GIG CYMRU NHS WALES | Y Weithrediaeth Executive

Right care, right place, first time

Six Goals for Urgent and Emergency Care

National Community-Based Falls Response Framework for Wales

October 2024

Contents

1. Executive summary

The **National Community-Based Falls Response Framework for Wales** aims to enhance urgent and emergency care for falls, focusing on improving outcomes, system efficiency and increasing referrals to falls pathways.

Ageing Well in Wales estimates that between 230,000 and 460,000 people over the age of 60 experience a fall in Wales each year. Falls and related injuries are common and drive demand for urgent and emergency care. They can negatively affect functional independence and quality of life, especially when resulting in a long lie. Not all falls result in serious injury and community-based response services can support NHS Wales statutory services to prioritise higher acuity patients.

Community-based falls response services can enhance outcomes and experience for those who fall, improve system efficiency and focus ambulance capacity where it is needed most. However, there is variation in coverage, often restricted by geographical footprint or specific population groups.

The framework aims to:

- Enhance outcomes and experience for those who fall by improving initial response times and reducing the risk of long lies.
- Improve system efficiency by focusing ambulance capacity where it is needed most and building on existing community-based provider models.
- Increase the number of patients referred to falls pathways.
- Ensure patient safety is prioritised with local governance processes, quality monitoring and data protection measures to ensure appropriate response and referrals.

NHS Wales Health Boards and the Welsh Ambulance Services University NHS Trust (WAST) are required to work with public sector and third sector partners across the region, to:

- Establish community-based falls response services in areas where there are gaps in provision, through either extending or enhancing existing provision or providing new services where required.
- Ensure there is full geographic coverage for all falls response services 12 hours a day between 8am and 8pm, seven days a week.
- Ensure all community falls responders are appropriately trained to attend to L1 and L2 falls.

- Have clear referral pathways into falls services, that initial responders can access.
- Ensure an inclusive response to falls with appropriate clinical assessments and consistent application of the National Community-Based Falls Response Framework.

NHS England have implemented a two-hour response (with a 70% target) as part of their national guidance[1]. This approach builds on the National Institute of Health and Care Excellence (NICE)[2] guidelines. While there is not a nationally agreed target in Wales, the ambition is for a maximum response time of two hours, which is in line with NICE guidance for urgent care response.

This applies to all falls for adults over 18, including falls in their own home or the place they call home (including care homes).

2. Introduction

Falls and related injuries are increasingly common and an important driver of demand for urgent and emergency care.

Falls can negatively affect functional independence and quality of life. When resulting in a lie of over one hour in length, there is a strong association 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 Wales 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.

This document sets out key principles and requirements for NHS Wales Health Boards and the Welsh Ambulance Services University NHS Trust to work with public sector and third sector partners to improve coverage of

[1] NHS England » Community services data set technical guidance for the two-hour urgent community response standard

[2] Overview | Intermediate care including reablement | Guidance | NICE / Intermediate care including reablement | NICE

community-based falls response services across their regional footprint, with a view to:

- Enhancing outcomes and experience for those who fall, through improving initial response times and reducing the risk of long lies.
- Improving system efficiency across regions, focusing ambulance capacity where it is needed most and building on existing community-based provider models.
- Increasing the number of patients referred onto falls pathways.

3. Background

The Six Goals for Urgent and Emergency Care (UEC) National Programme, co-designed by clinical and professional leads, spans the urgent and emergency care pathway and reflects the priorities in the Welsh Government Programme for Government 2021– 2026. Our strategic aim is to prevent unnecessary escalation of care where possible, by providing proactive support and to enable access to the right care, first time for people who have a need for urgent or emergency care.

This approach aligns with the **commitments** of A Healthier Wales (2018), the Workforce Strategy for Health and Social Care (2020), the Programme for Government (2021) and the National Clinical Framework (2021), to deliver:

- A whole system approach where seamless support, care or treatment is provided as close to home as possible:
- Services designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcomes.
- A system where people only present at, or are admitted to, a general hospital when it is essential, with hospital services designed to reduce the time spent in hospital.
- A shift in resources to the community that enables hospital-based care (when needed) to be accessed more quickly.
- The use of digital change and technology to support high quality services.
- A motivated and engaged workforce with the right capacity, capability and confidence.

