Best Start for Life	Indicators for dashboard	Ref	Commitment	What does success look like	Actions
First 1001 Critical Days	1. Smoking status at time of delivery 2. Infant Mortality 3. Low birth weight of term babies 4. New Birth Visits completed in 14 days 5. Caesarean Section? 6. A&E attendances - under 1 year? 7. babies first breast milk? 8. breastfeeding at 6-8 weeks? 9. Vaccination coverage - dtap/ipv/hib - 1 yr old	A.1	We will embed the Governments vision for 'The best start for life. A vision for the 1,001 critical days' through a local 1001 Critical Days Children's Manifesto and communication campaign	Positive local feedback from families confirming that they feel supported, through a range of integrated start for life services to develop their babies in the first 1,001 critical days -- Family feedback that services are working in more integrated and collaborative ways to support pre-school children and their families -- Increase in breastfeeding initiation and continuation rates --- Increase in immunisation rates, especially for the boosters at age 1 and 2years. --- Reduction in proportion of caesarean births	A.1.1 C&FPP Priority 1 (available at https://www.leicestershire.gov.uk/sites/default/files/field/pdf/2018/9/17/Partnership_plan.pdf) A.1.2 Saving Babies Lives V2 Priority 4 (available at https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf) A.1.3 NHS Long Term Plan TDP Priority 4 (Available at https://www.longtermplan.nhs.uk/) A.1.4 NHS Patient Safety Strategy priority 4 (available at https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/#patient-safety-strategy) A.1.5 Saving Babies Lives V2 Priority 1
		A.2	We will have joined up, accessible pre -school services, family hubs, an empowered workforce and clear local and national direction, vision and service improvement. This will include an integrated Early Years Pathway to identify and support vulnerable children.		A.2.1 C&FPP Integrated pathway Priority 1 A.2.2 NHS Long Term Plan TDP Priority 4 A.2.3 Saving Babies Lives V2 Priority 4 A.2.4 NHS Patient Safety Strategy priority 4
		A.3	Embed the additional 3-4month and 3.5 year checks into our public health nursing service.		A.3.1 NHS Long Term Plan TDP Priority 4 A.3.2 Saving Babies Lives V2 Priority 4 A.3.3 NHS Patient Safety Strategy priority 4 A.3.4 Recommissioning of the 0-11 public health children services
		A4	We will invest in evidenced based breastfeeding support for mothers across Leicestershire. Supporting them to initiate and continue breastfeeding for as long as they choose. Support will be prioritised for those in white other ethnic groups and younger mothers.		A.4.1 C&FPP Priority 5 See A.1 and A.3.4.
		A5	We will work to further increase uptake of childhood immunisations programmes especially boosters due at age 1 and 2years		See A.1 and A.3.4. A.5.1 Implementation of caesarian birth Nice guidance 192. A.5.2 Work with NHS E&I, CCG and PCN colleagues re uptake of the routine childhood Immunisation programme, potential health equity audits. Pilot in Charnwood see E.9.1.
		A6	We will empower families to feel confident and supported develop and grow. This will include support to access the most appropriate services for emotional health and wellbeing, minor aliments (including gastro, respiratory/ bronchitis and head injuries) and home safety.		A.6.1 EH - CFPP Supporting families to be resilient - Priority 3 A.6.2 CFPP Priority 5 - implementation of Trauma informed approach and reduction to children's A&E admissions. A.6.3. Review aapid access to jaundice clinics See A.1 and A.3.4.
School Readiness	10. School readiness: percentage of children achieving a good level of development at the end of Reception 11. School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception 12. Child development: percentage of children achieving a good level of development at 2-2½ years Proportion - % 13. Child development: percentage of children achieving the expected level in communication skills at 2-2½ years 14. Child development: percentage of children achieving the expected level in personal-social skills at 2-2½ years New data 15. Percentage of 2 year old children benefitting from funded early education		We will take a proportionate universalism approach and focus on narrowing the development gaps that affect children and families who are at the greatest disadvantage (e.g. those who access FSM, live in poverty or have a poor home environment, have SENDs and/or are in our care)	Reduce the gradient in developmental outcomes in those from disadvantaged backgrounds as compared to those in the most advantaged (i.e. split by deprivation, FSM and SEND). --- Families are clear on what good development in foundation looks like and what support is available to support their children to achieve this. --- Increase in the proportion of children achieving a good level of development at 2-2.5years and foundation stage across all development areas (fine and gross motor, communication) --- Improvement in maternal mental health	
		B1	We will support parents and families to build on their understanding of children's needs so that they are able to understand what good looks like and get their children off to a good development start		B.1.1 CFPP Priority 1
		B2	We will provide support to embed physical activity into young children's lives through interventions that improve fine and gross motor skills.		B.2.1 CFPP Priority 1
		B3	We will ensure access to support early development of speech, language and communication		B.3.1 CFPP Priority 1
		B4	We want to help families access free high-quality childcare and early education that is fully inclusive and accessible.		B.4.1 CFPP Priority 1
		B5	We will support improving maternal mental health and physical activity to allow parents and carers to be in the best position they can be to support their children		B.5.1 CFPP Priority 1
		B6			B.6.1 CFPP Perinatal MH Priority 5
