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Going further for winter: Community-based falls response

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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.

This document sets out key principles and requirements for Integrated Care Boards (ICBs) to improve coverage of community-based falls response services across their footprint in preparation for winter, with a view to:

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

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1. Summary

1.1 As outlined in the World Guidelines for Falls Prevention and Management for Older Adults, falls and related injuries are increasingly common; emergency admissions for falls in people aged 65 have increased year on year – from 185,000 in 2010/11 to 234,000 in 2019/20[1]. The impact of falling is significant – falls can negatively affect functional independence and quality of life, and falls 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[2,3,4].

1.2 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 to prioritise higher acuity patients. Level one and two falls (as described by the Association of Ambulance Chief Executives (AACE) Falls Response Governance Framework for NHS Ambulance Trusts) can often be managed by community-based falls response services, dependent on the availability of clinical resource for triage and assessment of the person who has fallen, and ongoing support to the community-based responder service for escalation, onward referral or discharge as appropriate.

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

1) Enhance outcomes and experience for those who fall, through improving initial response times and reducing the risk of long lies

[1] Office for Health Improvement and Disparities (2022), Fingertips Public Health Profiles, Emergency hospital admissions due to falls in people aged 65 and over, available online here. 2020/21 data excluded due to the effect of COVID19 on non-COVID related hospital admissions.
[2] 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, afac205, https://doi.org/10.1093/ageing/afac205
[3] Fleming J, Brayne C (2008) Inability to get up after falling, subsequent time on floor, and summoning help: prospective cohort study in people over 90. BMJ 337: a2227. PMID: 19015185
[4] National Institute for Health and Care Excellence (2013) Falls: the assessment and prevention of falls in older people. (Clinical Guideline CG161). London: NICE. https://www.nice.org.uk/guidance/cg161

2) Improve system efficiency, focusing ambulance capacity where it is needed most and building on existing community-based provider models.

1.4 Whilst these services already operate in many areas, there is variation in coverage which is often restricted by either geographical footprint, such as a place within an integrated care system (ICS), or to specific population groups, such as people who pay privately for technology enabled care services such as pendant alarms.

1.5 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.

1.6 In order to achieve this, ICBs and ambulance services should:

Essential Activity	ICB	999	111
Map current provision of community-based falls response services which can respond to level one and two falls between 0800 and 2000, 7 days a week	X		
Ensure existing provision is being utilised to its full potential by ensuring local **directories of service are updated** and NHS Service Finder includes accurate provider profiles	X	X	X
Establish community-based falls response services in areas where there are gaps in provision through either **extending or enhancing existing provision** into coterminous neighbourhoods	X	X	
Ensure **all UCR services are accepting falls referrals**, and that there is **full geographic coverage 0800-2000, 7 days a week, of the 9 clinical conditions/needs** set	X		

out in the national 2-hour guidance. As part of this, optimise use of UCR services to respond to level two falls and provide follow up multifactorial/clinical assessment to level one falls			
Adopt the **Association of Ambulance Chief Executives' (AACE) Falls Governance Framework** as a minimum national standard as part of pathways	X	X	X

1.7 Whilst an essential part of the broader falls pathway, prevention services are out of scope for this guidance. Further queries should be directed to england.communityservices1@nhs.net.

2. Requirements for community-based falls response services

2.1 It is critical that ICBs 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 and primary and community care providers.

2.2 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, normally advanced practitioners within the ambulance trusts' 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. All potential or suspected head injuries should be managed in line with the NICE guideline head injury: assessment and early management.

2.3 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 multifactorial falls risk assessment to address any potential underlying issues. This could be provided by Urgent Community Response (UCR) services who already operate 0800-2000, 7 days a week at a minimum.

2.4 Given NHS111 and 999 services may not be in the same ICB area as the person who has fallen, systems must ensure consistent implementation and application of the AACE Falls Response Model[5] and categorisation of fall severity.

