**Sexual Activity and Ageing**

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**Sexuality and Ageing: Perspectives of a Cognitive Psychologist**

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**Sexually Transmitted Infections (STIs) in the Older Population**

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Overcoming Issues Affecting Sexual Function

Kate Bennett discusses the importance of physiotherapy for sexual health, whether that be for pelvic floor dysfunction or improving musculoskeletal and rheumatological conditions.

IntimAge: Improving Sexual Communication between Health Professionals and Older People

The University of Sheffield have identified an unmet need in the field of sexual communication between health professionals and older patients. This has seen the development of IntimAge, a resource consisting of an e-learning platform, guidelines and materials for professionals.

Contributors:

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Welcome to issue 18 of Innov-age, focusing on the topic of sexual health.

Numerous challenges and opportunities arise from a rapidly ageing population; however the sexual health of this demographic is often overlooked in academia and the media. In many cultures it is regularly reported that sexual health in the elderly is a taboo subject, as well as the myth that sexuality disappears as you age. This issue looks to dispel this myth and portray the research taking place in this area.

Leading this issue, Mary Ni Lochlainn offers an insight into sexual health and the elderly. She discusses views from multiple perspectives including healthcare professionals and personal attitudes. Hayley Wright follows this with an interesting piece from the perspective of a cognitive psychologist and elaborates on the links between sex and cognitive ageing.

David Lee outlines the challenges and changes in relation to sexual health and satisfaction in later life. David’s article addresses sexual activities and attitudes in men and women in older age. To add to this issue, Kate Bennett promotes the work of physiotherapists in relation to sexual health, an often overlooked discipline in this area. Kate references pelvic floor exercises, rheumatological and musculoskeletal components such as hip replacements and recommends regular exercise and good communication with health professionals as a way forward.

Riccardo De Giorgi offers great insight and distinguishes between appropriate and inappropriate sexual behaviour in dementia. Sharron Hinchliff and Stephanie Ejegi-Memeh discuss a relatively new online platform, IntimAge, developed from identifying an unmet need in relation to communication in sexual health between older patients and health professionals. IntimAge aims to dismiss concerns for professionals and offers guidelines and materials to support an increased level of communication.

Evidently no systematic reviews were found to include in Cochrane Corner but a blog that aims to make Cochrane evidence accessible has encouraged discussion in areas including “No sex please, we’re menopausal!” and “Asking about your sex life isn’t vulgar, it’s vital.”

The Family Planning Association (FPA), the sexual health charity, believes a positive attitude towards older people’s sexuality and relationships is a vital part of promoting positive sexual health throughout people’s lives and ensuring that access to sexual health advice, support and services is there when required. Over the years, sexual health services have become readily acceptable for younger people to access. The key point this issue identifies is that there is still work to do to change the culture around sexual health and the elderly.

Samuel Bulford offers his insight of how he broached this somewhat ‘out-of-bounds’ topic to garner ample information from older patients as a then humble medical student with the hope to encourage more researchers to actively invest in this area.

Jackie Oldham
Honorary Director, Edward Centre for Healthcare Management Research
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Sexual Activity and Ageing

Mary Ni Lochnainn is an Academic Clinical Fellow in Geriatric Medicine, based at King’s College Hospital, London. Mary has just completed her term as British Geriatric Society (BGS) junior member’s representative on their trainee’s council, and continues to sit on their e-learning working group. Mary’s interest in sexual activity and ageing began following a successful submission to the BGS Amulree Essay prize. You can find Mary’s tweets @Younggeris.

Sexuality is an important component of physical and emotional intimacy that people experience throughout their lives. Research suggesting that a high proportion of men and women remain sexually active well into later life refutes the myth that ageing and sexual dysfunction are inexorably linked. Age-related physiological changes do not necessarily render a meaningful sexual relationship impossible or even difficult. Many of these physiological changes are modifiable and healthcare professionals can play a role in addressing these.

Are older people actually having sex?
The answer is yes. Lindau et al (2007) conducted a longitudinal survey and clinical study on the sexuality in a nationally representative cohort of 3005 US adults aged 57-85. Seventy-three percent of respondents aged 57-64, 53% aged 65-74, and 26% aged 75-85 were sexually active. In the oldest age group, 54% of sexually active persons were having sex at least twice a month (Laumann et al, 2007).

A recent study released by the Irish Longitudinal Study on Ageing at Trinity College Dublin (TILDA) on Valentine’s Day 2017 paints a positive picture of sexual lives of older adults in Ireland. The research involved over 8000 adults over 50, and found that frequent sexual activity is the norm with 59% being sexually active and of those, 69% sexually active weekly or monthly (Orr, McGarrigle, Kenny, et al., 2017). These results clearly counteract the stereotype of the “asexual older person” (George & Weiler, 1981).

There are significant gender differences in the incidence of sexual activity that are also apparent in adolescence and throughout adulthood (Meston, 1996). Lindau et al (2007) reported that 78% of men aged 75-85 reported having an intimate relationship, compared to 40% of women in this age group. It is a well-known fact that women live longer than men. The 2006 Irish Census concluded that by age 85 years or older, there are 2.25 women for every man (Central Statistics Office, 2012). As such, lack of opportunity may account for a large proportion of these gender differences. Indeed, in a study of men and women older than 70, 52% of women and 38% of men who were sexually inactive cited “no partner” as the main reason (Smith et al, 2007).

Lesbian, gay, bisexual, and trans-gender (LGBT) older adults and their sexual health needs must also not be forgotten. A report by the National Gay and Lesbian Task Force estimated the number of older LGBT individuals in the United States in 2000 to be approximately 3 million, and this could expand to 4 million by 2030 (Cahill et al 2000). There are very few services specific to the needs of these adults, and resistance to providing these services has been reported at agency level (Knochel et al, 2012). As the population continues to age, the needs of this sector of the population will need to be addressed.

So what about women?
Research shows that the prevalence of sexual dysfunction in women is high (Valadares et al, 2008). Laumann et al. (1999) reported a 43% prevalence, while in 2007; Lindau et al. reported 50%, illustrating a frustrating lack of progress in this area over the course of the decade.