Preparing for Life	16. Vaccination coverage - HPV Males 17. Vaccination coverage - HPV Females 18. Covid vaccination uptake 12-17 year olds 19. Children in care 20. 16-17 year olds NEET 21. School pupils with social, emotional and mental health needs 22. hospital admissions as a result of self harm (10-24) 23. Percentage of pupils with SEN or EHC Plan		We will work with young people, partners, parents and schools in increase HPV and Covid-19 vaccination uptake	High uptake of Covid vaccination in 12-17year olds --- Increase uptake of HPV vaccination in males and females --- Stabilising numbers and rates of looked after children --- Increased proportion of young people reporting strong emotional health and wellbeing --- Increased proportion of children at a healthy weight (not under or overweight/ obese, especially in SEND) --- Reduction in Adverse Childhood Experiences risk factors and increased proportion of young people that have a trusted adult in their life --- Reduction in A&E attendances in under 18's, including those caused by self harm	
		C1	We will investigate the causes of the increasing levels of children in care and work with families to prevent this whenever possible		C.1.1 Update trajectories following impact of Omicron variant on staffing numbers
		C2	We will ensure there are opportunities for all 16-17 years olds to gain education, employment and training		C.2.1 CFPP Priority 4
		C3			C.3.1. Recommissioning of 11+ children's public health services. C.3.2. Ensuring children get the correct support they need to consider options education, employment and training opportunities following

C4	We will develop the Healthy Schools and secondary school children's public health service to help build informed, healthy, resilient young people that have skills to stay safe from harm and are ready to enter the adult world	C.4.1 Ensure strategic and operational links to Mental Health Support Teams in Schools (MHSTs) See C.3.1. Recommissioning of 11+ children's public health services C.4.2. CFPP Priority 2 Link to children's mental health priority K4.
C5	We will ensure there is appropriate emotional and mental health support for children and young people as part of the Covid recovery	See C.3.1. Recommissioning of 11+ children's public health services
C6	We will ensure that children and young people have access to the services they need to gain and maintain an active lifestyle and healthy weight.	C.6.1 Further develop Healthy Schools and Healthy Tots programmes across Leicestershire. C.6.2 Coordinate actions through the Weight Management Sub Group See E3 linking to wider Healthy Weight and Physical Activity strategies
C7	We will support the workforce to embed a Trauma Informed Approach to reduce the impact of Adverse Childhood Experiences on later life	C.7.1 CFPP VRN Priority 5 C.7.2 Understand and share how uptake of Trauma Informed Approach is being monitored in provider workforces.
C8	We will ensure that children with SEND and learning disabilities have access to the support they need and a seamless transition into adult services.	C.8.1 CFPP Priority 4

Staying Healthy, Safe and Well	Indicators for dashboard	Ref	Commitment	What does success look like	Actions
Building Strong Foundations	1. Employment rate 2. Gap in employment rate for those in contact with secondary mental health services and the overall employment rate 3. Sickness absence 4. Homelessness 5. Proportion of adults in contact with secondary mental health services who live independently, with or without support 6. Violent Crime rate 7. Hate incidents recorded 8. Air pollution 9. Percentage of adults walking for travel, 3 days a week 10. Percentage of adults cycling for travel, 3 days a week 11. Air pollution	D1	We will work with partners to deliver the Leicestershire wider determinants action plan, this will include a Health and Equity in all Policies approach to all we do	Maintaining and increasing the employment rate. Specially for those with adult mental health. -- Improvement in sickness absence rate -- Reduction in the number of homeless single and family households and number of households where homelessness was prevented -- Improved numbers of adults with mental health living independently. -- Health and Equity in all policies approach embedded across the Leicestershire HWB partners. -- Ensure the appropriate, equitable infrastructure (including health services) is in place for the planned housing growth addressing health inequality through design and use of health impact assessments. -- Increasing access and uptake of active travel -- Increased proportion of Leicestershire residents who have access to green space within 10minutes walk. -- Improvement in air quality and its impact on health and health inequalities across Leicestershire -- Maintain low levels of crime especially violent and hate crime -- Reduction in fear of crime -- Reduction in the proportion of Leicestershire residents that experience fuel poverty	D.1.1 Populated Wider Determinants Action Plan (WDAP) agreed with partners. Delivery of the WD Action Plan against these SMART objectives.
					D.1.2 Training around Wider Determinants of Health, Health and Equity All Policies and health impact assessment for all levels across partners at Place.
					D.1.3 Agreement at Place on process to embed health and equity in all policies approach to key decision making.
		D2	We will further grow Leicestershire's economy and support recovery from the Covid pandemic including work with the Leicester and Leicestershire Enterprise Partnership, Levelling Up and having economic growth for all. We will support those in poverty to access the support to gain employment and eligible benefits and hardship.		D.2.1 Links to LLEP Recovery Plan https://llep.org.uk/app/uploads/2020/12/Economic-Recovery-Action-Plan-COVID-19-FOR-web.pdf
					D.2.2 Links to Strategic Growth Plan https://www.llstrategicgrowthplan.org.uk/wp-content/uploads/2019/01/Final-LL-SGP-December-2018-1.pdf weaknesses on page 3 might influence what does success look like
					D.2.3 Consider strengthening links between the WDAP to include growth that includes health considerations around employment needs.