2.5 Access criteria for community-based falls response services should be determined locally with agreed referral processes and governance in place.

[5] Safely Reducing Avoidable Conveyance Programmes

2.6 The below community-based provision should be considered for local adoption / extension:

Falls Response Level	Description	Examples of provision (see annex for definitions of response provision)
Level one: Fall – no known illness or injury	• 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 a 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 in order to establish that they are safe to be lifted from the floor.	• Technology Enabled Care (TEC) Responder Services • Fire and rescue service falls response scheme • Community First Responders trained in falls response • St John Ambulance and NHS Volunteer Responders

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. 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	• Urgent Community Response[6,7] • Other community-based teams providing clinical assessment and support in locally arranged 'Falls Rapid Response' teams e.g. multi-disciplinary team cars with paramedic and occupational therapist
Level three: Fall – serious injury or illness	• 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).	• Emergency Ambulance Response

[6] Currently regional maturity matrixes suggest that as of the end of September 2022, 36/42 ICBs had reported accepting falls referrals as part of their UCR provision and this figure is continuing to improve through ongoing monitoring and implementation.
[7] UCR services are required to provide care to a minimum of 9 clinical needs/conditions set out in the national 2-hour guidance, which includes support for level two falls.

3. Principles for community-based falls response services: level one and two

3.1 A **level one response** to a fall can be described as a non-clinical response, where the person who has fallen has been clinically triaged as having no injury or illness but requires some level of assistance to avoid poor outcomes and long lies[8].

Core principles for level one response

Deploy Community First Responders, ensuring:

- CFRs trained in falls response are being 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
- There is dedicated clinical oversight from either within the ambulance service or other clinical providers within the system (e.g. community providers) for CFRs. This should be at advanced clinical practice level.
- Clinical resource proactively reviews the ambulance stack to onward refer to available CFRs, providing provide clinical support for escalation / onward referral / discharge as appropriate.
- Using location video technology to enhance effectiveness and clinical support as available
- Clear onward referral routes are in place for CFRs to use as appropriate, such as to falls prevention services and Urgent Community Response (UCR) services – where there is a minor injury and/or to address any potential underlying issues.

Note: Given CFRs are volunteers, they should not be singly relied upon to cover the ask of this guidance for continuous 0800-2000 coverage and should not be deployed to release paid staff from waiting with people who have fallen (unless there is adequate clinical supervision and a volunteer can be released at any time).

[8] Association of Ambulance Chief Executives (2020) Falls Governance Framework for NHS Ambulance Trusts. https://aace.org.uk/wp-content/uploads/2020/10/AACE-FALLS-RESPONSE-09.2020-V4-HP.pdf

Increase coverage of Technology Enabled Care (TEC) Responder Services who are trained in falls assessment, management and pick up, ensuring:

- Providers are certified to the TSA Quality Standards Framework, a UKAS accredited scheme (UK Accreditation Scheme appointed by Government to ensure Quality and Safety), and provide pick up services including a holistic and outcomes based 'at home' assessment
- At home assessments are completed by the TEC Responder Service delivered within timescales of 45 minutes from deployment and 60 minutes in more rural areas of the referral – seeking to improve and reduce variation in response time where these standards are already being achieved
- Personal use of TEC equipment is encouraged in individuals at risk of falling, recognising that evidence indicates that poor patient acceptability and usability can detrimentally affect their use.

Ensure clear onward referral processes into existing support pathways, including but not limited to Falls Prevention services, Urgent Community Response (UCR) and Neighbourhood Teams, community rehabilitation services and primary care services

Learning from partnership working during the COVID-19 pandemic, consider:

- Commissioning organisations including St John Ambulance to respond to people who fall
- Working with local fire and rescue services through referrals to existing Home Fire Safety Visits, which consider mobility as part of fire safety and local fire and rescue services

- Utilising NHS Volunteer Responders to provide a 'neighbourly support' model (e.g., sitting with fallers waiting for clinical response, ensuring they have the necessary items for conveyance to hospital)

Ensure appropriate lifting equipment for management of people who have fallen is available to falls response services, and colleagues within these services are suitably trained in its use

3.2 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.

