

Notice of Meeting

Health and Wellbeing Board



Date & time
Wednesday, 28
September 2022
at 2.00 pm

Place
Council Chamber,
Woodhatch Place, 11
Cockshot Hill, Reigate,
Surrey, RH2 8EF

Contact
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@SCCdemocracy

If you would like a copy of this agenda or the attached papers in another format, e.g. large print or braille, or another language please either call 07929 725663 or email amelia.christopher@surreycc.gov.uk.

This meeting will be held in public. If you would like to attend, please contact Amelia Christopher on 07929 725663.

Please be aware that a link to view a live recording of the meeting will be available on the Health and Wellbeing Board page on the Surrey County Council website. This page can be accessed by following the link below:

<https://mycouncil.surreycc.gov.uk/ieListMeetings.aspx?CId=328&Year=0>

Board Members

Tim Oliver (Chairman)
Dr Charlotte Canniff (Vice-Chairman)

Leader of Surrey County Council
Joint Chief Medical Officer, Surrey Heartlands
Integrated Care System

Karen Brimacombe

Chief Executive, Mole Valley District Council (Surrey
Chief Executives' Group) (Priority 1 Sponsor)

Professor Helen Rostill / Kate Barker
and Liz Williams

Director for Mental Health, Surrey Heartlands ICS and
SRO for Mental Health, Frimley ICS (Priority 2 Co-
Sponsor) / Joint Strategic Commissioning Conveners,
Surrey County Council and Surrey Heartlands (Priority
2 Co-Sponsors)

Mari Roberts-Wood

Chief Executive, Reigate and Banstead Borough
Council (Priority 3 Sponsor)

Fiona Edwards

Chief Executive of the Frimley Health and Care
Integrated Care System (ICS) and Accountable Officer
for NHS Frimley CCG

Jason Gaskell (plus two rotational
VCSE Alliance representatives)

CEO, Surrey Community Action, VCSE Alliance
representative

Dr Russell Hills

Clinical Chair, Surrey Downs ICP

Kate Scribbins

Chief Executive, Healthwatch Surrey

Ruth Hutchinson

Director of Public Health, Surrey County Council

Liz Bruce

Joint Executive Director of Adult Social Care and
Integrated Commissioning, Surrey County Council and

Rachael Wardell	Surrey Heartlands ICS Executive Director for Children, Families and Lifelong Learning
Professor Claire Fuller	Senior Responsible Officer, Surrey Heartlands
Graham Wareham	Chief Executive, Surrey and Borders Partnership
Joanna Killian	Chief Executive, Surrey County Council
Mark Nuti	Cabinet Member for Adults and Health, Surrey County Council
Sinead Mooney	Cabinet Member for Children and Families, Surrey County Council
Denise Turner-Stewart	Cabinet Member for Communities and Community Safety, Surrey County Council
Jason Halliwell	Head of Probation Delivery Unit for Surrey at The Probation Service
Carl Hall	Deputy Director of Community Development, Interventions Alliance
Gavin Stephens	Chief Constable of Surrey Police
Borough Councillor Hannah Dalton	Chair of Residents' Association (Majority Group), Epsom and Ewell Borough Council (Surrey Leaders' Group)
Steve Flanagan	Representative, North West Surrey Integrated Care Partnership and Community Provider voice
Vacancy	Integrated Care Partnership Director and Director of Clinical Integration, Guildford and Waverley ICP
Vacancy	Crawley, East Surrey and Horsham (CRESH) ICP and Acute Hospitals/Acute Trust Providers
Lisa Townsend	Police and Crime Commissioner for Surrey
Deborah Dunn-Walters	Professor of Immunology and leads the Lifelong Health research theme, University of Surrey
Siobhan Kennedy	Homelessness, Advice & Allocations Lead, 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: 15 JUNE 2022

(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 (*22 September 2022*).

b Public Questions

The deadline for public questions is seven days before the meeting (*21 September 2022*).

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 - 98)

This paper provides an overview of the progress of local shared projects and communications activity supporting delivery of the three Health and Wellbeing Strategy priorities as of 6 September 2022 with the priority population groups.

The Highlight Report provides an overview of each Priority, describes what has been achieved in the previous period and how collaborative working has aided this progress.

The Young Carers Strategy is included for the Board's endorsement.

6 HEALTH AND WELL-BEING STRATEGY METRICS: REVIEW AND REFRESH (Pages 99 - 110)

Alongside the refresh of the Health and Wellbeing Strategy a revised set of metrics have been developed to better link with the updated priorities, outcomes and priority populations. The Health and Wellbeing Board is asked to agree the proposed set of metrics as a reflection of the greater focus in the Strategy on reducing health inequalities and wider determinants of health and Review and promote awareness of the metrics within their organisation to enable a common understanding and assessment of progress.

7 UPDATE ON THE MENTAL HEALTH IMPROVEMENT PLAN (Pages 111 - 138)

In recent months the MHIP, and mental health improvement and transformation work more broadly, has undergone a reset, in order to address some of the challenges which have been found to date, to align with wider system ambitions and to build on our successes. This paper provides an update on the changes that have been made, and next steps. It also asks the Health and Wellbeing Board to agree the Terms of Reference of the new Mental Health System Delivery Board.

8 A COUNTY-WIDE STRATEGY FOR HOUSING, ACCOMMODATION AND HOMES: BASELINE ASSESSMENT (Pages 139 - 146)

This report outlines the background to and drivers for the initiation of a county-wide housing, accommodation and homes strategy and sets out the initial findings of a baseline assessment exercise, upon which key priorities and action will be derived, through a partnership-based, collaborative deliberation programme.

9 EVALUATION REPORT FROM THE COMMUNITY SAFETY ASSEMBLY (Pages 147 - 164)

In March 2020, the then Community Safety Board merged with the Health and Wellbeing Board. The overriding aim of the merger was to create a whole systems approach and develop a sense of shared priorities through collaborative working. Following a detailed evaluation report and analysis of the feedback from the Community Safety Assembly, the Health and Wellbeing Board is being asked for agreement to explore some initial areas of focus.

10 SURREY PHARMACEUTICAL NEEDS ASSESSMENT (PNA) 2022 (Pages 165 - 442)

The purpose of this paper is to present key aspects of the Surrey PNA 2022, including its recommendations, to the Board for final approval and to seek agreement to its publication no later than 1 October 2022.

11 BETTER CARE FUND PLAN 2022-2023: NARRATIVE AND FINANCIAL PLAN (Pages 443 - 486)

This report is the Better Care Fund (BCF) Plan for 2022-2023. Guidance for the plan was published by NHSE in August 2022 and, following consultation with the Local Joint Commissioning Groups and data managers across Surrey, this plan has been developed and is for the Board's approval.

12 INTEGRATED CARE SYSTEMS (ICS) UPDATE (Pages 487 - 492)

The Board is asked to note the update provided on the recent activity within the Surrey Heartlands and Frimley Integrated Care Systems (ICS) regarding the Integrated Care Partnerships and Integrated Care Boards.

13 DATE OF THE NEXT MEETING

The next meeting of the Health and Wellbeing Board will be on 21 December 2022.

**Joanna Killian
Chief Executive
Surrey County Council**

Published on: Tuesday, 20 September 2022

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.

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It is requested that if you are not using your mobile device for any of the activities outlined above, it be switched off or placed in silent mode during the meeting to prevent interruptions and interference with PA and Induction Loop systems.

Thank you for your co-operation

MINUTES of the meeting of the **HEALTH AND WELLBEING BOARD** held at 2.00 pm on 15 June 2022 at Council Chamber, Woodhatch Place, 11 Cockshot Hill, Reigate, Surrey, RH2 8EF.

These minutes are subject to confirmation by the Committee at its meeting on Wednesday, 28 September 2022.

Board Members:

(Present = *)

(Remote Attendance = r)

- Fiona Edwards
- * Dr Charlotte Canniff (Vice-Chairman)
- Jason Gaskell
- r Dr Russell Hills
- * Tim Oliver (Chairman)
- * Kate Scribbins
- * Liz Bruce
- * Ruth Hutchinson
- Professor Claire Fuller
- Graham Wareham
- r Joanna Killian
- * Sinead Mooney
- * Clare Curran
- * Mark Nuti
- * Karen Brimacombe
- Jason Halliwell
- Carl Hall
- Gavin Stephens
- * Kevin Deanus
- r Steve Flanagan
- Professor Helen Rostill
- * Professor Deborah Dunn-Walters
- * Rachael Wardell
- Borough Councillor Nick Prescott
- Lisa Townsend
- Siobhan Kennedy (Associate Member)

Rotational VCSE Alliance Board members:

- r Maria Mills - Chief Executive Officer, Active Prospects
- Michelle Blunsom MBE - Chief Executive Officer, East Surrey Domestic Abuse Services

Substitute Members:

- r Dr Ian McPherson - Chair, Surrey and Borders Partnership NHS Foundation Trust (SABP)
- * Sue Murphy - CEO, Catalyst (VCFS representative)
- * Nicola Airey - Executive Place Managing Director, Surrey Heath (NHS Frimley CCG)
- r Alison Bolton - Chief Executive, Office of the Police and Crime Commissioner for Surrey (OPCC)
- * Borough Councillor Hannah Dalton - Chair of Residents' Association (Majority Group), Epsom and Ewell Borough Council (Surrey Leaders' Group)

The Chairman welcomed incoming Board members and thanked outgoing Board members:

- Welcomed Kevin Deanus - Cabinet Member for Community Protection (SCC) as agreed at March's Board meeting.
- Thanked Simon White as the outgoing Executive Director for Adult Social Care and Integrated Commissioning (SCC) for all of his hard work over the past four years; welcome Liz Bruce as the new Joint Executive Director.
- Welcomed Professor Deborah Dunn-Walters - Professor of Immunology and leads the Lifelong Health research theme (University of Surrey); and Dr Bernadette Egan as her Deputy - Senior Research Fellow and Deputy Director of NIHR Research Design Service South-East (University of Surrey); and thanked Rachel Hargreaves (interim) - Industry Partnerships Manager - Health (University of Surrey) as the outgoing Representative of further education / universities.
- Thanked outgoing Board member Vicky Stobbart, Integrated Care Partnership Director and Director of Clinical Integration, Guildford and Waverley ICP.

14/22 APOLOGIES FOR ABSENCE [Item 1]

Apologies were received from Gavin Stephens, Graham Wareham - Dr Ian McPherson substituted, Professor Claire Fuller, Professor Helen Rostill, Carl Hall, Jason Gaskell - Sue Murphy substituted, Fiona Edwards - Nicola Airey substituted, Lisa Townsend - Alison Bolton substituted, Borough Councillor Nick Prescott - Borough Councillor Hannah Dalton substituted, Michelle Blunsom MBE (rotational VCSE Alliance Board member).

15/22 MINUTES OF PREVIOUS MEETING: 16 MARCH 2022 [Item 2]

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

16/22 DECLARATIONS OF INTEREST [Item 3]

There were none.

17/22 QUESTIONS AND PETITIONS [Item 4]

a Members' Questions

None received.

b Public Questions

None received.

c Petitions

There were none.

**18/22 HEALTH AND WELLBEING STRATEGY HIGHLIGHT REPORT
INCLUDING: APPROVAL OF THE NEW TERMS OF REFERENCE OF
THE SURREY PREVENTION AND WIDER DETERMINANTS OF
HEALTH DELIVERY BOARD [Item 5]**

Witnesses:

Karen Brimacombe - Chief Executive, Mole Valley District Council (Surrey Chief Executives' Group) (Priority One and Priority Three Sponsor)
Liz Williams - Joint Strategic Commissioning Convener, Learning Disability and Autism, Surrey County Council and Surrey Heartlands ICS
Alison Bolton - Chief Executive, Office of the Police and Crime Commissioner for Surrey (OPCC)
Ruth Hutchinson - Director of Public Health, Surrey County Council

Key points raised in the discussion:

Priority One

1. The Priority One Sponsor noted that:
 - The updated Health and Wellbeing Strategy (HWS) was on the Healthy Surrey website.
 - Feedback from the Health in all Policies approach (HiAP) workshop in March was to ensure that the approach would be embedded through organisations and that needed to be given some consideration.
 - Referring to 'In the Spotlight' on health inequalities faced by people with learning disabilities in Surrey, highlighted the significant differences in life expectancy for males and females with and without a learning disability; understanding the systemic and unfair differences in health outcomes and access to services was crucial. The most notable health inequalities from the study were around type 2 diabetes, obesity, hypertension, the age of mortality and attendance to cancer screenings. She urged Board members to think about what their organisations can do to help.
2. The Joint Strategic Commissioning Convener, Learning Disability and Autism, (SCC and SH ICS) noted that:
 - There was now a more granular picture of those who are on the learning disabilities primary care GP register and the health inequalities they face.
 - The recommendations within the learning disabilities report were being finessed and would drive programmes of improvement forward firstly at neighbourhood level, then at place and system level.
 - Data had been combined with that of Active Prospects who had been commissioned to construct a whole system approach to obesity for people with a learning disability; a second phase of work was being commissioned as a result of the analysis in the report and the discussions had in various forums, she thanked the Place Leader / Chief Officer - North West Surrey Health & Care Alliance for his work around the inequalities.
 - No one in Surrey would be left behind as whilst the analysis for the report had taken place against Surrey Heartlands data, Frimley colleagues would provide further recommendations and support.
3. A Board member queried whether any of the recommendations in the learning disabilities report addressed the pre-14 years age group for children and young people with learning disabilities and their broader wellbeing, as the annual health check started from the age of 14 years onwards.

- In response, the Joint Strategic Commissioning Convener, Learning Disability and Autism (SCC and SH ICS) noted that the recommendations in the report did not address the pre-14 years age group for children and young people with learning disabilities, the second phase of analysis would look at Educational, Health and Care Plans (EHCPs) to do a further deep dive and look at the pre-14 years pre-annual health check. Once produced, the revised set of recommendations would be shared and scrutinised.
4. A Board member noted that regarding prevention and early intervention in screening, often people with a learning disability do not get accessible letters or invites, or their experience going into clinics for screening does not work well for them; and asked about how the accessibility requirements were met for those with learning disabilities in Surrey.
- In response, the Joint Strategic Commissioning Convener, Learning Disability and Autism (SCC and SH ICS) noted that there was an accessible letter generating ability on the learning disability website, which would be refreshed enabling primary and secondary care colleagues to add details into the website; analysis on the previous uptake was underway. She would look to liaise with the Board member on her experience of the matter from the previous system she worked at.
 - The Vice-Chairman noted that according to the data in North West Surrey, the uptake of the cervical smear was significantly below the target for women with learning disabilities. A piece of work looked at that cohort and the reasons why they were not coming forward, which led to the provision of delivering a service on a Saturday because many of them required a carer to take them to an appointment. She noted that accommodating those with learning disabilities required a bespoke process or for easy-read invites to be provided. That screening pilot would be reviewed to see whether it could be extended to other screening programmes.
 - The Joint Strategic Commissioning Convener, Learning Disability and Autism (SCC and SH ICS) noted that a lead was working closely with the Cancer Alliance to try and improve the uptake of the cervical screening offer. Another issue concerned the accessibility of buildings and the availability of hoists. Having the granularity of data across different levels in the system would help drive improvements and reduce the mortality gap.
 - The Chairman referred to a Board member's comment in the meeting chat, noting that tackling obesity would be a key area of focus given the impact on blood pressure and diabetes, and that historically some areas of screening for women with learning disabilities have been challenged with more need for support around cervical and breast screening by learning disability nurses to support learning disability residents and their carers.
5. A Board member referred to waiting well and asked whether that was specifically linked to learning disabilities within the Priority. She noted that Healthwatch Surrey had undertaken a small-scale survey in Surrey about how residents are experiencing being on waiting lists for elective care and Healthwatch England had published a broader survey on the impact of waiting and support provided. The findings were that those with multiple disadvantages faced a significant impact on the length of waiting time and the likelihood of cancellation. She asked what was known about people in Surrey with learning disabilities, how were they faring on waiting lists and how the

impacts were tracked; elective care was not a choice and waiting had a huge impact on people's ability to function and those around them.

- The Vice-Chairman noted that elective care describes the people who were waiting for an outpatient appointment, a surgical procedure or a diagnostic. She noted that Surrey Heartlands ICS about nine months ago had looked across all its health inequality domains - including learning disabilities - and did not identify anyone in those groups that were waiting any longer than the already unacceptable wait for everybody. The Covid-19 pandemic had exacerbated the waiting lists. An action had been taken away from the elective care board to refresh that work. Taking a broader view was needed of those with health inequalities who do not come forward to access services and therefore are not on the waiting lists.
- A Board member noted that regarding the Communities service, a piece of work was underway with the newly formed Community Link Officers, part of their remit would be to find out what issues there were in communities such as around health. He suggested that the officers could gather intelligence around waiting lists for people with learning disabilities or multiple disadvantages.

Priority Two

(Priority Three and Approval of the new Terms of Reference of PWDHDB were discussed before this)

6. The Joint Strategic Commissioning Convener, Learning Disability and Autism (SCC and SH ICS) (on behalf of the Priority Two Sponsor) noted that:
 - Referring to the changes to the Priority Two outcomes:
 - Outcome one had been amended to clarify that it covers all ages: 'Adults, children and young people at risk of' and with depression, anxiety and 'other' mental health issues access the right early help and resources.

Alison Bolton left the meeting at 2.44 pm.

- Outcomes two around the emotional wellbeing of carers and three around isolation remained the same.
 - The proposed fourth outcome 'Environments and communities in which people live, work and learn build good mental health'; had been aligned with the Mental Health Improvement Plan, retaining a strong focus on primary prevention which was critical.
 - The report included a suggestion for a Priority Two Working Group to be established, ensuring an integrated approach with workstream one of the Mental Health Improvement Plan around early intervention and prevention.
7. The Chairman highlighted the process underway to create a single mental health delivery board that would be chaired by Jonathan Perkins - Lay Deputy Chair at NHS Surrey Heartlands CCG. He noted the two different aspects to mental health, the prevention and early intervention agenda covering item 8 for example, and the more medicalised solutions and the work of Mindworks Surrey and Surrey and Borders Partnership NHS Foundation Trust (SABP). He noted that building on the recent conversations, work underway through various forums and support officers in place, it was the right time to focus on the practical delivery aspects around improving mental health.

8. Regarding the proposed fourth outcome, a Board member noted that for children and young people the environments where they learn is predominantly in schools and early education; she highlighted that point so that when discussing item 8, that important relationship with Surrey's schools is noted.

Priority Three

9. The Priority Three Sponsor noted that:
 - Extra capacity by the Public Health team (SCC) had been provided to deliver Priority Three and the HiAP approach.
 - Referring to the 'In the Spotlight' on the Community Safety Assembly event in Surrey in May which was well attended, there were three main aims around data, shared and holistic response as outlined in the report.
 - The afternoon session of the event focused on the Community Safety Agreement (CSA) and the key themes were vulnerability, community harm and community empowerment. Feedback from the three interactive sessions around the CSA were around investment, knowledge and data sharing, the accessibility of services and community problem-solving.

Joanna Killian left the meeting at 2.32 pm.

10. The Chief Executive (OPCC) highlighted that the Police and Crime Commissioner for Surrey (PCC) had found the event to be valuable, input from colleagues was being collated and it was a good opportunity to see community safety colleagues together in person. It was hoped that a report would be provided at the next public Board meeting and the PCC intended to hold another similar event in the autumn.
11. The Chairman and a Board member commended the event, and the Board member noted that attendees identified the close correlation between feeling safe in one's community and being able to enjoy good health such as being active, or elderly residents not being obstructed by cars on the pavement. She noted that regarding the Surrey Corporate Parenting Board, care leavers were engaged with regularly and they recognised the correlation between their wellbeing and good mental health and feeling safe in their communities.
12. The Chairman noted that it would be good to bring that report following the CSA event in May back to the Board - and the Community Safety Board - to ensure that there are more agenda items on community safety going forward.

Approval of the new Terms of Reference of the Surrey Prevention and Wider Determinants of Health Delivery Board (PWDHDB)

13. The Director of Public Health (SCC) noted that:
 - The PWDHDB had oversight of Priorities One and Two, following the HWS refresh the PWDHDB's terms of reference had been refreshed and the Board was asked to provide approval.
 - The refreshed terms of reference and scope and principles reflected the strengthened focus on health inequalities and wider determinants of health and the importance of working with communities, the membership had been revised with extra representation from those working in communities and places and colleagues representing the wider determinants of health.

- Place-based representatives were being engaged with and reviewed to see how the link between what happens at the PWDHDB and the delivery at place could be maximised.
 - The frequency of the PWDHDB had been moved from quarterly to six-weekly to ensure delivery and to have meaningful discussions particularly around Priority Three.
14. The Chairman provided reassurance around the terms of reference noting that the different responsibilities had been mapped, with the PWDHDB sitting alongside the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP).
 15. The Vice-Chairman noted that as the role of the Joint Chief Medical Officer was developing, clinical leadership would be delivered in a number of the priority programmes such as around cardiovascular disease (CVD); referring to the singular clinical lead representative, she asked whether the membership could be strengthened to include the system clinical leads against those high priority programmes.
 - In response, the Director of Public Health (SCC) noted that those roles would be essential, particularly around CVD as the prevention work had been aligned to the work in the CVD workstream.
 - The Vice-Chairman added that rather than having separate prevention plans for each health problem such as CVD, it would be good to think about how a single holistic prevention plan is presented for Surrey's residents.
 16. A Board member noted that although there was a representative of Voluntary Community and Faith Sector (VCFS) she could not see representation for people with lived experience on the PWDHDB which was important. She explained that Healthwatch held the contract for adult carers alongside the local Healthwatch contracts, and if useful Healthwatch Surrey could provide user voice representation to the PWDHDB.
 - In response, the Director of Public Health (SCC) noted Healthwatch Surrey's offer and would liaise with the Board member.
 17. A substitute Board member queried whether the VCFS representation would be via the VCSE (Voluntary, Community and Social Enterprise (VCSE)) Alliance.
 - In response, the Director of Public Health (SCC) confirmed that the above was her understanding.
 18. The Chairman acknowledged the importance of ensuring that the right voices were on the PWDHDB.

RESOLVED:

1. Noted progress against the three priorities of the Strategy in the Highlight Report.
2. Endorsed the changes to the outcomes of Priority 2 of the Health and Wellbeing Strategy.
3. Approved the revised Terms of Reference of the HWB's Prevention and Wider Determinants of Health Delivery Board.
4. Would utilise the link to the refreshed Health and Well-being Strategy to increase awareness through their organisations to elicit support for reducing health inequalities (as per findings of the HWB Health in All Policies workshop, March 2022).

Actions/further information to be provided:

Priority One

1. Board members will look to see how their organisations can help concerning the findings in report on the health inequalities faced by people with learning disabilities in Surrey.
2. The Joint Strategic Commissioning Convener, Learning Disability and Autism (SCC and SH ICS) will share the revised set of recommendations in due course concerning the report on the health inequalities faced by people with learning disabilities in Surrey.
3. The Joint Strategic Commissioning Convener, Learning Disability and Autism (SCC and SH ICS) will liaise with the Board member (Joint Executive Director, Adult Social Care and Integrated Commissioning, SCC and SH ICS) on her experience of ensuring accessible letters and invites to or experiences at screening appointments from the previous system she worked at.
4. The Joint Strategic Commissioning Convener, Learning Disability and Autism (SCC and SH ICS) will look to liaise with the Board member (Cabinet Member for Communities, SCC) on his suggestion on intelligence gathering around health via the newly formed Community Link Officers.

Priority Three

5. The Chief Executive (OPCC) and Police and Crime Commissioner for Surrey will look to provide the report following the Community Safety Agreement event in May back to the Board - and the Community Safety Board - at the next public Board meeting.

Approval of the new Terms of Reference of the Surrey Prevention and Wider Determinants of Health Delivery Board (PWDHDB)

6. The Director of Public Health (SCC) will look at the inclusion of multiple system clinical leads on to the PWDHDB's membership as opposed to a singular clinical lead representative.
7. The Director of Public Health (SCC) will liaise with the Board member (Chief Executive, Healthwatch Surrey) on providing user voice representation on the PWDHDB via Healthwatch Surrey.

19/22 PRIORITY 1: BETTER CARE FUND (BCF) REVIEW [Item 7]

Items 7 and 8 were taken before item 6.

Witnesses:

Liz Bruce - Joint Executive Director, Adult Social Care and Integrated Commissioning, Surrey County Council and Surrey Heartlands ICS

Jon Lillistone - Assistant Director Commissioning Health, Wellbeing and Adult Social Care, Surrey County Council

Key points raised in the discussion:

1. The Joint Executive Director, Adult Social Care and Integrated Commissioning (SCC and SH ICS) noted that:
 - The Better Care Fund (BCF) is a mechanism through which to pool, share and target money into priority areas across health and care.
 - Surrey's BCF totalled approximately £110 million.
 - The overall outcomes of the BCF review were that Surrey needed to: remain in a steady state this year, review the governance at a local commissioning level and establish a common governance framework, shift to prevention spend mapping and focus on prevention and early intervention, focus on health inequalities ensuring that the BCF reflects against the national guidance and Surrey's refreshed HWS.

- A shift in the direction of travel was needed for Surrey's BCF towards more strategic thinking and longer-term investment.
2. The Assistant Director Commissioning Health, Wellbeing and Adult Social Care (SCC) noted that:
 - Emerging from the BCF review was: the importance of setting system-wide expectations and ambitions for the spend of the BCF, it had been identified that more work needed to be done to strengthen the approach around evidence gathering and impacts and outcomes - particularly important around addressing health inequalities - to share good practice on the management of the BCF at place-level and system-wide.
 - Community Equipment Services were a key part of the BCF spend system-wide with the majority of places spending around 20% of their budget on that, places spent around 10-12% of their funding on Community Connections Services relating to mental health early intervention, BCF spend was invested in core functions within adult social care and integrated teams within the health system; recognising those key parts of the system was needed for the future strategic plans.
 - Having engaged with colleagues at place-level there was a strong desire to commit to system-wide priorities, whilst having a degree of flexibility.
 - The interface with Surrey's District and Borough Councils was critical as they were key delivery partners for many aspects of the BCF schemes, the Disabled Facilities Grant made up around 10% of BCF spend.
 - The BCF was comprised of a complex set of relationships, but there were real opportunities to deliver system-wide ambitions.
 3. The Chairman queried whether there was alignment within the system so that the BCF links in with the JSNA and the potentially increasing amount of Section 75 agreements following the Health and Care Act 2022, ensuring that there was a complete picture of what Surrey's priorities were and how those would be funded.
 - In response, Assistant Director Commissioning Health, Wellbeing and Adult Social Care (SCC) provided assurance that alignment was underway including linking in with the broader prevention spend mapping work underway system-wide.
 4. A Board member referring to the relationship between place and the system with BCF spending at place-level and services commissioned by the local joint commissioning groups, asked about how to ensure that residents across Surrey have equitable access to the services which are important to them such as Tech to Community Connect offered by the Surrey Coalition of Disabled People. Decision-making was at place-level and the inconsistency of services offered Surrey-wide was a problem, so too was the practical issue of voluntary sector organisations offering services having to make a different business proposal to each place which was time-consuming. She asked whether place-based decision-making would continue and how some services would be identified and decided to be provided on a Surrey-wide basis.
 - In response, the Assistant Director Commissioning Health, Wellbeing and Adult Social Care (SCC) noted that the above questions highlighted areas to be worked on in the next phase of the BCF review. It would be vital to ensure that there would be a simple governance process that balances place-level decision-making for their local population and the commitment to key strategic priorities for system-wide provision of identified schemes that could address health inequalities. The consistency in decision-making was fundamental, highlighting the example of the Community Equipment Services where decision-making was made at a strategic system-wide level; having the right interfaces to share good examples would be critical. He was happy to liaise further with the Board member.

