APPENDIX 1

HILLINGDON
LONDON

Hillingdon Joint Health and Wellbeing Strategy Refresh 2014-17

NHS
Hillingdon
Clinical Commissioning Group

Contents

1. Foreword

This refresh 2014-17, builds on Hillingdon's existing Health and Wellbeing Strategy, published in 2013. The strategy was produced following extensive consultation with residents and service users and their feedback and views were captured within the existing priorities. It provides the link between the identified needs of the population (in the Joint Strategic Needs Assessment) the agreed priorities and actions and the most important outcomes (as recorded in the statutory outcomes frameworks).

A number of significant changes have taken place since the first strategy was produced. Public Health responsibilities have transferred to Hillingdon Council. The Health and Social Care Act of 2012 is now business as usual with the Health and Wellbeing Board itself now firmly in place. The passage of the Care Act has set out to improve services and support, especially for carers. In addition, closer integration of health and social care has moved further up the agenda with the development of joint work, for example under the Better Care Fund and planned in Mental Health and Children's services.

These developments have been included in this refresh to ensure that it provides a strategic overview of the health, care and wellbeing priorities for Hillingdon and builds on existing work wherever possible.

This strategy also supports the 'Shaping a Healthier Future' vision for NHS services in North West London, which aims to bring as much care as possible nearer to our residents; centralise specialist hospital care onto specific sites; and incorporate all of this into one co-ordinated system of care.

It also links to the CCG 'Out of Hospital Strategy' which aims to put patients in the centre of better health care by intervening earlier, joining up care and supporting patients at home which will improve outcomes and patient satisfaction, whilst delivering greater value for money.

We have a strong track record of partnership working in Hillingdon between Local Government, the NHS and the voluntary/community sector. This strategy sets out our plans to continue to work together with our residents in an attempt to tackle the most pressing health problems in Hillingdon.

Health and wellbeing in Hillingdon is good overall but we are determined to build on our record to date and make it even better for the longer-term.

Signed

Cllr Raymond Puddifoot, MBE
Chairman of Hillingdon Health and Wellbeing Board

2. Health and Wellbeing Board (HWB)

The HWB in Hillingdon provides strategic oversight for health and care systems in the borough and brings together elected Councillors, the Hillingdon Clinical Commissioning Group, the Directors of Public Health, Adult and Children's services and representatives of Central North West London and The Royal Brompton and Harefield NHS Foundation Trusts and Hillingdon Healthwatch. Together, their expertise delivers a strategic, collaborative and targeted approach to meet the needs of the local population.

The HWB agrees, in consultation with the local community, the health and social care priorities which would make the most difference to improving health and wellbeing and reducing inequalities in the local area. While the priorities are also informed by outcomes set out in a national framework, this represents a move away from centrally driven targets, enabling Hillingdon's HWB to have a very local focus on benefiting the communities and residents it serves.

HWBs must undertake a detailed assessment of local needs, called the Joint Strategic Needs Assessment (JSNA), and then develop a Health and Wellbeing Strategy focussing on how the outcomes which matter most can be achieved or improved. Local people, including the Local Healthwatch, will be fully involved in the development of future JSNAs and the HWB strategy.

These two documents – the supporting JSNA and the Strategy itself - give direction to the two key decision-making bodies (Hillingdon Council and the NHS's Hillingdon Clinical Commissioning Group) to develop and/or purchase the right services locally to deliver on the strategy. Indeed these bodies have a legal duty to have regard to this strategy.

The particular value of the role of the Health and Wellbeing Board is in identifying the issues that this partnership can most influence, for example:

- How working together can bring the most benefit to outcomes for Hillingdon residents.
- How we can address the most important local needs, now and in the future.
- How we can build on the strengths in our communities and what is already working well.
- How we can best protect or include the most vulnerable people in our communities.
- How we can work together at a time of public sector financial restraint to use our resources most efficiently.

3. What is the Joint Health and Wellbeing Strategy?

Everyone has the right to enjoy good health and wellbeing and there are some groups in our society who may need more support than others to achieve this. Our health and wellbeing strategy has been developed to meet the needs of these groups as identified in our Joint Strategic Needs Assessment (JSNA).

The JSNA is the process we use to identify the current and future health and social care needs of the population in the local authority area. It looks at the big picture of the local population over both the short term (three to five years) and the long term. In Hillingdon our JSNA is web based and contains up to date intelligence across a large number of data sets, supported by bespoke analysis as required on specific themes.

