Notice of Meeting

Health and Wellbeing Board

Date & time
Thursday, 4 March 2021
at **2.00 pm**

Place
REMOTE meeting

Contact
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Please note that due to the COVID-19 situation this meeting will take place remotely.

Please be aware that a link to view a live recording of the meeting for members of the public will be available on the Health and Wellbeing Board page on the Surrey County Council website.

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Board Members

Dr Andy Brooks	Chief Officer, Surrey Heath and East Berkshire Clinical Commissioning Group
Dr Charlotte Canniff (Deputy Chairman)	Clinical Chair, Surrey Heartlands Clinical Commissioning Group
Rachael Wardell	Executive Director for Children, Families and Lifelong Learning, Surrey County Council
Jason Gaskell	CEO, Surrey Community Action, VCFS representative
Dr Russell Hills	Clinical Chair, Surrey Downs ICP
David Munro	Surrey Police and Crime Commissioner
Mr Tim Oliver (Chairman)	Leader of Surrey County Council
Kate Scribbins	Chief Executive, Healthwatch Surrey
Simon White	Executive Director of Adult Social Care, Surrey County Council
Ruth Hutchinson	Director of Public Health, Surrey County Council
Dr Claire Fuller	Senior Responsible Officer, Surrey Heartlands
Fiona Edwards	Chief Executive, Surrey and Borders Partnership
Joanna Killian	Chief Executive, Surrey County Council
Mrs Sinead Mooney	Cabinet Member for Adult Social Care, Public Health and Domestic Abuse, Surrey County Council
Mrs Mary Lewis	Cabinet Member for Children, Young People and Families, Surrey County Council
Rob Moran	Chief Executive, Elmbridge Borough Council (Priority 3 Sponsor)
Rod Brown	Head of Housing and Community, Epsom and Ewell

	Borough Council (Priority 1 Sponsor)
Robin Brennan	National Probation Service, South East and Eastern Division, Assistant Director and Head of Public Protection
Carl Hall	Community Rehabilitation Company, Kent, Surrey & Sussex, Assistant Chief Officer
Gavin Stephens	Chief Constable of Surrey Police
Ms Denise Turner-Stewart	Cabinet Member for Community Protection, Surrey County Council
Steve Flanagan	Representative, North West Surrey Integrated Care Partnership and Community Provider voice
Vicky Stobbart	Integrated Care Partnership Director and Director of Clinical Integration, Guildford and Waverley ICP
Michael Wilson CBE	Crawley, East Surrey and Horsham (CRESH) ICP and Acute Hospitals/Acute Trust Providers
Professor Helen Rostill	Director for Mental Health, Surrey Heartlands ICS and SRO for Mental Health, Frimley ICS (Priority 2 Sponsor)
Rachel Hargreaves (interim)	Industry Partnerships Manager - Health, University of Surrey
Borough Councillor Joss Bigmore	Leader of Guildford Borough Council
Siobhan Kennedy	Housing Advice Manager, Guildford Borough Council (Associate Member)

TERMS OF REFERENCE

The Health and Wellbeing Board:

- oversees the production of the Joint Health & Wellbeing Strategy for Surrey;
- oversees the Joint Strategic Need Assessment; and
- encourages integrated working.

PART 1
IN PUBLIC

1 APOLOGIES FOR ABSENCE

To receive any apologies for absence and substitutions.

2 MINUTES OF PREVIOUS MEETING: 3 DECEMBER 2020 (Pages 1 - 18)

To agree the minutes of the previous meeting.

3 DECLARATIONS OF INTEREST

All Members present are required to declare, at this point in the meeting or as soon as possible thereafter

(i) Any disclosable pecuniary interests and / or
(ii) Other interests arising under the Code of Conduct in respect of any item(s) of business being considered at this meeting

NOTES:

- Members are reminded that they must not participate in any item where they have a disclosable pecuniary interest
- As well as an interest of the Member, this includes any interest, of which the Member is aware, that relates to the Member's spouse or civil partner (or any person with whom the Member is living as a spouse or civil partner)
- Members with a significant personal interest may participate in the discussion and vote on that matter unless that interest could be reasonably regarded as prejudicial.

4 QUESTIONS AND PETITIONS

a Members' Questions

The deadline for Member's questions is 12pm four working days before the meeting *(26 February 2021).*

b Public Questions

The deadline for public questions is seven days before the meeting (*25 February 2021)*.

c Petitions

The deadline for petitions was 14 days before the meeting. No petitions have been received.

5 HEALTH AND WELLBEING STRATEGY HIGHLIGHT REPORT (Pages 19 - 38)

This paper provides an overview of the local shared projects supporting delivery of the Health and Wellbeing Strategy against the milestones within priorities one, two and three as of January 2021. It highlights specific areas where work has been adapted and stepped up to respond to the

impact of the pandemic and in response to the intelligence provided locally through the Community Impact Assessment and Rapid Needs Assessments which were presented at the December 2020 board meeting. A summary of progress is provided by project in Appendix 1.

6 HEALTH AND WELLBEING STRATEGY METRICS UPDATE AND PROPOSED REVIEW 2021 (Pages 39 - 44)

The current set of Health and Wellbeing Strategy (HWBS) metrics were finalised following the launch of the strategy in May 2019. These have been updated within the strategy dashboard to reflect the latest available data and some examples are referenced where there have been more significant changes in these current outcome measures. The latest available update is largely from 2018/19 due to national publishing schedules so does not factor in the expected impact that the pandemic will have had.

Alongside updating the data, a review the current HWBS metrics is proposed. This is intended to better reflect the impact of the pandemic and ensure the additional local work that is in progress, including the work relating to health inequalities, is incorporated and reviewed longer term by the Health and Wellbeing Board and its member organisations.

7 PALLIATIVE AND END OF LIFE CARE (PEOLC) STRATEGY 2021-2026 (Pages 45 - 100)

The Strategy sets out the collective ambitions we want to achieve across Surrey Heartlands as an Integrated Care System (ICS) to improve palliative and end of life care for our citizens.

It is now for Integrated Care Partnerships (ICPs) and local partners to work together to deliver these improvements for their local communities.

8 IMPROVING MENTAL HEALTH OUTCOMES, EXPERIENCES AND SERVICES IN SURREY (Pages 101 - 108)

This report provides an update for the Health and Wellbeing Board on:

i) the mental health pressures being experienced by residents - exacerbated by Covid-19 and the associated control measures;
ii) the consequent increased demand on and challenges being faced by the mental health system;
iii) the issues and concerns arising; and
iv) the steps being taken in response and in preparation for a post-Covid-19 period, to ensure improved mental health outcomes, experiences and services for Surrey residents.

9 EMPOWERING COMMUNITIES (Pages 109 - 114)

In developing the Surrey Health and Wellbeing Strategy in 2019 we identified the vital role that community engagement and development would play in delivering on our 10-year goals to improve health and wellbeing through a more preventive approach and addressing wider determinants. A range of fantastic community focused initiatives and approaches have since been progressed across our partnership, most notably in the form of the ongoing response to Covid-19. This has given extra energy to our shared ambition to engage with and empower

communities, and a number of key opportunities have been identified to build on progress to date. Work is already underway across the partnership to make the most of these opportunities and through the spring and summer we will also create a roadmap for embedding the empowerment of communities into our longer-term efforts to improve health and wellbeing and address health inequalities.

10 SURREY PHARMACEUTICAL NEEDS ASSESSMENT SUPPLEMENTARY STATEMENT 2021 (Pages 115 - 134)

The Surrey Health and Wellbeing Board (HWB) has a statutory responsibility to deliver a Pharmaceutical Needs Assessment (PNA) every three years. The PNA was delayed from 2020 to 2021 due to resources being diverted to the Covid-19 pandemic. The full Surrey PNA was last published in March 2018. This is regularly supplemented by the PNA Steering Group which reviews changes to the local population and local services annually to ensure that no substantive changes to the Pharmaceutical Needs Assessment are required. The attached report provides a supplementary statement to the 2021 Pharmaceutical Needs Assessment which reports no substantive changes are required to the findings of the 2018 Pharmaceutical Needs Assessment.

11 BETTER CARE FUND SUBMISSION 2020/21 (Pages 135 - 156)

This paper introduces the planned areas of spend for Surrey's 2020/21 Better Care Fund submission. The Better Care Fund is a local single pooled budget that facilitates integrated working between health, social care, and wider partners. Whilst the submission of a formal Better Care Fund plan is not required by NHS England, Annex 1 provides information of the Better Care Fund schemes commissioned in Surrey, to allow oversight and sign-off from the Health and Wellbeing Board. The attached Annex will also be submitted to NHS England for assurance.

12 SURREY LOCAL OUTBREAK ENGAGEMENT BOARD - UPDATE

The Board is to receive a verbal update on the work of the Surrey Local Outbreak Engagement Board (LOEB) including the Vaccination Programme. The LOEB is a formal sub-committee of the Surrey Health and Wellbeing Board. It is a member-led Board created in response to the COVID-19 pandemic, which leads the engagement with local communities and is the public face of the local response in the event of an outbreak.

13 DATE OF THE NEXT MEETING

The next meeting of the Health and Wellbeing Board will be on 3 June 2021.

Joanna Killian
Chief Executive
Surrey County Council
Published: Wednesday, 24 February 2021

QUESTIONS, PETITIONS AND PROCEDURAL MATTERS

The Health and Wellbeing Board will consider questions submitted by Members of the Council, members of the public who are electors of the Surrey County Council area and petitions containing 100 or more signatures relating to a matter within its terms of reference, in line with the procedures set out in Surrey County Council's Constitution.

Please note:

1. Members of the public can submit one written question to the meeting. Questions should relate to general policy and not to detail. Questions are asked and answered in public and so cannot relate to "confidential" or "exempt" matters (for example, personal or financial details of an individual – for further advice please contact the committee manager listed on the front page of this agenda).
2. The number of public questions which can be asked at a meeting may not exceed six. Questions which are received after the first six will be held over to the following meeting or dealt with in writing at the Chairman's discretion.
3. Questions will be taken in the order in which they are received.
4. Questions will be asked and answered without discussion. The Chairman or Board Members may decline to answer a question, provide a written reply or nominate another Member to answer the question.
5. Following the initial reply, one supplementary question may be asked by the questioner. The Chairman or Board Members may decline to answer a supplementary question.

MINUTES of the meeting of the **HEALTH AND WELLBEING BOARD** held at 2.00 pm on 3 December 2020 via Microsoft Teams.

These minutes are subject to confirmation by the Committee at its meeting on Thursday, 4 March 2021.

Elected Members:
(Present = *)

* Dr Andy Brooks
* Dr Charlotte Canniff (Deputy Chairman)
* Jason Gaskell
* Dr Russell Hills
* David Munro
* Mr Tim Oliver (Chairman)
* Kate Scribbins
  Michael Wilson CBE
* Simon White
* Ruth Hutchinson
  Dr Claire Fuller
* Fiona Edwards
* Joanna Killian
* Rachel Hargreaves
* Mrs Sinead Mooney
* Mrs Mary Lewis
* Vicky Stobbart
* Rob Moran
* Rod Brown
* Borough Councillor Joss Bigmore
  Robin Brennan
  Carl Hall
  Gavin Stephens
* Ms Denise Turner-Stewart
* Helen Rostill
* Steve Flanagan

In attendance

Siobhan Kennedy - Housing Advice Manager, Guildford Borough Council (Associate Member)
Miss Alison Griffiths - Deputy Cabinet Member – Place (SCC)
Dr Bill Chapman - Vice-Chairman of the Adults and Health Select Committee (SCC)
Hayley Connor - Director – Commissioning (SCC)

33/20 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [ITEM 1]

Apologies were received from Gavin Stephens, Dr Claire Fuller - Dr Charlotte Canniff acted as substitute, and Michael Wilson CBE.

34/20 MINUTES OF PREVIOUS MEETING: 10 SEPTEMBER 2020 [ITEM 2]

The minutes were agreed as a true record of the meeting.

35/20 DECLARATIONS OF INTERESTS [ITEM 3]

There were none.

36/20 QUESTIONS AND PETITIONS [ITEM 4]

a MEMBERS' QUESTIONS [ITEM 4a]

None received.

b PUBLIC QUESTIONS [ITEM 4b]

None received.

c PETITIONS [ITEM 4c]

There were none.

37/20 UPDATE ON COMMUNITY IMPACT ASSESSMENT, LOCAL RECOVERY INDEX AND SOCIAL PROGRESS INDEX [ITEM 5]

Witnesses:

Rob Moran - Chief Executive, Elmbridge Borough Council (Priority Three Sponsor)
Dr Naheed Rana - Health Consultant - Intelligence and Insight (SCC)
Rich Carpenter - Data Scientist - Insights, Analytics and Intelligence (SCC)
Satyam Bhagwanani - Head of Analytics and Insight (SCC)
Hayley Connor - Director – Commissioning (SCC)

Key points raised in the discussion:

1. The Chairman explained that the Community Impact Assessment (CIA) was an excellent piece of work that measured and highlighted the disproportionate impact that Covid-19 has had on Surrey's communities.
2. The Chairman explained that over the coming year, four workstreams would be combined to provide a more comprehensive picture of what was happening across Surrey: the CIA which was currently broken down to borough and district level, the Social Progress Index which included national benchmarks, the Local Recovery Index which was Surrey's version of SPI and the Health and Wellbeing Strategy metrics which measured key outcomes.
3. The Chairman highlighted that partnership work was key to ensure attainment of the Council's overarching priority that 'no one is left behind' as noted in the Community Vision for Surrey in 2030. He outlined the Council's four strategic priorities of focus for the next five years: 'tackling health inequality' - through the four workstreams listed above, 'growing a sustainable economy so everyone can benefit' - by supporting local high streets and upskilling residents, 'enabling a greener future' - through the Surrey Greener Future Strategy to achieve a carbon neutral future by 2050, and 'empowering

communities' - by working with partner organisations to increase engagement with residents.

4. The Priority Three Sponsor noted that through the recommendations the Board would ensure it would address the findings from the CIA and the Local Recovery Index (LRI) as it was crucial that the priorities aligned with current Covid-19 recovery and future service planning. He praised officers' work on the intelligence products within the CIA and particularly the Rapid Needs Assessments (RNA) which provided ten in-depth assessments of vulnerable communities; an easy read version was also available on Surrey-I.
5. The Health Consultant - Intelligence and Insight (SCC) explained that the aims of the CIA were to explore the impact that Covid-19 has had on health, social and economic elements of Surrey's communities and to understand the needs and priorities of communities for recovery.
6. The Health Consultant - Intelligence and Insight (SCC) noted that the CIA was composed of five discreet intelligence products using a mixed method approach combining qualitative and quantitative data which interlinked forming a high-level analysis of Surrey's diverse communities:
    - Geographical Impact Assessment (GIA)
    - Temperature Check Survey
    - Rapid Needs Assessments (RNA)
    - Place Based Ethnography
    - Local Recovery Index (LRI)
7. The Health Consultant - Intelligence and Insight (SCC) provided an overview of the first national lockdown which began on 23 March 2020 noting that:
    - the furlough scheme began on 19 March.
    - cases peaked in Surrey between April and May and started to fall towards the end of May.
    - there was a greater need for support with 40,000 vulnerable and shielded residents in Surrey contacted and the Surrey Community Helpline was stood up with high demand in March and April.
    - at the same time there was a decrease in demand for some services such as C-SPA (Children's Single Point of Access).
    - national and local evidence highlighted that certain groups were impacted disproportionately from Covid-19 and so ten RNAs were undertaken across vulnerable groups with pre-existing vulnerabilities or a greater risk of mortality from Covid-19.
    - lockdown led to a decrease in mobility and economic activity such as the reduction of traffic flow and passenger bus journeys in the county.
8. The Health Consultant - Intelligence and Insight (SCC) summarised the impacts of Covid-19 as highlighted through the CIA, noting that the:
    - health impacts had been felt the most in areas with higher numbers of over 80s and those in care homes and were mapped across the five most impacted areas in Surrey.
    - economic impacts had been felt the most in areas with a higher reliance on certain industries such as aviation and data was combined on estimated workers furloughed and increases in the claimant count, mapped across the five most impacted areas in Surrey.
    - residents who were not used to needing support struggled as evidenced from the Temperature Check Survey, the Place Based Ethnography and the RNAs with many seeking financial support such as Universal Credit and Jobseeker's Allowance for the first time.
    - lockdown had impacted many people's mental health, findings from the Temperature Check Survey and the Place Based Ethnography showed that 52% of those aged 16-25 said that they felt lonelier due to

lockdown; across each of the RNAs mental health and wellbeing were significantly affected.

- there were significant impacts on those already using mental health services, with key issues reported in interviews such as not knowing where to access services and support, the loss of coping mechanisms, the impact on staffing and on those with dementia, the fear of infection and social isolation.
- lockdown exacerbated the impact on people experiencing domestic abuse, particularly pre-existing domestic abuse as for example the closure of schools further exposed children. It was vital to raise awareness as reporting became difficult due to remote working, the first RNA focussed on service providers and key informants and when possible, a further update would be published on Surrey-I once survivors could be contacted.
- more people participated in unhealthy behaviours since the start of lockdown such as smoking tobacco and drinking alcohol, as shown by the Temperature Check Survey.
- people from Black, Asian and Minority Ethnic (BAME) communities struggled to access support such as food or financial help. Key findings included an increased experience of racism and racial discrimination, the lack of clear communication of guidelines which were also culturally sensitive, and that social distancing was a challenge for families living in multi-generational households.
- residents living in residential care homes had felt more isolated particularly due to the loss of mobility, digital forms of communication were challenging, adequate Personal Protective Equipment (PPE) was an issue as well as access to testing and limited visitors.
- positive impacts from the pandemic included strengthened partnership working between service providers and the Voluntary, Community and Faith Sector (VCFS), a reduction in travel and air pollution and behavioural changes such as increase in time spent outdoors.

9. The Health Consultant - Intelligence and Insight (SCC) detailed the strengthened partnership response across Surrey, highlighting that:
    - the Surrey Community Helpline had handled over 10,000 calls, 40,000 vulnerable and shielded residents in Surrey were contacted, a new community hospital had opened in just over a month, over 10,000 registered volunteers supporting the community delivering food boxes and over 7 million items of PPE were delivered to the front line.
    - regarding the Temperature Check Survey findings, the Health Consultant - Intelligence and Insight (SCC) noted that although the majority of vulnerable people had received the support they needed, there were a few areas of concern such as childcare - outreach needed to be increased.
    - there was a greater sense of community and neighbourliness, with over half reporting a positive impact on their connection to the local community.
    - some groups had felt excluded or stigmatised, several themes were identified through the ten RNAs: information, exclusion, isolation, stigma and rigidity of regulations.
    - there were gaps in service provision for some types of need, as crucially services with a lower demand had been harder to access. Shielded individuals and their carers felt there was a lack of contact from Adult Social Care and other support services.

- residents had found information around guidelines and rules confusing and there was a lack of culturally sensitive information.

10. The Health Consultant - Intelligence and Insight (SCC) outlined the current second wave, noting that cases in Surrey had started to rise again in September taking Surrey's total of cases to over 10,000 since the start of the pandemic; and that many residents had concerns regarding their long term physical and mental wellbeing and that of their family and friends.
11. Looking to the future, the Health Consultant - Intelligence and Insight (SCC) noted that:
    - local recovery efforts had started to show results since the easing of lockdown, with mobility trends around retail and recreation activities reverting to pre-pandemic levels. Although recovery and particularly the economic impact was uneven across the county.
    - residents indicated that the focus should be on supporting local businesses and vulnerable people in the county.
    - the CIA was published on Surrey-I and that the findings were being disseminated across key partners with strategic groups being established as well as alignment with phase 3 of the NHS' response to Covid-19.
    - tackling misinformation and providing targeted communications was key, Covid-19 surveillance was carried out daily and mass vaccination was a key area of focus.
12. The Data Scientist - Insights, Analytics and Intelligence (SCC) introduced the Local Recovery Index (LRI) which was a thematic subset of the Social Progress Index and measured Surrey's recovery from the pandemic - return to pre-pandemic levels - and the impact that COVID-19 has had across three dimensions: economy, health and, society and infrastructure.
13. The Data Scientist - Insights, Analytics and Intelligence (SCC) explained that the LRI produced a score and rank for each dimension and indicator to enable a comparison between areas. He provided a summary of the recently published quarter two scores and ranks, noting that there had been some movement between July-September 2020 since quarter one:
    - quarter two saw a reduction in infection rates and increased mobility, all three dimensions saw an increase in recovery, so the overall scores had improved for every borough and district.
    - the rankings of boroughs and districts changed slightly in that Tandridge ranked the highest for recovery whilst Spelthorne ranked the lowest. Woking which was ranked first in quarter one had dropped down the most.
    - a reduction in overall scores in quarter three was expected due to the second wave with increasing infection rates. Impacts on the economy continue to worsen with the increase in claimants for Universal Credit, although furlough had some beneficial impact.
14. The Data Scientist - Insights, Analytics and Intelligence (SCC) provided an update on the Social Progress Index (SPI) which although paused in response to Covid-19, some work was undertaken in the background as 70% of the data for the indicators had been collected. Work on the LRI was useful as it acted as a test of the process of the SPI using the same methodology.
15. The Data Scientist - Insights, Analytics and Intelligence (SCC) noted that there was a workshop early in the year on the SPI with partners to formulate key indicators which had since been shortlisted.
16. The Data Scientist - Insights, Analytics and Intelligence (SCC) added that piloting indicators at borough data in Elmbridge had been resumed, with data collected down to ward level. A beta version of the Surrey SPI was planned to

be produced by early next year and asked Board members to help with data collection and partners would be consulted on regarding the draft indicators within the four components under the three dimensions.

17. The Head of Analytics and Insight (SCC) noted that the team was happy to receive any feedback on the intelligence products.
18. A Board member praised the dedication of officers and was encouraged by the determination to get the data and information out to key partners that support hard to reach groups which was crucial particularly as there was often a deep sense of mistrust and a single source of truth in certain communities.
19. A Board member highlighted that according to the evidence, Surrey's communities should be given credit for their stoic acceptance of the severe restrictions; as from the policing side there was no widespread flouting of the restrictions. The data showed that social isolation was a damaging impact of the restrictions and must be addressed.
    - The Priority Three Sponsor noted that although there was initial pushback and queries from residents when Elmbridge was the first area in Surrey to be moved into Tier 2 in October, he positively noted the compliance of Surrey's residents with the restrictions.
    - A Board member echoed the stoicism reported to Healthwatch Surrey and gratitude of the services people have had, she emphasised the importance of taking note of the feedback during the pandemic as people were reluctant to speak out.
20. A Board member noted that it was encouraging that the majority of vulnerable people who needed help received the support they needed but highlighted that the single most negative perception of residents who needed help was in childcare as only 15% felt they received effective support and access to services. He hoped that the issue would be given greater priority by the Council as the Local Education Authority moving forward to develop a more coherent approach going forward in response to the haphazard closure and reopening of educational settings. However, he recognised the challenging circumstances of the ever-changing situation and the excellent provision stood up by educational settings.
    - In response the Director – Commissioning (SCC) noted that it was important to recognise that schools and early years settings did an incredible job during wave one when they had to close and subsequently when they had to reopen with social distancing measures and bubbles.
    - She recognised that it was difficult for parents working at home to juggle childcare and home learning; and that schools stayed open for the children of key workers and children with defined health, education, or social needs. Going forward it remained important to look at how the Surrey community and employers support members of staff with childcare whilst working at home.
21. A Board member queried that given the wealth of information from the CIA and the intelligence products, what the role of the Board was in having oversight of how that work was progressed. She asked whether the Board would receive a concise set of prioritised recommendations so that the Board could hold itself publicly accountable on how the CIA and intelligence products have informed various workstreams and how would the Board map that in relation to the priority boards.
    - The Priority Three Sponsor responded that the work only had value if it has utility within organisations and the Board has oversight of how the work is permeated through their work.
    - A Board member highlighted the comments in the Microsoft Teams chat noting that the CIA and intelligence products were already permeated

through ICPs, with an insight in recovery and restoration being presented in a later item from Surrey Heartlands CCG on the health inequalities work underway across the system. The tableau dashboard looked progress regarding the Health and Wellbeing Strategy, with more detailed annual review by the Board of the Strategy's metrics at its next meeting.

- The Health Consultant - Intelligence and Insight (SCC) noted that the team had offered some design workshops to different partners to look at integrating the findings and priorities along with the Strategy to ensure action.

22. Regarding the LRI, a Board member noted that from public point of view there were many health dimensions not included in the LRI, which as referenced in the paper was due to data not being available at the borough and district level. As for example mental health, rates for screening and immunisations, and return to normal for elective and urgent care were concerns to residents, she asked whether there were any next steps to get that data.

Dr Andy Brooks left the meeting at 2.52 pm

- In response, the Priority Three Sponsor noted that if such data was available that it should be captured so that the work followed an iterative and ongoing process adding to the richness of data.
- Regarding data collection on the LRI, the Head of Analytics and Insight (SCC) added that his team took that action away from the last Board and was being followed up through discussions with colleagues from Surrey Heartlands CCG and acute trust colleagues. He added that geography posed a challenge as for example waiting times information was available at NHS Trust level in Surrey, so the team was looking at how that data could be made available at borough and district level.
- The Health Consultant - Intelligence and Insight (SCC) noted that the CIA and RNA highlighted the health inequalities angle exacerbated by Covid-19. There were multiple workstreams and various indicators relating to health inequalities, so it was key to align those pieces of work whether through the LRI or through the comprehensive dashboard which was in development, to look at those health inequalities in consultation with healthcare partners.

23. The Priority Three Sponsor thanked officers for their expertise and ongoing work and that it was up to Board members to ensure that the findings were integrated into their organisations. Partnership work was vital to ensure collective ownership and the findings showed the insidious impact of loneliness and isolation in communities and the exacerbation of domestic abuse which must be addressed.
24. The Chairman thanked the Priority Three Sponsor for leading on the partnership work and emphasised that the CIA and intelligence products underpinned the Strategy's priorities. He thanked all and noted that the Board will follow up on the item in the upcoming year to ensure that improved outcomes were being delivered particularly targeting those vulnerable groups and communities identified.

RESOLVED:

That the Health and Wellbeing Board:

1. Considered how the findings from the Covid-19 Community Impact Assessment can best be incorporated into the council's strategic, financial and service planning and delivery.
2. Acknowledged the issues highlighted in the LRI and asked lead officers to incorporate them into the Health and Wellbeing Boards planning and response to Covid-19.
3. Supported the use of the LRI findings to refine the target communities and themes in the Health and Wellbeing Strategy and instigate actions within the delivery plans to tackle the impact of Covid-19 on at risk and vulnerable communities.
4. Provided individual and collective leadership to ensure LRI findings are incorporated into organisational strategies and inform decisions around future service delivery and resource allocation.
5. Acknowledged the proposals for the SPI and provides individual and collective leadership to ensure the SPI benefits from board members unique oversight and expertise to help us tailor the SPI framework for Surrey.
6. Highlighted areas or issues of interest and for future focus in terms of further research and analysis.

Actions/further information to be provided:

1. The Board will receive a beta version of the Surrey SPI in due course, including the pilot in Elmbridge and Board members are to help with data collection and partners will be consulted on the draft indicators.
2. The Board will continue to have oversight over the progression of the CIA and the intelligence products on how they will inform and permeate through workstreams across organisations concerning both current Covid-19 recovery and future service planning; and mapping that in relation to the priority boards. An update will be received by the Board in due course to ensure that improved outcomes were being delivered particularly targeting those vulnerable groups and communities identified.
3. Officers will ensure that the many workstreams and various indicators relating to health inequalities are aligned whether through the LRI or the more comprehensive dashboard through partnership working to capture data at the borough and district level.

38/20 HEALTH AND WELLBEING STRATEGY HIGHLIGHT REPORT [ITEM 6]

Witnesses:

Rod Brown - Head of Communities and Housing, Epsom and Ewell Borough Council (Priority One Sponsor)
Professor Helen Rostill - Director for Mental Health, Surrey Heartlands ICS and SRO for Mental Health, Frimley ICS (Priority Two Sponsor)
Rob Moran - Chief Executive, Elmbridge Borough Council (Priority Three Sponsor)

Key points raised in the discussion:

1. The Priority One Sponsor noted that although the Priority covered a broad area with seven focus areas and thirty-five targeted projects it was progressing. He noted:
   - the work within the Priority was overseen by the Prevention Board which was developing positively with increased membership and board members were proactively bringing assistance and working with other Priority leads to join up work and tackle challenges.

- the natural connectivity emerging between focus areas such as focus area 1 concerning excess weight working closely with focus area 5 concerning the incidence of serious conditions and diseases.
- that housing was a major factor, good progress had been made as for example two sites for homelessness cabins in Surrey were being established which would help alleviate winter pressures and some accommodation would be put aside for Covid-19 positive homeless so they could self-isolate.
- that due to Covid-19 several projects on domestic abuse had been accelerated such as the provision of additional domestic refuge capacity. The Priority Board were due to consider a fuller report on focus area 4 on domestic abuse and empowering survivors early next year, as well as reports on focus areas 5 and 6 later next year.
- that Covid-19 brought challenges such as in focus area 3, project 1: 'tackling fuel poverty, as a Senior Responsible Owner still needed to be identified and he welcomed suggestions; progress had been hindered in other areas but there were signs of those projects picking up momentum.

2. Discussing focus area 3 and project area 1 'tackling fuel poverty in Surrey' within Priority One, a Board member noted that there were various schemes across the county for those to donate their Winter Fuel Payment to charity who did not need it, but was struck by the small amount donated with only £19,000 donated last year in Waverley. He asked whether the Board could look into the matter to increase those donations.
    - In response, the Chairman explained that the Board would take that point away and look to work with charities.
    - The Priority One Sponsor added that he would look into the matter.
3. Discussing focus area 3 and project area 4 'supporting people who hoard in Surrey' within Priority One, a Board member asked for further detail on the matter and whether there was an impact on policing.
    - In response, the Priority One Sponsor would look to provide more detail.
4. The Priority Two Sponsor noted the shift seen concerning mental health in the last few weeks and system partners working closely together. She noted:
    - that the Surrey Mental Health Summit 2020 in November energised and renewed commitments to work in partnership to improve outcomes for residents. The Summit discussed the community impact of Covid-19 on mental health as highlighted by the CIA; as well as initiatives in the workplace such as in Australia promoting good mental health and its impact on productivity and partnership working in West Yorkshire promoting acts of kindness in communities.
    - the outputs from the Summit included concern over the ongoing resourcing of mental health, the importance of wellbeing and early intervention, training, partnership working and supporting carers of people with mental health. The next steps would be considered by the Surrey Heartlands Health and Care Partnership System Board in December.
    - the Adults and Health Select Committee's Mental Health Task Group report which took a bottom-up approach by looking at the journey for service users, carers and those who commissioned services. The Task Group were embedding recommendations within the Priority with further progress to be tracked.
    - the use of the CIA's insights and cross-checking priorities to target affected groups such as the recently unemployed or at risk of losing their job due to the pandemic through a working group with the Department for Work and Pensions, Citizens Advice and Richmond Fellowship.

- that pressure continued in mental health, recent benchmarking showed a surge in demand with a 22% increase in demand for children's services nationally with the impact being felt in Surrey. The increase in acuity for adults continued around the crisis pathway and inpatient services.
- the green social prescribing Expression of Interest submitted to the Department for Environment, Food and Rural Affairs to scale up existing local projects in Surrey including community gardens, community sheds and walking for health. Surrey was invited to submit a full application; to secure part of the £4 million funding.
- the completion of the first phase of the GP Integrated Mental Health Service (GPIMHS) programme across the county's eleven Primary Care Networks (PCNs) which had helped over 3,000 people. Development of an enhanced pathway for people with Personality Disorder (PD) traits was underway, development of the 18 to 25 Young Adults' pathway was also underway - with a bid submitted to NHS England for further funding to phase rollout across all PCNs.
- the small amount of funding awarded from NHS England to develop a workforce wellbeing hub to address Covid-19's disproportionate effects on the health and care workforce, to accelerate the promotion of prevention and self-care offers through a single gateway with an enhanced Im*proving Access to Psychological Therapies* (IAPT) offer and 1:1 support.
- the key risks included health inequalities and risks around physical health checks for people with serious mental illness and for those with learning disabilities with targets set through the NHS Long Term Plan not being reached nationally. There was a real focussed effort with NHS England nationally and regionally to increase the number of people getting those psychical health checks, as well as work with ICPs and PCNs to put together a local action plan.

5. The Chairman endorsed the comments on the Surrey Mental Health Summit 2020 which was a good opportunity to reinforce the key priorities and review the current model; partners recognised that there needed to be a real focus on prevention and early intervention work.
6. The Priority Three Sponsor summarised the progress in the three focus areas:
    - focus area 1 - the 2030 Economic Strategy Statement and the county's approach to skills and unemployment were key and were covered in the next item. The SPI also was also a crucial piece of work and was covered in the previous item.
    - focus area 2 - overseen by the Women and Children's Transformation and Assurance Board and key work included the First 1,000 days initiative.
    - focus area 3 - as a result of the Community Safety Board's merger with the Health and Wellbeing Board in March 2020, the community safety priorities have been merged with the Strategy fulfilling Surrey Police's vision for communities to be safe and to feel safe. Next February the Board would hold an informal session to agree key themes around the Community Safety Agreement and the relationship between health and policing, undertaking a risk-based and partnership approach to crime and disorder prioritisation and residents' perceptions of crime. The Board would receive an update on the milestones and programmes of work at its next meeting.
7. A Board member was glad that work on community safety was moving at pace as it was the foundation of many of the workstreams.

8. The Vice-Chairman noted Public Health England's insightful guidance document 'Health Matters: Cold Weather and COVID-19' which highlighted the impacts of the cold on vulnerable people with Covid-19 amplifying cold-related risks. The document noted the link between the risk of cold outdoor temperatures and winter weather with the increased incidence of heart attacks and strokes. Therefore, the message of keeping warm - particularly for vulnerable residents - was important and was included in Healthy Surrey's communications 'keep warm, keep well' linking to the County Council's 'Winter advice 2020-21', with similar communications and guidance prepared by the NHS.
9. The Chairman noted the positive progress across the three Priorities which were all interlinked.

RESOLVED:

That the Health and Wellbeing Board:

1. Noted the positive impact a sustainable economy, enabling a greener future and empowering communities to support each other, can have on reducing inequality and endorse a focus on these through the work of the Health and Wellbeing Board.
2. Considered and approved the Community Safety Agreement focus areas as described under Priority 3.
3. Noted the shared progress described across the three strategy priorities in adapting and responding to the impacts of the pandemic.
4. Noted the adoption of longer-term oversight of relevant work identified within the VCFS strand of the Recovery Coordinating Group which should inform relevant work and the system capability discussion at the March Board.

Actions/further information to be provided:

1. The Board will continue to identify a Senior Responsible Owner regarding Priority One, focus area 3, project 1: 'tackling fuel poverty in Surrey'.
2. The Priority One Sponsor on behalf of the Board will look to work with charities concerning increasing donations of the Winter Fuel Payment to charities.
3. The Priority One Sponsor will look to provide more detail on hoarding in relation to the policing impact.
4. Following the informal session to agree key themes around the Community Safety Agreement and the relationship between health and policing focus area 3, the Board will receive an update on the milestones and programmes of work at its next meeting.

39/20 SURREY 2030 ECONOMIC STRATEGY STATEMENT AND ONE SURREY GROWTH BOARD UPDATE [ITEM 7]

Witnesses:

Dawn Redpath - Director for Economy and Growth (SCC)

Key points raised in the discussion:

1. The Chairman explained that the Surrey 2030 Economic Strategy Statement and One Surrey Growth Board supported the Council's strategic priority of the Council for the next five years of 'growing a sustainable economy so everyone can benefit'.

2. The Director for Economy and Growth (SCC) hoped that the work would be the start of an ongoing relationship between the Board and the work within Surrey's 2030 Economic Strategy Statement, linking health with the economy to fulfil all four of the Council strategic priorities, particularly supporting 'growing a sustainable economy so everyone can benefit' which has a direct impact on 'tackling health inequality'.
3. The Director for Economy and Growth (SCC) reinforced the link between the economy and the wider determinants of health, noting that the socio-economic determinants of health such as housing and social inclusion were linked to having higher levels of income and more importantly good quality employment, which was vital for mental health and wellbeing.
4. The Director for Economy and Growth (SCC) noted that economic responses focussed on the quality of employment opportunity, skills and inclusion. The links between the economy and health could be seen geographically through a place-based approach as for example in pockets of deprivation health was poorer and there was higher economic inactivity and unemployment. It was vital to reduce unemployment and to ensure good quality employment in response to zero hours contracts and the gig economy, ensuring that individuals were not left behind in terms of a higher requirement of digital skills and access to digital services. She added that economic responses could also be thematic, for example looking at people with low level mental health or anxiety.
5. The Director for Economy and Growth (SCC) noted that Surrey Future Economy Commission chaired by Philip Hammond commissioned research from ARUP and the University of Surrey in 2019. The findings highlighted Surrey's comparative economic advantage, as well as challenges such as in the aviation sectors and high levels of unemployment, an unbalanced economy due to an ageing population and inability to retain young talent, structural issues relating to housing affordability, transport, and access to digital infrastructure. Action needed to happen on a whole-Surrey basis, to be a driver of the local, regional and UK economy.
6. The Director for Economy and Growth (SCC) explained that the Surrey 2030 Economic Strategy Statement brought together five areas of focus underpinned by the Surrey Future Economy Commission's findings:
    - growing the leading edge - by encouraging innovation, capitalising on the number of large multinational companies which provide 50% of employment to Surrey.
    - a whole-Surrey approach to quality places - place-based approach, create new hyper local places in line with the CIA's findings of supporting local services and revitalising town centres.
    - improving connectivity for the next generation - ensuing that the digital infrastructure is fit for purpose.
    - green economic ambitions - capitalising on the green sector in Surrey by using the established automotive industry and exploring the possible 4,000 additional jobs in electric vehicles available to Surrey residents.
    - maximising opportunities for all - the work aligns with Priority Three of the Health and Wellbeing Strategy: supporting people in Surrey to fulfil their potential by generating aspirations and developing skills:

Fiona Edwards left the meeting at 3.33 pm

- the Skills and Inclusion Framework looked at inclusion, high volume and high skills with the progression of employment provision in

Surrey across five stages: engagement, barrier removal, vocational activity, supporting job entry and in-work support.
- understanding what provision there was in Surrey was key to support target populations to go from stage one to stage five, although not always in a neat linear way. There was a lot of provision available and close working with the DWP, and Surrey Employment & Skills Board to engage closely with partners.

7. The Director for Economy and Growth (SCC) explained that the One Surrey Growth Board (OSGB) was working alongside the Board and offered the opportunity to bring together all place-related activity into 'One Surrey' leadership.
8. The Director for Economy and Growth (SCC) explained that the OSGB had wide representation across key partners and had started to look at the recommendations from the Surrey Future Economy Commission, after reviewing the findings from the Surrey 2030 Economic Strategy Statement it would develop a 'One Surrey Plan for Growth'. She noted that the key components of the Plan were cross-cutting with many linking to health as an outcome, the OSGB would have a role in recognising complementary objectives.
9. The Director for Economy and Growth (SCC) explained that the next steps were for the Surrey 2030 Economic Strategy Statement to be approved by Cabinet in December - with proposed stakeholder engagement with all partners to follow, continued engagement with the OSGB, and the 'One Surrey Plan for Growth' was being developed. She noted that updates would be provided at a future Board.

RESOLVED:

That the Health and Wellbeing Board noted the progress being made in supporting a more sustainable and inclusive whole-Surrey economy focusing on the links that good quality employment can have on health and wellbeing outcomes as well as the direct relationship between the economic strategy work and HWB Priority 3.