					D.2.4. Deliver the Work and Slills Leicestershire programme through Adult Learning services
		D3	We will work to ensure everyone has 'good work' for them. Supporting people to enter and maintain good employment/ skills and support those with health and care needs to keep their jobs, with particular attention to sickness absence (due to musculoskeletal and mental health conditions) and considering an aging workforce. . Work will also consider the role of workplaces in supporting health and wellbeing.		D.3.1 Creation of an expanded and integrated workplace Health offer, based on evidence of need post Covid for our working age population. Particular focus on development around the Musculoskeletal and mental health elements of the offer with a development of clear pathways for employers.
					D.3.2 Delivery of a range of Adult Learning courses provide opportunities to help individuals develop skills improving prosperity and life chances. Including the delivery of Leicestershire Work and Skills programme.
		D4	We want everyone to have access to a good home. We will work with partners to ensure high quality new and current housing that has access to green space and supports good health and wellbeing. We will also work collaboratively to prevent homelessness whenever possible.		D.4.1 A common, approved approach to embedding health and care considerations within the planning process on Leicestershire, informed by pilot work with NWL, Blaby and the TCPA. Link to actions in WDAP.
					D.4.2 Pilot and promote use of health place making portal with Planners and Developers.
					D.4.3 Complete Housing health needs assessment pilot for Charnwood
					D.4.4. Investigate the quality of current social housing stock and consider recommendations for improving this.
					D.4.5. Develop innovation in the use of adaptations and technology in homes that support people to live independently for longer in their own homes, including links to Lightbulb.
		D5	We will work with system partners to support adults with mental health challenges to live independently		D.5.1 Set up subgroup of Chief Housing Officers Group to review mental health considerations.
					See mental health priorities K.
		D6	We will effectively and equitably plan for our growing and older population to ensure everyone has access the services, transport and infrastructure they need		See D.4. actions.
					D.6.1. Deliver Home Care for Leicestershire framework.
					D.6.2. Consider links between Leicestershire Transport Plan and health and wellbeing.
		D7	We will work with Community Safety Partnerships to maintain low levels of crime and support community cohesion including work to reduce domestic violence and implement the Domestic Abuse Act 2021.		D.7.1 Develop links with Community Safety Partnerships and how the HWB can support the domestic violence agenda.
		D8			D.8.1 Ascertain contributors to and those unequally impacted by air pollution within Leicestershire
					D.8.2 Plan and deliver an informed engagement exercise with these target groups, communicating key messages around health risk, prevention and mitigation of harm.

			We will implement the Air Quality and Health action plan		D.8.3 Deliver an annual campaign around Clean Air Day to our population
					D.8.4 Investigate the relationship between air pollution and Children's hospital admissions within the county
					D.8.5 Upskill clinicians around the wider determinants of health and their impacts on respiratory/coronary health outcomes and health inequality
					See D1.3.
		D9	We will collaborate with the Leicestershire planning system and developers to explore a new approach to the design of our residential, employment and town centre environments to increases active travel, green infrastructure and reduction in motorised transport.		See D.4.1. Health and equity in all policies.
					See F4.
		D10	We will support families out of fuel poverty and into affordable warmth		D.10.1 Increase awareness of the First Contact Plus to ensure residents access the housing and fuel support they are eligible for.
					D.11.2 Consider links to Chief Housing Officers Group on fuel poverty.
		D11	We will review the health impacts of climate change to support wider environmental workstreams to embed a health lens into their approach.		D.11.1 Work with the National Institute of Health Research looking at creating a framework to capture co-benefits between Environment and Transport work and their outcomes and Public Health.
					D.12.2 Support work relating to Carbon Zero.
					D.12.3 develop link to biodiversity net gain work and requirement for consideration in planning approvals.
					See D.4.1.
Enabling healthy choices and environments	12. Smoking prevalence 13. successful completion of drug treatment - opiate users 14. Percentage of physically active adults 15. Percentage of adults classified as overweight or obese 16. Proportion of people eating 5 fruits and vegetables a day 17. Chlamydia detection rate 18. HIV Testing Coverage 19. Over 25 abortion rate 20. Percentage of adults who feel lonely often/always or some of the time 21. Fast food outlet density? 22. Cancer Screening - Breast Cancer 23. Cancer Screening - Cervical Cancer 24. Cancer Screening - Bowel Cancer 25. Percentage of cancers diagnosed at stages 1 and 2 26. Vaccination coverage - 27. Vaccination coverage - Flu aged 65+	E1	We will increase knowledge and access to prevention services through embedding Making Every Contact Count training and social prescribing approach across our collective workforce	Maintain and improve performance on smoking prevalence and substance misuse --- Reduced proportion of overweight/ obese adults and increased proportion of physical activity --- Improved access and uptake of five fruit and vegetables a day --- Improved Chlamydia detection and HIV testing rate --- Levelling and reversing the increasing trend in abortions for over 25's --- Reduction in loneliness, improvement in community cohesion and resilience Improved vaccination rates for Flu and Shingles, that are comparable to the areas with the best uptake rates in England --- Reversing the decline in cancer screening rates and more cancers diagnosed at Stages 1 and 2 --- Health Check coverage is on par with our ONS comparators in England --- Qualitative feedback that residents have improved knowledge and access to prevention services.	E.1.1 Embed MECC training across Leicestershire also to be delivered to support the Health and Equity in all policies work.
					E.1.2. Develop 3 conversations model across Adults and Communities linked to asset based commissioning.
					E.1.3. Continue to deliver active signposting training across primary care.