One of the most significant periods in female reproductive ageing is menopause. Women live on average 30 years after menopause (Canadian Medical Associations, 2004) indicating the importance to health care providers of providing high quality postmenopausal healthcare. Menopausal changes that arise from loss of oestrogen can include decreased vaginal lubrication, vaso-motor symptoms, and neurologic and psycho-sexual changes, including mood change, irritability, anorgasmia, decreased libido, and impaired sexual performance (Speroff, 1935).

And the men?
Lindau and Gavrilova (2010) concluded that sexual activity, good-quality sex life, and interest in sex were higher for men than for women and that this gender
gap widened with age. However, while they may still be interested, erectile dysfunction can be an issue for the ageing man. Indeed, erectile dysfunction can be considered an early marker for atherosclerosis, cardiovascular risk, and subclinical vascular disease (Billups, 2005).

**How does illness affect sexual health?**

Physical illness can affect sexual function directly by interfering with endocrine, neural, and vascular processes that mediate sexual responses; indirectly by causing pain or weakness; and/or psychologically by provoking changes in self-esteem or body image (Meston, 1997). Medical problems linked to sexual dysfunction include, but are not limited to, diabetes mellitus, hypertension, cardiac disease, prostate cancer, stroke, renal disease, lung disease, peripheral vascular disease, hyperthyroidism, lumbar disc disease, arthritis, and psychiatric disorders (Ni Lochlainn, Kenny, 2013).

The National Survey of Sexual Attitudes and Lifestyles (Natsal) reported that in Britain, poor health is independently associated with decreased sexual activity and satisfaction at all ages (Field et al, 2013). Lindau and Gavriloa (2010) reported a positive association between health in middle age and later life, and frequency of sexual activity, a good-quality sex life, and interest in sex. Flynn & Gow (2015) surveyed 133 people (mean age 74), and found both the frequency and importance of sexual behaviours were positively correlated with quality of life and sexually active adults tend to be more positive in their perceptions of ageing. They are less likely to consider themselves old and less likely to believe that ageing has negative consequences (Orr, McGarrigle, Kenny, et al., 2017).

Sexual activity is equivalent to mild-moderate physical activity, in the range of 3-5 metabolic equivalents (METS) (Levine et al, 2012). Evidently there is a strong link between a satisfactory sex life, good health, and better quality of life.

Interestingly, one study found a significant association between sexual activity & number sequencing and recall in men, and between sexual activity and recall in women (Wright & Jenks 2016) suggesting that maintaining a healthy sex life in later life could be beneficial for cognitive function.

**What role can healthcare professionals play?**

Although sexuality is an important means of expressing love and caring in older persons (Campbell, 1995), it receives scant attention in the education and training of health care professionals and is rarely detailed when taking a history and conducting a physical examination.

Lightner (2002) reported that fewer than 5% of older women volunteered their sexual problems during visits to their general practitioner; however, when specifically asked by the general practitioner, nearly 20% shared their sexual concerns. De Boer et al. (2005) carried out a study in the Netherlands and reported that 85.3% of men with erectile dysfunction wanted help, but only 10.4% of the men received medical care. In the United States, Lindau et al. (2006) reported that most women thought that doctors should ask about sex (75%), yet only 55% reported a doctor discussing sex with them since they turned 60 years old. Indeed a systematic review in 2012 reported that the majority of healthcare professionals do not proactively discuss sexuality issues with service users (Dyer & das Nair, 2015).

There is currently a Cochrane blog running on this topic, aiming to tackle reluctance to talk about this issue with patients (http://www.evidentlycochrane.net/problem-with-sex-reluctance-talk-harming-patients/). Understanding the sexual changes that accompany ageing may help doctors give practical and useful advice on sexuality as well as refute misconceptions that ageing equates to celibacy. Awareness of this aspect of older people’s quality of life can raise meaningful expectations for ageing patients.

**How do attitudes play a role?**

Waterman (2012) reported that college students were more surprised and more disgusted by incidents of sexuality of those who were 70-75 than those who were 30-35. Allen et al. (2009) suggests one reason for the negative attitudes towards older persons could be the media’s portrayal of the elderly as frail and asexual. Negative societal attitudes about older people’s sexuality may inhibit the discussions between patients and their doctors (Gott et al. 2004). With the existing stereotypic image of older people being sexually inactive, improved research, education, and policy are needed to ensure that age-related barriers to seeking information and treatment for reproductive health issues do not persist for older adults.

**Can people have sex in nursing homes?**

The transition into residential care can mark the end of many types of freedom for older adults. It can be
distressing for residents to eliminate sexual activity from their lives when entering a home (Spector & Fremeth, 1996). Although this is changing, many couples are still separated on admission (Parke, 1991). A systematic review in 2015 looked at the perspectives of nursing home residents and found that overall they had a positive attitude towards aged sexuality (Mahieu & Gastmans, 2015). Barriers to sexual expression in nursing homes may include lack of privacy, attitudes of staff, lack of knowledge among staff, and opinions of residents’ family (Stubbins, 2011).

The prevalence of inappropriate sexual behaviour ranges between 2% and 17% of patients with dementia and is more commonly seen in men (Black, Muralee & Tampi, 2005). There is no clear evidence on the best approach for dealing with this. More research is needed in this area for patients and health care workers alike.

Regular sexual activity is a normal finding in advanced age; many older people are sexually active despite the increase of sexual dysfunction as they get older. As such, appropriate consideration must be given to the needs of the ageing population in the planning and delivery of health care, and institutional and support services to help sustain their right to a sex life after 65.

The ageing population and increase in mean life expectancy has made older people and their well-being a matter of ever-increasing concern. It is imperative to have a thorough understanding of adults’ sexual behaviour and concerns, and to ensure that education programs, research, policy, and services are available to both the public and to professional communities so as to provide a more comprehensive service to this growing sector of the population.

References:
Lindau S, Gavriloa N., (2010). Sex, health, and years of sexually active life gained due to good health: evidence from two US population based cross sectional surveys of ageing, BMJ.
Sexuality and ageing research: perspectives of a cognitive psychologist

Dr Wright has a background in applied psychology, neuropsychology and neuroscience. She has broad research interests in the ageing brain and how we can protect cognitive function as we age. Hayley has led research projects on health and lifestyle factors that can influence cognitive function in healthy (non-clinical) ageing populations. More recently, she has explored the link between sexual activity and cognitive function in later life, and the biopsychosocial mechanisms underlying this association.