Our vision for urgent and emergency care is also founded on the Wellbeing of Future Generations Act (2015), 'Five Ways of Working', setting out:

- A longer-term vision for designing a seamless urgent and emergency care model along with short to medium term action requiring collaborative planning across health, social care and the third sector to optimise outcomes.
- Public involvement which has been key to shaping the Six Goals and will remain fundamental to tackling health inequalities, the delivery of personalised care and the co-design of new models of care, with a strong focus on preventive activity aimed at keeping people well and maintaining independence.
- This approach includes schemes that support people to remain safely at home, for example through healthier homes and focus on supporting individuals to manage their health conditions to avoid exacerbations that result in admission to hospital.
- Collaboration and partnership working across key partners in the Health and Social Care system, Health Boards and Trusts, Social Care, Regional Partnership Boards, the third sector and beyond, to deliver on the system changes required.

4. National Community–Based Falls Response Framework for Wales

Ageing Well in Wales estimates that between 230,000 and 460,000 people over the age of 60 experience a fall in Wales each year. Some of these falls will result in a 999 call to the Welsh Ambulance Service. Of these calls, almost half do not require an emergency ambulance.

Falls can have a devastating impact on health and wellbeing of older people. While physical injury can be significant when a fall occurs, there are also risks of negative impacts on mental health due to a loss of confidence and withdrawal. Falls can also negatively affect functional independence and quality of life, particularly with falls resulting in a lie of over one hour being strongly associated with serious injuries, admission to hospital and subsequent moves into long term care. *(Fleming J, Brayne C, 2008)*

Not all falls result in serious injury, and a proportion of falls can be responded to by community-based response services, delivered in collaboration with public sector and third sector partners, supporting NHS

Wales Health Boards and the Welsh Ambulance Service to prioritise higher acuity patients.

Level One and Two falls can often be managed by community-based falls response services. This, however, depends on the availability of resource for triage and assessment of the person who has fallen, as well as any ongoing support for escalation, onward referral or discharge as appropriate.

Use of community-based falls response services presents significant opportunities to:

- Enhance outcomes and experience for those who fall, through improving initial response times and reducing the risk of long lies.
- Improve system efficiency, focusing ambulance capacity where it is needed most and building on existing community-based provider models.

Whilst these services already operate in many areas and are delivered by a range of public sector and third sector partners, there is variation in coverage which is often restricted by either geographical footprint, hours of operation or is specific to population groups, such as people who are supported by technology enabled care services, such as lifeline/pendant alarms.

4.1 National framework implementation

As part of the implementation of the framework, NHS Wales Health Boards and the Welsh Ambulance Service are required to work with public sector and third sector partners to:

Essential activity	HBs	999	111
Map current provision of community-based falls response services that respond to L1 and L2 falls, including hours of operation and geographical cover.	X		
To identify gaps in provision, undertake an assessment against the National Falls Framework, which requires L1 and L2 falls services to be operational 12 hours a day between 8am and 8pm, seven days a week.	X		
Ensure existing provision is being utilised to its full potential by ensuring local directories of service are accurate and up to date.	X	X	X

Establish community-based falls response services in areas where there are gaps in provision through either extending or enhancing existing provision or providing new services where required.	X	X	
Ensure there is full geographic coverage for falls response services 12 hours a day between 8am and 8pm, seven days a week.	X		
Aim to achieve an urgent care response within two hours, in line with NICE guidelines.	X	X	X
Ensure all community falls responders are appropriately trained to attend to L1 and L2 falls.	X	X	
Have clear referral pathways into falls services, that initial responders can access.	X		
Ensure an inclusive response to falls with appropriate clinical assessments, and consistent application of the National Community-Based Falls Response Framework for Wales.	X	X	X

NHS England have implemented a two-hour response, with a 70% target as part of their national guidance[3]. This approach builds on the National Institute of Health and Care Excellence (NICE)[4] guidelines. While there is not a nationally agreed target in Wales, the ambition is for a maximum response time of two hours, which is in line with NICE guidance for urgent care response.

This applies to all falls for adults over 18, including falls in their own home or the place they call home (including care homes).

This guidance document is focussed on a community-based falls response as part of a National Falls Framework for Wales. While falls prevention, education and training are essential parts of the framework, they remain under development and will form part of the National Framework upon completion.

Any queries can be directed to ABB.SixGoalsUEC@wales.nhs.uk.

