EDT 28th May, 2025

Falls Prevention and Building Community Capacity

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Please confirm that in developing the policy/proposal/guidance you have considered Welsh Language, Equality, Sustainable Development, United Nations Convention on the Rights of the Child, any digital technology / ways of working, and socio-economic impacts:

	Confirmed – include a short description of how in the body of the paper, including confirmation that the necessary impact assessments have been completed.
x	Not applicable because: (e.g. internal corporate matter)

Please confirm that in developing the policy/proposal/guidance you have consulted the HSS Policy Forum ahead of EDT:

x	Confirmed – summarise the outcome of the discussion at Policy Forum in the body of the paper, including where you have secured alternative engagement with Policy Forum
	No. Describe in the body of the paper (e.g. internal corporate matter, time critical)

Please state if the paper is for:

x	Discussion
	Decision
	Information

EXECUTIVE DIRECTORS TEAM IS ASKED TO:
List clearly what EDT is asked to do.

	To *agree* a course of action
	To *endorse* a decision
x	To *advise* on an approach
	To *identify* action required
x	To *note* for information

It is essential that all of our polices consider and maximise the contribution to the Wellbeing of Future Generations (Wales) Act 2015. Please set out how your proposed policy meets the five ways of working which are:

- ***Long Term*** – The importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs.
- ***Prevention*** – How acting to prevent problems occurring or getting worse may help public bodies meet their objectives.
- ***Integration*** – Considering how the public body's wellbeing objectives may impact upon each of the wellbeing goals, on their other objectives, or on the objectives of other public bodies.
- ***Collaboration*** – Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its wellbeing objectives.
- ***Involvement*** – The importance of involving people with an interest in achieving the wellbeing goals, and ensuring that those people reflect the diversity of the area which the body serves

It is essential that all of our health-related polices and decisions consider the Duty of Quality and we can evidence they are made with a view to: a) secure improvements in the quality of health services and b) improve outcomes for the population of Wales. Please set out how your proposed policy has considered the Health and Care Quality Standards 2023.

- ***Safe*** – minimising harm, learning from when things go wrong.
- ***Timely*** – provided in the right place, at the right time and in clinical priority.
- ***Effective*** – evidence-based practice and whole of life pathways
- ***Efficient*** – avoiding waste and getting the best value for money.
- ***Equitable*** – providing everyone with the opportunity for a healthy life.
- ***Person-centred*** – treating people with kindness and respect.
- ***Leadership*** – Clear, focused and fully matured governance, leadership and accountability at all levels is vital in creating a functional quality management system.
- ***Culture and valuing people*** **-** encourage quality and system safety within a supportive, inclusive, and collaborative culture.
- ***Data to knowledge*** – develop understanding of service quality to inform learning, strategic decisions, and guide quality improvement.
- ***Learning, improvement, and research*** – create opportunities for system-wide learning to allow for continuous learning and quality improvement innovation.
- ***Whole-systems perspective*** – learn from quality planning, control, and insurance to improve quality across the healthcare system.
- ***Workforce*** – recruit, retain, develop, and extend roles to ensure enough confident people with the right knowledge and skills can deliver safe care.

PURPOSE

Falls and falls-related injuries for community dwelling individuals are a major public health concern. They are the leading cause of injury related deaths for individuals aged 65 and over and a significant driver of urgent and emergency care demand and associated hospital related pressures.

These incidences frequently lead to a loss of independence and a resultant increased demand for health and social care. For this population, we know that ‘What matters’ is to ‘remain active, independent in their own homes and connected to their communities’. Falls are however preventable and their incidence and prevalence can be reduced.

Appropriately, ‘Falls Prevention’ is therefore a priority area for action across policy and NHS Executive national programmes for 25 / 26 in recognition that optimal management will improve outcomes for the population and enhance system resilience through reducing conveyance and hospital admissions this winter.

Optimal falls prevention management requires a whole system / whole population approach. EDT has previously acknowledged that duplication of efforts exist across national policy and programme areas resulting in diluted impact and conflation on the ground in terms of delivery expectation. Further, EDT recognised that cohesive and coordinated delivery of key actions towards a shared outcome is integral to optimising impact.