Actions/further information to be provided:

1. The Board will continue to work closely with the Director for Economy and Growth (SCC) to ensure that the work within Surrey's 2030 Economic Strategy Statement aligns with the Health and Wellbeing Strategy and the Council's four strategic priorities, particularly supporting 'growing a sustainable economy so everyone can benefit'.
2. The Board will receive updates on the work of the One Surrey Growth Board, including the 'One Surrey Plan for Growth'.

40/20 BUILDING YOUR FUTURE HOSPITALS (BYFH) PROGRAMME [ITEM 10]

The Chairman considered Item 10 (this item) before Item 8

Witnesses:

Daniel Elkeles - Chief Executive, Epsom and St Helier University Hospitals NHS Trust

Key points raised in the discussion:

1. The Chief Executive, Epsom and St Helier University Hospitals NHS Trust explained that extensive planning had been undertaken since July when the

NHS Surrey Heartlands and NHS South West London Clinical Commissioning Groups made their decision to build a new emergency care hospital in Sutton; adding that in a subsequent review the Independent Reconfiguration Panel found no reason to contradict the choice of Sutton.

2. The Chief Executive, Epsom and St Helier University Hospitals NHS Trust noted that work was on track to submit the business case by the end of December to the Department of Health and Social Care, NHS and HM Treasury for completing the refurbishment of Epsom Hospital, the refurbishment of St Helier Hospital and for the new specialist emergency care hospital at Sutton. Part of the business case would look at co-locating nephrology services currently divided between St George's Hospital and St Helier Hospital; with intended public engagement on the business case between January to March if approved at national level.
3. The Chief Executive, Epsom and St Helier University Hospitals NHS Trust noted that the refurbishment of Epsom Hospital was moving at pace with two more large construction projects to start in January, that the design for the new specialist emergency care hospital at Sutton was exciting with a proposal to have curved walls in order to deliver 70% single rooms with the challenge of being the first carbon neutral hospital in the world as well as being a fully digital building.

RESOLVED:

That the Health and Wellbeing Board noted the verbal update on the 'Building Your Future Hospitals' (BYFH) programme.

Actions/further information to be provided:

1. The Board will continue to keep an eye on the progress of the 'Building Your Future Hospitals' (BYFH) Programme.

41/20 SURREY SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2019/2020 [ITEM 8]

Witnesses:

Mrs Sinead Mooney - Cabinet Member for Adults and Health (SCC)
Simon Turpitt - Independent Chair, Surrey Safeguarding Adults Board

Key points raised in the discussion:

1. The Cabinet Member for Adults and Health (SCC) explained that the Surrey Safeguarding Adults Board (SSAB) was a statutory multi-agency board with responsibilities set out in the Care Act 2014.
2. The Cabinet Member for Adults and Health (SCC) commended the SSAB for their work over the last year noting the improved format and presentation of the data gathered from key partners, acknowledging that it had been a busy year for the SSAB dominated in final months by Covid-19. The report highlighted the responsiveness of agencies in Surrey to keep safeguarding adults in the forefront of the work done in the county and she would continue to work closely with the SSAB to ensure improved safeguarding responses.
3. The SSAB Independent Chair noted that the annual report was a review of 2019/20 before Covid-19 and its significant impacts. He highlighted the continual increase in safeguarding referrals and a significant increase in Section 42 reports over the last year.

4. The SSAB Independent Chair highlighted that although referrals and Section 42 reports decreased due to Covid-19, they had since increased which showed that firstly, understanding of the need for safeguarding was continually improving and agencies were more responsive to that; and secondly, there were more vulnerable individuals out there and people under more pressure as demonstrated by the rise in domestic abuse referrals, scams and an increase in deaths due to Covid-19 in vulnerable individuals with care and support needs.
5. The SSAB Independent Chair noted that having heard the earlier discussions, he noted that it was vital for the SSAB to be more closely aligned with the Health and Wellbeing Board more so than presenting an annual report. The CIA and the Surrey Mental Health Summit 2020 highlighted that linkages needed between partners needed to be strengthened and suggested an informal session next year to further explore critical data sources and better processes to reduce the number of people requiring safeguarding.
6. The SSAB Independent Chair thanked all partners and organisations that supported the SSAB, noting improved partnership working over the last year including with the Surrey Safeguarding Children Partnership (SSCP) and that awareness needed to be raised on what safeguarding adults was as opposed to the safeguarding children model.
7. The SSAB Independent Chair noted the format of the annual report was made simpler to read and sought feedback on areas missing or which needed to be improved. He stressed that safeguarding was a concern for all and welcomed further Board collaboration to ensure it remained a priority for the Board.
8. A Board member noted that although there had been an increase in the number of cases reported, at the same time there had been a drop in the percentage reported by families and asked for an explanation on the importance of increasing knowledge and awareness amongst families of the reporting process. Particularly as the work of Healthwatch Surrey highlighted that there was a low level of awareness of the process of safeguarding and who to contact.
    - In response, the SSAB Independent Chair noted that Healthwatch Surrey's report showed that safeguarding was not understood clearly understood by the general public and the SSAB took action by looking at ways to better communicate with families such as leaving information in care homes, publicising National Safeguarding Adults Week 2020 a few weeks ago and working closely with the SSCP on joint initiatives to provide people with a greater understanding of safeguarding and the differences between adult and children safeguarding.
9. A Board member asked whether there was a breakdown between care homes and domiciliary care concerning the number of safeguarding enquiries related to neglect. In response, the SSAB Independent Chair noted that the data would be broken down into those areas as Covid-19 posed enormous pressures and risks exacerbating issues such as loneliness and safeguarding; it was noted that the Executive Director of Adult Social Care (SCC) would provide that breakdown.

RESOLVED:

1. That the Health and Wellbeing Board considered and noted the Surrey Safeguarding Adults Annual Report for 2019/2020.
2. Considered the Safeguarding Adults Annual Report in relation to the Health and Wellbeing Board strategic priorities.

Actions/further information to be provided:

1. The Board will ensure that it is more closely aligned with the SSAB going forward in order to ensure that safeguarding remained a priority; and will look at a possible informal session next year to further explore critical data sources and better processes to reduce the number of people requiring safeguarding.
2. The Executive Director of Adult Social Care (SCC) will provide the breakdown in relation to care homes and domiciliary care concerning the number of safeguarding enquiries related to neglect.

42/20 COVID-19 RECOVERY PLANNING - SURREY HEARTLANDS [ITEM 9]

Witnesses:

Steve Flanagan – CEO, CSH Surrey and Chair of ICS Recovery Board (Representative, North West Surrey Integrated Care Partnership and Community Provider voice)

Key points raised in the discussion:

1. The Representative, North West Surrey Integrated Care Partnership and Community Provider voice noted the progress made in restoration and recovery since the last update to the Board in September and was impressed with the presentations and discussions made in previous items which highlighted key interlinkages and partnership work.
2. The Representative, North West Surrey Integrated Care Partnership and Community Provider voice outlined the response to the letter 'Third Phase of NHS response to Covid-19' in which the focus was on restoring services lost through wave one of the pandemic. Covid-19 had developed and strengthened partnership work across acute colleagues, community services as well as primary and social care; and the work on Surrey Heartlands' Phase 3 plans was led by the Chief Executive of Royal Surrey County Hospital NHS Foundation Trust and the Recovery Director Surrey Heartlands ICS.
3. The Representative, North West Surrey Integrated Care Partnership and Community Provider voice highlighted that Surrey Heartlands was being recognised nationally on its restoration response as for example its elective services were back up and running above target at 89% of pre-pandemic levels. The challenges encountered were on the diagnostic side with teams now working more effectively together and endoscopy was a challenge at the start of the year although it was now operating at 125% of its target.
4. The Representative, North West Surrey Integrated Care Partnership and Community Provider voice provided updates from the two workstreams which had a significant overlap with the Health and Wellbeing Strategy:
    - Emotional Wellbeing - led by the Chief Executive, Surrey and Borders Partnership, as well as the Director for Mental Health, Surrey Heartlands ICS and SRO for Mental Health, Frimley ICS (Priority Two Sponsor); particularly as Covid-19 significantly impacted on mental health.
    - Equalities and Health Inequalities (formally known as 'Hidden Harm') - led by the Director of Public Health (SCC), the Surrey Heartlands ICS Director of Children's and Learning Disabilities Services and the and the Clinical Chair, Surrey Downs ICP; using the work of the CIA and other intelligence workstreams to identify and reduce multiple inequalities.
5. The Representative, North West Surrey Integrated Care Partnership and Community Provider voice noted the lessons learnt so far including the:

- challenge of getting partners to work together more to ensure a system first approach which was more of a challenge for the recovery side which focussed on long-term fixes - which had subsequently improved.
- challenge concerning the governance of the Surrey Heartlands ICS Recovery Programme and alignment with statutory powers.
- benefit of harmonising more back office activity such as finance, IT, and personnel amalgamating services across Surrey Heartlands for financial efficiency towards the betterment of healthcare.

David Munro left the meeting at 3.56 pm
Professor Helen Rostill left the meeting at 3.57 pm

6. The Chairman commended the groundwork made regarding both the practicalities of restoration and recovery and the partnership work.
7. The Chairman noted NHS England and NHS Improvement's '*Integrating Care: Next steps to building strong and effective integrated care systems across England'* paper published last week. As a result the future direction of travel for Surrey Heartlands ICS including its Integrated Care System Strategy would need to be revised early next year in anticipation of the proposed legislative changes in which all health and care systems were expected to become Integrated Care Systems by 2021.
    - He emphasised that it would be a good opportunity to link all workstreams in with the work on the Health and Wellbeing Strategy to ensure that the health system was delivering the three key priorities, via a possible Board informal session next year.

RESOLVED:

That the Health and Wellbeing Board noted the verbal update and presentation slides.

Actions/further information to be provided:

1. In relation to the NHS England and NHS Improvement's paper '*Integrating Care: Next steps to building strong and effective integrated care systems across England'* the Board will work with partners on the future direction of travel for Surrey Heartlands ICS including the revision of the Integrated Care System Strategy; linking all workstreams in with the work on the Health and Wellbeing Strategy to ensure that the health system was delivering the three key priorities, via a possible Board informal session next year.

Dr Charlotte Canniff left the meeting at 3.59 pm
Dr Russell Hills left the meeting at 4.00 pm
Mrs Mary Lewis left the meeting at 4.00 pm

43/20 SURREY LOCAL OUTBREAK ENGAGEMENT BOARD – UPDATE [ITEM 11]

Witnesses:

Sinead Mooney - Cabinet Member for Adults and Health (SCC)

Key points raised in the discussion:

1. The Cabinet Member for Adults and Health (SCC) as the Surrey Local Outbreak Engagement Board (LOEB) Chairman noted that the LOEB last met

on 20 November and had a both constructive and interactive meeting, receiving six public questions and a number of supplementary questions which were broad in range covering lateral flow tests, the impact of the pandemic on the economy and transitioning out of lockdown.

2. The LOEB Chairman noted the insightful update on Covid-19 Surveillance as the intelligence was key to identify areas of concern and ensure prompt action continued to be taken. The LOEB also received updates on the Covid-19 Local Outbreak Control Plan covering areas such as the local tracing partnership, Covid Marshals as well as care homes and winter pressures; from Spelthorne Borough Council on Covid Champions as well as an update on the Local Outbreak Control Communications Plan which was dynamic all and responsive to Covid-19 trends.
3. The LOEB Chairman thanked all that took part in the LOEB and looked forward to the upcoming year and further positive work.

RESOLVED:

That the Health and Wellbeing Board noted the report and verbal update on the work of the Surrey Local Outbreak Engagement Board.

Actions/further information to be provided:

None.

44/20 DATE OF THE NEXT MEETING [ITEM 12]

The next meeting of the Health and Wellbeing Board will be on 4 March 2021.

Meeting ended at: 4.03 pm

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Chairman

Health and Wellbeing Board Paper

1. Reference information

Paper tracking information	
Title:	Health and Wellbeing Strategy Highlight Report
Author:	Phillip Austen-Reed, Principal Lead – Health and Wellbeing (SCC); phillip.austen-Reed@surreycc.gov.uk, 07813538431
Priority Sponsor(s):	• Rod Brown, Head of Communities and Housing, Epsom and Ewell Borough Council (Priority 1 Sponsor) • Professor Helen Rostill, Director for Mental Health, Surrey Heartlands ICS and SRO for Mental Health, Frimley ICS (Priority 2 Sponsor) • Rob Moran, Chief Executive, Elmbridge Borough Council (Priority 3 Sponsor)
Paper date:	4 March 2021
Related papers	Appendix 1: HWBS Priorities milestones status (as at January 2021)

2. Executive summary

This paper provides an overview of the local shared projects supporting delivery of the Health and Wellbeing Strategy against the milestones within priorities one, two and three as of January 2021. It highlights specific areas where work has been adapted and stepped up to respond to the impact of the pandemic and in response to the intelligence provided locally through the Community Impact Assessment and Rapid Needs Assessments which were presented at the December 2020 board meeting. A summary of progress is provided by project in Appendix 1.

3. Recommendations

It is recommended the Health and Wellbeing Board:

1. Note the progress and adaptations made in response to the pandemic.
2. Review and approve the draft Community Safety Agreement shared via the recent informal session for wider consultation prior to alignment within strategy priorities, particularly priority three.
3. Agree review of focus areas that are currently reported within the three priority areas. This will be to ensure they continue to be relevant, are appropriately located under the priorities and continue to maintain a focus on collaborative work to address health inequalities and the longer term impact of the pandemic.

4. Strategy delivery and Implementation plans

The following summarises progress in the previous quarter and highlights areas where action has been adapted and stepped up (as of January 2021) to respond to the impact of the pandemic and the learning provided locally through the Community Impact Assessment and Rapid Needs Assessment.

Priority 1: Helping People to live healthy lives

5

Focus Area 1: Working to reduce obesity and excess weight rates and physical inactivity

Public Health and Active Surrey are joint strategic leads for the co design and implementation of the whole system approach to Obesity and Physical Inactivity. During lockdown overall more people were participating in unhealthy behaviours by eating unhealthy food and reducing exercise. During the most recent quarter the following within Focus Area 1 was progressed:

- Launching the Whole Systems Approach (WSA) Framework to healthy weight where a diverse range of organisations across Surrey were invited to complete a six-stage process to develop and deliver a plan which addresses the causes of obesity for their population. Grant funding is being sought to assist organisations to drive forward the WSA.
- At the launch in November 2020 in excess of 130 people from a variety of backgrounds booked onto the virtual WSA: Obesity and Inactivity Summit with representation of stakeholders from Planning, Countryside, Environmental Health Officers, Districts and Boroughs, Voluntary Sector.
- The WSA will mean working with communities with the highest prevalence of obesity, which are often those with the highest Index of Multiple Deprivation (IMD) scores and with populations most at risk e.g. people from diverse backgrounds such as BAME, Learning Disabilities and people with mental ill health.
- The co-production phase of the strategy development has begun: six co-production Focus Groups including people with lived experiences are scheduled, to work with priority audiences identified in the HWB strategy and referenced in the Community Impact Assessment (CIA) - obese/overweight people, people in lower socio-economic groups, ethnically diverse communities, disabled children and adults, people with poor mental health.
- A draft of the Physical Activity Strategy is scheduled for distribution from April 2021.

Focus Area 2: Supporting prevention and treatment of substance misuse, including alcohol

During the lockdown overall there was an increase in unhealthy behaviours such as smoking and drinking. In response to this, the following within Focus Area 2 was progressed:

- Additional promotional and engagement activities were carried out during Alcohol Awareness Week in November 2020 which resulted in 728% increase in the number of people assessing their drinking levels by completing a validated online screening test. Alcohol Test | Surrey — DrinkCoach; DrinkCoach
- Additional resource was committed to early intervention services to support people to reduce their alcohol consumption and to rebrand and promote services to residents and professionals. i-access Drug & Alcohol Service :: Surrey and Borders Partnership NHS Foundation Trust (surreydrugandalcohol.com)
- Self-Management and Recovery Training (SMART) Programme which helped people manage their recovery from any type of addictive behaviour including alcohol, nicotine, drugs or compulsive behaviours such as gambling, sex, eating or self-harm were enhanced https://www.catalystsupport.org.uk/smart-recovery/
- Supplementary engagement capacity was put in place by system-wide partners to support the most difficult to reach service users.

- Overdose reversal drug training and the distribution of Naloxone was put into place at temporary accommodation hostels, BBs and hotels for the homeless populations Naloxone is an opioid antagonist which can rapidly reverse the respiratory depression induced by heroin and other opioids.
- Additional resource was committed to Prevention and Early Intervention services including avoidance of Cuckooing (where drug gangs target vulnerable people's accommodation) and Checkpoint PLUS.
- Established a Hardship Fund which provided financial support for services to work with service users who had lack of resources to access their appointments and mutual aid groups online and ensure their recovery could be supported long-term
- One You Surrey Stop smoking service has had a significant increase in referrals and quits compared to 19/20. The service continues to target priority groups such as BAME populations, those with mental health conditions and routine and manual workers. Stop smoking - Healthy Surrey
- Stoptober' 2020, a national stop smoking campaign, saw a 120% increase in the number of clients setting a "quit date", compared to 2019. Stoptober: the 28-day stop smoking challenge | British Lung Foundation (blf.org.uk)

Focus Area 3: Ensuring that everyone lives in good and appropriate housing

The Covid-19 crisis coupled with people staying at home has pushed many families and individuals into debts and payment arrears with their fuel bills. Also, for a variety of reasons many people found themselves without a safe place to call home. Many of the hotels and B&Bs which housed the people without a home during the first lockdown closed. Winter night shelters which had dormitory type accommodation were not suitable during the pandemic. In response to the Community Impact Assessment:

- A project team to tackle fuel poverty was established and is linking to Priority 3.
- The Surrey Crisis Fund which supports residents who find themselves in a financial crisis was supplemented via an extra central Government Winter Grant and expanded from offering money for food, gas/electric on pre-payment meters, toiletries and sanitary products, to also provide money for certain essential clothing, white goods and furniture. Surrey Crisis Fund - Surrey County Council (surreycc.gov.uk)
- Enhanced preventative and early intervention services to avoid drug trafficking at hotels, BBs and hostels were put in place (Checkpoint PUS and Cuckooing)
- Two self-contained Cabin sites providing accommodation for homeless people symptomatic of Covid-19 and for winter shelter provision were established in partnership between Public Health and Elmbridge Borough Council (Elmbridge Borough Council - Supporting homelessness) and Reigate and Banstead Borough Council.
- A collaborative Trauma Informed Person-Centred Outreach Service was introduced using locally commissioned homeless services to support people dealing with multiple disadvantage (Bridge-the Gap Trauma Informed Outreach Services).
- Mental Health First Aid Training Courses, Suicide Prevention and overdose reversal training was offered to homeless charities, outreach services and networks.
- A review of commissioning accommodation options to accommodate homeless individuals with moderate to high needs was initiated with links to priority 2 to address mental health issues.
- Partnership arrangements with the Districts and Borough Housing Department strengthened enabling:

  - Flu and more recently COVID vaccination outreach programmes were targeted at the homeless communities including those in temporary accommodation.
  - Under the stop smoking campaign (Focus Area 2) e-cigarette kits are being considered for distribution to the homeless persons in temporary accommodation.
  - Initiatives to drive forward the Housing First agenda were initiated.
- Bidding strategies were developed system-wide to support identified health and wellbeing needs for those experiencing multiple issues of mental health, criminal justice, substance misuse and homelessness including:
  - A system-wide expression of interest was submitted to the Ministry of Housing Communities and Local Government (MHCLG) Changing Futures Fund which included further support for people with multiple disadvantage Changing Futures: changing systems to support adults experiencing multiple disadvantage - GOV.UK (www.gov.uk)
  - Support for a bid to the Ministry of Justice Prison Leavers Innovation - Local Leadership Integration fund to include a proposal for step down accommodation with health and wellbeing support for ex-offenders Prison Leavers Project: improving outcomes for prison leavers - GOV.UK (www.gov.uk)
  - Proposal to the Better Care Fund to embed selected projects detailed above into more mainstream funding.

F*ocus Area 4: Preventing domestic abuse (DA) and supporting and empowering victims*

In response to the pandemic and CIA findings, focus was placed on workstreams that could support DA Survivors through the 'peak' of the pandemic and the 'recovery phase' which included the following priorities:

- Opened a new refuge providing seven additional places in response to increase in demand.
- Established a Health Intervention Group to focus on the implementation of health interventions in Surrey's A&E Hospitals and GP settings.
- Established task and finish groups for the mobilisation of Independent Domestic Violence Advisors (IDVAs) into A&E settings.
- Hosted market warming events for Perpetrator Interventions to help inform the development of Surrey's Perpetrator Programme.
- Developing the Perpetrator Strategy to inform the implementation of a prototype Perpetrator Service in partnership with Safe Lives About us | Safelives
- Placed two DA workers in Surrey's Children's Single Point of Access (CSPA) to support and respond appropriately to referrals of DA and reduce the demand for children social care interventions and ensure children and families receive the right support at the right time.
- Surrey's Children's Academy and Domestic Abuse Outreach Services developed five new training courses for Surrey practitioners.
- Five webinars were delivered in partnership with North Surrey Domestic Abuse Service to designated safeguarding officers in Surrey Schools.
- Ensured that SCC managers were aware of how to support and respond effectively to Domestic Abuse survivors in the workplace.
- Developed a readiness assessment in preparation for the new Domestic Abuse Bill which will impose new responsibilities on the public sector and require safe and appropriate accommodation options.

- Awarded "White Ribbon" accredited status for a period of three years. White Ribbon - Healthy Surrey The award recognises Surrey to tackle domestic abuse not only for residents but also staff who may be experiencing abuse.

Focus Area 5 - Promoting prevention to decrease incidence of serious conditions and disease

In response to the pandemic and Community Impact Assessment, local partners and providers:

- Commissioned One you Surrey who currently provide the stop smoking service across Surrey to deliver of outreach NHS health checks. Each Health Check includes a range of clinical and non-clinical tests that provide an overall picture of an individual's health and their risk of developing certain health conditions. The programme will target vulnerable groups such as the BAME population and enable additional engagement with residents about their physical health and ways to remain active and maintain their health and wellbeing. One You Surrey Stop Smoking Service - Helping Surrey to go Smokefree
- Agreed actions which have resulted in referrals to the National Diabetes Prevention Programme (NDPP) across Heartlands now returning to pre-Covid levels.
- Are exploring further partnership working with Public Health commissioners and One You Surrey regarding referral and self-refer pathways via health checks to the NDPP.
- Stepped up the outreach provision of the flu and more recently COVID vaccination programme to deliver the outreach provision to the homeless populations in temporary accommodation.

Focus Area 6 - Improving environmental factors that impact people's health and wellbeing

Activity in progress relating to key environmental themes within recovery from the pandemic includes:

- Seasonal health information and advice to relevant organisations and partners is being provided through Healthy Surrey
- An embedded Health Impact Assessment Approach is on target to be delivered by 31 March 2021.
- New statutory transport plan which will include an active travel strategy and positively impact on the ability to develop a Walking Strategy for Surrey is in development.
- A Local Cycling and Walking Infrastructure Plan (LCWIP) has been completed for Woking, with three more due to be commissioned imminently. The forward plan is for three additional LCWIP's to be in place before September 2021 and a final three by April 2022.
- A Planning and Health Forum to improve collaborative working across planning and health departments and maximise opportunities for health to influence Local Plans has been established.

Focus Area 7 - Living Independently

In response to the pandemic and Community Impact Assessment the services and providers:

- Notified the Personal Assistants (PAs) of people who had opted to take a direct payment for their care of the availability of weekly Covid –19 tests and their entitlement to free PPE.

- Rolled out a project to provide technology, support in using technology and virtual groups to reduce feelings of loneliness and isolation in people with care and support needs. Tech to Community Connect Project « Surrey Coalition of Disabled People
- Focused initially on information, advice and distribution of PPE and later distributed information leaflets about a range of support
- Facilitated shopping and prescription delivery services in partnership with the borough and district partners, local volunteer centres and other agencies. Crossroad Care Home Page - Crossroads Care Surrey
- Procured and distributed through networks an online carer awareness programme about safe caring environments and targeted messaging was used to promote vaccine confidence in particular groups.
- Developed online health and wellbeing training course for young adult carers.
- Planned the falls prevention services further to create processes and ensure that people at risk of falls, or those having had a fall, are referred to falls prevention exercise classes in the community.
- Co-produced a Palliative and End of Life Care Strategy – See separate item on HWB agenda.

Priority 2: Supporting people's emotional wellbeing and mental health

The current circumstances of the Covid-19 pandemic have led to a huge increase in demand for emotional wellbeing and mental health support in Surrey. Due to current surges within the system, there has been a need to pause the Mental Health Partnership Board and stand-up emergency meetings to establish and deliver Mental Health COVID Emergency Response Priorities. This is intended to improve access to support and information:

- Develop a system-wide communication that highlights the support available with an emphasis on early intervention including IAPT, support to schools and primary care to reduce demand on crisis service.
- Develop a more assertive support offer for schools to provide children with extra support to avoid referrals to Children's Single Point of Access (SPA).
- Develop an enhanced accommodation offer for those who are homeless or at risk of becoming homeless with a mental health condition.
- Re-focus IAPT services to provide more support for people with more complex MH needs who may not need psychological therapies at the level traditionally provided by IAPT.
- Review support for non-GPIMHS PCNs to see if elements of GPIMHS can be accelerated to help primary care to support more complex people.
- Develop a workforce plan to support MH and consider if any staff can be re-deployed across system to support additional measures as part of COVID response, including workforce resilience measures.
- Review flow management across the system to identify opportunities for improved ways of working for professionals to best support user pathways.

Alongside this short-term emergency response, plans are underway to initiate a short- to medium-term Mental Health Partnership Board to bring about rapid improvement and system-wide transformation of mental health outcomes, experiences and services, support and signposting in Surrey. Although yet to be finalised, this would then likely transition to an ongoing Mental Health Prevention Board which would form the natural governance group for the Priority 2 work. This would be underpinned by the new Surrey Prevention Concordat for Better Mental Health that is currently being drafted.

Work in Focus Area 2 to support mothers and families with emotional wellbeing during and after pregnancy has slowed as workstreams were paused due to Covid-19. The update is largely a continuation of the work that was referenced in the December Health and Wellbeing Board meeting:

- First 1000 Days workstreams have been paused so efforts can be directed to COVID-19 and its impact on families. Once the programme is restarted the First 1000 Days strategy will be signed-off as final and programme development will continue.
- Working with Neonatal Intensive Care Units to support parents that cannot be with their new-borns due to requirement to self-isolate.
- Working with the perinatal mental health service to explore options to support women in ICU with COVID-19 who have given birth, including support for mental health and trauma.
- Funding has been extended so Home-Start can continue to provide the virtual post-natal peer support programme which is continuing to support parents with their mental health during the pandemic.
- Confirmation of funding for Maternity Mental Health Service expression of interest submitted to NHSE/I. The service will be piloted in two areas in Surrey and will support women during pregnancy who experience trauma, loss or tokophobia. The service will commence in October 2021.

Lockdown has left many individuals feeling isolated and cut off from friends, family and their local community. As a result, Focus Area 3 work continues in a range of areas. The Surrey funding submission was successfully selected as one of the seven sites which will test the ways in which connecting people with nature can improve mental wellbeing through the Green Social Prescribing programme. Work is also continuing to roll out the Tech to Community Connect project across areas of Surrey to support groups of people at risk of, or suffering from, digital exclusion.

Lockdown has also led to a decrease in mobility and economic impact. The need for help and advice around financial issues has increased. The working group including the Citizen's Advice Bureau, Job Centres, Community Connections and SABP is continuing its work to deliver on opportunities to support the long-term unemployed and the emotional impact on those being assessed on fitness to work.

There is greater stigma felt by some people, for example around perceptions of mental health and stereotypes of vulnerability. Support services continue and are continually being developed including Surrey Virtual Wellbeing Hub, Mental Health phonelines, Technology Integrated Health Management (TIHM) Monitoring Service, and welfare calls from the voluntary sector to connect with isolated and at-risk people with mental health needs.

Priority 3: Supporting people to fulfil their potential

Surrey Index (previously - Social Progress Index)

This has been renamed as the Surrey Index. This allows a more flexible framework that is more relevant to our local area and aligns closely to the Health and Wellbeing Strategy and the 2030 Community Vision for Surrey. In doing this, the Surrey Index will bring in aspects that were not explicitly part of the Social Progress index including wider components around Business and Economy, Transport and Communities. This means that the Index will be relevant across other partnership forums, such as the One Surrey Growth Board, as well as its core intention of supporting Priority 3 of the Health and Wellbeing Strategy. In total there are 12 proposed components which are: Education Skills and Employment, Business and

Economy, Health and Wellness, Health and Care Support, Environmental Quality, Inclusive Communities, Basic Needs, Access to Information and Communications, Transport, Children and Young People, Personal Safety and Personal Rights.

Good progress has been made since the start of the year, building on the work done on the Local Recovery Index. It is expected that a prototype of the Surrey Index will be ready by early April which will include the full range of indicators across all of Surrey at different geographies, including District and Borough, Primary Care Network, Local Community Network (TBC) and Ward levels.

The Surrey Index will be made up of two products – one fixed index based around 12 components, and one flexible index which allows users to build their own index based on the indicators that they wish to include. Both products will be published on Surrey-I and will be available to use by members of the board and the wider public. Feedback will be sought from various stakeholders in advance of bringing final versions of the two products to the Health and Wellbeing Board in June.

Focus Area 1: Supporting Adults to succeed professionally and/or through volunteering

Surrey's Economic Future /Skills and Inclusion Framework update:

In November 2020, Surrey County Council launched a strategy statement on '*Surrey's Economic Future, looking ahead to 2030'*, which was based on independent economic evidence and built on the work of the Future Economy Surrey Commission, chaired by Lord Hammond. As discussed at the December HWB, one of the priorities within the statement, '*maximising opportunities within a balanced, inclusive economy'*, will provide a focus area for action within priority three. Over the next few months, work plans will be created to improve the alignment of Surrey's skills system with workforce needs of growth sectors. The work will focus on inclusion (removing barriers and increasing opportunity), high volume upskilling and retraining for those most impacted by the Covid-19 pandemic (young 18-24 years and unemployed and long-term furloughed in sectors such as aviation), and developing intuitive and equitable pathways to high level skills.

Economies for Healthier Lives: An expression of interest for up to £500k Health Foundation funding has been submitted. The proposal addresses health inequalities by improving employment and training pathways for children and young people in Pupil Referral Units (PRU) in Surrey. The EoI submission is a partnership between Surrey County Council (Economy and Growth, Public Health and Education), together with the University of Surrey and NIHR Applied Research Collaboration (Kent, Surrey, Sussex).

Apprenticeships & Skills Hub was opened in Surrey and North Hampshire, in February, funded by Hampshire County Council and ESF (via Enterprise M3 LEP). The aim of the Hub is to increase employer engagement in apprenticeships and skills required for economic recovery and growth. The hub will also support large employers (public and private sector), who pay the apprenticeship levy, to transfer levy funding to small businesses to support apprenticeship training.

(Child) poverty

In December 2020, a Council motion committed was passed with a number of actions including producing a report on poverty in Surrey, a council wide response to the report, and activity across our key strategic partnerships.

SCC have a clear statement of intent in its Organisation Strategy around 'no one left behind' and a commitment to a radical equality, diversity and inclusion (EDI) agenda (going to Cabinet in February). Tackling inequality and driving growth for the benefit of Surrey are central to the work of the Health and Wellbeing/Community Safety Board and Growth Board. Poverty, and the causes of it, are complex and the 'solutions' long term, systemic, and likely 'upstream'. Whilst in an early phase, potential exists for this to move forward as part of priority three to support the wider engagement in this developing agenda.

Focus Area 2: Supporting children to develop skills for life

First 1000 days is overseen by the Women and Children's Transformation and Assurance Board which feeds into SOAG. Many workstreams have been paused so efforts can be directed to COVID-19 and its impact on families. The First 1000 Days strategy is still under revision after continued engagement but draft workstreams have been agreed:

- The needs of the child, parents and family
- Families in the Community
- Closing the Outcome Gap
- Information, Communication and Engagement
- Developing the Workforce across our System

Focus Area 3: Supporting communities to be safe and feel safe

Community Safety Agreement

The Task and Finish Group has developed and circulated an initial draft Community Safety Agreement which has been shared as part of the informal session in February. This recognises the opportunities for alignment and incorporation within HWBS. As highlighted within the review of health and wellbeing strategy metrics, relevant metrics for community safety will be incorporated within the HWBS dashboard from 2021/22 as part of the wider review.

An Informal HWB Board meeting with Police on 26th February is planned to bring board members together following the merger of the two boards in 2020 and to raise joint awareness of agendas and priorities along with beginning to explore opportunities for where collaborative working could be beneficial.

Following review by the Health and Wellbeing board, consultation will take place in April alongside Action Plan development and final sign off at the June meeting of the Health and Wellbeing Board (see milestones).

5. Key risks, issues and opportunities

- All SRO posts for the Prevention and Wider Determinants of Health Board are now filled and work is resuming on Priority 1 Focus Area 1 Healthy Behaviours and has commenced on Focus Area 3 Fuel Poverty.

- Public Health's capacity to support focus area 6 remains limited due to staff resources continuing to be needed within the pandemic. Whilst activity continues in a number of areas, this is limiting oversight of this important work for the purposes of this report.

6. Next steps

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1. Consult and engage on Community Safety Agreement for sign off in June 2021 (Board members have been sent the draft version for consideration at the informal meeting in February).
2. Review focus areas to ensure content of strategy and actions remain relevant to the pandemic recovery work and are appropriately distributed across the three priorities.

Appendix 1: HWBS Priorities milestones status (as at January 2021)

Priority 1: Helping People to live healthy lives

Focus Area 1: Working to reduce obesity, excess weight rates, and physical inactivity.