[3] NHS England » Community services data set technical guidance for the two-hour urgent community response standard

[4] Overview | Intermediate care including reablement | Guidance | NICE / Intermediate care including reablement | NICE

5. Requirements for community-based falls response services

It is critical that NHS Wales Health Boards and the Welsh Ambulance Service work with public sector and third sector partners to ensure an inclusive 'whole system response' to Level One and Two falls, building on existing ambulance and community-based response service provision and ensuring there are clear routes for onward referral to services including, but not limited to:

- Falls prevention
- Rehabilitation
- Fracture Liaison Services (FLS)
- Primary and Community Care providers
- Secondary care services (e.g. SDEC/acute frailty), if required.

All people who fall and are unable to get up must have appropriate clinical assessment to ascertain the appropriate level of falls response. The initial assessment should be coordinated by appropriate level clinicians within the Ambulance Trust Emergency Control Room. They should assess the person who has fallen, decide on the right level of response, despatch the appropriate and available response and continue to have clinical oversight of that response, particularly where the response is by non-clinicians.

Following the initial response there may be need for a clinical follow-up to assess the cause of the fall if not known and for further multi-factorial falls, a risk assessment must be undertaken to address any potential underlying issues. This should be provided 12 hours a day, seven days a week as a minimum.

Access criteria for community-based falls response services should be determined nationally with agreed referral processes, robust governance and clinical accountability in place.

The below community-based provision should be considered for local adoption/extension as recommended by National Clinical Leads as part of the clinical review process:

- Timely clinical advice and support is required to reduce the risk of hospital conveyance when the responder has concerns.
- Need to consider the underlying cause of the fall.
- Core information needs to be included in any referral form to allow a streamlined process.

- Consideration needs to be given to community accessible lifting cushions/equipment with associated training.
- Initial differentiation between the levels of fall is challenging, especially identifying a Level One vs Level Two fall. There needs to be a focus on the 'pick up' (with clinical advice if required) to prevent deterioration and then, any complex needs found at scene identifying the fall as Level Two can be managed subsequently with an urgent care response both remotely and face to face.
- NHS England have implemented a two-hour response as part of their national guidance[5]. This approach builds on the National Institute of Health and Care Excellence (NICE)[6] guidelines. While there is not a nationally agreed target in Wales, the ambition is for a maximum response time of two hours, which is in line with NICE guidance for urgent care response.
- Any responders to Level One and Level Two falls will require appropriate level of training.
- Staff (including care home staff) and volunteers need to be trained in the use of the ISTUMBLE as a decision support tool.
- Ensure alignment with national guidance, ensuring full geographic coverage 8am to 8pm, seven days a week for all Level One and Level Two response.

[5] NHS England » Community services data set technical guidance for the two-hour urgent community response standard

[6] Overview | Intermediate care including reablement | Guidance | NICE / Intermediate care including reablement | NICE

Level One: Fall – no known illness or injury	Level Two: Fall – minor injury/illness	Level Three: Fall – serious injury or illness
• These patients may be able to state that they feel well, do not have any new pain or known injuries and that they felt well before and after the fall. • The patient may be able to say that they want help getting up but are unable to by themselves. • The fall will be low acuity – not fallen from a height and may have slipped or legs given way or known to have tripped over an object. • Falls from standing, or trips over objects may result in occult injury especially in the elderly with low bone density. • These falls require a (remote) clinical assessment or an assessment using a recognised decision tool, such as iStumble, to establish that they are safe to be lifted from the floor. Examples of provision: • Technology enabled care (TEC) responder services (Incl: Pendant/lifeline services) • Local Authorities falls schemes • Fire and Rescue Service falls response scheme • WAST volunteers trained in falls response • St John Ambulance falls response service • Third sector community falls responders	• An identified or suspected minor injury may include a small skin tear, wound or laceration where the bleeding can be stopped. The patient may have some pain but is still able to move all four limbs as normal for them. • Minor illness, feeling unwell or having specific symptoms that on clinical assessment are not deemed life threatening. • Further clinical assessment is required by a health care professional. Examples of provision: • Urgent Primary Care • Other community-based teams providing clinical assessment and support in locally arranged 'Falls Rapid Response' teams. For example, multi-disciplinary team cars with paramedic and occupational therapist / St John response with appropriately training clinician.	• A patient who is known to have fallen but is deemed to have a life-threatening or very serious condition. This could include being not alert or a loss of consciousness, had or is having a fit, severe bleeding that cannot be stopped, has signs of a fracture, sudden confused state, breathing difficulties, chest pain or signs of a stroke, severe burns (such as falling into a fire or against a heater), has signs of a severe allergic reaction (anaphylaxis). Examples of provision • Emergency ambulance response