Research shows that slower cognitive decline in later life is associated with increased engagement in mental, social and physical activities (Valenzuela & Sachdev, 2006; Marioni, et al., 2012). That is, increased engagement in mental, social and/or physical activities can offer domain-specific (e.g. memory, attention, language) protection against cognitive decline (Wright, et al., 2013).

Given what we know about the neuroprotective factors of social, physical and mental activities, it is surprising that very little research has focussed on the potential influence of sexual activity on cognitive function. We already know that sexual activity is associated with positive wellbeing in older age (Lee, et al., 2016), and it is feasible that sexual activity could function as a form of social activity, physical activity, or both.

A novel study was undertaken, which showed a significant association between sexual activity and cognitive function in men and women aged 50-89 years (Wright & Jenks, 2016). Results showed that men and women who were sexually active had better scores on tests of memory and number sequencing than those who were not sexually active. It is interesting that these significant associations remained after adjusting for potentially mediating factors such as age, physical activity levels, depression, loneliness and quality of life. This was the first study of its kind, and further studies are now underway to follow up on specific research questions as detailed in the following section.

As better cognitive function is associated with increasing engagement in mental, social and physical activities in later life (Wang, et al., 2013), it is possible that increasing engagement in sexual activity may correspond to better cognitive function. Working with colleagues at University of Oxford, the association between increasing frequency of sexual activity (none, monthly and weekly) and specific cognitive domains using scores from the Addenbrooke’s Cognitive Examination (Hsieh, et al., 2013) in a sample of 73 participants aged 50-83 years has been explored (Wright, Jenks & Demeyere, 2017).

The study showed that as the frequency of sexual activity increased, so did the scores on tests of all cognitive domains. After adjusting for mediating factors (age, gender, education and cardiovascular health), weekly sexual activity was significantly associated with better scores on a verbal fluency task, in comparison to no sexual activity. The results support the existence of domain-specific associations between sexual activity and cognitive function in older adults; the biopsychosocial underpinnings of this are now being explored.

In another on going study, it has been shown that different sexual activities (e.g. intercourse, masturbation, petting/fondling) are associated with different cognitive functions, with opposite associations for men and women (Wright, Lee & Jenks, 2017). Furthermore, the research around sexual activity has highlighted issues with sexual health help-seeking in older adults. In a nationally representative sample, only 18% of older adults who have concerns about their sex life actually seek help for those concerns (Wright & Forshaw, 2016). This has implications for sexual health service provisions, as well as potential knock-on effects on cognition and wellbeing. A collaboration with Relate is currently exploring barriers to accessing relationship services that may be experienced by older adults and marginalised groups.

Exploring why sexual activity is linked to cognitive function can help to develop education strategies and interventions to promote healthy cognitive ageing. In addressing potential barriers to accessing relationship and sex therapy, many older people can be connected to sources of support to improve social and intimate relationships in later life.

References:
Challenges and changes: sexual health and satisfaction in later life

Dr Lee is a Research Fellow based at the Cathie Marsh Institute for Social Research, School of Social Sciences, University of Manchester. David is an epidemiologist and his research interests focus on how multiple biological, psychological and social problems impact on late-life health, quality-of-life and emotional wellbeing. He has been involved in several large-scale studies including the English Longitudinal Study of Ageing (ELSA) and the European Male Ageing Study (EMAS).

When we consider society’s prevailing view of late-life sexuality, the predominant view is often that older people are not particularly sexually active or interested in intimate sexual relationships. These preconceptions can be extreme, ranging from humour to disgust, or simply a refusal to believe that people in their 70s and 80s have sexual interests or needs. However, positive intimate sexual relations are increasingly recognised as a key aspect of health at all ages and practice and policy need to adapt to better support the sexual and intimate lives of older adults.

While there are clear differences between how older adults experience sexual desire, activity and satisfaction as compared to younger people, older people over the age of 50 generally remain sexually active, with sexual health an ongoing concern for men and women well beyond the reproductive years (Laumann et al., 2006; Lindau et al., 2007). These sexual activities and attitudes are outlined in figure 1 below in relation to the population group of men and woman aged 50-90+ years old in England.

In isolation, increasing age doesn’t necessarily result in reduced sexual activity and sexual problems (DeLamater and Koepsel, 2014). However, ageing-related changes in biology and health, such as declining sex hormones, chronic illness and the side effects of long-term medications, do influence the frequency of sexual activities in later life (Gillespie, 2016). Findings from the English Longitudinal Study of Ageing (ELSA) and the third National Survey of Sexual Attitudes and Lifestyles (NatSAL-3) have highlighted that common chronic conditions and poorer self-rated health were more likely to be associated with decreased sexual activity and functioning among men as compared to women (Field et al., 2013; Lee et al., 2016a). In addition, sexually active men aged 50 and over reported more concerns about their sexual activities and function than women and, with increasing age, these reports tend to become more prevalent among men and less prevalent among women (Lee et al., 2016a). The ELSA data also revealed that older women were less dissatisfied with their overall sex life than men, and reported decreasing levels of dissatisfaction with increasing age.

Historically, sexual health research has tended toward a biomedical perspective, where sexual problems and difficulties are considered as ‘dysfunctions’ with an underlying physical cause and thereby medically treatable (Marshall, 2012). More recently, research on later life sex and sexuality has recognised the broader contexts in which sexual relationships take place, and has increasingly considered how relational and psychological factors contribute to older people’s sexual activity and satisfaction (DeLamater and Koepsel, 2014). This concern has also been reflected in the literature where it is also argued that the partnership aspect of a couple’s sexual relationship is commonly overlooked in research and clinical practice (Verschuren et al., 2010). Indeed, what may be considered the key biological predictors of sexual health, such as chronic disease, sex hormones and medication use, only explain a relatively small amount of

![Figure 1 – Sexual activities and attitudes in England, men and women aged 50-90+ years (2012)](image-url)

*Reported by those who said they engaged in any sexual activity in the past 12 months. Source: English Longitudinal Study of Ageing (ELSA) 2012
the variation in sexual expression among older people (DeLamater and Koepsel, 2014).

