

P29 **OUT OF CONTROL? EXPERIENCES OF TRANSITIONS BETWEEN CARE SETTINGS AT THE END OF LIFE FOR OLDER ADULTS WITH HEART FAILURE: A QUALITATIVE STUDY**

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Background Transitions between care settings have been associated with poor continuity and quality of care for older people. Movements between places of care occur frequently in the months before death, making them an important influence on well-being and health status. People with heart failure may be particularly likely to experience frequent, unplanned admissions to hospital.

Objective To explore and understand experiences of care transitions for older adults with heart failure at the end-of-life.

Design In-depth qualitative interviews with 35 people with heart failure, lung cancer or stroke. Framework methodology was used for data analysis.

Participants Fifteen adults aged over 75 years with heart failure, whose hospital clinician answered "no" to the question, would you be surprised if this patient dies within the next 12 months? Half the participants were from socially disadvantaged backgrounds.

Findings Participants described how they struggled to have control over many of their end of life experiences. Their ability to negotiate their role with professionals, family and the wider world was threatened by their biographical experiences and physical helplessness. Long-standing relationships with family doctors were associated with low expectations and a perceived loss of control, particularly for the most disadvantaged people. A majority had lost all trust in their GPs, and the doctor was allowed to share in symptom management only when severe—preserving some autonomy for the older person, but threatening physical health and future choices. The rest had taken on the role of passive recipients of advice and treatment. Frequent admissions to hospital were tainted by the perception of being a burden to staff reluctant to help with basic care, and families obliged to visit.

Conclusions Notions of choice and empowerment prevalent in current health policy discourses appeared to have little relevance to the lived experiences of the older adults in this study. Without an understanding of biographical and social context, analyses of how older people experience health and social care at the end-of-life risk promoting concepts of individual control that many older adults do not enjoy. If end-of-life care policies are to produce equitable outcomes, they must go beyond simple solutions to address the complexity of relationships older adults have developed with health services over their lifetimes.

P30 **VALIDITY AND RELIABILITY OF TWO INDICATORS OF SOCIOECONOMIC POSITION IN A POPULATION SURVEY OF OLDER ADULTS**

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Objective There is increasing interest in measuring the influence of socioeconomic position (SEP) across the life-course. However, there are few cohorts that encompass the whole life-course, so many studies use data from cross-sectional studies, hence the need for ensuring the accuracy of recall of the SEP measures used. The aim of

this study was to investigate the reliability and validity of two measures of SEP: education and longest job.

Design Prospective cohort study.

Setting Large population survey of older adults from the general population in North Staffordshire, UK.

Main Outcome Measures Health Questionnaire (HQ) including a four-part question on education and a five-part question about the longest job.

Participant In two pilot studies, random samples of patients aged 50+ registered with different general practices were mailed a HQ (nested test–retest repeatability studies were included; n=500; n=160). In the main study, all patients aged 50+ registered with three different general practices were sent a HQ at baseline. 6 years later, 3410 responders consenting to further contact were mailed a follow-up HQ; a subsample of these participants took part in independent qualitative interviews, which included a reconstruction of critical landmarks in their life-course. Ethical approval was granted for all stages of the study.

Analysis Validity was assessed by: percentage completion; internal percentage agreement within each set of questions; percentage agreement of qualitative and quantitative data for age left school and longest job questions; comparing age left school data with historical change in legal school leaving age. Reliability of both questions was calculated from the pilot repeatability studies using ICC and κ , with 95% CI.

Results The adjusted response to all stages of the study was good (62–84%). In the main surveys, completion of the age left school and longest job questions was excellent (94–98%). Internal agreement within each set of questions was good (education: 80–97%; longest job: 95–100%). Comparison of survey and interview data showed good agreement for age left school (85%) and longest job (95%). The change in age left school data concurred exactly with the change in legal school leaving age implemented in 1947. Reliability from pilot test–retests was excellent for recalled age left school (ICC=0.95; 95% CI 0.93 to 0.96) and substantial for longest job (κ =0.69; 95% CI 0.55 to 0.83).

Conclusion The age left school and longest job questions in this study are valid and reliable measures.

Health behaviours/risk factors (obesity, smoking, physical activity, food)

P31 **SOCIAL CAPITAL AND HEALTH BEHAVIOUR**

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Objective To examine how different dimensions of social capital and health behaviour are associated.

Design Cross-sectional data of the Health 2000 Health Examination Survey including a personal interview and self-administered questionnaires.

Setting Representative sample (N=8028) of the Finnish adult population.

Participants 6986 (87%) adults aged 30 years or over.

Main Outcome Measures Non-smoking, non-excessive drinking, leisure-time physical activity, daily use of vegetables, adequate duration of sleep.

Results Social capital was found to be associated with health behaviour. The dimension of social participation and networks was positively associated with every type of health behaviour. High

levels of trust and reciprocity were related to non-smoking and adequate duration of sleep, and high levels of social support to adequate duration of sleep and daily use of vegetables. These associations persisted after controlling for age, gender, education and living arrangements. According to our findings, structural social capital seems to be associated with health behaviour more strongly than cognitive social capital.

