built on a platform of enhanced recovery which utilises evidence based best practice anaesthetic and surgical care for the type of cancer surgery being performed.

Respiratory - There is a strong emphasis on reducing respiratory complications after cancer surgery. Respiratory complications are the most common significant complication after major surgery affecting up to 30% of patients, increasing a patient’s hospital length of stay as well as conveying a mortality disadvantage for years afterwards. This problem has been tackled by working with colleagues in America from the Boston Medical Centre (BMC), to produce ICOUGH UK. The BMC team have demonstrated previously that a low cost bundle of simple measures including pre-operative oral care, and incentive spirometry alongside early post-op mobilisation
could reduce the incidence of postoperative pulmonary complications (POPC) by up to 50%.

**Activity** - Increased activity and exercise is recommended more and more as a very important method of improving survival from cancer as well as increasing lifespan generally. Within the ERAS+ model there is a clear focus on patient pre-hospital activity often termed pre-ablement. 150 minutes of activity per week is advised, and the team explain to patients that they are ‘training’ for their surgical event as an athlete would train for sports event, encouraging them to undertake an activity that they enjoy and to do it with a friend or relative, and supporting this with a diary to document their activity.

**Surgery School** - Patients are supported and trained in the elements of ERAS+ with a new surgical patient and family education tool, Surgery School. The Surgery School is a multidisciplinary led teaching session that happens every week and all major cancer surgery patients and their relatives are invited to attend. During the 60-90 minute session patients and their relatives receive instruction on how they can best prepare for their operation. Patients receive instruction in what is expected of them before and after surgery, so they can feel empowered. Terminology included in discussion with patients and their families highlights the benefit of patients being active and dynamic in their own recovery. It also provides a very useful question and answer forum for patients and relatives. Those attending were also offered a visit around the high dependency care unit to orientate them to where they will be cared for after surgery.

**ICOUGH TV** - Patient and family preparation is further supported by ICOUGH UK You Tube TV channel which houses Patient Information Videos multimedia support (https://www.youtube.com/channel/UCvOamR8Sb4RXENr56fRehA). There are similar developments of other teaching aids, patient information leaflets and multimedia resources.

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In 2014, critical care staff, cancer specialities nurses and surgical colleagues were trained in the principles of ERAS+ and over a 12 month period, ERAS+ has been utilised in more than 500 cancer patients. The team have collected high quality prospective data in these patients and have termed this the Manchester Surgical Outcomes Project (MSOP).

**Results of the ERAS+ Intervention**

Since September 2014, utilising ERAS+ within critical care in over 500 patients, has resulted in 40% reduction in pulmonary complications. This has major implications for UK cancer surgery and potentially 5 year survival. With the toolset of innovations developed this could be rapidly dispersed across the NHS.

**Patient Experience**

Patient surveys sent out to all patients who attended Surgery School, demonstrated that 97% of patients rated the surgery school as good or very good and 91% of patients recommended the Surgery School to friends or family. Patients appear to feel generally empowered and enjoy the structured preparation ERAS+ affords them as they build up to their surgical cancer event. The understanding that they are a key part of their own recovery resonates well with both patients and relatives and gives them some control back. This is supported in a very much joined up multidisciplinary-patient-family team approach. The CMFT team are continuing to strive to improve pathways and innovations through patient and family feedback supported by a large team of specialist Macmillan nurses.

**Partner involvement**

**Regional Innovation Fund England (RIF)**

Funding from an NHS England RIF award was used to fund weekly time for the medical lead of ERAS+, and also funded time for preliminary data collection as ERAS+ was introduced. This dataset was taken on by the critical care data collection team and funded on-going data collection – this is termed the Manchester Surgical Outcomes Project, and is based at CMFT.

**Resources**

**Video: ERAS+ - ICOUGHUK You Tube Channel**

https://www.youtube.com/channel/UCvOamR8Sb4RXENr56fRehA

**Website:** http://www.cmft.nhs.uk/information-for-patients-visitors-and-carers/enhanced-recovery-programme/icoughuk

**References:**

Should we reduce our saturated fat intake to reduce our cardiovascular disease risk?

Lee is a dietitian with a long term interest in the nutrition and hydration of older people. She is an expert systematic reviewer, has developed and managed many systematic reviews, and has been an editor for the Cochrane Heart Group for 14 years. Lee worked as a dietitian in the National Health Service for ten years, moved to research in 2000 and has since published over 80 peer-reviewed publications focussing on effects of dietary change on health. Lee is a member of the World Health Organization Nutrition Guidance Expert Advisory Group (NUGAG), and was a National Institute for Health Research Career Development Fellow from 2012-2015.