V0.4 with CB, ST and TC Comments considered

This paper:

- Defines what is meant by ‘fall’, its incidence and prevalence;
- Presents the case that reducing the risk / incidence of falls and reducing inequalities in Wales would benefit from a population health management approach across the whole system of health, social care and public sector agencies for risk stratified population groups;
- Summarises opportunities and makes recommendations in line with the Building Community Capacity priority to enhance outcomes for this population and build system resilience for Winter 25 / 26

Policy Forum on the 8th May provided an opportunity to discuss the current state in relation to proactive care of older people with complex needs and the need for best practice guidance in this area. The discussion did not explicitly address falls prevention however colleagues endorsed a Proactive Care Framework being integral to improving management of high risk population groups. Policy Forum also acknowledged that Proactive Care of high risk populations was a collective responsibility spanning policy areas and associated national programmes.

BACKGROUND: Falls, Definition, Prevalence and Incidence

Falls are defined as an event where a person unintentionally comes to rest on the ground or a lower level. Such events are not limited to ‘slips and trips’ known as ‘mechanical falls’ but includes intrinsic episodes where an individual has ‘collapsed’ to the floor of unknown origin.

People over the age of 65 are often considered at highest risk of fall. However, falls are not an inevitable part of the ageing process rather, the risk and incidence of falls directly correlates with Frailty and associated progressively complex needs.

Frailty is a long term condition. It describes a state of health whereby body systems gradually lose their biological, physical and mental resilience and individuals are therefore predisposed to sudden changes in function. This includes gait and balance compromise with the person often presenting as having fallen or ‘sudden collapse’. Falls are therefore associated with the ageing process and experienced by older people although not all older people are living with frailty. For instance, 20% of our > 90s population are fit and well. Similarly, younger adults with multi morbidity and associated complex needs may be considered as ‘frail’ and at high risk of fall.

A recent study undertaken by Public Health Wales (PHW) considered peer reviewed literature and specifically the use of a validated eFalls predictor model which stratified the risk of falls for > 65s using GP records in England. Utilising this peer reviewed information it was possible for PHW to provide an indication of falls risk distribution for the >65 population (Table 1. below). Risk in this context was described as the probability of emergency department attendance or hospitalisation with fall / fracture within one year.

Risk of Admission within a Year	Risk Distribution as % of all>65s	% of total >65s
High Risk > 25%	1% >65s are high risk	6% of our >65s fallers
Medium (Rising) Risk 10- 25%	8% >65s are medium risk	29% of our >65s fallers
Low Risk <10%	91% > 65s are low Risk	65% of our >65s fallers

Table 1.

The growth in population of the > 65 year demographic between now and 2035, assuming a constant % of 'high', 'medium' and 'low' risk, is expected to result in greater numbers of people being at risk (Figure 1. below). Similarly, it predicts a 28% increase in admissions relating to falls / fracture (Figure 2.below).

Risk strata	% of 65+ population	2025 pop 65+	2035 pop 65+ (projected)	Increase
High >25% 1y risk	1%	7,059	8,407	1,348
Medium 10-25% 1y risk	8%	56,473	67,253	10,780
Low <10% 1y risk	91%	642,381	765,003	122,622

Example growth of risk strata in Welsh population aged 65+ based on projected growth of the population aged 65+.
Note: Strata proportions very approximate based on data extracted from eFalls paper (Archer et al, 2024).
Source: Archer et al, 2024 and ONS population projections (2022-based; principal projection).

Figure 1.

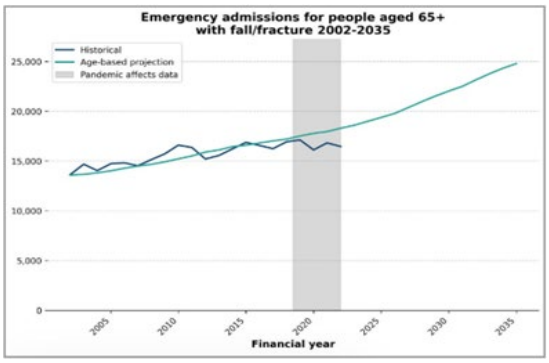


Figure 2.

