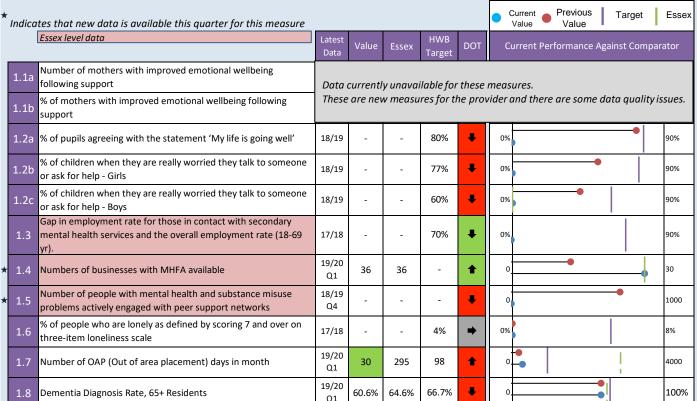
2019/20

Q1



Mid Essex CCG Essex

1	Improving Mental	Health and Wellbeing



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.

FUTURE OF ESSEX

Essex

2019/20

2 Addressing Obesity, Improving Diet and Increasing Physical Activity



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 2 019/20).

3 Influencing Conditions and Behaviours Linked to Health Inequalities

Mid Essex CCG

2019/20

<u>Year</u>

Essex

		<u> </u>										
★ Indicates that new data is available this quarter for this measure							Current Previous Target Esse					
		Essex level data	Latest	Value		HWB						
					Essex	Target	DOT	Current Performance Against Comparator				
	3.1a	Gap in 'Good Level of Development' between disadvantage and	10/10			12.8%		0%				
	3.1a	non-disadvantage children	18/19	-	-	12.0%	•	30%				
	0.41	Number of families identified as requiring evidence based										
	3.1b	parenting support, who show improvements in parenting/	Data	currentl	y unava	ilable for	these	measures.				
		Numbers receiving evidence based interventions in deprived	These are new measures for the provider and there are some data quality issues.									
	3.1c	areas	These are new measures for the provider and there are some data quality issu									
		% of young people (16-18) who are Not in Employment,	19/20			I	_					
*	3.2a	Education or Training (NEET) or unknown	Q1	2%	3%	4%	•	0%10%				
		% of Essex disadvantaged pupils achieving at least the expected										
	3.2b	standard at Key Stage 2 against the Reading, Writing and Maths	18/19	-	-	53%	•	0% 100%				
		Admission episodes for alcohol-related conditions - narrow										
	3.3a	•	17/18	-	-	8433	→	0 10k				
		definition % of people leaving structured treatment in a planned and	19/20									
*	3.3b			80%	80%	65%	1	0% 100%				
		agreed way - Opiate	Q1									
*	3.3c	% of people leaving structured treatment in a planned and	19/20	85%	85%	90%	1	0%				
	0.00	agreed way - Non-Opiate	Q1									
*	3.3d	% of people leaving structured treatment in a planned and	19/20	89%	89%	75%		0%				
	J.54	agreed way - Alcohol	Q1	0570	0370	7070	_					
	3.4	% of carers who find it easy to find information about support	16/17	_	_	80%		0%				
	3.4	78 of carers who find it easy to find information about support	10/17			0070		1 100%				
	2 62	Number of practices involved in encouraging physical activity	Metri	Metric not yet defined - to be discussed at PHLT.								
	3.0a											
+	3.6b	Number of practices referring/signposting people for social	18/19			90%	•	0%				
~	3.0D	isolation	Q4		-	90%						
	2.60	% of GP smoking population referred or treated year to date	19/20	0%	0%	5%	1	0%				
~	3.00	70 of Gr Smoking population referred of treated year to date	01	076	U70	3/0		11 070				

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 Li ve 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.

Mid Essex CCG

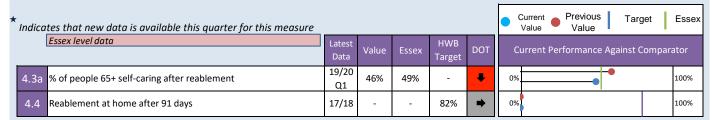
<u>Year</u>

2019/20

Q1

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

Essex



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.

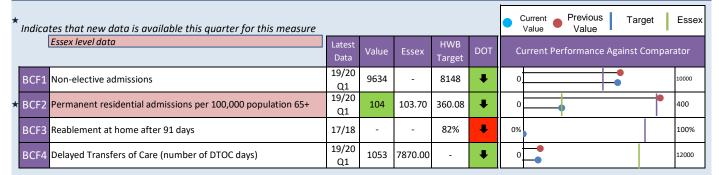
FUTURE OF ESSEX

Mid Essex CCG Ess

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2019/20 Q1

5 BCF Measures



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.

Mid Essex CCG

Q1

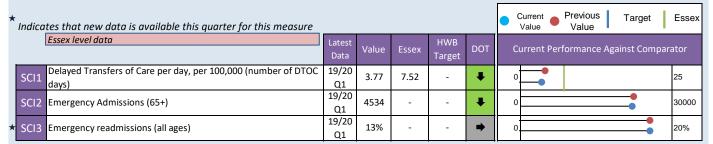
FUTURE OF ESSEX

Essex

Year 2019/20

2019/2

6 SCIE Integration Measures



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 readmissi on rates from reablement. Also plans to undertake further work with Provide colleagues to see if additional collaboration can prevent readmissions.

Produced by Research & Citizen Insight - Essex County Council