Saturated fats occur mainly in animal foods. The fat around meat (including visible fat on meat, lard and poultry skin) and in dairy foods (butter, cheese and full cream milk or yogurt) is rich in saturated fats, mainly palmitic (16:0) and stearic acids (18:0). UK recommendations suggest that we limit saturated fat intake to 11% of food energy, but on average we eat more than this in the UK, 12.6% of energy from saturated fat in 19 to 64 year olds (Public Health England, 2014). So should we all be reducing our saturated fat intake down to 11% of energy?

To assess the effects of reducing saturated fats on health the World Health Organization Nutrition Guidance Expert Advisory Group (WHO NUGAG) group commissioned new or updated systematic reviews of the following study types:

- the effect of saturated fat reduction on health outcomes in randomised controlled trials (RCTs)
- the effect of saturated fat reduction on biomarkers such as lipids in shorter highly controlled trials;
- the relationship between saturated fat intake and health outcomes in observational studies, adjusted for important confounders.

(Hooper, Martin, Abdelhamid, et al., 2015; de Souza, Mente, Maroleanu et al., 2015; Mensink, Zock, Kester et al., 2003).

### Systematic review of RCTs with health outcomes

A Cochrane systematic review of trials of adults with or without cardiovascular disease (CVD) was undertaken, randomised to reduced or usual saturated fat intake for at least 24 months, which measured mortality and/or cardiovascular morbidity (Hooper, Martin, Abdelhamid, et al., 2015). 15 RCTs with 59,000 participants were included. Meta-analysis of the 15 included RCTs suggested no clear effects on all-cause mortality, cardiovascular mortality, CHD mortality or stroke (see Table 1), but 17% fewer people who had reduced their saturated fat experienced cardiovascular events (statistically significant), 10% fewer a myocardial infarction (marginally significant) and 13% fewer coronary heart disease (CHD, marginally significant). Mean duration of included studies was 4 to 5 years.

This statistically significant reduction in CVD event risk was robust to multiple sensitivity analyses including removal of the largest trial (Women’s Health Initiative), meta-analysis methods, and removing studies where saturated fat or total cholesterol were not significantly reduced in the intervention arm. While included RCTs were not perfect effects in subgroups of trials with good allocation concealment, that were appropriately blinded and without

<table>
<thead>
<tr>
<th>Effects on numbers of people suffering from:</th>
<th>Effect size in meta-analyses of trials comparing reduced to usual saturated fat over at least 24 months:</th>
</tr>
</thead>
<tbody>
<tr>
<td>all-cause mortality</td>
<td>RR 0.97 (95% CI 0.90 to 1.05), 55,858 participants, 12 RCTs</td>
</tr>
<tr>
<td>CVD mortality</td>
<td>RR 0.95 (95% CI 0.80 to 1.12), 53,421 participants, 12 RCTs</td>
</tr>
<tr>
<td>CVD events</td>
<td>RR 0.83 (95% CI 0.72 to 0.96), 53,300 participants, 13 RCTs</td>
</tr>
<tr>
<td>CHD mortality</td>
<td>RR 0.98 (95% CI 0.84 to 1.15), 53,159 participants, 10 RCTs</td>
</tr>
<tr>
<td>CHD events</td>
<td>RR 0.87 (95% CI 0.74 to 1.03), 53,199 participants, 12 RCTs</td>
</tr>
<tr>
<td>MI, fatal &amp; non-fatal</td>
<td>RR 0.90 (95% CI 0.80 to 1.01), 53,167 participants, 11 RCTs</td>
</tr>
<tr>
<td>non-fatal MI</td>
<td>RR 0.95 (95% CI 0.80 to 1.13), 52,834 participants, 9 RCTs</td>
</tr>
<tr>
<td>Stroke</td>
<td>RR 1.00 (95% CI 0.89 to 1.12), 50,952 participants, 8 RCTs</td>
</tr>
</tbody>
</table>

CI: confidence interval, CVD: cardiovascular disease, MI: myocardial infarction, RR: relative risk
systematic differences in care between arms were very similar to the overall meta-analysis effects. This suggested that lower validity was not inflating the effect size. The level of reduction in CVD events did not appear to alter by primary or secondary prevention, study duration or sex so advice to replace saturated fats with polyunsaturated fats appears appropriate for men and women, CVD patients and the public.