- The Joint Executive Director, Adult Social Care and Integrated Commissioning (SCC and SH ICS) noted that it would be a reoccurring theme in the system working with partners, about what is done and at what spatial level and what the rationale is to do things at a system-wide level, a county level or a local level; having a commonality of governance would be key. The ICS structure would go live in July and included in one of the White Papers was that some of the decision-making around the BCF would go on a legal basis alongside the statutory ICS which would drive those geographical decisions being made as a system.
 - The Vice-Chairman noted that discussions were underway about subsidiarity, a balance was needed between being clear at a strategic level on the setting of high-level outcomes and the desirable outputs for citizens with the delivery of achieving those at community level through the BCF money.
 - The Chairman noted that the ICP would work on how to get BCF spending down to the community level.
5. A substitute Board member noted the current discussions underway about what level decisions are made. She noted that those working at the system-level need to have confidence that people who work at place-level make rational decisions; she had not experienced a situation where framing a recommendation to work at scale had not been supported by place-level. To ensure the engagement of places, it was important that they feel that they have some of that decision-making responsibility. She noted the fear from some people who work at a system-level who believe that if decisions are not taken at or delegated from the system-level the right decisions would not be made.
6. The Chairman highlighted a Board member's comment in the meeting chat around the 'Next steps for integrating primary care: Fuller Stocktake report' which was about how to address primary care and deliver it at community level, also the direction of travel from the Department of Health and Social Care. He noted that clarity was needed around the levels of decision-making, it was not a top-down situation, the ICSs would own the strategy and the budget for the whole system and it was vital to ensure that money is filtered down the right channels to where it is needed. He highlighted recommendation seven from the BCF review which required a structure to be designed to enable its delivery and the upcoming health inequalities White Paper might provide further detail.

RESOLVED:

Agreed the recommendations from the review:

- The BCF programme continues in a 'steady state' for FY22/23.
- That we review the governance across each of the Local Joint Commissioning Committees with the aim of creating a common governance framework between the places.
- That BCF spend is brought into the scope of the 'Prevention Spend Mapping' exercise currently being undertaken across the system.
- That the analysis from this exercise is used to inform a recommendation on the direction of travel to be taken from FY2023/24.
- This new direction of travel will be presented to ICS exec in Q3 22/23.
- The new direction of travel includes a commitment to longer-term funding arrangements where appropriate (rather than 1-year contracts). This decision acknowledges that the BCF is likely to continue with 1 year planning

frameworks but that longer-term funding arrangements are likely to result in better value for money.

- That the new direction of travel includes a commitment to use the BCF to address health inequalities, in line with national guidance and the refreshed HWB strategy, which has a strong focus on health inequalities and priority populations.
- To note the end of year report submission for 2021/22.

Actions/further information to be provided:

1. The Assistant Director Commissioning Health, Wellbeing and Adult Social Care (SCC) will look to liaise with the Board member (Chief Executive, Healthwatch Surrey) further on the questions asked around the levels of decision-making (place-based or Surrey/system-wide) concerning BCF spending.

20/22 PRIORITY 2: MENTAL HEALTH INVESTMENT FUND [Item 8]

Witnesses:

Liz Bruce - Joint Executive Director, Adult Social Care and Integrated Commissioning, Surrey County Council and Surrey Heartlands ICS

Kate Barker - Joint Strategic Commissioning Convener, Children and Young People, Surrey County Council and Surrey Heartlands ICS

Sinead Mooney - Cabinet Member for Adults and Health, Surrey County Council

Key points raised in the discussion:

1. The Joint Executive Director, Adult Social Care and Integrated Commissioning (SCC and SH ICS) noted that:
 - The £8 million early intervention and prevention in mental health investment via a 1% uplift in Council Tax, supported the delivery of the Surrey County Council's strategic priority of 'No one Left Behind'.
 - Ensuring clarity in the bidding process and its criteria, implementation plans and outcomes was vital; so that those with mental health needs receive better outcomes.
2. The Chairman noted that Surrey Heartlands ICS had also contributed £4 million and the Community Foundation for Surrey had provided some match funding.
3. The Joint Strategic Commissioning Convener, Children and Young People (SCC and Surrey Heartlands ICS) noted that:
 - Public accountability and co-production regarding the Mental Health Investment Fund (MHIF) was fundamental, there was a commitment to use the resources to translate the outcomes already co-designed through the mental health alliance and the independent networks into measurable outcomes for residents.
 - The aim was for the funding process to be inclusive, building on the successful Contain Outbreak Management Fund (COMF) process.

Dr Russell Hills left the meeting at 3.04 pm.

- The report sought the Board's support on the proposed criteria, principles and governance framework, so that it is assured that the co-designing process would contribute to the outcomes in the HWS. With short-term investment those proposals would enable innovation with

- measurable outcomes in relation to mental health identification, early intervention and prevention and that business intelligence evidence would be used to measure what the costs would be to reduce the demand on statutory services, to understand the lived experience of residents and to look at the long-term cost to sustain good innovation.
- Whilst the scope of the proposed investment covered all ages, teenage suicide was a key focus as was the mental health and wellbeing of men aged 18 to 30 years, support for those with eating disorders, carer support for families, and support in schools and community settings.
 - Support had been provided from Democratic Services in outlining the governance processes, ensuring that there is the appropriate accountability on the spending decisions around the MHIF. Spending might commence in autumn following approval through the governance bodies within Surrey County Council, the ICSs and the VCSE partners.
 - Ensuring alignment with partners and administrative support would be crucial.
 - The Board was to consider how it would contribute to future decision-making concerning the MHIF, how it would like to be kept informed of the developing outcomes and whether there was any additional evidence required for assurance that the proposals would align with the HWS.
4. The Cabinet Member for Adults and Health (SCC) noted that:
 - The report was thought-provoking and outlined system working to improve the mental health service provided in Surrey; it followed on from the work undertaken by the Adults and Health Select Committee's Task Group on Mental Health in 2019 with over thirty recommendations, the two Mental Health Summits and the creation of the Mental Health Improvement Board.
 - Funding had been recognised as a priority to improve mental health services and the Leader of Surrey County Council had a few months ago announced the creation of the MHIF to tackle health inequalities.
 - She agreed with the proposed principles in the report which balanced the focus on personalised improvements and better outcomes.
 - Acknowledged that more work needed to be done and it would be good to see engagement with service users and to ensure the clear and streamlined process for approvals for accessing the MHIF.
 - It was vital for the Board to recognise the importance of elected Members - through the Surrey-Wide Commissioning Committees in Common for example - taking public decisions around the MHIF noting the ring-fenced funding from the Council Tax rise.
 5. The Chairman commended the Cabinet Member for Adults and Health (SCC) for championing the MHIF, mental health issues had risen and it was a priority to residents and important that the rise in Council Tax for mental health was ring-fenced, with funding decisions to be made in public. The MHIF would accelerate important projects to support residents' mental health.
 6. The Vice-Chairman considered the question around Board member support and assurance on the right decisions to be made on the MHIF, agreeing with the proposed purpose which must focus on mental health early intervention and prevention; she would like to see granular detail on where the gaps are and whether there was mapping on the gaps so that the MHIF could be targeted. She asked whether a part of the MHIF should be ring-fenced for children and young people. She also asked how the Board would prove impact through the MHIF and whether there was best practice on the matter.
 7. A substitute Board member noted SABP's support of the ambitious approach to tackle mental health early intervention and prevention for all ages and the

importance of early identification particularly for those with eating disorders or neurodivergent disorders for example. He emphasised that it would be vital to go beyond the traditional provision of support and services, towards the innovative work already underway in Surrey. Whilst it would be important to demonstrate that the money would be well spent, the governance over it should not be too constrained, so to allow a flexibility approach and creative response.

8. A Board member noted the support from the Public Health team (SCC), referring to the 'Proposed Criteria & Principles' outlined in Annex 1 and point about supporting the implementation of the HWS Priorities, she noted that it felt lost in the scope and it was an opportunity in the bidding criteria to emphasise those, aligning with the assessment of the HWS outcomes and linking in with the health inequalities programme.
 - In response, the Joint Strategic Commissioning Convener, Children and Young People (SCC and Surrey Heartlands ICS) noted that the evidence base could be strengthened around health inequalities and the Community Vision for 2030. The report was high-level concerning the principles around the governance and the decision-making; and hoped that in the next few weeks the interdependencies with other strategies would be developed and that areas requiring support would be identified.

Liz Bruce left the meeting at 3.22 pm.

9. A Board member flagged the interest in the MHIF from Surrey's schools, welcoming the investment in all ages and highlighted the importance of ensuring children's voices and their practitioners are heard. She noted the comment made in the meeting chat by the Joint Strategic Commissioning Convener, Children and Young People (SCC and Surrey Heartlands ICS) which clarified that schools could meet the criteria for making a bid and that schools would be engaging with successful bidders in the delivery of the services to their children and young people. She queried how schools could be engaged with more broadly in the MHIF process, other than through her representation as the Executive Director for Children, Families and Lifelong Learning on the Board.
 - The Joint Strategic Commissioning Convener, Children and Young People (SCC and Surrey Heartlands ICS) noted that regarding the engagement with schools, she would engage with the Children, Families and Lifelong Learning leadership team and the Director for Education and Lifelong Learning (SCC) to consider the appropriate forum to start that conversation and to identify what support partners might need as part of the application process. She explained that work on the communications around the MHIF was needed and mapping was underway on the resource budget.
10. The Chairman provided assurance as the Leader of Surrey County Council that the Council's governance procedures would not delay decisions, as ensuring that the projects move forward as quickly as possible would be crucial and more detail on the MHIF would follow in due course.

RESOLVED:

Reviewed and commented on the proposed criteria, principles, and governance.

Actions/further information to be provided:

1. More detail will be provided on the MHIF in due course by the Joint Strategic Commissioning Conveners (SCC and Surrey Heartlands ICS) once the criteria, principles and governance arrangements of the MHIF have been approved through the governance channels.
2. The Joint Strategic Commissioning Convener, Children and Young People (SCC and Surrey Heartlands ICS) will engage with the Children, Families and Lifelong Learning leadership team and the Director for Education and Lifelong Learning (SCC) to consider the appropriate forum to start that conversation around engagement with schools and to identify what support partners might need as part of the application process to the MHIF.

21/22 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) REFRESH, PROGRESS AND NEXT STEPS [Item 6]

Witnesses:

Ruth Hutchinson - Director of Public Health, Surrey County Council

Key points raised in the discussion:

1. The Director of Public Health (SCC) introduced the report and noted that:
 - At the next informal Board meeting there would be an item on the Surrey-wide Data Strategy of which the JSNA forms a part of.
 - The JSNA was a continuously updated document and had been around for over a decade.
 - Due to the Covid-19 pandemic starting in February 2020, the Board in June 2020 decided to refresh the JSNA approach and Community Impact and Rapid Needs Assessments were produced in autumn 2020 to support recovery.
 - The JSNA Operational and Oversight Group was re-established in July 2021, the Government's 'Living with COVID-19' plan was published in February 2022 and the first round of refreshed JSNA chapters would be published from June 2022.
 - The Board sits above the JSNA Operational and Oversight Group which had a broad membership across Surrey and provided a robust process, below sat the JSNA Working Group which looked at the mechanics of the JSNA; below that sat the Chapter Delivery Groups.
 - As there were forty chapters in the current JSNA there was a period of prioritisation to refresh key chapters first, assessment criteria looked at the priority population groups, the chapters most out of date, health inequalities and the impact of the Covid-19 pandemic.
 - Priority One: the current JSNA chapters were sorted under the five outcomes of the Priority - those outlined in black sat across the outcomes - so gaps could be identified.
 - Priority Two: there was a new proposed chapter under outcome four 'loneliness and social isolation'.
 - Priority Three: there was a new proposed chapter on 'digital inclusion'.
 - The refresh of the JSNA sought to mirror the HWS.

Rachael Wardell left the meeting at 3.30 pm.

- There were a number of chapters underway in line with the timetable and the aim was to produce at least four chapters by the end of quarter 2 and in total ten new refreshed chapters by the end of the year.

- Producing a new chapter took around three months due to legislative requirements about what needs to be in the JSNA; co-produced by multiple partner organisations including the voices of lived experience, using up-to-date empirical evidence.
 - Stakeholder workshops were held and chapters were produced system-wide, clear roles and responsibilities ensured broad ownership, the host board would sign-off the relevant JSNA chapter.
 - Outlined the five recommendations and regarding the fifth it was important to ensure that when a chapter is produced that it would be used and promoted system-wide through communications.
2. A substitute Board member sought clarity that the way that the refresh of the JSNA was being approached would pick up some of the direction of travel within the ICB legislation such as around having more granular data down to smaller place and community-levels, would it make closer links with the wider determinants of health, and would it be future-facing so it was predictive.
 - In response, the Director of Public Health (SCC) explained that:
 - Firstly, small area data was included where feasible and meaningful, if not able to go down to a smaller geographical area a reason was provided.
 - Secondly, regarding the wider determinants of health during the scoping exercise it was recognised that there were large gaps for example in Priority Three and therefore the relevant chapters would have more weighting in the prioritisation process.
 - Thirdly, future-facing the JSNA where feasible was being done but that was challenging.
 - She would feed those three points back to the JSNA Oversight Group, to look to see how the third point particularly can be incorporated into the JSNA.
 3. The Chairman noted that it was a complicated and comprehensive piece of work and assumed that the choice of those first ten chapters to be refreshed had been prioritised in some way.
 - In response, the Director of Public Health (SCC) clarified that the JSNA Oversight Group had a prioritisation framework for refreshing the chapters.
 4. The Chairman asked for any detailed questions on any of the chapters or any particular issues with the process to be raised outside of the meeting.

RESOLVED:

1. Noted that:
 - a JSNA Operational and Oversight Group (Oversight Group) has been established to oversee and direct the production of the JSNA refresh;
 - a comprehensive governance structure has been established underneath the Oversight Group to ensure the delivery of individual JSNA chapters; and
 - there is ambition to deliver 10 Chapter refreshes by quarter four 2022-23, although this is dependent on resourcing and engagement from the local system.
2. Approved the continuation of a life-course based structure to the JSNA, i.e., publication of chapters under a life stage matrix. Noted and approved that chapters have been intentionally structurally aligned to HWB strategy priorities, outcomes and priority populations - the approach has already been agreed by the Oversight Group.

3. Provided support to ensure that the local system considers and makes use of the findings from individual JSNA chapters as they are published, specifically to inform local health and care strategies and subsequent implementation plans. Approved that procedures are designed and embedded to HWB protocols to ensure that any strategy brought to the HWB is quality assured for its use-of, and reference-to, JSNA evidence.
4. Provided support to increase awareness of and participation in the JSNA from partners across the Surrey health and social care system.
5. Requested the HWB task the Oversight Group with connecting and aligning the ongoing development of the JSNA communication plan to the work of the Health and Well-Being Board Communications Group.

Actions/further information to be provided:

1. The Director of Public health (SCC) will feed the three points made by the substitute Board member (Executive Place Managing Director, Surrey Heath (NHS Frimley CCG)) back to the JSNA Oversight Group, to look to see how the third point particularly can be incorporated into the JSNA.
2. Board members outside of the meeting may raise any detailed questions on any of the chapters or any particular issues with the process.

22/22 INTEGRATED CARE SYSTEMS (ICS) UPDATE [Item 9]

Witnesses:

Dr Charlotte Canniff - Joint Chief Medical Officer for Surrey Heartlands ICS
 Nicola Airey - Executive Place Managing Director, Surrey Heath (NHS Frimley CCG)

Key points raised in the discussion:

1. The Vice-Chairman (Joint Chief Medical Officer for Surrey Heartlands ICS) highlighted that concerning the Surrey Heartlands ICS, the transition work continued in Surrey Heartlands ICS regarding the establishment of its ICB on 1 July 2022.
2. The Executive Place Managing Director, Surrey Heath (NHS Frimley CCG) highlighted that concerning the Frimley ICS, the Executive Director for Children, Families and Lifelong Learning (SCC) would be joining the Frimley ICB as a county council voice representing Children's Services.
 - In response, the Chairman understood that the Local Authority Organisation partner members would rotate between Hampshire County Council and Surrey County Council in the case of the county council partner member.

RESOLVED:

Noted the report on the development of the Integrated Care Systems (ICS) - Surrey Heartlands and Frimley - including the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP).

Actions/further information to be provided:

None.

23/22 2022/23 NHS SYSTEM OPERATIONAL PLANS - SURREY HEARTLANDS ICS AND FRIMLEY ICS [Item 10]

Witnesses:

Nicola Airey - Executive Place Managing Director, Surrey Heath (NHS Frimley CCG)

Dr Charlotte Canniff - Joint Chief Medical Officer for Surrey Heartlands ICS

Key points raised in the discussion:

1. The Executive Place Managing Director, Surrey Heath (NHS Frimley CCG) highlighted that concerning the Frimley ICS:
 - Post submission NHS England and Improvement (NHSEI) had requested some updates to the System Operational Plans, Frimley ICS would be submitting an improved position about elective recovery; it would reach the 104% target partly due to a baseline adjustment rather than additional activity. Frimley ICS would be submitting a balanced financial plan, some additional money had been received from NHSEI but that did not cover the full deficit and different assumptions had been made about how that financial gap would be closed.
2. The Vice-Chairman (Joint Chief Medical Officer for Surrey Heartlands ICS) highlighted that concerning the Surrey Heartlands ICS:
 - The report described the developing System Operational Plan which recently had some significant changes, for example the submission of a balanced financial plan was proving difficult, given that there was a significant recovery target and that would require Surrey Heartlands ICS to make some difficult decisions which were being worked through; it was likely to be a key piece of work for the ICB going forward.

RESOLVED:

Noted the 2022/23 NHS System Operational Plans for Surrey Heartlands ICS and Frimley ICS submitted in April 2022.

Actions/further information to be provided:

None.

24/22 SURREY LOCAL OUTBREAK ENGAGEMENT BOARD – UPDATE [Item 11]

Witnesses:

Sinead Mooney - Cabinet Member for Adults and Health, Surrey County Council

Key points raised in the discussion:

1. The Surrey Local Outbreak Engagement Board (LOEB) Chairman (Cabinet Member for Adults and Health, SCC) noted that:
 - At the last public LOEB meeting on 21 April 2022, in line with the move towards business as usual nationally the LOEB had been stood down and all future meetings are hold invites to be cancelled unless required.
 - The Surrey Local Outbreak Management Plan (LOMP) version 17 was published on 19 May 2022 and reflects the Government's 'Living with COVID-19' plan and incorporates all the new guidance published on 1

April; a national Contingency Framework was expected to be published in June and the LOMP would be revised to reflect that.

- Planning was underway for a Surrey County Council and Surrey Local Resilience Forum COVID-19 debrief session, following that a Lessons Learnt report would be produced and circulated to partners.
 - Preparations for the COVID-19 public inquiry continued, and Surrey County Council was working with Surrey Heartlands ICS and other system partners, to establish the relevant processes ahead of the inquiry; the final terms of reference for the inquiry are yet to be published.
 - The Surrey COVID-19 Intelligence Summary was now published fortnightly on a Tuesday.
 - The Office for National Statistics estimated that the percentage of people testing positive for COVID-19 increased slightly in England in the week ending 2 June 2022; it was estimated that 1.5% of the population in England and 1.5% of the population in the South East had COVID-19.
 - Up to 12 June 2022, 85% of people aged 12 plus and Surrey have received the first dose of the COVID-19 vaccination, 81% of people in Surrey had received the second dose, 67% of people aged 12 plus in Surrey had received a booster or third dose of a vaccination.
 - COVID-19 hospital admissions had increased in Surrey and remained steady in England, with 134 in Surrey hospitals between 30 May to 5 June 2022.
 - It was never too late to book a COVID-19 vaccination.
2. The Chairman noted that there had been a slight rise in COVID-19 infections and noted the expectation that there might be an offer of a fourth booster vaccine from September. He hoped that there would not be another major outbreak and therefore it was important that the LOEB remained in place in the background. He thanked the LOEB Chairman and LOEB for its good work over the past two years.

RESOLVED:

Noted the verbal update on the work of the Surrey Local Outbreak Engagement Board.

Actions/further information to be provided:

1. The Lessons Learnt report once produced will be circulated to partners: Health and Wellbeing Board and the LOEB.

25/22 DATE OF THE NEXT MEETING [Item 12]

The date of the next public meeting was noted as 28 September 2022.

Meeting ended at: 3.46 pm

Chairman

Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	Health and Wellbeing Strategy Highlight Report (including endorsement of the Young Carers Strategy)
HWBS Priority - 1, 2 and/or 3:	Priority 1, 2 and 3
Outcome(s)/System Capability:	All
Priority populations:	All
Civic level, service based and/or community led interventions:	All
Author(s):	Helen Johnson, Senior Policy and Programme Manager - Health and Wellbeing, Surrey County Council; Helen.Johnson1@surreycc.gov.uk
Board Sponsor(s):	<ul style="list-style-type: none"> • Karen Brimacombe, Chief Executive, Mole Valley District Council (Priority 1 Sponsor) • Professor Helen Rostill, Deputy Chief Executive and Director of Therapies, Surrey and Borders Partnership/Director for Mental Health, Surrey Heartlands ICS and SRO for Mental Health, Frimley ICS; Kate Barker and Liz Williams Surrey County Council/Surrey Heartlands Joint Conveners (Priority 2 Co-Sponsors) • Mari Roberts-Wood (Priority 3 Sponsor), Chief Executive, Reigate and Banstead Borough Council
HWB meeting date:	28 September 2022
Related HWB papers:	N/A
Annexes/Appendices:	Annex 1 - Highlight Report Annex 2 - Young Carers Strategy 2022-2024

2. Executive summary

This paper provides an overview of the progress of local shared projects and communications activity supporting delivery of the three Health and Wellbeing Strategy priorities as of 6 September 2022 with the priority population groups. The Highlight Report provides an overview of each Priority, describes what has been

achieved in the previous period and how collaborative working has aided this progress. It also has a section on key items ('In the Spotlight').

Priority 2 of the Health and Wellbeing Strategy continues to cover projects and programmes focussed on primary/secondary/ tertiary prevention & mental health promotion. The highlight report now also includes the new agreed fourth outcome and further work is happening to develop oversight of agreed key work programmes that contribute to all the outcomes. This is happening in conjunction with the MH improvement programme and revised mental health governance.

An accessible and web-based version of the refreshed Health and Well-being Strategy is now available at [Surrey Health and Well-being Strategy - update 2022 - Healthy Surrey](#)

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Note progress against the three priorities of the Strategy in the Highlight Report (Annex 1).
2. Utilise the link to the refreshed Health and Well-being Strategy to increase awareness through their organisations to elicit support for reducing health inequalities
3. Endorse the Young Carers Strategy (Annex 2).

4. Detail

For Priority One a focus is given in the Highlight Report to the Young Carers Strategy 2022-2024. The draft Strategy was approved by the Carers Partnership Board on 5 September (see Annex 2) and will guide the system's work for the next two years until an all-age carers strategy to be live from the end of 2024. The stakeholder engagement and public consultation over the past 12 months highlighted the negative impact on young carers' Emotional Wellbeing and Mental Health. Budget has been allocated and a service will be developed to address their needs, informed by a wealth of insights.

For Priority Two a focus is given to the 'How are You Surrey?' Workplace Wellbeing Standards (for larger businesses). These have undergone consultation and as a result they are being re-designed to include more "stretch" and challenge. Agile working will also be considered across all the Standards. As well as describing the roll out in more detail the Highlight Report describes how it is a good example of how this programme is being related to and implemented specifically within the Key Neighbourhoods of the Health and Wellbeing Strategy.

For Priority 3 a focus is given to the emerging work around Health in All Policies, including Planning guidance, Health Impact Assessments, Healthy Workplaces and Making Every Contact Count. Next steps are for a draft phase 1 action plan to be brought to the November informal HWB Board meeting

See Highlight Report at Annex 1 and Young Carers Strategy at Annex 2.

5. Opportunities/Challenges

- Implementation plans with risk ratings (subject to ongoing review and refresh) continue to sit behind the Highlight Report P1 and P2, with risks escalated to the Board as necessary.
- The additional role to resource Priority 3 more effectively comes into effect on 3rd October.
- With this additional capacity in the SCC Public Health team, it will now be possible to progress the coordination of an initial whole system approach to poverty.

6. What communications and engagement happened/needs to happen?

The HWB Board Communications sub-group are holding a workshop in September (delayed from July due to heatwave) to update the existing communications plan to fully reflect the refreshed Strategy.

7. Next steps

- The Highlight Report continues to be reoriented to reflect the programmes and projects that form part of the refreshed Implementation Plans.
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<p>IMPACT SUMMARY Improved physical health through the prevention of physical ill-health and the promotion of physical well-being</p>	<p>WHAT WILL BE DIFFERENT FOR PEOPLE IN SURREY?</p>	<p>HOW HAS COLLABORATIVE WORKING BETWEEN HWB BOARD ORGANISATIONS ADDED VALUE AND CONTRIBUTED TO THE ACHIEVEMENT OF THE OUTCOMES?</p>	<p>DATA, INSIGHTS AND CHALLENGES – MATERNITY SUPPORT FOR REFUGEES AND ASYLUM SEEKERS</p>
<p> OUTCOMES By 2030:</p> <ul style="list-style-type: none"> • People have a healthy weight and are active • Substance misuse is low (drugs/alcohol & smoking) • The needs of those experiencing multiple disadvantages are met • Serious conditions and diseases are prevented • People are supported to live well independently for as long as possible <p>WHO IS LEADING THIS? Priority sponsor: Karen Brimacombe, Chief Executive, Mole Valley District Council Programme Manager: Helen Tindall, Policy and Programme Manager, Surrey County Council For more information on the performance of individual programmes and projects within this priority such as progress against key milestones please contact the relevant programme manager via healthandwellbeing@surreycc.gov.uk</p>	<p>The Community Vision for Surrey describes what residents and partners think Surrey should look like by 2030: <i>By 2030 we want Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind.</i></p> <p>In light of the Community Vision and the vital role, communities and staff/organisations in the health and care system play in its delivery, the Strategy sets out Surrey's priorities for improving health and wellbeing across the priority populations for the next 10 years. It identifies specific groups of people who experience poorer health outcomes and who may therefore need more support. It also outlines how we need to collaborate so we can drive these improvements, with communities leading the way.</p> <p>Priority 1 currently focuses on enabling residents to lead physically healthier lives. This priority area is focused on prevention, removing barriers and supporting people to become proactive in improving their physical health. Priority 1 programmes include those which focus on:</p> <ul style="list-style-type: none"> • Working to reduce obesity, excess weight rates and low levels of physical inactivity • Supporting prevention and treatment of substance misuse, including alcohol, and smoking cessation. • Ensuring that the needs of those experiencing multiple disadvantages are met. • Promoting prevention to decrease incidence of serious conditions/diseases • Living independently and dying well 	<ul style="list-style-type: none"> • In June, the first Surrey Substance Use stakeholder event was held at Surrey University. It was attended by over 120 local partners, treatment agencies and people with lived experience and provided the opportunity to showcase what is on offer in Surrey and our future treatment plans. This will be followed up with targeted training opportunities such as stigma awareness training for those working with people who use substances. • The retention and development of the workforce is a key focus of the Dame Carol Black Review and the most recent national ten-year Drug Strategy From Harm to Hope. Whilst there are moves at national level to develop a skills framework, work is taking place locally to identify the training and development needs of our substance use workforce and plan training opportunities as appropriate. • The Bridge the Gap Trauma Informed Outreach Services will provide intensive trauma-informed outreach support for up to eight hours a week for Surrey Adults Matter clients in need of life skills coaching and support. The Bridge the Gap service is being delivered by an alliance of ten local Surrey Homeless, Domestic Abuse and Mental Health Charities commissioned under the Changing Futures Programme. Recruitment is underway and as at 30th June 2022, 8 of 14 staff had been recruited by the ten VCSE charities. A Consultant Clinical Psychologist has been appointed to support these specialist VCSE organisations. • SCC Public Health team are working closely with the Surrey Heartlands CVD Steering Group to develop patient pathways for the detection of undiagnosed hypertension and Atrial Fibrillation in vaccination centres, community pharmacies and community outreach settings. • SCC and Surrey Heartlands ICS partners have been working on a campaign plan to raise awareness of the link between heart and brain health. The campaign will dovetail with the drive to encourage people to get their blood pressure checked and go for health MOTs at community pharmacies. Residents will be encouraged to find out about simple steps they can take to reduce their dementia risk, with a focus on weight, exercise and other lifestyle factors (e.g. smoking). 	<p>Healthwatch Surrey were commissioned by Surrey Heartlands Health & Care Partnership to gather insights on the challenges faced by refugees and asylum-seeking women when accessing maternity services. The project aimed to identify ways Surrey Heartlands can optimise maternity support, with a focus on digital inequalities.</p> <p>Key Insights The women felt well supported in their maternity care, and that they had good access to primary healthcare services. Services, support and advocacy groups, especially charities, were more concerned that the women were vulnerable to inequalities, however we heard about a wide range of initiatives in place that were designed to mitigate the challenges they faced. The study highlighted three issues regarding barriers to access to maternity services</p> <ol style="list-style-type: none"> 1. Language: Both the women and services, support and advocacy groups cited language and translation as a significant barrier: Access to translators is challenging; family translators raise questions around privacy and may not be able to translate medical language; some concepts and words are not translatable; dialect may impact comprehension. 2. The women don't know what they don't know: They are unfamiliar with the NHS, social services and UK charities; their assumptions and expectations of referral pathways, information sharing and the help available may well be incorrect. 3. Digital success is about more than access: a. Some women don't have good internet access / access to technology or awareness of digital. b. Others have excellent access to technology, but this does not mean they can or will access UK-based digital tools. Many prefer to access information created in their first language e.g., YouTube or by direct contact with friends.