This growth however is not inevitable and can be mitigated through evidence based interventions to reduce the risk of falls. Given the risk analysis presented in Table 1. above however, a strategy that focuses solely on finding and targeting the 'high risk' stratified population may have a large impact on individuals but a limited impact on total population falls incidence and impact on the system.

The demographic growth is not static, neither is the associated prevalence of frailty (complexity) and demand on our health and care system. A single focus on the 'high risk' is therefore not advocated. Counter effects demand a focus across 'low', 'medium' (rising) and 'high' risk populations simultaneously to engender greatest outcome now and into the future.

ASSESSMENT: Optimal Falls Prevention Management and our Current State

Optimal Falls Prevention and Management

As outlined above, falls are a symptom of frailty, effective management of falls should therefore be tantamount to that of frailty. Frailty however, like other long term conditions such as diabetes, with awareness and optimal management, can be prevented, its onset delayed and progression (including falls incidence) slowed down.

The Integrated Quality Statement (IQS) for Older People living with Frailty Older people and people living with frailty: integrated quality statement | GOV.WALES stresses that prevention, proactive and urgent care management of their needs are all

integral to reducing the risk and preventing falls. The IQS however recognises that, in terms of effective management 'one size does not fit all'. Our approach and evidence based actions will need to reflect their assessed level of risk, e.g 'low risk', 'rising risk' and 'high risk', to achieve the greatest impact in keeping people healthier, preventing falls and keeping them out of hospital and at home. These actions that are summarised in Table 1. below.

	Low Risk of Falls (91% > 65s)	Medium Risk of Falls (8% >65s)	High Risk Falls (1%)	Very High.Risk Falls (NB.6¡)
Population Descriptor (presence of frailty)	Fit and Well	Mild to Moderate frailty - Simple needs but are progressive in nature Managing with regular support from health professionals No social care needs	Severely Frail Complex fluctuating needs. Regular multi professional coordinated care to manage fluctuating and often urgent needs Mostly eligible social care needs	Very Severely Frail Complex Needs High level dependency on care and support at home / care home residents Multi morbidity Often Palliative
Community Intervention	Universal / Prevention Measures	Proactive Care	Proactive Care, Urgent Response, Step Up Multi Professional and Enhanced Community Care	
Specific Examples of Interventions	Community Falls Awareness Home Safety Checks Keeping Active Nutrition & Bone Health Visual Acuity	Holistic Assessment Future Care Planning / Targeted Effective Interventions Person Centred Goals Proactive Monitoring	Care Coordination / Continuity of Care Early Identification of Decline / Rapid Response to Assessment and Step up Care in Community	

Table 1.

Effective management of frailty, and therefore falls, is wholly dependent on health and social care systems understanding population need and effective resourcing of components of a frailty attuned integrated community care system 'at place' to ensure equitable outcomes for the population and the system. Essential components of a frailty attuned integrated community care system are outlined in Figure 3. below.