	Project	Milestone	RAG RATING Q1 2020	RAG RATING Q2 2020	RAG RATING Q3 2021
1	Develop a Whole Systems Approach to physical activity including improving green spaces, transport initiatives, and healthy planning	1. Secure strategic leadership support for a whole systems approach to physical activity. 2. Develop the Surrey Physical Activity Strategy 2020-29. 3. Support all NHS organisations, local authorities and schools (via completion of the Healthy Schools Evaluation Tool) to have a physical activity development plan (PDAP) - approved by their Board, Cabinet or Governing Body - as part of the Workplace Wellbeing Framework. 4. Implement the whole system approach (across the life course) through the Surrey Physical Activity Strategy 2020-29.			**On track**
2	Project 2 Implementing a Surrey obesity approach to encourage healthy weight	1. Set up a Surrey obesity approach 2. Building the Surrey obesity picture 3. Develop the Surrey draft obesity approach 4. Implementation 5. Evaluate, reflect and extend the obesity approach 6. Develop Surrey into a Healthy Food environment through a targeted approach 7. Implement Eat Out Eat Well in early years settings 8. Tackling maternal obesity 9. Working with partners to tackle childhood obesity 10. Implementation of the family healthy weight service			**Completion delays possible**
3	Project 3: Develop a Health Behaviour Framework	1. Scope the content and engagement for behaviour change framework 2. Develop an aligned behavioural insights capability 3. Develop a strategic commissioning framework across all healthy behaviour services to link across the life course.			**Completion delays possible**
Programme Manager's Draft Overall Focus Area Rating					**Completion delays possible**

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Focus Area 2: Supporting prevention and treatment of substance use, including alcohol

No	Project	Milestone	RAG RATING Q1 2020	RAG RATING Q2 2020	RAG RATING Q3 2021
1	Support prevention and reduce substance use, including alcohol use and alcohol-related harm	1. Develop five-year Drug & Alcohol Strategy for Surrey (2020-2025) 2. Support prevention and early identification of drugs and alcohol 3. Support effective treatment and recovery for those with drug and alcohol dependency 4. Develop safer, stronger communities			**Completion delays possible**
2	Implement targeted approaches for priority groups to stop smoking	1. Re-establish the Tobacco control and Alcohol Alliance 2. Surrey Tobacco Control Strategy Refresh 3. Ensuring priority groups are accessing stop smoking support 4. Developing a consistent response from the wider system 5. Develop a Surrey workforce smoke-free offer 6. Review and Development of next plan			**On track**
Programme Manager's Draft Overall Focus Area Rating					**Completion delays possible**

Focus Area 3: Ensuring that everyone lives in good and appropriate housing

	Project	Milestone	RAG RATING Q1 2020	RAG RATING Q2 2020	RAG RATING Q3 2021
1	Tackling fuel poverty in Surrey	1. Engaging communities 2. Partnership Governance 3. Develop data and understand existing impact 4. Develop and agree activity 5. Winter deaths review			**Completion delays possible**
2	Prevention of Rough Sleeping and Homelessness	Review of milestones in progress			**On-track**
3.	Supporting people with severe and multiple disadvantage (Surrey Adults Matter)	1. Data Sharing 2. Stakeholder Engagement 3. Induction 4. Referral Routes 5. Cohort Identification 6. Evaluation 7. Scope and set up Peer Network 8. Peer Mentor delivery 9. Peer Mentor training			**On track**

4	Supporting people who hoard in Surrey	1. Partnership Governance 2. Produce a multi-agency hoarding protocol for Surrey 3. Develop data and understand existing impact 4. Develop and agree activity			**Completion delays possible**
5	Specialist housing	1. Developing Extra Care Housing 2. Developing Independent Living			**On target**
Programme Manager's draft Overall Focus Area Rating					**Completion delays possible**

Focus Area 4: Preventing domestic abuse (DA) and supporting and empowering

	Refreshed Project Titles	Refreshed Milestones	RAG RATING Q2 Original Project Headings	RAG RATING (Refreshed) Q3
1	**NEW 1** System Requirements	1. Partnership endorsements, workstream leads and governance 2. Procurement of new joint DA services incorporating new areas of work and existing good practise		**On track**
2	**NEW 2** Health Interventions	1. Implementation of IDVAs in Surrey A 7E settings 2. Establishment of identification and referral processes to improve safety and training		**On- track**
3	**NEW 3** Perpetrator & Young Offender Interventions)	1. Development of the DA Perpetrator Offer and Implementation of a behavioural change programme		**On- track**
4	**NEW 4** Early Intervention	1. Development of Early Intervention approaches to DA		**On- track**
5	**NEW 5** Coercive Control	1. Development of system wide response to coercive control		**Completion delays possible**
6	**NEW 6** Recovery and Coping	1) Shared understanding and development of current DA specialist services 2. Recommendation to partners to share current good practices		**Completion delays possible**
Programme Manager's draft Overall Focus Area Rating				**On- track**

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Focus Area 5: Promoting prevention to decrease incidence of serious conditions and diseases

	Project	Milestone	RAG RATING Q1 2020	RAG RATING Q2 2020	RAG RATING Q3 2021
1	Establish a Surrey-wide CVD and Diabetes screening and testing programme	1. Identify High Priority Populations and Locations for Screening 2. Review access to screening programmes 3. Improve uptake of health checks in high priority groups 4. Review Quality Assurance Processes for Screening 5. Review Evaluation			**Completion delays possible**
2	Improve the diabetes pathways across identification, prevention, treatment and management	1. Review and Update Diabetes Pathways 2. Establish a Surrey-wide diabetes testing programme 3. Develop the Diabetes UK (DUK) Champions Programme to target key communities			**Completion delays possible**
3	Agree a Surrey-wide CVD prevention approach	1. Align Surrey CVD Programme with NHS Long Term Plan 2. Embed Lifestyle services across the system to prevent CVD 3. Optimise CVD Medication for CVD patients			**Completion delays possible**
4	Promote bowel and cervical screening as a preventative health measure rather than purely for those at high risk	1. Understand the challenges to uptake and develop a surrey-wide response			**On-track**
5	Targeted engagement with key geographies and groups to improve understanding and uptake of childhood immunisations	1. Scoping Coverage of immunisations and opportunities to address gaps			**On- track**
	Programme Manager's Draft Overall Focus Area Rating				**Completion Delays Possible**

Focus Area 6: Improving environmental factors that impact people's health and wellbeing

	Project	Milestone	Rag Rating Q1	RAG Rating Q2	RAG RATING Q3 2021
1	To promote healthy, inclusive and safe places through planning policies/decisions	1. Develop guidance to support health and local planning in Surrey 2. Establish a Planning and Health Forum to improve collaborative working across planning and health and maximise opportunities for health to influence Local Plans and draw on available funds, such as the Community Infrastructure Levy 3. Embed Health Impact Assessment approach 4. Engage in the Development Consent Order process for airport expansion application at Heathrow 5. Engage in the Development Consent Order process for the airport expansion application at Gatwick			**Completion delays possible**
2	To promote healthy, inclusive and safe places through transport/highways policy, projects and operations	1. Implement actions within Surrey Transport Plan that contribute to improved health and wellbeing			**On-track**
3	2. People who live and work in Surrey have an increased awareness of the health impact of poor air quality and take action to improve air quality	1. Deliver Schools Air Quality Programme (runs until July 2019) and Eco Schools 2. Surrey wide communications campaign to raise awareness of the importance of good air quality			**On-track**
4	People who live and work in Surrey have an increased awareness and take actions to support environmental sustainability	1. Surrey's Greener Future Design Challenge/Call for Evidence 2. Implement the Surrey Single Use Plastics Strategy 3. Surrey wide communications campaign to raise awareness of the importance of environmental sustainability 4. Promotion of passenger transport services, including park & ride			**Completion delays possible**
5	Public Sector across Surrey embed environmental sustainability within their organisations	1. Support local authorities across Surrey to embed sustainability 2. Support all NHS organisations across Surrey to have a Sustainable Development Management Plan approved by their Board			**On-track**
6	Reduce death and injury on Surrey roads	1. Deliver the Drive SMART Road Safety Strategy 2019-2021			**On-track**
7	Increase active travel across Surrey	1. Provide cycle training, pedestrian training and promotion of active travel to schools 2. Improving quality of walking, cycling, public transport and EV infrastructure in Surrey			**On-track**
8	Connect people with the natural environment	1. Promote health benefits of Surrey's countryside and green space, building on Explore Surrey 2. Make rights of way more useful/suited for everyday journeys to work and school and encourage contact with the natural environment through the Rights of Way Improvement Plan (Countryside Access Team, SCC)			**Completion delays possible**
9	Local residents and strategic partners understand the importance of seasonal health and wellbeing and undertake interventions to reduce the impact of hot/cold weather on health	1. Provide information and advice regarding seasonal health and wellbeing			**On-track**
Programme Manager's Draft Overall Focus Area Rating					**On-track**

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Focus Area 7: Living Independently

	ect	Milestones	Rag Rating Q1	Rag Rating Q2	RAG RATING Q3 2021
1	Supporting Carers	1. Scoping and Mapping 2. Supporting Carers in the Workplace 3. Developing Carer – Supportive Communities 4. Carers through Surrey provides 5. Developing an offer to young carers			**On-track**
2	Aligning the better Care Fund to the health and wellbeing Strategy	1. Better Care Fund Implementation 2. Future planning			**Completion delays possible**
3	Developing a Reablement Framework for Surrey and Integrating Intermediate Care	1. Governance 2. Developing a Reablement 3. Framework 4. Developing a Surrey Integrated intermediate care service			**Completion delays possible**
4	Improving End of Life Care in Surrey	1. Scoping and Mapping 2. Partnership Governance 3. Communications and Engagement 4. Out of Hours Crisis response 5. Developing Workforce 6. Develop and Agree activity 7. End of Life Training for all Carers			**Completion delays possible**
5	Housing Adaptations	1. Scoping and Mapping 2. Improving Hospital Discharge 3. Clarifying the Financial and legal position			**Completion delays possible**

Priority 2: Supporting the Mental Health and Emotional Wellbeing of people in Surrey

Focus Area 1: Enabling children, young people, adults and elderly with mental health issues to access the right help and resources

	Project	RAG RATING Q2 2020/21	RAG RATING Q3 2020/21
1	Children's Emotional Wellbeing and Mental Health Transformation	On track	Completion delays possible
2	Implementation of Mental Health in Schools	On track	On track
3	Wraparound Specialist Children Support Offer	Completion delays possible	Completion delays possible
4	Map and develop preventative mental health support access for Older People	Completion delays possible	Completion delays possible
5	Scale up anti-stigma work, including rollout of the Time to Change training programme	On track	On track
6	Using technology to support physical and mental health	On track	On track
7	Partnership physical and mental health links	Completion delays possible	Completion delays possible
8	Physical Health Check reporting for people with Severe Mental Issues	On track	Risk to project delivery
9	Co-Produce Plan to Retarget interventions to those with LD/Autism and Carers	Completion delays possible	Completion delays possible
10	Supporting wellbeing at work through the development of a Wellbeing Charter for businesses	On track	On track
11	Develop new integrated Crisis models of care to support people at risk of admission to secondary mental health services	On track	On track
12	Community Models of Care Transformation	On track	On track
13	Mapping of Dementia services and develop partnership responses to system opportunities, to support people and carers to live independently for as long as possible	Completion delays possible	Completion delays possible
14	Mental Health support for those within, or at risk of entering, criminal justice system	Risk to project delivery	Risk to project delivery
15	Strategic commissioning approach to supported living for people with a mental health problem	On track	On track
16-27	Suicide prevention projects	On track	On track
Programme Manager's Draft Overall Focus Area Rating		Completion delays possible	Completion delays possible

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Focus Area 2:

Supporting the emotional wellbeing of mothers and families throughout and after pregnancy

No	Project	RAG RATING Q2 2020/21	RAG RATING Q3 2020/21
1	Develop offer around the emotional wellbeing of mothers through First 1000 Days planning lens	On track	Completion delays possible
2	Develop a pregnancy Healthy Behaviours Framework	On track	Completion delays possible
3	Further development of wraparound care and support through Perinatal services	On track	Completion delays possible
4	Support the new, targeted provision delivered through Family Centres (such as the universal Family Centre offer in development in East Surrey)	Completion delays possible	Completion delays possible
5	Development of family support tools/apps	On track	Completion delays possible
Programme Manager's Draft Overall Focus Area Rating		On track	Completion delays possible

Focus Area 3:

Preventing isolation and enabling support for those who do feel isolated

No	Project	RAG RATING Q2 2020	RAG RATING Q3 2020/21
1	Community transport offer developed to support social connections	Completion delays possible	Completion delays possible
2	Develop youth social isolation approach, including bullying prevention and social media offer, with schools	Completion delays possible	Completion delays possible
3	Support for Surrey Dementia Action Alliance in establishing Dementia Friendly communities, as already seen in Oxted, Woking, and Hindhead	Completion delays possible	Completion delays possible
4	Establish business links to prevent isolation (such as Walking Friends) and unlock the potential of underutilised community space	Completion delays possible	Completion delays possible
5	Bereavement support and information offer developed	On track	On track
6	Volunteering, apprenticeships and supported employment opportunities for those at risk of mental ill health and social isolation	Risk to project delivery	Completion delays possible

7	Engagement to develop more community resources to support those at risk of mental ill health and social isolation	**Risk to project delivery**	**On track**
Programme Manager's Draft Overall Focus Area Rating		**Completion delays possible**	**Completion delays possible**

Priority 3: Supporting people to fulfil their potential

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Focus Area 1: Supporting Adults to succeed professionally and/or through volunteering

No	Project	Milestone	RAG RATING Q1 2020?	RAG RATING Q2 2020?
1	(Child) poverty report	1.Data collection 2.Report delivery 3.Establish timeframe for augmenting the data with additional insight 4.Respond report Define process for a systemic response 5.Create steering group 6.Present to Members /Cabinet	**On track**	**On track**
2	Surrey Index (was Social Progress Index)	1.Stakeholder engagement event and online consultation – completed 2.Draft list of indicators – completed 3.Refine indicators and cross reference against strategic priorities – completed 4.Final list of indicators – by Mid March 5.Training sessions with Social 6.Progress Imperative for analysts 7.Demo of RPI with HWBB – completed 8.Build beta version of SPI – by end March 9.Demo/training with key partners – spring/summer 10.Officially launch – June HWBB	**On track**	**On track**

Focus Area 2: Supporting children to develop skills for life

Programme oversight managed is currently managed by the Women and Children's Transformation & Assurance Board. Key highlights are included in the main paper.

Focus Area 3: Supporting communities to be safe and feel safe

Milestones and programmes of work will be developed and reported at the June 2021 Health and Wellbeing Board alongside the finalised Community Safety Agreement.

No	Project	Milestone	**RAG Rating Q1 2021**	**RAG Rating Q2 2021**
1.	Community Safety Agreement	1.Initial Draft circulated 2.Informal HWB Board meeting with Police 26 February 3.Consultation on first draft 4.Action Plan Development 5.Sign off by HWB Board 6. Delivery plan	**On track**	**On track**

Health and Wellbeing Board Paper

1. Reference information

Paper tracking information	
Title:	Health and Wellbeing Strategy Metrics Update and Proposed Review 2021
Related Health and Wellbeing Priority:	Priorities 1,2 & 3
Author:	Phillip Austen-Reed, Principal Lead – Health and Wellbeing (SCC); phillip.austen-Reed@surreycc.gov.uk, 07813538431
Sponsor:	Ruth Hutchinson, Director of Public Health (SCC)
Paper date:	4 March 2021
Related papers	Appendix 1: Highlights: Change in Individual Metrics Health and wellbeing strategy dashboard

2. Executive summary

The current set of Health and Wellbeing Strategy (HWBS) metrics were finalised following the launch of the strategy in May 2019. These have been updated within the strategy dashboard to reflect the latest available data and some examples are referenced where there have been more significant changes in these current outcome measures. The latest available update is largely from 2018/19 due to national publishing schedules so does not factor in the expected impact that the pandemic will have had.

Alongside updating the data, a review the current HWBS metrics is proposed. This is intended to better reflect the impact of the pandemic and ensure the additional local work that is in progress, including the work relating to health inequalities, is incorporated and reviewed longer term by the Health and Wellbeing Board and its member organisations.

3. Recommendations

It is recommended that the Health and Wellbeing Board:

1. Note those areas where we are seeing change in outcomes reported and ensure priority delivery boards have oversight, specifically where there is significant change.
2. Agree the review of the current HWBS metrics to reflect the work that has been stood up over the past year, particularly with regards to the Local Recovery Index, the new Surrey Index (which has emerged from the work on the Social Progress Index) as well as the Surrey Heartlands Health Inequalities workstream under the Recovery Board.
3. Support collaboration between organisations represented to ensure local and countywide measures align and can be built into a suite of dashboards that enable a common picture of progress to be shared across Surrey.

4. Reason for Recommendations

Following the production of the initial set of HWBS metrics in 2019, significant new workstreams have moved forward locally which enable further understanding of potential outcomes at a local level and countywide level. The need within health and social care to improve our understanding of the outcomes with regards to health inequalities has also further progressed.

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To be effective and ensure a common understanding across partners, there is growing recognition that these areas of work need to be brought together alongside a refreshed set of HWBS metrics to ensure we are able to have a common short and long term view of the progress being made with regards to assessing health outcomes and addressing health inequalities in Surrey.

5. Update to current HWBS metrics

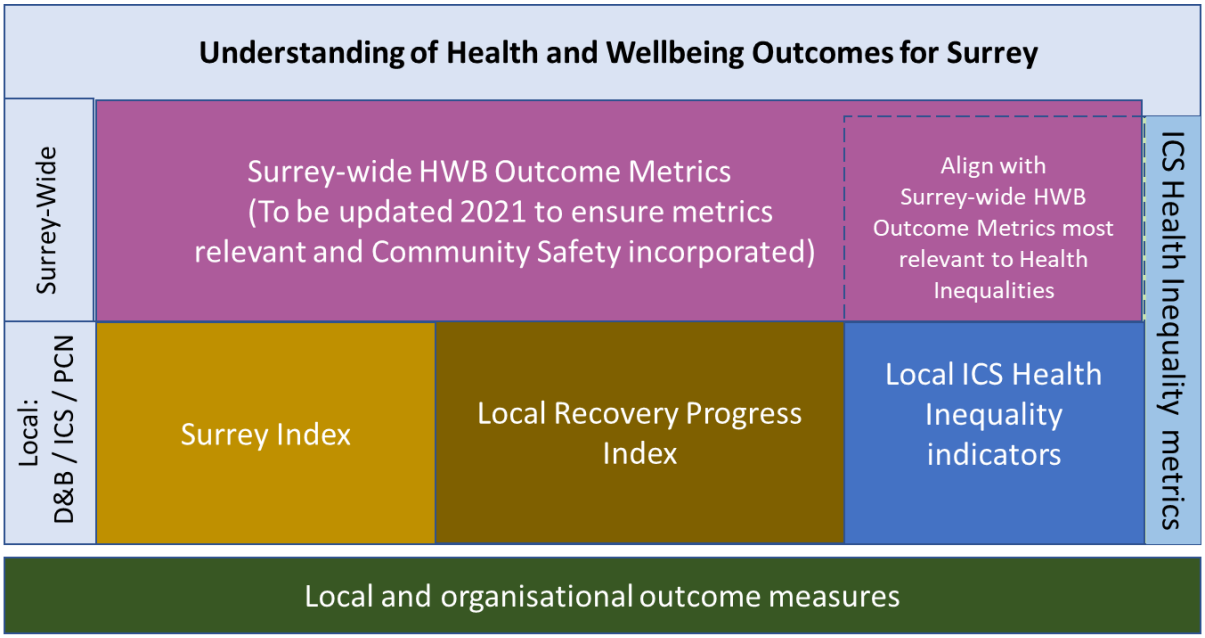
Following the update to the current set of HWBS metrics that is now live on the online dashboard, it is helpful to note where there has been more significant change in figures and these will be reviewed by the relevant priority oversight board or group. These are described in appendix 1.

With regards to the overarching metrics of Life Expectancy / Healthy Life Expectancy, these are measured on a three-year rolling basis. The latest period (2017-19) continues the trend we have seen in previous years of a very gradual increase in life expectancy and healthy life expectancy at birth for both males and females. This increase is in-line with both national and regional trends for life expectancy with Surrey being higher both nationally and regionally.

6 Review and alignment of HWBS metrics

Since the agreement of the 38 metrics to summarise outcomes being achieved in relation to the three priority areas, there has been significant additional work locally that needs to be reflected within our understanding of how outcomes are changing in Surrey. Figure 1 below attempts to represent some of the various work and related metrics that have been and are being developed. It emphasises the benefit of considering them collectively to understand progress in relation to the Surrey-wide HWB Strategy and the various local and / or organisational strategies that it seeks to align with.

Figure 1. Example of potential alignment of related health and wellbeing metrics to support the local system



Whilst the various streams of work have developed since the launch of the original HWB Strategy and metrics, there is clearly scope to ensure they are more fully aligned, building on the local relationships and partnerships that are already in place to ensure this is progressed in 2021/22.

At a Surrey-wide level these metrics can provide a clear picture of progress in health and wellbeing outcomes over the life of the Strategy and, given the focus of the Strategy, the extent to which health inequalities are being addressed. Having a longer term view, the data would most likely be available to the HWB Board on an annual basis.

At a more local level, metrics should support local organisations and areas within Surrey to form a local understanding of priorities, recognising some local variation and / or informing what can be done to improve outcomes either geographically or within particular organisations. With a more local, shorter term focus, the data would most likely be available more regularly e.g. on a quarterly basis.

The following briefly outlines the status of each of the elements referenced in Figure 1:

Community Safety Metrics

Alongside the development of the Community Safety Agreement in 2021, key metrics will need to be incorporated within the HWBS dashboard and also, where relevant, aligned with the Surrey Index and Health Inequalities outcome metrics.

Surrey Index (formerly the Social Progress Index)

The Surrey Index will bring in aspects that were not explicitly part of the Social Progress Index, including components around Business and Economy, Transport and Communities. This means that the Index will now be relevant across other partnership forums, such as the One Surrey Growth Board, as well as its original intention of supporting Priority 3.

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Local Recovery Index

As part of Priority 3 and following the initial scoping for the Social Progress Index, the Local Recovery Progress Index was developed and has now been published to support local understanding of how Surrey and local areas have been impacted by the pandemic. This is updated quarterly and going forward it is anticipated it will provide indicators that relate to recovery.

Surrey Heartlands Health Inequalities workstream

As part of the Equality and Health Inequalities workstream within Surrey Heartlands, work is underway to identify a set of process and outcome indicators that are most relevant to Surrey. These indicators enable the system to measure how well we are responding to and addressing health inequalities. The current set of draft indicators include both Surrey-wide (intermediate to long term) outcome indicators that are already within the Health and Wellbeing Strategy (such as educational achievement) as well as those relating to eight urgent actions on Covid health inequalities as set out by the NHS Phase Three letter. Inclusion of these indicators will be useful in understanding short and long term progress being made across the system.

7. Challenges

Given the current continued impact of COVID-19 on capacity in the system the following potential risks have been identified:

- Capacity not being available to drive forward due to resources allocated to pandemic response.
- Variation in deadlines for each element of work that may hinder a fully aligned approach to be adopted in the short term.

8. Timescale and delivery plan

A revised set of aligned metrics should be brought to Health and Wellbeing Board for approval at the September 2021 meeting, with an option of discussion at June meeting if required.

9. Next steps

- Review current HWBS metrics to assess relevance to continued priorities and ability to assess progress against health inequalities, particularly those highlighted by the Community Impact Assessment on the impact of COVID-19.
- Representatives of workstreams outlined in this paper will continue to collaborate to ensure alignment of indicators and how these can be presented/utilised both system-wide and locally.

Appendix 1: Highlights: Change in Individual Metrics

Whilst there has been variation in many of the metrics as shown on the online dashboard, the following are examples of where there has been more significant change either positively or negatively.

When reviewing these it is important to note that in most cases there is at least a 12 month lag on the outcome data being published, meaning the data does not reflect the period of the pandemic over the last 12 months.

1. **Effectiveness of reablement services** increased from 75.1% in 2017/18 to 78.9% in 2018/19.
2. **The number of rough sleepers** increased from 69 in 2018 to 81 in 2019. This is assessed by a count of rough sleepers on one night in November so is an indicative number. Following the programme of "everyone in" during the pandemic this number would expect to be significantly lower in 2020 once published.
3. **Smoking rates adults working in routine and manual jobs** increased from 21.51% in 2018 to 24.41% in 2019. Whilst this is similar to the value for England (23.16%) and the South East region (23.73%), the overall rate for the general population showed a continued reduction to 10% in 2019.
4. **Percentage of children aged 5 with 2 doses of MMR** increased from 79% in 2018/19 to 83.3% in 2019/20. Whilst still below the national figure of 86% it is the highest reported figure in the last 10 years.
5. **Percentage of those estimated to have anxiety or depression who are entering IAPT services** increased from 14.85% in 2017/18 to 16.53% in 2018/19. This is lower than the value for England (17.84%).
6. **% of Learning disabilities in settled accommodation** has decreased from 66.28% in 2017/18 to 59.31% in 2018/19. This remains lower than the value for England (77.34%) and the South East region (70.73%).

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Health and Wellbeing Board Paper

1. Reference information

Paper tracking information	
Title:	Palliative and End of Life Care (PEoLC) Strategy 2021-2026
Related Health and Wellbeing Priority:	Living independently and dying well is a focus area under Priority One of the 10 year Surrey Health and Wellbeing Board Strategy. One of the key system capabilities that the Health and Wellbeing Board is committed to developing and embedding is Community Development, of note in particular: 'Creating a new relationship between partners and our population, co-designing and co-producing solutions to our challenges'
Authors:	Vicky Stobbart, Guildford and Waverley Director of Integrated Partnerships and Executive lead for PEoLC, Surrey Heartlands Clinical Commissioning Group (CCG) 07867 443642 Abigail Groves, Senior Commissioning Manager – End of Life Care and Cancer, Surrey Heartlands Clinical Commissioning Group (CCG) 0300 561 1739/07796 173039 Suzi Shettle, Head of Communications, Surrey Heartlands CCG 0300 561 1403/07500 103034
Sponsor:	Dr Charlotte Canniff, Surrey Heartlands CCG Chair and HWB Vice-Chairman
Paper date:	4 March 2021
Related papers	Annex 1: Palliative and End of Life Care Strategy Annex 2: Palliative and End of Life Care Strategy Summary

2. Executive summary

The Strategy sets out the collective ambitions we want to achieve across Surrey Heartlands as an Integrated Care System (ICS) to improve palliative and end of life care for our citizens.

It is now for Integrated Care Partnerships (ICPs) and local partners to work together to deliver these improvements for their local communities.

3. Recommendations

1. The Health and Wellbeing Board is asked to approve the Strategy.
2. The Chairman of the Health and Wellbeing Board will write to the chairman of the Health and Social Care Select Committee, Rt Hon Jeremy Hunt MP, to share the PEoLC Strategy and seek clarification on the Government's plans for a central strategy and the allocation of resources to hospices.

4. Reason for Recommendations

In developing this strategy we have worked with organisations that provide palliative and end of life care, their staff, local voluntary organisations and other partners. We have also considered previous research and sensitively carried out our own insight work with individuals who are receiving end of life care and their relatives - and their experiences have helped ensure individuals and their families are at the centre of our plans to enhance end of life care.

5. Detail

In June 2019, Surrey's Health and Wellbeing Board made a commitment to identify Surrey-wide opportunities for partnership working around End of Life Care to improve outcomes for residents, as part of the new 10-year Health and Wellbeing Strategy. Dr Charlotte Canniff agreed to act as the Health and Wellbeing Board sponsor for this area, and chaired an initial roundtable meeting to discuss the current picture of End of Life Care in Surrey, and identify opportunities to join up as part of a partnership project.

The next meeting was stood down as the Covid-19 pandemic escalated, but partners continued to meet to discuss the system-wide palliative care response to Covid-19.

At this time, Vicky Stobbart was appointed as the Executive Lead for End of Life Care for Surrey Heartlands, alongside Dr Sian Jones as Clinical Lead for End of Life Care for Surrey Heartlands. They were asked to begin the development of a Strategy for Palliative and End of Life Care for Surrey.

A PEoLC Strategy Development Reference Group, with a wide range of stakeholders, met monthly to drive development of the strategy and be involved with its co-design. There was excellent engagement from all partners.

Research and engagement colleagues completed desk research and conducted interviews with families and workforce.

Digital colleagues undertook interviews with workforce, and ran a workshop, to identify digital opportunities.

All insight was used to draft the strategy.

The draft strategy (version 1.6) was presented to ICS Executive in November 2020. Feedback was received and it was revised and shared with Strategy Reference Group members for further review.

The draft strategy (version 1.11) reflects the extensive feedback received, and was approved by ICS Executive, when re-presented in December 2020. It was presented at the System Board on 17 February 2021.

We recognise that the strategy itself is detailed, so have produced a summary version (which we are also presenting today), which highlights key parts of the strategy and provides a more accessible alternative.

6. Challenges

Delivery of this strategy will need the commitment of all partners.

We will be working with our ICP colleagues to provide support and monitor progress to ensure these ambitions are realised for the benefit of our citizens.

7. Timescale and delivery plan

This is a 5 year Strategy covering 2021-2026.

We will monitor progress against specific outcomes through a range of methods including monitoring quality of care, data collection, surveys and feedback from individuals, families and staff. Specifically, an ICS dashboard for palliative and end of life care will be reported from the Palliative and End of Life Care Profiles developed by the National End of Life Care Intelligence Network: https://fingertips.phe.org.uk/profile/end-of-life

8. How is this being communicated?

This strategy has been co-designed with input from a wide range of partners and voluntary organisations, taking into account the experiences and insight shared by individuals, relatives, carers and local people.

A communications plan will be developed.

9. Next steps

Following approval, the strategy will be published on the Surrey Heartlands ICS, Surrey County Council and Surrey Heartlands CCG websites, and shared with partners. The intention is to develop an Easy Read version prior to publication.

It is for ICPs to determine the changes that are needed locally to deliver this strategy and agree realistic timescales for delivering these improvements for people living in Surrey Heartlands.

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Surrey Heartlands HEALTH AND CARE PARTNERSHIP

SURREY COUNTY COUNCIL

NHS

...DRAFT...

7

Palliative & End of Life Care

Strategy 2021-2026

Contents

This strategy has been co-designed with input from a wide range of partners and voluntary organisations, taking into account the experiences and insight shared by individuals, relatives and local people.

NHS Surrey Heartlands Clinical Commissioning Group

SURREY COUNTY COUNCIL

Princess Alice Hospice

NHS Surrey and Borders Partnership NHS Foundation Trust

First Community Health and Care

Phyllis Tuckwell Hospice Care ...because every day is precious

NHS Epsom and St Helier University Hospitals NHS Trust

Procare HEALTH

ST CATHERINE'S HOSPICE

Woking & Sam Beare Hospice and Wellbeing Care

South East Coast Ambulance Service NHS Foundation Trust

NHS Royal Surrey NHS Foundation Trust

NHS Ashford and St. Peter's Hospitals NHS Foundation Trust

THE BRIGITTE TRUST SUPPORT FOR PEOPLE FACING LIFE THREATENING ILLNESS

CSH Surrey

Primary Care Networks

Integrated Care Partnerships

Shooting Star Children's Hospices

Practice Plus Group

Children and Family Health Surrey

NHS Surrey and Sussex Healthcare NHS Trust

Foreword

“In Spring 2020, I was appointed as the Executive Lead for End of Life Care for Surrey Heartlands, alongside Dr Sian Jones as Clinical Lead. We were asked to work with partners to develop a strategy and a set of ambitions to improve palliative and end of life care across Surrey Heartlands.

The care a person receives at the end of their life - and how and where they receive it - can not only make it easier for them as an individual but it can also have a profound impact on their family, friends, loved ones, and the people that deliver the care. It can also leave a lasting impression of the health and care system on all those involved.

Surrey’s Health and Wellbeing Strategy identifies ‘helping people in Surrey to lead healthy lives’ as one of its high level strategic priorities, with partners working together to improve outcomes across the county. A key focus within this is to help people to live independently for as long as possible and to help them die well.

We have a wide range of providers involved in providing palliative and end of life care across Surrey Heartlands. Currently end of life care looks different in different parts of Surrey, with different standards and services across different providers. The aim of this strategy is to look at the collective ambitions we want to achieve across Surrey Heartlands as an Integrated Care System so that Integrated Care Partnerships and local partners can then work together to plan and design the right services for their local communities to realise these ambitions and enhance end of life care for our whole population. We are also working closely with colleagues across other parts of Surrey, including the Frimley Integrated Care System, to ensure our ambitions and priorities are aligned across the whole county.

In developing this strategy we have worked closely with a range of organisations that are involved in providing palliative and end of life care in Surrey, their staff, local voluntary organisations and other partners. We have also looked at previous research in this area and sensitively carried out our own insight work with individuals who are receiving end of life care and relatives - and their experiences have been invaluable in helping us to develop this strategy, making sure individuals and their families and carers are at the centre of our plans to enhance end of life care across Surrey.

At an unprecedented time as we continue to work together in our response to the Covid-19 pandemic, I have been hugely impressed by the willingness of partners to come together to find solutions and provide the best possible care.

With our shared ambition, and the care and compassion we see every day from frontline staff, I believe that together we can make a real difference to the end of life care experience of our citizens and their loved ones for years to come.”

Vicky

Vicky Stobbart
Executive Lead for End of Life Care
Surrey Heartlands Integrated Care System

Executive summary

Improving palliative and end of life care has been identified as a priority of the Surrey Health and Wellbeing Board. The publication of this strategy is the culmination of many months of work that has brought together partners involved in every part of end of life to look at how we can further enhance palliative and end of life care for our citizens.

In developing this strategy we have spoken to health and care staff, our local and system partners and the voluntary sector. We have also spoken to people receiving end of life care and their families and carers, and we have used this insight to develop our own local ambitions which set out our plans to improve care.

Our Surrey Heartlands ambitions build on the NHS' national priorities for end of life care. As a system our ambitions are that:

- Everyone is seen as an individual, with care tailored to meet their needs and wishes
- Everyone has equal access to palliative and end of life care
- People are made to feel comfortable and their wider wellbeing needs are met
- Care is coordinated, with different services working together
- Staff have the skills and knowledge to provide the best care
- Communities come together to provide help and support

These overarching ambitions encompass a range of projects and initiatives that will together enable us to meet our vision and future aspirations for end of life care across Surrey Heartlands.

The following areas are central to our plans:

- Increased use of advance care planning
- More support for carers
- Continued roll out of the Surrey Care Record to create shared records
- A digital workstream that will design innovative solutions to support end of life care at every stage
- Providing more support to our workforce, including further training and education to ensure health and care staff have the right skills and knowledge
- Improvements to the Medical Cause of Death Certification process
- Further targeted insight and engagement work to understand the barriers to accessing end of life care for some groups and communities
- A coordinated approach across the ICS to understand people's experiences of end of life care, in all settings, to inform future commissioning and service delivery

Delivery of this ambitious strategy will be led at a local level by our Integrated Care Partnerships. It will be for these partnerships to work together with local service providers and other partners to look at how they can best meet the aims of this strategy and how they can work together to improve care for their local populations. Recognising that these partnerships are still evolving and working through their own local priorities to meet local needs, as a system we are not mandating a timescale for delivering these improvements. However, we will work with local partnerships to ensure improvements are delivered as soon as possible in line with this strategy.

Currently, end of life care quality indicators are predominantly monitored at an organisation level by individual providers. As a result, there is no clear picture of end of life care experiences across all services and across the whole of Surrey Heartlands. To address this, working with partners, we have developed a set of detailed outcome measures that will measure performance across the ICS.

Progress against this strategy will be monitored by the Surrey Heartlands Integrated Care System, working with local Integrated Care Partnerships. Success will be measured against the following high level outcomes:

- People die with dignity and their wishes are respected
- Care is provided in the community, wherever possible, and palliative and end of life care is available when people, families and carers need it
- Palliative care needs across all health conditions are identified early and support is provided
- Palliative and end of life care is coordinated
- After someone has died, families and carers are supported, and the certification process is quick and easy so they can make arrangements swiftly if they wish to do so

Performance against these areas will be monitored through both qualitative and quantitative methods and adopt a holistic approach, considering people's wider wellbeing and the extent to which their wider support needs are being met. To ensure improvements are being implemented, we will also measure delivery of this strategy against specific metrics relating to a range of areas. These include a planned reduction in unplanned hospital admissions in the last three months of life, increased use of palliative care registers and advance care planning tools and increased compliance against required timescales in relation to the Medical Cause of Death Certification process.

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Following engagement with system partners, this strategy was presented to the Surrey Heartlands Health and Care Partnership System Board in February 2021. It is being presented to the Surrey Health and Wellbeing Board in March 2021 for final approval.

0.1 Introduction

In June 2019, Surrey's Health and Wellbeing Board made a commitment to identify Surrey-wide opportunities for partnership working around end of life care to improve outcomes for citizens, as part of the new ten year Health and Wellbeing Strategy.

Discussions were paused briefly as the system focused on its response to managing the Covid-19 pandemic. However, these were quickly picked up to support the development of a strategy, taking into account our learning as a system from Covid-19 and where there are opportunities to work together with partners to further improve care.

It was recognised that senior leadership to support this work would be essential and an executive lead and clinical lead were appointed to support, and oversee, the development of a Palliative and End of Life Care Strategy for the Surrey Heartlands system.

0.12 Development of this strategy

A Reference Group, comprised of representatives from across Surrey Heartlands, was formed to lead the development of this strategy, making sure our vision and ambitions for end of life care are driven by the experiences of staff from organisations that provide end of life care and support, as well as our citizens and their families and carers.

The Reference Group has worked collaboratively, bringing together a wide range of stakeholders from across the area to co-design this strategy. Membership has included acute trusts, community providers, the ambulance service, GP representatives, hospices, voluntary organisations, Healthwatch Surrey and other third sector partners.

0.13 Our vision for end of life care across Surrey Heartlands

"Throughout their journey, we want individuals, their families and carers to receive high quality and compassionate palliative and end of life care that is person-centred and co-ordinated, with partners working together to make sure people's wishes and choices are met, wherever possible".

To achieve this vision:

- We will be responsive to changing circumstances and provide person-centred care and support, tailored to individual needs and wishes
- We will ensure people who are approaching the end of life, and their families and carers, receive dignified and compassionate care, wherever they're being cared for
- We will make sure individuals and their families and carers have the best possible experience and a 'good death' where possible
- We will address inequalities and reduce variation in palliative and end of life care
- We will provide the right care in the most appropriate place, in line with people's wishes
- We will ensure care is joined up, with services that are integrated and people only having to 'tell their story' and provide information once
- We will not over medicalise death
- We will help people prepare for death and support individuals, their families and carers every step of the way, including through bereavement support.

0.14 Research, engagement and insight

Early on, we knew that meaningful engagement with citizens, relatives and carers would provide valuable insights into people's experiences of end of life care and their aspirations for how care should be provided that would help shape this strategy and inform our collective ambitions as a system. We also wanted to ensure broader views were sought as part of our wider engagement, with feedback from partner organisations and staff also informing our work, with key themes triangulated across all groups to see if themes were shared. For example, this included looking at whether a citizen's understanding of co-ordinated and integrated care was similar to the understanding held by a member of staff and whether priorities were aligned across different engagement groups.

As part of developing this strategy our comprehensive engagement programme has included:

- Completion of a 'desktop' research review that looks at findings from previous research and insight work, both locally, nationally and globally into end of life care
- Engaging with key stakeholders to look at potential themes around end of life care and areas we may want to explore as part of our engagement work
- Conducting 25 interviews with individuals, families, carers, staff and the voluntary sector

Given the sensitivities around this subject, we worked with voluntary organisations that are involved in supporting individuals, families and carers before, during and after death to help us identify people who may be willing to speak with us as part of our engagement work. In addition, participants from third sector organisations were interviewed to not only speak about their own experience, but also to speak on behalf of the families and carers they support to help us gain as much insight into people's experiences as possible.

We are grateful to everyone who has spoken to us and contributed to the development of this strategy. The key findings from our insight work, including areas for improvement, are summarised throughout this strategy and also feed into our local ambitions to improve care.

0.15 The national ambitions for end of life care

Following the work that has been conducted nationally, this Surrey Heartlands strategy builds on the national direction of travel and priorities set out in *Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020*, which is still considered to be the blueprint for delivery of palliative and end of life care.

This national framework sets out six ambitions, which are essentially principles for how care for those nearing death should be delivered at local level.

These ambitions are:

1. Each person is **seen as an individual**
2. Each person gets **fair access to care**
3. **Maximising comfort** and wellbeing
4. Care is **coordinated**
5. All **staff are prepared** to care
6. **Each community is prepared** to help

The framework also identifies eight enablers that will support delivery and enable us to drive forward the improvements in care we want to see for local people and their families and carers. These are covered in chapter 7 of this strategy.

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0.16 Plans for a national policy review

NHS England and Improvement plans to launch the Ambitions Framework for 2020-25, refreshing and reinvigorating the collective aspirations and ambitions for palliative and end of life care. This strategy will be reviewed in light of the new national framework and will be updated, where needed, to reflect any changes in national policy.

0.17 Meeting the needs of our population

Data about people living in Surrey can be found in a document called the Joint Strategic Needs Assessment. It is essentially an assessment of the current and future health and social care needs of the local community that is regularly updated. It informs the Joint Health and Wellbeing Strategy (JHWS) and informs the planning and delivery of health and social care services across the county.

The document has a section about end of life care, which is available online.

Key facts from the health profile that need to be taken into account as part of this strategy are summarised below.

Key facts

- The 65 years and over age group is projected to be the fastest growing age group in Surrey between now and 2039
- In Surrey there are approximately 10,000 deaths each year
- Some areas of the county have higher mortality rates than others. These areas include Reigate and Banstead, Spelthorne and Tandridge.
- The leading causes of death in Surrey are cancer (26% for females and 32% for males), diseases of the circulatory system (26% for females and 28% for males) and respiratory diseases (15% females and males) – these account for 67% of female deaths and 75% of male deaths in Surrey.
- Mental health is given as the underlying cause of death for 12% of females and 6% of males – this is predominantly dementia conditions. These figures are broadly consistent across Surrey, with very little variation.
- In Surrey 41% of the total number of deaths occur in hospital, followed by:
    - 27% in care homes
    - 20% at home
    - 10% in a hospice
- The current trend is that the percentage of deaths in hospital and in a hospice is decreasing while the percentage of deaths in care homes and at home are increasing. This may be due to a drive to support more people at home if it is their wish.

Ambition 1.

Everyone is seen as an individual, with care tailored to meet their needs and wishes

"I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible."

"[Conversations about dying] *can often be more emotive for the families rather than the person facing the death" (Voluntary sector representative)*

"*We might go in and think their three main problems are nausea, pain and constipation but actually it's who's going to look after my cat when I die? It's very different so we ask them to identify [their priorities] themselves" (Nurse consultant)*

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"[The palliative care charity] respect you as an individual person and provide you with bespoke care" (Palliative care patient)

What our insight work told us

Through our conversations, we have heard about the importance of identifying if someone would benefit from palliative care early on, the crucial role of advance care planning and the importance of having these conversations earlier.

We also heard about some of the challenges faced by our workforce in relation to being able to access records and information generated by another organisation, and how frontline staff can sometimes feel uncomfortable having honest conversations about end of life care with individuals, their families and carers because they are worried it will upset them.

As part of our interviews, we asked staff from primary, secondary and community care which factors are most important to people who have been planning their deaths. Whilst it was recognised that these factors will differ from one individual to another, depending on their own personal situation, we found there are some aspects of end of life care which are frequently discussed and considered to be important. Healthcare professionals reported that 'planning ahead, pain relief and symptom control, involving families and carers, and having flexibility and choices' all contribute to a 'good death'.

During our interviews we heard from a palliative care nurse who talked about her recent experiences with a young lady who decided right from the start that she did not want to discuss her end of life wishes, instead wanting to focus on symptom management and her emotional needs. Sometime later when her condition had deteriorated and she was told she had just two weeks to live she was then ready to have this conversation and talk about her wishes. The nurse talked about how initiating a conversation earlier would have gone against this lady's wishes and upset her so timing for the individual and being guided by them is really important.

Voluntary sector colleagues also told us that individuals often tell volunteers that they did not understand all of the information they were being given by health and care professionals, with many saying it would have been helpful to have had an opportunity to discuss aspects of care in more detail at a time when they felt less overwhelmed, and more able to take in information.

If we want to deliver truly person-centred care, we must listen to, and understand, the needs and wishes of individuals who may be nearing the end of their life. We must also listen to the wishes of their carers and loved ones, who will also need support during what will be a very difficult time for them.

And this is where what's known as **advance care planning** comes in.

Advance care planning helps ensure that the right questions are asked, at the right time, and that this information is stored in a record that can be accessed by health and social care professionals when they need it. It helps prevent people having to repeat key information and 'tell their story' many times. It helps individuals, their families and carers think pro-actively about their future wishes and gives them somewhere to record them. It also gives health and care staff access to important information so people's wishes can be followed wherever possible.

In an article entitled 'Don't torment me with hope' (published in The BMJ 09 September 2020), Alexandra Filby describes the last few weeks of her father's life and the importance of pre-emptive conversations about end-of-life care. Quite simply, no one said he was dying, and the family were carried away in unrealistic optimism about treatment options from clinicians. Alexandra explains "If the reality of death had been discussed at diagnosis, and access to palliative care services provided, we might have been able to seek out what we needed when it was lacking…"

Discussing end of life care early with palliative patients is not about predicting when they are going to die, but raising awareness and expectations for this inevitable outcome, no matter the timescale.