An increasing number of population-based surveys have highlighted relationship conflicts, lack of emotional closeness, not sharing the same sexual likes/dislikes and habituation of sexual activities as important factors explaining declining sexual desire and satisfaction in later life (Laumann et al., 2006). Discordant partnership factors have been shown to be associated with an increased likelihood of reporting concerns about and dissatisfaction with overall sex life in both men and women (Lee et al., 2016a). Some participants in ELSA reported that changes in their health led to them being more likely to engage in non-penetrative sexual activities, and it was the quality of the relationship that was of primary importance. Other couples, however, reported mismatches between themselves and their partners with respect to their individual desires and expectations concerning their sexual relations and overall relationship. Given that for most older people intimacy and sexual relations is a “coupled” activity, the partnership aspect of a couple’s sexual relationship should not be overlooked in either research or clinical practice.

An emerging area of investigation has highlighted the importance of positive sexual expression and intimacy with respect to higher levels of happiness and well-being. From a basic perspective it would seem reasonable to argue that sexual well-being and satisfaction would be related to well-being, but empirical evidence backing up this assertion has remained lacking. Recent research has demonstrated that within the context of a partnered relationship continuing sexual desire, activity and functioning are associated with higher subjective well-being among both women and men (Lee et al., 2016b). These are important findings as reduced subjective well-being is associated with an increased risk of premature mortality, coronary heart disease, diabetes, disability, and other chronic disorders (Stetkevych et al., 2014). If one argues that the well-being of older people is an important objective, both from a health perspective and by extension economically, then it seems reasonable that sexual health, and resources to maintain it, should be extended a higher priority within broader health policy.

The importance of positive sexuality and intimacy in the broader context of successful ageing demonstrates the necessity for health professionals to proactively engage with older people to better manage problems that impact on both individuals and couples sexual health and function. Continuing to build the evidence base to identify the determinants of positive sexuality in later life will inform policy and practice, as well as help develop positive health messages and lifestyle guidance to maximise the quality of sexual and intimate relations irrespective of age. While the quantitative data from studies such as ELSA and Natsal provide a valuable measure of the current burden of poor sexual health in later life, narrative findings from a number of qualitative studies (Hinchliff et al., 2017; Tetley et al., 2016) better describe the diversity of late-life sexual experiences and behavioural adaptions that older people use to maintain satisfying intimate relationships. It is important to stress that although data such as these can improve public health by countering stereotypes and misconceptions about late-life sexuality, and offer older people a reference against which they may relate their own experiences and expectations, a ‘one size fits all’ model of sexual ageing is clearly not warranted. While survey data can illustrate key issues that impact on the sexual health and well-being of older people, imposing norms of sexual health into discourses around health and ageing would be over-simplistic and even unhelpful. Nonetheless, health professionals need to act on these emerging data and be more open about discussing sexual health with older people – it can’t simply be assumed to be an irrelevance.

A key challenge now is to effectively exploit both quantitative and qualitative findings to explore how sexual difficulties intersect not only with age and gender but also with sexual identity, ethnicity, disability and social class. Aspiring to the World Health Organisations declaration that “sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity”, will require a concerted research effort to build an evidence base to inform improvements in sexual health services for older people.

References:
Can sex in later life improve brain health?

Research explores if sex for the over 50s can protect – and even improve – cognitive functions

A short blog from our very own contributor Dr Hayley Wright discusses research which explores the correlation between sexual activity and cognition in older age.

The research established that there is indeed an association between sexual activity and higher scores on tests for cognitive function in people over the age of 50 years. The article highlights that they have simply revealed an association between two variables – a correlation. However, the article states we need to be cautious when interpreting correlation data; there are many spurious relationships that can be detected if we look for them. For example, the divorce rate in Maine in the United States correlates with the per capita consumption of margarine!

To find out more please visit: https://www.theguardian.com/higher-education-network/coventry-university-partner-zone/2016/feb/15/can-sex-in-later-life-improve-brain-health

More elderly people being diagnosed with STIs

STIs in people aged 50-70 have risen by more than a third over the last decade

An increasing number of older people are contracting sexually transmitted infections such as chlamydia and genital warts, according to England’s Chief Medical Officer. In 2010, sexual health clinics recorded 11,366 new infections among this age group, which rose to 15,726 in 2014 – an increase of 38%. Another of our contributor’s Dr David Lee wrote the report chapter on sexual health, and told The Independent a number of societal factors could be behind the change. The most commonly diagnosed STIs in 2014 among those of the age-range identified were found to be warts, chlamydia, herpes and gonorrhoea. The report also examined other health concerns, cautioning that diabetes is also becoming an increasing problem.


Older people’s sexual health concerns ‘dismissed due to their age’

Researchers said healthcare workers should proactively talk about sex with older patients

According to The Telegraph; a study suggests older people’s problems in bed are being dismissed by GPs because pensioners are seen too old to be having sex. The study, published in the journal of Ageing and Society, examined the sex lives of more than 1,000 people aged 50-90 from around England. Respondents of both sexes expressed concern that they had not been taken seriously as they sought to overcome issues affecting their sex lives.

For further information please see: http://www.telegraph.co.uk/news/2016/12/06/older-peoples-sexual-health-concerns-dismissed-due-age/
Lust for life: why sex is better in your 80s

Sexually active older people are considered a curiosity, but a new survey suggests that lovemaking is often more fulfilling for ‘sexual survivors’ than those in middle age.

In a report co-authored by Dr David Lee and Professor Josie Tetley using data from the English Longitudinal Study of Ageing, David states that while physical challenges e.g. erectile difficulties, occurred more frequently with age, the emotional side of sex appeared more fulfilling for people over 80. Men and women in this age bracket reported more shared sexual compatibility and emotional closeness than those in their 50s, 60s, and 70s. David reiterates that we need to get used to the idea that some older people may want a fulfilling sex life – and take seriously the means to allow them to do this.

Read the full article here: https://www.theguardian.com/lifeandstyle/shortcuts/2017/feb/14/lust-for-life-why-sex-is-better-in-your-80s

Upcoming Events...