Among other things, it describes in detail the health, care and wellbeing needs of the local population, identifying those groups where health and care needs are not being met and those which are experiencing comparatively different outcomes. Once we have a collective understanding of the needs of people in Hillingdon, it is important that we also focus on those that we can most influence, change and improve.

Understanding Hillingdon and the characteristics of its population is critical for the development of our strategy as having this insight allows us to better judge current and future needs, for example for specific services such as maternity and the demand for the treatment of certain conditions which are more prevalent in specific population groups e.g. Type 2 diabetes.

The JSNA looks at the evidence of what works in both the prevention and the treatment of health problems. In some cases there is limited evidence of effective prevention and/or treatment of serious health problems.

The strategy shows how all the key organisations, through the HWB, are working together in a strategic and transparent way to improve outcomes for residents with more collaboration, integrated services and shared targets to meet the priorities identified as important.

4. Our common principles

In order for this strategy to work, all partners need to work to an agreed and common set of principles.

We want residents to be able to say:

- "I am helped to take control of my own health and social care provision"
- "It doesn't matter what day of the week it is - as I get the support appropriate to my health and social care needs"
- "Social care and Health Services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need to stay in hospital"
- "If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay"
- "I only have to tell my story once and they pass my details on to others with an appropriate role in my care"
- "I am treated with respect and dignity, according to my individual needs"
- "Systems are sustainable and what once might have been spent on hospital care for me is now spent to support me at home in my community"

We are facing unprecedented financial challenges at a time of major organisational change so it is imperative that the HWB is able to balance needs carefully and to influence its constituent organisations to make difficult decisions about priorities.

We will continue to put Hillingdon Residents first by finding ways to build and sustain value for money local services. We want to continue to use available health and social care budgets to focus on delivering improvements to health outcomes for local people. We will look at all services to assess whether they are desirable, affordable and sustainable in order to prioritise our expenditure.

5. About Hillingdon

Our borough

Hillingdon is a diverse, prosperous borough in West London bordered by Hertfordshire, Buckinghamshire, Hounslow, Ealing, and Harrow. It's the second largest of London's 32 boroughs covering an area of 42 square miles (11571 hectares), over half of which is a mosaic of countryside including canals, rivers, parks and woodland. As the home of Heathrow Airport, Hillingdon is London's foremost gateway to the world, and is also home to the largest RAF airport at RAF Northolt.

Hillingdon is a borough of contrasts. The north of the borough is semi-rural with a large proportion protected by green belt regulation with Ruislip as the major centre of population. The south of Hillingdon is more densely populated, urban in character and contains the administrative centre of Uxbridge and towns of Hayes and West Drayton.

Heathrow airport is situated in the south of the borough and is the largest employer offering a range of relatively well-paid skilled and unskilled manual positions. There are a number of major manufacturing and retail organisations with headquarters and sites in Hillingdon. Stockley Park, to the north of Heathrow, is one of Europe's largest business parks. Hillingdon Council, RAF Northolt, Brunel University, Harefield and Hillingdon hospitals are major public sector employers within the area.

Hillingdon is a borough where town and country meet, boasting 800 acres of woodland, country parks, fields and farms, several rivers and the Grand Union Canal. We have more land under prestigious Green Flag status than any other local authority.

There are a range of opportunities to live well including:

- Ruislip Lido, which boasts one of London's few sandy beaches.
- Ruislip Woods National Nature Reserve.
- The Hillingdon Sports and Leisure Complex, a multi-million pound Olympic-sized indoor swimming pool and leisure complex, which includes a restored 1930s open-air pool.
- The country's first playground designed specifically for disabled children.
- The picturesque villages of Harefield and Harmondsworth.
- Four public golf courses.
- Various theatres, arts centres and state of the art libraries.
- Uxbridge shopping centre, one of the top-ten shopping centres in London is also located in Hillingdon.

The Council shares a boundary with the NHS Hillingdon CCG. Hillingdon has 48 GPs; some of whose patients come from surrounding boroughs. The main acute provider is the Hillingdon Hospital and with Central North West London NHS Trust as the main

community and mental health provider, a strong geographical focus on Hillingdon supports closer working.

Our residents

- The Office for National Statistics estimates the Hillingdon population to be 291,000 in 2014 (2012 based Sub National Population Projections).