Core principles for level two response

Utilise and/or expand Urgent Community Response (UCR), ensuring all UCR services are:

- Aligned to the 2-hour guidance, ensuring full geographic coverage 0800-2000 7 days a week of the 9 clinical conditions/needs
- Accepting falls referrals and providing multifactorial assessment, including from TEC companies. As part of this, mapping skills and equipment needs and using existing funding to ensure UCR services are able to respond to level two falls
- Accurately profiled on the Directory of Services and NHS Service Finder to provide a falls response service and onward care
- Working closely with other services as part of universal falls response model to improve coordination of care pathways including via neighbourhood coordination hubs/single points of access
- Addressing unwarranted variations in UCR services' capacity and consistency, and ensuring that community services data set (CSDS) data quality issues are all mapped and being addressed, working with NHS England regional teams as appropriate.

Ambulance and UCR services should establish a partnership working model to further increase falls referrals to UCR services, including through: • Use of UCR or community clinicians in an ambulance Emergency Operations Centre (EOC) • Training up EOC ambulance clinicians to do dedicated work supporting referrals into UCR services • Facilitating an increase in referrals through managed access to the ambulance stack and utilising interoperability toolkit (ITK) messaging.
Consider utilising other response options such as: • Upskilling existing CFRs via enhanced training where this is not already in place, ensuring there is appropriate clinical support available for onward referral where clinically required • TEC 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, and where appropriate they are used to complete medical observations for other NHS services • Commissioning organisations with trained staff / volunteers who can respond to level two falls, including St John Ambulance.

3.3 Where this core principles are already in place, ICBs should:

- Extend the operating hours of UCR services beyond 2000 where they can and work collaboratively with ambulance services and other providers of falls response services to ensure out-of-hours cover for level two falls
- Extend Community First Responder coverage beyond the minimum hours of 0800-2000, where this is a locally adopted method of falls pick up response.

Case Study: Hull Fall First

Purpose: falls pick up and wellbeing response service within Hull.

Partners involved: Hull CCG, Humberside Fire & Rescue, Yorkshire Ambulance Service, Hull City Council and City Health Care Partnership (current community services provider)

A team of 10 firefighters were selected received clinical training from healthcare experts ranging from paramedics, occupational therapists and physiotherapists. The team also received a higher level of safeguarding training and safety awareness.

Due to the success of the trial scheme the team has since been commissioned and is still in operation today.

Quantitative impact has been difficult to size because of the way that falls are recorded in health datasets, but the following outcomes have been observed locally:

1. Reduced number of people requiring A&E attendance because of a fall
2. Reduced number of admissions avoided because of rapid response, and not having a long lie
3. Increased follow up from the therapy falls team
4. Better patient experience for those who have had a fall.

Case Study: London Ambulance Service

A co-designed 12month pilot project aimed at increasing appropriate referrals from 999 calls through to an initial integrated urgent community response (UCR) with ongoing care at place, primarily aimed at frail older people with complex needs. Three cars, staffed by both LAS and UCR teams operate 8am-8pm, 7days per week are allocated to suitable category 3&4 incidents direct from the 999 control room. Joint staffing allows the combination of unique skillsets, and better links to a range of alternative community services.

The response cars are able to respond to a range of patients including those who have fallen, but also those with other needs such as reduced function, catheter care and others. The service enables a swift and effective response to suitable patients who may have had to wait longer for an ambulance and may have been conveyed to hospital.

The pilot project has just started (Oct 22) and evaluation data is limited, but early indications are that around 50-60% of patients responded to are in relation to falls, with positive impacts on reducing conveyance of these patients to hospital.

