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Supporting an Ageing Population: new possibilities for 'non-traditional' interventions

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Isle of Man Government

Review of Ageing Population Report

Economic Affairs

Cabinet Office

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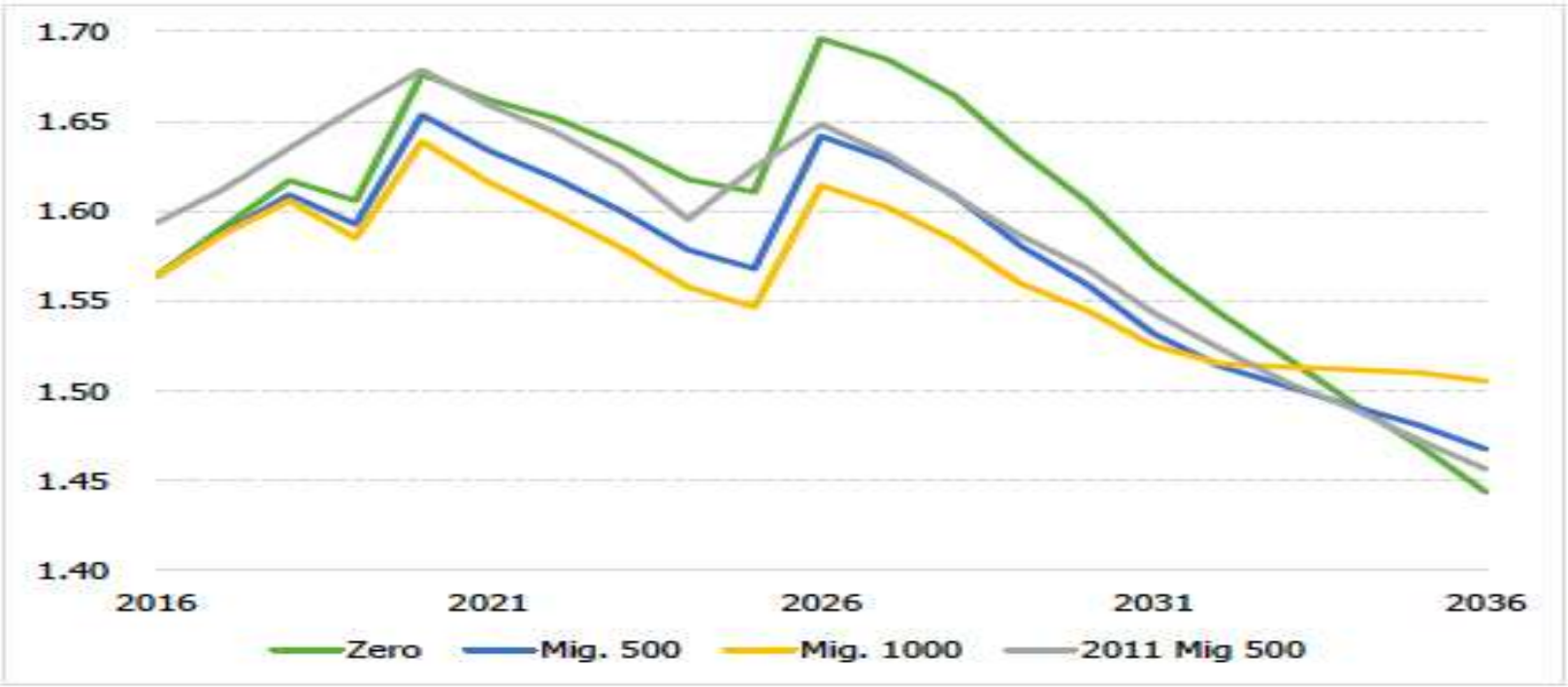
Figure 2 Isle of Man Retirement Age Population Projections 2016 to 2036