6. Principles for community-based falls response services: Level One and Level Two

A Level One response to a fall can be described as a non-clinical response where the person who has fallen has been triaged as having no injury or illness but requires some level of assistance to avoid further falls, poor outcomes and long lies *(AACE Falls Governance Framework).*

6.1 Core principles for Level One response

- Deploy a Falls Responder. All responders must be trained in falls response and can be deployed to both Level One falls and concern for welfare calls (which are often due to suspicion of a fall/pendant alarm activation post fall), subject to availability.
- Falls Responders can be from a variety of settings and may be already known to the patient, including (but not limited to) the Welsh Ambulance Service, Fire and Rescue Service, public and third sector partners, local authorities, St John, community organisations.
- There is dedicated clinical oversight from either within the ambulance service, the Health Board or other clinical providers within the system for Falls Responders. This should be at Advanced Clinical Practice level.
- Health Board(s) and the Welsh Ambulance Service to utilise existing clinical resource to proactively review the ambulance stack to onward refer to available Falls Responders, providing clinical support for escalation/onward referral/discharge as appropriate.
- Using location video (remote) technology, if required, to enhance effectiveness and clinical support as available.
- Ensure clear onward referral routes into existing support pathways for Falls Responders to use as appropriate including, but not limited to, falls prevention services and neighbourhood teams, community rehabilitation services, primary care services and minor injury units to address any potential underlying issues.

6.2 Core principles for Level Two response

A Level Two response to a fall would include falls with a minor injury or illness which require attendance from a healthcare professional for further assessment but may not require admission to hospital.

- Utilise and/or expand relevant clinical response pathways that are:
    - Accepting falls referrals and providing multi-factorial assessment, including the use of video (remote) assessment, where applicable.
    - Directory of Services must be up to date with falls response service details to enable appropriate onward care.
    - Working closely with other services to improve coordination of care pathways, including via coordination hubs/single points of access.
    - Ensuring robust data sets/data quality issues are addressed.

Establish partnership working between the Welsh Ambulance Service and Health Board falls services, and public sector and third sector partner initiatives, to further increase falls referrals to existing community services. For example, through Community Clinicians, expansion of Physician Triage and Streaming (PTAS).

Consider utilising other response options such as:

- Upskilling existing Falls Responders via enhanced training, where this is not already in place, ensuring there is appropriate clinical support available for onward referral where clinically required.
- Falls responder services who are commissioned and suitably trained to provide in-person response to people who have fallen and have been triaged as requiring a Level Two response. Where appropriate, they are used to complete medical observations for other NHS services.

Once these core principles are in place, NHS Wales Health Boards together with the Welsh Ambulance Service, should work with public and third sector partners to consider:

- Extending the operating hours of community falls services beyond 8pm where they can work collaboratively with ambulance services and other providers of falls response services to ensure out-of-hours cover for Level Two falls.
- Extending falls responder coverage beyond the minimum hours of 8am to 8pm, where this is a locally adopted method of falls ‘pick up’ response.
- Ensuring that clinicians can refer into appropriate services should further care or investigations be required (e.g. hospital at home, Acute Frailty Services, SDEC).

6.3 Core principles for Level Three response

- A patient who is known to have fallen but is deemed to have a life-threatening or very serious condition. This could include being not alert or a loss of consciousness, had or is having a fit, severe bleeding that cannot be stopped, has signs of a fracture, sudden confused state, breathing difficulties, chest pain or signs of a stroke, severe burns (such as falling into a fire or against a heater), has signs of a severe allergic reaction (anaphylaxis).
- Should a fall that has been pre-classified as Level One or Level Two and turns out to be a Level Three, the Responder needs a clear pathway to escalate to the Welsh Ambulance Service for a clinical response.
- Consider conveyance to a Minor Injury Unit if appropriate.