1.1 Encouraging difficult conversations

Individuals, their families and carers don't know what to expect, and when, so we need to encourage conversations much earlier and find ways to bring people together to help them achieve the best possible death for themselves and for their loved ones.

There will never be 'a right time' to approach such a sensitive issue and that's why having a conversation earlier, and giving people time to think about their wishes, is important. They may not have specific preferences but we won't know until we start the conversation. Online references and case studies of people who are going through something similar, or putting people in touch with those in similar circumstances, can sometimes help, but there is no easy answer – it will depend on the individual and their family so we need to be guided by them.

1.2 An ongoing conversation

People's views, preferences and wishes will change so we need to ensure that this is an ongoing conversation. To help achieve this we need to ensure there are mechanisms in place to ensure care plans are regularly re-visited and that plans can be updated by all of those involved in an individual's care.

1.3 Advance care planning across Surrey Heartlands

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process has now been introduced across most of the Surrey Heartlands area. This gives health and social care professionals access to information about an individual's care, treatment and wishes in an emergency situation, including their preferences in relation to end of life care. It also helps ensure clinicians have meaningful conversations with individuals, their families and carers sooner to ensure their wishes are followed throughout their future care.

Some Integrated Care Partnerships also use the Pro-active Anticipatory Care planning (PACe) approach, which is a more detailed personalised care management plan. The aim of PACe is to record preferences and decisions about care, usually as an illness progresses, but it can be completed at any time.

1.4 Our plans in this area

Everyone is seen as an individual, with care tailored to meet their needs and wishes	What we are doing and our plans for the future
Advance care planning	We will provide further training to educate health and care professionals on the role of advance care planning and use of the ReSPECT process. We will continue to actively promote engagement with families and carers in advance care planning, so they know what to expect, understand the individual's wishes and any implications on them. We will support 'Dying Matters Week' through a public awareness campaign that reinforces the need to have conversations about dying much earlier. We will continue our plans to further integrate our digital infrastructure, including continued development of the Surrey Care Record and looking at how we can make shared records accessible to all professionals involved in providing care.
Honest conversations	We will provide further training to ensure our health and care workforce has the skills needed, and confidence, to have conversations about death with individuals, their families and carers.
Setting out clear expectations	One of the themes we have seen from feedback to end of life care services is that sometimes people can feel let down if their expectations have not been met in the final days. We understand end of life care and support can be complicated to navigate, with many different services and providers. Looking ahead, we will do more to help individuals, their families and carers understand what to expect, the different sources of support and advice and where they can find more information. This will include promotion of the new Surrey Caring to the End support website.
Equal access to bereavement support	When a death is expected, we know that bereavement support is more likely to be offered to family members than when the death has been sudden. We also know some groups are less likely to access bereavement support. We want to address this and ensure there is support available to everyone who needs it. Many providers are offering additional bereavement support in response to Covid-19, and we need to ensure that such provision meets the needs of all of our population in the future. We will carry out a review of bereavement services to understand the demand for services, current provision and any gaps that need to be addressed.

Ambition 2.

7

Everyone has equal access to palliative and end of life care

"I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life"

"…a lot of BAME people want to care for their own at home or in a certain way and they think we can't accommodate that. I think that's certainly an area that needs to develop" (Nurse)

What our insight work told us

When we asked health and care professionals about access to end of life care and any barriers that may exist, it was recognised that the ways in which patients die vary significantly due to the nature of their underlying conditions, their degree of deterioration and their environment. However, health and care professionals reported five main barriers which contribute to a patient's end of life care wishes or needs not being met. These were late referrals, overstretched resources, unpredictable or emergency situations, lack of coordinated care and health or care professionals not having the training or confidence to provide care.

There is also a correlation between late referrals into end of life care services and some cultures and faiths. In some cultural groups, it is common practice to support family members at home without any external health and social care support. However, as the families and carers may not know the full extent and implications of the patient's conditions, they may struggle to facilitate that. This can lead to them seeking help for their family member at a very late stage of their deterioration, when their condition is difficult to manage and options will be further limited.

2.1 Access to end of life care

We know access to end of life care can vary from one individual to another and we also know some groups or communities report having poorer access to care. For example, people from black and minority ethnic (BAME) communities and deprived areas report a poorer quality of end of life care. The same is true of those who are living with non-malignant illnesses, people living in more deprived areas, the homeless or imprisoned and those who are more vulnerable or less able to advocate for their own care.

There are still unacceptable inequalities in access to palliative and end of life care, particularly for people with learning disabilities, dementia and non-malignant long term conditions. Quality of end of life care can be poorer and harder to access for people who live in rural or other isolated areas. There can also be unacceptable variations in aspects of palliative and end of life care such as access to symptom control, related to different care settings.

There is a collective responsibility on all of those involved in the commissioning and provision of end of life care to put this right and this is an area we are looking to address as part of this strategy.

2.2 Our plans in this area

Everyone has equal access to palliative and end of life care	What we are doing and our plans for the future
Further understand where communities may not be accessing end of life care and any barriers that may exist	Following on from our insight work, we will do more to understand where communities are not accessing end of life care, any barriers that exist and how we can work with communities to overcome these. We will address inequalities and gaps in services, and increase access and participation, working alongside diverse lived experience groups and networks. We will aim to ensure fair and equal access to care for all. We will work as a system to improve data monitoring (including key demographic data, social and ethnic group and data relating to health conditions) so we can understand who is accessing care and where inequalities may exist. We can then compare this data to the population data within the Surrey Joint Strategic Needs Assessment and use it to inform future service planning.
Understanding place of death	As a system, we already have access to data on place of death, and we will monitor this to understand where people are dying and if preferences are being met.
Engaging with our communities and faith groups	To ensure equal access to end of life care, we are keen to further engage local communities, including faith groups. As a system we will work closely with Surrey Faith Links and other organisations to gain insights from these communities. We will also be asking our Integrated Care Partnerships to engage with their communities and faith groups at a local level.
Using research and insight to enhance end of life care	Following on from the engagement work we have undertaken in the design of this strategy, we will continue to work with stakeholders, our workforce and our citizens to gain further insight that will help inform future service planning. We will also continue to work with the Academic Research Collaboration, the Clinical Research Network, and other partners to identify best practice and build innovation and evidence into our programmes of work and service planning.

Ambition 3.

7

People are made to feel comfortable and their wider wellbeing needs are met

"My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible."

"Fear and anxiety can be so much worse overnight." (family member)

"Focus on what we can do. We can give medication, we can support you, we can visit, we will spend more time. Sometimes there's not much you can do but you can still visit." (Consultant in Palliative Medicine)

What our insight work told us

One major theme that emerged from the interviews we carried out is that more education should be provided about palliative care and the holistic nature of it. We also heard that people feel a cultural shift is needed to get people talking about, and thinking about, dying much earlier as this would help people when it comes to making plans.

We spoke to one individual who was receiving palliative care who told us that from their experience there seems to be little time offered in the earlier stages of diagnosis to talk about the sudden change to their life, the realities of what treatments will involve and the possible side effects they may experience. They felt that more time to discuss their care in a non-clinical setting would be valuable. They would also like to have been offered more practical support, including how to get equipment, more information on medications and details of where they could get advice on financial issues.

Helpfully, for this individual these practical needs had been met by the voluntary sector but this does suggest more could be done to consider an individuals' wider wellbeing needs and to signpost people to sources of information and support.

All providers of end of life care - GPs, nurses, hospital staff, social care, nursing homes, hospice staff and the voluntary and faith sector – should work closely with individuals, families and carers to make people as comfortable as possible and support their wider wellbeing, helping them make the most of their time together.

Being able to measure this is very difficult. Aside from meeting people's medical needs, including symptom control, we don't always know whether there is more we could have done to provide comfort and support wellbeing in the final stages of someone's life. Looking ahead, we want to do more to measure this and find a way to have those very sensitive conversations with families and carers to understand if we achieved a 'good death'.

We have heard, from providers, families and carers, that service availability and capacity can sometimes be an issue, with people reporting particular pressures on district nursing, and challenges during the night when families and carers are caring for loved ones at home. Whether it's a face-to-face visit from a GP or community nurse, or being able to speak to someone over the phone who can provide reassurance and offer practical information and support, people need to have access to help and support when they need it most.

3.1 Symptom management

People nearing the end of their life often worry about being in pain and other symptoms including weakness, poor mobility, stress and fatigue. Health and care professionals aim to minimise these symptoms, while also trying to ensure individuals can maintain as much control over decision-making as possible. Symptom management plays a factor not just for patients, but for families and carers too, who are often are concerned about what might happen and how best to deal with any given situation.

3.2 Our plans in this area

People are made to feel comfortable and their wider wellbeing needs are met	What we are doing and our plans for the future
Measuring comfort and wellbeing	Health and care providers monitor quality of care through a holistic approach that looks beyond the medical care people are receiving to also consider comfort and wellbeing and helping people live well for as long as possible. However, this monitoring tends to take place within individual organisations and not across all providers. Looking ahead, we will work with Integrated Care Partnerships to develop a series of metrics that consider areas such as physical, psychological, emotional, social, or spiritual distress at the end of life to help us understand if comfort and wellbeing needs are being met as a system.
Symptom management	As part of our training and education offer, we need to ensure that our workforce are skilled and competent in managing end of life care symptoms. We know that the majority of end of life care is provided by general health and care professionals (not specialist staff) so we must increase the skills and competencies of this group to further improve care. We will look at anticipatory prescribing for symptoms that may present at the end of life, to ensure there are consistent arrangements in place. We will also explore other opportunities, working with our medicines management and community pharmacy colleagues.
Access to services and specialist support	Individuals, families, carers and professionals need access to advice and support 24/7 and especially during the night when it can be more challenging for relatives providing care at home. We need this to be in place and equitable across our area. We also need to ensure Specialist Palliative Care assessments can be undertaken when needed. We will work with Integrated Care Partnerships and providers to look at these issues, and service capacity, particularly overnight and at weekends.

Ambition 4.

Care is co-ordinated, with different services working together

"I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night."

"Part of the problem is that there are so many systems for information and communication and they don't all marry up" (Nurse for Supportive and Palliative Care)

"Out-of-hours is the hardest area, and quite significantly harder. If you're seeing someone who might need medication, the system is very disjointed." (Out-of-hours GP)

"It would have helped to have someone there to coordinate the services" (Voluntary sector)

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"We rely a lot on the GP and I have to say the GP is quite pivotal in a lot of the care because often they've known the patients the longest and know about the complexity of any other illnesses they've got." (Consultant in Palliative Medicine)

What our insight work told us

For coordinated care to happen effectively and to ensure that more people experience good deaths, certain barriers need to be addressed. One barrier that was frequently mentioned in interviews with health and care staff was sharing patient notes with colleagues from other organisations and sectors. Often patients nearing the end of life need a multi-disciplinary approach, however currently organisations tend to have their own IT system and records.

From the perspective of health and care staff, there is a challenge to provide the right care as efficiently as possible with limited knowledge about the patient and limited resources to hand. One GP explains that they sometimes are called to treat a patient at the end of life during out-of-hours work. However, without knowing the patient well, without knowing their relatives and without easy access to their records, providing the right care can be difficult.

We also heard that the transition from child to adult services for end of life care can be difficult to navigate, with the children's hospice providing a very different service to an adult hospice. Ensuring a smoother transition to adult services was felt to be an area that could be improved. Through our conversations, we also heard that we need to do more to ensure we are meeting the individual needs of people with learning disabilities, autism and specific mental health needs.

4.1 Joining up care

Fragmented and disjointed care can cause unnecessary frustration and anxiety to someone who is dying and to those close to them. Carers often report the difficulties of multiple professionals and organisations working with little awareness of each other. This lack of coordination causes significant distress and leads to poor communication and duplication, with conversations being repeated unnecessarily.

Looking ahead we will focus on joining up services and care across the NHS, social care, hospices and the wider voluntary sector, putting the individual at the centre. The closer integration of services and the continued roll out of shared patient records (which can be accessed by everyone who is involved in an individual's care) will be key but there are also other areas we need to address, taking into account what we have learnt through managing our response to the Covid-19 pandemic and the move to more digital services.

Our experiences from our Covid-19 response

During our response to Covid-19 many providers replaced face-to-face support with virtual support, where this was needed to comply with social distancing and other measures. In many situations, we found that reaching out to families and carers, and providing support through video conferencing, was well received and effective, particularly in reaching younger age groups. However, we also found that some people did not have access to digital services and alternative solutions were needed. Looking ahead, our plans will need to be mindful of the digitally excluded and ensure that services are delivered in a way that ensures equal access to all members of our communities.

4.2 Our plans in this area

Care is coordinated, with different services working together	What we are doing and our plans for the future
Joining up information through a shared care record	We have launched a Surrey Care Record, which gives health and care professionals access to key information to help join up care. We are currently exploring how we can use this to enhance end of life care, through a Palliative and End of Life Care Surrey Care Record user working group.
Coordinating care through GP practices	General practice plays a crucial role in supporting people who are receiving end of life care. There are many benefits in having a regular forum in primary care, which brings together multi-professional teams to discuss an individual's care and holistic needs. By coming together in this way, partners can share intelligence and coordinate care. Currently, there are different arrangements in place across different practices, so we will work with Integrated Care Partnerships and our colleagues in primary care to look at how best to do this as a system.
Improving communication	When complaints are received, communication is often a key theme. Whether this is due to families and carers feeling they were not kept informed, mis-communication between different partners or the way in which health and care professionals communicated, we know communication can be an issue. Improvements including shared care records will help address this and we will look at staff awareness and training in this area.
Clearer information	During what is an emotional and stressful time for families and carers, we want to make it easier for people to know who to contact to get the help and support they need. Providing clearer information about services and how they work together is an area we are looking to improve. The new Surrey Caring to the End website will help provide information.
Making sure care is coordinated for specific groups	We are working with partners to improve coordination of care for particular groups including children who transition into adult services, people living with dementia and people with learning disabilities, who all have specific needs that need to be considered. We will explore potential opportunities in relation to these areas with partners.

Care is coordinated, with different services working together	What we are doing and our plans for the future
Certification of death	We want to make the certification of death process as quick and simple as possible, for health and care professionals and families and carers, and we are exploring ways to do this, working with our council and digital colleagues. Currently the next of kin are required to liaise with a number of different professionals and organisations to receive a copy of the Medical Certificate of Cause of Death and register the death before they can make arrangements. Sometimes if information is missing or inaccurate this can lead to unnecessary delays. We want to make this a faster and easier process for relatives, building on our learning through the Covid-19 pandemic. Following the successful introduction of the Medical Examiner Service at some acute hospitals to support the certification process (where information is reviewed and checked prior to submission), we plan to introduce a similar process for deaths that happen in the community. This will help increase the quality and accuracy of medical certificates and help reduce the number of forms referred back to the GP or coroner. As part of this work we believe there is also an opportunity to design a digital solution that could support and help streamline the process.
Opportunities to include end of life care in other digital projects	There are a wide range of digital projects underway across Surrey Heartlands to improve and integrate care and we are currently exploring these to understand where these could also benefit end of life care. These include projects relating to assisted technology (such as Telecare) and remote monitoring, which we are currently using with dementia patients and their carers as part of a Technology Integrated Health Management (TIHM) project.

Ambition 5.

Staff have the skills and knowledge to provide the best care

"Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care"

"Some of those softer skills about actually dealing with families [who are bereaved]. I think that could be really improved." (Pharmacy representative)

"I think the community are… really overstretched… and I think that sometimes people at home find it a struggle." (Nurse for Supportive and Palliative Care)

"We found people with heart failure recognised when they were less well and potentially facing death but their healthcare professionals didn't want to discuss it with them" (Hospice staff member)

What our insight work told us

Through our interviews with staff we heard that health and care professionals not always having the training, education or confidence to start conversations about end of life care could impact on the quality of care being provided. In particular, it was felt that training frontline staff should be prioritised so they developed the right skills and felt equipped to have these conversations. We heard that sometimes health and care professionals may be worried about upsetting an individual or getting it wrong because they haven't yet developed the skills or confidence to start conversations slowly and with empathy and understanding.

It was also recognised that other support roles would benefit from additional training and support, including pharmacists and volunteers who can play a valuable role but who may not have received any training in this area.

Caring for the dying and supporting people facing loss and grief, before and after death, is difficult and distressing. It challenges the resilience of those working in end of life care and makes for a difficult working environment. It also means making sure these staff get the support they need is essential for their own wellbeing, and the care and wellbeing of those they are looking after.

5.1 Supporting our workforce

Most health and care staff look after people who are nearing death, so if care is to improve, they must be trained in those aspects of end of life care that are appropriate to their role. Given the demands frontline staff experience every day, it's really important staff get the training and support they need, not only to do their job, but also to help them cope with stressful situations.

Staff can only provide compassionate care when they are cared for themselves and they must be supported to sustain their compassion so that they can remain resilient, and use their empathy and apply their professional values every time.

Following the Covid-19 pandemic, this has become an even greater area of focus for us. As a system, we have launched new online training packages, increased the mental health support that is available and offered counselling to those staff who would find this helpful. Following publication of the NHS People Plan, we have developed our own Surrey Heartlands Plan and through this we will ensure the health and wellbeing of our workforce remains a top priority.

5.2 Symptom management and supporting careworkers

We know that good symptom management benefits both the dying and those who spend time with them. If we are to make deaths at home more achievable, for those that want it, we know that we have to do more to ensure sufficient support for careworkers who may be vital to sustaining the viability of care at home.

5.3 Our plans in this area

Staff have the skills and knowledge to provide the best care	What we are doing and our plans for the future
Supporting our staff	We recognise that those working in end of life care are working in a challenging environment and they need to be supported, both in their job and in their wider wellbeing. Following the Covid-19 pandemic we have seen unprecedented demand for services so supporting our workforce has never been more important. We have already referenced our plans for further education and training in relation to some areas of palliative and end of life care, and we will be building on this, and our local People Plan, to ensure we have the right support in place.
Upskilling our general workforce	We know that the majority of end of life care is provided by GPs, nurses and other 'general' health and care professionals, and not by staff who have specialist end of life care roles. In view of this, we need to make sure our general workforce has the right training and feels equipped to provide high quality end of life care, linking in with specialist staff for advice and support when they need it. We will work with Integrated Care Partnerships to understand training offers available for the generalist workforce, and aim to increase the number of professionals who receive specialist training, and carers who receive relevant skills training.
Developing specialist skills	We are also looking at more specialist roles within end of life care and where these may be required to provide support and help coordinate care for specific groups. These roles need to be developed in partnership with local providers but could include specialist roles in end of life care for people with learning disabilities.

Ambition 6.

7

Communities come together to provide help and support

"I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways."

"Talking about death and dying remains the biggest taboo in our society." (Palliative Care Clinical Nurse Specialist)

What our insight work told us

Although willingness to discuss death and dying depends on an individual, their background and their illness, talking about death isn't really seen to be the 'done' thing. This can make staff reluctant to have these conversations, even when they are needed.

We also heard from frontline staff that there is often a misconception about palliative care solely focusing on end of life. Through our conversations, both health and care professions and voluntary representatives emphasised the need for people to understand that these conversations are not simply about the end of the patient's life, but also about the *rest* of their lives. By taking this approach we can empower the individual and their families and carers and help them to enjoy a good quality of life while also preparing for death.

Dying, death and bereavement are not medical issues – they are part of life and shouldn't be over medicalised.

Dying and bereaved people often feel disconnected or isolated from their communities and networks of support. Despite some real progress, and the growing reach and impact of the Dying Matters Coalition, there remains a continued need to address and dissolve the taboo that many people feel when it comes to talking about dying, death and bereavement and facing up to their own mortality and that of the people important to them.

6.1 Normalising death

Earlier in this strategy we have talked about the need to have conversations earlier, and find a way to normalise death. We understand it is a very sensitive subject and for many talking about death may either lead to anxiety over their own immortality or it may bring back feelings of grief or sadness, thinking about loved ones they have lost.

6.2 Developing compassionate communities

There are ways to foster and support compassionate communities and to put end of life care at the heart of community health and wellbeing. Supporting and working with communities, to develop their capacity to play a significant role in supporting individuals and those important to them, at the end of life and through bereavement, can help achieve the best outcomes for those who need support. As we have seen through the Covid-19 outbreak, volunteers can play a vital role in offering practical support and this is something that could be used more in end of life care and support.

6.3 Our plans in this area

Communities come together to provide help and support	What we are doing and our plans for the future
Building compassionate communities	To change how we think about, plan for, and respond to death as a society, we need to start by building compassionate communities. Integrated Care Partnerships will need to work with partners, the voluntary sector and local communities to talk about end of life care and what needs to change to help us give better support when people need it.
Helping people to talk about death and dying	If we want to improve care, we need to start these conversations earlier so we can understand how people would like to die so we can make sure wishes are followed. It will also help us get communities talking about how people want to be supported at the end of life and throughout bereavement. As a system we will take part in national awareness campaigns such as Dying Matters Week to get people in Surrey Heartlands thinking and talking about death. Our focus will be on normalising conversations about death and dying so everyone feels more equipped to have better conversations. Together, we are keen to explore the concept of a 'dying friendly' initiative, similar to the 'dementia friendly Surrey' scheme, where we offer training and support to help people have these conversations. We need to think creatively about how we can get people's attention and encourage conversations to happen, learning from other areas.
Starting conversations in schools	Partners feel that schools would be a good place to start, so we will be working with Surrey County Council to understand what is already covered as part of children's Personal and Social Education, and if there is more we can do to support teachers and encourage conversations during school age children. This would help increase understanding and it may also slowly lead to a shift in attitudes towards death and dying as children grow up and become adults.
Empowering local communities to provide support	End of life care isn't just about medical support so we will be working with partners to explore how we might be able to create a network of volunteers who can provide practical help to people who need it, as we have seen happening in communities during the Covid-19 pandemic. We will work closely with our voluntary, community and faith sector partners to build on the volunteer networks that already exist.

7.

Delivering on our ambitions

7. Delivery and enablers

Delivery of this ambitious strategy will be led by Integrated Care Partnerships. These are partnerships of local organisations that are working together to plan and deliver healthcare for local communities. The partnerships include local NHS organisations (such as hospital, community, mental health and ambulance trusts), local authorities, hospice and specialist palliative care providers, the voluntary sector and other local partners. There are four partnerships in the Surrey Heartlands area – Guildford and Waverley, North West Surrey, Surrey Downs and Crawley, Horsham and East Surrey (sometimes referred to as the CRESH partnership).

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It will be for these partnerships to work together with local service providers and other partners to look at how they can best meet the aims of this strategy and how they can work together to improve care for their local populations.

We recognise that the partnerships all have their own local services and practices in place, with some further ahead than others in terms of care planning and the implementation of processes such as ReSPECT. There will also be differences in terms of the provider landscape (such as the number of care homes), as well as differences in demographics (such as the number of people with learning disabilities). It will be for local partnerships to consider local services and local needs and to prioritise elements of this overarching strategy, based on local needs. Where there are opportunities to deliver improvements once at scale, across the whole of Surrey Heartlands, we will explore these as a system so that local partnerships can focus on the areas that need to be tailored to meet the needs of local communities.

It is recognised that local partnerships will need the infrastructure and resource in place to deliver this strategy and that this will vary from one area to another. This will need to be considered by the ICPs as part of next steps to ensure they have the resources in place to deliver this strategy.

7.1 The role of the Integrated Care System

The Surrey Heartlands Integrated Care System (which is responsible for setting the high level ambitions across the area and overseeing how partnerships are performing against these) will monitor progress and support local partnerships as they develop their own local plans.

7.2 Timescales for delivery

As Integrated Care Partnerships are still evolving and are still working through their own local priorities to meet local needs, as a system we are not mandating a timescale for delivering these improvements. However, we will work with local partnerships to ensure improvements are delivered as soon as possible in line with this strategy.

7.3 Enablers

Delivery of this strategy will be linked to a number of overarching enablers that will help us achieve our ambitions for end of life care (see Figure 1 below).

Figure 1 – System enablers (source: Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020

Many of these enablers have been referenced throughout this strategy, and are central to our plans for the future. Areas such as delivering more co-ordinated care will only be possible through closer integration, better personalised care planning and the roll out of the Surrey Care Record which will give us a secure platform where we can hold and share information across partners with everyone involved in delivering an individual's care.

Moving forwards we know that leadership, and a commitment from local partnerships to deliver these ambitions, will also be key, as will the continued input from staff, partners, local people, those nearing the end of their life and their loved ones to help make sure the right services, and the right support are in place.

The changes we have seen to the local landscape, with the emergence of Integrated Care Partnerships and Primary Care Networks will help us focus on local communities and local needs and it will also further strengthen the collaboration needed across partner organisations to maximise every opportunity to improve care, in line with our shared system ambitions.

7.4 Digital

Currently information that is recorded about palliative and end of life care can be fragmented, not available in 'real time' and sometimes information cannot be accessed by everyone involved in an individual's care. For example, if someone is taken to hospital in an emergency, A&E staff may not be able to access information about the medication an individual is taking, their care plan or about their wishes. None of this makes for co-ordinated care, so bringing this information together, and connecting partners through one shared record, will be a major step forward.

The Surrey Care Record is helping to join up information and care by making sure important information can be viewed by everyone who needs to see it.

We have also heard from both clinicians and carers that they would welcome technology that could support them when providing end of life care. Remote monitoring and systems such as telecare may have a role to play and these are areas we are now exploring.

7.41 Our digital strategy for end of life care

Building on the findings from recent insight work, we are developing a digital strategy to support the realisation of our ambitions, embracing digital technology to help improve end of life care for our citizens. Our digital approach is focused on six person-centred principles, which are outlined below in Figure 2. These principles link back to the national ambitions, with digital solutions under each that will act as enablers to help us realise our plans.

Figure 2 – Digital principles and our digital solutions

Principle 1 – Know me, know my needs (enabling data sharing)
Digital solution – Sharing care records We will join up records so health and care professionals can read and update records across systems used by GPs, hospices, hospitals, emergency services, out-of-hours staff, pharmacies and community services. This will help share vital information across different partners, reducing duplication, help to reduce clinical interventions and unnecessary admissions, help the system work more efficiently and importantly, it will help ensure individuals and their families and carers only have to tell their story once. This will be achieved through the continued roll out of the Surrey Care Record and connecting existing systems directly where needed to join up care. **Digital solution – empowering individuals, their families and carers** As part of our digital solution, we want individuals, family members and carers to be able to see some parts of their record, within the Surrey Care Record. We believe this will empower them and give them more control in their care and decisions and help them navigate their journey through end of life care.

Principle 2 – Initiating the difficult conversation (early identification of palliative care needs)

Digital solution – 'Bringing death to life'

Through our insight work we heard that when people are starting their end of life journey sometimes it can be helpful to see stories from other people who are going through a similar experience. We want to explore how we can use digital technology to bring together existing materials from local hospices and other partners and share them, creating new materials where needed.

Digital solution – Identifying those at risk

We also want to look out how we can use data that is already stored in the Surrey Care Record and other systems to use Artificial Intelligence (AI) to proactively identify those who could be moving into end of life care to help make sure these individuals get the care and support they need.

7

Principle 3 – Do they truly know my wishes? (enabling a flexible and transparent approach to advance care planning)

Digital solution – telling stories once and sharing information

We will standardise the information that exists currently and bring it all together into one system, which can be updated by the right person at the right time. This will ensure individuals only have to tell people their wishes once and it will save time and duplication in updating records for staff.

Digital solution – conversation reminders to update people's wishes

We will also introduce new AI generated flags within IT systems that will trigger a planning review and the need for a further conversation with an individual to understand if their wishes or preferences have changed as they have continued their journey.

Principle 4 – Allow me to safely be where I want to be (technology enabled monitoring and support)

Digital solution – remote monitoring

We plan to use the latest technology and remote monitoring systems to enhance care, give individuals more control and help them stay at home for longer. By deploying a range of sensors (including biometric and environmental sensors) we will be able to proactively monitor an individual's condition. This will help alert us to any deterioration quickly and help reduce anxiety and stress for those caring for the individual at home.

This can be achieved by coordinating and combining existing tools and systems and synchronising these with remote monitoring tools being used in other pathways (e.g. dementia care, frail and older people's care). We will also use the data captured to inform future planning.

Principle 5 – Help me start my end of life journey and find my way through it

Digital solution – an online portal to help people 'navigate the system'

There are many different organisations involved in end of life care. This can make it difficult for individuals, families and carers to navigate the system and know who to contact, when. By bringing together information and resources into one place we can help share people's experiences and signpost people to organisations and groups that may be able to provide further support, outside of the support we can provide through health and social care. The development of the new Surrey Caring to the End website is a positive first step that we will build on.

Principle 6 – Balance convenience with support and compassion (use of virtual services)
Digital solution – virtual engagement and virtual appointments We will work with our workforce, with insight from individuals, families and carers, to design virtual services that meet the needs of individuals and their loved ones, and enable the system to continue to provide the best possible care, without the need for travel. Virtual services will not replace face-to-face care and would only be offered where it was felt to be appropriate and if individuals and their families and carers agreed this was the right option. Being mindful of access to services, and digital exclusion, face-to-face appointments will always be available.

7.5 Carers

Carers are vital in providing end of life care. They also face many challenges including difficulties in coping as the person's physical, emotional and social needs become more complex and demanding. This is whilst also trying to coordinate care on a 24/7 basis, managing symptom relief and starting to think about funeral arrangements, all while managing their own feelings of grief. With such an important role to play, it's essential we recognise that carers have their own needs and rights, which should be assessed, and that we do all we can to work together to support carers.

Nationally there are approximately half a million people caring for someone who is under end of life care. To help build resilience carers need to be able to access a range of support services that are appropriate to their needs, responsive and readily available. Whilst there is already good practice in some areas, this is not consistent across Surrey Heartlands, especially in relation to the identification, assessment and involvement of carers – and we need to change this.

The national End of Life Care Strategy recognises carers not just as care providers but also as people in need of support. The national Carers Action Plan also recognises the importance of supporting carers in end of life care. Locally, this is also an area of focus in our draft Carers Strategy 2021-24.

Through our work with carers, the voluntary sector and partner events focusing on the needs of carers during end of life care, we have identified the following themes:

- Carers want to be more involved in an individual's care and in discussions around advance care planning - they will know the individuals and be able to support this
- More training is needed to ensure everyone involved in end of life care understands the importance of engaging carers and making sure wrap-around care is provided.
- Carers are worried about managing pain relief at home – and knowing when to call for help.
- Carers want more support and information to help them manage the strain on their own finances – and their own lives
- Services can feel very fragmented so greater co-ordination, and continuity of care, would help individuals and their carers who sometimes find it hard to 'navigate the system'
- Carers want good access to support and advice, including medicines advice, out of hours.
- Dignity and respect are important and small things can make a big difference to individuals and their families and carers - so personalised and individual care is crucial.

We are very aware of the impact dying, death and bereavement can have on a carer and we want to make sure that carers are supported and fully involved in decisions related to an individual's care. Education is required to make sure health and care professionals are actively engaging in a whole family approach to end of life care. Carers are expert partners in care so it's crucial that they are fully involved in care planning. Carers that have been supported have not only helped achieve 'better deaths' through their involvement, but this sense of purpose has also potentially helped to reduce physical and mental health issues experienced by carers.

Professional staff should offer carers repeated opportunities to discuss and absorb information relating to the cared for person's end of life care. Carers also need information concerning legal and logistical issues.

Addressing some of the key issues and themes that we have heard through our engagement with carers and voluntary groups is a key focus of our work and of this strategy.

8. Key challenges

Through the development of this strategy, we have identified a number of challenges that will need to be considered in delivering this strategy. These are outlined in Figure 3 below.

Figure 3 – Risks and mitigation

Key challenge/ risk	Mitigation
Advance care planning Ensuring that Advance Care Planning is promoted and facilitated effectively to enable people to express their wishes and care preferences and make them known so care can be planned and managed according to individual need	We will work with local partnerships on training and support for health and care professionals to increase knowledge and use of advance care planning. We will also raise awareness with the public of the need to have these conversations so wishes are known.
Effective partnership working Developing and maintaining effective partnership working across the public, private and third sector organisations to achieve more co-ordinated care	The new Integrated Care Partnerships bring together many of the organisations involved in end of life care so this will help facilitate partnership working in a much more effective way. We have seen great examples in response to the Covid-19 outbreak.
Workforce As a system our ability to recruit and retain clinical staff in all areas of end of life care, including in specialist roles	Workforce planning will need to be considered and addressed as part of local planning to ensure the right skills and the right resources are in place to achieve the ambitions of this strategy. This includes the role of community pharmacists and also needs to take into account that the majority of end of life care is provided by general health and care professionals, not specialists.
Training and education Ensuring adequate resources are available to support the provision of multidisciplinary training for the NHS and its partners and that resources are available to cover the cost of releasing staff to attend training courses.	This strategy identified education and training as a key area that needs to be addressed and local partnerships will need to ensure training needs are met, with resources allocated to support this.
Funding and investment Securing sustainable funding for all areas of end of life care, including the voluntary sector, to realise the ambitions within this strategy.	Funding and plans for investment will need to be considered by local partnerships as they take on responsibility for devolved budgets and local service planning and delivery. This should include greater investment in early intervention to join up care and reduce admissions, which is beneficial to individuals and also helps ensure value for money in use of resources.

9. Measuring outcomes

To determine the success of this strategy, and the extent to which we achieve our collective system ambitions to improve palliative and end of life care, it will be essential that key outcomes with measurable indicators of success are defined and closely monitored.

Whilst it is recogised that defining outcomes in relation to end of life care is challenging, our high level outcome measures will include monitoring how local partnerships are performing against the following high level ambitions:

Desired outcome	Individual and family outcome	System outcome
People die with dignity and their wishes are respected	**Individuals can choose where they are cared for and die, and they die with dignity.** **Their wishes, and those of their loved ones, are met, wherever possible.** **Symptom control is effectively managed for the dying patient in all settings.**	**Increase in achievement of preferred place of care and death.**
	Evaluation methods include: - surveys for individuals who have been bereaved - feedback from individuals and families and carers - complaints and compliments	Metrics include: - Upward trend in positive response to the question: 'Overall do you feel the person close to you died in the right place?'
Care is provided in the community, wherever possible, and palliative and end of life care is available when people, families and carers need it	**Trips to, and stays in, hospital are minimized for people at end of life, only happening when clinically necessary.** **Individuals and their families and carers have access to rapid advice and support, including out of hours or in a crisis situation, in the community.**	**More individuals are being supported in the community.** **The general workforce have access to specialist telephone advice and support when required.**
	Evaluation methods include: - surveys for individuals who have been bereaved - feedback from individuals and families and carers - complaints and compliments	Metrics include: - Downward trend in unplanned admissions to hospital in the last three months of life.

Desired outcome	Individual and family outcome	System outcome
Palliative care needs across all health conditions are identified early and support is provided	**Palliative care needs are identified early on and a care offer is made from the start.** **Individuals are given the opportunity to plan ahead, and be involved in decisions about their care.**	**Timely identification of palliative care needs for all disease types, with appropriate support**
	Evaluation methods include: - surveys for individuals who have been bereaved - feedback from individuals and families and carers - complaints and compliments	Metrics include: - Evidence, from general practice palliative care registers, that all disease types are represented proportionally.
Palliative and end of life care is coordinated	**Individuals and their families experience coordinated care, with clear and consistent information and different organisations coming together to seamlessly wrap care around the individual.**	**Partners are working together effectively to provide co-ordinated care.** **Continued expansion of advance care planning (ReSPECT, PACe etc) with effective solutions to share clinical records and care plans to enable the system to work efficiently.**
	Evaluation methods include: - ICS wide survey for individuals who have been bereaved, seeking insight on their experiences - feedback from individuals and families and carers - complaints and compliments	Metrics include: - Increase in the number of personalised care plans created - Increase in the number of personalised care plans being reviewed and updated - Evidence that digital solutions are in place to share clinical records and personalised care plans.

Desired outcome	Individual and family outcome	System outcome
After someone has died families are supported and the certification process is quick and easy so they can make arrangements swiftly if they wish to do so	**The next of kin is offered bereavement support. They also experience a faster and easier death certification process so they can make the necessary arrangements.**	**The Medical Certificate of Cause of Death (MCCD) process is streamlined, leading to death certificates being issued more quickly.**
	Evaluation methods include: - surveys for individuals who have been bereaved - feedback from individuals and families and carers - complaints and compliments	Metrics include: - increase in achievement of death certificates being issued within 5 days of death (Surrey currently at 58%) - reduction in the number of MCCDs referred to the coroner due to missing information (nationally around 50% of cases are referred to the coroner, some of which could be avoided)

Metrics have not been determined before for palliative and end of life care across the ICS. Whilst much data is collected at national or individual organisation level, baseline measurement for the ICS is not readily available. We will not duplicate any existing data collection or surveys, but will form a working group to:

- agree standardisation of measurement across all settings, where possible;
- use or adapt existing data or intelligence to understand the ICS position, and drive system improvement in the future;
- work with CCG business intelligence colleagues to develop an ICS dashboard for palliative and end of life care.

With plans for a refresh of the NHS' Ambitions Framework for Palliative and End of Life Care for 2020-2025, NHSE/I are developing a palliative and end of life care dashboard. We will keep the above outcomes under review and update them to reflect any changes in the national dashboard.

10. Conclusion and next steps

This strategy sets out our ambitious plans to improve palliative and end of life care for people living in Surrey Heartlands. Delivery of this strategy will require the commitment of all partners and implementation will be taken forward at a local, place-based level through Integrated Care Partnerships.

Once this strategy has been approved it will be for Integrated Care Partnerships to take forward these improvements at a local level, working with partners, prioritising areas as needed, based on local health needs.

As an Integrated Care System, we will be working with our local partnerships to monitor delivery of this strategy and ensure these ambitions are realised for the benefit of our citizens.

7

Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

SURREY COUNTY COUNCIL

NHS

Palliative & End of Life Care
Strategy 2021-2026

This strategy has been co-designed with input from a wide range of partners and voluntary organisations, taking into account the experiences and insight shared by individuals, relatives, carers and local people.

NHS Surrey Heartlands Clinical Commissioning Group

SURREY COUNTY COUNCIL

Princess Alice Hospice

THE BRIGITTE TRUST
SUPPORT FOR PEOPLE FACING LIFE THREATENING ILLNESS

Practice Plus Group

NHS Surrey and Sussex Healthcare NHS Trust

First Community Health and Care

NHS Surrey and Borders Partnership NHS Foundation Trust

Shooting Star Children's Hospices

NHS Epsom and St Helier University Hospitals NHS Trust

Phyllis Tuckwell Hospice Care
...because every day is precious

NHS Royal Surrey NHS Foundation Trust

Woking & Sam Beare Hospice and Wellbeing Care

Procare HEALTH

Children and Family Health Surrey

ST CATHERINE'S HOSPICE

South East Coast Ambulance Service NHS Foundation Trust

CSH Surrey

NHS Ashford and St. Peter's Hospitals NHS Foundation Trust

Primary Care Networks

Integrated Care Partnerships

Background

This strategy sets out the collective ambitions we want to achieve across Surrey Heartlands as an Integrated Care System to improve palliative and end of life care for our citizens.

In developing this strategy we have worked with organisations that provide palliative and end of life care, their staff, local voluntary organisations and other partners.

We have also considered previous research and sensitively carried out our own insight work with individuals who are receiving end of life care and their relatives - and their experiences have helped ensure individuals, their families and carers are at the centre of our plans to enhance end of life care.

It is now for Integrated Care Partnerships and local partners to work together to deliver these improvements for their local communities.

