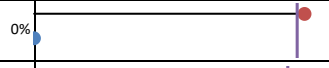

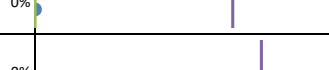
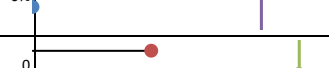
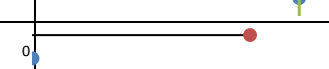



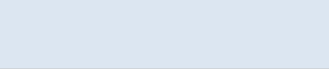


1 Improving Mental Health and Wellbeing

★ Indicates that new data is available this quarter for this measure

● Current Value ● Previous Value | Target | Essex

Essex level data

Essex level data		Latest Data	Value	Essex	HWB Target	DOT	Current Performance Against Comparator	
1.1a	Number of mothers with improved emotional wellbeing following support	Data currently unavailable for these measures. These are new measures for the provider and there are some data quality issues.						
1.1b	% of mothers with improved emotional wellbeing following support							
1.2a	% of pupils agreeing with the statement 'My life is going well'	18/19	-	-	80%	↓		90%
1.2b	% of children when they are really worried they talk to someone or ask for help - Girls	18/19	-	-	77%	↓		90%
1.2c	% of children when they are really worried they talk to someone or ask for help - Boys	18/19	-	-	60%	↓		90%
1.3	Gap in employment rate for those in contact with secondary mental health services and the overall employment rate (18-69 yr).	17/18	-	-	70%	↓		90%
★ 1.4	Numbers of businesses with MHFA available	19/20 Q1	36	36	-	↑		30
★ 1.5	Number of people with mental health and substance misuse problems actively engaged with peer support networks	18/19 Q4	-	-	-	↓		1000
1.6	% of people who are lonely as defined by scoring 7 and over on three-item loneliness scale	17/18	-	-	4%	→		8%
1.7	Number of OAP (Out of area placement) days in month	19/20 Q1	-	295	445	↓		4000
1.8	Dementia Diagnosis Rate, 65+ Residents	19/20 Q1	65.9%	64.6%	66.7%	↓		100%

Commentary from Mid CCG:



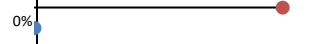




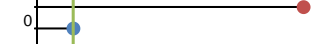
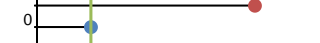
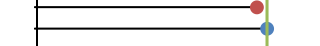


Metric 1.7: From April to July 2019 there were 4 Essex Partnership University NHS Foundation Trust patients totalling 51 days. There was one more patient in July 2019 and an increase of 12 bed days compared to June 2019.

2 Addressing Obesity, Improving Diet and Increasing Physical Activity

★ Indicates that new data is available this quarter for this measure

● Current Value ● Previous Value | Target | Essex

Indicates that new data is available this quarter for this measure

Essex level data		Latest Data	Value	Essex	HWB Target	DOT	Current Performance Against Comparator	
2.1a	Local Delivery Plan Pilot measures	Metric will be added once LDPs are set up.						
2.2a	Prevalence of overweight (including obese) among children in Reception	17/18	-	-	21%	➡		30%
2.2b	Prevalence of overweight (including obese) among children in Year 6	17/18	-	-	29%	➡		40%
2.2c	Percentage of children undertaking at least 60 minutes of physical activity per day	18/19	-	-	-	⬇		40%
★ 2.2d	Number businesses engaged in Tuck-in scheme	18/19 Q4	-	-	-	➡		200
2.3a	% of physically active adults	17/18	-	-	70%	➡		100%
2.4	% of adults aged 65+ that are physically inactive	17/18	-	-	-	➡		40%
2.5a	% of adults (aged 18+) classified as overweight or obese	17/18	-	-	64%	➡		80%
★ 2.5b	Number of people engaged in weight management programmes	19/20 Q1	1038	1038	-	⬇		8000
★ 2.5c	Number of adults supported to lose weight	19/20 Q1	758	758	-	⬇		4000
★ 2.5d	Average weight loss achieved (kg)	19/20 Q1	4.7	4.7	-	⬆		6kg
2.6a	Diabetes prevalence (QoF)	17/18	-	-	-	➡		20%
2.6b	Newly diagnosed patients with diabetes referred to education programme within 9 months	17/18	-	-	-	➡		100%

Commentary from Mid CCG:

Metric 2.6a: Mid Essex Clinical Commissioning Group (CCG) continues to oversee successful local implementation of *The Healthier You: NHS Diabetes Prevention Programme*. At end of quarter 1 (Financial Year 2019/20) the CCG remains the highest referring CCG in the wider STP (Sustainability and Transformation Partnership) and has achieved 434 referrals onto the course against a year to date plan of 206.

Metric 2.6b: Mid Essex Clinical Commissioning Group (CCG) has received funding for 2019/20 to continue increased provision of course places from 320 to 1,100. The CCG is offering diabetes patients increased flexibility for attending the course by making 100 of these places available digitally via a nationally accredited App called MyDiabetes. The new digital pathway is scheduled to go live in quarter 3 (Financial Year 2019/20).