- 49.8% of the population is male and 50.2% female. There are more women at the older age groups (age 85+). Source: Office for National Statistics

- The age and gender distribution in Hillingdon is similar to London and higher than England for the 0-4 age group. The proportion of the population in Hillingdon is higher than the proportion in London and England for the 5-10 age groups and similar to England (higher than London) for the 11-18 age groups. Source: Office for National Statistics

- The Greater London Authority 2012 Round Final Ethnic Group projection figures (GLA EGRP 2012) for 2015 estimate that Hillingdon is becoming more diverse with Black and Minority Ethnic (BAME) groups accounting for 45% of the usual resident population and White ethnic groups accounting for 55% of the population in 2015.

- This proportion of BAME groups is lower than across London (55%) and considerably higher than across England (20%). This trend is projected to continue with BAME groups expected to account for 49% of the population in 2020 with an increase across all age groups. Source: Greater London Authority

- The population increase in Hillingdon over the next 5 years is expected to be 7.2% (around 1.4% per annum). This is higher than the anticipated 5 year increases in London (6.4%) and England (4.1%). The main driving force behind the increase in population between 2015 and 2020 is natural change, ie 15,000 more births than deaths. Net migration is expected to account for around 6,300 persons over the 5 year period. Source: Office for National Statistics

- The number of older people in the population is increasing, with a 9% increase in people aged over 65 predicted between 2015 - 2020. People are living longer and we need to make sure that we have services in place to meet these needs. Source: Office for National Statistics

- As of January 2014, the number of pupils with Special Educational Needs in Hillingdon schools was 8,885, 17% of the total school age population. Of these, 3% have a Statement and 14% do not. Source: Department for Education

- The number of residents aged 18-64 who have been predicted to have a moderate or severe physical disability in 2014 is 13,240 and 3,729 respectively. Source: PANSI

- The number of residents aged 18-64 who have been predicted to have a mental health need in 2014 is 45,191. This is predicted to rise to 48,657 by 2020. Source: PANSI

- The number of residents aged 18-64 who have been predicted to have a learning disability in 2014 is 4,519. Source: PANSI

- 144,000 residents (72% of the working age population aged 16-64) in Hillingdon are economically active. This includes those who are employed and self employed. 28% of working age residents are economically inactive, including students, those who are retired and those looking after homes and family. Source: NOMIS

- Hillingdon is ranked 23 out of 33 London boroughs for deprivation in London (including City of London) and 138 out of 326 Local Authorities in England (1 being the most deprived) Source: DCLG 2010 Indices of Multiple Deprivation

- According to the Income Deprivation Affecting Children Index, about 15,300 children aged 0-15 in Hillingdon (27% of the total) were deemed to be living in poverty. Source: DCLG 2010 Indices of Multiple Deprivation

6. Our priority areas for action

This section of the strategy identifies the four priority areas for action with the current position and progress to date for each. Outcome measures from the main statutory frameworks are identified in Appendix B.

Priority one: Improve health and wellbeing and reduce inequalities - we know that people will feel better and be healthier if they are more active and are able to access facilities across Hillingdon.

Current position

- Hillingdon has a higher birth rate than England as a whole. Between 2006 and 2012 there was an increase of over 800 births per year, an increase of 23%. In 2012 there were 4,600 live births in Hillingdon and this figure is expected to increase to 4,900 births per year over the next 5 years. The future rate of increase is estimated to be much lower than that over the past 10 years. The 7 wards in the Hayes and Harlington locality are in the top 9 wards of highest projected birth rate in Hillingdon. Harefield and Ickenham have the lowest number of births expected per year in the next 5 years. Source: Vital Statistics, GLA & ONS

- Infant mortality rates in Hillingdon are not significantly different to the England average. Source: Office for National Statistics

- In Hillingdon around 2.9% of babies born at term (37 weeks +) are of low birth weight, defined as under 2,500 grams. This is similar to the national rate and lower than the London average. However this varies between wards and the greatest number of low birthweight babies are born in the south of the borough. Source: Public Health Outcomes Framework 2012

- Hillingdon's life expectancy from birth for males for the period (based on 2008-12 data) is 79.4 years, which is similar to London (79.3) and England average (78.8). The female life expectancy for Hillingdon was 83.5 years which is higher than the England average (82.7) and similar to London average (83.5). There are inequalities in health for both men and women within the borough. The gap in male life expectancy between Eastcote and East Ruislip in the north of the borough and Botwell in the south of the borough is 8.5 years. Source: Greater London Authority