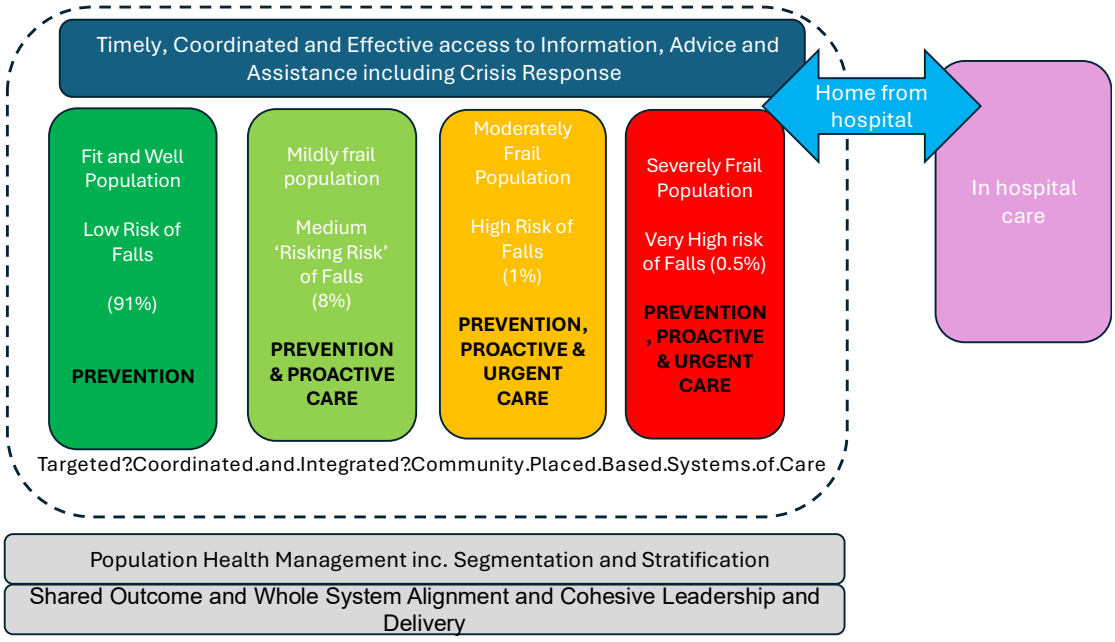


Figure 2. High Level Components of an Integrated Community Care System (Derived from IQS and ICCS Blueprint for Wales, RIF)

Current State

The infographic presented above in Figure 2. offers an organising framework to assess our current state against core components of an effective system that optimises population health management and reduces the risk of adverse outcomes (falls) for our ageing population. This was therefore used to undertake a high level assessment of our current state in preparation for this paper. Please note, while inpatient falls are a recognised challenge to healthcare quality and patient experience, this paper however has not explored inpatient falls prevention strategies. Given that hospital admission itself increases falls risk, the most effective prevention is to avoid admission where possible; an approach that is within the scope of this paper.

The assessment confirmed the breadth of interventions that are being undertaken across our integrated health and social care systems in Wales with reference to managing frailty, reducing falls risk and the effective management of injurious and non-injurious falls in the community.

The interventions are wide ranging with leadership for the initiatives spanning a range of policy and national programme areas many of which have benefited from investment (RIF, Allied Health Professional, Further, Faster, Six Goals Programme and most recently 50 Day Challenge). This activity, and activity that has previously been undertaken that can be reviewed, considered and refreshed should also be recognised.

While there is no doubt that each initiative is grounded in ‘best practice’ to achieve optimal impact a focus on 2 pillars of improvement is suggested.

Pillar One - Population Health Management as a vehicle for prevention and reducing health Inequalities

The assessment demonstrated that current focus is disproportionately focused on ‘high risk’ populations and greater targeted effort is required for ‘rising risk’ populations and ‘low risk’ groups. To realise the greatest impact we need a greater focus on prevention and this will be most impactful through community interactions.

<u>Low Risk Populations</u>
Health inequalities significantly influence falls risk and addressing these disparities will be essential. The focus on this population group therefore requires a strong focus on **prevention** and a public health approach which includes building resilience within the community. Such an approach requires system level organisation and multi agency ownership that includes public messaging promoting healthy ageing, active lifestyles and environmental safety. This messaging would benefit from regular public health campaigns particularly seasonal messaging in a manner that engenders community engagement and empowerment. Collaboration with Public Sector Boards and our Social Prescribing model presents us with a significant improvement opportunity. The key for this will be a systematic programme of public awareness and actively engaging with services that connect to people in the community.

A priority action in Quarter 2 (25 / 26) will be to bring together key players such as the Third Sector (eg Age Cymru, Care and Repair), Local Authorities, NHS, Community Housing Cymru and wider public sector organisations (Fire and Rescue) to map

current activities, agree a shared approach and a targeted programme that will be delivered collaboratively to reduce duplication and ensure high level of awareness across society. We would anticipate this approach to be endorsed by the Older People's Commissioner.

Rising Risk and High Risk Populations

Universal preventative approaches outlined above remain integral for these population groups however for 'rising risk' and 'high risk' population groups their needs have an increasing tendency to fluctuate particularly those who are severely frail many of whom will be benefiting from multiprofessional high volume and frequency care, support and treatment at home and in care homes. Their level of frailty is also likely to be such that their needs could be considered palliative.

Embedding a preventative **proactive care** approach is globally accepted as integral to managing their needs in a manner that enables targeted anticipatory management and early identification of compromise before crisis (such as a fall).