3 Influencing Conditions and Behaviours Linked to Health Inequalities

★ Indicates that new data is available this quarter for this measure

Essex level data						Current Value	Previous Value	Target	Essex
		Latest Data	Value	Essex	HWB Target	DOT	Current Performance Against Comparator		
3.1a	Gap in 'Good Level of Development' between disadvantage and non-disadvantage children	18/19	-	-	12.8%	↓	0%		30%
3.1b	Number of families identified as requiring evidence based parenting support, who show improvements in parenting/	Data currently unavailable for these measures. These are new measures for the provider and there are some data quality issues.							
3.1c	Numbers receiving evidence based interventions in deprived areas								
★ 3.2a	% of young people (16-18) who are Not in Employment, Education or Training (NEET) or unknown	19/20 Q1	2%	3%	4%	↓	0%		10%
3.2b	% of Essex disadvantaged pupils achieving at least the expected standard at Key Stage 2 against the Reading, Writing and Maths	18/19	-	-	53%	↓	0%		100%
3.3a	Admission episodes for alcohol-related conditions - narrow definition	17/18	-	-	8433	→	0		10k
★ 3.3b	% of people leaving structured treatment in a planned and agreed way - Opiate	19/20 Q1	80%	80%	65%	↑	0%		100%
★ 3.3c	% of people leaving structured treatment in a planned and agreed way - Non-Opiate	19/20 Q1	85%	85%	90%	↓	0%		100%
★ 3.3d	% of people leaving structured treatment in a planned and agreed way - Alcohol	19/20 Q1	89%	89%	75%	↑	0%		100%
3.4	% of carers who find it easy to find information about support	16/17	-	-	80%	↓	0%		100%
3.6a	Number of practices involved in encouraging physical activity	Metric not yet defined - to be discussed at PHLT.							
★ 3.6b	Number of practices referring/signposting people for social isolation	18/19 Q4	-	-	90%	↓	0%		20
★ 3.6c	% of GP smoking population referred or treated year to date	19/20 Q1	0%	0%	5%	↓	0%		10%

Commentary from Mid CCG:

Metric 3.6a: Mid Essex Clinical Commissioning Group (CCG) rolled out a Live Well Link Well programme for social prescribing across all GP practices in Mid Essex in April 2019. The CCG's expectation is that by end of March 2020, all GP practices in Mid Essex will use the Live Well Link Well to refer patients for physical activities such as running clubs, exercise classes for weight management, and support with long-term conditions etc.

Metric 3.6b: Along with the encouraging physical activity benefits intended from the Live Well Link Well initiative, Mid Essex CCG's expectation is that by end of March 2020, all GP practices in Mid Essex will also use the Live Well Link Well programme to refer patients for support with social isolation such as befriending services, group activity clubs and classes, and community coffee services, etc.

4 Enabling and Supporting People with Long-term Conditions and Disabilities

★ Indicates that new data is available this quarter for this measure

Essex level data

		Latest Data	Value	Essex	HWB Target	DOT	Current Performance Against Comparator	
4.3a	% of people 65+ self-caring after reablement	19/20 Q1	43%	49%	-	↓	0%	100%
4.4	Reablement at home after 91 days	17/18	-	-	82%	→	0%	100%

The CCGs can use this space to include any supporting commentary for the above theme.

The draft packs will be circulated and any commentary that is collected by the deadline will be added before the final versions are submitted.

5 BCF Measures

★ Indicates that new data is available this quarter for this measure

Essex level data

							Current Value	Previous Value	Target	Essex
							Current Performance Against Comparator			
BCF1	Non-elective admissions	18/19 Q4	-	-	8148	↓	0			10000
★ BCF2	Permanent residential admissions per 100,000 population 65+	19/20 Q1	104	103.70	360.08	↓	0			400
BCF3	Reablement at home after 91 days	17/18	-	-	82%	↓	0%			100%
BCF4	Delayed Transfers of Care (number of DTOC days)	19/20 Q1	783	7870.00	-	↑	0			12000

Commentary from Mid CCG:

Metric BCF1: Work continues with partners to reduce admission numbers. Work includes; working with the Acute Emergency Care (AEC) network, conducting a clinical audit of patient notes (26th November) to look at where we can increase ambulatory pathways and conducting a deep dive into care home admissions.

Metric BCF4: Work continues with system partners to maintain a low level of delayed transfers of care. A Discharge Operational Group (DOG) has been set up and cases are taken to this group to ensure there is constant learning.

6 SCIE Integration Measures

★ Indicates that new data is available this quarter for this measure

Essex level data

		Latest Data	Value	Essex	HWB Target	DOT	Current Performance Against Comparator
							<div> <div>Current Value</div> <div>Previous Value</div> <div>Target</div> <div>Essex</div> </div>
SCI1	Delayed Transfers of Care per day, per 100,000 (number of DTOC days)	19/20 Q1	6.07	7.52	-	↑	<div> <div>0</div> <div>25</div> </div>
SCI2	Emergency Admissions (65+)	18/19 Q4	-	-	-	↓	<div> <div>0</div> <div>30000</div> </div>
★ SCI3	Emergency readmissions (all ages)	18/19 Q4	-	-	-	↓	<div> <div>0</div> <div>20%</div> </div>

Commentary from Mid CCG:

Metric SCI1: Work continues with system partners to maintain a low level of delayed transfers of care. A Discharge Operational Group (DOG) has been set up and cases are taken to this group to ensure there is constant learning.

Metric SCI2: In addition to the works being undertaken to reduce non-elective admissions, there are a number of work streams specifically targeted for those over 65. Including direct patient referral from the ambulance service into the Acute Frailty Unit to accelerate the patient pathway as well as reducing pressures being faced by A&E.

Metric SCI3: Work continues with a planned deep dive into readmissions, particularly with reablement as there are currently high readmission rates from reablement. Also plans to undertake further work with Provide colleagues to see if additional collaboration can prevent readmissions.