		E2	We will deliver targeted, effective and consistent health and wellbeing communications to empower Leicestershire to make healthy choices, including how to access services.		E.2.1. Maintain coordinated communication campaigns across Leicestershire to support healthy choices.
					E.2.2. Communication campaign regarding access to prevention services.
					E.2.3 Communicate with businesses as part of the development of the wider workplace health offer.
		E3	We will work with partners to deliver the Leicestershire Healthy Weight strategy, Food Plan and Active Together Partnership Physical Activity Framework		E.3.1 Support implementation of Leicestershire Healthy Weight and Food Plan including piloting a fast food policy.
					E.3.2. Support delivery of Active Together Partnership Physical Activity Framework
		E4	Through the Leicestershire Sexual Health Strategy, we will improve sexual health outcomes including chlamydia detection, HIV testing and combatting the increasing levels of abortion		E.4.1. Support implementation of the Leicestershire Sexual Health Strategy
					E.4.2. Investigate the reasons behind the trends in chlamydia detection rate and HIV testing with integrated sexual health provider.
					E.4.3. Review the increasing levels of abortion and termination of pregnancy pathway.
		E5	We will further develop the ABCD, strength-based approach to build social capital and strong, connected and resilient communities		E.5.1 TBC
					See D.4.
		E6	We will work with businesses to support enabling healthy choices through their shop/ supermarket		E.6.1 TBC
					See D.4.1. Health and equity in all policies.
		E7	We will work to further develop active travel across Leicestershire including a review of connected and walkable neighbourhoods and		E7.1 Develop stronger links between Environment and transport and public health to progress plans on connected, walkable, rural communities. (Links to 30minute neighbourhoods.)
					E7.2 Consider Healthy Schools Programme role in increasing active travel in children and young people.

	28. NHS Health checks		rural connectivity to understand how these impacts on healthy behaviour and environments		See D4.
					See E.3.2. Support delivery of Active Together Partnership Physical Activity Framework
		E8	We will work with planners and licensing officers to further build a healthy environment across Leicestershire reviewing fast food outlet and alcohol premise density		E.8.1 Develop link to Strategic Planning Group, Environmental Health and Licensing to progress discussion re fast food and alcohol licensing policy.
					See D.4.1. Health and equity in all policies.
		E9	We will invest in improving vaccination and screening rates (including cancer and health check coverage). This will include understanding the reasons for the decline in cancer screening rates and a targeted approach for those populations most at risk of premature		E.9.1 Review vaccination and screening uptake across Place and at neighbourhood level through Community Health and Wellbeing plan. Pilot completed with Charnwood PCN.
					E.9.2. Link to wider system work regarding vaccination and screening uptake, including health equity audits.
					E.9.3. Reviewing delivery of health checks across Leicestershire.

Living and Supported Well	Indicators for dashboard	Ref	Commitment	What does success look like?	Actions
Up Scaling Prevention and Self Care	1. Frailty collaborative measure: falls for people aged 65+ and falls in care homes 2. Fingertips hip fracture measures 3. BCF indicator/NHS OF: unplanned hospital admissions for chronic ambulatory care sensitive conditions 4: NHS OF: emergency admissions for acute conditions that should not require hospital admission Lucy Hulls to see if there is anything else from falls group that could be used here Christine Collingwood to see if there is a way to measure some of the asset based work in ASC John to advise on a measure looking at no. of people with 2 or less LTC's progressing into 5 or more	F1	We will empower patients to self-manage their long-term condition(s) through a variety of routes for different needs, including the use of expert patient programmes, social prescribing, digital approaches, assistive technology, accessible diagnostics and support.	Slowing the number of people who progress from living with 1 or 2 LTC's to 5 or more --- Qualitative feedback suggests multi-disciplinary, holistic care planning and self-management support packages that enable people to live well with long term conditions for longer, with less need for acute care --- An asset-based approach is taken to recognise and build on the strengths of individuals, families and communities --- Reduction in rates of falls across Leicestershire for people aged 65+, being on a par with the best performing authorities Reduction in rates of hip fractures across Leicestershire	F.1.1 Strengthen links between the HWB and frailty collaborative to support implementation of Leicestershire specific actions. F.1.2 Delivery of the Adults and Communities Strategy. See F2. F.1.3 Evolution of Integrated Neighbourhood Teams and role of care coordinators proactively identifying patients who require Care Plans as part of multidisciplinary working. F.1.4 Embedding different options for assistive technology including work through the Lightbulb such as assistive technology pilots to support individuals with a new diagnosis of dementia. F.1.5. Implement Technology Enabled Care (TEC) service across adult social care in Leicestershire County Council.
		F2	We will deliver the Adults and Communities strategy including building asset-based approaches to working with people and communities		F.2.1 Delivery of the Adults and Communities Strategy Including the development of asset based commissioning and the communities and wellbeing volunteering offer. F.2.2 Strengthen Carers Support Services. F.2.3 Review volunteering and voluntary sector support to building asset based approaches across Leicestershire. F.2.4. Deliver the adult and community learning programme through LALS. See E.1.2. Implement 3 conversations model across adults social Care in Leicestershire
		F3	We will reduce the number of falls that people over 65 experience, including people in residential and nursing care homes		F.3.1 Complete a mini needs assessment to look in more depth at the rates of hip fractures, causes for this and possible preventative measures. F.3.2 Scoping a self assessment tool for falls risk for 60+ with onward signposting and app to help manage balance F.3.3 Piloting of a falls crisis response service F.3.4 Reviewing Assistive technology services to support Falls Risk See F.1.