There is also opportunity to use community first responders with appropriate clinical support) to provide an early response to some of these incidents, and then be backed-up by the 999 and UCR joint response vehicle.

4. Management of falls in care homes

4.1 Falls are three times more common among care home residents than in people of a similar age living in their own homes[9]. Falls in care homes carry a significant burden both to the individual and to the health and care system – 25% of falls in care homes result in serious injuries[10] and up to 40% of admissions from care homes are falls related[11].

[9] Public Health England. Falls: Applying All Our Health. www.gov.uk/government/publications/falls-applying-all-our-health/falls-applying-all-our-health
[10] Inspectorate. TC. Managing Falls and Fractures in Care Homes for Older People. 2016. www.careinspectorate.com/images/documents/2737/2016/Falls-and-fractures-new-resource-low-res.pdf
[11] Cooper R. Reducing falls in a care home. BMJ Quality Improvement Reports 2017;6:u214186.w5626. doi:10.1136/bmjquality. u214186.w5626

4.2 There is a growing body of evidence demonstrating the efficacy of alternative pathways for falls in care homes. Partnerships between independent equipment providers, ICBs, ambulance services 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 (see below case study).

4.3 In line with the Framework for Enhanced Health in Care Homes:

- Falls risk assessments should, where relevant, form part of the CGA-based holistic assessment process which is included in the nationally commissioned EHCH model
- 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.

ICBs should 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 Urgent Community Response teams and 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

- Engage care homes in implementing the use of post fall decision support tools, for example ISTUMBLE or HelpFall, 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 MDT is notified of the fall so they can determine appropriate follow up for the individual.

Case Study: Wales Care Home Project

A 2018 partnership with Aneurin Bevan Health Board and the Welsh Ambulance Service saw 600 care homes receive Winncare's Mangar cushion lifting equipment and training including the use of the ISTUMBLE app, and recorded the following results:

1. 87% of falls were managed in-house
2. Falls which would have previously required an ambulance reduced from 379 to 75 (Reduction of 80%)
3. The number of residents conveyed to hospital as a result of a fall reduced from circa 65% to 16%.

Case Study: Mid and South Essex ICS

As part of a pilot in Mid and South Essex ICS 81 Raizer II chairs were purchased and distributed across care homes, secondary care and Urgent Care Response Teams.

Care homes were also given access to an interactive post falls assessment tool (to support care staff to identify when it is safe to lift a resident from the floor without calling for assistance from the Ambulance Service) and a Samsung Digital tablet where this app can be accessed.

The pilot resulted in:

1. A reduction in call outs – 244 falls occurred, which would have resulted in 134 call outs. This was reduced to 42 call outs through use of the equipment and technology
2. If costed at £252 for an ambulance call out, the 92 avoided call outs totalled a saving of £23,184 over six weeks.

"Our 111 calls have decreased by 100% since we've had the Raizer chair. We haven't needed to call them since. That chair is absolutely invaluable – and we can't manage without it now. There is just so much calmness now around the residents – they actually enjoy using it!! We've had one or two falls which other residents have then witnessed us using the Raizer, and they have asked if they can have a go!" Adalah Care Home

5. Governance and risk management

5.1 It is essential that all ICBs ensure patient safety is at the centre of any falls response model. 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.

5.2 ICBs 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.

5.3 ICBs should monitor the quality and safety of services through their system quality groups/boards 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.

5.4 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[12]. 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[13].

5.5 Ambulance services must ensure they have appropriate Data Protection Impact Assessment in place to pass calls to alternative services in a timely manner.

[12] 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, afac205, https://doi.org/10.1093/ageing/afac205
[13] 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. 1999 Jan 9;353(9147):93-7. doi: 10.1016/S0140-6736(98)06119-4. PMID: 10023893.

5.6 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 multidomain interventions should be considered. As part of a multifactorial falls risk assessment clinicians should enquire about the perceptions the older adult holds about falls, their causes, future risk and how they can be prevented[14].