Ambition 1

Everyone is seen as an individual, with care tailored to meet their needs and wishes

"*We might go in and think their three main problems are nausea, pain and constipation but actually it's who's going to look after my cat when I die?" (Nurse consultant)*

What we are doing and our plans in this area

Advance care planning	We will continue to educate health and care staff on the role of advance care planning and in involving families and carers in these conversations. We will also continue roll out of the Surrey Care Record to share information.
Honest conversations	We will provide further training to ensure staff have the skills and confidence to have conversations about death with individuals and their families and carers.
Setting out clear expectations	We will do more to help individuals, families and carers understand what to expect, including launching a new website for carers with information and advice.
Equal access to bereavement support	We will review current access to bereavement services and address any barriers to ensure fair access for all.

Ambition 2

Everyone has equal access to palliative and end of life care

"…a lot of Black Asian and Minority Ethnic people want to care for their own at home or in a certain way and they think we can't accommodate that. I think that's certainly an area that needs to develop." (Nurse)

What we are doing and our plans in this area

Understanding where communities may not be accessing end of life care and any barriers that exist	We will address inequalities and any gaps in services and work with partners to overcome barriers.
Understanding place of death	We will monitor information to understand where people are dying and if people's preferences are being achieved.
Engaging with our communities and faith groups	We will continue to engage communities and faith groups, working with local Integrated Care Partnerships.
Using research and insight to enhance end of life care	We will continue to gain insight and work with colleagues to identify and spread best practice in end of life care.

Ambition 3 

People are made to feel comfortable and their wider wellbeing needs are met

“Focus on what we can do. We can give medication. We can support you. We can visit. We will spend more time.” (Consultant in Palliative Medicine)

What we are doing and our plans in this area

Measuring comfort and wellbeing	We will work with Integrated Care Partnerships to improve our quality monitoring and help us understand if comfort and wellbeing needs (including physical, psychological, emotional and social needs) are being met.
Symptom management	We will increase training and education in managing symptoms (particularly for non specialist staff) and also look at anticipatory prescribing to help manage symptoms.
Access to services and specialist support	We will work with Integrated Care Partnerships and providers to ensure people have access to advice and support 24/7 and that specialist palliative care assessments can be carried out when needed.

Ambition 4

Care is coordinated, with different services working together

“Part of the problem is that there are so many systems for information and communication and they don’t all marry up.” (Nurse for Supportive and Palliative Care)

What we are doing and our plans in this area

Introducing a shared record and other digital services	We will continue the roll out of the Surrey Care Record and explore other digital solutions to join up care.
Coordinating care through practices	We will work with Integrated Care Partnerships to understand how GP practices can best support end of life care.
Improving communication	We will work with providers to improve communication and make sure information is clear and informative.
Making sure care is coordinated for specific groups	We will improve coordination of care for children who transition into adult services, those living with dementia and people with learning disabilities.
Certification of death	We will streamline and improve this process for families, working with our council and digital colleagues.

Ambition 5

Staff have the skills and knowledge to provide the best care

“Some of those softer skills about actually dealing with families [who are bereaved]. I think that could be really improved.” (Pharmacy representative)

What we are doing and our plans in this area

Supporting our staff and carers	We will build on the education and training we provide to our staff and we will ensure staff and carers get the support they need.
Upskilling our general workforce	We will make sure our general workforce has the right training and feels equipped to provide high quality end of life care, linking in with specialist staff when they need to.
Developing specialist skills	We are looking at where more specialist roles may be needed. These need to be developed with local providers but could include specialist roles in end of life care for people with learning disabilities.

Ambition 6

Communities come together to provide help and support

“Talking about death and dying remains the biggest taboo in our society.” (Palliative Nurse Specialist)

What we are doing and our plans in this area

Building compassionate communities	Integrated Care Partnerships will work with partners, the voluntary sector and local communities to talk about end of life care and how we build compassionate communities.
Helping people to talk about death and dying	Together, we will take part in national awareness campaigns such as Dying Matters Week to get people thinking and talking about death earlier.
Starting conversations in schools	We will work with Surrey County Council to explore if there is more we can do to support teachers to start conversations with school age children.
Empowering local communities to provide support	We will work closely with our voluntary, community and faith sector partners to build on the volunteer networks that already exist, helping to provide practical support to people who need it.

Delivering this strategy

This strategy sets out our ambitious plans to improve palliative and end of life care across Surrey Heartlands.

Delivery of this strategy will need the commitment of all partners.

We will be working with our ICP colleagues to provide support and monitor progress to ensure these ambitions are realised for the benefit of our citizens.

We will monitor progress against specific outcomes through a range of methods including monitoring quality of care, data collection, surveys and feedback from individuals, families, carers and staff.

Monitoring our progress

Desired outcome	Individual and family outcome	System outcome	Metrics and evaluation
People die with dignity and their wishes are respected	Individuals can choose where they are cared for and die, and they die with dignity. Their wishes, and those of their loved ones, are met, wherever possible. Symptom control is effectively managed for the dying patient in all settings.	Increase in achievement of preferred place of care and death.	Upward trend in positive response to the question: 'Overall do you feel the person close to you died in the right place?' Feedback from individuals, families and carers (including surveys, complaints and compliments)
Care is provided in the community, wherever possible, and palliative and end of life care is available when people, families and carers need it	Trips to, and stays in, hospital are minimized for people at end of life, only happening when clinically necessary. Individuals, their families and carers have access to rapid advice and support, including out of hours or in a crisis situation, in the community.	More individuals are being supported in the community. The general workforce have access to specialist telephone advice and support when needed.	Downward trend in unplanned admissions to hospital in the last three months of life. Feedback from individuals, families and carers (including surveys, complaints and compliments)
Palliative care needs across all health conditions are identified early and support is provided	Palliative care needs are identified early on and a care offer is made from the start. Individuals are given the opportunity to plan ahead, and be involved in decisions about their care.	Timely identification of palliative care needs for all disease types, with appropriate support.	Evidence from general practice palliative care registers that all disease types are represented. Feedback from individuals, families and carers

Monitoring our progress (continued)

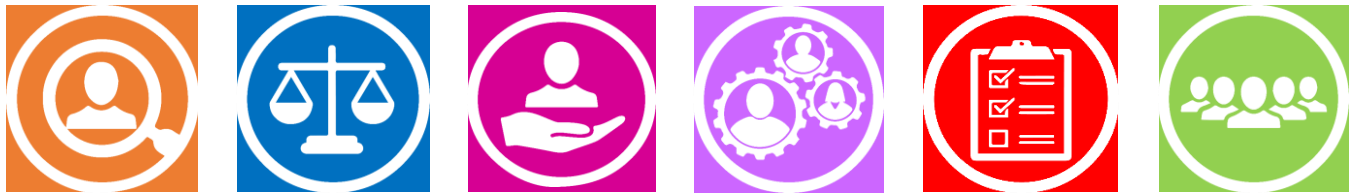
Desired outcome	Individual and family outcome	System outcome	Metrics and evaluation
Palliative and end of life care is coordinated	Individuals, their families and carers experience coordinated care, with clear and consistent information and different organisations coming together to seamlessly wrap care around the individual.	Partners are working together effectively to provide co-ordinated care. Continued expansion of advance care planning (ReSPECT, PACe etc) with effective solutions to share clinical records and care plans to enable the system to work efficiently.	Increase in the number of personalised care plans created Increase in the number of personalised care plans being reviewed and updated Evidence that digital solutions are in place to share clinical records and personalised care plans. Feedback from individuals, families and carers (including system-wide survey, complaints and compliments)
After someone has died families and carers are supported and the certification process is quick and easy so they can make arrangements swiftly if they wish to do so	The next of kin is offered bereavement support. They also experience a faster and easier death certification process so they can make the necessary arrangements.	The Medical Certificate of Cause of Death (MCCD) process is streamlined, leading to death certificates being issued more quickly.	Increase in achievement of death certificates being issued within 5 days of death (Surrey currently at 58%) Reduction in the number of certificates referred to the Coroner due to missing information Feedback from individuals, families and carers

Next steps

It is now for local Integrated Care Partnerships (ICPs) to work with other partners and the voluntary sector to make this vision a reality, putting local plans in place to deliver improvements, taking into account local needs.

It is for ICPs to determine the changes that are needed locally to deliver this strategy and agree realistic timescales for delivering these improvements for people living in Surrey Heartlands.

You can read our full
Palliative and End of Life Care Strategy
online at www.surreyheartlands.uk



Health and Wellbeing Board Paper

1. Reference information

Paper tracking information	
Title:	Improving Mental Health Outcomes, Experiences and Services In Surrey
Related Health and Wellbeing Priority:	Priority 2: Supporting the mental health and emotional wellbeing of people in Surrey
Author (Name, post title and telephone number):	Michael Coughlin, Deputy Chief Executive, SCC michael.coughlin@surreycc.gov.uk; 07974 212290
Sponsor:	Mr Tim Oliver - HWB Chairman and Leader of Surrey County Council (SCC)
Paper date:	4 March 2021
Related papers	Annex 1: Mental Health Pressures and Pandemic Impacts

2. Executive summary

This report provides an update for the Health and Wellbeing Board on:

i) the mental health pressures being experienced by residents - exacerbated by Covid-19 and the associated control measures;
ii) the consequent increased demand on and challenges being faced by the mental health system;
iii) the issues and concerns arising; and
iv) the steps being taken in response and in preparation for a post-Covid-19 period, to ensure improved mental health outcomes, experiences and services for Surrey residents.

3. Recommendations

It is recommended that the Health and Wellbeing Board:

1. Note the significant demands, issues, concerns and performance associated with the mental health system in Surrey, particularly arising from the additional pressures created by Covid-19, and the impact this is having on Surrey residents.

2. Approve and support the range of multi-agency work going on and being initiated to address the situation, including through the Surrey Heartlands Mental Health Partnership and Improvement Board.

3. Receive a further report on the issue of mental health outcomes, experiences and services in Surrey in July.

4. Reason for Recommendations

Priority 2 of the Health and Wellbeing Strategy is 'Supporting the mental health and emotional wellbeing of people in Surrey'.

Poor mental health is a key factor in a range of conditions and personal situations, such as substance abuse, unemployment, poor physical health, that create and/or worsen health inequality. The mental health system in Surrey is under great stress and struggling to manage the demands made upon it. This report and its recommendations, the work to date and the work proposed are intended to support the mental health system deal with the immediate demands and pressures as well as building an effective and sustainable improvement programme.

5. Detail

More Surrey residents, of all ages, are experiencing more pronounced mental health problems as a result of being affected by Covid-19, national or tiered lockdowns, social distancing and the general disruption to the patterns and rhythm of normal life (see Annex 1). Such experiences are known to heighten and worsen health inequality, with those experiencing mental health problems feeling and/or being, left behind.

The Surrey Mental Health Summit in November highlighted some of these issues and poor service user experiences, as well as best practice and alternative models from elsewhere. Some of the issues and concerns, included:

Children and adolescents:

- unacceptably high numbers of children waiting for Children and Adolescents' Mental Health Service (CAMHS) assessment, intervention and support,
- accommodation for young people in crisis
- in-school support reaching fewer pupils, making it harder to target early help loneliness and isolation, experience of self-harm, influence of social media and varying levels of parental, school and agency awareness on mental health problems
- inconsistent CAMHS services and the absence of effective step-down services were a key feature in the review.

Adults:

- the lower than average bed provision in Surrey per 100,000 population,
- the high number of out-of-area placements (33 in November).
- The insufficiency of s136 suites and people waiting in inappropriate 'places of safety',
- the exacerbation of health inequality and impact of poor mental health on individuals' work and economic activity

User experiences: service users expressing the following:

- 'caught between two stools'
- unable to access what they felt were adequate treatment services

- reliant on the services offered by third sector organisations, when experiencing mental health crises out of hours.
- a lack of communication between different services
- repeating their stories multiple times when moving between services
- a lack of involvement in their care planning
- feeling as if they had been “put in a box” by the clinical approach

In response the immediate pressure of demand, a number of steps have been taken and work initiated to mitigate the impacts in support of individuals experiencing poor mental health. The Surrey Mental Health Summit was a valuable awareness raising and ‘call to arms’ event, which has prompted additional commitment, focus, attention and effort from many in the system. .

Surrey and Borders Partnership Trust have established a multi-agency Emergency Response team to consider and address the immediate pressures arising from Covid-19. Issues arising are being escalated to the Surrey Heartlands Covid-19 Incident Management Group as required, for immediate attention.

With regard to accommodation and beds for adults in crisis, priorities for action have been established and winter pressures schemes rapidly mobilised to enable timely discharge from hospital.

On the specific issue of the provision of s136 suites for young people, work has been initiated to develop and implement alternative arrangements for ‘places of safety’ for children. The mobilisation of the new CAMHS contract will be used to accelerate these as an urgent task, as well as addressing the backlog in Autistic Spectrum Disorder (ASD) assessments and development of early help and intervention.

In considering the serious concerns being expressed relating to mental health services, outcomes and user experiences, the Surrey Heartlands ICS Board at its meeting on 16th December agreed to the establishment of an independently chaired Partnership Board with the following responsibilities, reporting to the Health and Wellbeing Board, to identify and drive the necessary priority improvements, in accordance with the following:

- To develop and oversee the delivery of a shared action plan for the rapid improvement and system-wide transformation of mental health outcomes, experiences and services, support and signposting in Surrey
- To review best practice across the world in early help for preventing mental ill health and facilitate shared learning amongst stakeholders for mental health service provision in Surrey
- To hold organisations to account where poor outcomes, experiences and/or performance has been highlighted
- To review and determine the adequacy of the whole system approach to performance management and evaluation of mental health outcomes, experiences and services
- To support awareness raising of the key issues relating to mental health service provision

Board meetings have been held on 5th and 25th February and a verbal update can be given at the HWB meeting, as required.

6. Next steps, timescale and delivery plan

Alongside the urgent, immediate work in train, it is currently anticipated that the work of the Board will fall into three main phases:

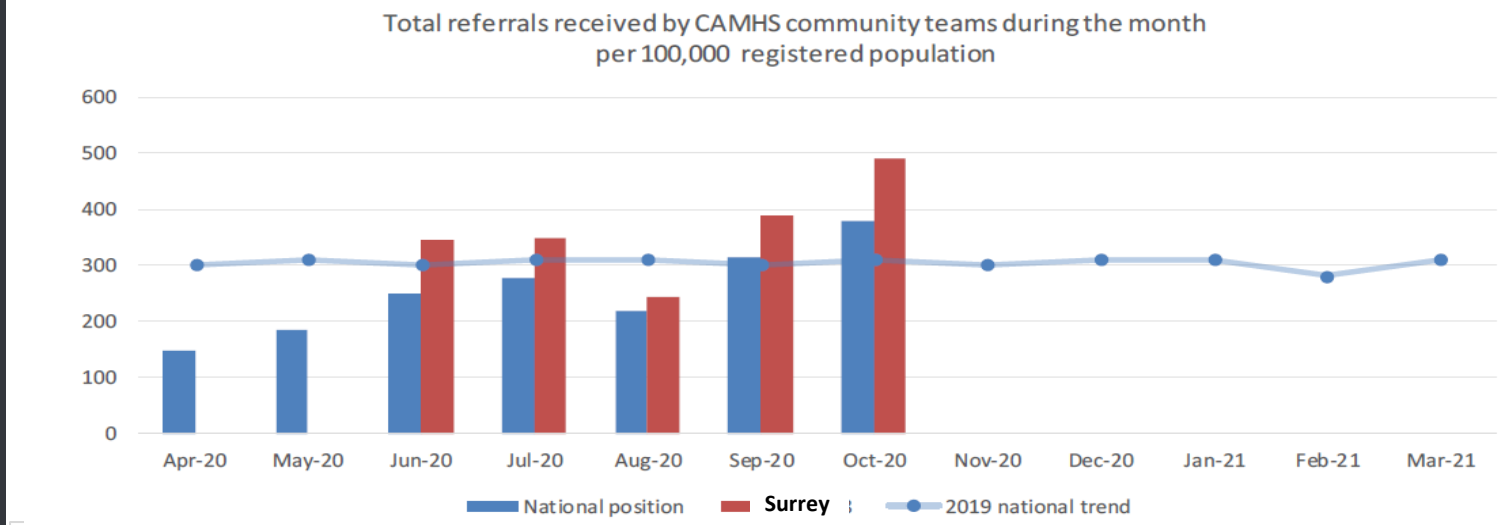
- engagement and data/information/intelligence gathering (possibly involving system-wide, external Peer support),
- assessment and identification of priority improvements required and preparation of a programme for their delivery, and
- oversight of the early stages of improvement, including assurance over the longer-term delivery and review of the future role, purpose and need for the Board.

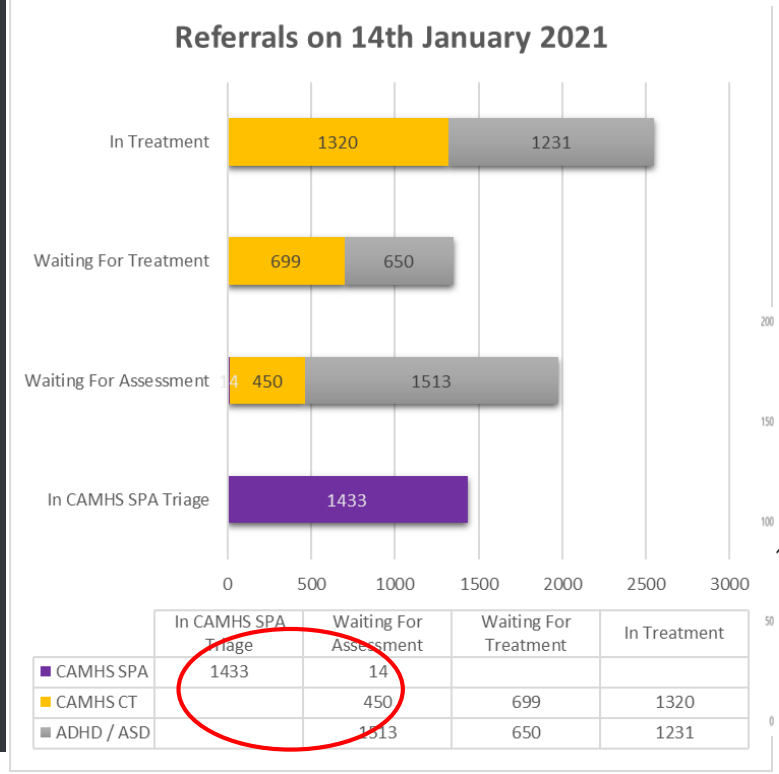
Current pressures – children

- CAMHS is currently showing a **22% increase in demand** above the same time last year. For example, experiencing a 66% increase in demand for children's eating disorder services and a 3-fold increase in urgent cases.

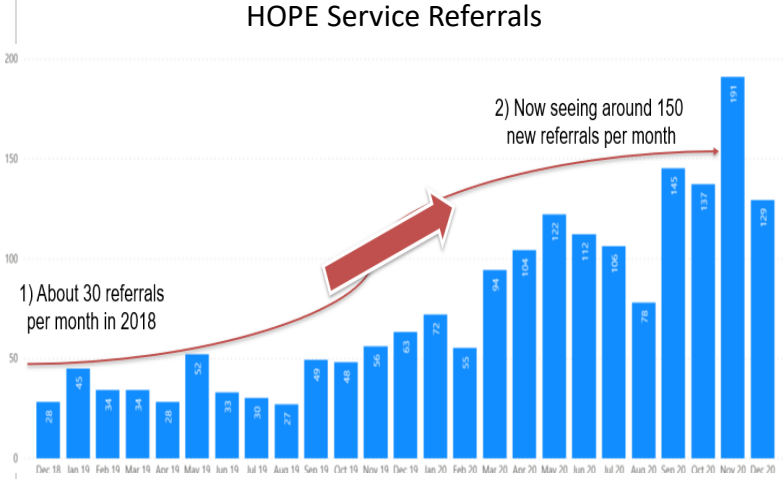
- Since November there has been an **89% increase** in referrals triaged by the Children's Single Point of Access (SPA) from 758 on 1 November to 1433 on 14 Jan, and increasing delays creating a backlog

- There is also a 12% increase in referrals waiting for assessment.





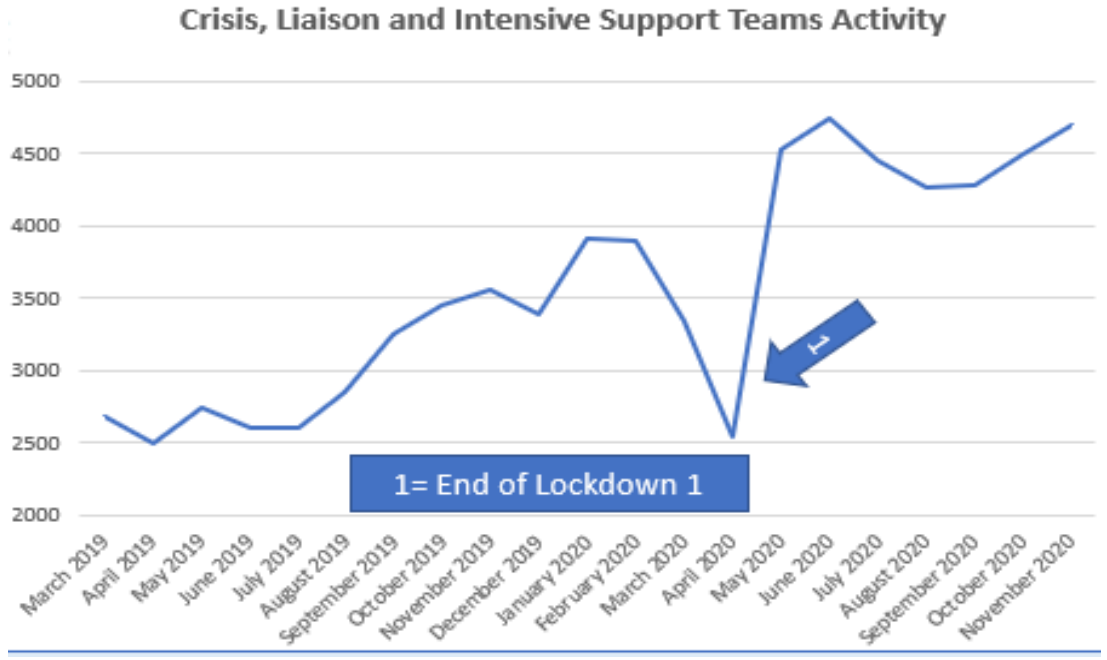
	In CAMHS SPA Triage	Waiting For Assessment	Waiting For Treatment	In Treatment
CAMHS SPA	1433	14		
CAMHS CT		450	699	1320
ADHD / ASD		1513	650	1231

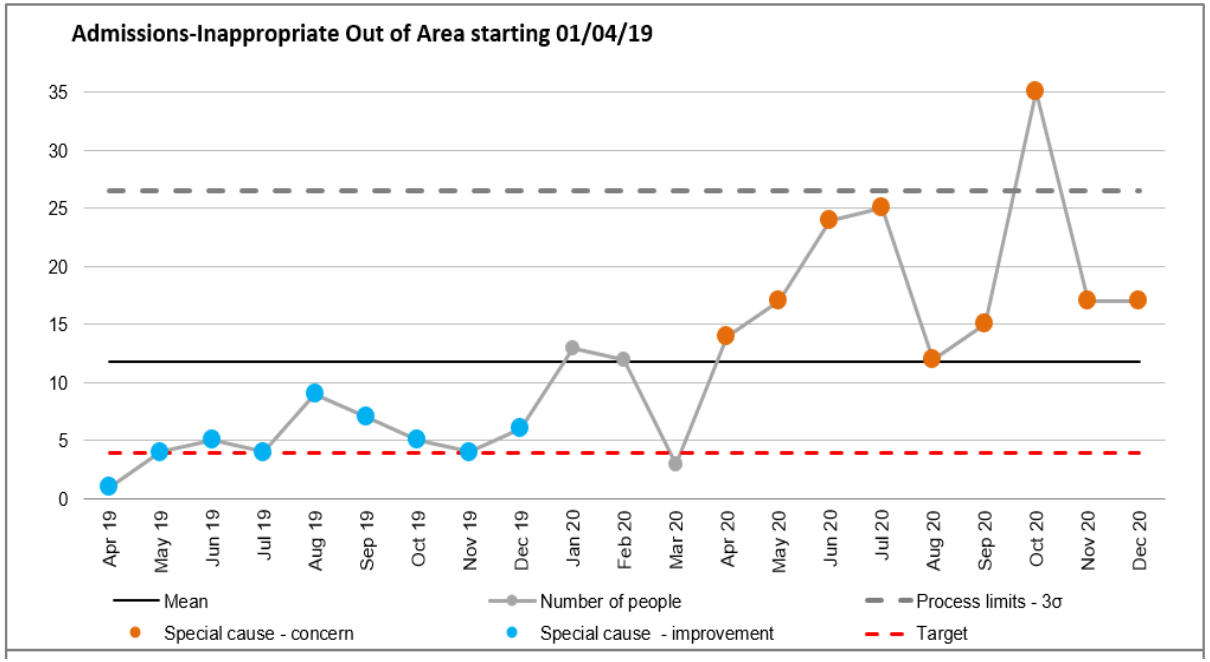


Current pressures – adults

- Contacts **'in crisis' now over 80%** compared to 37% in 2019, with a 45% increase in referrals to Home Treatment Teams, Psychiatric Liaison and intensive support teams

- Increased inpatient admissions and higher average **occupancy rates of over 96+%** are leading to significant increase in Out-of-Area placements. Accommodation is the biggest barrier to discharge with approx. 40% of those medically fit delayed as a result.





Pandemic Impacts

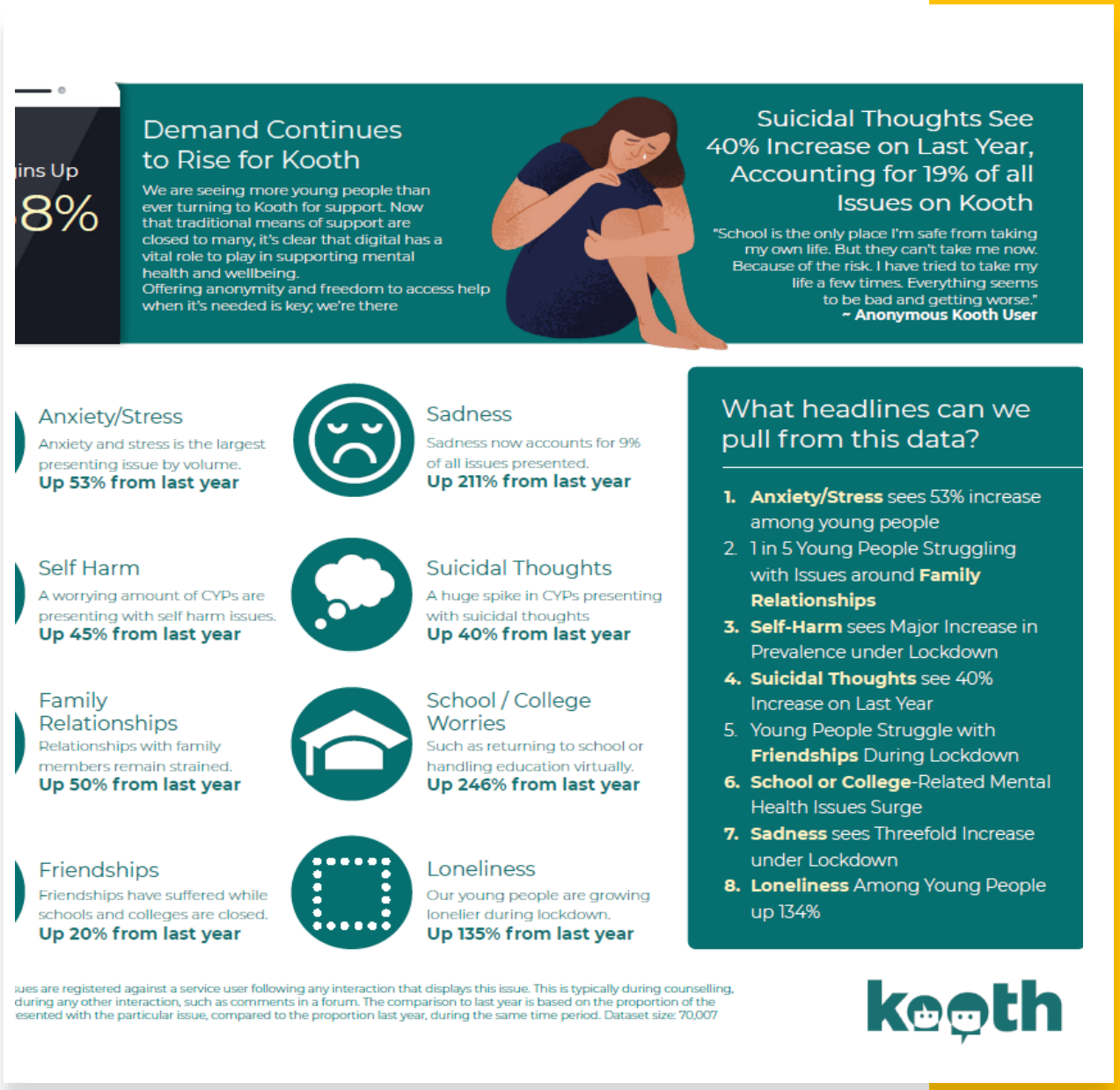
Community Impact Assessment (CIA)

Key concerns from residents

- social isolation due to lockdown (particularly on working-age adults living alone and those in poor health)
- loss of coping mechanisms (e.g. ability to connect with friends and family and taking daily outdoor exercise)
- fear of becoming infected (self and family)
- conflicting information
- ability to access care (patients as well as carers)
- working in frontline

Key findings

- 75% of residents reported lockdown affected their mental wellbeing.
- 52% of 16-25 year-olds and 46% of those in low income (under £25k) households felt more lonely.
- An increase in unhealthy behaviour: smoking (↑38%) drinking (↑35%).
- Increase in number of residents claiming Universal Credit or Job Seekers Allowance by over 300%.



Pandemic impacts - CIA Rapid Needs Assessment

- 69% of adults in the UK report feeling somewhat or very worried about the effects of COVID-19 on their lives
- Both Surrey Drug and Alcohol Care (SDAC) helpline and Community Communications reported an increase in the number of calls and referrals respectively.
- Increase in the presentation of MH related issues were also reported by the local community helplines set up during the lockdown.
- There was also a significant increase in the use of the Emergency MHA (Mental Health Act) Powers. This was demonstrated by an increase in the MHA Detention rate of 37% in 2020 compared to 30% and 31% in previous 2 years.
- Data also shows an upward trend both in the number of people with mental health social care packages and the average cost of the package.
- The mental health burden and the long-term health impacts of job losses will be unequally distributed across society. In addition, older, younger people, homeless, those from BAME groups, people with drug and alcohol dependencies who don't access services under normal circumstances are more likely to have been impacted by further lockdowns.

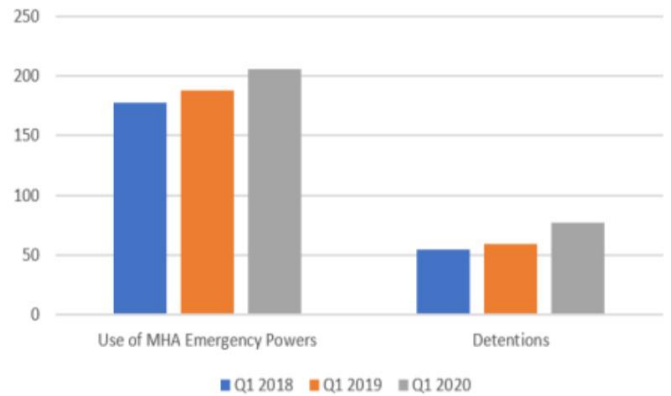


Figure 5A change in use of Emergency MHA and detention rate from 2018 to June 2020

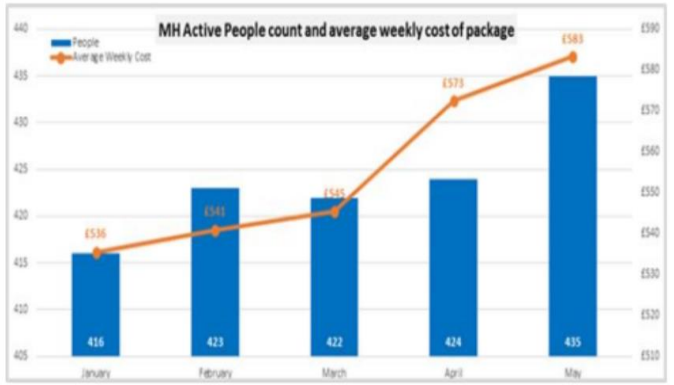


Figure 5B Trend in number of people and average weekly cost of Mental Health package from Jan 2020 to June 2020

Health and Wellbeing Board Paper

1. Reference information

Paper tracking information	
Title:	Empowering Communities
Related Health and Wellbeing Priority:	System Capability – Communities
Author:	Marie Snelling - Executive Director Communities & Transformation (SCC); marie.snelling@surreycc.gov.uk, 07971 664631
Sponsor:	Mr Tim Oliver - HWB Chairman and Leader of Surrey County Council (SCC)
Paper date:	4 March 2021
Related papers	n/a

2. Executive summary

In developing the Surrey Health and Wellbeing Strategy in 2019 we identified the vital role that community engagement and development would play in delivering on our 10-year goals to improve health and wellbeing through a more preventive approach and addressing wider determinants. A range of fantastic community focused initiatives and approaches have since been progressed across our partnership, most notably in the form of the ongoing response to Covid-19. This has given extra energy to our shared ambition to engage with and empower communities, and a number of key opportunities have been identified to build on progress to date. Work is already underway across the partnership to make the most of these opportunities and through the spring and summer we will also create a roadmap for embedding the empowerment of communities into our longer-term efforts to improve health and wellbeing and address health inequalities.

3. Recommendations

It is recommended that the Health and Wellbeing Board:

1. Endorse the renewed ambition to empower communities (see section 5.2).
2. Confirm support for the ongoing work on key opportunities, and highlight any additional suggested areas of focus (see section 5.3).
3. Agree that the Executive Director Communities & Transformation (Surrey County Council) leads and coordinates, on behalf of the wider system, the development of a longer-term roadmap to embed the empowerment of communities at the heart of our efforts to improve health and wellbeing and address health inequalities (see section 5.4).

4. Reason for Recommendations

Work to deepen our engagement with communities and empower them is essential to deliver the long-term goals in the Health and Wellbeing Strategy. There is an important opportunity to build on the closer working between communities and organisations in response to Covid-19 and embed this into our next phase of recovery and transformation.

5. Detail

5.1 Background

In developing the Surrey Health and Wellbeing Strategy in 2019 we identified the vital role that community engagement and development would play in delivering our 10-year goals to improve health and wellbeing.

A range of fantastic community focused initiatives and programmes have since been progressed right across our partnership – these include, but are not restricted to, the examples listed below in figure 1.

Over the last year we have also seen the incredible power of the community response to Covid-19, with thousands of colleagues and volunteers from across our partnership working with and alongside communities to help people be safe, healthy, and well. And we have seen the benefit of using approaches such as the Community Impact Assessment (CIA) to get closer to residents and understand priorities in our local communities.

Figure 1: Examples of community focused initiatives and programmes

- Strength-based practice models in children's and adult social care
- Population Health Management
- Social Prescribing through Primary Care Networks (PCNs)
- The Voluntary, Community and Faith Sector (VCFS) significantly growing the number of active volunteers and connecting them to vital work across all Surrey's communities
- Well North West Surrey initiative
- Community conversations in East Surrey, expanding out from the Healthy Horley initiative
- Work on building health partnerships in Guildford and Waverley
- The Epsom Health & Care @Home service in Surrey Downs
- The Community Deal Programme in Surrey Health and Farnham
- Policing Your Community engagement events by Surrey Police and the Office of the Police and Crime Commissioner
- Your Fund Surrey, a £100m community projects fund from Surrey County Council
- Practices to deepen understanding and amplify community voices (e.g. Surrey Heartlands Citizen Panel, Healthwatch programmes, engagement by district and borough councils)

5.2 Ambition

The ongoing Covid-19 response and planning for recovery has given extra energy to our shared ambition to empower communities. It has brought into even sharper focus the significant potential for us, as a partnership, to:

- deepen community engagement and involvement, making sure we connect with and hear those in our communities we have sometimes struggled to; and

- empower and support individuals, families, and communities to be stronger, more resilient, and more independent - with organisations and services *working alongside*, not *doing to.*

This ambition is informed by our own local experiences in Surrey, and well-established national and international research that demonstrate how community life, social connections and having a voice in local decisions contribute positively to people's health and wellbeing[1], and how empowerment, self-efficacy and resilience act as protective factors[2]. It positions citizens and communities at the centre, with our organisations facilitating and supporting them to lead a good life and be happy and well in communities where social capital is built and social cohesion is strong.

We also know that the cohesion and the safety of communities are closely interrelated and with the Health and Wellbeing Board and Community Safety Board coming together there is a fantastic opportunity to collaborate on this agenda.

5.3 Key opportunities

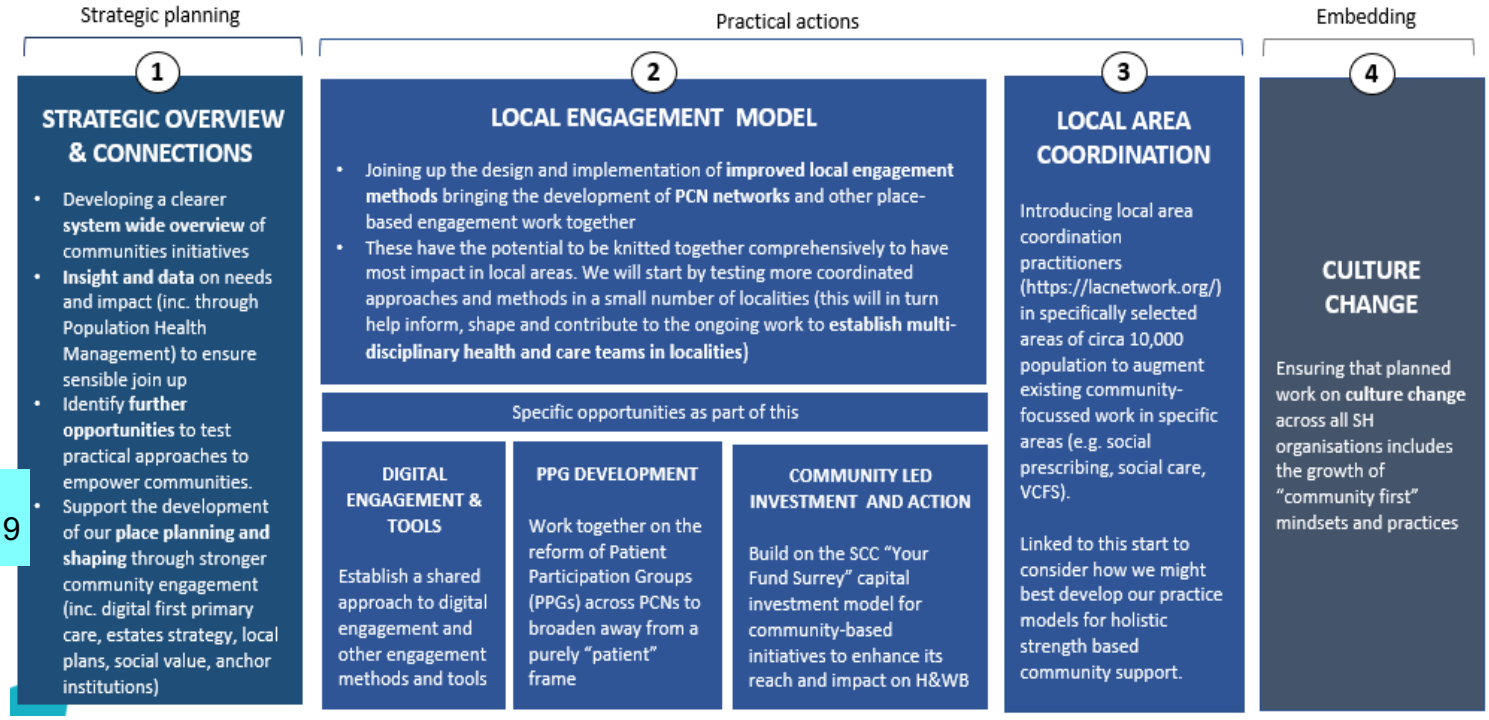
Discussions across the partnership in recent months have identified some key opportunities that can help build on our progress to date (see figure 2 below).