Figure 3 Projected Dependency Ratios



Appendix Two – Dependency Ratios

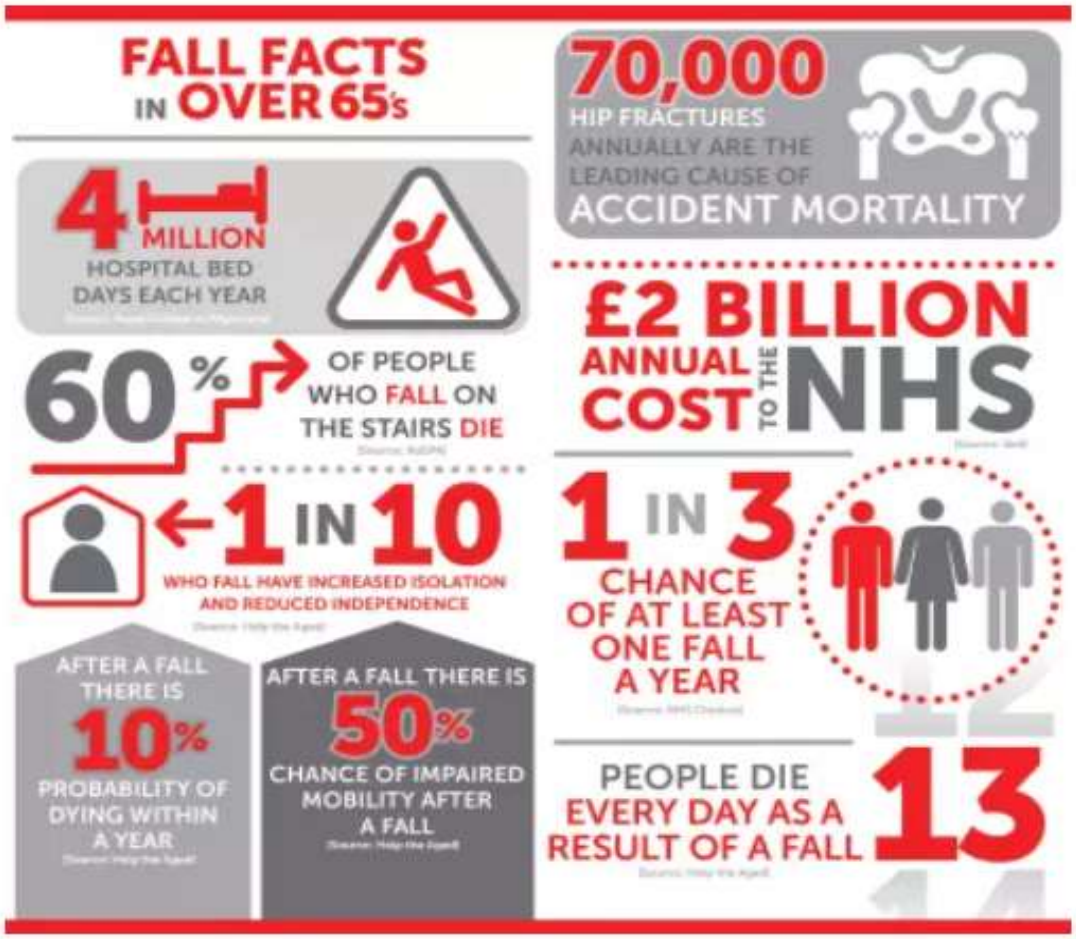
	2016	2018	2020	2022	2024	2026	2028	2030	2032	2034	2036
Zero	1.56	1.62	1.68	1.65	1.62	1.70	1.66	1.61	1.54	1.49	1.44
Mig. 500	1.56	1.61	1.65	1.62	1.58	1.64	1.61	1.56	1.51	1.49	1.47
Mig. 1000	1.56	1.61	1.64	1.60	1.56	1.61	1.58	1.54	1.52	1.51	1.51

Recommendation 25:

A fit for purpose workforce model needs to be developed to reflect the emerging needs of the new model of care. It should maximise the potential skills available within the workforce as well as the opportunity to recruit and retain high quality professionals. It will then increase the attractiveness of the Isle of Man as a career destination.

Women older than age 80 years are at a very high risk of falling.

Falls Facts in the Over 65's



Falls and associated injuries from a fall are increasing and have resulted in a demand surge for urgent and emergency care services in the United Kingdom (UK) (NHS England, 2022). A fall is defined as, *“an event which causes a person to, unintentionally, rest on the ground or lower level, and is not the result of a major intrinsic event (such as a stroke) or overwhelming hazard”* (Office for Health Improvement and Disparities, 2022).