WHAT HAS BEEN ACHIEVED THIS QUARTER UNDER REFRESHED PRIORITY 1 OUTCOMES?	IN THE SPOTLIGHT – YOUNG CARERS STRATEGY
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People have healthy weight and are active

- Active Surrey are currently recruiting a new Head of Strategy and Innovation to drive forward the establishment of a cross-system network of 'Movers for Change'. The new Head of Strategy will also be considering the development of a monitoring and evaluation framework for the Movement for Change Strategy.
- 9 Friday Night Projects funded and established with 4 achieving around 100 young people visiting per week. Developing plans to establish another 10 FNP's across the county in leisure and youth centres, focussed on anti-social behaviour hotspots.

Substance misuse is low (drugs/alcohol/smoking)

- Surrey Smoking Cessation Service Review has been completed to improve service delivery, reach and effectiveness. A report was shared at the Prevention and Wider Determinants of Health Delivery Board on the 8th of June.
- Surrey has been awarded additional 5-year funding to supplement the work already being commissioned and undertaken through the Public Health Grant. The supplemental funding will allow further development of work with partners to support the reduction in drug-related criminal justice and drug-related deaths. In addition, further investment has been awarded to enable additional capacity for those requiring inpatient detoxification and also those needing residential rehabilitation.

The needs of those experiencing multiple disadvantage are met

- An Independent Project Lead has been appointed within the Changing Futures Programme. They will drive forward the Alliance and the reporting of outcomes via an Outcomes Delivery Board.
- The next step for Changing Futures is the development of a Sustainability Prospectus.
- The next phase of the Programme involves co-developing a co-occurring condition pathway for people with mental health/behavioural and substance misuse issues and evaluating the outcomes
- The Bridge the Gap Trauma Informed Outreach Service will provide support for up to 8 hours per week for Surrey Adults Matter clients. The Service is being delivered by 11 local charities under the Changing Futures programme. 11 of the 14 staff have been recruited. A consultant Clinical Psychologist is in post supporting these staff.

Serious diseases and conditions are prevented

- Work is taking place on the development of a dementia prevention page on the Healthy Surrey. This would be somewhere to direct residents and staff to for more information, including tips on how to help prevent dementia. Visits to the page will be measured.
- As part of dementia prevention in the Dementia Strategy, a campaign plan will raise awareness of the link between heart and brain health. Alongside use of all partner channels this will dovetail with the drive to encourage people to get their blood pressure checked and go for health MOTs at community pharmacies and align with Active Surrey.

People are supported to live independently for as long as possible

- In discovery phase of gathering insights into what a Reablement Night Service could look like in Surrey.
- Discovery phase almost complete on a reablement offer for transitions client group (transition from children to adult services).

In 2021 a consultation process began to understand the needs, demands and impacts of being a young carer. Young carers are first and foremost children and young people and ensuring that caring does not negatively impact on their childhood and life opportunities is a key driver both in developing the strategy and the ensuing actions.

Context
Surrey County Council has a duty under the Care Act (2014) and the Children and Families Act (2014) to identify and support young carers. Recognition and support of young carers is a system responsibility (including health, education and the voluntary, faith and community sector). These key touch points bring young people into contact with trusted adults who need to be inquisitive about young carers' needs.

Scale
In Surrey, based on local prevalence data, between 4% and 8% of the 5-17 year old population are young carers. That equates to 1-2 young carers in every classroom (between 7,880 and 15,760). Nationally, research suggests the figure could be as high as 20% of all young people. This would equate to potentially circa 38,500 young carers in Surrey. The Young Carers service commissioned in April 2021 is designed to meet the needs of 2,250 young carers per year. The results of the 2021 Census (due late 2023) will provide further clarity on the numbers of young people that recognise they are a young carer in Surrey.

Engagement
During the consultation period, we heard from many young carers that whilst they are proud to care, being a young carer can have negative impacts on schooling, health, friendships and opportunities to be "a child". Many young carers see their caring as part of family life, as it is normalised to them, so do not recognise that they are in a caring role and as a result do not consider seeking support.

Next Steps
The Young Carers Strategy 2022 – 2024 will guide our work for the next two years. This will be developed into an all-age Carers Strategy to be live from the end of 2024. The engagement highlighted the negative impact on young carers' Emotional Wellbeing and Mental Health (EWMH). Budget has been allocated and a service will be developed to address.

The Vision
Our vision is that young carers feel supported and confident to say that they are a young carer. They are identified, recognised, valued, and supported, and protected from providing inappropriate care, to achieve their full potential, and to have equitable access to the same opportunities as their peers. They have a strong voice that results in services that work for them, and we hear their voice when the responsibility of caring is not their choice. Across the system, staff will have the tools, skills and knowledge to increase identification of young carers, enable young carers to self-identify and provide the right support to young carers and their families.

For more information, contact Gary Wood at g.wood@surreycc.gov.uk.

 <p>IMPACT SUMMARY Improved mental health through prevention of mental ill-health and the promotion of emotional well-being</p>	<p>WHAT WILL BE DIFFERENT FOR PEOPLE IN SURREY?</p>	<p>HOW HAS COLLABORATIVE WORKING BETWEEN HWB BOARD ORGANISATIONS ADDED VALUE AND CONTRIBUTED TO THE ACHIEVEMENT OF THE OUTCOMES?</p>	<p>DATA, INSIGHTS AND CHALLENGES – YOUNG PEOPLE’S MENTAL HEALTH</p>
<p>OUTCOMES By 2030:</p> <ul style="list-style-type: none"> Adults, children and young people at risk of and with depression, anxiety and other mental health issues access the right early help and resources The emotional well-being of parents and caregivers, babies and children is supported Isolation is prevented and those that feel isolated are supported Environments and communities in which people live, work and learn build good mental health <p>WHO IS LEADING THIS? Priority co-sponsors: Professor Helen Rostill, Deputy Chief Executive and Director of Therapies, Surrey and Borders Partnership Kate Barker - Joint Strategic Commissioning Convener Liz Williams - Joint Strategic Commissioning Convener Programme Manager: Jason Lever, P2 Policy and Programme Manager, Surrey County Council For more information on the performance of individual programmes and projects within this priority such as progress against key milestones please contact the relevant programme manager via healthandwellbeing@surreycc.gov.uk</p>	<p>The Community Vision for Surrey describes what residents and partners think Surrey should look like by 2030: <i>By 2030 we want Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind.</i></p> <p>In light of the Community Vision and the vital role, communities and staff/organisations in the health and care system play in its delivery, the Strategy sets out Surrey's priorities for improving health and wellbeing across the priority populations for the next 10 years. It identifies specific groups of people who experience poorer health outcomes and who may therefore need more support. It also outlines how we need to collaborate so we can drive these improvements, with communities leading the way.</p> <p>Priority Two of the Health and Wellbeing Strategy focuses on enabling our citizens to lead emotionally healthier lives. This priority area is focused on prevention, removing barriers, and supporting people to become proactive in improving their emotional health and wellbeing. Priority Two aims to impact in the following ways:</p> <ul style="list-style-type: none"> Ensuring the right early help and resources are available to support mental health across life stages Support during pregnancy and for young families Recognising and addressing the impact of isolation Building good mental health in the range of spaces and places including schools/workplaces 	<p>Engagement about a potential Front Door Phoneline for emotional/mental health/wellbeing (and options for delivery) conducted with: SCC Health and Welfare phoneline leads, the Adult Mental Health Alliance (addressed all their questions at the second meeting), SABP Single Point of Access Lead, IAPT Providers Forum, and engagement is underway with a sample of the Surrey residents living in priority neighbourhoods.</p> <p>HOPE Community Project: Oakleaf, Catalyst, Mary Frances Trust & Richmond Fellowship are each running different initiatives offering residents the opportunity to explore HOPE and what it means to them, including visual arts, walking, gardening, workshops on Active HOPE. During this pilot year, a robust but person-centred evaluation will be carried out utilising the PHE Arts in Health Framework Arts for health and wellbeing - evaluation framework (publishing.service.gov.uk) to establish the value and impact, both on individuals and community groups, especially in relation to prevention and early intervention. The aim for successive years will be to learn, further scale and embed this ethos/ programme at place.</p>	<p>Healthwatch Surrey have heard from families supporting young people with mental health challenges who are concerned as their child is approaching 18 and will then transfer into adult services. The main concerns heard are that there will not be good continuity of care from what they have received previously or, for those waiting for care, there are concerns about how these might be impacted.</p> <p>Families of teenage children have experienced long waits for assessments and treatment. Extended waits can have a big impact, affecting a vital period of development and growth. Families say they don't know where to turn for support, and are not aware if there are other services that can help or places they can get advice from.</p> <p>A key theme is that challenges experienced by children and young people with mental health needs are felt across their family and wider support network and often the family feel in more need of support and advice on how they can care for their loved one. The experiences heard are often complex cases crossing multiple providers and sources of support. However, when complaints are raised it's not clear if there has been learning across the providers involved.</p>

Page 25



Adults, children and young people at risk of and with depression, anxiety and other mental health issues access the right early help and resources

- Public Health Team engagement with partners and residents (in Key Neighbourhoods) undertaken about a potential “front door” phonenumber for mental health and wellbeing.
- Public Health Mental Health team focusing on key neighbourhoods with asset mapping being supported. Through this and other work, key barriers to engagement have been identified and structures in place to share insights with place transformation boards.
- Delivery on the [Dementia Strategy](#) has resulted in accessible resources on dementia for those with a learning disability and increasing access to assessments for those with Downs syndrome. In addition, actions are in place to:
 - Monitor capacity of dementia navigators to ensure provision is able to manage predicted growth.
 - Complete first stage of the mapping of all voluntary services
 - Promote Alzheimer’s Society in-house training for GP surgeries in Reigate / Redhill and could be widened to other practices
- New contract for the suicide bereavement service is expected to be awarded in September.
- Men’s mental health project and services are being mapped by Public Health who are developing a men’s mental health working group to coordinate and deliver in partnership with other agencies.
- Refresh and engagement on the Suicide Prevention Strategy is underway. (On agenda for future HWB Board meeting).

The emotional well-being of parents and caregivers, babies and children is supported

- A first draft of the Best Start for Surrey Strategy is due to be published soon. This is a system strategy, spanning all partners, bringing together existing strategies to help drive collaboration and alignment (including First 1000 Days existing priorities). It will focus on where we need to work collaboratively as a collection of partners to improve outcomes for pregnant people, babies, children, and families in the earliest years.
- The refresh of the Children and Young People Emotional Well-being and Mental Health Strategy is underway.
- The CYP suicide prevention group has agreed to a children and young people suicide prevention coordinator post.

Isolation is prevented and those that feel isolated are supported

- Green Social Prescribing (GSP) pilot at Epsom Primary Care Network developing well with community engagement event scheduled for 24th September and pilot integrated into Health Creation Alliance PCN Learning Programme – GSP team asked to support delivery of a £70K community development fund.
- Through Time to Change, a survey was conducted to find out the extent, nature, and effects of mental health stigma in Surrey. Respondents reported the most common sources of stigma were from family/friends, colleagues and managers, primary care, hospital, community MH services. Focus groups to be held to explore findings with under-represented groups- men, BAME, GRT..

Environments and communities in which people live, work and learn build good mental health

- Papyrus Suicide Prevention training and the Lucy Rayner Foundation training for Youth Mental Health First Aider and Self-Harm awareness are both due to resume to schools in September as well as the [Papyrus](#) 18 month school post has been recruited to support schools to roll out suicide prevention work.
- They will initially be working on combining the [Surrey Suicide Prevention Toolkit](#) and the [Papyrus Building Suicide-Safer Schools and Colleges](#) work, and then will be supporting schools to roll the suicide prevention work.
- “Virtual reality films of Surrey countryside currently in production. When ready they’ll be shared with 4 small groups in a pilot to improve wellbeing; hospital staff, people with dementia, people with a disability, and unpaid carers.”
- 2 Primary Care Networks and 1 Child and Adolescent Mental Health team selected to attend [Nature Well courses](#) with Wild Gathering CIC in September/October.

The ‘How are You Surrey?’ Workplace Wellbeing standards (for larger businesses) have undergone consultation and as a result they are being re-designed to include more “stretch” and challenge. Agile working will also be considered through all standards

A Surrey County Council pilot of the (larger business) standards commenced and will also be applied in detail in Adult Social Care in the first instance. A repository for learning resources to support implementation of the standards will be collated and available via web portal which is under development on the healthy surrey page.

A toolkit to apply ‘How are you Surrey’ to micro and Small and Medium Enterprises is complete and ready for dissemination with the support of a training offer.

Community mapping is underway in three priority neighbourhoods within the Health and Wellbeing Strategy to identify businesses within the area and workplaces of those who live in the priority neighbourhoods. An engagement plan is being developed for outreach support to priority businesses to complete standards.

Full Alignment with the Healthy Schools Approach Self-Evaluation checked and alignment with healthy schools’ communication and engagement is underway.

For more information please contact sabina.stanescu@surreycc.gov.uk.

 IMPACT SUMMARY People and adults reach their potential	WHAT WILL BE DIFFERENT FOR PEOPLE IN SURREY?	HOW HAS COLLABORATIVE WORKING BETWEEN HWB BOARD ORGANISATIONS ADDED VALUE AND CONTRIBUTED TO THE ACHIEVEMENT OF THE OUTCOMES?	DATA, INSIGHTS AND CHALLENGES - NO-ONE LEFT BEHIND EMPLOYMENT NETWORK RESEARCH
<p>OUTCOMES By 2030:</p> <ul style="list-style-type: none"> • People’s basic needs are met (food security, poverty, housing strategy etc) • Children, young people and adults are empowered in their communities • People access training and employment opportunities within a sustainable economy • People are safe and feel safe (community safety incl. domestic abuse, safeguarding) • The benefits of healthy environments for people are valued and maximised (incl. through transport/land use planning) <p>WHO IS LEADING THIS? Priority sponsor: Mari Roberts-Wood, Chief Executive, Reigate and Banstead Borough Council</p> <p>Programme Manager: Helen Johnson, Senior Policy and Programme Manager, Surrey County Council</p> <p>For more information on the performance of individual programmes and projects within this priority such as progress against key milestones please contact the relevant programme manager via healthandwellbeing@surreycc.gov.uk</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Page 27</p>	<p>The Community Vision for Surrey describes what residents and partners think Surrey should look like by 2030: <i>By 2030 we want Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind.</i></p> <p>In light of the Community Vision and the vital role communities and staff/organisations in the health and care system play in its delivery, the Strategy sets out Surrey’s priorities for improving health and wellbeing across the priority populations for the next 10 years. It identifies specific groups of people who experience poorer health outcomes and who may therefore need more support and outlines how we need to collaborate so we can drive these improvements, with communities leading the way.</p> <p>Priority 3 of the Health and Wellbeing Strategy focuses on enabling our citizens to lead healthier lives. This priority area is focused on primary prevention and addressing the wider determinants of health. Priority 3 cuts across five outcomes and action focuses around:</p> <ul style="list-style-type: none"> • Ensuring that everybody has enough income to live on and lives in good and appropriate housing • Building social capital in communities • Improving access to training and jobs • Preventing crime and supporting the victims of crime including domestic abuse - supporting and empowering survivors • Improving environmental factors that have an impact on people’s health and well-being. 	<p>SCC now have three Local Area Coordinators (LACs) working alongside local communities in Maybury/Sheerwater - Woking, Horley (Central/West) - Reigate & Banstead and Hurst Green – Tandridge. SCC are in the process of recruiting a fourth to work in Old Dean / St Michael’s, Camberley. This has been achieved in collaboration with district & borough council colleagues as well as community members, who are a vital part of the recruitment process.</p> <p>LACs are based in the local community for the local community and offer a unique type of individual support at a very local level. They help people of all ages become stronger, healthier, happier and more connected members of their community. Their job is to build relationships and make connections with local people, before offering practical help to anyone who may need it. With no thresholds or time limits, they can walk alongside people for as long as they need, helping them explore how they can achieve their vision of a good life and to find non-service solutions.</p> <p>The first three LACs are now actively taking introductions and are walking alongside residents who need support. Positive stories are already emerging about how this approach is complementing existing support and services by virtue of being locally based and having no eligibility criteria or time limits. SCC look forward to sharing some of these stories in the coming months. SCC are also part of a LAC national network and were delighted to have the opportunity to share Surrey’s journey in implementing LAC at the recent LGA Innovation Zone in Harrogate.</p> <p>You can find out more about Local Area Coordination on the national network website: LAC Network or for more information please contact Sarah Bogunovic at sarah.bogunovich@surreycc.gov.uk.</p>	<p>The literature review commissioned by the No-one Left Behind Employment Network of those most at risk of being left behind from skills and employment is complete. This identified 15 key groups most at risk of being left behind which were Care leavers*; Older people over 50; Individuals with physical or mental health conditions or disabilities*; Single parents; Young people*; Ethnic minorities*; Low income individuals; Refugees; Low skilled individuals; Ex-offenders*; Veterans; Carers*; Homeless*; Discouraged workers; Modern slavery survivors.</p> <p>The groups asterisked are already priority populations of the HWB Strategy and/or the Changing Futures Programme. The report contains some information on the barriers to employment faced by each of these groups. Interestingly stigma and discrimination was the most significant barrier across nearly every cohort.</p> <p>The SCC Analytics teams will be building a profile of these cohorts in Surrey and a specification for the primary research will be drawn up. This primary research will be co-designed with any frontline workers already interacting with these cohorts. SCC Analytics team will be organising the co-design workshop. Please contact Rebecca Brooker at rebecca.brooker@surreycc.gov.uk for more information.</p>



People’s basic needs are met

- SCC is examining the impacts of the Cost of Living crisis on residents, staff, and local business with a view to identifying interventions across services provided by SCC, projects existing (or which could exist) through the VCFS, and partnerships in the wider system to mitigate impacts. SCC is approaching this issue as an extended and developing crisis issue which must be managed in an agile way – continually adapting approach as new insights or ideas come into play. As such, it will be using existing mobilisation structures internally and with partnerships to marshal resources and insights. A residents’ panel survey has been completed.
- Fuel Poverty Programme approach was endorsed by SCC Informal Cabinet and HWBB. A Programme Manager has been appointed. [Warm Hubs](#) in geographical areas of need including HWBS Key Neighbourhoods are in development, to be sustained by community volunteers; they will host access points to a digital self-service advice tool which will be promoted on partner websites from November. Additional funding source applications were submitted in August.

Children, young people and adults are empowered in their communities

- SCC Community Link Officers roles now exist in all district and boroughs, initially focusing on HWBS Key Neighbourhoods. The CLOs will run and join up local engagement and learning; join in with local events; Understand community strengths and any support needed, aid problem solving; join up local activity and connect people to [Make it Happen](#).
- Health Creation learning programme for Primary Care Networks, community members and their local partners is now in delivery phase, with 14 PCNs engaged in the programme, most of which have a HWBS Key Neighbourhood within their boundary.

People access training and employment opportunities within a sustainable economy

The Surrey Skills Plan is in development. There will be the following engagement opportunities for partners:

- Late Sept/early October – Online external consultation event
- Throughout October – Bilateral discussions with interested stakeholders
- 10 November 2022 – Surrey Skills Summit, Sandown Park
- SCC has been allocated £4.7m over the next three years to support adult numeracy interventions through the Multiply programme and has been successful in accessing the first £1.3m to deliver numeracy courses.
- SCC have been successful through a competitive bidding process to secure £0.5m of DWP funding to deliver a local supported employment pilot to support adults in social care into work and to retain work.

People are safe and feel safe

- The pilot of the Independent Domestic Violence Advisers in Surrey A and E settings has reached the end of year 1 of 2. There have been 686 referrals to date. A and E Staff point to greater levels of confidence in identifying and inquiring about DA, which are also reflected in increasing referrals from A and E staff themselves. Staff receive support in dealing with DA in their own personal lives too. Staff show increased awareness of and support in dealing with their Safeguarding concerns, an increased ability/willingness to deal with them, and greater satisfaction in being involved in creating positive outcomes for patients. Support to survivors is timely, with the vast majority receiving same- or next-day contact with an IDVA. Survivors report receiving non-judgemental support with a variety of needs, that their experience and point of view is taken into consideration, and that the support is designed around their wishes, enabling them to make their own decisions on next steps. Sustainable funding now needs to be secured.

The benefits of healthy environments for people are valued and maximised

- Surrey’s ten-year Local Transport Plan (LTP4) was approved by SCC on July 12th. The three central components for LTP4 are: Local Cycling and Walking Infrastructure Plans, Liveable Neighbourhoods and Bus Plans. Focus will now be on delivery. Money has been secured from the Department for Transport for a 3rd tranche of active travel funding for cycling infrastructure. Establishing Liveable Neighbourhoods involves both reimagining existing places and influencing new developments to support Surrey’s 2050 Place Ambition.
- Market research was commissioned to understand key motivations and barriers for walking and cycling in Surrey. The findings from the research will be fed into the planning and design of an active travel marketing campaign which is expected to launch in September 2022.

An evolving Health in All Policies plan is being put in place for Surrey, the full first phase plan will be presented and reported back on at the informal Health and Wellbeing Board in November. Key objectives are already being delivered on as the first phase plan is shaping up and underway, including identifying and responding to health and wellbeing issues which are cross-cutting and addressed by multiple key players including with planning and transport.

For example, a newly convened Health and Planning Forum is meeting in September to further embed health and wellbeing into planning policies and decisions. ‘Creating healthier environments strategic guidance’ for Surrey is being updated to help guide this workstream as well as considerations for embedding a proposed process and consistent model (including thresholds) for Health Impact Assessments as part of planning applications to create health promoting spatial environments.

Other core areas of development include a focus on healthy workplaces including healthy workplace standards under a banner of ‘How are you Surrey?’ which will inform an innovative Surrey Workplace Charter. NICE guidance on how to create the right conditions for mental wellbeing at work (published in March 2022) is shaping our healthy workplace approach to promote supportive and inclusive work environments, including training and support for managers and helping people who have or are at risk of poor mental health (see Priority 2 ‘In the Spotlight’)

Making Every Contact Count (MECC) approaches are a core theme of the evolving HiAP plan, MECC seeks to maximise opportunities in routine and everyday interactions in council, health and partner services to empower individuals and communities to make positive changes to their health and wellbeing. Proposals for maximising the delivery of MECC train-the-trainer programmes across the ICS including dedicated training resources and opportunities to deliver new training to new cohorts of partners are being explored. Roll out of new MECC training will begin from September from the Vaccination hubs. There will be further opportunities in consultation with Health and Wellbeing Board members to continue to shape the MECC programme as part of the HiAP phase one programme.

There will be a HiAP agenda item covering the Phase 1 Implementation Plan at the November informal HWB Board meeting. For more information please contact Russell Styles at russell.styles@surreycc.gov.uk.

- [Changing Futures Programme](#) – We worked with the Bridge the Gap Alliance and people with lived experience of multiple disadvantage to co-design an identity. The insight gained enabled us to deliver an identity which resonated with both residents and service users. We are using the identity across all comms activity, including social media and assets. We also created a video to raise awareness of the programme [Changing Futures - Sinead Mooney](#).



- We cascaded messages on our social media channels about staying safe during the recent [heatwaves](#) across the South East of England. We used a combination of SCC and national assets, whilst pausing BAU comms to ensure key messages got to priority groups in the lead up to and during the hot weather. The messages reminded people that high temperatures can lead to health impacts on the most vulnerable in our society including elderly and children and infants. Messages including top tips on staying safe in warmer weather, including whilst at work, looking out for family, neighbours and others in our communities, including pets, and some crucial wildfire and water safety messages which were also shared by partners such as Healthy Surrey and SFRS.

Page 29



- Substance Use – We ran a campaign to highlight the life-saving potential of [Naloxone](#) in reducing deaths by accidental drug overdose, this was focused around International Overdose Awareness day 31st August. We used our social channels and also provided printed posters to all our Surrey partners to ensure visibility of the campaign.



- We highlighted the publication of the [joint health and social care dementia strategy](#), which sets out collective ambitions to improve the dementia care pathway across Surrey. This followed a period of engagement with those affected by the condition and organisations which support them. A [joint news release](#) was accompanied by radio interviews. The [Surrey Matters resident newsletter](#) highlighted the system ambition to create dementia-friendly communities across Surrey and make sure people have access to the care and support which will enable them to live well at home for as long as possible. Filming at a respite care centre brought to life the impact such support can have on residents with conditions such as dementia and their families.



- During Carers Week, in June, we highlighted the [support available for carers including carers' breaks and new drop-in hubs](#) which are now up and running around the county. The hubs offer support on all aspects of caring – practical, emotional and financial – as well as a cuppa and a chat. During the week we featured pen portraits of carers who passed on advice to those following in their footsteps. We also took the opportunity to raise awareness of the [consultation on the young carers strategy](#).



- We provided reactionary comms during the [Monkeypox](#) outbreak, ensuring residents were informed about the actions they should take if they suspected they had monkeypox or had been in contact with someone. We provided reassuring and informative messages to help contain the transmission of cases.



This draft strategy has been informed by initial engagement with young carers and their families/carers and practitioners. It will undergo further consultation to ensure that the vision, strategic priorities, and initial actions to embed change reflect what young carers and our partners would wish to see.