A number of these emerged from the purposeful joining together of the plans to grow Thriving Community Networks developed through the Surrey Heartlands PCNs and Surrey County Council's new strategic commitment to empower communities. This list it is not exclusive and will continue to be developed through partnership discussions.

[1] *A guide to community-centred approaches for health and wellbeing*, Public Health England (2015)

[2] *Psychosocial pathways and health outcomes*, Public Health England (2017)

Figure 2: Key opportunities to support engaged and empowered communities



Taken together these opportunities seek to strike a balance that:

- joins up and adds extra partnership drive to work already underway – for example, bringing additional skills and resources around the Healthy Horley local engagement work led by Dr Gill Orrow;
- introduces some new innovative approaches - for example, the introduction of the local area co-ordination model in specific neighbourhoods to augment existing community and preventive work;
- strengthens our approaches across the full spectrum of participation, from information sharing and consultation through to community-led activity; and
- embeds the mindset, principles, and practices of empowering communities across our wider system, through our strategic planning, major transformation programmes and culture change work.

The current activity underway is resourced primarily through the assignment of existing team members from our organisations, in some cases working together in matrixed project teams. Where additional investments for schemes or initiatives have been required these have been agreed through specific business cases for transformation funding and approved through the appropriate governance routes.

5.4 Longer-term road map

Our ambition to empower communities presents exciting potential implications for the design of our local public services and how we transform to recover from Covid-19, narrow existing and emerging health inequalities, and achieve long lasting improvements in health and wellbeing in Surrey.

We need to plot a course that enables us to genuinely tackle these fundamental challenges through practical action and learning - making a difference on the ground and generating the insight to inform future strategic direction and choices.

Recognising that this is a medium to long term endeavour we plan to develop a longer-term roadmap for empowering communities over the spring and summer. This will also enable us to locate the current work and opportunities more firmly alongside other longer-term system developments. This will be shaped through further joint thinking and planning with system-wide stakeholders, research, and insight from existing engagement work with local communities.

6. Challenges

A key challenge is ensuring we join up efforts to engage with and empower communities across our partnership – and that we are consistently responsive to what we learn. Activities will often be led by specific organisations, but we need to take every opportunity to co-ordinate, make connections and share insights about our communities and places.

Given the broad nature of our goal to empower communities there are multiple connections and interdependencies with other programmes and services across the system. Key programme related interdependencies will be managed through the Surrey Heartlands architecture and appropriate connections will be made within the Frimley Health and Care Partnership through the Community Deal Programme.

7. Timescale and delivery plan

The opportunities and activities underway are running to a variety of timescales but we are currently working to the following broad phases:

- Confirm the renewed ambition and key opportunities (March 2021).
- Progress the key opportunities, ensuring that where we start any new initiatives/programmes delivery plans are in place (April 2021 onwards).
- Develop the longer-term system roadmap for empowering communities (May 2021 - Sept 2021).

8. How is this being communicated?

The ambition and opportunities set out have been developed through a range of partnership conversations to date, including at the following governance groups:

- Surrey Heartlands Primary Care Transformation Board
- Surrey Heartlands Recovery Workstream 8
- Surrey Chief Executives
- Surrey Charities Forum

Further discussions will take place with other key partners and stakeholders as part of developing the longer-term roadmap. We will also complete some specific targeted research to better understand resident and community views on our engagement methods and approaches.

9. Next steps

- Continue to progress the key opportunities to engage and empower communities through partnership conversations and action.

- Complete further engagement with partners and stakeholders to develop a longer-term roadmap for empowering communities and present this to the Health and Wellbeing Board in early Autumn 2021.

Health and Wellbeing Board Paper

1. Reference information

Paper tracking information	
Title:	Surrey Pharmaceutical Needs Assessment Supplementary Statement 2021
Related Health and Wellbeing Priority:	Statutory responsibility of the Health and Wellbeing Board
Authors:	Authors: Rachel Abbey, Lynne Sawyer, Public Health Analysts (SCC) Reviewer and Approver: Dr Naheed Rana, Consultant in Public Health (SCC)
Sponsor:	Ruth Hutchinson, Director of Public Health (SCC)
Paper date:	4 March 2021
Related papers	Annex 1: Surrey Pharmaceutical Needs Assessment: Supplementary Statement – March 2021 2018 Pharmaceutical Needs Assessment (PNA) and 2020 PNA Supplementary statement (Available on www.surrey-i.gov.uk)

2. Executive summary

The Surrey Health and Wellbeing Board (HWB) has a statutory responsibility to deliver a Pharmaceutical Needs Assessment (PNA) every three years. The PNA was delayed from 2020 to 2021 due to resources being diverted to the Covid-19 pandemic. The full Surrey PNA was last published in March 2018. This is regularly supplemented by the PNA Steering Group which reviews changes to the local population and local services annually to ensure that no substantive changes to the Pharmaceutical Needs Assessment are required. The attached report (Annex 1) provides a supplementary statement to the 2021 Pharmaceutical Needs Assessment which reports no substantive changes are required to the findings of the 2018 Pharmaceutical Needs Assessment.

3. Recommendations

1. The Board is asked to approve the 2021 Pharmaceutical Needs Assessment Supplementary Statement, on the advice of the Pharmaceutical Needs Assessment Steering Group.
2. The Board is asked to publish the approved Supplementary Statement on surrey-i.gov.uk and surreycc.gov.uk by 31 March 2021.

4. Reason for Recommendations

The Surrey Pharmaceutical Needs Assessment Steering Group has met to discuss findings in the 2021 Pharmaceutical Needs Assessment Supplementary Statement and have agreed the supplementary statement for approval and publication by the Health and Wellbeing Board.

5. Detail

Policy and Governance Framework
Health and Wellbeing Boards were given responsibility from 2013 for delivering a Pharmaceutical Needs Assessment (PNA) for their area. The PNA determines the local need

for pharmaceutical services. The PNA is used principally to inform decisions on whether to allow new pharmaceutical services in a given area (a process called market entry) based on that need. NHS England is responsible for those commissioning decisions. The Surrey PNA, which uses Integrated Care Partnership geographies, can also be used to support the work of local clinical commissioning groups around primary care, the management of long-term conditions, and urgent and emergency care.

The 2013 NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations set out the legislative basis for developing and updating PNAs. HWBs are required to publish a revised assessment every 3 years. Following the introduction of these regulations in Surrey, the first PNA was published in Surrey in March 2015 and the second in March 2018, the next full PNA was due to be published by April 2021. In 2020 it was agreed to implement a 1-year delay in the PNA (delayed until 2022) due to Covid-19 response.

Pending the publication of the 2022 Pharmaceutical Needs Assessment, the HWB may publish a supplementary statement explaining changes to the availability of pharmaceutical services relevant to the granting of applications and where the HWB is satisfied that making a revised statement would be a disproportionate response to those changes. The 2021 supplementary statement is expected to become part of the 2022 PNA. In Surrey, we review the PNA annually to determine if a full revision is required and, if not, publish a supplementary statement.

The Surrey HWB delegated responsibility for delivering the Surrey Pharmaceutical Needs Assessment (PNA) to the PNA Steering Group, now chaired by Dr Naheed Rana, Public Health Consultant.

The responsibilities of the PNA Steering Group are:

a) Ensure the PNA project objectives are clear, defined in the PNA Project Initiation Document (PID), for the initial PNA and PNA revisions
b) Provide executive approval and sign-off of high-level project documentation and plans for the PNA project
c) Agree quality criteria for all aspects of the PNA project
d) Undertake executive reviews of the performance and monitor progress against plans for the PNA project
e) Ensure the business, executive, clinical, user and technical perspectives are fully represented
f) Resolve any conflicts between business, clinical, user and technical requirements, priorities and preferences
g) Ensure the final products shown in the PID are delivered on schedule.
h) Make recommendations as to agreed tolerances (with respect to time and scope) and at-risk activities
i) Endorse sign off for each project stage and authorise continuation to the next stage as stated in the PNA PID and timeline.
j) Ensure all relevant guidance and policies are followed, and ensure probity at all times
k) Ensure the PNA is utilised to influence commissioning
l) Communicate with key stakeholders about the PNA

2021 PNA Supplementary Statement

The PNA Steering Group met on 29th January 2021 to review changes to the local population and to pharmaceutical provision since the publication of the Surrey PNA 2018 and the 2019 and 2020 Supplementary Statement.

The Steering Group agreed that the changes to demographic need and pharmaceutical provision were minimal and that the supplementary statement outlining identified changes was sufficient until work on the full 2022 PNA commences. The attached 2021 PNA Supplementary Statement details the changes to pharmacy provision and services and the conclusion reached.

2022 full PNA

Planning for the next full PNA has started; this will be published by 1st April 2022. Discussions are being held with representatives of the healthcare system, including members of the Primary Care Transformation Board, to consider how the PNA could support the aims of the NHS Long Term Plan and the primary care transformation in Surrey. Discussions with planning officers in the local District and Boroughs will also be used to inform how the PNA process can be utilised to support the planning of pharmacy provision for future large-scale housing developments within Surrey.

6. Challenges

The process for determining the PNA Supplementary Statement is robust and therefore risks are minimal for this part of the process.

There remains one issue to be resolved as part of the 2022 PNA; this relates to challenge between the way in which planning takes account of the need for health infrastructure, especially in new large-scale housing developments (needs based on future build) and the way in which the PNA determines the need for market entry for community pharmacies (need for the current population). One additional challenge to delivery of the 2022 PNA is to secure the required data from stakeholders in a timely way.

7. Timescale and delivery plan

An outline plan for delivery of the 2022 PNA has been developed and will be refined based on discussions with local health and care partners. The draft report should be completed by September 2021 with consultation on the report taking place in October and November 2021. Further redrafting required from the feedback received will take place in December 2021 under the guidance of the PNA Steering Group. The final 2022 PNA report is due for completion in January 2022. This final report will be submitted to the HWB for approval by March 2022.

8. How is this being communicated?

The Health and Wellbeing Board Communications Group have been advised of the consultation related to the 2022 PNA.

9. Next steps

If the Health and Wellbeing Board approves the 2021 Supplementary Statement, it will be published by 31 March on surreycc.gov.uk and surreyi.gov.uk websites.

The PNA Steering Group will meet at critical points in the delivery of the 2022 PNA to approve actions to date and escalate any issues. An in-year PNA progress report can be provided to the HWB, if required.

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Surrey Pharmaceutical Needs Assessment: Supplementary Statement – March 2021

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Version 07

SURREY COUNTY COUNCIL

Table 1 Record of timeline for approvals

Version	Date	Comment
0.1	21.1.2021	First Draft
0.2	29.01.2021	Draft Supplementary Statement – Rachel Abbey & Lynne Sawyer (PHIIT Team)
0.3	31.01.2021	Revised following comments from PNA Steering Group – Rachel Abbey & Lynne Sawyer
0.4	03.02.2021	Reviewed and approved by Dr Naheed Rana, Consultant in Public Health
0.5	04.02.2021	Revised and approved by Public Health Leadership Team
0.6	12.02.2021	Revised following comments from Leadership Team – Rachel Abbey & Lynne Sawyer
0.7	12.02.2021	Approved by Surrey PNA Steering Group
0.8	04.03.2021	Approved by HWB

PHARMACEUTICAL NEEDS ASSESSMENT
SUPPLEMENTARY STATEMENT

This supplementary statement:

- has been prepared by the Public Health team at Surrey County Council, in collaboration with the Pharmaceutical Needs Assessment (PNA) Steering Group on behalf of the Surrey Health and Wellbeing Board;
- is issued in accordance with Part 2; (6) 3 of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013[1];
- provides updates to the PNA published in March 2018[2] and the PNA Supplementary Statement published in March 2020[3];
- provides information which supersedes some of the original PNA information, so should be read in conjunction with the original PNA and supplementary statement; and
- relates to changes in population and pharmacy provision between the end of data collection for the 2018 PNA and 2020 Supplementary Statement, that is, January 2020 to December 2020.

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Members of the PNA Steering Group include:

- Tacye Connolly, Healthwatch Surrey
- Hinal Patel, Service Development and support pharmacist
- Amanda Marshall, Pharmacy & Optometry Commissioning Manager, NHS England and NHS Improvement – South East Region
- New Post, Senior Commissioning Manager (Pharmacy and Optometry), NHS England and NHS Improvement – South East Region
- Karthiga Gengatharan, Surrey and Sussex Local Medical Committee
- Rachel MacKay, Associate Director of Medicines Management, Guildford and Waverley Clinical Commissioning Group
- Chief Executive Officer, Surrey and Sussex Community Pharmacy, representing the Surrey and Sussex Local Pharmaceutical Committee
- Dr Naheed Rana, Public Health Consultant, Surrey County Council (Chair)
- Supported by Lynne Sawyer, Public Health Analyst, Surrey County Council.
- Rachel Abbey, Advanced Public Health Analyst, Surrey County Council

The Surrey Pharmaceutical Needs Assessment 2018 (2018 PNA) and subsequent 2020 Supplementary Statement identified no additional needs for the provision of necessary, essential or advanced pharmaceutical services. This 2021 supplementary statement serves as an update for current service provision and a review of findings. A full PNA revision will be published prior to the 1st April 2022, in line with National Guidance.

[1] http://www.legislation.gov.uk/uksi/2013/349/regulation/6/made
[2] Surrey Pharmaceutical Needs Assessment 2018
[3] PNA_Supplementary_Statement_March 2020_Final.pdf

Executive Summary

The 2021 Supplementary Statement for the Pharmaceutical Needs Assessment (PNA) has been prepared by the Public Health team at Surrey County Council, in collaboration with the PNA Steering Group on behalf of the Surrey Health and Wellbeing Board. The statement serves as an update to the 2018 PNA[4] and the 2020 PNA Supplementary Statement[5]. The information within this statement predominantly relates to changes in demand for pharmacy services based on population projections for Surrey. Changes in service coverage by geographical area are also assessed via a provisional analysis of the impact of pharmacy closures, relocations, and mergers that took place over 2020.

The PNA Steering Committee noted a number of large housing developments planned in Surrey over the course of the coming decade, particularly in Epsom and Ewell, Guildford and Mole Valley. Once complete, the additional populations these developments will mean that additional pharmacies are required in order to maintain coverage in pharmacy services. However, at the present stage of development and planning, additional pharmacies are not yet required in the identified areas. It is noted that the ceiling for triggering additional pharmacies is at present based largely on assumptions and that a more specific, objective criteria will be required for future assessments.

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Interventions under Covid-19 were recognised to cause significant disruption to council funded services commissioned to community pharmacies. The national lockdown led to enforced reductions in mobility disrupting some services requiring face-to-face contact. Further changes resulted from the initiation of emergency hours and the need to work behind closed doors to implement sanitation measures whilst facilitating service provision. These factors predominantly affected services with low coverage such as NHS health checks alongside uptake for supervised consumption. The impacts from reductions in contact services were to some extent mitigated by the greater use of telephone consultations and amendment of scheduled pick-ups. Due to the factors outlined, it was similarly noted that the presence of Covid-19 interventions had put on hold the implementation of the new pharmaceutical services contract to include *hepatitis C* checks and emergency services related to NHS 111. A further risk to service provision in the coming year is the Brexit Agreement via disruption to supply and oversight.

The current assessment concludes that no new pharmacies/ pharmaceutical services are required at present, this decision was taken in recognition of the increasing role of online services and telephone consultations. However, it has been agreed by the PNA Steering Group that an in-depth assessment into the impact of these trends on health inequalities and service access for more vulnerable populations will be undertaken as part of the complete 2022 Pharmaceutical Needs Assessment.

[4] Surrey Pharmaceutical Needs Assessment 2018

[5] PNA_Supplementary_Statement_March 2020_Final.pdf

Assessment of additional coverage: Population Projections

Projection of population coverage against demand for compounding pharmacies[6]

The provisional assessment of housing constrained population projections[7] has been undertaken utilising data provided the Planning Departments in each district and borough. This assessment has not identified any major changes to demography or infrastructure that is likely to affect the level of demand for pharmaceutical services. The districts and boroughs where there are plans for the highest number of additional dwellings are Guildford (planned 937 dwellings per year until 2036), Mole Valley (636 per year over 2022-2034), and Epsom and Ewell (577 per year until 2037).

Projection of population coverage against demand for Community Pharmacies

Utilising the same datasets from district and borough Planning Departments, a provisional assessment was completed into the potential impact of proposed housing developments classified as large (greater than 1,500 houses). Large housing developments were identified as a future potential risk on the demand for community pharmacies in the boroughs Guildford, Waverly, Runnymede, and Reigate and Banstead.

- Guildford and Waverley Borough Councils have significant housing developments planned, which on completion will provide 5,600 and 2,600 units respectively.
- Mole Valley Borough Council has submitted a draft proposal for 7,000 dwellings
- Tandridge are proposing future developments of approximately 4,000 dwellings in South Godstone.

However, given the moderate proportion of dwellings completed to date, these developments do not yet warrant the opening of another community pharmacy. As part of the 2022 Pharmaceutical Needs Assessment, Surrey Council will engage with planners in local districts and boroughs to further assess demand within the identified developments (see Appendix A).

Assessment of existing coverage

The rate of pharmacies per every 100,000 people is used to assess existing coverage. The rate for pharmaceutical service coverage in Surrey is below England's average by a difference of 1 pharmacy for every 100,000 people (this equates to a difference of 12 pharmacies against total Surrey's population of approximately 1.2 million[8]). The rate for Surrey has increased since the 2018 PNA. However, this increase has not been even across the county with the rate of service coverage witnessing reductions in several districts/ boroughs. The districts/boroughs of Guildford, Runnymede, and Epsom and Ewell have the lowest rates of service coverage (see Table 2). Please refer to Appendix B for an assessment of coverage by CCG.

It is important to note that there has been a shift towards online pharmacy service provision; this creates opportunities and there will be associated risks for individuals who are more isolated, less mobile and/or digitally aware. An in-depth analysis of online pharmacy provision will be undertaken as part of the full 2022 Pharmaceutical Needs Assessment.

[6] Pharmacies based in clinical or residential settings

[7] Housing constrained population forecasts are based on assumptions similar to the ONS subnational population projections which take into account births, deaths and inward and outward migration. Housing constrained population forecasts also considers data from local boroughs on the availability of housing stock. Local data is available at Surrey Housing constrained population projections

[8] Surreyi, accessed 02 February 2021: https://www.surreyi.gov.uk/jsna/surrey-context/

Table 2 The number of pharmacies per 100,000 people in Surrey[9]

Area	All Community Pharmacies[10]	Population[11]	2020 Rate of pharmacies per 100,000 people	2018 rate of pharmacies per 100,000 people
England (2019)	11, 700	66,796,800	18	21
Surrey County	204	1,196,236	17	18
Elmbridge	30	136,795	22	24
Epsom & Ewell	11	80,627	14	18
Guildford	18	148,998	12	14
Mole Valley	15	87,245	17	16
Reigate & Banstead	26	148,748	17	19
Runnymede	12	89,424	13	15
Spelthorne	21	99,844	21	23
Surrey Heath	18	89,305	20	18
Tandridge	14	88,129	16	16
Waverley	25	126,328	20	20
Woking	15	100,793	15	15

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Service Provision

The changes in service provision since the 2018 PNA, are detailed in Tables 5-9 and shown on the map in Appendix C. The tables show that there were no new pharmacy contracts provided from January to December 2020. Six community pharmacies closed over the same period; these closures were found to be located close to alternative sites. Following an assessment of coverage by population, it was concluded that the 6 identified closures have not left clear gaps in service coverage.

Table 3 Changes to pharmaceutical contracts (hours, ownership, closures)

Type of Change	Pharmacies affected by change
Change of Core hours	2
Change of Ownership	5
Change of Supplementary hours	11
New Pharmacy Contract	0
Pharmacy Closures (community)	6
Pharmacy Merger (resulting in one closure)	1
Relocation (inc. 1 distance appliance contractor)	3

[9] Table 1 includes pharmacies in the Surrey HWB area (distance-selling or appliances are excluded)
[10] NHSE, 2020, No. of Pharmacies
[11] ONS (2019) Small Area Population Estimates

Core opening hours[12]

Pharmacies can apply to NHS England to make changes to their core opening hours or to notify them of changes to additional supplementary hours[13]. There have been two changes to core opening hours since the publication of the 2020 PNA Supplementary Statement (see table 3). There have also been 11 changes to pharmacy opening hours. All data in this section is taken from www.nhs.uk.

Table 4 Changes to Core Opening Hours[14]

Please note all pharmacies listed were operating on 40-hour contracts.

Name	Location	Core Opening Hours	Previous Core Opening Hours
Trio Pharmacy	19-21 High Street Farnham Surrey, GU9 7PB	Mon-Fri: 09:00-13:00 14:00 -17:30 Sat: 09:00 -12:00	Mon-Fri: 08:30-13:00 14:00-17:30 Sat: 08:30-13:00 14:00-17:30
Lightwater Pharmacy	48 Guildford Road Lightwater Surrey, GU18 5SD	Mon-Fri: 09:00-13:00 14:00-18:00 Sat: 09:00-12:00	Mon-Fri: 09:00-17:00 Sat: Closed

Table 5 Changes of ownership

Ownership Change	Change Registered	Location	Core Hours	Opening Hours (inc. Supplementary Hours)
Chobham Pharmacy *Former name:* *Lloyds Pharmacy*	02/01/2020	18 Windsor Road Chobham Surrey, GU24 8LA	Mon-Thu: 09:00 - 13:00 15:30 -18:30 Fri: 09:00 -13:00 14:30 - 18:30 Sat: 09:00 -13:00	Mon-Fri: 09:00 -13:00 14:00 -18:30 Sat: 09:00 -13:00
VSM Pharmacy *Former name:* *V S Mithani*	01/04/2020	124 Frimley Road Camberley Surrey, GU15 2QN	Mon-Fri: 09:00 – 13:00 14:00- 18:00 Sat: Closed	Mon-Fri: 09:00 -18:00 Sat: Closed
Boots the Chemist *Former name:* *Millman Pharmacy*	30/10/2020	57 High Street Egham Surrey, TW20 9EX	Mon-Fri: 09:00-13:00, 13:30-17:30 Sat: Closed	Mon-Sat: 08:00-18:00 Sun: 11:00-17:00
Kamsons Pharmacy *Former name:* *Lloyds Pharmacy*	01/12/2020	Catershall Mill Cattershall Road Godalming Surrey, GU7 1NJ	Mon-Sat: 08:30-19:00	Mon: 08:30 -11:00 16:00 -17:00 Tue-Fri: 08:30 -11:00 16:00 -19:00 Sat: 08:30 - 17:00

[12] All data on this section is extracted from NHSE (accessed December 2020)
[13] Supplementary hours are additional to the core hours
[14] Core hours are the minimum contracted hours (a contract can be 30, 40, or 100 hours)

Boots the Chemist *Former name:* *Lloyds Pharmacy*	08/12/2020	4 Aldershot Road Guildford Surrey, GU2 8AF	Mon-Fri: 09:00-13:00 13:30-17:30 Sat: Closed	Mon-Tues:08:30-18:00 Wed: 08:30-18:30 Thu-Fri: 08:30-18:00 Sat: 08:30-13:00

Table 6 Pharmacy Closures

Please note all pharmacies listed were operating on 40-hour contracts.

Name	Date of Closure	Location	Core Opening Hours	Opening Hours (inc. Supplementary Hours)
Boots the Chemist	08/02/2020	33 Station Road Redhill Surrey RH1 1PQ	Mon-Fri: 09:00-13:00 14:00-18:00 Sat: 09:00-13:00 13:30-17:00	Mon-Fri: 09:00-13:00 14:00-18:00 Sat: 09:00-13:00 13:30-17:00
Lloyds Pharmacy	23/02/2019	The Old Cottage Alexandra Road Epsom Surrey KT17 4BL	Mon-Tue: 08:30-12.00 15:00-19.00 Wed: 08:30 - 12:30 15:00 - 19:00 Thu-Fri: 08:30-12.30 15:00-19.00 Sat: 08:30-13:00	Mon-Fri: 08:30 -19:00 Sat: 09:00-13:00
Lloyds Pharmacy	09/03/2020	1 & 2 London Buildings High Street Ripley Surrey GU23 6AA	Mon-Thu: 09:00-12:00 15:00- 18:00 Fri: 09:00- 13:00 14:00- 18:00 Sat: 09:00- 17:00	Mon-Fri: 09:00-18:00 Sat: 09:00-17:00
Woodhatch Pharmacy	24/07/2020	5 Prices Lane Reigate Surrey RH2 8BB	Mon - Fri: 09:00 - 17:00 Sat: Closed	Mon - Sat: 09:00-17:30
Lloyds Pharmacy	28/10/2020	22 Church Street Weybridge Surrey KT13 8DW	Mon- Tue: 08:30-12.00 15:30-19.00 Wed: 08:30-12.30 15:00-19.00 Thu- Fri: 08:30-12.00 15:30-19.00 Sat 09:00-13:00	Mon-Fri: 08:30 -19:00 Sat: 09:00 -13:00
Lloyds Pharmacy	28/10/2020	96 Victoria Road Horley Surrey RH6 7AB	Mon-Fri: 10:00-15:30 17.00 - 18:00 Sat: 10:00 -17:30 Sun: Closed	Mon-Fri: 08:30 -19:00 Sat: 08:30 -17:30 Sun: 10:00 - 16:00

Table 7 Mergers

Please note all pharmacies listed were operating on 40-hour contracts.

Name	Location	Core Opening Hours	Opening Hours (inc. Supplementary Hours)
Woodhatch Pharmacy (Closed see closure table 8) *(merged with Townsend Chemist)*	5 Prices Lane Reigate Surrey, RH2 8BB	Mon-Fri: 09:00-17:00 Sat: Closed	Mon-Sat: 09:00-17:30
Townsend Chemist	1 Western Parade Woodhatch Reigate Surrey RH2 8AU	Mon-Fri: 09:00-17:00 Sat: Closed	Mon-Fri: 09:00-18:00 Sat: 09:00-13:00

Table 8 Relocations

Please note all pharmacies listed are operating on 40-hour contracts unless stated otherwise.

Pharmacy	Date of Relocation	New Location	Old Location
Millman Pharmacy	01/08/2020	57 High Street Egham Surrey, TW20 9EX	56 High Street Egham Surrey, TW20 9EX
Charles S Bullen Stomacare Ltd ***Distance Selling***	01/10/2020	8 Farnham Business Park Farnham Godalming Surrey, GU7 7AL	8a Farncombe Street Farncombe Godalming Surrey, GU7 3AY
Boots the Chemists	02/12/2020	8-10 Wolsey Walk Woking Surrey, GU21 6XX	Unit 24-26 Bandstand Mall Peacock Centre Woking Surrey, GU21 6GB

The Impact of Covid-19 and associated interventions on pharmaceutical services

There is clear evidence that pharmaceutical services were significantly impacted by the Covid-19 pandemic over March 2020 to December 2020. The reasons for this impact are:

- Rules around social distancing leading to a reduction in health checks, screenings, sexual health services, and needle syringe programme activities.
- The implementation of emergency hours with a number of pharmacies reducing their opening hours.
- Increased demand for repeat prescription services as other dispensing facilities reduced and/or were diverted to other priority areas.

Emergency Hours

During the pandemic, contractors have been able to apply for the flexible provision of hours or services to assist them to manage their workload and pressures; this is in accordance with the emergency provisions of the NHS (Pharmaceutical and Local Pharmaceutical Service) Regulations 2013. As part of emergency provisions, dispensations have the option of working behind closed doors for a maximum of 2.5 hours per day. Applications for the implementation of emergency hours are documented in Table 3 with data provided by NHS England & Improvement.

Table 9 Pharmacies that applied for emergency hours during Covid-19 over 2020

Lockdown	Changed opening hours	Work behind closed doors
April/May 2020	13	17
Nov-Dec 2020	4	0

The Impact of Covid-19 on Locally Commissioned Services through Community Pharmacies

There are range of services commissioned locally by Surrey County Council through community pharmacies, many of which were impacted by the Covid-19 pandemic. Due to the national lockdown, reductions in pharmacy activity and service use during this period are more a reflection of decreases in demand rather than gaps in service coverage. There were also disruptions to in-person services requiring a longer contact period such as NHS Health Checks[15]. In order to counter these service disruptions, there have been amendments in how services are provided resulting in the greater use of telephone consultations (where appropriate) to ensure that services can be safely maintained.

As seen from Table 4, the largest reduction was seen in the use of Supervised Consumption services. Despite this reduction in the number of service visits, stakeholders collectively worked together to ensure the supply of medicines was maintained to all clients. Clients were reviewed against clinical safety and a risk assessment completed with pick-up schedules altered accordingly (these were mainly reduced where it was clinically safe to do so). The reduction in this service use recorded by the number of visits to pharmacies therefore reflects the alteration in the frequency of pick-ups rather than treatment provision.

Table 10 Comparison of Active Service Providers from 2019 to 2020

Activity	Providers	2019		2020		% change
		Active	%	Active	%	
Needle Syringe	53	40	75	36	68	-4
Supervised consumption	130	74	57	57	44	-17
Blood Pressure	27	23	85	24	89	1
Contraception	115	57	50	63	55	6
Chlamydia	77	22	29	19	25	-3
Health Checks	39	16	41	13	33	-3

[15] NHS health checks predominantly provide routine screenings for people aged 40-74 years. Pre-existing conditions covered by health checks include diabetes, high blood pressure, heart disease, high cholesterol, liver disease, kidney disease, dementia, stroke, atrial fibrillation, transient ischemic attack, heart failure, peripheral arterial disease, and the risk of cardiovascular disease.

The potential impact of Brexit on pharmaceutical coverage[16]

It should be noted that it is expected that the impact of the Brexit deal which came into effect at the end of 2020 is expected to affected pharmaceutical supplies, costing, and regulations. The full PNA revision will assess the impact of Brexit (due to be published prior to 1st April 2022).

New Community Pharmacy Contract

In July 2019, the Pharmaceutical Services Negotiating Committee (PSNC) who represent community pharmacies, NHS England & NHS Improvement (NHS E&I) and the Department of Health and Social Care (DHSC) agreed to a five-year contractual framework deal for community pharmacies[17]. This deal guarantees funding levels until 2023/24 and provides guidance to pharmacies on providing: new services for disease prevention, urgent care services; support to patients leaving hospital, and to help patients avoid unnecessary visits to GPs and hospitals. The change brought under this framework from 1 October 2019 are outlined:

New national services

In 2019/20, community pharmacies were commissioned to provide two new services:

- *The Community Pharmacist Consultation Service (CPCS):* This service is designed to relieve pressure on the wider NHS by connecting patients with community pharmacies as a first point of contact for minor illness or for the urgent supply of medicines where it has previously been prescribed to the patient. The service will take referrals from NHS 111 alongside referrals from other settings, such as GP practices in future years.
- *Hepatitis C testing:* Pharmacies will offer testing for people under the pharmacy needle and syringe programme to support the elimination of Hepatitis C at the national level.

Changes to existing services

To open capacity for new services, the NHS is decommissioning the Medicines Use Review (MUR) service. Previously undertaken by community pharmacies, this service is being phased out. Pharmacies will be able to offer a limited number of MURs until 2020/21. However, there will also be an extension in the outreach of the six mandated public health campaigns that community pharmacies undertake; many community pharmacies may choose to take part in the Pharmacy Quality Scheme (PQS). From April 2020, all pharmacies will further be required to be able to process electronic prescriptions and to have attained Healthy Living Pharmacy (HLP) Level 1 status. Accreditation as an HLP enable pharmacies to be recognised as local hubs for health promotion, wellbeing, and self-care, and in providing services to prevent ill-health.

Structural changes

HM Government has committed to ensuring that technology can transform the supply of medicines and the delivery of pharmaceutical services. This will include exploring means to improve the efficiency of dispensing to free up the capacity of pharmacists.

Conclusion

The number of pharmacy closures documented, are not deemed sufficient at this stage to warrant a need for new community pharmacy. This conclusion is based on the assessment of proposed housing developments utilised as a proxy for population projections against the timeline for these projects (continuing into 2030). Changes to local service provision, are also not sufficient to create the need for a new community pharmacy. This decision was reached taking into account the timeline for proposed large housing developments (again continuing into 2030) and rate of pharmacists per 100,000 people. However, it should be noted that analysis at the district and borough level (as opposed to CCG) suggests a more in-depth review of coverage by local authority is required for the full 2022 Pharmaceutical Needs Assessment

[16] Community Pharmacy, the UK-EU Trade deal and the end of the Transition Period: PSNC Main site

[17] https://www.gov.uk/government/publications/community-pharmacy-contractual-framework-2019-to-2024

with oversight from key stakeholders. As stated, decisions on what constitutes adequate coverage (service cover rate per 100,000) are at present based largely on judgement and it is recommended that a more transparent criteria be set and agreed with the HWB.

It was concluded that Covid-19 is likely to have had a disproportionate impact on individuals in some population groups and geographical areas. This conclusion was reached in light of the increasing role of digital services and telephone consultations in service provision and access. The recognition of this factor reinforces the importance of tackling underlying health inequalities, as set out in the out in the NHS Long Term Plan and Health and Wellbeing Strategy. As part of the full 2022 Pharmaceutical Needs Assessment, there will be an in-depth review of Covid-19 interventions and their associated impact on health inequalities focusing on the assessment of access to pharmacy service provision. This has been planned in light of the wider trend towards the use of digital services and the recognition of the need to better the associated opportunities and risks this carries for more isolated, less mobile and/or digitally aware population groups.

The 2022 Pharmaceutical Needs Assessment will review pharmacy provision in further detail; this is due to be published by 1st April 2022.

10

Appendix A – Large Housing Developments

**Large scale developments = 1,500 to 2,000+ planned dwellings

District/ Borough	Status	Period	Number of dwellings	Area *(large developments only)*
Elmbridge	Confirmed	2020-N/A	Below threshold	
Epsom and Ewell	Planning	2020-2037	577 p/year (total 9,809)	
Guildford	Confirmed	2020-2036	**937 p/yr (total 15,000)**	*Site A24: Weyside urban village: 1,500 homes* *Site A25: Gosden Hill Farm: 1,700 homes* *Site A26: Blackwell Farm: 1,800 homes Site A31 Ash and Tongham: urban extension is allocated for 1,700 homes.* *Site A35 Former Wisley Airfield: 2,000 dwellings*
Mole Valley	Planning	2022-2034	636 p/yr (total 7,000)	
Reigate and Banstead	Confirmed	2020-2034	108 p/yr (1,510) (820 complete by 2020)	*Site Meath Green, Horley - 1,510 dwellings*
Runneymede	Confirmed	2020-N/A	2,902 planned (2,300 complete by 2020)	*Site: Addlestone – 1,265 dwellings* *Site: Chertsey – 2,212 dwellings* *Site Egham - 951 dwellings,* *Proposed new "Garden Village" settlement of 1,746 dwellings at Longcross, Chertsey to include C2 accommodation and travelling show person plots.*
Spelthorne	Confirmed	2020-N/A	Below threshold	
Reigate and Banstead	Confirmed	2020-2034	316 p/yr (total 4,428) (1,746 more proposed)	
Surrey Heath	Provisional planning permission	2020-NA	1,200	*Phase 1: 2019-2024, 300 units* *Phase 2: 2025-2029, 450 units* *Phase 3: 2030-2034, 448 units*
Tandridge	Unknown	2020-2028 From 2026	500 p/yr (total 4,000)	*South Godstone*
Waverly	Provisional	2020-2032	383 p/yr (total 4,600)	*Dunsfield Aerodrome* *Dunsfield Park* *Phase 1 2017-2022, 273 units* *Phase 2 2022-2027 1,285 units* *Phase 3 2027-2032 1,042 units* *2,000 dwellings at Dunsfold Park, Stovolds Hill, Cranleigh* *Phase 1 2020-2025, 225 units.*
Woking	Confirmed		Below threshold	

10

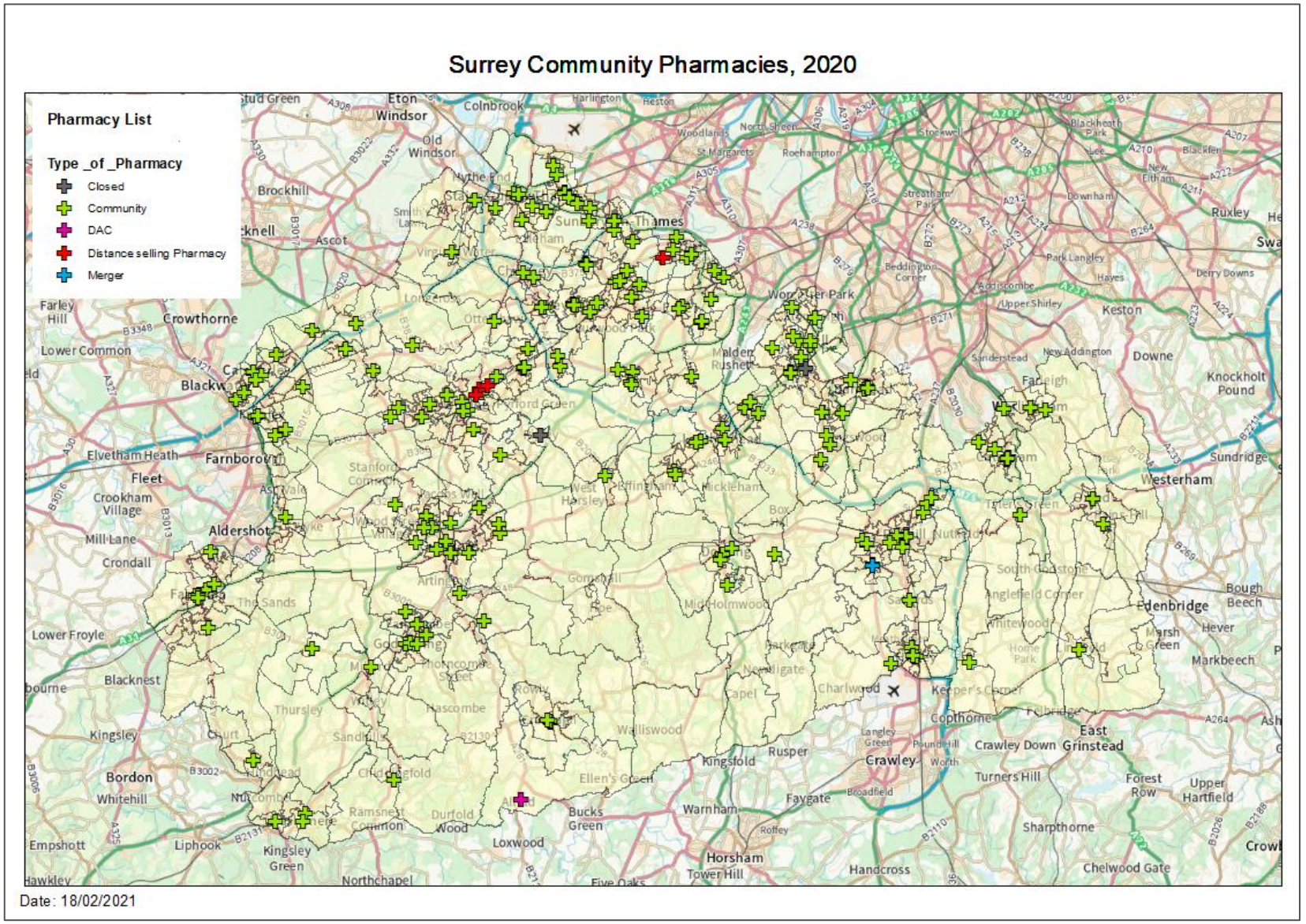
Appendix B - Pharmacies per 100,000 population by CCG

It should be noted that whilst the rate of pharmaceutical coverage for East Berkshire appears low, the population in this area are covered by pharmacies in Bracknell situated on the fringe of this area (see map in Appendix C).