The impact of a fall can result in reduced functional independence and can have a negative impact on quality of life (NHS England, 2022). Falls categorised as a **'long lie',** defined as *"being unable to get up from the floor for over one hour after the fall"* (Blackburn et al., 2022), increase the risk of serious injuries or admission to hospital due to medical complications including dehydration, carpet burns, pressure sores, hyperthermia and pneumonia (Fleming & Brayne, 2008).

Falls and related injuries are increasingly common, and an important driver of demand for urgent and emergency care. They can negatively affect functional independence and quality of life and, when resulting in a lie of over one hour in length, are also strongly associated with serious injuries, admission to hospital, and subsequent moves into long term care.

Not all falls result in serious injury, and a proportion of falls can be responded to by community-based response services, supporting NHS statutory services such as ambulance services to prioritise higher acuity patients. Whilst these services are already in place in many areas, there is variation in coverage across geographical footprints and population groups.

However, an injury is not always present following a fall, and, in these circumstances, it is possible to mobilise a community-based response capability, thereby releasing NHS statutory services to prioritise resources to where they are most needed (NHS England, 2022). Falls are categorised in three levels (Association of Ambulance Chief Executives, 2020):

There are two principal advantages from community-based falls response services. Firstly, to improve the outcomes and experiences of individuals who have fallen, by providing improved response times and reducing the likelihood and consequences of a long lie. Secondly, by releasing emergency ambulance response resources to the most critical demand, there are opportunities to improve overall system efficacy.

As such, all integrated care boards (ICBs) are required to have full geographical coverage between the hours of 0800 and 2000, 7
days a week, of community-based alternatives to double crewed ambulance response for level one and two falls. This applies to all falls
for adults over 18 in people’s own homes or the place they call home, including care homes.

Level one: Fall – no known illness or injury

- Patients able to state they feel well, no new pain or known injuries and felt well before or after fall
- Patient may need help getting up, or unable to by themselves
- Low acuity fall – not fallen from height, may have slipped, legs given way or known to have tripped over an object
- Falls from standing, or trips over object, may result in injury especially in individuals with low bone density; these falls require a remote clinical assessment to establish they are safe to be lifted from the floor

Level two: Fall – minor injury/illness

- An identified or suspected minor injury may include a small skin tear, wound or laceration where the bleeding can be stopped, patient may have some pain but still able to mover all four limbs as normal for them
- Minor illness, feeling unwell or having specific symptoms that on clinical assessment are not deemed life threatening

full geographical coverage between the hours of 0800 and 2000, 7 days a week, of a community-based alternative to double crewed ambulance response for level one and two falls (NHS England).

The core principles of a community-based response service include (NHS England):

- Appropriate training for falls incidents
- Dedicated clinical oversight at advanced clinical practice level
- Clinical resource to review ambulance falls incidents ‘stack’ for onward referral to community-based response services including support for escalation, onward referral and/or discharge as necessary
- Appropriate lifting equipment for individuals who have fallen and suitable training to use lifting equipment
- Referral processes to other services such as falls prevention, or to address any potential underlying issues

The Evaluation Team adopted a mixed methods approach, which involved capturing qualitative and quantitative data from several groups. Data was collected from:

- Recipients of the service
- SFRS staff involved in delivering and managing the Service
- Stakeholder organisations

Age group	Number of respondents (%)
50-60	3 (3.3%)
61-70	8 (8.7%)
71-80	26 (28.2%)
81-90	46 (50.0%)
91-100	8 (8.7%)
100+	1 (1.1%)
Total	92 (100%)

Living arrangements	Number of respondents (%)
Alone	45 (48.9%)
With partner/spouse	40 (43.4%)
With children	1 (1.1%)
With other family members	1 (1.1%)
With friends	0
Other	3 (3.3%)
Prefer not to say	2 (2.2%)
Total	92 (100%)

No. of Falls	Number of respondents (%)
None	11 (12.2%)
Once	11 (12.2%)
2 or 3 times	33 (36.7%)
More than 3 times	35 (38.9%)
Total	90 (100%)