Proactive Care provision has 4 key principles for delivery:

1. **Case Identification (Risk Stratification)**
   'Deep dive' exercises were undertaken with Regional Partnerships earlier this year to better understand their implementation of 'Identification of the 0.5% most at risk' (50 Day Challenge Intervention 6). These exercises demonstrated significant variation and inconsistency in scope and approach in relation to stratification. The approach varied from utilising professional judgement to more sophisticated stratification within GP systems using a recognised stratification tool, 'electronic Frailty Index' (eFI).

   In terms of scope, broadly there was a recognition that segmentation and stratification required a focus on older people living with frailty and that the 'high risk' population group would naturally include those at high risk of falls and should also provide a focus on those individuals living in care homes and those in receipt of high volume / high frequency care at home. Populations tended to be stratified in 'pockets' such as within Cluster areas with few adopting Pan Cluster approaches for effective proactive management of stratified populations and commissioning integrated services 'at place'.

2. **Holistic Multi Professional Assessment**
   Best practice encompasses the offer of an assessment and subsequent anticipatory care planning (known as Future Care Planning) to all individuals stratified. This assessment should determine 'what matters' to the individual and the risk factors presenting that compromises them achieving this. For this population it should routinely include falls risk assessment.

3. **Future Care Planning (FCP)**
   The holistic assessment should result in an outline plan that sets out how the person and their multi professional team would mitigate risk factors through effective interventions. The plan should also outline how and when the individual should advise escalating needs (at the earliest stage i.e before fall). FCP should provide the basis for proactive monitoring and review of this vulnerable cohorts

needs on a regular basis. The 'deep dive' exercises referenced above demonstrated that FCP in Wales has a propensity to focus on assessment and planning for 'end of life wishes' for those with palliative needs. While there is no doubt that this is important for this population group, gaining greater impact on falls prevention will require multiprofessional teams to adopt a purposeful focus on proactively managing the person's wider risk factors and the provision of anticipatory care and effective care coordination by integrated teams at the earliest point of needs escalation.

4. *Care Coordination and Continuity of Care*

The complex needs of this stratified population group demand the provision of timely, integrated and coordinated information, advice and assistance (IAA) that meets their fluctuating needs 7/7 a week at 'neighbourhood' level. This IAA should provide the means to proactively manage high risk cohorts (routinely reviewing FCPs) while responding to escalating needs in a manner that mitigates the need for urgent care in crisis.

There is evidence that primary care and community health services are integrating with Local Authority IAA services however the level of maturity in terms of that integration is inconsistent across Wales. Effective integrated IAA provision enables proportionate response to need by the right service / professional at the right time and reducing urgent care requirement and 'handoffs'.

Positioned correctly, Technology Enabled Care (TEC) and Alarm Receiving Centres (ARCs) can contribute to effective proactive care management and efficient resource utilisation. Across Wales the use of TEC and ARC in the proactive care space is limited.

Implementation of proactive care approaches across all 4 key principles is sub optimal and lacks the maturity, focus and prioritisation of resources afforded to reactive interventions. Consequently, escalating needs all too often result in crisis (fall or collapse due to physiological compromise), trigger urgent and emergency care response and result in increased demand for finite long term care provision.

A Proactive Care Framework outlining the principles and standards that should be considered by Regional Partners in their planning and service design has recently been endorsed by Policy Forum. This is attached to the report for your reference. The Proactive Care Framework will complement the SPOA for Urgent Care Framework being published by Six Goals Programme and Local Authority Information, Advice and Assistance (IAA) arrangements. A Framework outlining principles for best practice in relation to integrated IAA provision has also been drafted by All Wales Heads of Adult Social Services and Social Care Wales.

Implementing the principles of Proactive Care for high risk population groups as a key component of Building Community Capacity is being overseen by the Strategic Programme for Primary Care as a key action of the Building Community Capacity priority for 25 / 26. The 'Deep Dive' exercise and community data sets / dashboard developed to date will provide the baseline to monitor progress going forward. It is anticipated that the inclusion of 'risk stratification of the 0.5%' utilising eFI in the GMS contract will be valuable both in the short term and in ensuring effective data sharing / data systems are in place to enable national population segmentation and stratification

in the future. Implementation of a national Population Segmentation and Stratification Tool for Wales is being led by Data, Digital, Technology, Innovation and Value Team of the NHS Executive.