DRAFT



SURREY JOINT STRATEGY FOR YOUNG CARERS 2022 - 2024



Table of contents

Foreword.....	4
Introduction	6
Young carers in Surrey	10
Plan on a Page	12
Vision Statement.....	14
Values	14
Strategic Priorities.....	16
Actions	21
Delivering the Strategy.....	23
Appendix 1: Local Context	25
Appendix 2: Interviews with Young Carers and their Parents	28
Appendix 3: Survey of Young Carers.....	30
Appendix 4: Survey of Parents of Young Carers and Parent Carers	42
Appendix 5: Survey of Social Workers.....	49
Appendix 6: Survey of Schools	50
Appendix 7: Young Carers Rights.....	53
Appendix 8: Thrive	55
Appendix 9: The Voice of Young Carers and their Parents.....	57
Appendix 10 Online Consultation Feedback on the Draft Strategy	59

Foreword

5

In Surrey we have the ambition that no one is left behind, by actively recognising and supporting young carers we will be a step closer to that ambition for both young carers and their families.

Throughout the development of this Surrey Young Carers Strategy 2022-24 we have worked alongside young carers and their families. They told us about the impacts the COVID-19 restrictions had on young carers and family life. Young carers felt increased isolation, home schooling took away the break from caring that school provided, temporary closure of after school clubs took away both respite and support networks, young carers had less time to relax, and overall COVID had a negative impact on their emotional wellbeing and mental health. We have heard both the positive and negative impacts of being a young carer. We recognise the huge contribution young carers make to their families. This contribution should not be to the sacrifice of educational achievement, friendships, and their own wellbeing.

For the life of this strategy and beyond we set a number of commitments that enable us to value the contribution of young carers and put in place the support across the system young carers and their families require to minimise the negative impacts and maximise each young carer's potential.

The strategy recognises that identifying young carers is the start of that support process. We know many children and young people will not identify as a young carer. The strategy tasks all adults working with children and young people to be inquisitive to the fact that they may be a young carer, and ensure they feel supported.

Rachael Wardell – Executive Director of Children, Families and Lifelong Learning

Cllr Sinead Mooney – Cabinet Member for Children and Families

We are delighted to introduce the Surrey Young Carers Strategy 2022-24, which sets out our young carers agenda in Surrey, reaffirming our recognition of the importance of young carers and to make specific commitments to how we will ensure support and opportunities to build meaningful friendships, exceed in educational achievement and future job prospects.

Surrey partners are committed to ensuring that all young carers feel valued, respected and cared for. The strategy sets out the ambition to create a safe environment for young carers to talk about their home life and to ensure that they are connected in their communities and have a life of their own alongside caring responsibilities. Through our collaborative efforts, we will ensure young carers and their families receive the right support, at the right time to enable each young carer the same opportunities as their peers.

Vicky Stobbart

Director of Long-Term Planning Delivery (Surrey Heartlands ICS)

It is vitally important that Surrey Heartlands continues to identify, support and value our young carers who demonstrate such high levels of determination and courage to help their loved ones. We know that many young people are looking after family members who could not manage without their help and many will not be currently known to us. Caring is such a significant and sustained responsibility on them and we must do everything we can to ensure that our young carers are not undertaking inappropriate and onerous levels of caring which may leave them feeling isolated and alone in their caring role.

Our new strategy sets out our revised ambition in this regard, to provide comprehensive support, informed by the voices of those children and young people that we seek to assist to balance their caring responsibilities, alongside their education and other life opportunities. In this way we hope that our Young Carers feel valued, visible and supported and that no one is left to care alone.

Dr Susan Tresman

Independent Carers Lead: Surrey Heartlands

Co-Chair : Surrey Carers Partnership Board

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Introduction

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We want to ensure that young carers in Surrey are recognised, valued, and given the support they need across the system. Children and young people who are carers have told us that they are proud of the care that they provide and the support they offer to their family and the wider community. However, caring can also put some strain on young people, particularly affecting their mental health. Young carers have the right to the same opportunities as all young people, to learn and enjoy, and have happy, healthy childhoods.

This strategy sets out how partners in Surrey will work together to develop and improve the way services work together to identify, assess and improve outcomes for young people with caring responsibilities. This will happen in partnership with young people. This strategy will show young carers and their families the direction of travel that Surrey's statutory and voluntary agencies are moving towards.

Carers are people who are unpaid, look after someone who otherwise couldn't manage without their help. This may be because of long term illness, frailty, disability, a mental health need and/or an addiction. Each caring situation is different and is influenced by factors relating to both the carer and the person they care for. Some young carers take on a level of responsibility or aspects of care that no child/young person should be expected to undertake, and they must be protected from this occurring, the welfare of the child is paramount (The Children Act 1989). This, in turn, can have adverse effects on their educational attainment, their own health and well-being, restrict their opportunities to engage in social activities, impact on their life choices when compared with those experiences enjoyed by children who are not carers.

In May and June 2021 consultation with young carers, parents, schools and practitioners in Surrey, took place through a range of surveys and interviews, building on previous and ongoing consultation with young carers and their families. This feedback showed how young carers and their parents are proud of the care that they provide, how they see their caring responsibilities as helping a family member. This lived experience needs to be respected whilst ensuring the young person is not exposed to an inappropriate scope and scale of caring and that life options are not adversely impacted compared to their peers ensuring the rights of the child are respected and upheld (UN Convention On the Rights of the Child, 1992).. Across the health, care and education system we need to ensure organisations act in an integrated and interconnected manner, identify, assess and support young carers to be protected from inappropriate caring, to thrive, achieve their full potential, and to have access to the same opportunities as their peers.'

The continued development of schools understanding and recognition of young carers with support from the wider system to enable schools and colleges to support young carers is a key element of the delivery of this strategy. School and college is a key constant in our young carers' lives and if this is a supportive and empathising environment, that allows them to thrive by recognising their personal challenges and lived experience to better meet their support needs. This balance across all aspects of their lives, will enable young carers to have all of the opportunities of their peers. Conversely an unsupportive and poorly resourced environment, even one where identification and assessment occurs, is likely to lead to increased stress, poor balance and adverse impact on life trajectory.

This strategy therefore sets the vision, priorities and actions to support this transformation being achieved across Surrey. Through the strategy, we as local leaders, will ensure that the system is best placed to meet those needs, work together to minimise the impacts of caring on a young carer's life, and ensure that the caring they undertake is valued by the system.

This strategy has been developed with the intention to evolve, and for the action plan to be constantly updated. The ambition is to integrate with the [adult carers strategy](#) to create an all-age carers strategy for Surrey.

National Context

In England, there were estimated to be 166,000 young carers aged 5 to 17 in the 2011 census but this is understood to be a considerable underestimate. A survey by the [BBC in conjunction with Nottingham University in 2010](#) estimates there may be as many as 700,000 young carers in the UK, which is one young carer for every 12 secondary aged pupils. The [BBC repeated the survey in 2018](#) and indicated an even higher prevalence of potentially 800,000 Young carers in England(8%).

The 2017 national survey '[The Lives of Young Carers in England](#)' by the Department of Education reveals that most of the young carers were caring for someone inside the home. Of these, over half (55%) were caring for their mother and a quarter were caring for a sibling. Younger carers (aged 5 to 11) were most likely caring for siblings, while older children (aged 16 to 17) were most likely caring for their mother. A small number of young carers were caring for a grandparent, or sibling that they did not live with.

National research by the [Children's Society](#) suggests that young carers are 1.5 times more prevalent in black and minority ethnic communities and are twice as likely to not speak English. However, children and young people from black and ethnic minority communities are less likely to self-identify. Children and young people in the Gypsy Roma Traveller community are at greater risk than their peers of becoming young carers and young adult carers as the adults from the GRT community are more likely to suffer chronic ill health or suffer more than one health condition, waiting longer to access health services and may need to access services in a different The 2016 [Children's Commissioner report on young carers \(2016\)](#), highlighted the difficulties in defining and identifying young carers. It recognised that any estimates were based on self-identification by young carers and their families and that certain family groups are less likely to identify a child in the family as a young carer. The report cited that the 2011 Census data stating 166,365 young carers was likely to be an underestimate. The report also states that nationally just 20% of young carers receive support from their local authority.

Being a young carer can have a negative effect on the child or young person's emotional health and wellbeing. The findings in the 2017 Report – The Lives of Young Carers in England indicated a number of negative impacts for young carers compared to their peers including increased instances of school absence, increase in finding it hard to concentrate, finds it harder to make friends and generally being in trouble at school. These findings have been reflected in the consultation responses we received from young carers (54% cited negative impact), parents/guardian (41% cited negative impact on the young carer), and social workers (20% specifically cited a negative impact on emotional health and wellbeing with 72% citing factors that would contribute to that). This strategy has been developed to ensure that young carers get the support that they need.

Both the Carers Trust ([My Future My Feelings My Family \(2020\)](#)) and SIBS ([Lonely Lockdown. Life for siblings of disabled children in the UK \(2021\)](#)) have produced reports on the impact of Covid-19 on the lives of young carers.

Carers Trust findings included that 67% of young carers were worried about the future, 58% felt the amount of time they spent caring had increased, 67% were feeling more stressed, 40% said their mental health was worse and 30% said they cared for more people.

SIBS findings included 81% of parents said their sibling child's mental health had worsened, 43% of siblings were providing more care in lockdown, 40% of young siblings were feeling isolated and missing support from family /friends and 54% of parents said that respite or a break would have helped siblings cope.

Local Context

The [Community Vision for Surrey](#) describes what residents and partners think Surrey should look like by 2030. Underpinning this vision is a set of ambitions for people and for place. By 2030, Surrey will be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community and no one is left behind. The county's economy will be strong, vibrant and successful and Surrey will be a great place to live, work and learn. A place that capitalises on its location and natural assets, and where communities feel supported and people are able to support each other.

The system-wide [Surrey Health and Well-being Strategy](#) was refreshed in 2022 in the wake of COVID-19 and the exacerbation of existing inequalities. The update has maintained a preventative approach but there is now a greater focus on addressing the wider determinants of health and reducing health inequalities within the priority populations that experience the poorest health outcomes, including young carers. The Surrey Health and Well-being Strategy acknowledges the importance of meaningfully engaging with those with the greatest needs, in order to design services that meet those needs and deliver outcomes.

The Legislative Framework

The [Care Act \(2014\)](#) and the [Children and Families Act \(2014\)](#) require the development of an integrated response to the specific needs of young carers. Legislation places the responsibility for identifying and supporting young carers on both Adults' and Children's Services in the council. The expectation is that when a child is identified as a young carer, or an adult or child is being assessed for care support, the needs of everyone in the family are to be considered, including all children.

The Care Act (2014) requires local authorities to put in place a transition plan for young carers aged 16 –18. This legislation refocuses the law around the person rather than the provision of a service, strengthening the need for a more integrated approach by both Childrens and Adults services.

The Children and Families Act (2014) requires local authorities to take reasonable steps to identify young carers in their area, provide assessments for young carers under the age of 18, and identify whether caring responsibilities are appropriate

A young carer is defined in the Children and Families Act as: *“a person under 18 who provides or intends to provide care for another person”*. The person supported can be of any age and relates to care, emotional support or additional duties related to having a family member who has a physical disability, mental health need, learning disability, or who is affected by drugs, alcohol or other substance use. An exclusion is made where that care is provided for payment, as part of a contract or as voluntary work.

A young carer may become a “Child in Need” when caring responsibilities impact their ability to achieve or maintain a reasonable standard of health or development.

[Working Together to Safeguard Children 2018](#) strengthens the emphasis on early identification, assessment, and intervention. This reinforces the need for agencies to work together effectively to support families with young carers, developing a whole-family approach.

The NHS 10 Year Long Term Plan sets out the ambition and direction for health and care services in England over the next ten years. It recognises that carers are twice as likely to suffer from poor health compared to the general population and identifies specific areas where the NHS will look to better identify and support carers. including emergency plans as part of summary care records, developing carer GP friendly practices and providing more mental health prevention support for young carers.

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Young carers in Surrey

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In 2019, ECORYS ([Surrey Young carers in Schools Research](#)) undertook a detailed study to understand prevalence of young carers in Surrey, across 11 secondary schools and involved 10,460 pupils. This found that an average 4% of all pupils identified as a young carer (more detail can be found in Appendix 1). This equates to at least one carer in every class of 30. However, we also know that young carers sometimes do not see themselves as carers and importantly are not always comfortable in identifying as a carer due to concerns about any potential impact on their family or that they do not want to stand out from their peers. Therefore, this is likely to be an underrepresentation and The Childrens Society states that there are 800,000 young carers aged 5-17 which would indicate that the figure is closer to 8% of all pupils who are young carers which equates to circa 15,398 young carers.

The 2017 young carers' JSNA noted that between April 2014 and Feb 2017 there were 1,518 Child and Family Assessments where "young carer" was selected as a factor in the assessments.

- The numbers of male and female young carers were roughly equal.
- The majority of young carers were aged 5 to 9 (30%) and 10 to 15 (43%).
- 75% of the young carers were white British.
- There were 210 (14%) young carers recorded as having some form of disabilities.

The 2019 Healthy Related Behaviours Questionnaire found that being a young carer has an impact on primary age pupil's experiences with more young carers trying smoking, reporting that they are worried about body changes, or being afraid of bullying.

In 2021 we undertook surveys with young carers, their families, schools and social workers. From the conversations with young carers, it was clear that Covid-19 and being unable to meet together physically had a negative impact on young carers.

Enforced isolation during the Covid-19 lockdowns impacted negatively on all young people but this was exacerbated for young carers. Without the break from caring that school provides many took on increased caring responsibilities and it is likely the numbers of young carers increased.. Negative impacts included not being able to meet with friends, it meant young carers did not have a space to relax or learn new skills. 37% of young carers stated Covid-19 had negatively impacted spending time with their family and 55% that it had negatively impacted their emotional wellbeing and mental health. These findings are similar to those by the Carers Trust in the report [My Future My-feelings My Family \(2020\)](#).

It has also impacted on the ability of schools, who are actively engaged, to support young carers. For schools that were developing young carer support it had created a delay in developing that provision.

Further feedback from young carers tells us:

- There is a need for more localised young carers' services. Many young carers struggle to access services due to a combination of financial restraints, no access to a car or the limitations of public transport.
- Service provision needs to consider when services are available, young carers sometimes need the service to be available when they finish caring and to help relieve the stress of caring, not during the school day.

- School is an important constant – when schools work well, they provide a break from caring, time with friends, a safe place to be open about being a young carer and seek support. Some schools are flexible with young carers such as allowing a different start time and this has a positive impact on young carers. When schools don't recognise young carers it creates stress and anxiety. Furthermore, when phones are confiscated, this removes the ability to stay in touch with the person they care for, causing further anxiety.
- Young carers provide significant emotional support, they and their family recognise that their own emotional mental health and wellbeing can be impacted by this.

There are two key commissioned services that can offer Young Carers a break from caring.

Surrey Young Carers service provided by Action for Carers includes opportunities to meet with peers (both virtually and in person) and attend events that are more social and an opportunity to be a child. Appendix 9 includes some quotes from young carers and their parents on their experiences of these events.

Crossroads includes a carer breaks at home service enabling both young and adult carers to have a break from caring, This is a time limited, short term preventative offer to ease the impacts of caring.

In addition, commissioned service providers also offer Short Breaks services for children and young people who have additional needs and disabilities (AN&D). These offer positive benefits for the child such as developing skills, confidence, independence and develop relationships with other children and adults. These short breaks will also have a positive impact on the families as whole including any sibling young carers who will have a break from caring responsibilities.

Plan on a Page

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Our shared vision is that:

Our vision is that young carers feel supported and confident to say that they are a young carer. They are identified, recognised, valued, and supported, to be protected from providing inappropriate care, to achieve their full potential, and to have access to the same opportunities as their peers. They have a strong voice that results in services that work for them, and we hear their voice when the responsibility of caring is not their choice. Across the system, staff have the tools, skills and knowledge to increase identification of young carers, enable young carers to self-identify and provide the right support to young carers and their families.

Values

- We are young carer focused, ensuring they are considered in every service and by every individual.
- We have a whole family approach, meaning we support the young carer in the context of what the wider family needs.
- We provide the right support at the right time for young carers, in their community, recognising their needs before they escalate.
- We focus on continuous improvement in our services for young carers, ensuring that we provide the best support possible.
- Our services will promote inclusivity and diversity

Strategic Priorities

- Increased awareness visibility and support of young carers in education, health and social care
 - Training for improved identification of young carers and a whole family approach
 - Improved transfer of information
 - Consider young carers in any system change
- Staff have a good understanding of young carer's rights and young carers and their families have the tools they need to advocate for themselves.
 - Ensuring that young carers and their families feel able to request a young carer's assessment and staff have the skills to put them in place
 - Championing young carer's rights
 - Transition to adult services
- Young carers are enabled to and feel safe to self-identify
- Young carers have access to appropriate services that meet their needs
 - Information and peer support for young carers
- Young carers have improved Emotional Wellbeing and Mental Health (EWMH)

- Young carers safeguarding needs are identified and supported
 - Appropriate referrals made for early help to avoid any escalation and preventing the threshold of 'significant harm' being reached

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Vision Statement

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Our vision is that young carers feel supported and confident to say that they are a young carer. They are identified, recognised, valued, and supported, to be protected from providing inappropriate care, to achieve their full potential, and to have access to the same opportunities as their peers. They have a strong voice that results in services that work for them and we hear their voice when the responsibility of caring is not their choice. Across the system, staff have the tools, skills and knowledge to increase identification of young carers, enable young carers to self-identify and provide the right support to young carers and their families.

Values

Young carers have told us what is important to them; what they would like to see in all work we do with them and for them. We have developed our values using feedback from partners and providers across the education, health and care system in Surrey. Adopting these values will help us to keep young carers at the heart of what we do and enable them to thrive as young people.

We are young carer focused, ensuring they are considered in every service and by every individual.

Young carers will be considered in everything we do, throughout the education, health and care system in Surrey. We need to ensure adult and children's services have the skills to recognise when there is a young carer involved in supporting an adult or child and the knowledge to make appropriate assessment and referral. Greater awareness of young carer rights and universal recognition of the contribution that carers make is integral to ensuring we value and empower young carers.

We have a whole family approach, meaning we support the young carer in the context of what the wider family needs

It is important that the young carer's family context is respected, and that a whole family approach to caring is embedded across Surrey. Young carers will be assessed in this context. The whole family will be supported in the caring experience, with ready access to information and appropriate support services when they need.

We provide the right support at the right time for young carers, recognising their needs before they escalate

Caring can have a significant impact on a young person's experiences. It can impact on education, physical health, mental health and wellbeing, and often future life opportunities. Young carers therefore need to be identified and recognised at the earliest opportunity to enable appropriate support to both protect the young carer and enable them to have the same opportunities as their peers. Adults working with children and young people need to be mindful that there are likely to be young carers in every group and have the skills and knowledge to recognise this, support the child and respond to that need. Young carer services respond to the differing needs of young carers and there is a personalised, holistic approach to information, advice and support.

We focus on continuous improvement in our services for young carers, ensuring that we provide the best support possible

We will strive to continually do the best we can for and with young carers. We will work with all our partners to increase recognition and awareness of young carers making them everyone's business. Services across Surrey will respect every young carer's aspiration, personal circumstances and choice, and be accessible to young carers in the way that works best for them.

We will continue to engage and listen to the voices of young carers about their needs. Young carers will be empowered to influence the design and provision of services. Health and social care will work together to commission services, develop the market and enhance the local offer. This will help ensure that high quality, flexible and reliable services for carers are available across Surrey.

Our services will promote inclusivity and diversity

We will ensure that our services for young carers are inclusive, culturally appropriate, and address the needs and preferences of diverse groups and communities by monitoring where the commissioned services work and who they are working with. This includes recognising and understanding people's cultural needs, their choices and preferences and looking at how best to support these needs. These needs will vary and are based on ethnicity, religious beliefs, age, sex, sexual orientation, gender identity, area of Surrey, family, income and employment history etc.

We will continue to work closely with Surrey Minority Ethnic Forum to reach into the faith and multi-ethnic communities of Surrey. We will ensure our services and their uptake is representative of our communities and their needs. To achieve this, we will build equality monitoring into all service specifications and contracts and will monitor equity of access to services as well as activity and outcomes.

All partners and services will value and evidence inclusivity. The commissioned Surrey Young Carers service will engage with young carers, run regular young carers forums, and promote the voice of young carers. . .

Strategic Priorities

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Priority 1 – Increased awareness, visibility and support of young carers in education, health, social care, voluntary, community and faith sector

We need to ensure there is greater visibility and awareness of young carers across Surrey. Recognising the huge contribution of young carers to supporting families is essential, however, nationally there is under reporting of and lack of recognition for young carers. Services that have the most opportunities to identify young carers include:

- 1) Education (schools and colleges)
- 2) Health including GPs and other medical professionals
- 3) Adult social care
- 4) Children's social care
- 5) Youth workers
- 6) Voluntary, community and faith sector

Training for improved identification of young carers and whole family approach

We will develop mandatory training and resources for staff across the system that encourages and enables the identification, recognition and support of young carers and that embeds the whole family approach. Staff will have the skills to embed a whole family approach to services so that when any assessment is undertaken whether by a statutory or voluntary organisation, the staff undertaking the assessment are aware of and inquisitive to situations where children may be undertaking care activities and considered as part of the assessment process. It is especially key that any assessment looks for instances where very young children are involved inappropriately in providing care where they are too young to make an informed choice and to ensure appropriate support is put in place to ensure this does not happen.

Schools and colleges can play a key role in identifying young carers in their classrooms. School and college is constant in young carers lives, there may well be many signs that a child is a young carer and that it is impacting on their school life. It is important that schools recognise this. Surrey Young Carers supports schools to understand how to recognise, support and nurture young carers – awarding schools an Angel Award when they demonstrate appropriate success. In Surrey the Healthy Schools Approach includes assessing the schools support of young carers and encourages working through the process to attain an Angel Award.

In line with the Children's Commissioners recommendations, we will aim for all schools to have as a minimum:

- an effective Young Carers Policy/Statement in place
- a young carer lead/champion
- a process where the school always considers whether a child is a young carer and that is why they are late, behaving differently, not completing homework etc. and will open a discussion to understand their circumstances
- flexibility to provide support for young carers in school by making

- reasonable adjustments to support the young carer e.g. agree a different start time or extensions to complete homework
- facilitated young carer support groups
- appropriate links to partners that support young carers

These elements will also be assessed as part of determining a school meets the Healthy Schools Approach. It is our ultimate aim that all schools will achieve an Angel Award and Healthy Schools recognition. Currently there are 37 schools with the Angel Award.

Improved transfer of information

Our consultation with schools highlighted that information about being a young carer is not always passed from primary education to secondary. We will undertake a rapid review to identify the challenges in ensuring an appropriate transfer of information from primary to secondary education that shows when a child is a young carer and input appropriate measures to tackle this.

Consider young carers in any system change

As part of the Surrey Integrated Care Systems digital strategy, we will consider any potential impacts on young carers acting as digital interpreters for their parents. We will work with fellow commissioners to review the instances where young carers act as interpreters for their parents in a health and social care setting.

Priority 2 – Staff have a good understanding of young carer’s rights and young carers, and their families have the tools they need to advocate for themselves.

The Care Act (2014), and the Children and Families Act (2014) requires the development of an integrated response to the needs of a young carers with responsibility for identifying young carers placed on both Adult and Children’s services within social care. It is our vision for health, care, education and wider workforces to understand the impact of being a young carer, to promote and support young carers.

Ensuring that young carers and their families feel able to request a young carer’s assessment and staff have the skills to put them in place

The Children and Families Act (2014) requires local authorities to take reasonable steps to identify young carers in their area, on appearance of need provide assessments for young carers under the age of 18 and identify whether caring responsibilities are appropriate and where required provide appropriate support.

To ensure high quality assessments that make a difference to young people and their families take place:

- All social care staff will have access to mandatory carer and young carer awareness training. This will improve recognition of young carers and show how the whole family approach should be used.
- All assessments will be undertaken using language that that is accessible and appropriate to the age of the young carer.

- All assessments will consider the impact of passive caring – where for example the child foregoes activities or cannot meet friends at home due to parental constraints or the needs of siblings.
- We will look at best practice to broaden the reach of who has the skills and experience to conduct a young carers assessment, to see if a trusted assessor model could be developed to support making young carers being everyone's business.
- Young carers and their family will know about their right to a young carer's assessment, what this is, the benefits of having one and how to exercise those rights.
- Information, advice and support is available using appropriate language that both respects their caring role and the fact that the young carer is still going through their childhood and adolescence.
- Young carers will be recognised as important partners in providing care needs and their voice will be heard in the care planning for their family members to encourage acceptance of appropriate replacement support.
- As set out in Children and Families Act, young carer assessments will be reviewed regularly using a whole family approach, including young carer health and wellbeing, and are updated to reflect changing needs.

It is important that the system, as well as recognising someone as a young carer, also remembers that they are still a child. So, any discussions, information shared, assessments undertaken, support offered needs to be age appropriate whilst respecting their lived experiences and any changes are discussed so they are understood before they happen.

Championing young carers' rights

We will identify and build on opportunities to raise awareness of young carers' rights, including participating in national campaigns and events (for example: Young Carers Day, Carers' Week, Carers' Rights). These activities will be inclusive of all partners and providers.

Transition to adult services

We will develop closer working between children's and adult social care ensuring from the age of 16 transition planning starts, a transition assessment occurs when they are known to services and where not known a carer assessment occurs as part of the whole family unit. For the commissioned young carers service they will start the transition planning for the young carer to their adult service from when young carer reaches 17.

Priority 3 – Young carers are enabled to and feel safe to self-identify

Our consultation highlighted that many young carers do not come forward as they do not want to stand out from their peers. We are aware that young carers who support their parents or guardians can be more cautious about identifying as a young carer because they are concerned there will be a negative impact on their family. There can be parental pressures not to identify for example where there are substance misuse issues, or the parent has concerns about their own mental health condition. We want to maximise the number of young carers that are recognised as such by services that support them, such as their schools and GPs.

Using the whole family approach, we want parents and guardians to feel safe informing us of the caring activities their children are undertaking so appropriate support can be put in place. Commissioned services will be an enabler in this.

Training for health, adult and children's social care teams will increase recognition. Providers of young carers services will provide support and training to key young carer touch points (e.g., schools), to enable them to work proactively with children. This will include the [Angel Award](#) which recognises schools who develop strong positive practice supporting young carers.

Priority 4 – Young carers have access to appropriate services that meet their needs

Services providing direct support to young carers will ensure that young carers are supported to have a life that recognises their caring, removes inappropriate caring, ensures a normal childhood experience and transition to adulthood with no detriment in relation to their peers, The design of any service will have input from young carers and their families.

Services need to be responsive to the changing needs of young carers and provide flexible opportunities for young carers to access the services including young carers Emotional Wellbeing and Mental Health (EWMH).

The commissioned service provided by Action for Carers offers a tiered service based on the young carers assessed need. The service design ensures they will be working closely with Schools to develop their knowledge, understanding and support of pupils who are young carers. Where appropriate they will refer to Children's Single Point of Access (C-SPA) where it is clear there is a need for a young carers assessment or there are safeguarding matters to be addressed.

All commissioned services will need to respond to young carers needs in a flexible way that enables support when young carers need it and respond to the challenges in young carers accessing services in such a large county by being offered in locations across the county. Services will be developed that offer a wider a choice of locations and availability to improve access. Use of technology will enable continued support for those unable to travel or who may be minimising contact with others.

