LIVING AND SUPPORTED WELL

	Ref	Commitment	Actions	Links to other Plans/Strategies	What does success look like?	Dashboard Indicators
Upscalaing prevention and self care	F1	**Empowering self-care** - We will work together to support people to manage their long-term health conditions in ways that work best for them. This includes offering different types of local support to meet different needs.	**F1.1** Developing and implementing proactive care service delivery within neighbourhood models of care **F1.2** Implementing Integrated Neighbourhood Team offer to support Multi Disciplinary Team's and work with Patient need groups 1-5	Staying Healthy Partnership delivery plan - Neighbourhood Plans - NHS 10 Year Plan - Carers Strategy	Qualitative feedback that suggests that multi-disciplinary, holistic care planning and self-management support packages, enable people to live well with long term conditions for longer, with less need for acute care. - Producing care plans for people with multi co-morbidities to reduce the need for urgent or emergency care. - Reduction in permanent admissions to residential and nursing homes. - Increase in the use of technology to support people to live independently - Evidence that an asset-based approach is being taken to recognise and build on the strengths of individuals, families and communities. - Sustained reduction in the rate of admissions due to falls for people aged 65+. - Sustained reduction in the rate of hip fractures. - Reduction in the percentage of adult carers reporting loneliness or social isolation.	E13 - Hip fractures in people aged over 65 and over - Percentage reporting at least two long-term conditions, at least one of which is MSK related - Permanent admissions to residential and nursing care homes per 100,000 - BCF Indicators / NHS OF - Unplanned hospital admissions for chronic ambulatory care sensitive conditions - NHS OF emergency admissions for acute conditions that should not require hospital admission
	F2	**Access to care services** - We will make the best use of our resources to improve access to health and care services to ensure people get the support they need, when they need it.	**F2.1** Development of a system wide single point of access **F2.2** Improving access to Integrated locality teams aligned to include crisis response services **F2.3** Improve responsiveness to community Stroke services linked to locality teams functions			
	F3	**Supporting independence** - We will support people with disabilities and long-term health conditions to live independently. This includes making sure they can access suitable housing, care, equipment, adaptations, technology and personalised support that meet their needs.	**F3.1** Expanding Lighbulb integrated housing service delivery including Disabled facilities grant's **F3.2** Assisted technology and equipment review across partners			
	F4	**Falls prevention & management** - We will strengthen support to reduce the impact of falls and reduce their impact, particularly on hospital admissions, to help people stay safe and well.	**F4.1** Recommission and / or develop falls car service and link to single point of access to reduce long-lies and hospital admissions **F4.2** Increase step-up services linked to frailty and reducing admissions due to effective triage and treatment at hospital attendance			
	F5	**Support for carers** - We will support carers to improve their quality of life by making sure they are included in decisions about the person they care for and can easily find the information they need, when they need it.	**F5.1** Delivery of the carers strategy and improving comms to residents in order for them to access appropriate support Develop support for carers and those that they care for is in place when a hospital attendance or admission is required			
t of frailty and complex care	G1	**Early identification of need** - We will build on the local population health management (PHM) framework to create a proactive care model that identifies people's needs earlier, helping to prevent crises before they happen.	**G1.1** Develop Neighbourhood care models derived from Population Health Management data against highest needs and likelihood for crises. **G1.2** Develop Integrated Neighbourhood Team prevention focused neighbourhood care models based on Population Health Management data	NHS 10 Year Plan -	Early identification of individuals at high risk of hospitalisation and social care needs using a Population Health Management approach and delivering outcomes within a neighbourhood care model. - Reduction in emergency admissions for those aged 65+. - Reduction in emergency bed day usage for those with 5 or more Long Term Conditions. - Improved timeline of discharges across all pathways - Increased utilisation of reablement - 95% of people identified as vulnerable have a co-produced care plan, which takes into account their wider needs e.g., multiple LTCs, social/psychological elements and carer arrangements - Improvement in the percentage of patients aged 65+ discharged back to their Usual Place of Residence - Reduction in long-term admissions to residential care homes and nursing homes	B18b - Social isolation - percntage of sdult carers who have had as much social contact as they would like - BCF Indicator/NHS/OF - unplanned admissions for chronic ambulatory care sensitive conditions - BCF Indcator/NHS/OF - Proportion of older people (65+) who were still at hom 91 days after discharge from hospital into rehab/reablement - BCF indicator - percentage of people discharged from acute to normal place of residence - BCF Indicator - percentage of patients who have been an inpatient in acute care for more than 14 and 21 days - Home first outcome - To ensure 95% of patients who are identified as vulnerable have an agreed care plan
	G2	**Supporting independent living** - We will provide joined up health and care services that help people, and their carers live independently for as long as possible in the place they call home. This will be supported by a joined-up workforce that will make sure people get the right support at the right time.	**G2.1** Development of integrated care teams linked to Single Point of Access and crisis response services **G2.2** Increased capacity in Intermediate care services both in Home First including expansion of Homecare Assessment and Reablement Team reablement and step-up admission avoidance **G2.3** Continued development of the Integrated Personalised Care Framework			

Effective management	G3	**Care in the community** - We will develop community-based health and care models that proactively support people to manage their long-term health conditions. These models will build on local strengths and work closely with voluntary and community organisations wherever possible.	**G3.1** Develop consistent Neighbourhood care models for all people with Long Term Conditions across Leics **G3.2** Design a hub and spoke model of Voluntary sector support to neighbourhood services Link utilisation of frailty virtual wards to support neighbourhood and crisis response services		for people aged 65+. - Improvement 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 and reduced non-elective admissions into hospital. - Improved patient satisfaction and coordination in the complex care pathway and care coordination across the system especially for those with multimorbidity (5+ chronic conditions). - 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. - Reduction in unplanned admissions for those with ambulatory care conditions	- Home first outcome - To stablise ED attends for complex patients at 19/20 levels - Home First outcome - to increase 2 hour urgent community response compliance to 80% across all providers - BCF Indicator - Residential & Nursing admissions planed rate of 519 = 3% reductions across all providers - Home first target - to increase 2 day reablement compliance to 80% across all providers