Given the current immaturity of proactive care approaches, an effective **urgent care** response is integral to ensure that Level one and Level two falls are managed in a manner that ensures appropriate assessment within two hours, a reduction of harm from 'long lies' and the provision of safe alternatives to conveyance and hospital admission where appropriate. National enabling actions relating to improving timeliness of access featured in the NHS Planning Framework for this year set out requirements for Health Boards to to implement Single Points of Access for Urgent Care and seven day a week community falls response services (Framework published in October 2024).

The Six Goals programme is actively supporting Health Boards and partners to deliver the latter through a national implementation group. A dashboard is being developed that will outline:

I. The length of time people wait for ambulance patient handover

II. The length of time people wait in emergency departments before discharge or admission; and

III. Their average length of stay if they are admitted

Health Boards are working with partners on implementation plans towards achievement of outcomes set by UEC policy officials i.e. to reduce ambulance transport of non-injured (level 1) and minor injury / illness (level 2) to emergency departments as well as reduction in admissions.

A high level plan for the 'pillars' is appended providing further detail of those actions that are being progressed that support effective approaches to prevention, proactive care and urgent care in respect of falls prevention for older people living with frailty and adults living with complexity.

Pillar Two – Shared Outcome and Whole System Alignment and Cohesive Delivery recognising that 'the sum is greater than the parts'.

<u>Building Community Capacity Governance, Monitoring and Reporting</u>

The greatest benefit of the 50 Day Challenge has been acknowledged as engendering effective collaboration across Regional Partnerships in Building Community Capacity across the 10 Best Practice Interventions. Further, in building our Integrated Community Care System (ICCS) the need for better alignment across policy and national programme has been recognised with constructive planning being realised through the ICCS Leadership Group. Revised governance, monitoring and reporting arrangements have been agreed by Ministers to ensure these efforts are sustained and enhance delivery towards a shared outcome. The revised governance is appended to this paper.

It is recognised that, to ensure whole system alignment and cohesive delivery a shared outcome is required.

The Outcome we Want?

We know that what matters to adults with complex needs / older people living with frailty is to remain as well and independent as possible in their own homes and connected to their communities. Our population outcome indicator is therefore considered to be 'healthy days at home' or alternatively 'independent at home'.

We are currently unable to systematically measure this outcome across Wales. The following system level indicators are suggested as reasonable proxy indicators and have been a core component of the Care Action Committee for Building Community Capacity since October 2023. Quality outcome measures should also provide us the patient / service user's experience.

These system indicators also allow us to monitor how the ICCS at Regional level may be optimising health and social care resource. Process measures should also be monitored that tell us 'how much' and 'how well' components of the system are delivering and subsequently contributing to impact on the system.

Ultimately, we would expect that our system contributes to reducing falls incidence, maintaining independence and avoiding conveyance and admission to hospital. As a minimum we should expect the following with implementation of relevant actions.

System Level Indicators	Process Measures	Targets Suggested
Proportionate Long Term Care Commissioning per 100k Reduction in Long Term Care Waits per 100k	Increased referrals to Reablement (Step Up from the Community) Increase District Nursing Capacity	Reduction in emergency transport to hospital (L1 and L2 falls specific) 10% against March 2025 baseline by December and 25% by March 2025
Reduction Emergency Admissions > 75s Reduction in Emergency Admissions LOS > 21 days	Increased referrals to Enhanced Community Care (Step Up from the Community eg Community Falls Crisis response)	Reduction in emergency admissions (L1 and L2 falls specific) 10% against March 2025 baseline by December and 25% by March 2025

A draft outcomes and measures framework is appended to provide some insight to the thinking however this work is in progress and being reviewed and finalised by senior leaders and officials from Welsh Government, NHS Executive, Public Health Wales, Health Boards, Local Authorities and Regional Partnerships.

Recommendations

EDT is asked to:

1. Acknowledge that the greatest impact to reducing the prevalence of falls requires a population health approach of frailty which focuses on prevention

and will be most impactful through community interactions for ‘at risk’ populations.