Area (CCG)	All Community Pharmacies[6]	Population[7]	2020	2018
			Ratio (pharmacies per 100,000 pop)	Ratio (pharmacies per 100,000 pop)
England (2019)	11, 700	66,796,800	18	21
Surrey County	204	1,138,920	18	18
East Berkshire	1	13,191	8	9
East Surrey	30	187,795	17	18
Guildford & Waverley	35	210,958	18	18
North East Hampshire & Farnham*	7	44,125	16	16
North West Surrey	62	350,722	18	19
Surrey Downs	52	292,881	19	18
Surrey Heath	17	96,564	16	18

Appendix C - Community Pharmacy changes since the 2018 PNA

The map below shows pharmacies, dispensing applicator contractors (DAC) and distance selling (online) pharmacies with a trading postcode in Surrey.



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Health and Wellbeing Board Paper

1. Reference information

Paper tracking information	
Title:	Better Care Fund Submission 2020/21
Related Health and Wellbeing Priority:	Priority 1 - Helping people in Surrey to lead healthy lives Priority 2 - Supporting the mental health and emotional wellbeing of people in Surrey
Author:	Christopher Tune, Policy and Programme Manager (Health and Wellbeing), (SCC) Christopher.Tune@surreycc.gov.uk
Sponsor:	Simon White, Executive Director for Adult Social Care, (SCC)
Paper date:	4 March 2021
Related papers:	Annex 1: Draft Surrey 2020/21 Better Care Fund Submission

2. Executive summary

This paper introduces the planned areas of spend for Surrey's 2020/21 Better Care Fund submission. The Better Care Fund is a local single pooled budget that facilitates integrated working between health, social care, and wider partners. Whilst the submission of a formal Better Care Fund plan is not required by NHS England, Annex 1 provides information of the Better Care Fund schemes commissioned in Surrey, to allow oversight and sign-off from the Health and Wellbeing Board. The attached Annex will also be submitted to NHS England for assurance.

3. Recommendations

The Health and Wellbeing Board is asked to:

a) Note that the national planning conditions have been met; including the minimum CCG funding contribution, the minimum funding allocation to NHS Commissioned Out of Hospital Spend, and minimum funding allocation to Adult Social Care services.
b) Sign off the Surrey 2020/21 Better Care Fund submission.
c) Note the responsibilities of the Health and Wellbeing Board in providing an end of year reconciliation to Departments and NHS England.

4. Reason for Recommendations

The 2020/21 Better Care Fund submission for Surrey has been agreed following local discussions with a wide range of stakeholders, including strategic leaders, finance colleagues, and commissioners. The areas of spend set out in the Annex will support joint working to deliver integrated, holistic services that put Surrey residents at the centre of their health and social care services. NHS England have asked that the submission secures approval from the Council, the relevant CCGs, and the Health and Wellbeing Board.

5. Detail

Context

The Better Care Fund (BCF) is a national programme announced by the Government in the June 2013 spending round. The aim of the programme is to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services.

Earlier in the year, Health and Wellbeing Boards were advised that BCF policy and planning requirements would not be published during the initial response to the COVID-19 pandemic and that they should prioritise continuity of provision, social care capacity and system resilience and spend from ringfenced BCF pots based on local agreement in 2020 to 2021, pending further guidance. Given the ongoing pressures on systems, Departments and NHS England and NHS Improvement have agreed that formal BCF plans will not have to be submitted to NHS England and NHS Improvement for approval in 2020 to 2021.

HWB areas must, however, ensure that use of the mandatory funding contributions has been agreed in writing, and that the national conditions are met.

Planning requirements

The Better Care Fund brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), and the improved Better Care Fund (iBCF) which now includes the Winter Pressures grant.

The national conditions for the BCF in 2020/21 are that:

- Submissions covering all mandatory funding contributions have been agreed by HWB areas and minimum contributions are pooled in a section 75 agreement.
- The contribution to social care from the CCG via the BCF is agreed and meets or exceeds the minimum expectation.
- Spend on CCG commissioned out of hospital services meets or exceeds the minimum ringfence.
- CCGs and local authorities confirm compliance with the above conditions to their Health and Wellbeing Boards.

The national expectation is for the delivery of the Better Care Fund through 2020/21 will continue to deliver the strategic aims agreed in prior Surrey Better Care Fund plans:

- **Enabling people to stay well -** Maximising independence and wellbeing through prevention and early intervention for people at risk of being unable to manage their physical health, mental health and social care needs;
- **Enabling people to stay at home -** Integrated care delivered seven days a week through enhanced primary and community services which are safe and effective and increase public confidence to remain out of hospital or residential/nursing care; and
- **Enabling people to return home sooner from hospital** – Excellent hospital care and post-hospital support for people with acute, specialist or complex needs supported by a proactive discharge system which enables a prompt return home.

Benefits to Surrey residents of the Better Care Fund

The Surrey Community Impact Assessment, Surrey Joint Strategic Needs Assessment, and local area profiles have been used as the shared evidence base to develop the draft Surrey BCF submission. The recently published Surrey Community Impact Assessment[1] explores health, social and economic impacts of COVID-19 among communities across the county, communities' priorities for recovery, and what support these communities might continue to need throughout the pandemic. It found that the health impacts have been felt the most in areas with higher numbers of over 80s and care homes. The focus of the Better Care Fund for 2020/21 remains on supporting adults, and older adults in particular. We are seeing that residents who aren't used to needing support are also beginning to struggle, and so prevention and early intervention continues to form a key part of the work being undertaken in each locality. Lockdown has left many individuals feeling isolated and cut off from friends and family, and with a lack of knowledge about how and when to seek help. Commissioned within the 2020/21 submission are a range of schemes to support residents' emotional wellbeing and to improve information and advice available for Surrey residents.

Financial Implications

The BCF submission in the Annex sets out the plan for how £99.2m of funding across Surrey's health and social care system will be spent. This includes the £76.7m minimum contributions from CCGs to the BCF, £11.1m of iBCF grant funding paid directly to SCC and £10.2m of DFG monies paid to D&B Councils.

The minimum amount Surrey's CCGs are required to add into the BCF as stipulated by NHSE is increasing in 2020/21 by £3.7m (5.1%) Of this increase, £2.2m will be allocated to Adult Social Care. The Annex confirms how this increased funding will be spent in line with agreements reached between SCC and CCG partners.

Legal Implications

The Care Act 2014 places a duty on local authorities to exercise their functions under the Care Act with a view to ensuring the integration of health and social care provision. Similarly, the National Health Service Act 2006 places a duty on CCGs to do the same in the exercise of their functions. Furthermore, under the Health and Social Care Act 2012, the Surrey Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner. The BCF and Section 75 agreements that underpin it are intended to enable compliance with these duties. The 2019/20 Section 75 agreements between Surrey County Council and the CCGs will be updated for the 2020/21 funding period.

6. Challenges

[1] https://www.surreyi.gov.uk/covid-impacts/

The challenge, as always with health and social care integration work, is to ensure that the Better Care Fund supports joined-up care that is person-centred, and the transition between services and organisations is as seamless as possible to deliver the best possible outcomes for Surrey residents.

Delivery of the Surrey Better Care Fund in 2020/21 will support the achievement of outcomes for older adults set out in the Surrey Health and Wellbeing Strategy:

- Within Priority 1, 'helping people in Surrey to lead healthy lives', it supports the specific focus areas around 'promoting prevention to decrease incidence of serious conditions and diseases', and 'helping people to live independently for as long as possible and to die well'.
- Within Priority 2, 'supporting the emotional wellbeing of people in Surrey, it supports the specific focus areas around 'enabling…adults and elderly with mental health issues to access the right help and resources', and 'preventing isolation and enabling support for those who do feel isolated'.

7. Timescale and delivery plan

Given the lateness of the release of guidance from NHS England and central government, delivery of the 2020/21 Better Care Fund schemes are well underway. It is expected that the planning process for 2021/22 will begin soon, once guidance is released.

8. How is this being communicated?

The Better Care Fund submission is Surrey-wide, however, local delivery is tailored in each area through the commissioning of different schemes to suit the local population. In developing the local plans that this BCF submission is built upon, local providers have been engaged with through each of the Local Joint Commissioning Groups (LJCGs).

The important role district and borough councils play in the provision of local preventative services, engagement within local communities and as the local housing authority, is fully recognised in Surrey. The Disabled Facilities Grant (DFG) for 2002/21 will be pooled and cascaded to the eleven district and borough councils in line with the national guidance, with discussions in each locality to agree the use of the funds.

9. Next steps

- Once agreed by the Surrey Health and Wellbeing Board, the Better Care Fund submission will be sent to NHS England for oversight.
- Section 75 partnership agreements will be signed between Surrey County Council and CCGs to confirm the pooling of funds for 2020/21.
- In April 2021, Surrey Health and Wellbeing Board will provide an end of year reconciliation to Departments and NHS England/ Improvement, confirming that the national conditions have been met, total spend from the mandatory funding sources and a breakdown of agreed spending on social care from the CCG minimum contribution.

Annexes

Annex 1 – Draft Surrey 2020/21 Better Care Fund submission

BCF 2020-21 Income & Expenditure Calculator

1. Guidance

Overview

Note on entering information into this template

This template is intended to be used by local BCF planners to record locally agreed plans and ensure that minimum requirements on BCF funding sources are met (for instance the minimum contribution to social care from the CCG minimum). The template does not need to be submitted to the Better Care Fund Team, as plans for 2020-21 are not being assured. All areas will need to send a completed expenditure template as part of year end reporting and to confirm to their HWBs that the national conditions of the fund have been met;, so we recommend that you do complete this template in the next few weeks.

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the data fields that have not been completed.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear 'Red' and contain the word 'No' if the information has not been completed. Clicking on the corresponding 'Cell Reference' column will link to the incomplete cell for completion. Once completed the checker column will change to 'Green' and contain the word 'Yes'

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green.

3. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's Better Care Fund (BCF) plan and pooled budget for 2020-21. On selected the HWB from the Cover page, this sheet will be pre-populated with the minimum CCG contributions to the BCF, DFG (Disabled Facilities Grant), and iBCF (improved Better Care Fund) allocations to be pooled within the BCF. These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from Local Authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be utilised to include any relevant carry-overs from the previous year.
3. In March 2020, guidance on a revised Hospital Discharge Service Policy, backed with central funding, was published. Systems were advised to implement the enhanced discharge to assess services in this policy through a single lead commissioner (usually the local authority) and to pool the additional funding drawn down into a s75. Some areas pooled additional funding available from the Hospital Discharge Policy through the Better Care Fund agreement. If you wish to record this discharge funding in your Better Care Fund plan to reflect the conent of your local s75 agreement, you can record this as an additional contribution. End of year reporting will not be required to include discharge funding.

4. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.

5. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

4. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information will be required at year end to analyse BCF spending nationally, to contribute toi national statistics and to provide assurance that National Condition 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.
On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers.
2. Scheme Name:
- This is a free field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available at the end of the table (follow the link to the description section at the top of the main expenditure table).
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- While selecting schemes and sub-types, the sub-type field will be flagged in 'red' font if it is from a previously selected scheme type. In this case please clear the sub-type field and reselect from the dropdown if the subtype field is editable.
4. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard spend areas where possible.
5. Commissioner:
- Identify the commissioning entity for the scheme based on who commissions the scheme from the provider. If there is a single commissioner, please select the option from the drop-down list.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns alongside.
6. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
7. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop-down list
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
8. Expenditure (£) 2020-21:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
9. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

5. CCG-HWB Mapping (click to go to sheet)

The final sheet provides details of the CCG - HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity figures.

BCF 2020-21 Income & Expenditure Calculator

2. Cover

Version 1.3

Please Note:
- This template is password protected to ensure data integrity and accurate aggregation of collected information. Whilst there is no requirement for a formal submission of this template, breaching the protection may result in inaccurate data transfer for the year-end template.

Health and Wellbeing Board:	Surrey

[<< Link to the Guidance sheet]

Checklist

5. Income

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	Cell Reference	Checker
Are any additional LA Contributions being made in 2020-21?		Yes
Additional Local Authority		Yes
Additional LA Contribution		Yes
Additional LA Contribution Narrative		Yes
Are any additional CCG Contributions being made in 2020-21?		Yes
Additional CCGs		Yes
Additional CCG Contribution		Yes
Additional CCG Contribution Narrative		Yes

Sheet Complete	Yes

6. Expenditure

^^ Link back to top

	Cell Reference	Checker
Scheme ID:		Yes
Scheme Name:		Yes
Scheme Type:		Yes
Sub Types:		Yes
Specify if scheme type is Other:		Yes
Area of Spend:		Yes
Specify if area of spend is Other:		Yes
Commissioner:		Yes
Joint Commissioner %:		Yes
Provider:		Yes
Source of Funding:		Yes
Expenditure:		Yes
New/Existing Scheme:		Yes

Sheet Complete	Yes

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BCF 2020-21 Income & Expenditure Calculator

5. Income

Selected Health and Wellbeing Board: Surrey

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Surrey	£10,155,847
DFG breakerdown for two-tier areas only (where applicable)	
Elmbridge	£976,997
Epsom and Ewell	£785,282
Guildford	£805,901
Mole Valley	£886,819
Reigate and Banstead	£1,286,692
Runnymede	£874,205
Spelthorne	£943,241
Surrey Heath	£884,021
Tandridge	£522,380
Waverley	£852,606
Woking	£1,337,703
Total Minimum LA Contribution (exc iBCF)	**£10,155,847**

iBCF Contribution	Contribution
Surrey	£11,073,082
Total iBCF Contribution	**£11,073,082**

Are any additional LA Contributions being made in 2020-21? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Surrey	£441,731	Additional LA funds to contribute in increase
Surrey	£403,755	Carry forward from 2019-20
Total Additional Local Authority Contribution	**£845,486**	

CCG Minimum Contribution	Contribution
NHS North West Surrey CCG	£22,740,942
NHS Surrey Downs CCG	£19,034,327
NHS Guildford and Waverley CCG	£13,246,071
NHS East Surrey CCG	£11,837,716
NHS Surrey Heath CCG	£6,146,212
NHS North East Hampshire and Farnham CCG	£2,892,753
NHS East Berkshire CCG	£774,191
Total Minimum CCG Contribution	**£76,672,212**

Are any additional CCG Contributions being made in 2020-21? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
NHS East Surrey CCG	£51,809	Carry forward from 2019-20
NHS Guildford and Waverley CCG	£28,457	Carry forward from 2019-20
NHS North East Hampshire and Farnham CCG	£106,681	Carry forward from 2019-20
NHS Surrey Downs CCG	£102,227	Carry forward from 2019-20
NHS Surrey Heath CCG	£178	Carry forward from 2019-20
NHS East Berkshire CCG	£114,404	Carry forward from 2019-20
Total Addition CCG Contribution	**£403,755**	
Total CCG Contribution	**£77,075,967**	

	2020-21
Total BCF Pooled Budget	**£99,150,382**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over
LA additional funding includes carryforward from 2019/20 and additional funding for Mental Health Community Connections contract. CCG additional funding amounts to 2019/20 carryforward.

BCF 2020-21 Income & Expenditure Calculator

6. Expenditure

Selected Health and Wellbeing Board: Surrey

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£10,155,847	£10,155,847	£0
Minimum CCG Contribution	£76,672,212	£76,672,212	£0
iBCF	£11,073,082	£11,073,082	£0
Additional LA Contribution	£845,486	£845,486	£0
Additional CCG Contribution	£403,755	£403,755	£0
Total	£99,150,382	£99,150,382	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£21,790,581	£32,069,301	£0
Adult Social Care services spend from the minimum CCG allocations	£45,168,917	£45,665,707	£0

Link to Scheme Type description

					Expenditure								
Scheme ID	Scheme Name	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	ES 1a - Responsibilities under the Care	Care Act Implementation Related Duties	Other	Homecare Service Provision	Social Care		LA			Local Authority	Minimum CCG Contribution	£373,696	Existing
2	ES 1b - Responsibilities under the Care	Care Act Implementation Related Duties	Deprivation of Liberty Safeguards (DoLS)		Social Care		LA			Local Authority	Minimum CCG Contribution	£4,552	Existing
3	ES 1c - Responsibilities under the Care	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum CCG Contribution	£17,752	Existing
4	ES 2 - Carers Funding	Carers Services	Carer Advice and Support		Social Care		LA			Local Authority	Minimum CCG Contribution	£380,000	Existing
5	ES 3 - Health Commissioned Services	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£4,008,254	Existing
6	ES 4 - Prescription Schemes	Prevention / Early Intervention	Social Prescribing		Social Care		CCG			Local Authority	Minimum CCG Contribution	£518,005	Existing
7	ES 6 - Community Grants	Prevention / Early Intervention	Other	Physical Health /	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£143,650	Existing
8	ES 7 - Supported Employment	Prevention / Early Intervention	Other	Mental Health /	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£120,341	Existing
9	ES 8 - FCHC Discharge to Assess	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£202,767	Existing
10	ES 9 - Contingency / other	Community Based Schemes			Community Health		CCG			CCG	Minimum CCG Contribution	£368,521	Existing
11	ES 10 - Home from Hospital	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£88,000	Existing
12	ES 11 - Stroke Support	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£17,000	Existing
13	ES 12 - Telecare	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£120,000	Existing
14	ES 13 - Information & Advice	Integrated Care Planning and Navigation	Care Coordination		Social Care		LA			Local Authority	Minimum CCG Contribution	£27,899	Existing
15	ES 14a - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£211,658	Existing
16	ES 14b - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£75,987	Existing
17	ES 15 - Handy Persons	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£41,046	Existing
18	ES 16 - Community Equipment	Assistive Technologies and Equipment	Community Based Equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum CCG Contribution	£495,139	Existing
19	ES 17 - Integrated Multi Disciplinary Teams - Social	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£528,456	Existing
20	ES 18 - Integrated Multi Disciplinary Teams - Mental	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Mental Health		LA			Local Authority	Minimum CCG Contribution	£36,770	Existing
21	ES 19 - BCF Administration	Enablers for Integration	Implementation & Change Mgt capacity		Other	Portion of Finance post for BCF	LA			Local Authority	Minimum CCG Contribution	£6,909	Existing
22	ES 20 - Protection of Adult Social Care	Other		Carers Service / Community Equipment /	Social Care		LA			Local Authority	Minimum CCG Contribution	£4,127,301	Existing
23	ES 21 - Disabled Facilities Grant	DFG Related Schemes	Adaptations		Social Care		LA			Local Authority	DFG	£1,268,237	Existing
24	ES 22 - Improved BCF 20/21	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Local Authority	iBCF	£1,679,134	Existing
25	ES 23 - CCG Carry Forward from 19/20	Community Based Schemes			Social Care		LA			Local Authority	Additional CCG Contribution	£51,809	Existing
26	ES 24 SCC Carry Forward from 19/20	Community Based Schemes			Social Care		LA			Local Authority	Additional LA Contribution	£51,809	Existing
27	GW 1a - Responsibilities under the Care	Care Act Implementation Related Duties	Other	Homecare Service Provision	Social Care		LA			Local Authority	Minimum CCG Contribution	£427,399	Existing
28	GW 1b - Responsibilities under the Care	Care Act Implementation Related Duties	Deprivation of Liberty Safeguards (DoLS)		Social Care		LA			Local Authority	Minimum CCG Contribution	£5,207	Existing
29	GW 1c - Responsibilities under the Care	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum CCG Contribution	£20,394	Existing
30	GW 2 - Carers Funding	Carers Services	Carer Advice and Support		Social Care		LA			Local Authority	Minimum CCG Contribution	£435,000	Existing
31	GW 3 - Health Commissioned Services	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£3,823,212	Existing
32	GW 4 - Supported Employment	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£141,927	Existing
33	GW 5 - End of Life Care - Contract	Personalised Care at Home			Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£168,501	Existing
34	GW 6 - Psychiatric Liaison Services	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£171,779	Existing
35	GW 7 - Mental Health wards	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Mental Health		LA			Local Authority	Minimum CCG Contribution	£159,760	Existing
36	GW 8 - Funding for NEA in acute	Other		Funding for NEA levels	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£200,000	Existing
37	GW 9 - Blue Box	HICM for Managing Transfer of Care	Chg 8. Enhancing Health in Care Homes		Community Health		CCG			CCG	Minimum CCG Contribution	£6,054	Existing
38	GW 10 - Falls Co-ordinator	Community Based Schemes			Community Health		CCG			Local Authority	Minimum CCG Contribution	£53,000	Existing
39	GW 11 - Care Home Matrons	HICM for Managing Transfer of Care	Chg 8. Enhancing Health in Care Homes		Community Health		CCG			Private Sector	Minimum CCG Contribution	£76,080	Existing
40	GW 12 - Hoppa Bus	HICM for Managing Transfer of Care	Other approaches		Social Care		CCG			Local Authority	Minimum CCG Contribution	£160,363	Existing
41	GW 13 - Let's get steady, Fall prevention	Community Based Schemes			Community Health		CCG			Local Authority	Minimum CCG Contribution	£26,000	Existing
42	GW 14 - Very High Intensity Users Programme	Integrated Care Planning and Navigation	Care Coordination		Community Health		CCG			CCG	Minimum CCG Contribution	£54,434	Existing
43	GW 15 - Reconnections matched funding	Community Based Schemes			Community Health		CCG			CCG	Minimum CCG Contribution	£50,000	Existing
44	GW 16 - Carers Partnership Manager shortfall	Enablers for Integration	Implementation & Change Mgt capacity		Community Health		CCG			CCG	Minimum CCG Contribution	£17,600	Existing
45	GW 17 - Community Initiatives	Community Based Schemes			Community Health		CCG			CCG	Minimum CCG Contribution	£417,095	Existing
46	GW 18 - Home from Hospital	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£49,000	Existing
47	GW 19 - Stroke Support	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£20,000	Existing
48	GW 20 - Telecare	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£107,000	Existing
49	GW 21 - Information and Advice	Integrated Care Planning and Navigation	Care Coordination		Social Care		LA			Local Authority	Minimum CCG Contribution	£32,664	Existing
50	GW 22a - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£241,325	Existing

51	GW 22b - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£59,181	Existing
52	GW 23 - Handy Persons	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£44,186	Existing
53	GW 24 - Community Equipment	Assistive Technologies and Equipment	Community Based Equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum CCG Contribution	£586,216	Existing
54	GW 25 - Home First Project	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Private Sector	Minimum CCG Contribution	£168,360	Existing
55	GW 26 - Social Prescribing	Prevention / Early Intervention	Social Prescribing		Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£60,000	Existing
56	GW 27 - Integrated Multi Disciplinary Team	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£611,436	Existing
57	GW 28 - Integrated Multi Disciplinary	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Mental Health		LA			Local Authority	Minimum CCG Contribution	£44,543	Existing
58	GW 29 - BCF Administration	Enablers for Integration	Implementation & Change Mgt capacity		Other	Portion of Finance post for BCF	LA			Local Authority	Minimum CCG Contribution	£7,895	Existing
59	GW 30 - Protection of Adult Social Care	Other		Carers Service / Community Equipment /	Social Care		LA			Local Authority	Minimum CCG Contribution	£4,859,641	Existing
60	GW 31 - Disabled Facilities Grant	DFG Related Schemes	Adaptations		Social Care		LA			Local Authority	DFG	£1,253,448	Existing
61	GW 32 - Improved BCF 20/21	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Local Authority	iBCF	£1,922,931	Existing
62	GW 33 - CCG Carry Forward from 19/20	Community Based Schemes			Social Care		LA			Local Authority	Additional CCG Contribution	£28,457	Existing
63	GW 34 - SCC Carry Forward 19/20	Community Based Schemes			Social Care		LA			Local Authority	Additional LA Contribution	£28,457	Existing
64	NW 1a - Responsibilities under the Care	Care Act Implementation Related Duties	Other	Homecare Service Provision	Social Care		LA			Local Authority	Minimum CCG Contribution	£734,033	Existing
65	NW 1b - Responsibilities under the Care	Care Act Implementation Related Duties	Deprivation of Liberty Safeguards (DoLS)		Social Care		LA			Local Authority	Minimum CCG Contribution	£8,943	Existing
66	NW 1c - Responsibilities under the Care	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum CCG Contribution	£35,025	Existing
67	NW 2 - Carers Funding	Carers Services	Carer Advice and Support		Social Care		LA			Local Authority	Minimum CCG Contribution	£747,000	Existing
68	NW 3 - Health Commissioned Services	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£7,018,530	Existing
69	NW 4 - Supported Employment	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£237,148	Existing
70	NW 5 - Mental Health Virtual Wards	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£406,550	Existing
71	NW 6 - Acute Contributions	Other		Funding for NEA levels	Acute		CCG			CCG	Minimum CCG Contribution	£1,687,000	Existing
72	NW 7 - Community Initiative	Community Based Schemes			Community Health		CCG			CCG	Minimum CCG Contribution	£271,224	New
73	NW 8 - Home from Hospital	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Local Authority	Minimum CCG Contribution	£96,998	Existing
74	NW 9 - Stroke Support	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£33,000	Existing
75	NW 10 - Telecare	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£210,000	Existing
76	NW 11 - Information & Advice	Integrated Care Planning and Navigation	Care Coordination		Social Care		LA			Local Authority	Minimum CCG Contribution	£53,787	Existing
77	NW 12a - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£412,465	Existing
78	NW 12b - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£172,379	Existing
79	NW 13 - Handy Persons	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£90,056	Existing
80	NW 14 - Community Equipment	Assistive Technologies and Equipment	Community Based Equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum CCG Contribution	£810,538	Existing
81	NW 15 - Integrated Multi Disciplinary	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,161,993	Existing
82	NW 16 - Integrated Multi Disciplinary	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Mental Health		LA			Local Authority	Minimum CCG Contribution	£70,670	Existing
83	NW 17 - BCF Administration	Enablers for Integration	Implementation & Change Mgt capacity		Other	Portion of Finance post for BCF	LA			Local Authority	Minimum CCG Contribution	£12,824	Existing
84	NW 18 - Protection of Adult Social Care	Other		Carers Service / Community Equipment /	Social Care		LA			Local Authority	Minimum CCG Contribution	£8,643,159	Existing
85	NW 19 - Disabled Facilities Grant	DFG Related Schemes	Adaptations		Social Care		LA			Local Authority	DFG	£3,622,770	Existing
86	NW 20 - Improved BCF 20/21	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Local Authority	iBCF	£3,300,370	Existing
87	SD 1a - New responsibilities under the Care	Care Act Implementation Related Duties	Other	Homecare Service Provision	Social Care		LA			Local Authority	Minimum CCG Contribution	£610,436	Existing
88	SD 1b - New responsibilities under the Care	Care Act Implementation Related Duties	Deprivation of Liberty Safeguards (DoLS)		Social Care		LA			Local Authority	Minimum CCG Contribution	£7,437	Existing
89	SD 1c - New responsibilities under the Care	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum CCG Contribution	£29,127	Existing
90	SD 2 - Carers Funding	Carers Services	Carer Advice and Support		Social Care		LA			Local Authority	Minimum CCG Contribution	£621,000	Existing
91	SD 3 - Health Commissioned Services	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£5,722,320	Existing
92	SD 4 - Supported Employment	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£173,715	Existing
93	SD 5 - End of Life Care Contract	Personalised Care at Home			Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£318,160	Existing
94	SD 6 - Integrated Teams	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£496,720	Existing
95	SD 7 - Care Home support post	Integrated Care Planning and Navigation	Care Coordination		Continuing Care		CCG			CCG	Minimum CCG Contribution	£37,000	New
96	SD 8 - Mental Health - Psychiatric Liaison	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£421,948	Existing
97	SD 9 - Local CCG Schemes mapped to BCF projects	Community Based Schemes			Community Health		CCG			CCG	Minimum CCG Contribution	£83,899	Existing
98	SD 10 - Funding for NEA in acute	Other		Funding for NEA levels	Acute		CCG			CCG	Minimum CCG Contribution	£334,000	Existing
99	SD 11 - Community Initiatives	Community Based Schemes			Community Health		CCG			CCG	Minimum CCG Contribution	£399,508	New
100	SD 12 - Hospital to Home Support Service	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£70,000	Existing

101	SD 13 - Stroke Support	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£31,000	Existing
102	SD 14 - Telecare	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£225,000	Existing
103	SD 15 - Information & Advice	Integrated Care Planning and Navigation	Care Coordination		Social Care		LA			Local Authority	Minimum CCG Contribution	£47,927	Existing
104	SD 16a - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£328,955	Existing
105	SD 16b - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£86,001	Existing
106	SD 17 - Handy Persons	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£66,178	Existing
107	SD 18 - Community Equipment	Assistive Technologies and Equipment	Community Based Equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum CCG Contribution	£840,202	Existing
108	SD 19 - Social Precribing	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum CCG Contribution	£103,000	Existing
109	SD 20 - Integrated Multi Disciplinary Teams - Social	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,008,436	Existing
110	SD 21 - Integrated Multi Disciplinary Teams - Mental	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Mental Health		LA			Local Authority	Minimum CCG Contribution	£67,160	Existing
111	SD 22 - BCF Administration	Enablers for Integration	Implementation & Change Mgt capacity		Other	Portion of Finance post for BCF	LA			Local Authority	Minimum CCG Contribution	£10,854	Existing
112	SD 23 - Protection of Adult Social Care	Other		Carers Service / Community Equipment /	Social Care		LA			Local Authority	Minimum CCG Contribution	£6,980,344	Existing
113	SD 24 - Disabled Facilities Grant	DFG Related Schemes	Adaptations		Social Care		LA			Local Authority	DFG	£2,763,648	Existing
114	SD 25 - Improved BCF 20/21	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Local Authority	iBCF	£2,744,174	Existing
115	SD 26 - CCG Carry Forward from 19/20	Community Based Schemes			Social Care		LA			Local Authority	Additional CCG Contribution	£102,227	Existing
116	SD 27 - SCC Carry Forward from 19/20	Community Based Schemes			Social Care		LA			Local Authority	Additional LA Contribution	£102,227	Existing
117	NEHF 1a - Responsibilities under the Care	Care Act Implementation Related Duties	Other	Homecare Service Provision	Social Care		LA			Local Authority	Minimum CCG Contribution	£92,462	Existing
118	NEHF 1b - Responsibilities under the Care	Care Act Implementation Related Duties	Deprivation of Liberty Safeguards (DoLS)		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,126	Existing
119	NEHF 1c - Responsibilities under the Care	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum CCG Contribution	£4,412	Existing
120	NEHF 2 - Carers Funding	Carers Services	Carer Advice and Support		Social Care		LA			Local Authority	Minimum CCG Contribution	£94,000	Existing
121	NEHF 3 - Health Commissioned Services	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,061,934	Existing
122	NEHF 4 - Supported Employment	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£31,396	Existing
123	NEHF 5 - End of Life Care - Contract	Personalised Care at Home			Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£37,500	Existing
124	NEHF 6 - Integrated Team Management	Enablers for Integration	Integrated workforce		Social Care		CCG			Local Authority	Minimum CCG Contribution	£60,000	Existing
125	NEHF 7 - Discharge to Assess	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Community Health		CCG			CCG	Minimum CCG Contribution	£40,000	Existing
126	NEHF 8 - Community Schemes	Community Based Schemes			Community Health		CCG			CCG	Minimum CCG Contribution	£65,291	New
127	NEHF 9 - Home from Hospital	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£5,070	Existing
128	NEHF 10 - Stroke Support	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£5,000	Existing
129	NEHF 11 - Telecare	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£24,000	Existing
130	NEHF 12 - Information & Advice	Integrated Care Planning and Navigation	Care Coordination		Social Care		LA			Local Authority	Minimum CCG Contribution	£7,236	Existing
131	NEHF 13a - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£49,172	Existing
132	NEHF 13b - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£9,272	Existing
133	NEHF 14 - Handy Persons	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£11,039	Existing
134	NEHF 15 - Community Equipment	Assistive Technologies and Equipment	Community Based Equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum CCG Contribution	£188,141	Existing
135	NEHF 16 - Integrated Multi Disciplinary	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£131,560	Existing
136	NEHF 17 - Integrated Multi Disciplinary	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Mental Health		LA			Local Authority	Minimum CCG Contribution	£9,158	Existing
137	NEHF 18 - BCF Administration	Enablers for Integration	Implementation & Change Mgt capacity		Other	Portion of Finance post for BCF	LA			Local Authority	Minimum CCG Contribution	£1,966	Existing
138	NEHF 19 - Protection of Adult Social Care	Other		Carers Service / Community Equipment /	Social Care		LA			Local Authority	Minimum CCG Contribution	£972,290	Existing
139	NEHF 20 - Disabled Facilities Grant	DFG Related Schemes	Adaptations		Social Care		LA			Local Authority	DFG	£282,969	Existing
140	NEHF 21 - Improved BCF 20/21	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Local Authority	iBCF	£415,979	Existing
141	NEHF 22 - CCG Carry Forward from 19/20	Community Based Schemes			Social Care		LA			Local Authority	Additional CCG Contribution	£106,681	Existing
142	NEHF 23 - SCC Carry Forward from 19/20	Community Based Schemes			Social Care		LA			Local Authority	Additional LA Contribution	£106,681	Existing
143	SH 1a - New responsibilities under the Care	Care Act Implementation Related Duties	Other	Homecare Service Provision	Social Care		LA			Local Authority	Minimum CCG Contribution	£200,019	Existing
144	SH 1b - New responsibilities under the Care	Care Act Implementation Related Duties	Deprivation of Liberty Safeguards (DoLS)		Social Care		LA			Local Authority	Minimum CCG Contribution	£2,437	Existing
145	SH 1c - New responsibilities under the Care	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum CCG Contribution	£9,544	Existing
146	SH 2 - Carers Funding	Carers Services	Carer Advice and Support		Social Care		LA			Local Authority	Minimum CCG Contribution	£204,000	Existing
147	SH 3 - Health Commissioned Services	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,512,132	Existing
148	SH 4 - Supported Employment	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£83,615	Existing
149	SH 5 - End of Life Care Contract	Personalised Care at Home			Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£77,626	Existing
150	SH 6 - End of Life Care Clinical Lead	Enablers for Integration	Integrated workforce		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£11,093	Existing

151	SH 7 - Mental Health - Psychiatric Liaison	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£198,000	Existing
152	SH 8 - Integrated Care Team	Enablers for Integration	Integrated workforce		Social Care		CCG			CCG	Minimum CCG Contribution	£383,861	Existing
153	SH 9a - Out of Hospital	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			CCG	Minimum CCG Contribution	£137,829	Existing
154	SH 9b - Out of Hospital	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		CCG			CCG	Minimum CCG Contribution	£59,069	Existing
155	SH 9c - Out of Hospital	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		CCG			CCG	Minimum CCG Contribution	£5,099	Existing
156	SH 9d - Out of Hospital	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			CCG	Minimum CCG Contribution	£5,099	Existing
157	SH 10a - Social Prescribing Post	Prevention / Early Intervention	Social Prescribing		Social Care		CCG			CCG	Minimum CCG Contribution	£32,000	Existing
158	SH 10b - Social Prescribing Post	Prevention / Early Intervention	Social Prescribing		Social Care		CCG			CCG	Minimum CCG Contribution	£32,000	Existing
159	SH 11a - Time to Talk	Community Based Schemes			Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£10,000	Existing
160	SH 11b - Time to Talk	Community Based Schemes			Social Care		CCG			CCG	Minimum CCG Contribution	£10,000	Existing
161	SH 12a - Neighbourhood resilience Social	Prevention / Early Intervention	Social Prescribing		Social Care		CCG			CCG	Minimum CCG Contribution	£5,000	Existing
162	SH 12b - Neighbourhood resilience Social	Prevention / Early Intervention	Social Prescribing		Social Care		CCG			CCG	Minimum CCG Contribution	£5,000	Existing
163	SH 13a - Locality Director	Enablers for Integration	Integrated workforce		Social Care		CCG			CCG	Minimum CCG Contribution	£26,490	Existing
164	SH 13b - Locality Director	Enablers for Integration	Integrated workforce		Social Care		CCG			CCG	Minimum CCG Contribution	£26,490	Existing
165	SH 14a - MH Case Worker (Homelessness)	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		CCG			CCG	Minimum CCG Contribution	£6,250	Existing
166	SH 14b - MH Case Worker (Homelessness)	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		CCG			CCG	Minimum CCG Contribution	£6,250	Existing
167	SH 14c - Community Based Projects	Community Based Schemes			Community Health		CCG			CCG	Minimum CCG Contribution	£90,173	New
168	SH 15 - Home from Hospital	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£10,920	Existing
169	SH 16 - Stroke Support	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£9,000	Existing
170	SH 17 - Telecare	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£55,000	Existing
171	SH 18 - Information & Advice	Integrated Care Planning and Navigation	Care Coordination		Social Care		LA			Local Authority	Minimum CCG Contribution	£15,223	Existing
172	SH 19a - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£113,864	Existing
173	SH 19b - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£31,992	Existing
174	SH 20 - Handy Persons	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£29,348	Existing
175	SH 21 - Community Equipment	Assistive Technologies and Equipment	Community Based Equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum CCG Contribution	£314,673	Existing
176	SH 22 - Integrated Multi Disciplinary Teams - Social	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£404,178	Existing
177	SH 23 - Integrated Multi Disciplinary Teams - Mental	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Mental Health		LA			Local Authority	Minimum CCG Contribution	£21,230	Existing
178	SH 24 - BCF Administration	Enablers for Integration	Implementation & Change Mgt capacity		Other	Portion of Finance post for BCF	LA			Local Authority	Minimum CCG Contribution	£3,951	Existing
179	SH 25 - Protection of Adult Social Care	Other		Carers Service / Community Equipment /	Social Care		LA			Local Authority	Minimum CCG Contribution	£2,009,748	Existing
180	SH 26 - Disabled Facilities Grant	DFG Related Schemes	Adaptations		Social Care		LA			Local Authority	DFG	£882,488	Existing
181	SH 27 - Improved BCF 20/21	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Local Authority	iBCF	£900,057	Existing
182	SH 28 - CCG Carryforward	Community Based Schemes			Social Care		LA			Local Authority	Additional CCG Contribution	£177	Existing
183	SH 29 - SCC Carry Forward	Community Based Schemes			Social Care		LA			Local Authority	Additional LA Contribution	£177	Existing
184	EB 1a - New Responsibilities under the Care	Care Act Implementation Related Duties	Other	Homecare Service Provision	Social Care		LA			Local Authority	Minimum CCG Contribution	£24,531	Existing
185	EB 1b - New Responsibilities under the Care	Care Act Implementation Related Duties	Deprivation of Liberty Safeguards (DoLS)		Social Care		LA			Local Authority	Minimum CCG Contribution	£299	Existing
186	EB 1c - New Responsibilities under the Care	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,170	Existing
187	EB 2 - Carers Funding	Carers Services	Carer Advice and Support		Social Care		LA			Local Authority	Minimum CCG Contribution	£25,000	Existing
188	EB 3 - Health Commissioned Services	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£235,143	Existing
189	EB 4 - Podiatry - Virgin Contract	Community Based Schemes			Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£22,495	Existing
190	EB 5 - D2A Risk Contingency Pool	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Community Health		CCG			CCG	Minimum CCG Contribution	£10,600	Existing
191	EB 6 - End Of Life - TVHC	Community Based Schemes			Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£25,000	Existing
192	EB 7 - Commissioning Reserve	Community Based Schemes			Community Health		CCG			CCG	Minimum CCG Contribution	£48,905	Existing
193	EB 8 - Stroke Support	Prevention / Early Intervention	Other	Physical Health / Wellbeing	Community Health		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£1,000	Existing
194	EB 9 - Telecare	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£8,000	Existing
195	EB 10 - Information & Advice	Integrated Care Planning and Navigation	Care Coordination		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,581	Existing
196	EB 11a - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£16,070	Existing
197	EB 11b - Mental Health Community	Prevention / Early Intervention	Other	Mental Health / Wellbeing	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£6,919	Existing
198	EB 12 - Handy Persons	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£4,355	Existing
199	EB 13 - Community Equipment	Assistive Technologies and Equipment	Community Based Equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum CCG Contribution	£45,450	Existing
200	EB 14 - Community Schemes	Community Based Schemes			Community Health		CCG			CCG	Minimum CCG Contribution	£16,402	Existing

201	EB 15 - Integrated Multi Disciplinary Teams - Social	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£22,794	Existing
202	EB 16 - Integrated Multi Disciplinary Teams - Mental	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge		Mental Health		LA			Local Authority	Minimum CCG Contribution	£713	Existing
203	EB 17 - Protection of Adult Social Care	Other		Carers Service / Community Equipment /	Social Care		LA			Local Authority	Minimum CCG Contribution	£264,682	Existing
204	EB 18 - Disabled Facilities Grant	DFG Related Schemes	Adaptations		Social Care		LA			Local Authority	DFG	£82,287	Existing
205	EB 19 - Improved BCF 20/21	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access		Social Care		LA			Local Authority	iBCF	£110,437	Existing
206	EB 20 - CCG Carry Forward from 19/20	Community Based Schemes			Social Care		LA			Local Authority	Additional CCG Contribution	£114,404	Existing
207	EB 21 - SCC Carry Forward from 19/20	Community Based Schemes			Social Care		LA			Local Authority	Additional LA Contribution	£114,404	Existing
208	SH 30 - Carer's E Learning	Community Based Schemes			Social Care		CCG			CCG	Minimum CCG Contribution	£20,000	New

^^ Link back up

Assistive Technologies and Equipment	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	
Care Act Implementation Related Duties	Funding planned towards the implementation of Care Act related duties.	
Carers Services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	
Community Based Schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood level (eg: Integrated Neighbourhood Teams)	
DFG Related Schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	
Enablers for Integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint	
High Impact Change Model for Managing Transfer of Care	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM as such, is included in this section.	
Home Care or Domiciliary Care	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	
Housing Related Schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	
Integrated Care Planning and Navigation	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches like Single Point of Access (SPoA) and linking people to community assets. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the	
Intermediate Care Services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the	
Personalised Budgeting and Commissioning	Various person centred approaches to commissioning and budgeting.	
Personalised Care at Home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.	
Prevention / Early Intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.	
Residential Placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.	
Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.	