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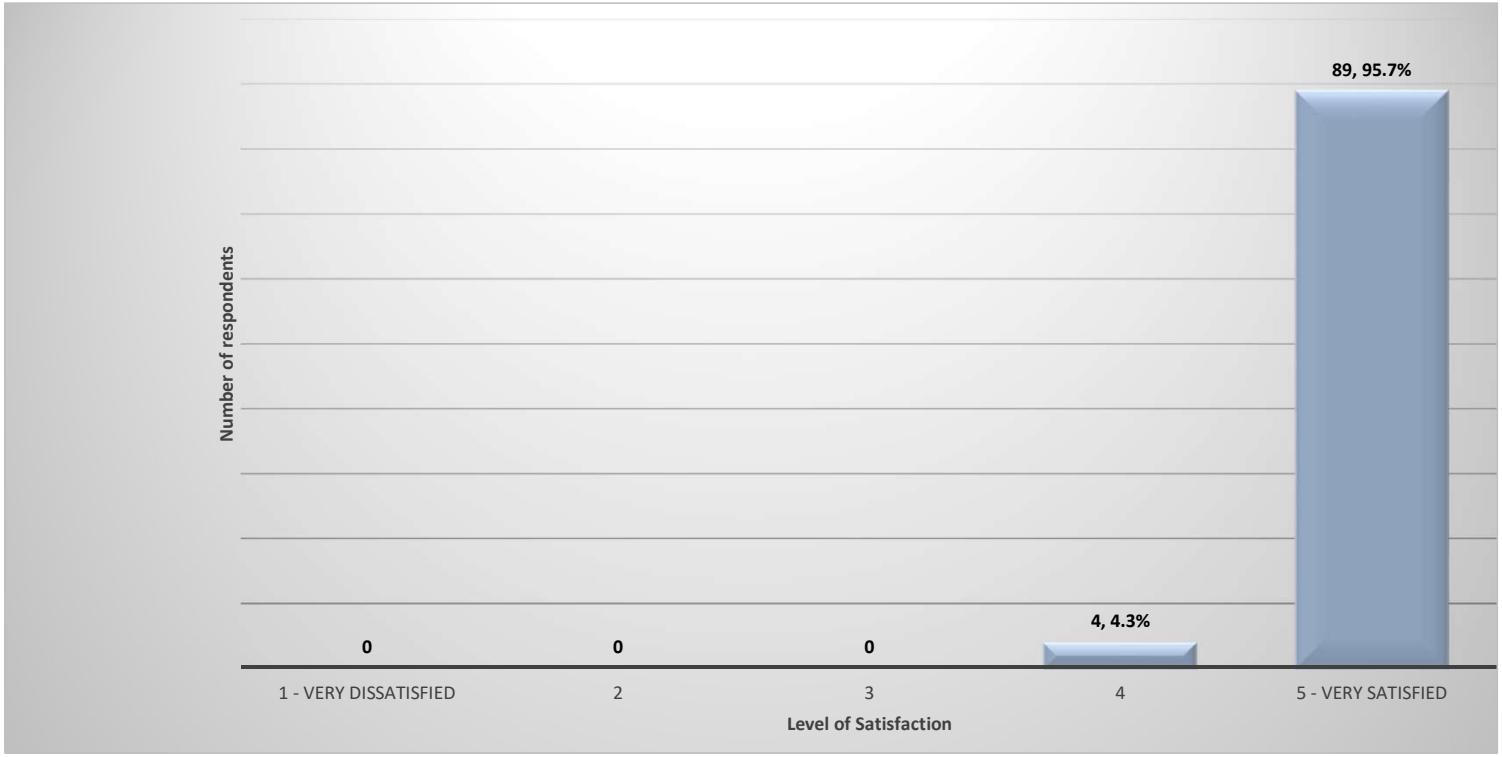
Can the fire and rescue service work with primary care toimprove identification of mental health problems in olderadults?Fisher, Tamsin; Chew-Graham, Carolyn A.; Corp, Nadia; Farooq, Saeed;Kingston, Paul; Read, Ian; Southam, Jane; Spolander, Gary; Stevens, Dean;Walchester, Mark; Warren, Carmel; Kingstone, Tom