2. Acknowledge that the 0.5% ‘most at risk’ population groups is not currently clearly defined, stratification approaches and population scope is variable and inconsistent nationally, regionally and pan-cluster.
3. Acknowledge that risk stratification is possible through GP systems utilising eFI and can contribute to integrating primary care and community services and effective management of the population
4. Acknowledge that the 0.5% ‘most at risk’ would naturally include individuals at high risk of falls and those residing in care homes and;
5. Agree that management of 0.5% most at risk is ‘one priority’ for 25 / 26 and Building Community Capacity (BCC) plans this Winter will include preventative, proactive and urgent care actions relating to falls, care home management and end of life care (where appropriate);
6. Acknowledge Proactive Care approaches are variable and inconsistent across Wales and would benefit from all Wales guidance outlining principles and standards and;
7. Acknowledge that Outcomes and Measures framework is in development;
8. Acknowledge high level plan outlining key actions attributed to two ‘pillars of improvement’
9. Acknowledge the revised Care Action Committee governance arrangements lend themselves well to providing oversight and seeking assurance on Building Community Capacity (including falls prevention) across policy, national programme and delivery partners

Appendix One – High Level Plan for Pillars of Improvement

Pillar One - Population Health Management as a vehicle for prevention and reducing health Inequalities	Action	When	By Who
Prevention **Low Risk, Rising Risk and High Risk Population Groups** Effective public health approach to the provision of timely targeted and accessible information, advice and assistance for falls prevention	Commission National Falls Task Group to bring together key players such as the Third Sector (eg Age Cymru, Care and Repair), Local Authorities, NHS, Community Housing Cymru and wider public sector organisations (Fire and Rescue) to map current activities, agree a shared approach and a targeted programme that will be delivered collaboratively to reduce duplication and ensure high level of falls prevention awareness across society. Task Force to also consider how Social Prescribing and Local Authority IAA services can support timely and targeted information and advice provision.	September	ICCS Leadership Group
Proactive Care Rising Risk and High Risk Population Groups Case Identification, Holistic Assessment, Future Care Planning, Care Coordination and Continuity of Care	Define 0.5% and its Scope and parameters for approach Publish Proactive Care Framework Issue Comms to Directors Primary Care / Senior Accountable Officers requesting submission BCC Joint Improvement Plans and trajectories Establish Regional Performance Meetings Quarterly IQPD focus on Building Community Capacity Increase use of TEC to proactively manage 'at risk' cohorts Continued focus on use of Telehealth in Enhanced Community Care	End June End June End July End July September TBC TBC	ICCS Leadership Group SPPC SPPC / 6 Goals ICCS Leadership DDTIV & Leadership Group DDTIV