- 8% of mothers in Hillingdon smoke at the time of delivery, compared to 13% in England and 6% in London. Source: Health and Social Care Information Centre

- Levels of excess weight and obesity are a growing threat to population health. In 2012/13, over 21% of Reception year and 34.6% of year 6 children in Hillingdon were overweight or obese. These are slightly lower than the levels in London and England. 67% of the adult population in Hillingdon are estimated to be overweight or obese which is close to the national average for England (64%). Source: Public Health England

- During 2013/14, Hillingdon Adult Social Care supported 180 residents aged 18 to 64 with Mental Health needs. Of these 140 received community based packages of

care (i.e. Day Care, Home Care, Meals on Wheels) and 45 were in residential care homes. Source: National Adult Social Care Intelligence Service

- During 2013/14, 3,035 referrals were made to Central North West London NHS Foundation Trust for Mental Health issues with 1,660 accepted into services. Source: CNWL

Progress to date

- There have been improvements in breastfeeding initiation rates (82% in 2013/14) and continuation of breastfeeding (62% in 2013/14). These are above the England averages for initiation and continuation and close to the London averages. Source: Public Health England

- In Hillingdon the estimated prevalence of smoking is 16.2% of the population aged over 18. This is lower than the England average of 18.4% and the London average of 17.3% of the population aged over 18. Source: PHOF 2013. In surveys of manual workers and workers in routine occupations, the prevalence of smoking is higher, assessed as 21% of the population in Hillingdon and 24.9% in London. Source: PHOF 2013

- In 2013/14, the Hillingdon Stop Smoking Service (HSSS) helped 1,900 people to set a quit date and 1,040 to quit smoking.

Priority two: Invest in prevention and early intervention - we need to spend more on preventing disease and illness. The sooner health and social care are delivered, the better the chance of a good outcome.

Current position

- Circulatory diseases and cancers are the two major causes of death in Hillingdon. Deaths as a consequence of circulatory diseases accounted for an annual average of 570 deaths (31% of all deaths) in the 5 year period 2008-2012. Deaths from all cancers accounted for an average of 530 deaths (29% of the total). Source: National Statistics

- Hypertensive disease is the most prevalent condition recorded on GP registers (13%), followed by obesity (9%) and diabetes (6%) Source: Quality Outcomes Framework

- Dementia presents major challenges for health and social care services. Currently there is a significant gap between the estimated prevalence of dementia and the actual numbers on the GP registers suggesting that there are possible issues with diagnosis with primary care. In 2013/14, 1,150 people in Hillingdon were diagnosed with dementia according to the GP register. Source: Quality Outcomes Framework

  During 2013/14, Hillingdon Adult Social Care supported 465 residents aged over 18 with dementia. Of these 280 received community based packages of care (i.e. Day Care, Home Care, Meals on Wheels), 130 were in residential care homes and 90 were in nursing homes. Source: National Adult Social Care Intelligence Service

- During 2013/14, Hillingdon Adult Social Care supported 55 residents aged over 18 with a Sensory Disability with community based services; 15 had a hearing impairment (all aged over 65), 35 had a visual impairment (15 were aged over 65) and 5 had a dual sensory loss (all were aged over 65). Source: National Adult Social Care Intelligence Service
- The early support programme has been embedded locally with a key working model across the local authority and health provider. This empowers parents/carers, co-ordinates the provision of services and produces significantly improved outcomes for children. Work so far has been fully operating with children under school age but this will be extended.