A crucial issue is what to replace the energy from saturated fats with. While the subgroup of studies that replaced saturated fat with polyunsaturated fats showed 27% reductions in people experiencing CVD events (RR 0.73, 95% CI 0.58 to 0.92), replacing saturated fats with protein or carbohydrates was not protective. A similar pattern was seen for those experiencing CHD events (Figure 1). Only one small study replaced saturated with mono-unsaturated fats, and in another Cochrane review there were insufficient RCTs directly comparing replacing saturated fat with polyunsaturated or monounsaturated fats to compare health effects (Hooper, Summerbell, Thompson, et al., 2012).

There was no suggestion that reducing saturated fat intakes worsened cancer mortality, cancer diagnoses or blood pressure, but saturated fat reduction reduced body weight and body mass index just as much as total fat reduction (saturated fat reduction lead to weight reduction of 2.0kg compared to controls (95% CI -3.7 to -0.3kg), while total fat reduction lead to falls of 1.5kg (95% CI -2.0 to -1.1kg compared to usual fat intake in adults (Hooper, Abdelhamid, Bunn et al., 2015)).

Figure 1. Meta-analysis of the effects of reduced saturated fat intake on people experiencing CHD events, subgrouped by macronutrients substituted for the missing saturated fat (some studies replaced with several macronutrients so appear more than once).

...continued on next page
Systematic review of observational studies
De Souza’s systematic review included observational studies reporting associations between saturated fat intakes and health and mortality outcomes (de Souza, Mente, Maroleanu et al., 2015). Meta-analysis of most-adjusted results of high vs low intake suggested no association between higher saturated fat intake and all-cause mortality (RR 0.99, 95%CI 0.91-1.09), CVD mortality, total CHD (RR 1.06, 95%CI 0.95 to 1.17), ischaemic stroke or type 2 diabetes, but suggested non-significantly increased CHD mortality in those with greater saturated fat intakes (RR 1.15, 95%CI 0.97-1.36). They did not assess associations with CVD events.

A recent non-WHO systematic review of observational studies that assessed associations between circulating fatty acids and coronary disease (which corrected its data soon after publication) found non-significant suggestions of increased risk of coronary disease associated with both palmitic (RR 1.15, 95%CI 0.96–1.37) and stearic (RR 1.23, 95%CI 0.93–1.61) acids, the main dietary saturated fats associated with meat and dairy intake (Chowdhury, Warnakula, Kunutsor et al., 2014).

Neither of these reviews of observational studies directly assessed the crucial effects of substitution, of what was being consumed in place of saturated fat. In the discussion De Souza suggests that replacement with polyunsaturated fats may have greater effects.

Systematic review of trials with lipid outcomes
Meta-analyses of controlled trials found that replacing 1% of dietary energy isoenergetically with saturated fats increased LDL cholesterol by 0.032mmol/L (95%CI 0.025-0.039, 43 studies) and the most favourable total cholesterol:HDL ratio was achieved when saturated fats were replaced by polyunsaturated fats (Mensink, Zock, Kester et al., 2003). This review is in the process of being updated for WHO.

Summary of the evidence
The reviews on health outcomes concur in a lack of relationship between saturated fat intake and all-cause or CVD mortality, at least within the confines of study reliability. Such effects could possibly be evidenced with longer RCTs or in cohorts that measure saturated fat intake better over time. They also concur in suggesting some health effect on combined cardiovascular events, coronary events or coronary deaths (the difference between coronary and cardiovascular events is generally inclusion or not of stroke). The review of lipid trials concurs with RCTs with health outcomes that replacing saturated fat with polyunsaturated fats has the most favourable effect.

None of the individual trials or cohort studies were perfect. Long term trials of health outcomes suffer from lack of control over dietary intake and lack of blinding (implicit in getting participants to follow a dietary intervention over a long period of time). Shorter trials of lipid outcomes were much more tightly controlled in terms of dietary intake and can be blinded, but there remains a need to infer health outcomes from effects on lipids. Cohort studies can show effects of diet on long term health outcomes, but suffer from confounding effects – those who eat less saturated fats consistently choose healthier lifestyles in terms of smoking, exercise, other dietary patterns, and tend to be wealthier, better educated, with better social support and health insurance – so appropriate adjustment is key. Cohort studies and longer term RCTs tend to assume long term dietary patterns from one or a handful of lipid or dietary assessments. This means that none of the study types, and none of the systematic reviews of any study type, is perfect in addressing the effect of reducing saturated fat on health, though perhaps short controlled dietary trials of lipid outcomes have the edge, given the strong relationship between LDL cholesterol and cholesterol:HDL ratio and cardiovascular risk.

Overall the systematic review evidence suggests that reducing saturated fats improves lipids and reduces cardiovascular events, when replaced by polyunsaturated fats. Lifestyle advice to people with, or at risk of cardiovascular disease and also to lower risk groups should continue to include permanent reduction of dietary saturated fat and replacement by polyunsaturated fats.