Information and peer support for young carers

Young carers support those they are caring for with a range of conditions and undertake tasks which may involve physically supporting others. It is important that the care provided is reasonable and suitable for the young carers age. Young carers should be supported to understand what inappropriate care is and that the correct support is assessed and put in place for the family when inappropriate care is recognised.

Information and training will be co-designed with young carers and be developed to be accessible. It may be delivered as a structured programme or one to one guidance with an appropriate practitioner.

We also recognise the value of peer-to-peer support, with professional involvement and guidance as needed. This involves young carers having the opportunity to share experiences, practical advice and emotional support with other young carers.

It is vital that young carers know they are not alone, and that support is available. Group meetings in school or run by third sector partners can lead to friendships based on their shared experiences. Commissioned services will be required to continue to use and develop online groups as a means of making groups accessible to as many young carers as possible.

Priority 5 - Young carers have improved Emotional Wellbeing and Mental Health (EWMH)

As detailed earlier, being a young carer can have a negative impact on their emotional mental health and wellbeing. Covid-19 and the lockdowns that ensued increased the negative impacts of caring on young carers EWMH. They experienced, reduced face to face peer support, support was accessed in a different way (e.g. digital), no chance to attend school to get a break from caring all of which increased isolation and stress for young carers.

Surrey has signed up to implement the THRIVE framework for System Change (Wolpert et al 2019) (see Appendix 8) to support the mental health and wellbeing needs of all children, young people and their families and to design services to meet need in this way. THRIVE model looks at a child's needs as being in four categories (or quadrants). The lowest level is those who need advice and sign posting, next is looking at focused and goals-based help, next is where more extensive and specialised help is needed and finally is the quadrant where greater intervention may be needed. It assumes each child needs will change, and the support can be increased or decreased between the different quadrants with an aim that the child will be coping well – Thriving. This relies on close working of all parties; the young person, their parents//carers, schools, social care, health, emotional wellbeing and mental health services and any third sector providers.

A key aim is to reduce the number of times a child is assessed. Referral and assessment routes will need to be made simple, consistent and clear. Each part of the system supporting the young carer needs to understand the boundaries and limitations of the services that they interact with and have the tools to share appropriate information to best support the young person.

We will co design and develop services to meet young carers EWMH needs as part of the broader young carers service development.

Priority 6 - Young carers safeguarding needs are identified and supported

Safeguarding is part of a continuum where prevention and early intervention can help young carers and their families work through the challenges they face. Safeguarding is about keeping children safe from harm and abuse and is an important part of integrated working. By working together in an integrated way professionals place the child at the centre of all activities and are better able to identify holistic needs earlier and improve outcomes.

We will ensure the voice of the child is heard to understand whether or not it is their choice to care in order to safeguard the child/young person.

We will ensure that all practitioners are aware of local safeguarding policy and practice and accept a joint responsibility to work in partnership to identify and respond to any young carers who are suffering, or likely to suffer, significant harm.

Actions

These actions will form the basis of the young carers strategy action plan that will continue to be built on and developed.

1. We will work with young carers, staff and organisational development to develop training and resources for staff that cover:
 - a. Improved identification of young carers across the system in Surrey.
 - b. How to involve young carers in care planning and shared decision making, whilst recognising that they are still a child or young person.
 - c. Embedding a whole family approach when supporting young carers and their families.
 - d. Undertaking a high-quality young carers assessment
2. We will monitor the number of young carers that are identified in different parts of the system, for example, the number of schools that identify young carers, identification in GP surgeries, identification by adult and children's social care. This will require the development of a new information system. This will also provide local information regarding the demographic make-up of young carers.
3. We will work with Surrey Young Carers to proactively work alongside Surreys personal, social, health and economic (PSHE) and inclusion lead to identify schools to prioritise to develop young carer good practice.
4. We will work with the Schools and Education Safeguarding Forum to further develop awareness, understanding and support of young carers.
5. We will monitor the number of schools with appropriate young carers policies, carers leads, proactive young carers groups and attainment of the Angel Award and Surrey Healthy Schools award
6. We will challenge schools who identify as having no young carers attending the school.
7. We will undertake a rapid review to identify the challenges in ensuring an appropriate transfer of information from primary to secondary education that shows when a child is a young carer and input appropriate measures to tackle this.
8. We will ensure that, where appropriate, children and young people who identify as a young carer have their needs appropriately assessed and receive a joined-up package of support in order to maintain and/or improve their physical, mental and emotional health and wellbeing.
9. We will embed young carers' voices in every aspect of our work, respecting and listening to young carers as 'experts by experience'. To do this, we will work with the young carers' forum and report quarterly on the implementation of these actions.
10. All young carers will have access to appropriate and accessible information to enable them to make informed choices about their caring role. This will include access to training, where needed, to support them in their caring role.
11. Young carers will be supported through key transition and stress points by commissioned services with personalised support planning and early intervention.

12. Young carers will have access to peer support that is both in person and online, this will be facilitated by the commissioned young carers support service.
13. Young carers will have access to services that are inclusive, culturally appropriate and address diverse needs. This will be through our commissioned services for young carers which will be monitored on the equity of access to service.
14. We will, in partnership with young carers, develop an appropriate service to support their Emotional Wellbeing and Mental Health needs. This will be commissioned in line with current procurement rules.
15. We will raise awareness of young carer's rights with a co-developed communications plan for national events. This will be led by the commissioned service, in partnership with the young carers' forum.

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Delivering the Strategy

Delivery of the strategy will be undertaken across the health, care and education system, with young carers front and centre in planning and implementation, with collaborative commissioning that aligns effort and resources wherever possible to ensure outcome improvement for young carers.

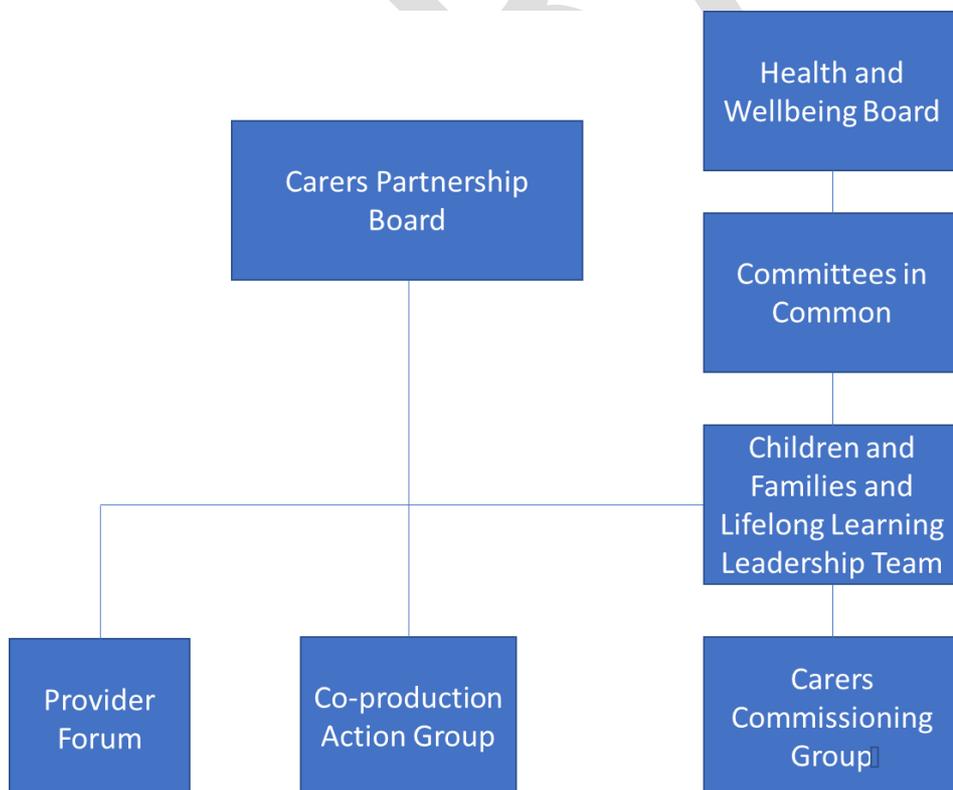
Further work will develop the actions discussed earlier, and others yet to be listed, into a young carers Action Plan which will be a live document to identify areas for continual improvement, using feedback from young carers and their families and track progress towards the vision set out in this strategy.

The Surrey Carers Commissioning Group will be responsible for the operational implementation and delivery aspects of county wide young carers support services. Other services important to young carers such as Short Breaks, will be the responsibility of other teams.,.

For Young Carers services the Surrey Carers Commissioning Group reports to the Children and Families and Lifelong Learning Leadership Team (CFLLT) and the Surrey Carers Partnership Board (SCPB). The CFLLT reports to the Surrey Committees in Common with representatives of Surrey CC and Health, which in turn reports to the Health and Wellbeing Board.

The SCPB has representatives from Children’s Services, Adult Services, Health Services, Education Services, Carers and the Voluntary Sector and will have strategic oversight of the strategy to embed change for young carers, holding the Commissioning Groups and providers to account. The Surrey Carers Partnership Board works alongside the Health and Wellbeing Board.

Diagram of the decision-making process described above.

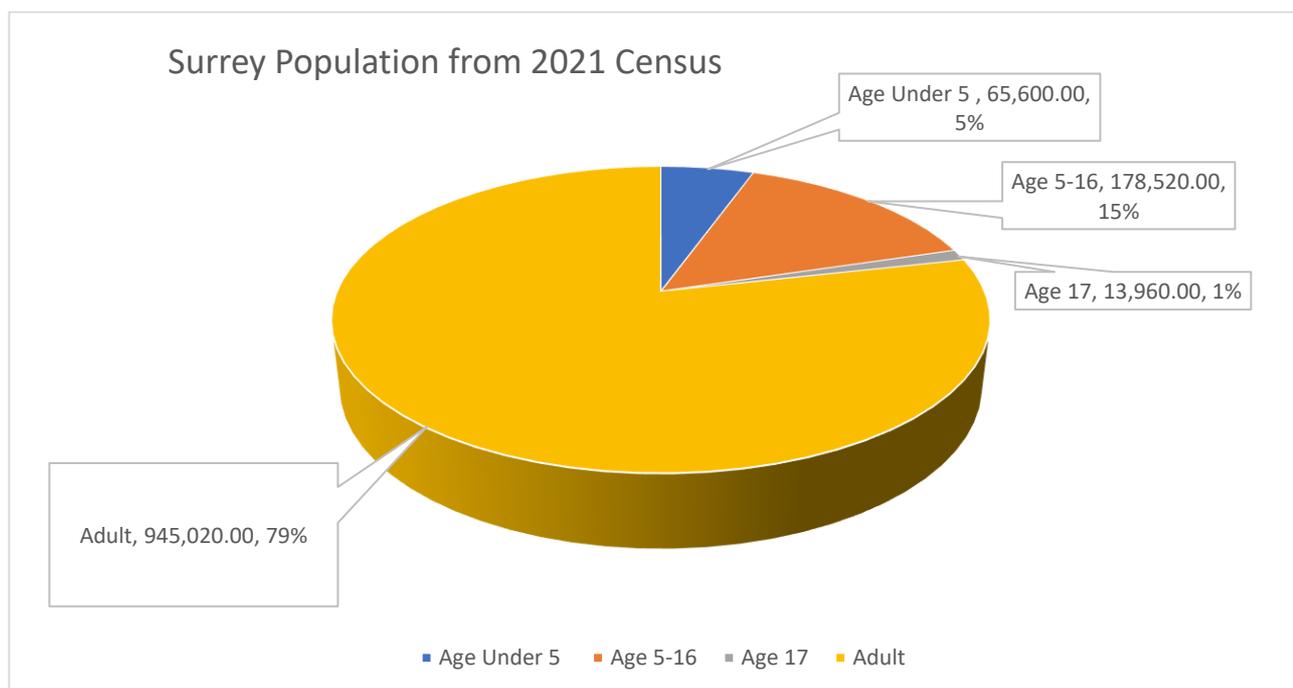


The Surrey Carers Partnership Board terms of reference are to::

1. Oversee delivery of the Surrey Adult Carers Strategy and the Surrey Young Carers Strategy and the intended future all-age Surrey Carers Strategy (together the Strategy(ies))
2. Steer and provide scrutiny for the carer commissioning activity and commissioning services
3. Ensure the support available to carers in Surrey is shaped and delivered by all partners
4. Keep the Strategy(ies) and Programme under review within the Strategy period, adjusting to meet changes priorities, and prepare updates for the next periods
5. Through detailed scrutiny, gain assurance from partners, providers and carers regarding delivery of the Strategy(ies) and Programme, and carer support overall, in their organisation, service and/or Place
6. Develop and improve the Board, seeking to continuously evolve and improve carers experiences

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Appendix 1: Local Context



Age band	Number of residents	Percentage of residents
Under 5	65,600	6%
5-16	178,520	15%
17	13,960	1%
18+	945,020	78%

The 2021 census data estimates the Surrey population as having 258,080 children and young people aged from 0-17 a reduction of 1,358 from the 2017 JSNA data.

The 2017 [JSNA](#) in Surrey noted that between April 2014 and Feb 2017 there were 1,518 Child and Family Assessments where “young carer” was selected as a factor in the assessments.

- The numbers of male and female young carers were roughly equal.
- The majority of the young carers were aged 5 to 9 (30%) and 10 to 15 (43%).
- 75% of the young carers were white British.
- There were 210 (14%) Young carers recorded as having some form of disabilities.

The estimated number of young carers aged 0 -18 years old in Surrey, is somewhere between 4% and 8% of all pupils (the higher figure is based on findings from the BBC and University of Nottingham survey in 2010, and the lower figure from a 2019/20 Surrey based study by ECORYS researching the prevalence of young carers in Surrey Schools looking at 10,460 students in 11 schools).

The 2019 Health Related Behaviour Questionnaire undertaken by Surrey Public Health in partnership with Children, Schools and Families looked at 4,322 primary age pupils 2,429 secondary aged pupils.

It reported that 7% of primary age pupils responded that they are a young carer and only 24% of these pupils said their school knew they were a young carer (2% of all pupils).

Being a young carer has an impact on primary age pupil's experiences:

- 2 % have tried smoking (compared with 1% overall)
- 22% are worried about body changes (compared to 13% overall)
- 50% report being afraid of bullying (compared to 37% overall)
- 5% of young carers have had an alcoholic drink (compared with 2% overall).

In contrast 4% of secondary aged pupils stated that they were a young carer (with 5% not sure and 1% didn't want to say). The difference in experiences continues for young carers enter secondary education:

- 6% smoke occasionally or regularly (compared with 4% overall)
- 13% are worried about becoming pregnant before being ready (compared to 6% overall)
- 38% report being afraid of bullying (compared to 24% overall)
- 13% of young carers have had an alcoholic drink in last 7 days (compared with 12% overall).

The figures demonstrate the inequalities in life experience faced by young carers. Young carers are more likely to have tried smoking or drinking than their peers, they have increased body concerns, are more likely to be concerned at becoming pregnant and are more likely to be afraid of being bullied. The impact of bullying is reflected in our Survey of young carers (Appendix 3) and in the 2017 National Survey (also in Appendix 3).

The importance of schools and colleges in recognising that a young person is a carer cannot be underestimated. Recognition and following this up with support and signposting for the young person as appropriate is a key element in reducing the impacts of being a young carer.

The Period between Spring 2020 and Autumn 2020 was greatly impacted by COVID 19 restrictions. Over the period of Autumn 2019, Spring 2020 and Autumn 2020 school & college terms, a total of 346 different schools & colleges reported at least one pupil who had been identified as a young carer.

Statistically somewhere between 4% and 8% of pupils are likely to be young carers. This is equivalent to 1-2 pupils who are young carers in every class of 30 pupils. In September 2020 there were almost 197,000 pupils across all schools and colleges in Surrey. If 4% are young carers that would indicate potentially 7,700 young carers and at 8% that figure rises to 15,398 young carers.

A total of 151 schools & colleges in the Autumn 2020 term reported that they had identified no pupils who were young carers (36 of which had previously identified young carers).

The school's data between Autumn 2019 and Autumn 2020 had a peak figure of 2521 identified young carers.

The data indicates significant level of underreporting of pupils with caring responsibilities. This demonstrates a need for continued work with schools to skill them to recognise pupils are young carers and make the environment safe for the pupils to come forward and self-identify knowing they will be supported appropriately.

5

Term	Number of Schools	Number YP Identified as a carer	Number YP Accessing Young carer Services
Autumn 19	277	2421	1040
Spring 20	270	2490	1186
Autumn 20	269	2521	919

Action for Carers supports schools to better understand young carers needs and support them. They provide resources, PSHE materials. Work with Home School Link Workers and SENCOs. To support this, Action for Carers developed the Angel Award Scheme with young carers to accredit schools that demonstrate they are young carer friendly.

Appendix 2: Interviews with Young Carers and their Parents

5

In May-June 2021, with support from Surrey Young Carers we conducted seven interviews with young carers and their parents/guardians, a group interview was also undertaken with a young carers group in Woking to understand their lived experience in their own words.

On the caring role

All the young carers we interviewed support a sibling, five of whom has Autistic Spectrum Disorder (ASD).

When young carers are at secondary school, they can be more conscious about their home life and less likely to feel comfortable about being identified as young carer.

They support the person they care for both emotionally and at times more actively by supporting siblings – for example distraction tactics, walking them to school, calming them down as well as assisting with dressing and meal making.

When their sibling attends a different school to them, school becomes a place for the young carer to switch off from caring. At home they often never fully switch off whenever the cared for sibling is at home. When young carers support older siblings, it leads to a feeling of being the “older one, responsible one” which makes them feel different to peers who can behave like the younger sibling.

Being a young carer means they have less time for themselves and to socialise with peers. This can make young carers more isolated, more likely to stay at home and less confident in navigating social situations.

Being a young carer enhances life skills including making the young person better at listening and being attentive to the needs of others.

The young carers raised the importance of the weekly young carer group in Woking. It gave them a structured time of the week where they did not have to worry about caring and enabled them to be with peers who understood the challenges and pressures they felt.

On Carer Identification

It was clear that many families do not have prior awareness that their child is a young carer and are unlikely to reach out for assistance – therefore identification by a professional is key to recognition.

Parents and carers appreciate their young carer children being acknowledged for their role helping their sibling with additional needs.

Team Around the Family (TAF) meetings for a child with additional needs can identify young carer(s) in the family.

Emotional Literacy Support Assistant (ELSA) play a part in identifying young carers at school and helping parents refer them as young carers. Likewise Social Workers and Family Support Workers can be key in recognising that a child is a young carer and enabling appropriate referrals.

On School and College

Schools are a constant in young people's lives – a key touchpoint for young carers and for some, an important time away from caring.

The response from schools can be varied. Some teachers although aware of the young carer's additional responsibilities, don't seem aware of what a young carer is or that there is support for them out there.

For secondary school pupils' recognition and support in schools can be better where young carers have a trusted person at school they can talk to (e.g., their form tutor) and they have a long relationship with them with knowledge of their history.

Teachers can be helpful in giving young carer time out, extended homework deadlines etc. Young carers appreciate a young carers support team or Head of Young carers where they can go to for support, although they report that these people can carry several positions and be very busy

Some schools are not supportive of young carers or understanding of how home life may impact on the young carers ability to learn and / or emotional wellbeing / behaviour at school.

Young carers felt more awareness of young carers needs to be had across the school, even in schools that have a young carers group. However as young carers get older, they often don't want peers to know have been to a young carer support group. This was also highlighted by the group of young carers in Woking – they wanted their school to understand their challenges but not single them out – for example in an assembly.

What Works What Doesn't

We asked the young carers about some of the challenges they face. The location of any young carers event can prove challenging – the group in Woking citing the cost of a bus and how in winter it is harder to attend evening events due to safety concerns.

The group felt the weekly young carers session was very important as it gave both a regular break and a chance to build relationships with others.

The need for increased mental health support was highlighted and, in some cases, they were waiting for a CAMHS referral. A number of training sessions were also suggested by the group,

1. Manual Handling – although we need to ensure young carers do not undertake inappropriate care
2. Safeguarding – to understand when what you do is what is common to most your age and when it tips over into being a carer, when as a child you may want to refer
3. Further training for schools to support young carers

The young carers group suggested subsidised access to leisure activities including leisure centres to help with stress.

Appendix 3: Survey of Young Carers

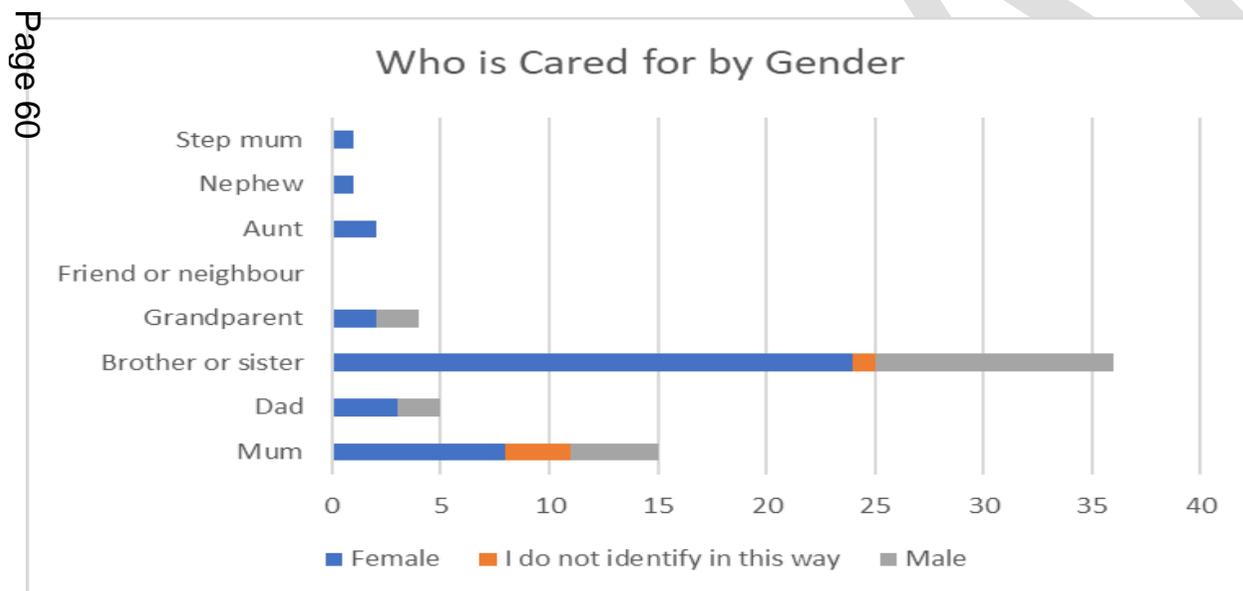
In June 2021 we undertook an online survey of young carers and their parents in total we had fifty-four responses from young carers and seventy from parents of young carers.

Young carers survey findings

The young carers survey highlighted that almost two thirds of the young carers were female and over half were aged 12-15 years old. Given the online nature of the survey the age range is perhaps to be expected. However, of note is the fact that 30% were aged 9-11 and 2% were aged 5-8.

We had responses from 10 of the 11 boroughs with the highest responses from young carers living in Elmbridge (19%), Waverley (17%) and Woking (15%).

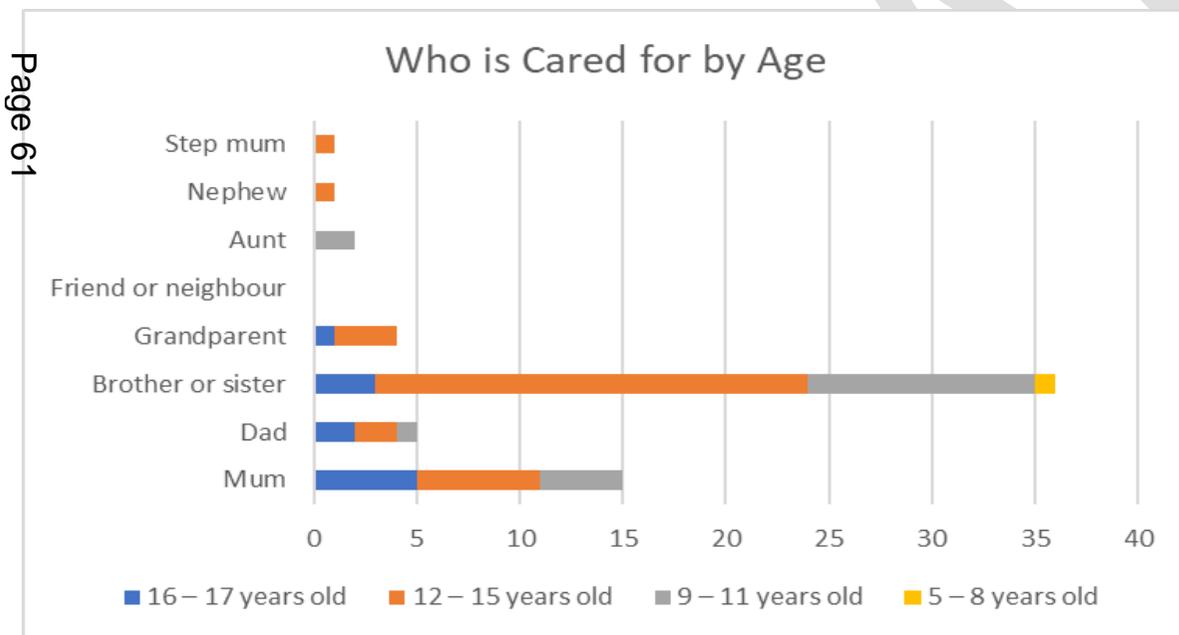
Who is cared for by Gender



The data in the above image is shown in the table below.

Gender	Mum	Dad	Brother or sister	Grandparent	Friend or neighbour	Aunt	Nephew	Step mum
Female	8	3	24	2	0	2	1	1
I do not identify in this way	3	0	1	0	0	0	0	0
Male	4	2	11	2	0	0	0	0
Grand Total	15	5	36	4	0	2	1	1

Who is cared for by Age



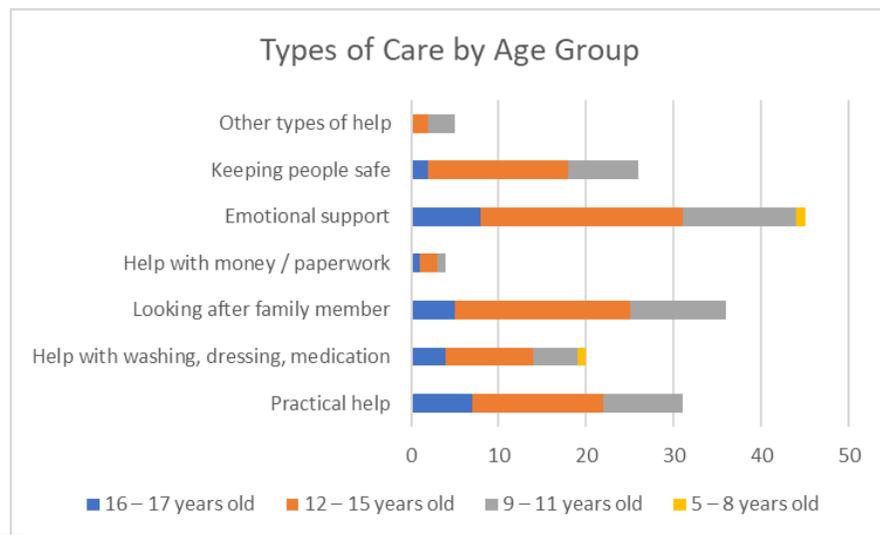
The data in the above image is shown in the table below.