Conclusion Irrespective of their social status, people with higher levels of social capital—especially in social participation and networks—engage in healthier behaviour. When trying to reduce health inequalities, one strategy could be to promote social participation especially among people in danger of social exclusion.

P32 USING EVIDENCE TO PRIORITISE AREAS FOR PUBLIC HEALTH ACTIONS FOR TACKLING CHILDHOOD OVERWEIGHT

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Objective To use evidence from systematic reviews of environmental influences on childhood overweight to prioritise areas for development of public health interventions.

Design Systematic literature reviews of intervention and longitudinal studies of environmental factors which could influence overweight via diet and/or physical activity, followed by a questionnaire-based ranking exercise for (a) the strength of the evidence for a causal association between the environmental factor and childhood overweight and (b) the likely effect size of public health actions on each factor on the prevalence of overweight in children. Environmental factors for which there was both strong evidence of causality and a larger effect size were selected for detailed modelling of the likely impact of public health interventions in children in Scotland.

Setting Children up to 8 years in Scotland.

Participants Academics and policy makers with experience of reviewing evidence of public health interventions on obesity.

Main Outcome Measure Ranking of environmental factors to identify those which should be prioritised for future public health interventions.

Results Of the twenty-four environmental factors initially identified at stakeholder workshops, no studies were found for three factors influencing physical activity and one factor affecting diet. For the remaining twenty factors a median of six (range 1–28) studies were identified and summarised in tabular form. Fourteen academics and policy makers were given the tables to complete the rating exercise, which took approximately 1 h. The strength of the evidence and the likely effect size of actions were rated on a scale of 0 (low) to 5 (high). Eight of the environmental factors obtained mean ratings >3 for both strength of evidence and likely effect size: six were factors related to diet (high energy-dense snacks, sugar-sweetened soft drinks, infant feeding, availability of high fat, sugar and salt foods and portion size of manufactured foods and of restaurant and cafeteria items) and two were related to physical activity (physical education in schools and sedentary leisure activity). The ratings were lowest for access to local amenities, safe routes to schools and provision of healthy foods in schools.

Conclusion The ranking exercise provided a structured approach for obtaining a consensus view on priorities for public health action using tables of evidence from a systematic review. Use of this approach with a larger number academics and policy makers from different sectors would be useful to assess whether the area of expertise and sector (academia vs policy) influences the rating of the evidence.

P33 TOWARDS A SMOKE FREE MINISTRY OF HEALTH IN ITALY

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Background In 2009, a health promotion initiative targeted the employees of the Italian Ministry Health aimed to promote compliance with the smoking ban and provide support for any smokers who wanted to quit, by providing free of charge tobacco cessation programme, available during working hours and in the workplace, for all smoking employees who agreed to participate in the programme. Activities included: an information seminar for employees on the risks of smoking; a questionnaire-based survey on the smoking habits of employees in the Ministry of Health head-quarter; the launch of “Groups to quit smoking” run by personnel from the Italian anti-cancer league (LILT).

Results The programme is still ongoing but some results can be highlighted: The seminar held on February was attended by over 200 employees; all employees received an information booklet on the damage caused by smoking; the survey on the smoking habits of employees was completed. Out of the 1244 questionnaires distributed, 1030 were returned (participation rate 82.8%), analyses were carried out on 994 of them. Data showed that 25.1% of employees are smokers, smoking an average of 13.3 cigarettes a day; 43% of them are heavy smokers. Sixty-three percent of smoking employees claim they want to quit, but only 40% of them were advised to do so by their physician. Non-smokers account for 50.5% of employees, and former smokers 24.4%; second-hand smoke is a serious nuisance for 61% of them. Thirty-six percent of non-smokers is exposed to second-hand smoke in different places within the Ministry, including their own room and other rooms (in 2% and 6% of cases, respectively). Four tobacco cessation courses were launched in May 2009. A total of 74 employees (29% of smoking employees) signed up. Of these, 57 participated, and after having completed the course, 32 (56%) quit smoking and 25 (44%) smoked fewer cigarettes a day. Follow-up activities 6 months after the completion of the course are currently ongoing, and the rate of abstention from smoking is above 37%, in line with data reported in the literature. A new course has been launched in January 2010, 22 employees participated and at the end of the course 32% quit smoking.

Conclusions The program seems to work, law that bans smoking together with cessation program, free of charge and during working hours, are useful to protect non smokers from passive smoking and to help smokers to quit.

P34 DEFINING A TARGET PROFILE FOR PROMOTING SMOKING CESSATION IN ITALY

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Background In Italy, smoking cessation programmes rarely consider the characteristics of people who make quit attempts during life (independently from quitting or still smoking) as an useful starting point for effective intervention. Behavioural risk factor surveillance systems can provide information about sociodemographic and health profile of smokers who express intention to quit smoking and therefore represent a potential target of cessation treatment and health promotion intervention.

Objective To evaluate the percentage of people who reported smoking cessation or at least an attempt once in the last 12 months;