References:
Elaine Mcnish
Director of the British Heart Foundation
National Centre for Physical Activity and Health

What is your current position and what was your career path that took you there?

I am the Director of the British Heart Foundation National Centre for Physical Activity and Health (BHFN C). We’re based at Loughborough University and sit within the new National Centre for Sport and Exercise Medicine.

I’ve worked in the physical activity sector for nearly thirty years. During this time I’ve experienced looking at physical activity from a number of different perspectives. I’ve worked within a governing body of sport, for a local authority and in public health; I’ve also worked in the Welsh Government. More latterly I’ve worked in the charity sector with Macmillan and am now supporting the work of the British Heart Foundation.

What challenges do you face in your current position and which has been the greatest one?

Change is always a challenge. In the past few years we have seen public health in England going into local government and ever present cuts in services, particularly leisure and other services that impact on the support that is available for people to become more active.

We’re very lucky that we have been supported by the British Heart Foundation for the past 15 years but we recognise that charities also face funding challenges so it is important that we ensure that we maximise the impact of our work so every penny counts.

In your opinion, what are the top three issues affecting the care of older people?

In the area of physical activity I think there is a skills gap in terms of practitioners who work in the care industry understanding the benefits of physical activity and how they can encourage their clients to be more physically active.

I think there is also a need for the fitness and leisure industry to recognise the needs of older people more when they are looking at their planning; older people are not a homogenous group and leisure providers need to provide support for people that are in different transitions of their life; those that are still very active, those that are beginning to experience some functional difficulty and those who are frailer. I think we need to make sure that leisure staff are trained to work with older people effectively and services are aligned to meet a wide range of needs.

There are also challenges around how social care is going to be delivered in the future and how that impacts on people’s continued support. Physical activity needs to be integrated into care planning so that people can maintain independence for longer.

What changes in elderly care do you anticipate in the next few years?

I’m hopeful that the role that physical activity has in maintaining people’s independence for longer will get recognised. The evidence of the benefits physical activity has on physical and psychological health is increasingly growing, but also the impact it has on conditions such as dementia. I’m hopeful that as a result of this there will be more commissioning of services that have physical activity at their core, an increase in older people’s knowledge of the benefits of physical activity and as a result better support to maintain active and healthy lives.

If you hadn’t become Director at the BHFN C, what might you have done?

I’ve always had an interest in sciences and health sciences in particular so I suspect I would have ended up in physiotherapy or something similar.

What experience has influenced your career the most?

For me it’s some of the key people that I have worked with over the years. I’ve been really lucky to have so many really good mentors and role models who have influenced me and supported me in what I’ve done. For example in my early career, Professor Tom Riley, was one of my key lecturers at Liverpool Polytechnic. I was fascinated by the areas he taught - life sciences - and this sparked my interest in that even more.

What advice would you give to someone contemplating following in your footsteps?

I think I’ve always known what I’m interested in and have a passion for but I’ve not always known my exact career pathway so I would say look for and grab opportunities that excite you when they arise.

Where do you go for advice and information?

The BHFN C has a wonderful website with information on physical activity that I find really helpful; it has a variety of evidence reviews and briefings which we produce. I also use our weekly bulletin service so I can keep up to date with what’s going on in physical activity. I’m also very lucky that we sit within a University where I can access research papers relatively easily. I believe in learning from people as well, including others that I work with and I also learn a lot on Twitter.

Who would you most like to work with?

I am really keen to work more closely with the care sector to understand and learn more about its needs and how physical activity can be promoted on the ground.

What do you enjoy doing when you are not working?

I like getting out and about in the open air. I enjoy walking, cycling and a bit of running; anything that gets me outside.

What do you do in a typical working day?

Every day is different. It depends on what pieces of work we have going on. My role is to support staff and to provide help and advice and a sounding board for them. At the moment we’re particularly looking at planning for the future and learning and understanding what our priorities should be going forward. Every day is a learning experience.

If you were stranded on a desert island what would be your one luxury?

I’d like a solar powered Kindle so that I can keep reading and continue to learn. I’d like it to have music too so I could do a bit of dancing and singing.
In our next quarterly issue of Innov-age we will be looking at Diabetes and Older People.

Average life expectancy is reduced for those with diabetes. Treatment and self-management amongst older people can present additional challenges due to complications associated with ageing. Life expectancy between those with Type 1 and those without reduces as the age range increases. In Type 2 diabetes, the average reduced life expectancy for someone diagnosed in their 50s is about 6 years. Join us for the next issue of Innov-age where our contributors share their knowledge and experiences of this and other important eldercare issues.