Age Range	Cares For Mum	Cares For Dad	Cares For Brother or sister	Cares For Grandparent	Cares For Friend or neighbour	Cares For Aunt	Cares For Nephew	Cares For step mum
5 – 8	0	0	1	0	0	0	0	0
9 – 11	4	1	11	0	0	2	0	0
12 – 15	6	2	21	3	0	0	1	1
16 – 17	5	2	3	1	0	0	0	0
Total	15	5	36	4		2	1	1

We asked who the young carers cared for, and two thirds cared for a brother or sister. This caring responsibility was proportional across gender. When looked at from an age perspective it is the person that the greatest number of 9–11-year-olds care for. 27% of the young carers care for their mum and just under 10% for their dad.

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Types of care undertaken



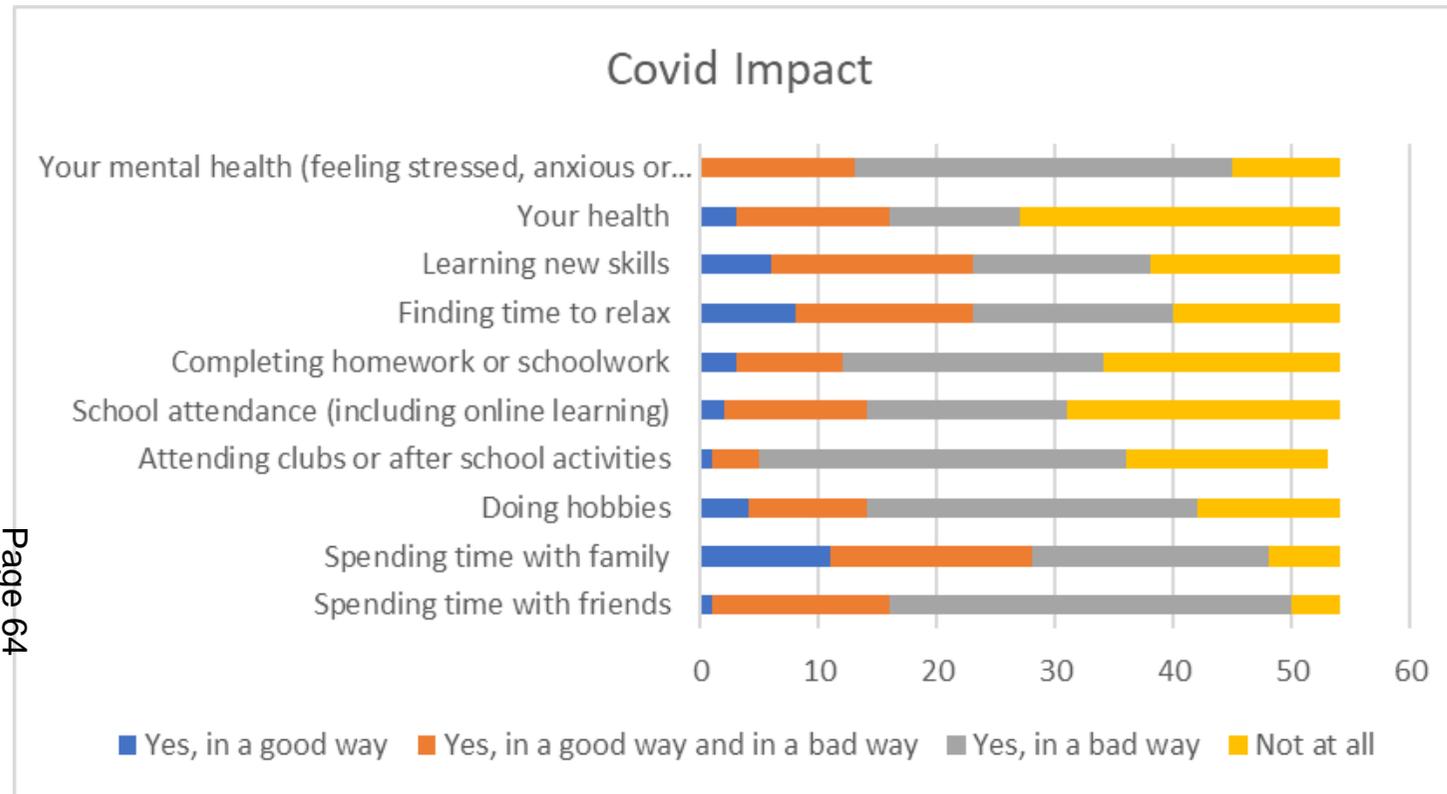
Page 63

The data in the above image is shown in the table below.

Age Range	Practical help, cooking, cleaning, shopping	Help with washing, dressing, medication	Looking after family member	Help with money / paperwork	Emotional support	Keeping people safe	Other types of help
5 – 8	0	1	0	0	1	0	0
9 – 11	9	5	11	1	13	8	3
12 – 15	15	10	20	2	23	16	2
16 – 17	7	4	5	1	8	2	0

Young carers are involved in practical help from a young age with 17% of 9–11-year-olds (9) providing practical help, 24% (13) providing emotional support, 15% (8) helping keep someone safe and 9% (5) providing help with washing, dressing, moving around or medication. This care is provided to a combination of their mum/ dad, brother, or sister and in 2 cases their aunt.

Impacts of Covid



Page 64

The data in the above image is shown in the table below.

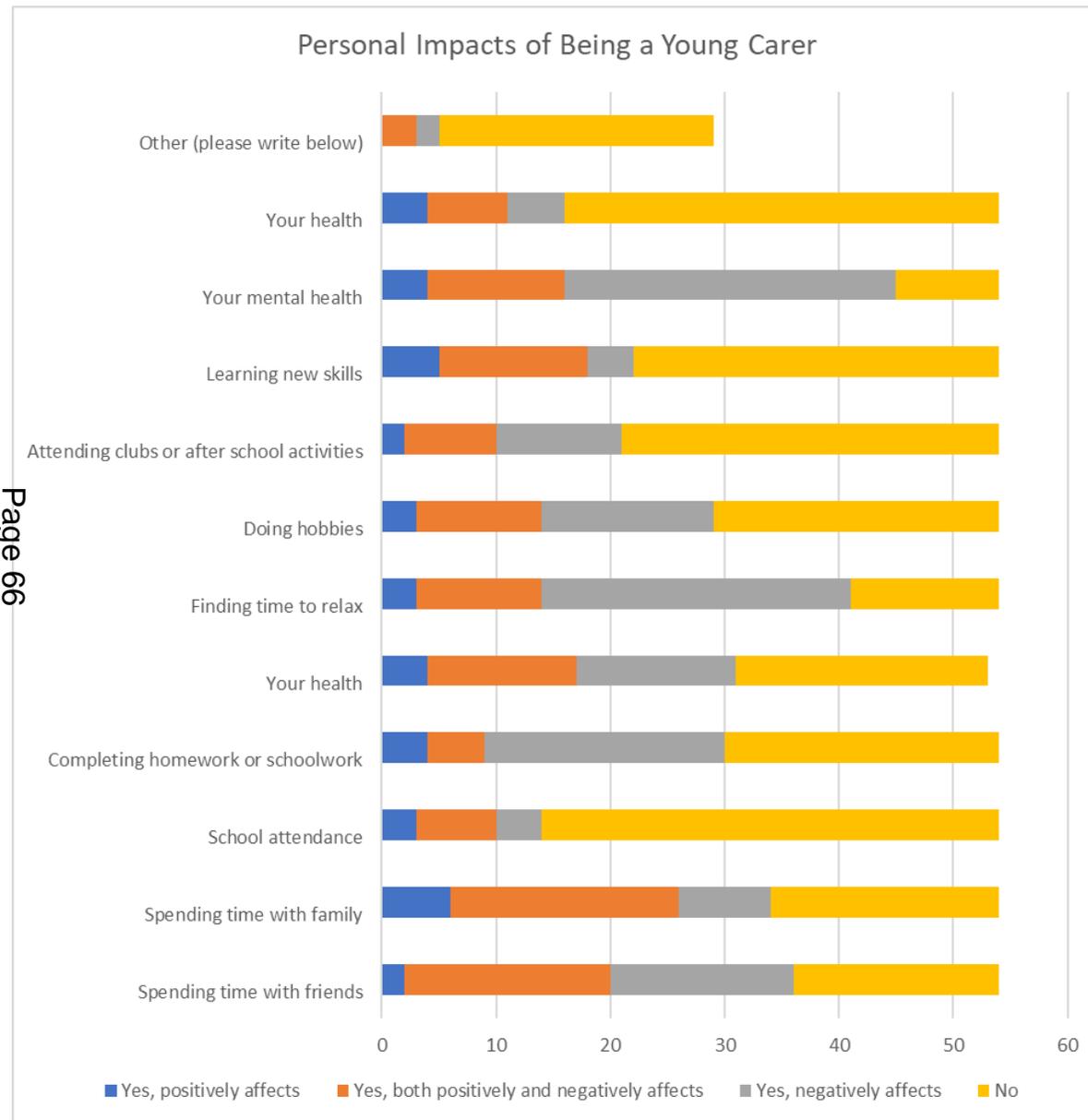
Impact	Spending time with friends	Spending time with family	Doing hobbies	Attending clubs or after school activities	School attendance (including online learning)	Completing homework or school work	Finding time to relax	Learning new skills	Your health	Your mental health (feeling stressed, anxious or low)	Other (please write below)	Covid impact other
Yes, in a good way	1	11	4	1	2	3	8	6	3	0	0	0
Yes, in a good way and in a bad way	15	17	10	4	12	9	15	17	13	13	2	0
Yes, in a bad way	34	20	28	31	17	22	17	15	11	32	2	0
Not at all	4	6	12	17	23	20	14	16	27	9	16	0

Page 65

The survey covered the impacts on covid for the young carers and their families. By far the biggest impact was on spending time with friends and attending school clubs and activities – it is likely that this is a contributing factor to the feeling of isolation.

As a follow up we asked what young people were most looking forward to in the next six months. Going out with friends, holidays, attending events such as weddings, going to venues like Chessington and Harry Potter World, attending the cinema, new schools, and a return to normal schooling and for a number of young carers they were looking forward to Christmas (In June!).

Impact of being a young carer



The data in the above image is shown in the table below.

Impact	Spending time with friends	Spending time with family	School attendance	Completing homework or schoolwork	Your health	Finding time to relax	Doing hobbies	Attending clubs or after school activities	Learning new skills	Your mental health	Your health	Other
Yes, positive impact	2	6	3	4	4	3	3	2	5	4	4	0
Yes, both positive and negative impact	18	20	7	5	13	11	11	8	13	12	7	3
Yes, negative impact	16	8	4	21	14	27	15	11	4	29	5	2
No	18	20	40	24	22	13	25	33	32	9	38	24

Our findings showed that caring does have a negative impact on young carers., The greatest impact is on the young carer's mental health 54% (29), possibly linked is finding time to relax 50% (27) and completing homework 39% (21). Caring also has a negative impact on doing hobbies, meeting friends, and attending clubs/afterschool activities.

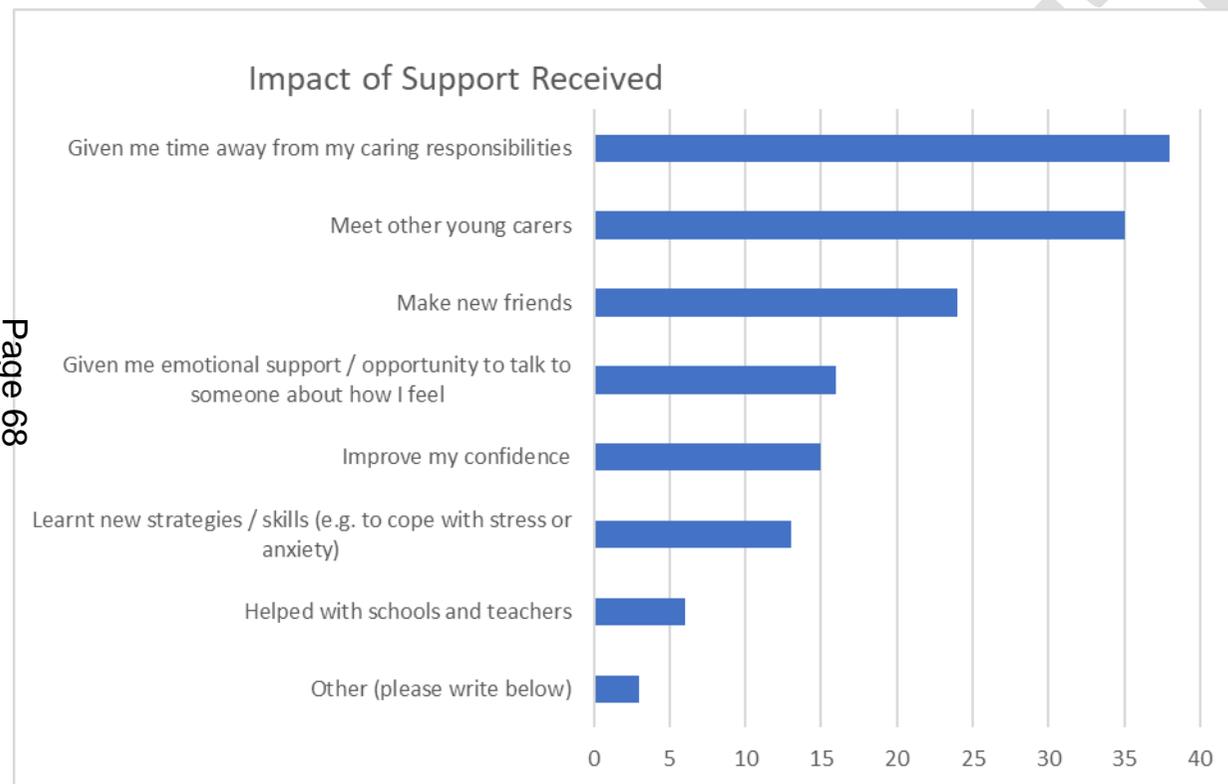
Caring impacts on friendships with 67% saying they felt isolated or lonely at least some of the time and 75% stated they found it hard to make friends.

Being a Young carer impacts their education. Nationally 10 % of young carers indicated that their caring responsibilities led them to being late for school; in this study a much higher proportion of young carers 31% stated that they had been late due to their caring responsibilities. The prevalence of bullying or being afraid of bullying at 52% is very similar to the 2019 Health Related Behaviour Questionnaire undertaken by Surrey Public Health in partnership with Children, Schools and Families.

Nearly 80% of all the young carers said that their school knew they were a young carer with 19% stating they did not know if their school was aware. Primary education settings were more likely to be aware that a pupil was a young carer.

78% of the young carers surveyed said their school had support for young carers. 81% of all young carers worry about the person they care for at least some of the time.

Impact of support received



The data in the above image is shown in the table below.

Impact of Support Received	Number of Responses	Percentage
Given me time away from my caring responsibilities	38	70.37%
Meet other young carers	35	64.81%
Make new friends	24	44.44%
Given me emotional support / opportunity to talk to someone about how I feel	16	29.63%
Improve my confidence	15	27.78%
Learnt new strategies / skills (e.g. to cope with stress or anxiety)	13	24.07%
Helped with schools and teachers	6	11.11%
Other (please write below)	3	5.56%

Page 66

We asked Young carers if they had heard of the support services available to them. 98% of the young carers had heard the services and 89% had either read or been given information and 81% had attended an event run for young carers.

We asked about the benefits of young carers support they had received. Over 70% said that it gave them time away from caring responsibilities, 65% appreciated the opportunity to meet other young carers and 44% said it enabled them to make new friends. The impact was also on a more emotional level with nearly 30% stating it gave them emotional support/ opportunity to talk to someone how they feel or improved their confidence. Nearly 25% said that it helped by learning new strategies and skills to cope with stress and anxiety.

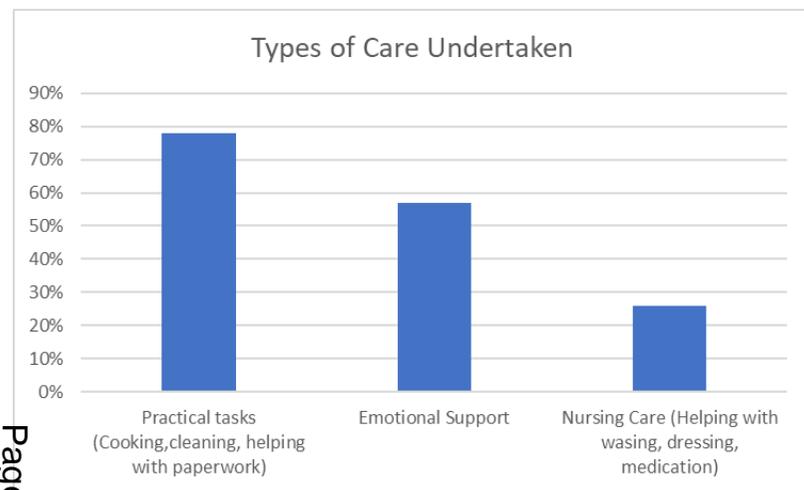
We asked those who attended an event what they most liked the two most common themes were being away from home being able to relax away from the stress of caring and meeting new people who had similar experiences (making friends). A large number mentioned how much fun the events were, and they were often something different and a chance to learn new skills.

We also asked about what they least enjoyed and variations on being shy, not knowing anybody were the biggest issue, some mentioned when they went from attending 8–11-year-old events to the next group 12-16 they were the youngest and found it intimidating. A large number said there was nothing they didn't like.

The positives are common to the findings from the parental survey.

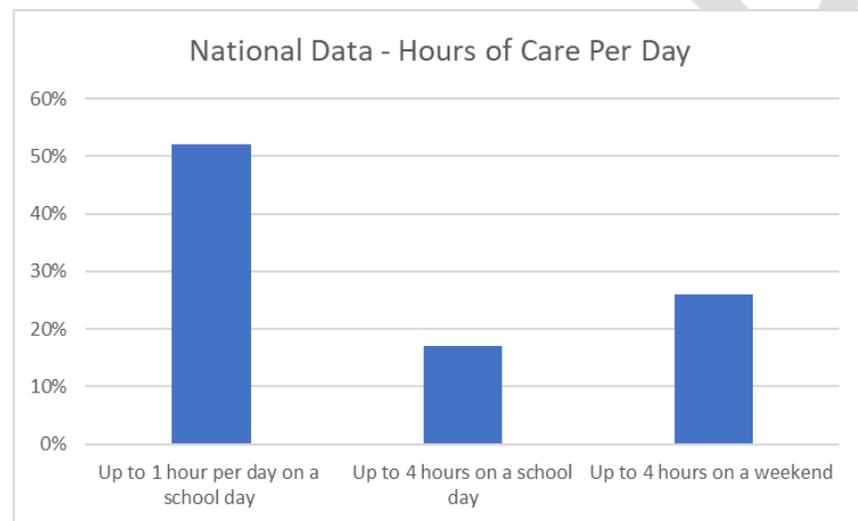
2017 National Survey - The Lives of Young carers in England

The 2017 survey looked at the kind of tasks young carers were undertaking. Practical caring responsibilities increased with age but involvement in nursing care and emotional support was similar across age groups.



Page 70

Young carers provide a substantial number of caring hours across the country including on school days.



Caring can have a negative impact on young people. Young carers reported a greater prevalence of experiencing anger “a lot” (14% compared to 8% of non-carer peers). 19% of young carers aged 11-17 reported difficulty in making friends (compared to 12% in non-carer peers) and were much more likely to be bullied (16% v 3%).

Caring has an impact on education to, 10% of young carers reported being late for school at least once a week, compared to 1% of peers and much more likely to have fallen asleep at school 31% (compared to 20% of peers). Young carers had a higher prevalence of absenteeism with 74% absent at least a few times in the year compared to 49% of their peers. Only 28% of young carers were never absent in comparison to 51% of their peers.

One positive was that 64% said they felt happy “a lot” compared to 55% of their peers.

Overall, the findings from the 2017 National Survey are like the findings of the Surrey Survey in 2021.

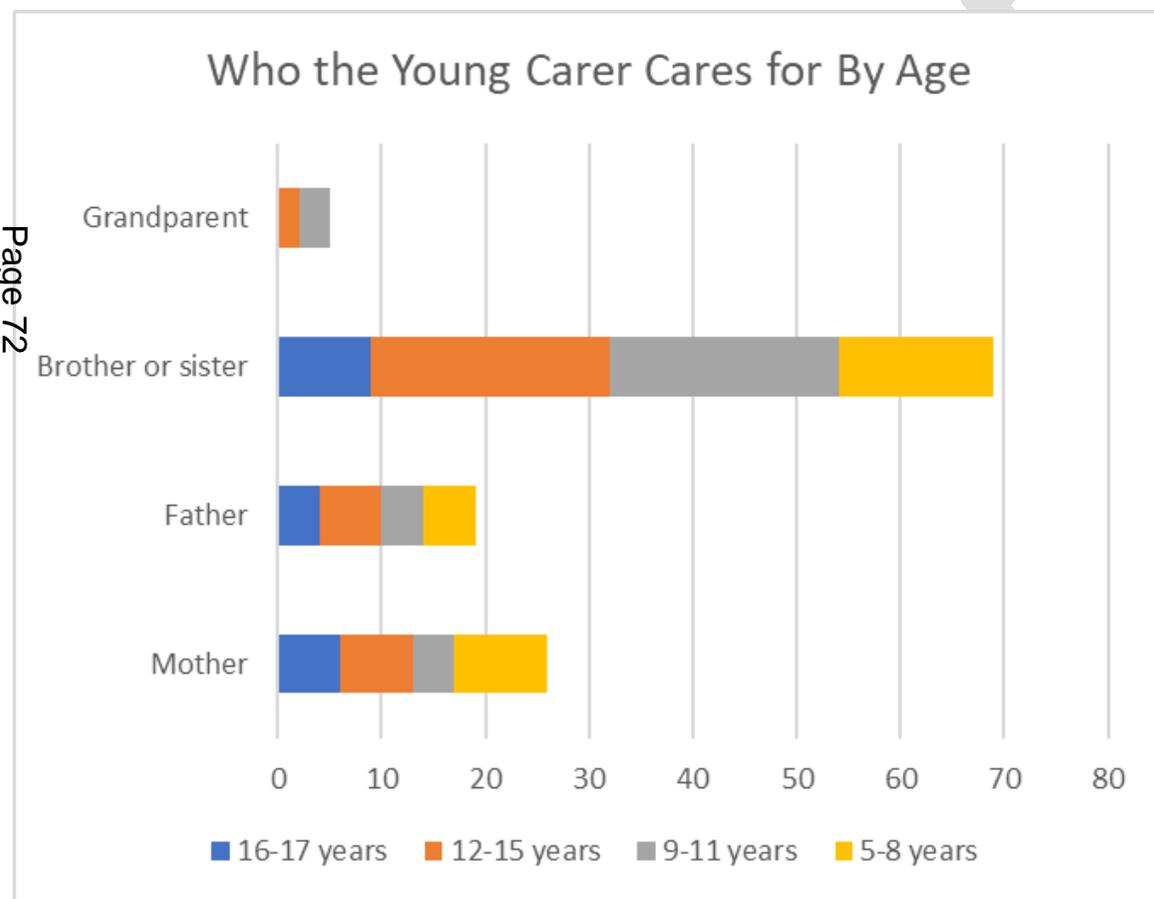
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Appendix 4: Survey of Parents of Young Carers and Parent Carers

This survey was conducted between 17/06/21 and 01/07/21/

In total we received Seventy responses from parents who were responding giving their perception of the care provided by the young carers in their family. The parent's survey was structured so they completed a single response no matter how many young carers were in their family.

Who is Cared for by Age



The data in the above image is shown in the table below.

Age Range	Mother	Father	Brother or sister	Grandparent
16-17	6	4	9	0
12-15	7	6	23	2
9-11	4	4	22	3
5-8	9	5	15	0

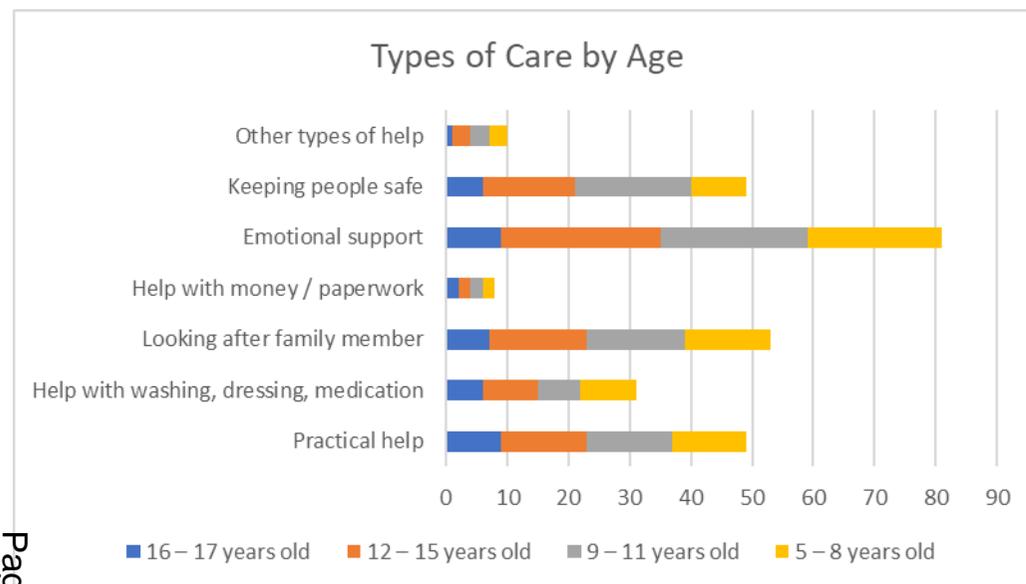
There was a more even split of young carers across the age ranges. Parents highlighted 22, 5–8-year-old young carers making up 25% of young carers identified (compared to 2% of young carer responses) The percentage of 16–17-year-olds is almost identical at 15% (13 children), as is the percentage of 9–11-year-olds at 29% (26 children). The number of 12–15-year-olds is much lower at 31% (28).

The proportion of who the parents perceive the young carer cares for is very similar to the responses of the young carers themselves. 98% of parents say that the young carer looks after a brother or sister, 37% their mother and 27% their father.

Parents from all 11 Boroughs are represented. Once again Guildford (21%) Elmbridge (14%) and Waverley (13%) are heavily represented.

Page 76

Types of Care by Age



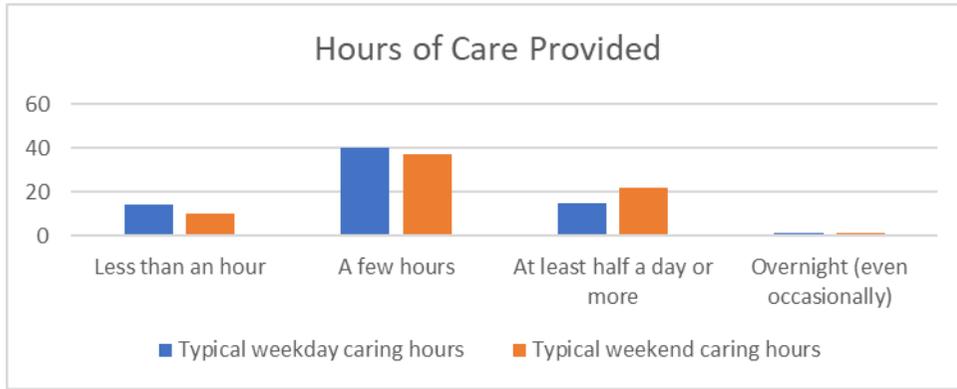
Page 74

The data in the above image is shown in the table below.