Small but significant – Innovation, Impact and Evidence: Practical Housing interventions to improve older people’s health and wellbeing  13 July 2017
Care & Repair England is offering free places at a forthcoming conference, supported by the British Society of Gerontology and the University of Manchester’s Institute for Collaborative Research on Ageing (MICRA). This event will examine the evidence, cutting edge practice and related policy in the field of increasing safe independence home living for older people. Issue 19 of Innov-age will follow on nicely from this event as it focusses on home adaptations for the elderly.

ESHMS 4th Special Interest Meeting: Discourses of Health in Old Age
24 August 2017 - 25 August 2017
The aim of this Special Interest Meeting is to examine critically the discourses of aging and health in Europe and their implications for national, European and global contexts. The format of the meeting will be in-depth discussions of high quality paper presentations. They are keen to receive submissions from are postdoctoral researchers and PhD students in the final stage of their research. Early PhD students are welcome when accompanied by their supervisor.
http://www.sussex.ac.uk/sociology/outreach/sociology-conferences/eshsms

Celebrating 20 years of Population Ageing Research at the University of Oxford
26 September 2017 - 28 September 2017
Emerging Researchers Conference for graduate students and postdoctoral researchers will provide an opportunity to network and present research to an international research community. The Conference will combine international keynote speakers with themed sessions on biology and ageing, cognition and the brain, changing demographic and socio-economic environments and ageing, and technology and ageing.
Overcoming issues affecting sexual function

Kate Bennett is a specialist physiotherapist with extensive experience working with the older population in a variety of settings. She is based in the NHS in Southampton, providing services to people in the community. Kate is vice-chair of AGILE, the association of physiotherapists working with the elderly population.

A couple of weeks ago I was discussing a patient with a colleague. She had asked me to review this lady and provide some exercises for her back pain. My colleague was relating how when performing one of the stretches the lady in question had started giggling; on being asked what was so funny she replied: “it reminds me of having sex with my husband. I do so miss having sex.” I hasten to add the exercise was only a simple muscle stretch!

In the older population sex can be a very taboo subject. The population is ageing and more and more focus is being placed on issues affecting older people. However, sexual health is rarely discussed by health professionals and equally patients are often also embarrassed to bring these issues up during consultations. The Department of Health (2001) published the National Service Framework for Older People, a comprehensive document outlining the issues affecting older people and recommendations around these issues. However, it made no mention of any issues affecting sexual activity or sexual health that affect this population.

Physiotherapists may not be thought of as the first person to discuss sexual issues with. Indeed when searching journal databases for physiotherapy and sexual function no publications come to light. However there are some simple physical issues that may be affecting elderly peoples sex life that a physiotherapist could advise and provide treatment for.

Pelvic floor function
Pelvic floor dysfunction is thought to affect one third of all women (Aschkenazi & Goldberg, 2009). However in women over the age of 55 the incidence is thought to be much higher, and could affect as many as half of all women in this age group.

The pelvic floor consists of a series of muscles, ligaments and connective tissues that support the pelvic organs. Common issues in older women include prolapse (when the structures of the pelvic floor fail to support the pelvic organs internally) and incontinence (the involuntary loss of urine or faeces), both of which can affect sexual function (Trowbridge et al, 2006). A number of studies have shown that women undergoing pelvic floor training programmes reported an increase in sexual function (Weber, Walters & Piedmont, 2000) and studies demonstrated a significant reduction in the number of women reporting decreased sexual function (Zahariou, Karamouti, Papaionnou, 2008). Pelvic floor exercises have also been shown to have a significant beneficial effect on erectile dysfunction in men and should be considered as the first line of treatment (Dorey et al, 2005).

Pelvic floor exercises can be performed easily as part of a daily routine. They are discrete to undertake and can be done in lying, sitting or standing positions. For advice about how to perform them correctly or for advice regarding pelvic floor issues there is an association of Pelvic, Obstetric and Gynaecological Physiotherapy (PGOP) who will be able to provide specialist advice and information (http://pogp.csp.org.uk/)

It’s all about logistics
One of the basic components of sexual activity is the ability to move freely and without pain. Sadly for a number of older people musculoskeletal and rheumatological conditions prevent this, making sexual activity difficult. In one study up to two thirds of people undergoing a hip replacement reported difficulties due to hip pain and stiffness rather than loss of libido (Meiri, Rosenbaum & Kalichman, 2014). The surprising outcome of hip and knee replacement surgery is that sexual function has been shown to improve significantly due to the reduction in pain (Rathod et al, 2013).

Hip and knee replacements are becoming commonplace in the older population. The main issue with sex after hip and knee replacements is around positioning to accommodate the surgery and the
wound. After surgery for a hip replacement there is a risk of dislocation in the immediate time period directly after the operation. Whilst sex is not completely off limits a general rule of thumb is ‘if a walking aid is needed patients are probably not quite ready’. When ready, patients should also be aware of which positions to avoid minimising risk. This often depends on the approach taken by the surgeon to perform the surgery (anterior or posterior), the extent of surgery and any pre-existing health conditions.

Knee surgery does not carry the same risks but there will be issues with kneeling or deep knee bends. A good time to discuss this is at the 4 – 6 week post-surgery check-up by either the surgeon or physiotherapist. The exercises provided by the physiotherapy team after surgery are designed to help patients return to normal (pre-surgical) level of function including return to sexual activity. PeerWell have produced an app with lots of information about hip and knee replacements in general including how and when to return to sex, and positions to embrace and avoid: https://www.peerwell.co/blog/2016/05/25/sex-after-joint-replacement-surgery-how-to/

The same advice applies also to back pain. Back pain is the most prevalent health condition leading to functional limitations in older adults (Wong and Samartzis, 2016). However, by finding the right position a full and active sex life can still be enjoyed without aggravating symptoms. In cases of ongoing back pain physiotherapy can help by providing gentle exercises to strengthen core muscles and support the spine more effectively which can help to relieve any pain.

Finally it is important not to underestimate the effects of regular exercise on sexual function. A study by Bacon et al (2003) found that exercise was associated with a much lower risk of erectile dysfunction while obesity was associated with a much higher level. In women exercise has been shown to increase sexual function for those on anti-depressants as well as all the other benefits it brings.