Progress to date

- A Department of Health funded project HAEDI (Hillingdon Awareness and Early Diagnosis Initiative) was delivered to raise awareness of Bowel Cancer in Hillingdon.
- As part of the physical activity scheme for cancer survivors, a dedicated vegetable garden in Cranford provides the opportunity for exercise and to grow your own fruit and veg. An information day for cancer survivors took place in October 2014 at the Civic Centre, to raise awareness of support available.
- Responsibility for the commissioning of substance misuse services transferred to the Council on 1st April 2013. The Council is currently assessing delivery options for substance misuse services and Identification and Brief Advice (IBA) is being considered as a potential model of delivery for the future.
- Responsibility for the commissioning of sexual health services transferred to the Council on 1st April 2013. Since then transition work has been underway towards service integration. Hillingdon Hospital is the lead provider for genitourinary medicine services and CNWL is the lead provider for community contraceptive, sexual health and Chlamydia screening services.
- During 2013-14 the NHS Health Check programme assessed 5,700 people between age group 40-74 years. Source: PHOF
- The MEND programme, commissioned to tackle the increasing rates of childhood obesity for ages 5-7 years and 7-13 years across geographic areas in Hillingdon continues to work well. The National programme has identified the borough as being particularly good at targeting and directly referring children into the programme.
- The CCG has invested in Memory Assessment Services to improve the diagnosis rates for Dementia and the treatment of individuals and support to their carers. There are currently 386 patients in receipt of this service.
- The CCG has also increased investment in Improving Access to Psychological Therapies Services to improve local provision, in particular these services will expand to those with long term conditions such as diabetes and pain management.
- As part of the Shifting Settings of Care initiative an enhanced primary care mental health service has been developed to support individuals with mental health problems in primary care and help reduce referrals to secondary mental health services.

- A review of diabetes services is underway and a Diabetes Service User Group has been set up and met in November to discuss how diabetes services could be improved. To support patients with Diabetes the CCG has piloted an education programme in Hayes and Harlington to give patients the knowledge to better manage their diabetes. 55 patients attended the sessions and all said that the information provided was very helpful and gave them more confidence to manage their health. The pilot therefore is being rolled out across Hillingdon and a Health Champions scheme is being developed.

- A similar programme of support has been piloted for patients with COPD and is also being rolled out across Hillingdon. A Community based Quality Assured Spirometry service will start in January 2015 to enable patients to have quicker access to this test without having to go to hospital.

- For patients with suspected heart failure and other heart problems GPs are now able to refer directly for diagnostic tests that will speed up diagnosis and ensure they receive the right care more quickly.

- The CCG also ran a pilot education programme in Hayes and Harlington for children with asthma and held interactive demonstrations and activities at 3 schools which reached 1,590 children and 30 teachers. Approximately 60 parents were contacted through workshops held in libraries.

Priority three: Develop integrated, high quality social care and health services within the community or at home - the Care Act 2014 is designed to create a more joined up set of services for our patients, their families and carers. We want to make this the normal experience for the people of Hillingdon.

Current position

- Over the last three years Hillingdon has reduced the number of people aged over 65 living in Residential Care (down by 140 residents per 100,000 (-14%)), Nursing Care (down by 203 residents per 100,000 (-27%)). Source: National Adult Social Care Intelligence Service

During 2013/14, Hillingdon Adult Social Care supported:-

- 2,397 residents aged over 65; 2,095 received community based packages of care (i.e. Day Care, Home Care, Meals on Wheels), 205 were in residential care homes and 190 were in nursing homes.
- 600 residents aged over 18 with a Learning Disability; 395 received community based packages of care, 240 were in residential care homes and 15 were in nursing homes.
- 480 residents aged between 18 and 64 with a Physical Disability (excluding Sensory Disabilities). Of these 430 received community based packages of care, 25 were in residential care homes and 25 were in nursing homes. Source: National Adult Social Care Intelligence Service

Progress to date

- The take-up of personal budgets for social care is increasing which helps people who need care to be in control of the care and support they need.
- Telecareline assistive technology, in combination with the Council's Reablement Service is proving very effective in helping people to feel safe in their own homes and to regain their mobility to live independently. The services are critical in helping to prevent unnecessary admissions to hospital and/or residential / nursing homes. From 7 April 2014, the service is now free of charge to Hillingdon residents aged 80 or over.
- Two extra care schemes for the 55 and over population were opened, one in 2011 and one in 2012. These were Cottesmore House in Ickenham and Triscott House in Hayes.
- Two purpose built supported living schemes for people with learning disabilities have also recently been opened and these are Glenister Gardens, which opened in 2012 and Swan House, which opened in 2014. Two more schemes are due to open in 2015.
- A supported living scheme for people with mental health called Sessile Court is due to open in early 2015.

Priority four: Creating a positive experience of care - we will tailor our services in a more personalised way which will be achieved by listening to views and experiences.