		F4	We will support the Adults and Communities Accommodation Strategies and Investment Strategy Prospectus to ensure people living with disability and long term conditions have access to the right housing, care and support		F.4.1. Implementation of the Adults and Communities Accommodation Strategies and Investment Prospectus. See F.1.4
		F5	We will work to improve access to health and care services including primary care and appropriate funding support		F.5.1. Support LLR action to improve access to primary care (system wide) and translate specifi
Effective management of frailty and complex care	5. BCF indicator/NHS OF: Unplanned admissions for chronic ambulatory care sensitive conditions 6. BCF indicator/NHS OF: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into rehab/reablement 7. BCF indicator: % of people discharged from acute to normal place of residence 8. BCF indicator: % of patients who have been an inpatient in acute for more than 14 and 21 days 9. Home First outcome: To ensure 95% of patients who are identified as vulnerable (eol, care home, frailty flag) have an agreed care plan by Dec 21	G1	We will build on the LLR Population Health Management framework and development programme, translating implications to Leicestershire to identify those at greatest risk of poor health outcomes including multiple hospital admissions	Early identification of patients at high risk of hospitalisation and social care needs using a Population Health Management approach --- Reduced numbers of hospital admissions for hip fractures and COPD -- Reduction in emergency bed days for those with 5 or more Long Term Conditions -- 95% of people identified as vulnerable have a co-produced care plan, which takes into account their wider needs e.g. multiple LTC's, social/psychological elements and carer arrangements --- Improved performance on the Better Care Fund metrics: reduced permanent admissions to residential and nursing care, increases in the number of people (aged 65+) still at home 91 days after discharge into rehabilitation/reablement services, reduction in delayed transfers of care from hospital	G.1.1 The care co-ordination service will work proactively with GP surgeries and PCN's. The service will fund co-ordinators (one for each PCN), using risk stratification data to identify those at highest risk of emergency admission in the next 18 months, frailty score of 5+ or those with 5 or more co morbidities and disabilities. G.1.2 Development of a frailty training strategy that will effect a cultural change in how we approach frailty more proactively. G1.3 Work to address Tier 1 of frailty toolkit (patients, carers, domiciliary care, care homes) to develop practical education aimed at enabling them to understand frailty, how to identify it, how to address it and who to approach for support. This is being developed via Carers delivery group and care homes sub group. G.1.4. Further development of MDT Framework and wider Integrated Neighbourhood Team (INT) working (operational elements of population health management.) G.1.5. Development of the strategic approach to population health management at neighbourhood level, aligning strategic work of the INT with the Community Health and Wellbeing Plans.

	10. Home First Outcome: to stabilise ED attends for complex patients at 19/20 levels 11. Home First Outcome: To increase 2 hour urgent community response compliance to 80% across all providers by April 22 12. BCF indicator: Res and nursing admissions: planned rate of 519 = 3% reductions from 19/20 rate of 536 13. Home First target: to increase 2 day reablement compliance to 80% across all providers by April 2022 John considering whether we can get a measure for reduction in emergency bed days for 5 or more LTC's	**G2** We will provide joined up services that support people and carers to live independently for as long as possible, including those with dementia. Supported by integrated health and social care workforce this will ensure that the patient sees the right person for your problem at the right time	services, reduction in delayed transfers of care from hospital and reduced non-elective admissions into hospital -- Improved patient satisfaction and coordination in complex care pathway and care coordination across the system especially for those with multimorbidity (5+ chronic conditions) --- Improved quality of life for carers --- Improved identification of people with moderate or severe frailty in the short term, followed by a reduction in the number of people with moderate or severe frailty as a result of proactive action	G.2.1 Annual review of f BCF schemes that are funded across CCG's and LCC Adult Social Care to ensure co-ordinated care and support is available to keep people living independently as long as possible. This includes services such as: care co-ordinators, home care, community response and reablement, integrated discharge hub and case management, the housing enablement scheme and therapy led D2A beds. G.2.4. Support delivery of the wider LLR workforce strategies such as the NHS People Plan, A&C strategy to ensure we have the capacity and capability in the health and care workforce to meet current and future needs. G.2.3 Delivery Transforming Care programme See F.2.2. regarding Carers services and E.1.2. re 3 conversation model in adult social care.
		G3 We will deliver an effective health and care integration programme that will deliver the Home First step up and step down approach for Leicestershire		G.3.1 Delivery of the Home First model of care including integrated teams for hospital discharge and reablement, operating on a "home first" philosophy that provides immediate support in the community and assesses ongoing need. The service will support people to step down after a stay in hospital or step up care at home when needs change or there is a G.3.2 Delivery of Joint Commissioning bed framework with Midlands and Lancashire. G.3.3 Delivery of Discharge to Access (D2A) Therapy beds. G.3.4 Increase the numbers or people able to benefit from reablement via HART Reablement. Key performance indicator is 87 starts per week. G.3.5 Increase in workforce within our Crisis Response Service G.3.6 Delivery of Community Hospital Link Workers
		G4 We will seek to develop a more qualitative, holistic approach to care planning and risk management, exploring ways in which this could be delivered by a wider range of professionals across Leicestershire through Integrated Neighbourhood Teams.		G.4.1 Holistic approach in case management function for adults social care. Links to G.1.1. G.4.2 Revision of Integrated personalised care framework. G.4.3. Implement Shared Care Record across health and social care in LLR. See G.1.1. Re care planning.