An open relationship
In short there are no barriers to maintaining an active sex life into older age. With some advice and planning, and guidance from healthcare professionals, issues can be addressed and worked with to ensure people’s needs are met and intimacy in relationships is maintained. A large part of this is the duty of healthcare professionals to talk about the subject of sex; indeed there are calls to make it a standard part of any medical or health related assessment because it is so frequently overlooked but considered to be so important. If anyone is struggling with sex they should not be afraid to speak up. There are lots of resources providing help and advice out there and local GP or local physiotherapy services should be able to advise how to access appropriate services. It’s time to lift the taboo!

References
What is inappropriate sexual behaviour in dementia?

Dr Riccardo De Giorgi is a core psychiatry trainee at Oxford Health NHS Foundation Trust in Oxford. He has shown an interest in old age psychiatry since his medical studies at ‘Università Vita-Salute San Raffaele’ in Milan. He has developed his clinical experience with older adults during his foundation training in Aberdeen and core training in Oxford. He collaborates in research within the University Department of Psychiatry in Oxford and has published articles about mental health in elderly people. He aims to become a clinical academic with an interest in dementia.

Sexuality in older adults and dementia

Sexuality is a key aspect of human nature throughout the life cycle. People frequently have sex at times when conception is not achievable, such as in older age, upholding the notion that human sexual behavior can serve both reproductive and non-reproductive functions (Symons 2017). Tenderness, warmth, emotion, passion, and contact are all substantial for the bio-psycho-social wellbeing of older adults (Torrisi et al. 2016). The general population has historically perceived sexual expression among the elderly as non-existent, grotesque, or even sordid (Kessel 2001). Conversely, several epidemiological studies show that 50-80% of individuals over 60-years-old are sexually active (Comfort & Dial 1991; Marsiglio & Donnelly 1991). The issue around sexuality becomes more challenging when considering older patients affected by dementia, because of ethical and legal underpinnings that include respecting the principles of autonomy and capacity to consent (Lichtenberg & Strzepk 1990; Kamel & Hajjar 2004). The ageing population and resulting growing prevalence of dementia syndromes warrant further research and improved healthcare practices around sexuality in later life and its relationship to dementia. However, this is an often-neglected area that, if addressed properly, has the potential to contribute significantly to the quality of life of people with dementia, their carer, and their family (Benbow & Beeeston 2012). Hence, an indispensable first step is to differentiate between what is appropriate and inappropriate sexual behaviour in dementia.

Appropriate versus inappropriate sexual behaviour in dementia

The definition of appropriate sexual behaviour in dementia is problematic as it mostly relies on the reversal of what is considered inappropriate, and vice versa. A previous study coded sexual behaviour as appropriate (e.g., sitting in close contact with arms or legs touching; caressing on the face, hands, or arms; kissing), ambiguous (e.g., being unclothed outside personal spaces, brushing against another person, fondling self on breast or genitals in public), and inappropriate (e.g., expressing indecent sexual comments, touching someone other than partner on breast or genitals, touching partner on breast or genitals in public, exposing breast or genitals in public) (Zeiss et al. 1996). Although detailed, this classification does not account for several confounding factors. For instance, public exposition of intimate parts in patients with dementia can be a consequence of fever and severe pain, or an effort to disengage from restrictions such as excessively tight clothing (Johnson et al. 2006). Moreover, sexual appropriateness is interpreted differently by different subjects, according to their personal history, their cultural background, their societal views, and their religious beliefs (Hajjar & Kamel 2003a). Likewise, other parties including carers, families, and professionals may easily misinterpret sexual activity of elderly individuals with dementia because of prejudice and erroneous assumptions (Hajjar & Kamel 2003b).

Here, we support the value of a holistic model whereby inappropriate sexual behaviour is part of the symptom cluster of behavioural and psychiatric disturbances in dementia, is disruptive and distressing, is impairing the patient’s care, and needs to be understood in the context of previous ideas and expectations of the person.

Overall, there is a tendency to label elderly people with dementia as displaying inappropriate sexual behaviour because of a few convincing instances (Torrisi et al. 2016). It is important to reassure patients and relatives that several pharmacological and non-pharmacological treatments are available once the problem has been identified (De Giorgi & Series 2016). However, a thorough assessment needs to be carried out before considering any intervention that has the potential to diminish the quality of life of the patient and to violate an incontestable right of the person. Professional bodies should incorporate specific training requirements in their curricula and appropriate training must be provided by institutions caring for older adults affected by dementia who may experience inappropriate sexual behaviour.

References:
IntimAge: improving sexual communication between health professionals and older people

Sharron Hinchliff is a Senior Lecturer at the School of Nursing and Midwifery, University of Sheffield. She has a PhD and a BSc (Hons) in Psychology, and has conducted research into gender and health for over 20 years. Sharron currently leads the sexual health and well-being, ageing, and gender programme of research which focusses on understanding health-related behaviours to improve health and inform professional practice. She has published extensively in these areas, and her co-edited book ‘Addressing the sexual rights of older people: Theory, policy and practice’ is due for publication in 2017.

Stephanie Ejegi-Memeh is a PhD candidate at the School of Nursing & Midwifery at the University of Sheffield. She is a registered nurse with international experience in migrant health, well-being of older women and communication in primary care.

On Friday 24th March 2017, Cochrane UK began a two-week campaign which explored the topic of sexual communication between health professionals and patients. The problem with sex: Is our reluctance to talk about it harming patients? was based on the argument that patients should be able to have ‘honest discussions’ with health professionals about treatment options for sexual difficulties in the context of chronic health conditions.

Research at the University of Sheffield has identified unmet need in this area with older patients. A key finding was that older people and health professionals involved in their care experienced barriers to communication about sexual health and sexual wellbeing (Gott et al, 2004; Gott & Hinchliff, 2011). The majority of older participants reported that sex was important to their quality of life, and that their general practitioner (GP) was the first point of contact if they experienced a sexual difficulty. However, they also identified barriers to seeking help and these included attributing the sexual difficulty to ‘normal ageing’, feeling embarrassed, fearing the underlying cause, the GP’s demographic characteristics (e.g. gender and age), and the perceived attitude of the GP towards later life sexuality. Many older people mentioned that their GP had not asked them about sexual matters even if they, the patient, thought that it was relevant to their consultation.