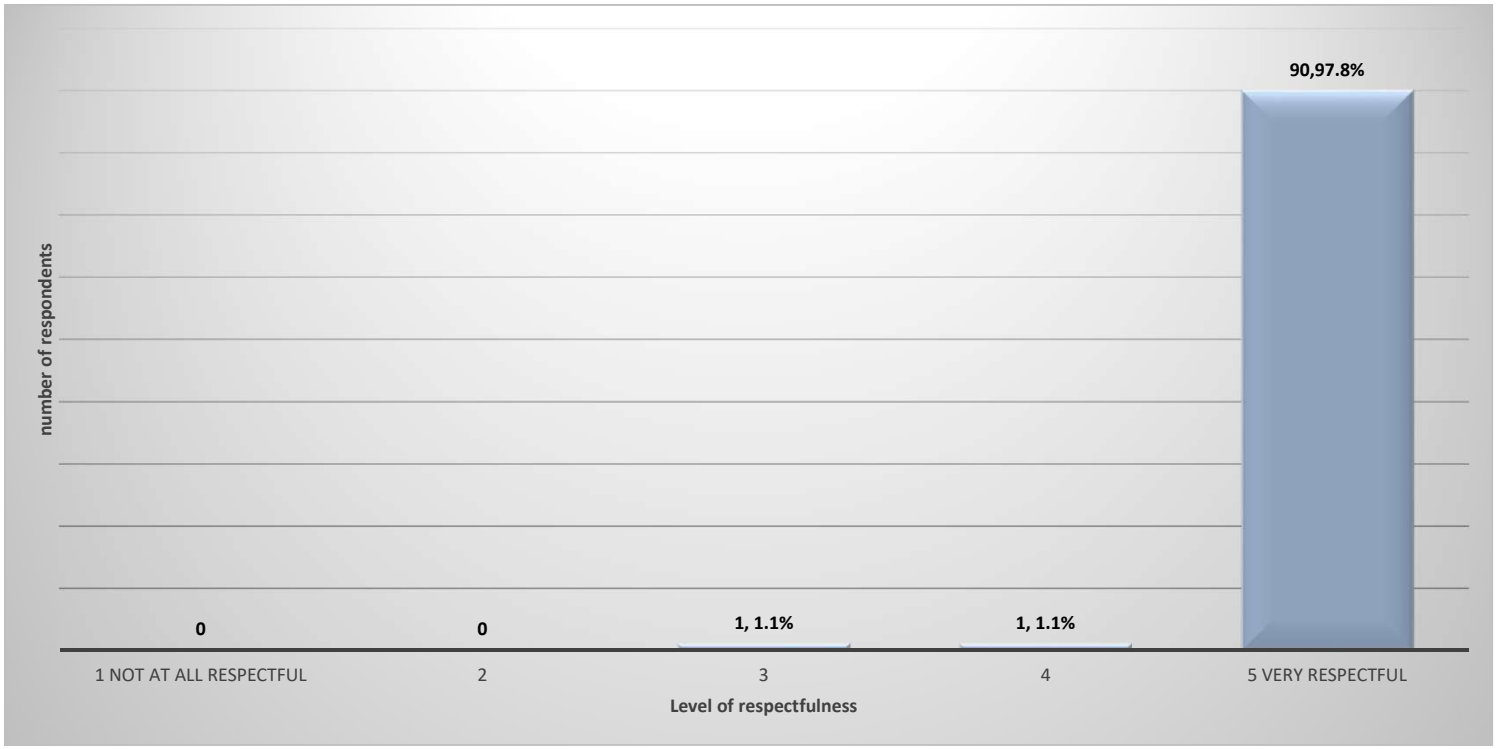
(13) (PDF) Can the fire and rescue service work with primary care to improve identification of mental health problems in older adults?. Available from: https://www.researchgate.net/publication/372635256_Can_the_fire_and_rescue_service_work_with_primary_care_to_improve_identification_of_mental_health_problems_in_older_adults#fullTextFileContent[accessed Oct 11 2023].