Cont'd overleaf

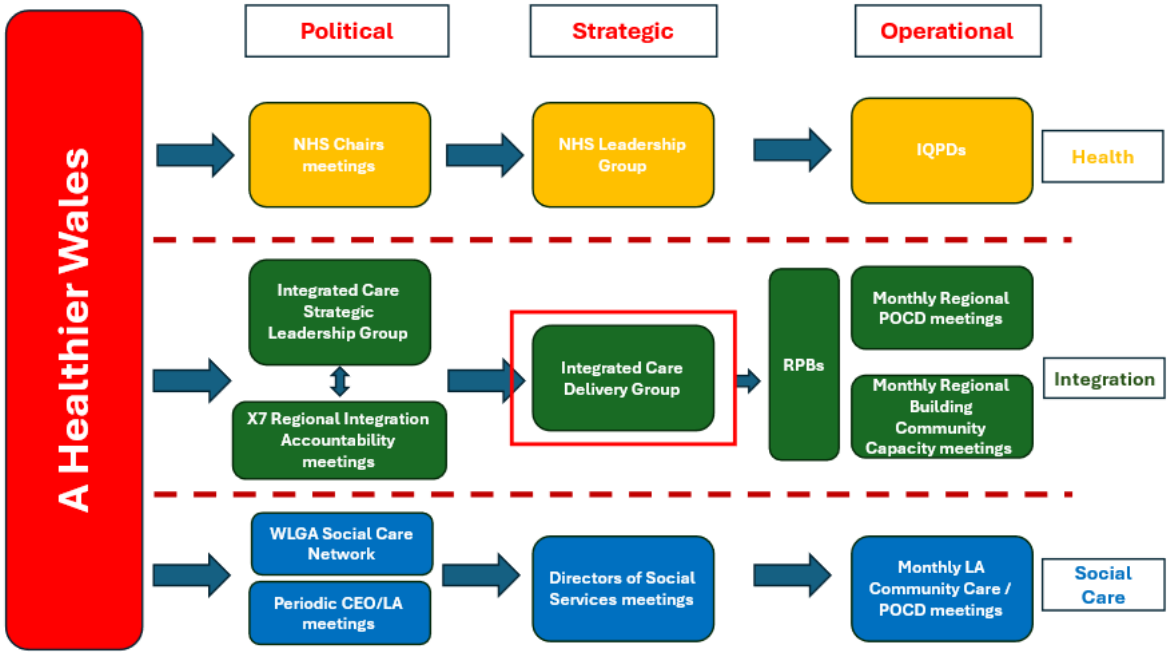
Pillar One - Population Health Management as a vehicle for prevention and reducing health Inequalities	Action	When	By Who
Urgent Care	Issue SPOA Framework for Urgent Care	End June	6 Goals
Rising Risk and High Risk Population Groups	Improvement Plans submitted by Health Boards outlining implementation timeline	End July	
SPOA for Urgent Care and equitable Crisis Response services for falls	Health boards to submit improvement plans for delivery against expected outcomes	End July	6 Goals
	Monitor implementation through BCC 6 weekly Regional Monthly meetings	July onwards	SPPC and Six Goals

Pillar Two – Shared Outcome and Whole System Alignment and Cohesive Delivery	Action	When	By Who
What is the Outcome we Want? How do we measure improvement / What are the Measures?	Agree overarching population and system outcome Agree improvement (process) measures across ICCS components Demand & Capacity Modelling	End June August	ICCS Leadership Group SSID / DDTIV
Compendium of Frameworks or Guidance for 'what success looks like' for ICCS and Building Community Care Capacity priority Maturity Matrix for ICCS would be helpful to benchmark Regional position	Create a repository of Frameworks and guidance documents e.g SPOA Urgent Care, Integrated IAA Community Coordination, Proactive Care, PHM etc Develop and publish a Maturity Matrix for PHM and components of ICCS	End June	ICCS Leadership Group
Delivering the ICCS through PHM requires collective approach across policy and national programmes – reducing disconnect and silos / aligning resource	Collectively known as **Building Community Capacity (BCC)** priority and delivers preventative, proactive and urgent care actions that improve outcomes for people (care closer to home) and the system Winter Plan Alignment to the ambition Approve BCC (ICCS) governance beyond CAC	End June	EDT

Appendix Two DRAFT Outcomes and Measures Framework 'The Outcome we Want'

Population / Quality & Experience	Well and Independent	Improved Patient Experience	Reduced deconditioning in the community				
System Resilience (Proxy for Independent at Home)	Count of People receiving Social Care in the Community per 100k (will increase with demographic)	Count of People waiting for Social Care in the Community per 100k (reduce, stabilise or grow relative to demographic	Reduction Emergency Admissions to Hospital > 75s (Reason Codes Falls / Collapse)	% Emergency Admissions LOS > 21 days	Reduction in Transport to ED for L1 and L2 fallers (10% end December and 25% end March 2026)	Reduction in Admission for L1 and L2 fallers (10% end December and 25% end March 2026) Against March '25 baseline	
System Process Measures	% of individuals identified as being at risk who have been offered holistic assessment and Future Care Planning (Should be 100%)	Number of Future Care Plans in place	District nursing capacity at weekend in at 80% of that of weekday	Increase number of referrals to reablement and enhanced community care (Against March '25 baseline)	% of urgent care response to crisis (falls) responded to within 2 hours during core hours (8am - 8pm 7/7)	Care Home Consult before Conveyance *Measure TBC*	Number of contact assessed in HB SPOA as benefiting from redirection to community service provisions and % that were referred to community pathways with successful outcome *Measure TBC*

Appendix Three: Revised Governance, Reporting and Monitoring Structure



V0.4 with CB, ST and TC Comments considered