The GPs themselves reported that they did not always proactively address sexual matters with older patients. Barriers included the GP feeling embarrassed, being concerned about invading their patient’s privacy, causing offence, and ultimately breaking down the doctor-patient relationship. Indeed, GPs tended to equate sexual health with young people, and some did not view sex as a legitimate topic of discussion with older people. GPs were very much aware that sexual matters could be embarrassing for older patients, and they shared examples from their own practice. For instance, the older man with erection difficulties who ‘test out’ his GP by having two to three consultations before saying what the actual problem was. Another example was the postmenopausal woman for whom reproductive health was no longer a useful gateway to broach the topic of sexual matters in consultations. Consequently, the sexual difficulties of older female patients were in danger of not being picked-up.

The context of the medical consultation is important. One way to help overcome barriers such as the lack of openings to ask about sexual matters is the GP taking a proactive approach during consultations, including new patient and well-person checks (Sarkadi & Rosenqvist, 2001; Wakley & Chambers, 2002). However, GPs in the Sheffield study above identified that training at medical school was inadequate in this area as it focused predominantly on the sexual and reproductive health issues of young people. They therefore felt that they lacked the skills to manage later life sexual concerns in an appropriate way, including knowing how to initiate discussions about sex with older patients. Training at undergraduate and postgraduate levels regarding sexual health and older age was highlighted by GPs as potentially highly beneficial.
Health professionals and researchers have worked together to develop ways of improving this aspect of care for older people. A European team has designed a resource specifically directed towards facilitating sexual communication between professionals and older people. The IntimAge project, led by the University College of Health Sciences, Slovenia, included a consortium of educational and training providers from Austria (Association for Interdisciplinary Education and Consulting), Germany (Friedrich-Alexander University), Slovenia (Integra Institute), Italy (University delle LiberEita), the U.K. (University of Sheffield), Ireland (National University of Ireland, Galway) and Greece (GJNet: the Greek Academic Network). It involved the design of health promotion materials that focus on intimacy and sexuality in the third age, to help raise professional awareness and understanding of the sexually-related issues older people can face.

The resource consists of an e-learning platform, guidelines, and a toolbox of materials for professionals to use in their assessment of, and interactions with, older patients. It is available online; there is no need to register or supply an email address, and it is free to use. Funded by Erasmus+, a European Union based education and training programme, the resource is available in five languages: English, Italian, German, Slovenian, and Greek. It can be accessed by this direct link: http://etraining.intimage.gunet.gr/

The resource has four main modules:

- Module 1: sexuality & the third age
- Module 2: relationships & intimacy
- Module 3: long-term care
- Module 4: professional practice & ethics

Each module consists of four or five individual units which cover key issues for older people’s sexual health and well-being. These include: ageing in context; active ageing; changes in sexual practice; sexually-transmitted infections; sexuality with or without a partner; same-sex issues; relationship changes; long-term care; sexual practices in long-term care; communication around sexuality; intercultural competence and cross-cultural communication; residential care facilities and dementia; and sexual violence.

IntimAge has been developed with health professionals in mind. However, other professionals and service providers whose work brings them into contact with older people may benefit from the resource and training materials. Allowing flexibility for learners, users can complete the whole course or sections of it at their own pace. Educators can download the materials to use with services and organisations where they deliver training to health professionals. IntimAge is available under a Creative Commons Attribution – Non Commercial – No Derivatives License, so users are asked to give appropriate credit and provide a link to IntimAge in their own resources. The license prevents the use of IntimAge for commercial purposes.

While recognising that not all older people will be sexually active or want to be, sex is important to the quality of life of many. Sexual pleasure and satisfaction can be hindered by changes that occur due to the ageing process, chronic diseases, and medications, which health professionals can be ideally placed to help with. It has been argued that health professionals have a responsibility for facilitating sex-related discussions with older patients (Dunning, 2005; Nappi & Nijland, 2008). Although it is important to get this right because the relationship between healthcare professionals and patients has been recognised as one of the most significant elements of healthcare, and a major influencing factor of patient satisfaction with care (Northouse & Northouse, 2007).

References:
Investigating sexual health in older age

Samuel Bulford is a Foundation Year Two Doctor in North London, and an Honorary Clinical Teaching Fellow specialising in Pre-Hospital Emergency Medicine for University College London (UCL). He has delivered a number of national and international presentations on this subject, and continues to lead the Undergraduate pre-hospital care programme at UCL. As part of the six-year undergraduate degree, Samuel studied primary care and it is through this intercalated Bachelor of Science degree that he completed his work around sexual health in older age.

The traditional view of an asexual older age is no longer relevant and in fact the number of Sexually Transmitted Infections (STIs) diagnosed amongst over 45 year olds in some parts of the UK doubled in the short space of time between 1996 and 2003 (Bodley-Tickell et al, 2008). Between 1999 and 2008, there was a 102% increase in reported cases of Chlamydia amongst 16-19 year old women, whereas there was an increase of 119% amongst 45-64 year olds (FPA, 2010) - one example of a specific increase for a particular pathology.

The reason for such a change can be speculated upon. Society is much more open to talk about and acknowledge sex nowadays and there is greater mobility in old age. There are also treatments for sexual dysfunction (such as Viagra and to some extent Hormone Replacement Therapy (HRT) for women). Whatever the reason behind it, there is great evidence to suggest that more elderly people are engaging in sexual habits which cause them to have an increased incidence of STIs. Indeed, the Family Planning Association (FPA) ran a campaign in late 2010 aimed directly at older individuals encouraging them to wear condoms and reduce the spread of STIs (FPA, 2010). However, there is very little research into how current and potential patients feel about the current sexual health service provision for STIs and how, if at all, they would like the service altered to better suit their needs and wants.

To address the paucity of research in this area, patients who self-identified as over 45, sexually active, single and heterosexual, were recruited through a North London GP practice, over the space of 4 months. These attributes were chosen as, in speaking to expert clinicians in this area, this group was felt to be the most underserved by current sexual health provision. Full NHS ethics approval was granted for the project. Fourteen participants were recruited and undertook recorded semi-structured interviews. Analysis principally used Pope and May's thematic framework technique (Pope et al, 2006) for this predominantly qualitative data.