7. Management of falls in care homes

Falls are the highest cause of incidents within NHS Wales and nationally it is the second leading cause for accidents in the home. It is estimated 130,000 older people will fall at least once in Wales this year. *(D'arcy, 2023)*[7]

Falls in care homes carry a significant burden both to the individual and to the Health and Social Care system. There are high individual/personal and socio-economic cost to falls, with a cost to the NHS of £2.3 billion annually. Approx 25% of falls in care homes result in serious injuries and up to 40% of admissions from care homes are falls related *(Care Inspectorate. Managing Falls and Fractures in Care Homes for Older People. 2016*[8]*).*

There is a growing body of evidence demonstrating the efficacy of alternative pathways for falls in care homes. Partnerships between tech enabled care providers, independent equipment providers, NHS Wales Health Boards, the Welsh Ambulance Service, public sector partners, third sector partners and care homes have been shown to safeguard residents who fall, support care home staff in their decision-making after a person has fallen, and to reduce the cost of post-fall responses to the Health and Social Care system.

[7] sbuhb.nhs. wales/about-us/key-documents-folder/quality-and-safety-committee-papers/quality-and-safety-committee-may-2023/3-2-falls-prevention-pdf/

[8] Cooper R. Reducing falls in a care home. BMJ Quality Improvement Reports 2017;6: u214186.w5626. doi:10.1136/bmjquality. u214186.w5626 https://www.careinspectorate.com/index.php/low-graphics/9-professional/2737-falls-and-fractures

Since 2018, care homes across Wales have been involved in the 'Wales Care Home Project' to safeguard the lives of care home residents and help to reduce the impact on the Welsh Ambulance Service. Mangar ELK lifting cushions have been provided to care homes (and every emergency ambulance in the UK) and care home staff received training on post-fall management protocols. This included how to use a lifting cushion and introducing them to health assessment techniques used by paramedics. However, not all care homes utilise the equipment available to them.

In line with the All Wales Care Home Framework (2020), all NHS Wales Health Boards must adhere to the following principles:

- The care home sector is an integral part of the Health and Social Care system, and as such are key partners in delivering effective, appropriate and timely services.
- Each care home resident has the same right to and access to, primary and community healthcare services as those living in their own home.
- Consideration of the impacts on and implications for care homes is a key factor when developing/implementing primary and community healthcare service models in Wales.
- Relationships form a key component of effective service delivery, and this must extend to effective communication and engagement with the care home sector.
- Service outcomes are developed and measured that reflect the service user perspective. For care homes, this would mean from the perspective of the individual resident.

The following key principles should be considered by all partners to support better outcomes for people who reside in care homes:

- A falls risk assessment should, where relevant, form part of any assessment process.
- Care homes should have a policy in place to determine how falls risks will be assessed and managed. This should include how to get the resident from the floor when they have fallen and when to call for additional support/advice, e.g. via 111/999.
- People living in a care home should have access to local falls specialist services as clinically necessary.

NHS Wales Health Boards and the Welsh Ambulance Service together should work with public sector and third sector partners to establish

community-based response options for care home residents who have fallen, by working in collaboration with care homes to:

- Ensure that care homes have easy access to local services through a single point of access where they will have clinical support, communicated in an effective way.
- Ensure all relevant Health and Social Care providers are aware of local services which can support the immediate health and care needs of the person who has fallen, such as virtual wards.
- Identify and assess care providers with higher ambulance call out rates (per head) for people who have fallen, to identify policies, competence, management practices and equipment needs which will both reduce hospital admissions and ensure effective management of the falls.
- Procure and supply appropriate lifting equipment and training for identified training needs, taking into consideration what may already be available and in use locally (recognising previous work undertaken in Wales when Manger Cushions and training were supplied to care homes).
- Engage care homes in implementing the use of post-fall decision support tools, for example iSTUMBLE, by providing financial and practical support of local services to ensure appropriate responses to their population.
- Determine a mechanism to ensure that when a person has fallen, this is recorded, and the care home multidisciplinary team (MDT) is notified of the fall so they can determine appropriate follow up for the individual.

8. Governance and risk management

It is essential that all NHS Wales Health Boards and the Welsh Ambulance Service, working in partnership with public sector and third sector partners, ensure patient safety is at the centre of any Community-Based Falls Response Framework. Existing quality standards regarding falls and falls related injuries, such as those around assessment and early management of head injuries, should continue to be adhered to.

NHS Wales Health Boards should ensure local governance processes are in place, specifying the organisation holding clinical responsibility for people who fall and the escalation processes for responding to people who have

fallen, who deteriorate or have a higher acuity need than originally anticipated.

NHS Wales Health Boards and the Welsh Ambulance Service should monitor the quality and safety of services through their internal governance processes as part of assurance of the quality-of-care provision, ensuring there is appropriate clinical leadership and oversight on decisions about safe discharge from the ambulance service stack, onward referral, safety-netting and prevention of future falls.