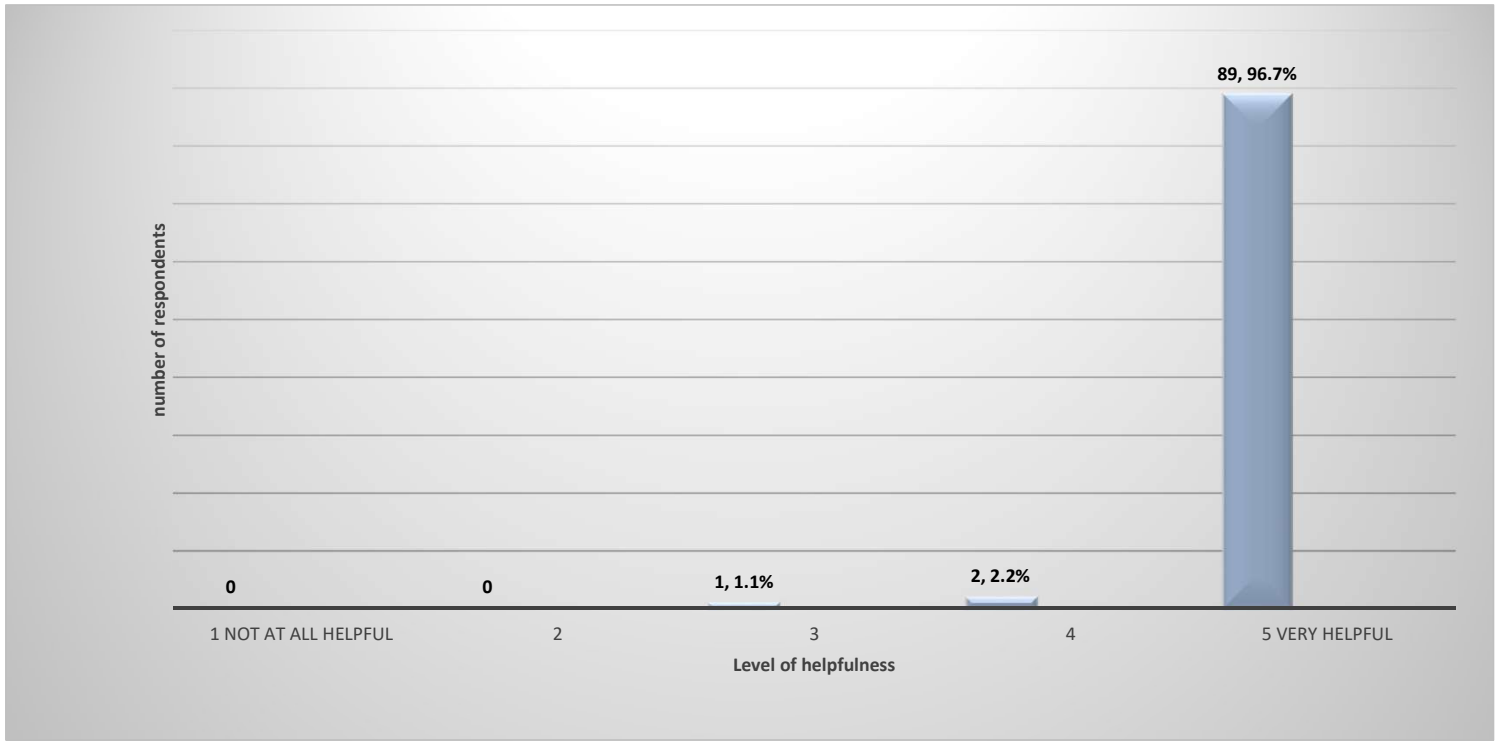
Time of fall	Number of respondents (%)
Midnight to 2.00 AM	2 (2.1%)
2.00 AM to 4.00 AM	2 (2.1%)
4.00 AM to 6.00 AM	3 (3.2%)
6.00 AM to 8.00 AM	12 (12.8%)
8.00 AM to 10.00 AM	27 (28.7%)
10.00 AM to Noon	19 (20.2%)
Noon to 2.00 PM	9 (9.6%)
2.00 PM to 4.00 PM	8 (8.5%)
4.00 PM to 6.00 PM	7 (7.4%)
6.00 PM to 8.00 PM	0
8.00 PM to 10.00 PM	2 (2.1%)
10.00 PM to Midnight	1 (1.1%)
Don’t know	2 (2.1%)