^^ Link back up

CCG to Health and Well-Being Board Mapping for 2020-21

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HV	% HWB in C
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	90.4%	87.2%
E09000002	Barking and Dagenham	08C	NHS Hammersmith and Fulham CCG	0.1%	0.2%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.8%	8.0%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.4%	0.7%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.7%	3.7%
E09000002	Barking and Dagenham	08W	NHS Waltham Forest CCG	0.1%	0.2%
E09000003	Barnet	06N	NHS Herts Valleys CCG	0.0%	0.1%
E09000003	Barnet	07P	NHS Brent CCG	2.1%	2.0%
E09000003	Barnet	08C	NHS Hammersmith and Fulham CCG	0.8%	0.5%
E09000003	Barnet	08E	NHS Harrow CCG	1.3%	0.8%
E09000003	Barnet	08Y	NHS West London CCG	0.2%	0.1%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.3%	0.2%
E09000003	Barnet	93C	NHS North Central London CCG	25.0%	96.3%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.6%	98.1%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.4%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.5%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	1.1%
E06000022	Bath and North East Somerset	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	21.0%	98.4%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.7%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	78H	NHS Northamptonshire CCG	0.2%	0.6%
E09000004	Bexley	08C	NHS Hammersmith and Fulham CCG	0.0%	0.1%
E09000004	Bexley	72Q	NHS South East London CCG	12.5%	98.4%
E09000004	Bexley	91Q	NHS Kent and Medway CCG	0.2%	1.5%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	38.7%	17.5%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E08000025	Birmingham	08C	NHS Hammersmith and Fulham CCG	0.6%	0.2%
E08000025	Birmingham	15E	NHS Birmingham and Solihull CCG	78.5%	81.8%
E08000025	Birmingham	18C	NHS Herefordshire and Worcestershire CCG	0.7%	0.4%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	88.9%	95.7%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.8%	1.8%
E06000009	Blackpool	00R	NHS Blackpool CCG	86.0%	97.7%
E06000009	Blackpool	02M	NHS Fylde and Wyre CCG	2.0%	2.3%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.5%
E08000001	Bolton	00V	NHS Bury CCG	1.5%	1.0%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000058	Bournemouth, Christchurch and Pool	11A	NHS West Hampshire CCG	0.2%	0.3%
E06000058	Bournemouth, Christchurch and Pool	11J	NHS Dorset CCG	52.7%	99.7%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.2%	0.1%
E06000036	Bracknell Forest	15A	NHS Berkshire West CCG	0.5%	2.1%
E06000036	Bracknell Forest	15D	NHS East Berkshire CCG	26.0%	96.7%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.0%
E08000032	Bradford	02T	NHS Calderdale CCG	0.3%	0.1%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.2%	0.0%
E08000032	Bradford	15F	NHS Leeds CCG	0.9%	1.4%
E08000032	Bradford	36J	NHS Bradford District and Craven CCG	90.5%	98.5%
E09000005	Brent	07P	NHS Brent CCG	89.1%	85.8%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	1.0%	0.7%
E09000005	Brent	08E	NHS Harrow CCG	6.0%	4.0%
E09000005	Brent	08Y	NHS West London CCG	4.1%	2.5%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.4%	0.8%
E09000005	Brent	93C	NHS North Central London CCG	1.4%	5.6%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.8%	99.7%
E06000043	Brighton and Hove	70F	NHS West Sussex CCG	0.0%	0.2%
E06000043	Brighton and Hove	97R	NHS East Sussex CCG	0.0%	0.1%
E06000023	Bristol, City of	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	49.6%	100.0%
E09000006	Bromley	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000006	Bromley	36L	NHS South West London CCG	0.3%	1.5%
E09000006	Bromley	72Q	NHS South East London CCG	17.2%	98.1%
E09000006	Bromley	91Q	NHS Kent and Medway CCG	0.0%	0.2%
E06000060	Buckinghamshire	04F	NHS Milton Keynes CCG	1.3%	0.7%
E06000060	Buckinghamshire	06F	NHS Bedfordshire CCG	0.5%	0.4%
E06000060	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E06000060	Buckinghamshire	08G	NHS Hillingdon CCG	0.7%	0.4%
E06000060	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.5%	0.7%
E06000060	Buckinghamshire	14Y	NHS Buckinghamshire CCG	94.5%	94.9%
E06000060	Buckinghamshire	15D	NHS East Berkshire CCG	1.4%	1.2%
E06000060	Buckinghamshire	78H	NHS Northamptonshire CCG	0.1%	0.2%
E08000002	Bury	00T	NHS Bolton CCG	0.7%	1.1%
E08000002	Bury	00V	NHS Bury CCG	94.0%	94.4%
E08000002	Bury	01A	NHS East Lancashire CCG	0.0%	0.1%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.9%
E08000002	Bury	14L	NHS Manchester CCG	0.6%	1.9%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.4%	98.8%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.3%	0.3%
E08000033	Calderdale	36J	NHS Bradford District and Craven CCG	0.2%	0.7%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.7%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	71.7%	96.8%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.8%	0.7%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	3.9%	1.4%
E10000003	Cambridgeshire	26A	NHS Norfolk and Waveney CCG	0.3%	0.4%
E09000007	Camden	07P	NHS Brent CCG	1.2%	1.7%
E09000007	Camden	08C	NHS Hammersmith and Fulham CCG	1.1%	1.2%
E09000007	Camden	08Y	NHS West London CCG	0.3%	0.3%

E09000007	Camden	09A	NHS Central London (Westminster) CCG	5.4%	4.7%
E09000007	Camden	93C	NHS North Central London CCG	15.4%	92.1%
E06000056	Central Bedfordshire	04F	NHS Milton Keynes CCG	0.1%	0.1%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.7%	94.9%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.3%	0.7%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.9%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.1%	1.7%
E06000056	Central Bedfordshire	14Y	NHS Buckinghamshire CCG	0.8%	1.6%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.2%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.2%	0.6%
E06000049	Cheshire East	15M	NHS Derby and Derbyshire CCG	0.1%	0.2%
E06000049	Cheshire East	27D	NHS Cheshire CCG	51.6%	97.4%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.3%
E06000050	Cheshire West and Chester	27D	NHS Cheshire CCG	47.3%	99.5%
E09000001	City of London	07T	NHS City and Hackney CCG	1.8%	66.3%
E09000001	City of London	08C	NHS Hammersmith and Fulham CCG	0.1%	4.3%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.3%	12.8%
E09000001	City of London	08Y	NHS West London CCG	0.0%	0.2%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.1%	3.4%
E09000001	City of London	72Q	NHS South East London CCG	0.0%	0.3%
E09000001	City of London	93C	NHS North Central London CCG	0.0%	12.7%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000052	Cornwall & Scilly	15N	NHS Devon CCG	0.3%	0.6%
E06000047	County Durham	00P	NHS Sunderland CCG	1.1%	0.6%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	16C	NHS Tees Valley CCG	0.1%	0.1%
E06000047	County Durham	84H	NHS County Durham CCG	96.8%	98.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.6%	99.8%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.4%	0.2%
E08000026	Coventry	05R	NHS South Warwickshire CCG	0.1%	0.0%
E09000008	Croydon	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000008	Croydon	36L	NHS South West London CCG	23.9%	93.7%
E09000008	Croydon	72Q	NHS South East London CCG	1.0%	4.7%
E09000008	Croydon	92A	NHS Surrey Heartlands CCG	0.6%	1.4%
E10000006	Cumbria	01H	NHS North Cumbria CCG	99.9%	63.5%
E10000006	Cumbria	01K	NHS Morecambe Bay CCG	53.2%	36.5%
E06000005	Darlington	16C	NHS Tees Valley CCG	15.2%	96.6%
E06000005	Darlington	42D	NHS North Yorkshire CCG	0.0%	0.1%
E06000005	Darlington	84H	NHS County Durham CCG	0.7%	3.3%
E06000015	Derby	15M	NHS Derby and Derbyshire CCG	26.6%	100.0%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	13.9%	4.3%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.6%	0.3%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	7.9%	1.4%
E10000007	Derbyshire	15M	NHS Derby and Derbyshire CCG	70.9%	92.5%
E10000007	Derbyshire	52R	NHS Nottingham and Nottinghamshire CCG	0.9%	1.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E10000008	Devon	15N	NHS Devon CCG	66.0%	99.2%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.3%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.7%	0.6%
E08000017	Doncaster	02X	NHS Doncaster CCG	97.0%	97.7%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.2%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.2%
E06000059	Dorset	11A	NHS West Hampshire CCG	1.7%	2.5%
E06000059	Dorset	11J	NHS Dorset CCG	45.9%	95.7%
E06000059	Dorset	11X	NHS Somerset CCG	0.6%	0.9%
E06000059	Dorset	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.4%	0.9%
E08000027	Dudley	05C	NHS Dudley CCG	91.9%	90.6%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	4.0%	7.0%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.7%	1.5%
E08000027	Dudley	15E	NHS Birmingham and Solihull CCG	0.1%	0.6%
E08000027	Dudley	18C	NHS Herefordshire and Worcestershire CCG	0.1%	0.3%
E09000009	Ealing	07P	NHS Brent CCG	2.1%	1.9%
E09000009	Ealing	07W	NHS Ealing CCG	87.0%	89.7%
E09000009	Ealing	07Y	NHS Hounslow CCG	4.4%	3.3%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.1%	3.5%
E09000009	Ealing	08E	NHS Harrow CCG	0.4%	0.3%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.7%	0.5%
E09000009	Ealing	08Y	NHS West London CCG	0.8%	0.5%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.4%	0.2%
E09000009	Ealing	93C	NHS North Central London CCG	0.0%	0.1%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.2%	85.1%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	8.7%	7.5%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.8%	7.1%
E06000011	East Riding of Yorkshire	42D	NHS North Yorkshire CCG	0.2%	0.2%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.6%
E10000011	East Sussex	70F	NHS West Sussex CCG	0.7%	1.2%
E10000011	East Sussex	91Q	NHS Kent and Medway CCG	0.2%	0.7%
E10000011	East Sussex	97R	NHS East Sussex CCG	99.4%	97.5%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000010	Enfield	93C	NHS North Central London CCG	21.6%	98.9%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.5%	0.6%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.5%
E10000012	Essex	06T	NHS North East Essex CCG	98.6%	22.7%
E10000012	Essex	07G	NHS Thurrock CCG	1.5%	0.2%
E10000012	Essex	07H	NHS West Essex CCG	97.2%	19.9%
E10000012	Essex	07K	NHS West Suffolk CCG	3.0%	0.5%

E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.2%	0.0%
E10000012	Essex	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E10000012	Essex	08F	NHS Havering CCG	0.4%	0.0%
E10000012	Essex	08N	NHS Redbridge CCG	2.9%	0.6%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.1%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.3%	11.4%
E10000012	Essex	99G	NHS Southend CCG	3.4%	0.4%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.8%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E08000037	Gateshead	00P	NHS Sunderland CCG	0.0%	0.1%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	38.1%	97.7%
E08000037	Gateshead	84H	NHS County Durham CCG	0.5%	1.2%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.6%	0.3%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.5%	98.6%
E10000013	Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.1%	0.1%
E10000013	Gloucestershire	18C	NHS Herefordshire and Worcestershire CCG	0.5%	0.6%
E10000013	Gloucestershire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.1%	0.2%
E09000011	Greenwich	08C	NHS Hammersmith and Fulham CCG	0.8%	0.8%
E09000011	Greenwich	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000011	Greenwich	72Q	NHS South East London CCG	15.2%	99.2%
E09000011	Greenwich	93C	NHS North Central London CCG	0.0%	0.1%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.1%	92.2%
E09000012	Hackney	08C	NHS Hammersmith and Fulham CCG	1.4%	1.3%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.7%	0.7%
E09000012	Hackney	08W	NHS Waltham Forest CCG	0.1%	0.1%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.3%	0.2%
E09000012	Hackney	93C	NHS North Central London CCG	1.0%	5.5%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.5%
E06000006	Halton	01J	NHS Knowsley CCG	0.2%	0.3%
E06000006	Halton	02E	NHS Warrington CCG	0.7%	1.2%
E06000006	Halton	27D	NHS Cheshire CCG	0.2%	1.0%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.5%	1.0%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.6%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	67.9%	87.0%
E09000013	Hammersmith and Fulham	08Y	NHS West London CCG	7.0%	7.6%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.5%	2.6%
E09000013	Hammersmith and Fulham	36L	NHS South West London CCG	0.0%	0.4%
E09000013	Hammersmith and Fulham	72Q	NHS South East London CCG	0.0%	0.1%
E09000013	Hammersmith and Fulham	93C	NHS North Central London CCG	0.0%	0.2%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.9%	0.0%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.3%	16.0%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.4%	14.1%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.5%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.7%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	4.9%	1.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.2%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	15A	NHS Berkshire West CCG	1.6%	0.6%
E10000014	Hampshire	15D	NHS East Berkshire CCG	0.2%	0.0%
E10000014	Hampshire	70F	NHS West Sussex CCG	0.2%	0.1%
E10000014	Hampshire	92A	NHS Surrey Heartlands CCG	0.6%	0.5%
E10000014	Hampshire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.6%	0.4%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.6%	12.4%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.0%	3.1%
E09000014	Haringey	08C	NHS Hammersmith and Fulham CCG	0.9%	0.9%
E09000014	Haringey	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000014	Haringey	93C	NHS North Central London CCG	18.3%	95.9%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.5%
E09000015	Harrow	07P	NHS Brent CCG	3.8%	5.1%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	2.0%
E09000015	Harrow	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000015	Harrow	08E	NHS Harrow CCG	89.6%	83.9%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.8%	1.9%
E09000015	Harrow	08Y	NHS West London CCG	0.1%	0.1%
E09000015	Harrow	93C	NHS North Central London CCG	1.1%	6.2%
E06000001	Hartlepool	16C	NHS Tees Valley CCG	13.6%	99.2%
E06000001	Hartlepool	84H	NHS County Durham CCG	0.1%	0.8%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.0%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	3.7%	3.1%
E09000016	Havering	08C	NHS Hammersmith and Fulham CCG	0.1%	0.1%
E09000016	Havering	08F	NHS Havering CCG	91.6%	95.6%
E09000016	Havering	08M	NHS Newham CCG	0.1%	0.2%
E09000016	Havering	08N	NHS Redbridge CCG	0.7%	0.8%
E09000016	Havering	08W	NHS Waltham Forest CCG	0.1%	0.1%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	1.0%
E06000019	Herefordshire, County of	18C	NHS Herefordshire and Worcestershire CCG	23.2%	98.6%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	97.0%	46.5%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.0%	50.8%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.9%	0.2%
E10000015	Hertfordshire	08C	NHS Hammersmith and Fulham CCG	0.2%	0.0%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.5%	0.1%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.2%	0.6%
E10000015	Hertfordshire	14Y	NHS Buckinghamshire CCG	0.2%	0.0%
E10000015	Hertfordshire	93C	NHS North Central London CCG	0.2%	0.2%
E09000017	Hillingdon	07P	NHS Brent CCG	0.1%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.3%	7.0%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.2%	1.2%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.4%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.1%	1.7%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.4%	89.5%
E09000017	Hillingdon	08Y	NHS West London CCG	0.1%	0.0%
E09000017	Hillingdon	14Y	NHS Buckinghamshire CCG	0.0%	0.1%

E09000018	Hounslow	07W	NHS Ealing CCG	5.3%	7.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.5%	87.1%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.2%	1.1%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	08Y	NHS West London CCG	0.2%	0.2%
E09000018	Hounslow	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000018	Hounslow	36L	NHS South West London CCG	0.7%	3.8%
E09000018	Hounslow	92A	NHS Surrey Heartlands CCG	0.1%	0.4%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07T	NHS City and Hackney CCG	3.3%	4.0%
E09000019	Islington	08C	NHS Hammersmith and Fulham CCG	1.5%	1.8%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.6%	0.6%
E09000019	Islington	93C	NHS North Central London CCG	15.0%	93.7%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.2%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	1.4%	2.3%
E09000020	Kensington and Chelsea	08Y	NHS West London CCG	63.8%	91.6%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.0%	5.4%
E09000020	Kensington and Chelsea	36L	NHS South West London CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	93C	NHS North Central London CCG	0.0%	0.4%
E10000016	Kent	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E10000016	Kent	72Q	NHS South East London CCG	0.4%	0.5%
E10000016	Kent	91Q	NHS Kent and Medway CCG	84.6%	99.4%
E10000016	Kent	97R	NHS East Sussex CCG	0.3%	0.1%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.4%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	91.3%	98.6%
E09000021	Kingston upon Thames	08C	NHS Hammersmith and Fulham CCG	0.1%	0.2%
E09000021	Kingston upon Thames	36L	NHS South West London CCG	11.3%	98.8%
E09000021	Kingston upon Thames	92A	NHS Surrey Heartlands CCG	0.2%	1.1%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.3%	0.7%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.5%	54.6%
E08000034	Kirklees	03J	NHS North Kirklees CCG	98.9%	42.3%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.6%	1.4%
E08000034	Kirklees	15F	NHS Leeds CCG	0.1%	0.3%
E08000034	Kirklees	36J	NHS Bradford District and Craven CCG	0.5%	0.7%
E08000011	Knowsley	01F	NHS Halton CCG	1.0%	0.8%
E08000011	Knowsley	01J	NHS Knowsley CCG	87.0%	88.1%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.2%	0.2%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.7%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.4%	8.1%
E09000022	Lambeth	08C	NHS Hammersmith and Fulham CCG	1.6%	1.3%
E09000022	Lambeth	08Y	NHS West London CCG	0.1%	0.0%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	1.5%	0.9%
E09000022	Lambeth	36L	NHS South West London CCG	1.2%	4.9%
E09000022	Lambeth	72Q	NHS South East London CCG	18.3%	92.6%
E09000022	Lambeth	93C	NHS North Central London CCG	0.0%	0.3%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.1%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	14.0%	1.9%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01A	NHS East Lancashire CCG	99.0%	29.9%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.8%	0.2%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	16.7%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Morecambe Bay CCG	45.0%	12.3%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.3%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.4%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	97.0%	8.6%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.7%	0.2%
E10000017	Lancashire	02M	NHS Fylde and Wyre CCG	98.0%	13.7%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.5%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.4%	0.6%
E08000035	Leeds	15F	NHS Leeds CCG	97.6%	98.7%
E08000035	Leeds	36J	NHS Bradford District and Craven CCG	0.6%	0.5%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	1.6%	1.3%
E06000016	Leicester	04C	NHS Leicester City CCG	93.0%	96.0%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.8%	2.7%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.9%	39.8%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.0%	4.1%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	53.1%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	15M	NHS Derby and Derbyshire CCG	0.4%	0.6%
E10000018	Leicestershire	52R	NHS Nottingham and Nottinghamshire CCG	0.6%	1.0%
E10000018	Leicestershire	71E	NHS Lincolnshire CCG	0.9%	1.0%
E09000023	Lewisham	08C	NHS Hammersmith and Fulham CCG	0.9%	0.8%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000023	Lewisham	36L	NHS South West London CCG	0.0%	0.2%
E09000023	Lewisham	72Q	NHS South East London CCG	16.6%	98.7%
E09000023	Lewisham	93C	NHS North Central London CCG	0.0%	0.1%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	5.0%	1.1%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.3%
E10000019	Lincolnshire	52R	NHS Nottingham and Nottinghamshire CCG	0.3%	0.4%
E10000019	Lincolnshire	71E	NHS Lincolnshire CCG	96.4%	97.5%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.3%	2.6%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.5%	1.0%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.4%	96.4%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.7%
E06000032	Luton	06P	NHS Luton CCG	97.5%	95.3%
E08000003	Manchester	00V	NHS Bury CCG	0.4%	0.1%
E08000003	Manchester	00Y	NHS Oldham CCG	0.8%	0.3%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01W	NHS Stockport CCG	1.7%	0.9%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	3.8%	1.4%

E08000003	Manchester	14L	NHS Manchester CCG	91.1%	95.8%
E06000035	Medway	91Q	NHS Kent and Medway CCG	15.0%	100.0%
E09000024	Merton	08C	NHS Hammersmith and Fulham CCG	0.4%	0.5%
E09000024	Merton	36L	NHS South West London CCG	14.5%	97.5%
E09000024	Merton	72Q	NHS South East London CCG	0.3%	2.0%
E06000002	Middlesbrough	16C	NHS Tees Valley CCG	22.4%	99.8%
E06000002	Middlesbrough	42D	NHS North Yorkshire CCG	0.0%	0.2%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.2%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	78H	NHS Northamptonshire CCG	0.5%	1.3%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.9%	0.8%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	59.5%	95.2%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	5.9%	3.9%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.6%	0.3%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000025	Newham	08C	NHS Hammersmith and Fulham CCG	1.3%	0.9%
E09000025	Newham	08M	NHS Newham CCG	96.6%	96.1%
E09000025	Newham	08N	NHS Redbridge CCG	0.3%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.3%	0.3%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000025	Newham	72Q	NHS South East London CCG	0.0%	0.1%
E09000025	Newham	93C	NHS North Central London CCG	0.0%	0.2%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.6%	0.7%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.1%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.5%	0.7%
E10000020	Norfolk	26A	NHS Norfolk and Waveney CCG	87.7%	98.6%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.5%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.2%	0.2%
E06000012	North East Lincolnshire	71E	NHS Lincolnshire CCG	0.3%	1.3%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.2%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.2%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.2%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	94.8%	96.8%
E06000013	North Lincolnshire	71E	NHS Lincolnshire CCG	0.3%	1.4%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E06000024	North Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	21.5%	98.3%
E06000024	North Somerset	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.4%	1.5%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.5%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.3%	96.5%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	01K	NHS Morecambe Bay CCG	1.8%	1.0%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.5%	0.7%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.8%	19.0%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	1.9%	1.2%
E10000023	North Yorkshire	15F	NHS Leeds CCG	0.9%	1.3%
E10000023	North Yorkshire	16C	NHS Tees Valley CCG	0.3%	0.4%
E10000023	North Yorkshire	36J	NHS Bradford District and Craven CCG	8.1%	8.3%
E10000023	North Yorkshire	42D	NHS North Yorkshire CCG	99.4%	67.9%
E10000023	North Yorkshire	84H	NHS County Durham CCG	0.1%	0.1%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	2.0%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.1%	1.1%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.5%	1.9%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.0%	1.0%
E10000021	Northamptonshire	71E	NHS Lincolnshire CCG	0.2%	0.2%
E10000021	Northamptonshire	78H	NHS Northamptonshire CCG	99.0%	94.8%
E06000057	Northumberland	00L	NHS Northumberland CCG	97.9%	98.7%
E06000057	Northumberland	01H	NHS North Cumbria CCG	0.1%	0.1%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.4%
E06000057	Northumberland	84H	NHS County Durham CCG	0.0%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.8%	0.6%
E06000018	Nottingham	52R	NHS Nottingham and Nottinghamshire CCG	33.5%	100.0%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	96.9%	13.5%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.6%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	15M	NHS Derby and Derbyshire CCG	1.4%	1.7%
E10000024	Nottinghamshire	52R	NHS Nottingham and Nottinghamshire CCG	64.7%	83.8%
E10000024	Nottinghamshire	71E	NHS Lincolnshire CCG	0.2%	0.2%
E08000004	Oldham	00Y	NHS Oldham CCG	94.6%	96.3%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.5%	1.4%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E08000004	Oldham	14L	NHS Manchester CCG	0.8%	2.1%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.7%	0.3%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.4%	96.6%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	14Y	NHS Buckinghamshire CCG	2.5%	1.8%
E10000025	Oxfordshire	15A	NHS Berkshire West CCG	0.4%	0.3%
E10000025	Oxfordshire	78H	NHS Northamptonshire CCG	0.1%	0.1%
E10000025	Oxfordshire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.7%	0.8%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	23.2%	96.4%
E06000031	Peterborough	71E	NHS Lincolnshire CCG	1.1%	3.6%
E06000026	Plymouth	15N	NHS Devon CCG	21.9%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.6%	1.4%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.5%	98.3%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.2%	0.2%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.3%	1.0%
E06000038	Reading	15A	NHS Berkshire West CCG	35.3%	99.0%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.6%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	4.8%	3.2%
E09000026	Redbridge	08C	NHS Hammersmith and Fulham CCG	0.3%	0.3%
E09000026	Redbridge	08F	NHS Havering CCG	0.8%	0.7%
E09000026	Redbridge	08M	NHS Newham CCG	1.3%	1.6%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.2%	89.5%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.2%	3.0%
E09000026	Redbridge	93C	NHS North Central London CCG	0.0%	0.1%

E06000003	Redcar and Cleveland	16C	NHS Tees Valley CCG	19.9%	98.8%
E06000003	Redcar and Cleveland	42D	NHS North Yorkshire CCG	0.4%	1.2%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	4.7%	6.8%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.6%	0.7%
E09000027	Richmond upon Thames	08Y	NHS West London CCG	0.0%	0.1%
E09000027	Richmond upon Thames	36L	NHS South West London CCG	12.3%	92.2%
E09000027	Richmond upon Thames	92A	NHS Surrey Heartlands CCG	0.0%	0.1%
E08000005	Rochdale	00V	NHS Bury CCG	0.7%	0.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.9%	1.0%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.6%	96.5%
E08000005	Rochdale	14L	NHS Manchester CCG	0.6%	1.6%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.2%	3.1%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	0.9%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.0%	1.1%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.8%	1.9%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	10.0%	86.6%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.4%
E06000017	Rutland	71E	NHS Lincolnshire CCG	0.6%	12.5%
E06000017	Rutland	78H	NHS Northamptonshire CCG	0.0%	0.5%
E08000006	Salford	00T	NHS Bolton CCG	0.3%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.3%
E08000006	Salford	01G	NHS Salford CCG	94.1%	94.5%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.2%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.1%
E08000006	Salford	14L	NHS Manchester CCG	1.1%	2.6%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.7%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	55.5%	88.5%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.7%	1.4%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000028	Sandwell	15E	NHS Birmingham and Solihull CCG	1.9%	7.2%
E08000014	Sefton	01J	NHS Knowsley CCG	1.9%	1.1%
E08000014	Sefton	01T	NHS South Sefton CCG	95.9%	51.6%
E08000014	Sefton	01V	NHS Southport and Formby CCG	96.7%	41.8%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.2%	0.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.4%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.9%	0.4%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.4%	0.2%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.5%	99.1%
E08000019	Sheffield	15M	NHS Derby and Derbyshire CCG	0.2%	0.4%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.5%	0.4%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.7%	95.3%
E06000051	Shropshire	05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	1.3%	0.9%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.4%	1.5%
E06000051	Shropshire	18C	NHS Herefordshire and Worcestershire CCG	0.6%	1.6%
E06000051	Shropshire	27D	NHS Cheshire CCG	0.2%	0.4%
E06000039	Slough	07W	NHS Ealing CCG	0.0%	0.2%
E06000039	Slough	07Y	NHS Hounslow CCG	0.0%	0.2%
E06000039	Slough	08G	NHS Hillingdon CCG	0.0%	0.1%
E06000039	Slough	14Y	NHS Buckinghamshire CCG	1.7%	5.7%
E06000039	Slough	15D	NHS East Berkshire CCG	34.3%	93.7%
E06000039	Slough	92A	NHS Surrey Heartlands CCG	0.0%	0.1%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.3%	0.4%
E08000029	Solihull	15E	NHS Birmingham and Solihull CCG	16.9%	99.0%
E08000029	Solihull	18C	NHS Herefordshire and Worcestershire CCG	0.0%	0.3%
E10000027	Somerset	11J	NHS Dorset CCG	0.4%	0.6%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.4%
E10000027	Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.3%
E10000027	Somerset	15N	NHS Devon CCG	0.2%	0.5%
E10000027	Somerset	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.8%	1.2%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.9%	1.9%
E06000025	South Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	28.2%	97.6%
E06000025	South Gloucestershire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.2%	0.6%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.2%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.2%
E06000045	Southampton	10X	NHS Southampton CCG	95.1%	99.5%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.5%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.7%	4.5%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.6%	95.5%
E09000028	Southwark	08C	NHS Hammersmith and Fulham CCG	1.9%	1.5%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.6%	1.7%
E09000028	Southwark	36L	NHS South West London CCG	0.0%	0.2%
E09000028	Southwark	72Q	NHS South East London CCG	17.7%	95.9%
E09000028	Southwark	93C	NHS North Central London CCG	0.1%	0.6%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.2%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.4%	2.2%
E08000013	St. Helens	01X	NHS St Helens CCG	91.6%	96.3%
E08000013	St. Helens	02E	NHS Warrington CCG	0.1%	0.1%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.7%	1.2%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.4%	14.9%
E10000028	Staffordshire	05C	NHS Dudley CCG	2.9%	1.1%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	92.1%	14.9%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	94.9%	23.1%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.2%	0.3%
E10000028	Staffordshire	05N	NHS Shropshire CCG	0.9%	0.3%
E10000028	Staffordshire	05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	96.1%	23.0%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.7%	16.7%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	9.2%	3.0%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.7%	0.6%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.5%	0.8%
E10000028	Staffordshire	15E	NHS Birmingham and Solihull CCG	0.3%	0.4%
E10000028	Staffordshire	15M	NHS Derby and Derbyshire CCG	0.5%	0.6%
E10000028	Staffordshire	27D	NHS Cheshire CCG	0.3%	0.2%
E08000007	Stockport	01W	NHS Stockport CCG	94.7%	96.7%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%

E08000007	Stockport	14L	NHS Manchester CCG	1.0%	2.1%
E08000007	Stockport	27D	NHS Cheshire CCG	0.4%	1.0%
E06000004	Stockton-on-Tees	16C	NHS Tees Valley CCG	28.5%	99.3%
E06000004	Stockton-on-Tees	42D	NHS North Yorkshire CCG	0.0%	0.1%
E06000004	Stockton-on-Tees	84H	NHS County Durham CCG	0.2%	0.6%
E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.4%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.3%	0.1%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	90.8%	97.2%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.2%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.9%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.4%	0.7%
E10000029	Suffolk	07K	NHS West Suffolk CCG	90.5%	29.8%
E10000029	Suffolk	26A	NHS Norfolk and Waveney CCG	12.0%	16.4%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.5%	0.3%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	95.9%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.9%
E08000024	Sunderland	84H	NHS County Durham CCG	1.6%	3.0%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.8%	0.2%
E10000030	Surrey	08C	NHS Hammersmith and Fulham CCG	0.2%	0.0%
E10000030	Surrey	10C	NHS Surrey Heath CCG	98.7%	7.6%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	15D	NHS East Berkshire CCG	3.4%	1.3%
E10000030	Surrey	36L	NHS South West London CCG	1.2%	1.6%
E10000030	Surrey	70F	NHS West Sussex CCG	1.4%	1.0%
E10000030	Surrey	72Q	NHS South East London CCG	0.0%	0.1%
E10000030	Surrey	92A	NHS Surrey Heartlands CCG	97.3%	84.1%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	22.8%	4.1%
E09000029	Sutton	08C	NHS Hammersmith and Fulham CCG	0.0%	0.1%
E09000029	Sutton	36L	NHS South West London CCG	12.7%	97.8%
E09000029	Sutton	72Q	NHS South East London CCG	0.0%	0.3%
E09000029	Sutton	92A	NHS Surrey Heartlands CCG	0.4%	1.8%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.1%	0.2%
E06000030	Swindon	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	24.9%	99.8%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.9%
E08000008	Tameside	01W	NHS Stockport CCG	1.8%	2.4%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.2%	87.9%
E08000008	Tameside	14L	NHS Manchester CCG	2.1%	5.8%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	2.9%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.6%	97.1%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.4%	98.7%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.4%	0.4%
E06000034	Thurrock	08F	NHS Havering CCG	0.3%	0.4%
E06000034	Thurrock	08M	NHS Newham CCG	0.0%	0.1%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.3%
E06000027	Torbay	15N	NHS Devon CCG	11.6%	100.0%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	1.2%	1.1%
E09000030	Tower Hamlets	08C	NHS Hammersmith and Fulham CCG	2.6%	2.2%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.3%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.6%	94.5%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.7%	0.5%
E09000030	Tower Hamlets	72Q	NHS South East London CCG	0.0%	0.2%
E09000030	Tower Hamlets	93C	NHS North Central London CCG	0.3%	1.3%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.2%
E08000009	Trafford	02A	NHS Trafford CCG	95.9%	92.3%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000009	Trafford	14L	NHS Manchester CCG	2.8%	7.4%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.8%	0.6%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.5%	98.0%
E08000036	Wakefield	15F	NHS Leeds CCG	0.4%	1.1%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.6%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.7%	3.3%
E08000030	Walsall	05Y	NHS Walsall CCG	92.7%	90.4%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.5%	1.4%
E08000030	Walsall	15E	NHS Birmingham and Solihull CCG	1.0%	4.7%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.4%	0.4%
E09000031	Waltham Forest	08C	NHS Hammersmith and Fulham CCG	0.8%	0.8%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.3%	1.7%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.3%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.2%	95.3%
E09000031	Waltham Forest	93C	NHS North Central London CCG	0.0%	0.4%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	1.9%	1.4%
E09000032	Wandsworth	08Y	NHS West London CCG	0.9%	0.6%
E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	1.3%	0.8%
E09000032	Wandsworth	36L	NHS South West London CCG	22.0%	93.3%
E09000032	Wandsworth	72Q	NHS South East London CCG	0.8%	3.8%
E09000032	Wandsworth	93C	NHS North Central London CCG	0.0%	0.1%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	1.9%
E06000007	Warrington	02E	NHS Warrington CCG	97.5%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.1%	21.6%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.6%	30.4%
E10000031	Warwickshire	05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.0%	46.0%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	15E	NHS Birmingham and Solihull CCG	0.2%	0.5%
E10000031	Warwickshire	18C	NHS Herefordshire and Worcestershire CCG	0.2%	0.2%
E10000031	Warwickshire	78H	NHS Northamptonshire CCG	0.2%	0.2%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.6%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	15A	NHS Berkshire West CCG	29.7%	97.7%
E06000037	West Berkshire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	0.0%	0.4%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.4%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.0%	1.0%
E10000032	West Sussex	70F	NHS West Sussex CCG	97.7%	97.4%

E10000032	West Sussex	92A	NHS Surrey Heartlands CCG	0.8%	1.0%
E10000032	West Sussex	97R	NHS East Sussex CCG	0.3%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	1.5%	1.7%
E09000033	Westminster	08Y	NHS West London CCG	22.4%	21.6%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	77.6%	70.8%
E09000033	Westminster	72Q	NHS South East London CCG	0.0%	0.2%
E09000033	Westminster	93C	NHS North Central London CCG	0.6%	3.7%
E08000010	Wigan	00T	NHS Bolton CCG	0.2%	0.2%
E08000010	Wigan	01G	NHS Salford CCG	0.8%	0.7%
E08000010	Wigan	01X	NHS St Helens CCG	3.5%	2.1%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.3%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.9%	1.0%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.9%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.2%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.2%	0.4%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.5%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.4%	0.4%
E06000054	Wiltshire	15A	NHS Berkshire West CCG	0.2%	0.2%
E06000054	Wiltshire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.5%
E06000054	Wiltshire	92G	NHS Bath and North East Somerset, Swindon and Wiltshire CCG	51.0%	97.8%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.2%	0.1%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	14Y	NHS Buckinghamshire CCG	0.3%	1.0%
E06000040	Windsor and Maidenhead	15A	NHS Berkshire West CCG	0.4%	1.3%
E06000040	Windsor and Maidenhead	15D	NHS East Berkshire CCG	33.7%	96.9%
E06000040	Windsor and Maidenhead	92A	NHS Surrey Heartlands CCG	0.0%	0.5%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.6%
E08000015	Wirral	27D	NHS Cheshire CCG	0.2%	0.4%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.4%
E06000041	Wokingham	15A	NHS Berkshire West CCG	32.1%	97.0%
E06000041	Wokingham	15D	NHS East Berkshire CCG	1.0%	2.5%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.3%	1.4%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.2%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	1.9%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.4%	3.4%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	94.0%	93.4%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.7%	0.4%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.4%	1.1%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	15E	NHS Birmingham and Solihull CCG	0.9%	2.0%
E10000034	Worcestershire	18C	NHS Herefordshire and Worcestershire CCG	74.6%	95.8%
E06000014	York	03Q	NHS Vale of York CCG	59.8%	99.9%
E06000014	York	42D	NHS North Yorkshire CCG	0.0%	0.1%

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