		G5 We will improve the quality and coverage of joined up care planning for the most vulnerable including strengthening care planning links across primary and secondary care to achieve 95% of the vulnerable population having a care plan in place		G.5.1 Delivery of several priority schemes are defined under the Home First Programme see G.3.1. G.5.2 Implementation of Integrated Case Management Function. Link to Shared Care Record G.4.3. See G.1.1. Re care planning.
		G6 We will continue to implement the LLR Carers strategy for Leicestershire and strengthen links with the LLR Carers Board.		G.6.1 Support implementation of the Leicestershire elements of the LLR Carers strategy. G.6.2. Strength links between the LLR Carers Board and Leicestershire HWB. G.6.3. Ensure health and wellbeing needs of carers are prioritised across the system. See L.2.4. Auditing the number of carers across key LLR anchor institutions.
		G7 We will work to measure and reduce the number of emergency bed days people with Long Term Conditions experience		See G.3.1 and G.5.1. re delivery of Home First. See G.1.1. and G.4.1. Re care planning and operational population health management. In particular patients that have 5-7 co morbidities.
		G8 We will offer a two hour crisis response for people that may otherwise need to attend hospital (target 80% by April 2022).		See G.3.1 and G.5.1. re delivery of Home First. G.8.2 Improved data reporting to reflect 2 hr response activity including implementation of new form and staff training G.8.3 Submit data through CSDS to NHS Digital for national reporting G.8.4 Workforce recruitment campaigns to increase the Crisis Response Service

		G9 We will reduce the number of permanent admissions to residential and nursing homes.	See G.2.1. RE BCF programmes. G.9.1 Increased brokerage resource for quicker point of care (POC) starts G.9.2 Maintain HC4L framework to improve access to care packages particularly within rural areas. G.9.3 Continued business analysis on the increase in demand for domiciliary care ensuring that this demand can be reached effectively within the community. See F.1.4. re housing adaptations and F.1.5. Implement Technology Enabled care (TEC) service
		G1 We will ensure eligible people receive reablement within 2 days of discharge	G.10.1 15% increase in HART service, funded through BCF. G.10.2 Target operating model implemented within HART to increase the numbers able to benefit from reablement to 87 starts per week. G.10.3 Ongoing recruitment campaigns to support increase in staffing numbers into reablement services - increasing overall capacity by circa 15%. Link to G.8.4. G.10.4 Reduce % of inappropriate patients referred to reablement services with improved triaging G.10.5 Effective use of Multi-Disciplinary Team approach to reablement, involving health and therapy partners to maximise independence and sustainability of individual progress. Link to G.1.1.

Dying Well	Indicators for dashboard	Ref	Commitment	What does success look like?	Actions
Understanding the need		H1	We will carry out a Joint Strategic Needs Assessment chapter looking at end of life specifically	Reduction in the percentage of deaths occurring inside of hospital, aiming to achieve LLR target of a maximum of 35% in adults aged 18 and over. -- Clear qualitative understanding of what 'dying well' looks like across Leicestershire and what support is needed to ensure this happens.	H.1.1 JSNA undertaken
		H2	We will seek to gather views from people to understand what dying well means to them and how this could be achieved		H.2.1 Engagement undertaken to understand people's views of what dying well looks like and how this could happen.
Effective transitions	1. Home First Outcome: To ensure 95% of patients who are identified as vulnerable (eol, care home, frailty flag) have an agreed care plan by Dec 21 2. No. of ReSPECT plans in place	I1	We will seek your views on what planning and services for late and end of life should look like and how you should be informed about your choices	Increased proportion of people planning for late stages and end of life at a time when they are still able. -- Qualitative feedback that people know and have support on what to expect and what choices are available to them. They have the time to consider and plan for these decisions and to discuss them with family, friends and carers should they wish.	See H.2.1. Engagement
		I2	We will ensure there is a clear transition in care planning from living with long term conditions into the later and end of life		I.1.2. Consider the roles of cemeteries, crematoriums and public health burials in wider end of life pathways. I.2.1 Ensure effective transition between living with several long term conditions and end of life. See G.1.1. re care planning and G.1.4. re MDT working.
		I3	We will ensure there is appropriate support for carers following the bereavement of a loved one so they can have a supportive transition into the next stage of their lives		I.3.1 To be informed by the new carers strategy (under development) and the JSNA on dying well. Link to H.1.1. and G6.
Normalising end of life planning	3. Home First Outcome: To ensure 95% of patients who are identified as vulnerable (eol, care home, frailty flag) have an agreed care plan by Dec 21 4. No. of ReSPECT plans in place 5. Home First Measure: to reduce deaths in hospital from 40% to 35% by April 2022 6. Place of death measure (i.e. home, hospital or residential care) Do we have any workforce measures we could use here? E.g. no of training places provided?	J1	We will offer care plans and ReSPECT plans to all vulnerable people with a take up target of 95%	Care plans offered to all vulnerable people that may benefit from having one with a target of 95%, this should include a ReSPECT plan -- High levels of take up with people specifically opting out of having a plan in place rather than being missed from the offer of one --	J.1.1. Workforce training to support care planning at the end of life to meet 95% take up of a care ReSPECT plan. Link to I.2.1.