Response time	Number of respondents (%)
<30 minutes	17 (17.9%)
30-60 minutes	40 (42.1%)
60-90 minutes	18 (18.9%)
90-120 minutes	7 (7.4%)
>120 minutes	10 (10.5%)
Don’t know	3 (3.2%)
Total	95 (100%)

Action taken	Number of respondents (%)
Picked me up	74 (79.6%)
Picked me up and referred me onto another service	9 (9.7%)
Nothing – I managed to get up by myself before Staffordshire FRS arrived	2 (2.1%)
Nothing – someone else picked me up before Staffordshire FRS arrived	6 (6.5%)
I was injured so the called another service, e.g., ambulance	2 (2.1%)
Total	93 (100%)


89, 95.7%
4, 4.3%
0
0
0
Number of respondents
1 - VERY DISSATISFIED
2
3
4
5 - VERY SATISFIED
Level of Satisfaction


number of respondents
0
0
1, 1.1%
1, 1.1%
90,97.8%
1 NOT AT ALL RESPECTFUL
2
3
4
5 VERY RESPECTFUL
Level of respectfulness


89, 96.7%
number of respondents
0
0
1, 1.1%
2, 2.2%
1 NOT AT ALL HELPFUL
2
3
4
5 VERY HELPFUL
Level of helpfulness

"so when we've actually done the lift there's another sort of care package with them and a lot of time we are finding that people haven't got any smoke alarms so by the time we leave we've got working smoke alarms and that they are safe as they physically can be when we leave them" (SFRS personnel)

"it's a win-win for us…I think by us going to falls…we're finding more vulnerable people out there which is not good because they've fallen, but it's good because we're finding these people and we are aware they are there…so it's been a double win for us" (SFRS personnel)

"from my experience we are finding quite a few more people that are vulnerable out there…it's not just that we are picking somebody up" (SFRS personnel)

“The fire and rescue service were fabulous. Helped me to my chair using a blow up chair. They were considerate of my dignity and personal needs”

“I have fallen before several times and been on the floor uninjured for 20 hours, which was horrendous and resulted in a hospital stay because of the length of time I was on the floor but had no injuries at the time of the fall. This service was brilliant. Back on my feet within an hour. Staff very caring and talked me through very step”

Brilliant. I was expecting to lie on very cold, tiled floor for hours and was so relieved to receive such a prompt response. Firemen were empathetic and friendly. Assessed the situation and manoeuvred me out of the very small toilet into the hallway where they could operate their equipment to lift me into a sitting position. And then helped me get back into bed.

Exceptional, professional much needed service, caring, competent team, professionally focused on the situation and requirements of the individual in need. Brilliant link service with NHS provider. This service should be nurtured, supported and developed, to enable non-injured individuals to fell safe, confident and cared for in unforeseen difficult circumstances.

Arrived much more quickly than paramedics. I wasn't injured by the fall so prevented me using up the valuable time of the paramedics. I didn't have to go to hospital, if I had waited for paramedics and they didn't come for hours and I had been on the floor for hours they would have had to take to hospital and again I would have used up valuable NHS time.

The service "did what it said" and got someone who had fallen off me ground before an ambulance could arrive. The firemen were courteous, mindful of my pain and managed the lift well. They are not medical personnel and the service is clearly a sticking plaster for inadequate government spending for the health service. But very grateful that they came and made the situation better for all involved.

In the Socratic dialogue 'Republic', Plato famously wrote: “our need will be the real creator” (Wikipedia.org, 2020) which was moulded over time into the English proverb 'Necessity is the mother of invention'

To increase the capacity to deliver vaccinations the Human Medicines Regulations (2012) were temporarily amended in 2020 to expand the range of trained personnel permitted to administer Covid-19 or influenza vaccines, beyond healthcare professionals. This included a volunteer workforce to assist with the mass vaccination campaigns taking place against Covid-19 and seasonal influenza .