5.7 Services commissioned should aim to meet standard response times as outlined in national guidance, where available – for example, 2-hour UCR services have an expectation of ensuring that at least 70% of 2-hour referrals are seen within two hours by the end of December 2022. Where this is not possible, ICBs need to agree the local escalation process.

5.8 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.

[14] 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, afac205, https://doi.org/10.1093/ageing/afac205

6. Measurement and metrics to support implementation

6.1 National teams will work through regional teams to monitor performance against key metrics and support implementation. Implementation of the standard outlined by this guidance will be monitored through:

Progress metrics
• Number of ambulance trusts using Community First Responders across their footprint to respond to falls within people's own homes 0800-2000 • Number of ICBs having full coverage of level one (AACE guidance) QSA accredited TEC / LA falls response services across their footprint responding 0800-2000 • Number of ICBs with UCR services covering the footprint responding to level two (AACE guidance) falls and accepting TEC referrals, 0800-2000 • Number of care home that have falls equipment and trained staff to support falls management and pick up • Number of referrals to UCR from the ambulance service (and rate of acceptance) • Number of referrals to UCR from care homes (and rate of acceptance).

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’ (e.g. via CFR) to falls which have been clinically triaged as level one or two

- Increase in the number of referrals from TEC Responder Services to UCR services
- Decrease in the number of 999 call outs from all adult care homes related to falls.

6.2 ICBs should work with their ambulance trust(s) to:

6.2.1 Implement reporting processes that align to the frequency and detail that is required for reporting of both local and national key metrics

6.2.2 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

6.2.3 Monitor call waiting times and the time elapsed from identifying need to receipt of care for both level one and level two falls

6.2.4 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

6.2.5 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.

Annex: Definitions of falls response options

999 emergency ambulance response: double-crewed ambulances and rapid response vehicles, staffed by a range of staff including paramedics, specialist/advanced paramedics, available 24/7, 365. Providing emergency and urgent out-of-hospital treatment and stabilization for serious illness or injury, and where appropriate convey to definitive care.

999 ambulance urgent / low acuity crews: some ambulance services may have additional vehicles staffed with non-paramedics.

Urgent Community Response (UCR) services: two-hour UCR services provide multidisciplinary assessment, treatment and support to people over the age of 18 in their own home or usual place of residence who are experiencing a health and/or social care crisis, including falls, and who are at risk of hospital admission within the next two to 24 hours.

Access to these services is usually provided via a local single point of access, and should be underpinned by multidisciplinary clinical & non-clinical input.

Falls Rapid Response Services – Multidisciplinary Teams (MDTs): some areas have established bespoke MDTs to respond to people who have fallen. These may include different health care professionals (e.g. combination of paramedics, physiotherapists, occupational therapists), and may be commissioned to work variable hours across defined geographical patches.

Community First Responders (CFRs): CFRs are trained, community-based volunteers working within and despatched by ambulance services – some of whom have access to and training to use falls lifting equipment – who can be safely deployed to falls. There are approximately 6,000 CFRs nationally, who responded to 236,000 incidents nationally in 2021/22. The majority of ambulance trusts already use CFRs to respond to falls, but day-to-day and geographical availability varies. Some CFRs can also be sent to other levels of fall, to provide ‘eyes on’ support whilst waiting for a healthcare professional to arrive.

Technology Enabled Care (TEC) falls response providers: some providers offer 24/7 falls response service to individuals with wearable equipment, often known as ‘pendant/telecare alarms’.

St John Ambulance fall response: St John Ambulance delivers clinical and holistic care in treating and preventing further falls. The service also supports people - primarily the elderly - to stay in their homes and maintain their independence for as long as it is safe to do so.

Fire & Rescue Services falls co-responder schemes: local fire and rescue services provide Home Fire Safety Visits, which consider mobility as part of fire safety and local fire and rescue services

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