		J2	We will use our better understanding of needs through the JSNA chapter to consider other aspects of end-of-life planning	Qualitative feedback that Leicestershire feels comfortable and supported to plan for the end of life.	J.2.1 Once the engagement activity has completed, we will consider the findings of this and the JSNA and produce an action plan for improvement if this is necessary.
		J3	We will develop a social marketing campaign based on insight to normalise end of life planning	End of life as everyone's business - an educated and compassionate workforce that can support people at the end of life. Care co-ordination for people in the last days and weeks of life operates well.	J.3.1 This will be considered once more is known about what people want from end of life planning and how they would like to receive communication (i.e. following the engagement)
		J4	We will educate our workforce so that everyone understands how to support people at end of life		J.4.1 Workforce training to support conversations regarding end of life planning and decision making.
		J5	We will improve co-ordination of care at end of life, as measured through patient feedback		J.5.1 Review end of life pathway following results of JSNA chapter and regularly review feedback to see if outcomes and coordination have been improved.

Reducing Health Inequalities	Indicators for dashboard	Ref	Commitment	What does success look like	Actions
	1. Healthy Life Expectancy - Males 2. Healthy Life Expectancy - Females 3. Life Expectancy at birth - Males 4. Life Expectancy at birth - Females 5. Inequality in Life Expectancy at birth - Males 6. Inequality at Life Expectancy at birth - Females 7. Any indicators suitable from health inequalities dashboard?	L1	We want equitable access, excellent experiences and optimal outcomes for all those using health and care services across Leicestershire. To do this we will embrace a proportionate universalism' approach where interventions are targeted to enable a 'levelling up' of the gradient in health outcomes. This means that although there will be a universal offer of services to all, there will be justifiable variation in services in response to differences in need within and between groups of people, that will aim to bring those experiencing poorer outcomes the opportunity to 'level up' to those achieving the best outcomes. (I.e. developing the national CORE20PLUS5 initiative.)		L.1.1. All services to consider a proportionate universalism approach tailored to the local need as appropriate, including regular Equalities Impact Assessments and Health Equity Audits on L.1.2 See actions L2 below L.1.3 See actions in L3 below. L.1.4. Review the specific needs of the military and veteran populations across LLR and identify recommendations to support delivery of the military Covenant.
		L2	We will translate the Leicester, Leicestershire and Rutland Health Inequalities framework for Leicestershire. This will include embedding a Health and Equity in all policies approach, utilising anchor institutions, training our leaders on health inequalities and ensuring we are collating data to analyse health inequalities effectively	Reduction in the slope index of inequality or 'levelling up' of the social gradient -- A greater rate of improvement in life and health life expectancy in the most deprived communities and vulnerable groups across Leicestershire (including those from specific ethnic or vulnerable groups and disabilities.)	L.2.1 Embed Health and Equity in all polices approach across Leicestershire to ensure health and inequalities are considered for all key strategic decisions across Leicestershire. See D.4.1. L.2.2 Implement Health inequalities training (including the LLR Inclusive Decision Making Framework) for all senior managers across Leicestershire. L.2.3 Support key public sector organisations to collect accurate data on the protected characteristics including ethnicity and disability. L.2.4. Key organisations to understand the scope and role of being anchor institutions in relations to reducing health inequalities and climate change. This may include an audit of carers across the L.2.5 Development of a LLR Health Inequalities Unit/ Population Health Management Unit.
		L3	Within the NHS we will also prioritise the five key clinical areas of health inequalities including early cancer diagnosis (screening & early referral), hypertension case finding, chronic respiratory disease (driving Covid & Flu vaccination uptake), annual health checks for people with serious mental illness and continuity of maternity carer plans .		L.3.1 Implementation of the CORE20PLUS5. Including specific interventions to reduce health inequalities aligned to the national priority areas of maternity, severe mental health, chronic respiratory illness, early cancer diagnosis and hypertension case L.3.2 Review of obesity pathway including the adult tier 3 weight management services across LLR. L.3.3 Further implementation of the CURE project to support stopping smoking during a hospital admission in LPT and UHL. L.3.4 Review of Health Check delivery model. See E.9.3.
		L4	We will review the health inequalities across Leicestershire in particular understanding the impact of Covid-19 on our most disadvantaged populations including those living in the most deprived areas or groups (including military and veterans, carers, those with a disability and LGBT+)		L4.1.1. Review of key health inequalities across Leicestershire following Covid -19 pandemic.