Many falls can be prevented, and managing the risk factors for falls will have wider benefits for individuals, such as improved intrinsic capacities (physical and mental health), functioning and quality of life[9]. It is important to recognise that a history of one or more falls in the previous year, a fall occurring indoors, the inability to get up off the floor and polypharmacy are predictive risk factors for falling and serious injury[10]. This would be further supported through Fracture Liaison Services (FLS) across Health Boards.

The Welsh Ambulance Service must ensure they have appropriate data protection impact assessments in place to pass calls to alternative services in a timely manner.

Whilst prevention is not the focus of this work, it is important that any community-based falls response should be linked to and have clear referral routes into local established prevention pathways, where it is considered appropriate following response. In care homes and hospital settings, all older adults should be considered as high risk and a standard comprehensive assessment followed by multi-domain interventions should be considered. As part of a multi-factorial falls risk assessment, clinicians should enquire about the perceptions an older adult holds about falls, their causes, future risk and how they can be prevented.

Where necessary, there should be appropriate service level agreements in place that detail how services will be engaged, trained, equipped, deployed and governed in their response to falls. As services are established or expanded as part of this work, review of safe delivery should be undertaken in a timely manner to ensure appropriate feedback and learning and sight of unintended consequences.

---

[9] Manuel Montero-Odasson et al, the Task Force on Global Guidelines for Falls in Older Adults, World guidelines for falls prevention and management for older adults: a global initiative, Age and Ageing, Volume 51, Issue 9, September 2022. https://academic.oup.com/ageing/article/51/9/afac205/6730755

[10] Close J, Ellis M, Hooper R, Glucksman E, Jackson S, Swift C. Prevention of falls in the elderly trial (PROFET): a randomised controlled trial. Lancet. https://pubmed.ncbi.nlm.nih.gov/10023893/

9. Measurement and metrics to support implementation

Welsh Government and NHS Wales Executive colleagues will monitor performance against key metrics and support implementation. Implementation of the standard outlined by this guidance will be monitored through:

Progress Metrics

- Number of Falls Responders used to respond to falls within peoples' own homes 8am to 8pm.
- Number of NHS Wales Health Boards having full coverage of Level One falls response services across their regional footprint responding 8am to 8pm, seven days a week.
- Number of NHS Wales Health Boards having full coverage of Level Two response services across their regional footprint responding, 8am to 8pm, seven days a week.
- Number of care homes that have falls equipment and number of trained staff to support falls management and pick up.
- Number of referrals to community falls services from the ambulance service (and rate of acceptance).
- Number of referrals to community falls services from care homes (and rate of acceptance).
- Number of falls conveyed to hospital by level of response.
- Number and percentage of responses achieved within two hours of initial call.

Impact Metrics

- Proportion of Level One and Two falls responded to by alternative response services (split by response service to understand coverage).
- Increase in patient experience and self-reported outcome measures (such as confidence to maintain activities of daily living following a fall).
- Increase in the number of 'alternative responses' to falls which have been triaged as Level One or Two.
- Increase in the number of referrals from falls/TEC responder services to community services.
- Decrease in the number of 999 calls from all adult care homes related to falls.
- Length of time from initial call to physical response for Level One, Two and Three (irrespective of the response service used).

- Safe decrease in the number of Level One and Two conveyances to hospital.

NHS Wales Health Boards and the Welsh Ambulance Service should work together with public sector and third sector partners to:

1) Implement reporting processes, via the Six Goals Programme Leads, that align to the frequency and detail that is required for reporting of both local and national key metrics.

2) Monitor use of the falls response services to identify potential gaps in provision/access, or in cohorts/population groups not accessing falls response services. This should include checking geographical coverage, analysing ethnicity data and monitoring patient conditions to identify disparities in access.

3) Monitor call waiting times and the time elapsed from identifying need to receipt of care for both Level One and Level Two falls.

4) Review ambulance records and work with local hospitals to review records of hospital attendances and admissions to identify patients who could have benefited from a falls response service but did not do so and then identify the lessons that can be learned from this and potential solutions.

5) Monitor for potential unintended consequence such as delays to definitive treatment for hip fracture or head injury. This could be approached via audit of alternative responses against national clinical standards, utilising datasets such as the National Hip Fracture Database.