Age Range	Practical help	Help with washing, dressing, medication	Looking after family member	Help with money / paperwork	Emotional support	Keeping people safe	Other types of help
16 – 17	9	6	7	2	9	6	1
12 – 15	14	9	16	2	26	15	3
9 – 11	14	7	16	2	24	19	3
5 – 8	12	9	14	2	22	9	3

The types of care provided percentages are broadly like that stated by the young carers. When looking at the ages we had to assume that all young carers undertook all tasks as this was not further extrapolated in the questions.

Hours of Care Provided

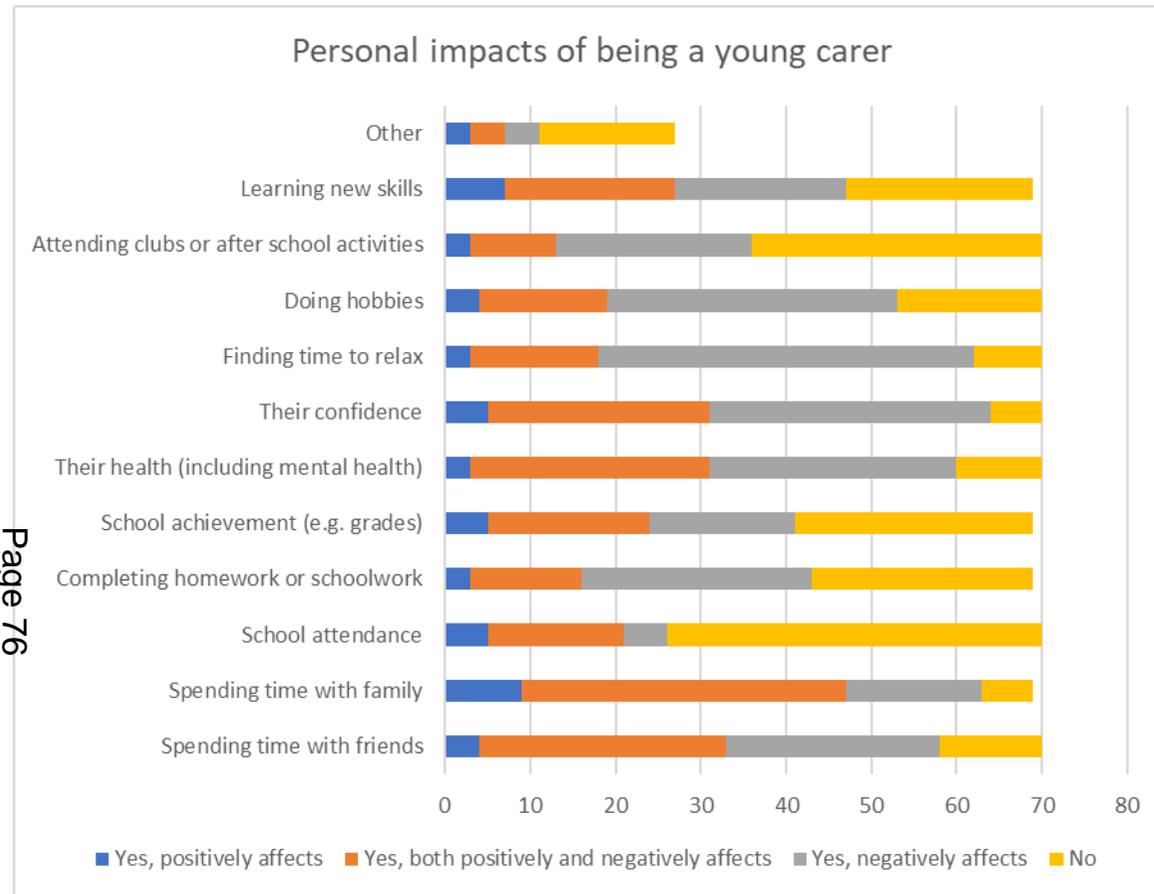


We asked parents for information on the hours of care their children undertake. Young carers provide both care midweek and care at the weekend. 16% (14) provide less than an hour care midweek and 11% (10) provide the same at the weekend. Nearly half all young people 45% (40) provide a few hours care each weekday and 42% (37) do the same at the weekend

17% (15) of all young carers provide care at least half a day or more midweek rising to 25% (22) at the weekend.

Finally, one young carer aged 16-17 occasionally provides overnight care to their sibling in the week and at weekends.

Personal Impacts of Being a Young Carer



The data in the above image is shown in the table below.

	Spending time with friends	Spending time with family	School attendance	Completing homework or schoolwork	School achievement (e.g. grades)	Their health (including mental health)	Their confidence	Finding time to relax	Doing hobbies	Attending clubs or after school activities	Learning new skills	Other
Yes, positive affects	4	9	5	3	5	3	5	3	4	3	7	3
Yes, both positive and negative affects	29	38	16	13	19	28	26	15	15	10	20	4
Yes, negative affects	25	16	5	27	17	29	33	44	34	23	20	4
No	12	6	44	26	28	10	6	8	17	34	22	16

Page 77

Parents were also asked about their perception of the personal impacts of being a young carer. As with the Young carers themselves their parents felt that in very few areas caring had a solely positive impact, as before spending time with family 13% (9 parents) and learning new skills 10% (7 parents) are the two most common positive areas.

Parents are very aware of the negative impacts citing finding time to relax 63% (44), time to do hobbies 49% (34), their confidence 47% (33), their health including mental health 41% (29), completing homework 39% (27), spending time with friends 36% (25) and attending clubs 33% (23).

Just 1 parent said caring had a wholly positive effect on the young carer.

Overwhelmingly 86% (60) of the parents said the school was aware that their child was a young carer 7% (5) were not sure, and 7% (5) said the school did not know.

We asked parents a free text question on the support schools provided 16 parents answered. Three highlighted supports from home school link workers. Five parents talked about clubs either ongoing or starting and the importance of key staff, one mentioned a dedicated member of staff and another that the school kept an eye on their child and the school offered a safe space. One parent mentioned the child being given an exit card to leave lessons. Three parents said no support or very little was offered, and another parent praised the fact that their child was able to attend lessons during lockdown.

90% of all parents had heard of Surrey Young carers (SYC) however only 70% said they had a child that attended an event and just 34% said that they had received information.

That said 27% said the service totally met their needs and a further 41% that it partially met their needs. We asked for further detail and the following is common to several responses from parents on the benefits of the service

Parents really appreciated the opportunity for their children to make friends, especially with children in a similar position to themselves. The fact that the events and time away allowed the child to be a child, have time focussed on them and not be interrupted by or worry about the person they care for. Several parents were very positive about the events online over lockdown.

We also asked about what stopped their child attending. Only eleven parents (15%) responded, but three of these mentioned travel difficulties getting to the events or location of the event being an issue.

Appendix 5: Survey of Social Workers

This survey was conducted between 27/04/21 and 07/05/21.

A total of 29 social workers answered the survey and there were a number of key themes addressing the biggest needs of young carers and areas where they need support.

A common theme is the need for greater recognition that they are young carers but that we need to ensure that at the same time they are not singled out and stigmatised by this.

There is a need for more localised activities – making access easier with little or no travel. Additionally, a broader range of services, (possibly through school), as Surrey Young carers and My Time does not appeal to some young carers.

Counselling and Emotional Support, there is an emotional impact from the caring role, with an impact on their physical and mental well being

Where they are caring for siblings an opportunity for 1:1 time with parents with undivided attention or with the family away from caring. This tied in with generally care packages for the cared for enabling the young carer more free time.

There is still a fear from families to ask for help or to recognise their child as a young carer for fear of being removed from the family home. Families do not always agree to referrals to Surrey Young carers.

Overarching was a recognition on the negative impact caring had on the young carers impacting their ability to socialise with friends, social isolation, know how to access things like public transport.

There is a recognition that some young carers may be missed by Adult Social Care as assessments often take place during the school/college day so the young carers may not be present.

Children with Disability social workers know most siblings of the child with disabilities are young carers – it was not explicit that they will be referred to Surrey Young carers

Many requested clearer information on the service offer from Action for Carers/Surrey Young carers to better inform potential service referrals and discussions. In fact, 2 social workers stated they were not aware of the services/resources offered by Action for Carers/Surrey Young carers

Access to Young carer support needs to be timely.

Appendix 6: Survey of Schools

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This survey was conducted between 26/04/21 and 12/05/21. In total we had 81 responses from schools (77), access to education (3) and the Hope Service.

The 77 Schools and colleges represent 16.8% of all schools and colleges in Surrey.

Identification

Our first question asked all the ways young carers were identified within their school.

By far the most common way schools know about a young carer (41 responses 51%) was following parents informing them and linked to these 14 schools (17%) stated that the information came from information on the school application. Prior family knowledge (siblings with SEND for example) was cited by 17 schools.

Schools indicate positive identification by staff with 32 responses (40%) stating that identification was following monitoring concerns and/or staff identifying the person as a young carer.

In 28 Schools (35%) the child/young person identified themselves and linked to this, 16 schools (20%) mentioned identification came following promotion in an assembly.

6 Schools (7%) specifically mentioned being informed by Surrey Young carers and an additional 4 schools mentioned external agencies. 2 schools stated that their GDPR had caused data sharing issues and that the school could not be provided with names of young carers from Surrey Young carers

In total 8 out of 25 schools and colleges indicated that they were informed a pupil was a young carer by the previous school (year 7 or Year 11).

4 schools mentioned the work of the ELSA in identifying young carers and 8 mentioned the safeguarding team

Barriers

We asked schools about the barriers to identifying young carers, and 28 schools (35%) stated it was because young carers do not want to be identified, they do not want to be seen as different, feel embarrassed by being a young carer or that there is a stigma or taboo. 24 schools (30%) stated that parental barriers (a combination of accepting that their child is a young carer, not giving permission to share information with Surrey Young carers and are not motivated to allow their child to access support). 9 schools highlighted the fact that the children and young people did not realise they were a young carer.

18 Schools stated a lack of knowledge of services available and 6 said a combination of identification of young carers could be improved or they lacked clarity on the threshold were helping at home becomes being a young carer

A challenge for the young people in accessing services can be a lack of local events as families often have no car/transport can be an issue. (11 schools) and the challenging family lives (6 Schools).

Awareness

There was an almost 50/50 split in terms of schools and colleges that rated their awareness of young carers as excellent or very good in contrast to good or fair. The same number stated their knowledge was excellent as stated their knowledge was fair.

Awareness	Number	Percentage
Excellent	15	18.5%
Very Good	26	32.1
Good	25	30.1
Fair	15	18.5%

This question indicates more work is required in schools to develop further understanding of young carer issues, young carer recognition and information on services available to young carers.

What is in place to support young carers

From a young carer viewpoint 40 (50%) respondents said they either had a club/group to support young carers or one was in development/ being planned – often working closely with Surrey Young carers. Assemblies focusing on young carers was a tool used by 9 (11%) schools. 4 schools have this on their PHSE curriculum. 11 have mentoring programs.

7 schools stated they have emotional support in place, four use Thrive, 2 mentioned using Mindup and two stated they had developed tailored programs.

Recognising the impact of caring 5 schools had homework clubs or offered homework passes, one allowed young carers to continue to attend school in lockdown, and one offered flexible timetabling

14 (17%) Schools specifically mentioned either Action for Carers or Surrey Young carers as being part of the support offered. In total 7(9%) schools stated they had worked with Action for Carers and had achieved their [Angel Award](#), which recognises schools that are “Young carer friendly”. A further 6 (7%) schools are striving to achieve this award.

Staff within schools can be key in providing support, ELSA’s were named by 20 (25%) schools as being important in the support of young carers. 11 (14%) schools stated the importance of having a lead member of staff or a young carers champion, 9 (11%) schools mentioned pastoral support. Within these 7 (9%) schools highlighted staff training to recognise and support young carers. 7 schools highlighted the role of the home school link worker can be key in building relationships with the family.

5 (6%) Schools stated that they had no young carers.

Knowledge of current services

Schools and Colleges were asked if they had heard of Action for Carers/Surrey Young carers and about their knowledge of the Angel Award.

Knowledge of..	Yes	No
Action for Carers and Angel Award	55	22
Action for Carers but not Angel Award	3	
Angel Award but not Action for Carers	1	

Of the respondents, overall, 58 (72%) schools had heard of Action for carers and 56 (69%) Schools had heard of the Angel Award with 55 (68%) schools stating they had heard of both. Just 22 (27%) schools were unaware of both Action for Carers and the Angel award.

What can be improved

The most common named improvement was the need for better information/marketing in schools regarding the support that is present for young carers (14 schools).

Covid-19 has had an impact 10 schools in answering this question felt the restarting of groups and face to face contact would be a major improvement. 8 Schools though stated that funding to run bespoke support/clubs/sibling groups was an area for improvement.

Appendix 7: Young Carers Rights

As a Young carer it is important that they are supported to understand their rights and what support they and their family are entitled to. Under the Children and Family Act 2014 a local authority has a duty to conduct a Young Carers needs assessment where:

- (a) it appears to the authority that the young carer may have needs for support, or
- (b) the authority receive a request from the young carer or a parent of the young carer to assess the young carer's needs for support

The assessment should consider

- The young carers age understanding and family circumstances
- The wishes feelings and preferences of the young carer
- any differences of opinion between the young carer, the young carer's parents and the person cared for, with respect to the care which the young carer provides (or intends to provide).
- the outcomes the young carer seeks from the assessment.
- the extent to which they are participating or wish to participate in education, training, education and work
- the nature and type of care and how much this is relied on
- the impact the care provided has on the young carers , well being, education and development
- whether any tasks are inappropriate or excessive in regard to the young carer's age, sex, wishes and feelings;
- whether the young carer is a child in need
- If there is any support that could be offered to the cared for to help the young carer and their family.

The assessment should involve the whole family including the young carer, the person cared for, their parents and any person the young carer or parents request to involve.

The aim of a 'Young carers assessment' is to understand the impact on caring on the young carer and determine the impacts of caring and what mitigating support can be put in place. The support could be given to the person they care for care for, so that the young carer can live their life, get involved in activities, go to school or other things that would give them the same chances as other people their age.

A young carer's assessment is for young carers under the age of 18.

A young carers assessment is offered when the young carer is aged under 18. If they have a children's social worker this could be from this social worker, a young carers support worker or someone else involved with the family.

The assessment will look at caring tasks the young carer undertakes and seeks to find out how the young carer feels about caring and whether it is impacting on their daily life at school, with friends, if it is affecting their health and any worries the young carer may have.

Once the assessment is completed the young carer should be given a written report that is for the young carer and their parent/guardian to know what the Local Authority feel may support the young carer, what was agreed at the assessment, what support we feel the whole family could receive and what will happen next. that you need, what has been agreed will happen next.

The assessment should enable the young carer and their family to receive the support they need and should then involve other support services who could provide this.

A transition assessment is undertaken before the young carer reaches 18

A child or young person under the age of 18 may receive support from services aimed at children. After a young person turns 18, the support would come from services aimed at adults.

We call this move from services aimed at children to those aimed at adults - Transition.

Young carers should be offered help to think about this change in a transition assessment meeting. This discussion could happen with a social worker, young carers support worker or another person who can help the young person think about their future and aspirations. The discussion should particularly cover how the caring role may have an impact upon any future for after they leave school and after they turn 18.

The transition assessment should take place well before the young person is 18 so that there is time to discuss and plan what support may be needed.

A transition assessment should look

- The young person's aspirations in terms of education and employment
- How the caring role impacts access to future education or employment
- What support could be put in place for the family of enable the young carer to achieve those ambitions.
- Housing options
- The young person's Mental health and well-being
- Any financial support they be entitled to

The young person and parent/guardian should receive a copy of the completed assessment report detailing what support we feel is appropriate, what was agreed at the assessment, the next steps and ongoing support plan for the young person and the person they care for. The assessment should enable the young person and their family to receive the support they need and should then involve other support services who could provide this.

Appendix 8: Thrive

Surrey has signed up to implement the THRIVE framework for System Change (Wolpert et al 2019) to support the mental health and wellbeing needs of children, young people and their families.

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The essential approach of THRIVE is that there is a graduated response based on the child's individual circumstances. It recognises that a child's needs † may change and the response will then adapt to meet to those needs. As such there are five levels of support

- 1) Thriving
- 2) Getting Advice
- 3) Getting help
- 4) Getting more help
- 5) Getting risk support.

Thrive is needs led and focuses on shared decision making with the voice of children, young people and their families central to THRIVE. This relies on close working of all parties including Schools, Social Care, Health, CAMHS and any 3rd Sector providers.

Thriving

This is at the centre of the model and is where a young carer is coping well, there is no adverse impact on their education and their caring responsibilities are balanced, so that they are able to have a similar life experience to their peers. They are considered to be Thriving and no additional input or support is needed.

Getting Advice

Where it is recognised that the caring is having a minor impact on their education or ability to meet friends, and the caring responsibilities are more significant, it is recognised that young carers may need advice and signposting to appropriate sites. They are in the Getting Advice response area. Examples of advice include accessing child friendly information on the conditions of their cared for person, engaging with online forums for young carers, accessing a help line etc.

Getting Help

If a young carers' caring responsibilities are having a more significant adverse impact on their education, or they are perhaps more isolated or need some training to safely undertake their caring roles, they are in the Getting Help response area of the model. Examples of help include referral to get a travel card to access the community, an Early intervention payment, referral to a young carer group for peer support or some practical training for caring.

Getting More Help

Some young carers may need more intense intervention such as 1-2-1 supports, perhaps mentoring, and specialist intervention. There may be the need for additional personal support intervention in the form of carers for their cared for person. Or there may be a need to work with the school to allow reasonable adjustments so the caring has less of a negative impact – for example allowing a young carer pupil to arrive at a later time so they can take a sibling to school.

Getting Risk Support

If the Getting Help and Getting Help response interventions have not resolved the issues for the young carer or they have been unable to access the help for whatever reason, an even higher level of intervention may be needed. Examples of this include going through safeguarding to assess risk, further increased support packages to their cared for, and closer work with the school or college including tutoring to enable completion of assignments and homework.

Appendix 9: The Voice of Young Carers and their Parents

Below are some selected comments from young carers and their Parents from the completed surveys.

On The Caring Role

It's more just making sure that he stays calm. ..., it's just talking to him. And just doing stuff with him. (Young carer aged 17 at College)

I take care of my sister who has a few disabilities. I do a bunch of different tasks for her. Mental and physical things. And sometimes also I have to mentally support my mum because caring is also hard for her because she works a lot, so I have to support her as well. (Young carer aged 17)

She knows when he's getting fizzy and when we can't deal with him, she has a way of settling him. She'll give him a hug and he'll calm down. And she doesn't have to be told to do that. (Parent of Young carer aged 8)

On Carer Recognition

We actually asked the SENCo last year to do a referral to Surrey Young carers and they said wouldn't do it, so it's not always that easy to know how to get that support (Parent of Young carer aged 10)

I had community nurses at the time. And she gave us Surrey Young carers details and that's when we joined. (Parent of young carer aged 10)

I knew about Surrey Young carers because a friend of mine's got a similar child and her other child has done it. And she said it was really good. So I asked my family support worker to get my daughter into it. (Parent of Young carer aged 10)

We were referred through surrey family services (Parent of Young carer aged 17)

On School and College

...they could probably do assemblies on it and just mention that there are Young carers out there, but it's a difficult thing, because helping out with one odd job or just doing a little bit around the house, it's hard to find the differentiation between being a carer and just helping out. person I spoke to most was my old form tutor from when I was in the main school, not in the Sixth Form, and I still go and see her now, even though she's not my form tutor. (Young carer aged 17 at a school with a Young carers Support Group)

I felt most relaxed on all my school trips..... The fact I didn't have to take care of anything and it being a break where it was just me (Young carer aged 17)

Like, if I'm upset, school can be a great place for me to focus on some things because I like playing with my friends at school and stuff like that (Young carer aged 10)

we wrote to the school... we basically said to the school look we are not in a position to do this home learning like we can put alternative to online learning in place for [Young carer]. But she's not going to do any of the schoolwork that you've given her because we don't have capacity to manage it. And they basically just wrote back and said that's fine. (Parent of Carer aged 10 with 2 children with additional needs).

On Attending Young Carer Events

Distraction from my role for a bit.

Going out without having to have any responsibility.

Being away from the stress of caring.

We met other families and children in the same situation as us which made us not feel as alone it was really lovely to get out and meet new people and have freedom.

They got a break from the family environment for a few hours and discovered hobbies my daughter may want to take up when she's older.

A sense of special attention as reward and recognition that their life is not normal. In person activity days gave him the opportunity to talk a little bit to other children about their caring responsibilities..... This was golden.

DRAFT

Appendix 10 Online Consultation Feedback on the Draft Strategy

We undertook 8 weeks consultation of the draft Young Carers Strategy between 09/06/22 and 08/08/22. This encompassed

- a mass direct email campaign (233 emails) to all partners with an offer to attend and discuss in person
- all partners asked to forward to contacts
- an online consultation via Surrey says (54 responses)
- an in-person event run by Surrey Young Carers where 33 young carers attended
- a young carers group run by the User Voice and Participation Team with 8 young carers
- Twister a group for young people aged 14-19 who are LGBT+ 4 of whom are young carers
- GRT Partnership Group
- SEND partnership board
- Face to face (Via Teams) with the Surrey Healthy Schools lead
- Face to face via (teams) with Family Health Leads
- Phone conversation with Interim Designated Nurse for Safeguarding Children in Surrey Heartlands

Summary of online and young carer consultation - Vision

In Total there were 54 respondents to the online consultation and 33 Young Carers at the Young Carers Forum organised by Surrey Young Carers. Consultation also occurred with 2 young carers groups this was less structured and took the form of an open discussion about both their lived experience and the strategy.

A breakdown of information about our respondents is below

Online we asked a single question looking at whether the respondent agreed with the vision. in total **79.6%** of all respondents agreed or strongly agreed with the Vision with just 16.7% either disagreeing or strongly disagreeing.

At the young careers event the vision was broken down to its constituent elements. There was a consensus of agreement on the vision:

- 93.9% agreed or strongly agreed that it was important (for me) that the adults around me know about my caring role
- 100% agreed or strongly agreed it was important (for me) to know my rights as a young carer
- 90.9% agreed or strongly agreed It is important to feel happy in my body, head and heart
- 90.9% agreed or strongly agreed It is important (for me) to feel safe

The Young Carers were asked about their experiences of seeking help from professionals and feeling safe to speak up.

- 69.7% of young carers agreed or strongly agreed that they feel that they can speak up
- 27.4% of young carers agreed or strongly agreed that they feel that they can get help from professionals when they need it, with 51.5% neither agreeing nor disagreeing.

Priority 1 Overall - Increased awareness and visibility of young carers in education, health and social care

88.5% agreed with this priority - somewhat (28.9%) or to a great extent (59.6%)

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	0	0.0%	2	6.1%	2	2.3%
Very little	1	1.9%	8	24.2%	9	10.4%
Somewhat	6	11.1%	19	57.6%	25	28.9%
To a great extent	47	87.0%	4	12.1%	52	59.6%
Not Answered	0	0.0%	0	0.0%	0	0.0%

Priority 1 - its important teachers know a child is a young carer when they move schools

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	0	0.0%	4	12.1%	4	4.6%
Very little	2	3.7%	10	30.3%	12	13.8%
Somewhat	8	14.8%	12	36.4%	20	23.2%
To a great extent	44	81.5%	9	27.3%	54	61.9%
Not Answered	0	0.0%	0	0.0%	0	0.0%

Priority 1 - Ensure knowledge to be able to identify a young carer when the cared for attends medical appointment

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	1	1.9%	3	9.1%	4	4.6%
Very little	1	1.9%	8	24.2%	9	10.4%
Somewhat	13	24.1%	16	48.5%	29	33.6%
To a great extent	38	70.4%	6	18.2%	45	51.4%
Not Answered	1	1.9%	0	0.0%	1	1.2%

Priority 1 - Ensure social care staff always adopt a family approach when in contact with individuals

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	1	14.8%	0	0.0%	1	1.3%
Very little	1	14.8%	5	15.2%	6	7.1%
Somewhat	14	14.8%	12	36.4%	26	30.1%
To a great extent	38	14.8%	16	48.5%	54	62.2%
Not Answered	0	14.8%	0	0.0%	0	0.2%

Priority 2 Overall - Staff have a good understanding of young carer's rights

96.5% agreed this was important (28.9%) or very important (67.6%)

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not important	0	0.0%	0	0.0%	0	0.0%
Quite important	1	1.9%	3	9.1%	4	4.6%
Important	9	16.7%	16	48.5%	25	28.9%
Very important	44	81.5%	14	42.4%	59	67.6%
Not Answered	0	0.0%	0	0.0%	0	0.0%

Priority 2 - We will ensure families know they have the right to a young carers assessment

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	0	0.0%	0	0.0%	0	0.0%
Very little	2	3.7%	3	9.1%	5	5.8%
Somewhat	9	16.7%	16	48.5%	25	28.9%
To a great extent	42	77.8%	14	42.4%	57	65.3%
Not Answered	1	1.9%	0	0.0%	1	1.2%

Priority 2 - We will ensure families are aware how a young carers assessment could benefit them

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	0	0.0%	3	9.1%	3	3.4%
Very little	2	3.7%	3	9.1%	5	5.8%
Somewhat	7	13.0%	20	60.6%	27	31.2%
To a great extent	44	81.5%	6	18.2%	51	58.4%
Not Answered	1	1.9%	1	3.0%	2	2.3%

Priority 2 - Assessments, information, advice and support will be in accessible language

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	0	0.0%	0	0.0%	0	0.0%
Very little	2	3.7%	3	9.1%	5	5.8%
Somewhat	12	22.2%	21	63.6%	33	38.2%
To a great extent	38	70.4%	6	18.2%	45	51.4%
Not Answered	2	3.7%	3	9.1%	5	5.8%

Priority 2 - Young carers will be recognised as partners in care

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	0	0.0%	2	6.1%	2	2.3%
Very little	3	5.6%	22	66.7%	25	28.8%
Somewhat	12	22.2%	1	3.0%	13	15.2%
To a great extent	38	70.4%	5	15.2%	44	50.2%
Not Answered	1	1.9%	3	9.1%	4	4.6%

Priority 3 Over all - Young carers are enabled to and feel safe to self-identify

85% agree this priority - important (26.6%) or very important (58.4%)

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not important	0	0.0%	2	6.1%	2	2.3%
Quite important	1	1.9%	11	33.3%	12	13.8%
Important	8	14.8%	15	45.5%	23	26.6%
Very important	45	83.3%	5	15.2%	51	58.4%
Not Answered	0	0.0%	0	0.0%	0	0.0%

Priority 3 - Using a whole family approach families will be confident to share what support the young carer provides in the home

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	0	0.0%	0	0.0%	0	0.0%
Very little	2	3.7%	5	15.2%	7	8.1%
Somewhat	14	25.9%	14	42.4%	28	32.5%
To a great extent	37	68.5%	14	42.4%	52	59.4%
Not Answered	1	1.9%	0	0.0%	1	1.2%

Priority 3 - Staff in education to actively seek and support young carers

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	0	0.0%	5	15.2%	5	5.7%
Very little	2	3.7%	2	6.1%	4	4.6%
Somewhat	9	16.7%	11	33.3%	20	23.2%
To a great extent	41	75.9%	15	45.5%	57	65.2%
Not Answered	2	3.7%	0	0.0%	2	2.3%

Priority 4 - Overall Young carers have access to appropriate services that meet their needs (this question was not asked of young carers)

100% agreed with this priority.