Improved Mental Health	Indicators for dashboard	Ref	Commitment	What does success look like	Actions
	1. Estimated prevalence of common mental disorders - 16+ 2. Estimated prevalence of common mental disorders - 65+ 3. Gap in employment rate for those in contact with secondary mental health services and the overall employment rate 4. Adults in contact with secondary mental health services who live in stable and appropriate accommodation 5. Loneliness: percentage of adults who feel lonley often/always or some of the time 6. Self reported wellbeing - people with a high anxiety score 7. Suicide rates 8. Hospital admissions for mental health conditions - under 18 years 9. Hospital admissions for as a result of self harm - 10-24 years 10. Estimated number of children and young people with mental disorders - aged 5-17 11. School pupils with social, emotional and mental helath needs - school age 12. Percentage of looked after children whose emotional wellbeing is a cause of concern - aged 5-16 13. Estimated Dementia diagnosis rate (65+)	K1	We will prioritise Mental Health on an equal basis to physical health in plans, investment and focus also considering the links between physical activity and good mental health and how mental health is linked to other conditions.	Increased proportions of Leicestershire experiencing good mental health and wellbeing. -- Qualitative feedback that good emotional health and wellbeing is actively promoted and supported across the county including for carers and that services are joined up and meeting patient's needs at the right time and place. -- Reduction in the proportion of people with mental health challenges that need intensive and specialist offers. -- Maintain rate suicide rates that are lower than the national average. -- Increase dementia diagnosis rates to meet NHSE target of 67% and clear links made between healthy lifestyle and the risk of dementia. -- To increase the proportions of people with mental health challenges that: o Access and take up high quality advice, support and access to local amenities, including activities and groups to strengthen mental health and wellbeing o Live as independently as possible o Be supported around their individual recovery goals o Access to education, employment, training and housing and are supported by their employer/ institution o Have easy and timely access to the right, local, coordinated service o Have their physical health needs monitored and key health / lifestyle needs supported o Have their carers and families caring and mental health needs identified and supported	K.1.1 - Joint commissioning of LLR Mental Health Wellbeing and recovery support service K.1.2 - Place Based Mental Health Multi-agency group to be established with the goal of providing cross-agency collaboration on mental health objectives K.1.3. Identifying the links between good mental health and physical activity. See E3.
		K2	We will seek to co-produce a Prevention Concordat for Better Mental health for Leicestershire to align organisations to further support mental health and wellbeing and prevent poor mental health		K.2.1 - Draft and implement a Prevention Concordat for Better Mental Health across Leicestershire
		K3	We will continue to focus on maintaining low rates of suicide and impact of suicide, supporting work of the LLR Suicide Strategy.		K.3.1 Implementation of the LLR suicide prevention strategy, translating and implementing the specific actions for Leicestershire. Link to Suicide Audit Prevention Group (SAPG).
		K4	We will continue to support the system work on children and young people's emotional health and well being		K.4.1 Implement the LLR Trauma Informed Practice Strategy K.4.2 Piloting Wellbeing App in secondary schools K.4.3 Implementation of emotional health and resilience elements of Healthy Schools work. K.4.4 Delivery of youth engagement activators programme K.4.5 Determine youth counselling/peer engagement programme of work
		K5	We will listen and respond to the Leicestershire population in the 'Step up to Great Mental Health' consultation and propose to deliver a variety of changes for our population through the LLR and Leicestershire specific Step up to Great Mental Health		K.5.1 Translate Leicestershire specific elements of feedback into JHWS delivery plan and also neighbourhood level community health and wellbeing plans. K.5.2 Establish Leicestershire specific mental health subgroup.
		K6	We would support key recommendations of the Dementia JSNA Chapter and LLR Dementia Strategy (due to be reviewed in 2022). This will include improving dementia diagnosis rates and ensuring clear links between healthy lifestyle and risk of dementia through MECC Plus and Health Checks		K.6.1 Support implementation of the Dementia JSNA chapter as part of the wider LLR Dementia Strategy

COVID-19 Recovery	Indicators for dashboard	Ref	Commitment	What does success look like	Actions
	1. Covid vaccination rates for D1, D2 and Boosters? 2.Hospital Admissions linked with Covid 3. Deaths due to Covid 4. ·No. of settings based outbreaks due to Covid 5.Long Covid numbers	M1	We will support our population to get timely access to the Covid-19 vaccinations that are appropriate to them	High uptake of the Covid-19 vaccination -- Reduction in hospitalisations and deaths due to Covid-19 -- Reduction in settings based outbreaks due to Covid-19 -- Numbers of people accessing support for Long Covid -- Patient feedback that health and care services are equipped to manage the Covid-19 in the longer term	M.1.1 Delivery of LLR Covid vaccination programme. Targeted work to meet the needs of MSOAs and groups with low uptake. M.1.2 Targeted communication campaigns to support increase in uptake and reduce myths about vaccination. M.1.3
		M2	We will ensure our health and care services are equipped to manage the impact of Covid-19 directly and indirectly for the longer term.		M.2.1 Services to regularly review business continuity plans in relation to Covid-19 pandemic including impact on the workforce. M.2.2 Services to consider the impact of the Covid pandemic, how services reopen and recovery in the longer term model of service delivery. Services recommissioned and redesigned as appropriate. M.2.3 Services supported by upper and lower tier local authorities through Covid funding as available and appropriate.
		M3	We will use the results from the Covid-19 Impact Assessment to target specific interventions and vulnerable groups throughout the wider		M.3.1 Review the results of the Covid-19 impact assessment and implement specific interventions and support as needed.
		M4	We will support Leicestershire to live with Covid-19 circulating within our population in the longer term.		M.4.1 See M.2.2. M.4.2 Understand the impact of long Covid-19 and review services available to support people living with long Covid-19.
		M5	We will ensure we maintain a collaborative health protection approach and response ready for future Covid-19 surges or other future pandemics.		M.5.1 Establishment and maintenance of partnership working through Outbreak Control Meetings and Incident Management Team as needed to respond to Covid-19 and future health protection incidents. This includes linking into organisation recovery groups and LLR Prepared cells. M.5.2 Regular review and update of Local Outbreak Management Plan