The results comprised three principal themes. The first was ‘who to see’, with participants expressing a lack of knowledge of the availability and walk-in nature of sexual health clinics. Some participants felt the most appropriate place to seek medical attention was the emergency department. Participants consistently stated they would, if at a sexual health clinic, ideally like to see an older clinician as they felt they may be judged by younger staff for ‘not having known better.’

This concern was also present into the second theme – ‘Barriers in accessing services’. Study participants felt concerned younger people in the same clinic space may be judgemental. Interestingly, participants felt this same potential to feel awkward around their GP, many of whom had been the patient’s principal clinician for many years.

The final theme concerned the ‘ideal characteristics of [the] specialist service’. Practical points concerning later opening hours to fit around scheduled work predominated, as did the desire for a separate service for older people in the same way there is for younger people. A wider feeling concerned the desire for sexual health services to help break the more societal-wide taboo around the perceived asexuality of older age – which the study participants universally felt to be misrepresentative.

Whilst the study participants were self-selecting, there was a real desire to share, educate and help shape services. Researchers should allay their anxieties around the taboos of this subject, and engage this receptive and ever growing population.

References:
Sexually Transmitted Infections (STIs) in the older population

Dr Khaw is a Consultant Sexual Health Physician at Clinic 275, Infectious diseases unit, royal Adelaide Hospital, South Australia and Senior Lecturer, School of Medicine, University of Adelaide. Her interests include HIV medicine, STIs, medical management of Hepatitis, PrEP, mPeP, gay men’s sexual health in particular sexual dysfunction, chemsex, transgender medicine and various aspects of female dysfunction. She is passionate about sexual health education and promotion in the community and in healthcare providers, as well as research.

Sexually Transmitted Infections (STIs) are considered mostly a health concern for the younger population because of higher incidences and health consequences including fertility implications, but the potential for increased STI diagnoses in older adults exists due to on-going sexual activity.

Although STIs in older persons remain uncommon, rates appear to be increasing in 50 year olds and above (Minichiello et al., 2012; Poynton et al. 2013). In 2010, sex, genitals and breasts – socially taboo topics may be a barrier. Patients may choose to have several partners. They may travel and experience sexually transmitted infections elsew here including overseas or may finally feel comfortable after divorce, separation, as a result of aging or other life changes. They may be exposed to similar sexual health risks as younger adults. They may be less likely to get tested for STIs including HIV (Negin et al., 2012) resulting in later presentations for medical attention and perhaps resulting in more complications.

There is a need for greater sexual health awareness amongst older adults. They may be exposed to similar sexual health risks as younger adults. If older adults do not consider their sexual health, there may be a greater risk of STIs increasing dramatically.

The older population should be encouraged and supported to have increased STI diagnoses in older adults exists due to on-going sexual activity.

Early diagnoses allow early treatment, less complications, less transmission of infection. For example, with HIV, commencement of treatment early especially in older population acquiring the infection decreases complications and allow for better prognosis.

References:
Dr David Lee
Research Fellow in the Cathie Marsh Institute for Social Research

What is your current position and what was your career path that took you there?
I’ve been a Research Fellow in the Cathie Marsh Institute for Social Research at the University of Manchester for the past four years, the first three of which were funded by an Age UK Research into Ageing Fellowship. I was originally a biochemist, but a Masters in Public Health from the Karolinska Institute got me into epidemiology and survey research.

What challenges do you face in your current position and which has been the greatest one?
I’d say the usual challenges facing most academics… securing research funding, juggling time around writing papers, student supervision, research meetings, conferences and securing research funding (again)!

In your opinion, what are the top three issues affecting the care of older people?
- Funding and delivery of health and social care going forward – state provision is clearly under extreme pressure and we appear ill-prepared for the continuing demographic changes in society.
- Older people are not a homogeneous group and how best to engage with a population that spans five decades with varying resources, attitudes and needs remains a key challenge.
- Stereotypes around ageing still need to be debunked and countered – ageist prejudices only serve to diminish older people’s lived experience.

What experience has influenced your career the most?
Ironically it was redundancy from a biotech company a decade ago. That in turn instigated a family move to Sweden where I ended up studying for an MPH from the Karolinska Institute in Stockholm. Unplanned events can throw up unforeseen opportunities.

What changes in elderly care do you anticipate in the next few years?
Perhaps this is more of a personal opinion… but more emphasis and funding needs to directed at preventative social and health care services to allow older people to live in a community setting for as long as possible. Research has clearly shown that low level practical support can enable older people to live healthily and minimise ill health and a reliance on services later in life.

If you hadn’t become an Epidemiologist what might you have done?
In reality it probably would have been something else science-related, although I always fancied the idea of becoming an architect.

Where do you go for advice and information?
I’m fortunate in having a great network of colleagues from a range of different discipline areas (nursing, medicine, sociology, epidemiology, statistics etc)… certainly helps to bring fresh perspectives to the research questions I’m working on. Of course that’s not forgetting friends and colleagues outside of academia.

Who would you most like to work with?
I would simply say work with as many people from different walks of life as possible. We always run the risk of having a somewhat silo mentality in academia and a diversity of views on how to approach a particular problem can throw up unique and unexpected solutions.

What do you enjoy doing when you are not working?
I live in the Peak District so I try to fit in as much walking as I can. I’m also a member of the Derbyshire and Lancashire Gliding Club and can often be found trying to stay airborne without an engine (with varying degrees of success!). I’m also learning to play the clarinet which invariably leads to the cat promptly exiting the house when I practice…

What do you do in a typical working day?
Trying to stick to a well-intentioned list of stuff to do!

If you were stranded on a desert island what would you be your one luxury?
I think I’d cheat and be ‘stranded’ with the rest of my family (sorry kids!).

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In our next quarterly issue of Innov-age we will be looking at home adaptations and Older People.

As people age, adaptations to their home environment may become necessary. The purpose of an adaptation is to modify the home environment in order to restore or enable independent living. In 2014-15, around 1.9 million households in England had one or more people with a long-term limiting illness or disability that required adaptations to their home (Department for Communities and Local Government, 2016).