As an outcome of training, 510,540 vaccines have been administered by FRS personnel (7/1/22), including more than 82,000 by Merseyside FRS and 90,000 by Cheshire FRS . However, it is not just the delivery of vaccinations during Covid-19 that has initiated a new role for the FRS, but also the temporary shift in professional responsibilities, which could provide an opportunity for the FRS to support a wider H&SC agenda.

New possibilities

- Vaccination
- Mental Health
- Safeguarding
- Hospital discharge
- Hoarding
- Environment cleanliness/safety
- Blood pressure
- Wider general concerns

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Can the fire and rescue service work with primary care to improve identification of mental health problems in older adults?

Fisher, Tamsin; Chew-Graham, Carolyn A.; Corp, Nadia; Farooq, Saeed; Kingston, Paul; Read, Ian; Southam, Jane; Spolander, Gary; Stevens, Dean; Walchester, Mark; Warren, Carmel; Kingstone, Tom

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Falls in later life: status passage and preferred identities as a new orientation

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ABSTRACT This article argues that medical hegemony has constructed a dominant discourse around falls in later life. This medical dominance has subjected the fall to randomized control trials (RCTs) in an attempt to evaluate post-fall interventions especially in older populations. However, there has been a paucity of literature from any discipline other than medicine. This article attempts to rectify this imbalance by utilizing *status passage* and *preferred identities* as sociological theories that can offer insights into falls. First, it is suggested that *status passage* offers a useful theoretical starting point to develop critical insights into 'what it means to fall in later life'. Second, analogies are drawn from the work of Charmaz in attempting to understand the role of *preferred identities* after a fall. Finally, it is suggested that the fall is a powerful metaphor that perpetuates the homogeneous view of decremental decline in older age which serves to reinforce ageism within health and welfare agencies.

KEYWORDS *ageing; decrementalism; falls; preferred identity; status passage*

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Older people and falls: a randomized controlled trial of a health visitor (HV) intervention

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Introduction

Research shows that approximately one in three people over the age of 65 years falls in any one year, with approximately one in three falling again in the following year.[1–3] Prevalence of falls also increases with age,[4] and women are more likely to fall than men.[5] However, in advanced old age the ratio of men and women fallers reaches equal proportions.[6,7]

Injuries are noted in approximately half of the individuals who fall, and range in severity from minor soft-tissue damage to serious fractures. The Health of the Nation *Key Area Handbook on Accidents* states that accidents (of which 65% are falls) 'are an important cause of disability'. Furthermore, 'in the over-75s in England in 1991, falls were responsible for 67% of the female accidental deaths and 52% of the male accidental deaths'.[8]

A number of approaches have been found to be effective in preventing falls, including exercise[9] and the combination of geriatric medicine and occupational therapy interventions.[10] However, it is not yet clearly established which is the most successful approach. This particular paper reports an approach towards rehabilitation post-fall that utilized a Health Visitor (HV) intervention. The hypothesis tested was that such an intervention within five working days of attending an Accident and Emergency Department (A&E) with a fall would improve the medium-term self-reported functional status of elderly females who had fallen.

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Patients and methods

Patients were selected from those attending North Staffordshire NHS Hospital Trust Accident and Emergency Department (A&E) if their case record noted any reference to a 'fall'. To be included in the study, patients had to be female, aged 65–79 years, and subsequently discharged directly to their own home from the department. Males were excluded from the trial, as were those females who were either admitted to hospital or to any form of institutional care, and those individuals who could not complete the test battery because of cognitive impairment.

A total of 193 individuals fitting the above criteria were identified from case records and were randomly allocated to control or intervention groups. However, because of refusal and non-contactability, the actual sample enrolled was 109, comprising 60 intervention patients and 49 control. Recruitment is shown diagrammatically in Figure 1.

Health Visitor intervention

The intervention group received a rapid HV intervention within five working days of the index fall. Additionally, all the individuals allocated to the intervention group were care-managed on an individual requirement basis for 12 months post-fall. The HV intervention included:

1) Pain control and medication – this included advice on appropriate analgesia. The advice from the HV included the type of analgesics to use and the correct times they should be taken. It was considered important to advise individuals that it was acceptable to take analgesics, and advise on their use with other prescription medications. Pain control advice also included suggestions about the most appropriate

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