Current position

Hillingdon Council and Hillingdon CCG regularly engage with, and seek views from local residents, service users and carers to guide service redesign, maintain quality and safety, and inform commissioning intentions. In developing the Better Care Fund plans, for example, both organisations used this approach to inform the strategic direction. As a first step intelligence was gathered across a two year period, from forums such as the older people's assembly, *meet the CCG* public events, disabled tenants' forum, patient and carer focus groups and public board meetings.

These findings were then cross referenced with intelligence gathered by Healthwatch Hillingdon, evidence from the Hillingdon JSNA and with local and national patient and carer satisfaction surveys to inform the BCF plan. Phase 2 of the BCF engagement plan identifies the need to develop the changes within the workstreams in discussion with service users and to ensure that the voice of the customer is heard in designing outcomes.

The CCGs overarching vision for engagement is that every patient, carer and resident living in Hillingdon is given the opportunity to engage and be involved in the work of the CCG, and where they use a service commissioned by the CCG, they experience a positive outcome.

Central to this is empowering patients and carers to self-care. Where the need arises, the CCG regularly urges patients and carers to have confidence in themselves and that of their local health system, to bring to light via a complaints system and those of providers, instances, where they feel their treatment or level of care has not been satisfactory.

Healthwatch Hillingdon has become established as an effective independent "consumer voice" for users of health and social care services and has developed an advice and guidance signposting function. Healthwatch is also a key partner for commissioners to help understand views of communities and has a seat on the HWB and at other partnership boards.

Since April 2013, the Council has commissioned a NHS complaints advocacy service to enable most vulnerable residents to be supported in making complaints.

The Parent Carers Forum (parents of children and young people with SEND) has been set up to ensure parents are actively involved in all aspects of the SEND reform work. This forum allows real listening and joint working with families, the LA, CCG and CNWL.

A new mediation service has also been set up for families when there is disagreement through the Education, Health and Care (EHC) assessment and planning process.

Progress to date

The 2013-14 Adult Social Care Survey found that 57.2% of users of care and support services said they were 'extremely satisfied' or 'very satisfied' with their care and support. This relates well to the London average of 60.2%. A combination of responses to the Survey relating to how satisfied or dissatisfied users are with indicators of quality of life, such as personal cleanliness and safety, showed a value of 18.4 out of 24 for Hillingdon service users. This is almost at the same level of the London score of 18.5.

Over the last two years, the CCG engagement team have tested a number of engagement methods. Its first engagement exercise, as early as July 2012, adopted a 'grass roots' style to what is now an established quarterly 'Meet the CCG' event. First hosted in GP practice patient waiting rooms, the Governing Body, then in shadow form, used these meetings as a way to build its 'Friends Network'.

This early identification has meant that the CCG have interacted face to face with more than 3000 residents between April 2013 – April 2014. This is in addition to using the Hillingdon CCG website, leaflets, posters and other mediums such as local newspapers and libraries. This has shaped the way for other projects across 2013 – 14 including, but not limited to: Integrated Care Programme Patient & Carer Consultation, Diabetes Self-Management Education Pilot with South Asian Communities in Hayes & Harlington, Asthma awareness and education pilot and Wheelchair Focus Group.

The richness of the CCGs engagement has influenced a number of key themes that has fed into the 2015/16 commissioning intentions. These themes have also influenced the developing GP networks education proposals. Some examples are: training for GP receptionists, the new Urgent Care Centre and evolving Integrated Care and IT programmes.

One of the CCGs recent successes is that of its musculoskeletal service. Working closely with the Hillingdon Hospital, the CCG explored ways to redesign the existing service to ensure that patients are seen by the right clinician the first time they visit. The redesign has seen a reduction in delays to patients receiving care and increased support to avoid unnecessary trips to the hospital. A patient survey also found that on average 98% of patients would recommend the revised service to their friends and family.

Earlier in the year the CCG piloted 'Pathway Experience' tracking using the Friends and Family patient experience survey test. Over 1500 patients and carers with either a Mental Health or Musculoskeletal condition participated. The data identified areas for improvement for example in the area of pain management, better crisis planning for known conditions and in particular the need for increased access to talking therapies.

7. Delivery Plan

The Delivery Plan at A shows the objectives and activities that will support the delivery of the above priorities. Unless otherwise stated, the deadline for delivery of the objectives will be for the lifetime of the strategy. The comments provide narrative on progress made during the review period.

Appendix B shows the metrics that will be monitored and provided in a scorecard type format as part of the delivery plan update.