Option	Online Consultation	Online Percentage
Not at all	0	0.00%
Very little	0	0.00%
Somewhat	4	7.41%
To a great extent	50	92.59%
Not Answered	0	0.00%

Priority 4 - We provide the right support at the right time for young carers, recognising their needs before they escalate

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	3	5.6%	1	3.0%	4	4.7%
Very little	5	9.3%	1	3.0%	6	7.0%
Somewhat	8	14.8%	11	33.3%	19	22.0%
To a great extent	38	70.4%	20	60.6%	59	67.5%
Not Answered	0	0.0%	0	0.0%	0	0.0%

Priority 4 - Continue to support and develop and support the Young Carers Forum

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not important	0	0.0%	3	9.1%	3	3.4%
Quite important	2	3.7%	4	12.1%	6	6.9%
Important	14	25.9%	18	54.5%	32	37.1%
Very important	37	68.5%	8	24.2%	46	52.5%
Not Answered	1	1.9%	0	0.0%	1	1.2%

Priority 4 - Continue use of both online groups and in person to offer peer to peer support.

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	0	0.0%	4	12.1%	4	4.6%
Very little	3	5.6%	10	30.3%	13	15.0%
Somewhat	14	25.9%	8	24.2%	22	25.6%
To a great extent	36	66.7%	10	30.3%	47	53.6%
Not Answered	1	1.9%	0	0.0%	1	1.2%

Priority 4 - Services for young carers are flexible to meet their needs

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	1	1.9%	2	6.1%	3	3.5%
Very little	1	1.9%	7	21.2%	8	9.2%
Somewhat	6	11.1%	14	42.4%	20	23.1%
To a great extent	43	79.6%	10	30.3%	54	61.8%
Not Answered	3	5.6%	0	0.0%	3	3.5%

Priority 5 - Young carers have improved Emotional Wellbeing and Mental Health (EWMH)

97.7% agreed – important (21.8%) and very important (75.9%)

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not important	0	0.00%	0	0.0%	0	0.0%
Quite important	0	0.00%	3	9.1%	3	3.4%
Important	0	0.00%	19	57.6%	19	21.8%
Very important	54	100.00%	11	33.3%	66	75.9%
Not Answered	0	0.0%	0	0.0%	0	0.0%

Priority 5 - Ensure that advice, information and support activities are readily available, including digital support

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	0	0.0%	0	0.0%	0	0.0%
Very little	4	7.4%	1	3.0%	5	5.8%
Somewhat	8	14.8%	12	36.4%	20	23.2%
To a great extent	41	75.9%	23	69.7%	65	74.4%
Not Answered	1	1.9%	0	0.0%	1	1.2%

Priority 5 - Take account of the needs of young carers from vulnerable communities

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	0	0.0%	4	12.1%	4	4.6%
Very little	3	5.6%	7	21.2%	10	11.6%
Somewhat	6	11.1%	12	36.4%	18	20.8%
To a great extent	44	81.5%	13	39.4%	58	66.5%
Not Answered	1	1.9%	0	0.0%	1	1.2%

Priority 6 Overall - Young carers safeguarding needs are identified and supported (this question was not asked of the young carers group)

98.15% agreed with this priority - important (5.56%) or very important (92.59%)

Option	Online Consultation Total	Online Percent
Not important	0	0.00%
Quite important	1	1.85%
Important	3	5.56%
Very important	50	92.59%
Not Answered	0	0.00%

Priority 6 - We will make clear how safeguarding can support you and your family

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	1	1.9%	2	6.1%	3	3.5%
Very little	2	3.7%	4	12.1%	6	6.9%
Somewhat	13	24.1%	12	36.4%	25	29.0%
To a great extent	38	70.4%	13	39.4%	52	59.4%
Not Answered	0	0.0%	0	0.0%	0	0.0%

Priority 6 - We will ensure that you feel comfortable seeking assistance when you need it

Option	Online Consultation	Online Percentage	YCF Consultation	YCF Percentage	Total	Percent
Not at all	0	0.0%	0	0.0%	0	0.0%
Very little	0	0.0%	2	6.1%	2	2.3%
Somewhat	12	22.2%	8	24.2%	20	23.2%
To a great extent	42	77.8%	26	78.8%	69	79.1%
Not Answered	0	0.0%	0	0.0%	0	0.0%

Health and Wellbeing Board (HWB) Paper

1. Reference information

Paper tracking information	
Title:	Health and Well-being Strategy Metrics: Review and Refresh
HWBS Priority - 1, 2 and/or 3:	Priorities 1,2 and 3
Outcome(s)/System Capability:	Data, Insights and Evidence
Priority populations:	All priority populations
Civic level, service based and/or community led interventions:	All interventions
Author(s):	Phillip Austen-Reed, Principal Lead – Health and Wellbeing, Surrey County Council; phillip.austen-Reed@surreycc.gov.uk
Board Sponsor(s):	Ruth Hutchinson, Director of Public Health, Surrey County Council
HWB meeting date:	28 September 2022
Related HWB papers:	N/A
Annexes/Appendices:	<ul style="list-style-type: none"> Appendix 1 - Existing and new indicators for inclusion in Surrey Index HWB Strategy Dashboard Appendix 2 - Examples of HWBS indicators viewable through Surrey Index format

2. Executive summary

Alongside the refresh of the Health and Wellbeing Strategy a revised set of metrics have been developed to better link with the updated priorities, outcomes and priority populations. The metrics are intended to draw together local publicly available data sets within the [Surrey Index](#) (replacing the [existing stand alone Health and Well Being dashboard](#)). As these have a broader focus across health, wellbeing and the wider determinants it is intended that it can be used by organisations alongside their internally available organisational indicators such as those being reviewed regularly by the Equalities and Health Inequalities Board at Surrey Heartlands ICS. Having this common set of publicly available indicators is intended to aid our understanding of our collective progress against outcomes that have many contributing factors.

This common set of indicators will also be reflected within the developing refresh of the JSNA chapters and be complemented by the additional detailed health data that is coming through population health management. This will enable further understanding and prioritisation at a local level within the system.

Where gaps in data and indicators exist (for example, to understand progress on outcomes for particular priority populations), this will be highlighted via the developing governance arrangements of the Surrey Data Strategy as in most cases developments to address this will require a collective partnership approach but also prioritisation of capacity.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Subject to consideration, agree the proposed set of metrics as a reflection of the greater focus in the HWB Strategy on reducing health inequalities and wider determinants of health.
2. Review and promote awareness of the metrics within their organisation to enable a common understanding and assessment of progress.

4. Reason for Recommendations

Following the production of the initial set of HWB Strategy metrics in 2019, the refreshed Strategy represents a stronger focus on reducing health inequalities and the role of the wider determinants of health. To be effective and ensure a common understanding across partners, it is beneficial to align the revised set of HWBS metrics with this new focus to ensure we can have a common long-term view of the progress being made.

5. Detail

Following the refresh of the Health and Wellbeing Strategy published this year, [the original Strategy metrics](#) produced in 2019 have been reviewed. This has been done through consideration of other indicators already in use locally through the Surrey Index as well as other recognised publicly available indicators such as the National Public Health Outcomes Framework.

As previously discussed with the Board, alongside life expectancy and healthy life expectancy indicators, assessment of progress against our over-arching ambition of 'reducing health inequalities so no-one is left behind' is now included more obviously through a new indicator that shows the gap in life expectancy for males and females. This represents the difference in life expectancy between the Lower Super Output areas in the highest and lowest deprivation deciles which means it enables understanding of how much life expectancy varies with deprivation in Surrey.

The full list of existing and new indicators being incorporated, along with some that are in development are provided within Appendix 1. Whilst all outcomes have some form of indicator aligned to them, there remain some that would benefit from further indicators, such as those relating to multiple disadvantage in priority one, isolation in priority two and health environments in priority three. One way of addressing this gap will be through the greater alignment that is being developed, for example, with the information will soon begin to be collected locally through the updated Surrey Residents Survey. This will result in the survey data being more obviously aligned with the HWB Strategy outcomes within priorities one and three particularly along with the priority populations when published. Collection of this updated local data is due to begin from towards the end of 2022.

The list of indicators in Appendix 1 also shows where they are universal or have some relevance to at least one of the priority populations. In reviewing the indicators it is clear there are a number of gaps with regards to being able to interrogate them by the various priority populations in the HWB Strategy. This is largely due to the way in which data is collected and published; however, this is being flagged as a development need to understand where it may be possible to make improvements across the system and locally.

Whilst this presents a long term challenge, the move to use of the Surrey Index to view the HWB Strategy indicators means that wherever it is available, the indicators will be able to be interrogated at the lowest possible geographical level. This will add to the local view of areas covered by our Key Neighbourhoods. This will also be complemented by local community insight gathered through various means such as inclusion in new JSNA chapters and through community engagement and frontline staff to inform action that is taken at a local level.

The longer term ambition is to replicate this approach wherever possible within the dashboard to improve the level of data that can be understood in terms of the various other priority populations eg. carers.

The first phase of new indicators will be published within the new dashboard utilising the Surrey Index format in October; however some examples of how the indicators will be able to be viewed is available in Appendix 2.

As previously mentioned, through placing the Health and Wellbeing Strategy dashboard within the Surrey Index, the intention is that it can be used as the common reference point for shared health inequality related indicators for all partners. These are often included and referenced in individual organisational strategies, however with no single organisation being able to significantly impact individually, this will ensure a common system wide focus on these indicators. The proposed alignment of these various elements is represented below in figure 1.



Figure 1: Health and Wellbeing Strategy dashboard is located within the Surrey Index using public indicators that can be referenced by partners alongside internal organisational indicators to understand progress being made against the strategy priorities and reducing health inequalities.

It is intended that this will aid the movement towards a greater system wide understanding of reducing health inequalities that will complement the work of partner organisations and how they are collectively contributing to reducing health inequalities.

One example of this is as part of the Equality and Health Inequalities (EHI) Board which is within Surrey Heartlands where a set of internal process and outcome indicators has been identified that are most relevant to the ICS. These indicators are regularly reviewed internally by the EHI Board and where there are links to those indicators covered within the HWB Strategy reference, will be made to this revised dashboard in recognition of these shared indicators.

6. Challenges and opportunities

- Some indicators relevant to assessing progress of the Strategy's priorities continue to only be available at a higher Surrey footprint which limits the benefit of use at a local system level.
- The new approach to align with the Surrey Index does mean that where more local data is available this will be more obviously accessible which supports the Surrey-wide data strategy and work to align dashboards and processes within the health inequalities landscape.

7. Next steps

- Progress more detailed logic model workshops with senior responsible officers and partners from programmes delivering against the health and wellbeing strategy. This will help identify whether there are further indicators that would be appropriate for inclusion alongside giving proper consideration to the impact of these programmes on these higher level indicators.
 - Publish first phase of new indicators in October within a new health and wellbeing strategy dashboard framed within the Surrey Index approach.
 - As the Surrey Data Strategy gathers further momentum these indicators will continue to be reviewed and developed to ensure we are utilising the most appropriate indicators to monitor our progress against our overall ambition, outcomes and the needs of our priority populations.
-

Appendix 1: Existing and new indicators for inclusion in Surrey Index HWB Strategy Dashboard

The following lists the revised set of strategy indicators which are a combination of existing, new and some that are noted for further development / engagement. The indicators are shown alongside the priorities and outcomes from the health and wellbeing strategy as well as whether they are specifically related to a HWBS priority population (either explicitly or through a breakdown of the data available) or another cohort of the population.

6

Priority	Priority Outcomes	Population cohort or HWBS Priority Population focus	Indicator	New or Existing HWBS indicator
Overarching	-	Population cohort	Inequality in Life expectancy (Male / Female)	New
Overarching	-	Population cohort	Inequality in Healthy life expectancy (Male / Female)	New
Priority One: Supporting people to lead healthy lives by preventing physical ill health and promoting physical well-being	People have a healthy weight and are active	Population cohort	Use of outdoor space for exercise	Existing
		HWBS Priority Population focus	Completing rate of weight management programme *	For development
		HWBS Priority Population focus	Inequality in prevalence of obesity	For development
		Population cohort	% of inactive adults	Existing
		Population cohort	% active adults	New
		Population cohort	% active children	New

Substance misuse is low (drugs/alcohol/smoking)	HWBS Priority Population focus	Deaths from drug misuse	New
	HWBS Priority Population focus	Alcohol related hospital admissions	Existing
	HWBS Priority Population focus	Reduction in smoking in priority populations (COPD, Pregnancy, Routine & Manual workers), SMI, BAME	Existing
The needs of those experiencing multiple disadvantage are met	HWBS Priority Population focus	Homelessness - households owed a duty under the Homelessness Reduction Act (also P3)	Existing
Serious conditions and diseases are prevented	Population cohort	GP QOF hypertension % Prevalence	Existing
	Population cohort	GP QOF Diabetes % Prevalence	Existing
	Population cohort	% children aged 5 with 2 doses of MMR	Existing
	Population cohort	under 75 mortality from colorectal cancer	New
	Population cohort	under 75 mortality from breast cancer	New
	HWBS Priority Population focus	LD Health Check	New

		HWBS Priority Population focus	SMI health check	New
	People are supported to live well independently for as long as possible	Population cohort	Dementia diagnoses rate	Existing
		Population cohort	% of deaths in usual place of residence	Existing
		HWBS Priority Population focus	Effectiveness of short-term reablement services leading to nil or lower level ongoing support (%)	Existing
Priority Two: preventing mental ill health and promoting emotional well-being	Adults, children and young people at risk of and with depression, anxiety and other mental health issues access the right early help and resources	Population cohort	Self-reported wellbeing - people with a low worthwhile score	New
		Population cohort	Self-reported wellbeing - people with a low satisfaction score	New
		Population cohort	Self-reported wellbeing - people with a high anxiety score	Existing
		Population cohort	Self-reported wellbeing - people with a low happiness score	New
		HWBS Priority Population focus	Access to IAPT services: people entering IAPT as % of those estimated to have anxiety/depression (in a financial year) (%)	Existing

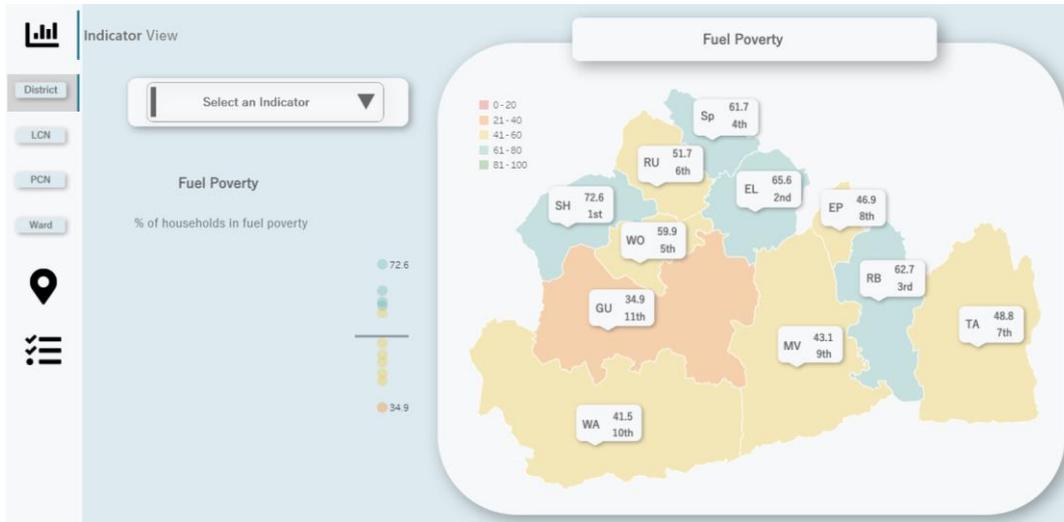
	The emotional well-being of parents and caregivers, babies and children is supported	Population cohort	Proportion of children receiving a 12-month review with their Health Visitor	Existing
	Isolation is prevented and those that feel isolated are supported	HWBS Priority Population focus	% of adult carers who have as much social contact as they would like (18+ yrs)	New
	Environments and communities in which people live, work and learn build good mental health	HWBS Priority Population focus	Gap in the employment rate between those with a learning disability and the overall employment rate (also P3)	
		HWBS Priority Population focus	Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (also in P3)	
		HWBS Priority Population focus	Adults with MH in appropriate accommodation (also in P3)	Existing
		Population cohort	% Children aged 0-19 in relative low-income families	New
Priority Three: Supporting people to reach their potential by addressing the wider determinants of health	People's basic needs are met	Population cohort	Households in Fuel Poverty	New
		HWBS Priority Population focus	Adults with LD in settled accommodation (also P1)	Existing
		HWBS Priority Population focus	Homelessness - households owed a duty under the Homelessness Reduction Act (also P1)	Existing
		HWBS Priority Population focus	Adults with MH in appropriate accommodation	Existing

Children, young people and adults are empowered in their communities	Population cohort	% Children FSM achieving 5 A* - C GCSE	Existing
	Population cohort	Children FSM achieving good level of development at KS 2 /4	Existing
People access training and employment opportunities within a sustainable economy	Population cohort	Unemployment rate	Existing
	HWBS Priority Population focus	Gap in the employment rate between those with a learning disability and the overall employment rate (also P2)	New
	HWBS Priority Population focus	Participation rate education, training and employment – 16-18yrs	Existing
	HWBS Priority Population focus	Employment and Support Allowance claimants aged 16-24	New
	Population cohort	Job seekers over 12 months	New
	HWBS Priority Population focus	Gap in the employment rate between those with a learning disability and the overall employment rate	New
	HWBS Priority Population focus	Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	New
	People are safe and feel safe (community safety incl. domestic abuse; safeguarding)	Population cohort	Community safety (feeling safe in community)

People are safe and feel safe (community safety incl. domestic abuse; safeguarding)	Population cohort	Children's safeguarding	Requires further engagement
	Population cohort	Adults' safeguarding	Requires further engagement
	HWBS Priority Population focus	Domestic abuse-related incidents and crimes	New
	Population cohort	Violent crime - violence offences per 1,000 population	New
The benefits of healthy environments for people are valued and maximised (including through transport/land use planning)	Population cohort	Proportion of adults who cycle for travel purposes	Existing

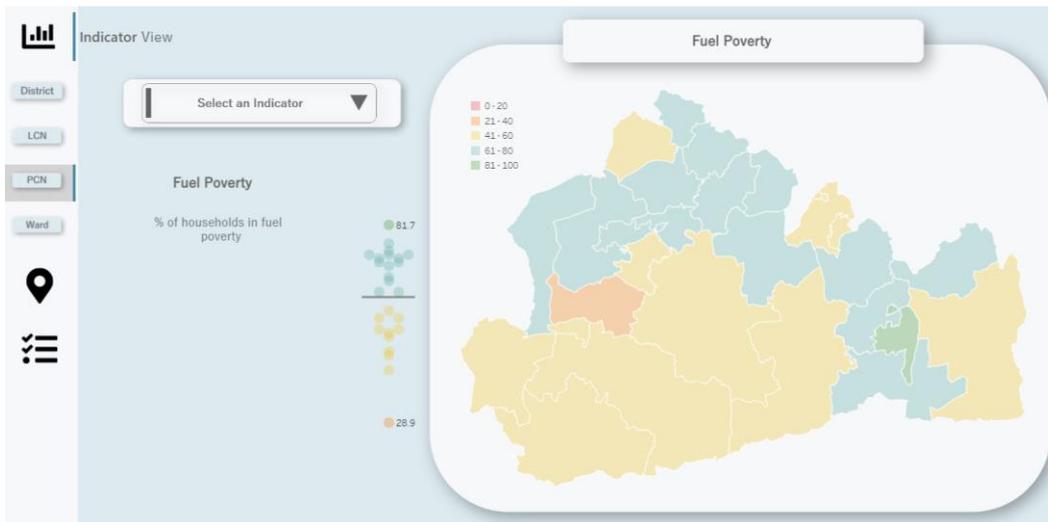
Appendix 2: Examples of HWBS indicators viewable through Surrey Index format

Example 1: Households in Fuel Poverty at Borough / District council level

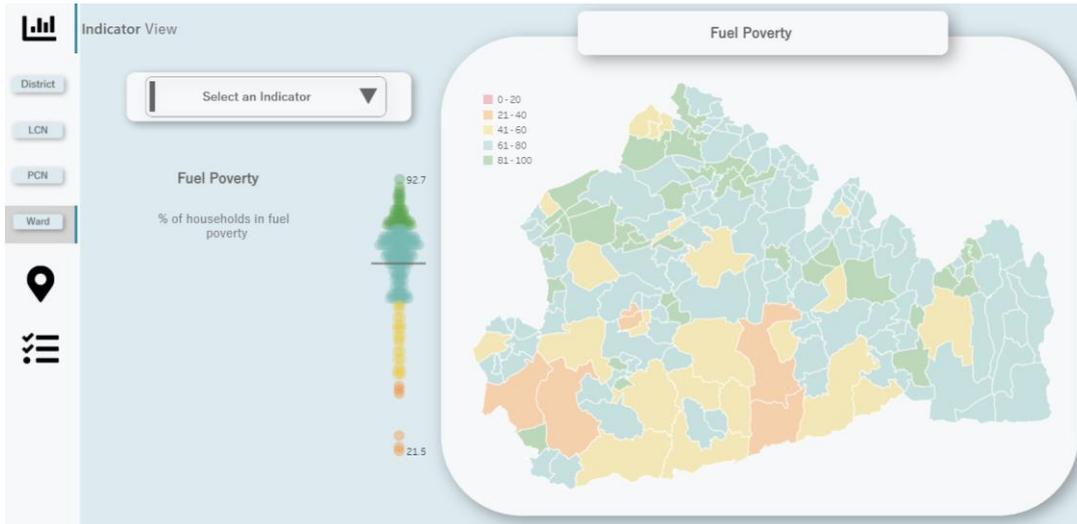


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Example 2: Households in Fuel Poverty at Primary Care Network level



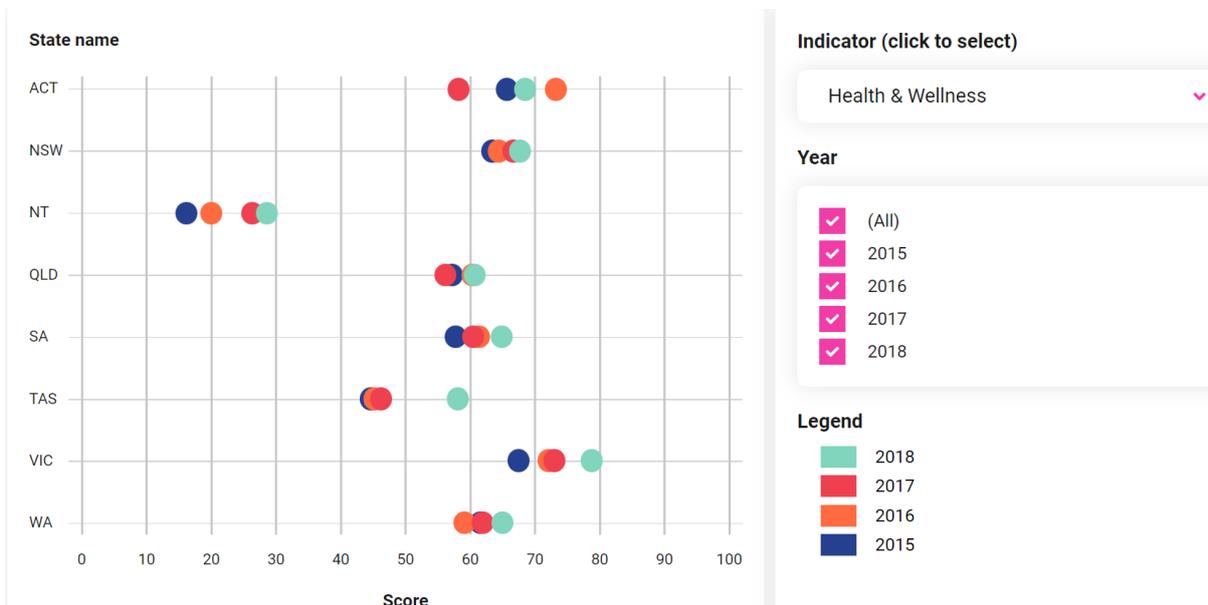
Example 3: Households in Fuel Poverty at Electoral Ward level



Whilst not shown above as yet to be formatted, for indicators such as Fuel Poverty where Lower Super Output Data is available, this will always be made available in the new dashboard in order to highlight pockets of inequality in outcomes.

It is also intended to produce visualisations of trend over time for the various HWB metrics, so that changes over the lifetime of the Strategy can be easily visualised.

Whilst these are still in development for the Surrey dashboard, the intention is to emulate the approach used in, for example, the Australian Social Progress Index and enable users to select different geographies, time periods, and indicators. **An example from the Australian Social Progress Index is reproduced below.** This format depicts different geographic areas as individual rows, with coloured points showing the indicator value in different time periods. This visualisation technique quickly permits the degree and direction of change to be evaluated and compared across multiple geographic areas.



Screenshot taken from Amplify Social Impact, developed by the Centre for Social Impact at UNSW Sydney and in partnership with Swinburne University of Technology (CSI Swinburne) and The University of Western Australia (CSI UWA). Available online at: <https://amplify.csi.edu.au/social-progress-index/>

Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	Update on the Mental Health Improvement Plan
HWBS Priority - 1, 2 and/or 3:	Priority 2
Outcome(s)/System Capability:	Outcomes: All outcomes under Priority 2 System capabilities: particularly Clear Governance and Programme Management
Priority populations:	All, particularly People with serious mental illness
Civic level, service based and/or community led interventions:	The overall programme will look to use interventions across the Population Intervention Triangle
Author(s):	Tim Beasley, Programme Director - Mental Health Improvement Plan, Surrey and Borders Partnership NHS Foundation Trust; tim.beasley@sabp.nhs.uk
Board Sponsor(s):	<ul style="list-style-type: none"> Professor Helen Rostill, Deputy Chief Executive and Director of Therapies, Surrey and Borders Partnership / Director for Mental Health, Surrey Heartlands ICS and SRO for Mental Health, Frimley ICS (Priority 2 Co-Sponsor) Kate Barker and Liz Williams - Joint Strategic Commissioning Conveners, Surrey County Council and Surrey Heartlands (Priority 2 Co-sponsors)
HWB meeting date:	28 September 2022
Related HWB papers:	N/A
Annexes/Appendices:	Appendix 1 – Summary of governance arrangements Appendix 2 – Mental Health System Delivery Board draft terms of reference Appendix 3 – Phasing workplan

2. Executive summary

The Mental Health Improvement Plan (MHIP) is our response to the 19 recommendations of the May 2021 report “*Emotional wellbeing and mental health in Surrey: A review of outcomes, experiences and services*”. The 19 recommendations describe how we can improve the services and support which we provide to our residents and promote their mental health and emotional wellbeing.

In recent months the MHIP, and mental health improvement and transformation work more broadly, has undergone a reset, in order to address some of the challenges

which have been found to date, to align with wider system ambitions and to build on our successes. A key element of this reset is the establishment of a new Mental Health System Delivery Board for Surrey.

This paper provides an update on the changes that have been made, and next steps. It also asks the Health and Wellbeing Board to agree the Terms of Reference of the new Mental Health System Delivery Board.

7

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Approve the draft terms of reference of the new Mental Health System Delivery Board (Appendix 2); and
2. Note the contents of this update and endorse the proposed next steps.

4. Reason for Recommendations

We have refreshed our governance and are currently phasing our broad and ambitious work plan. Further input from the Board will be requested in future updates.

5. Detail

Since the MHIP was launched in 2021 there has been a wide range of work undertaken across the system which contributes to meeting the 19 recommendations and promoting the mental health and emotional wellbeing of our residents.

However, we have also been held back by the absence of some key enablers. Our governance arrangements did not provide the right leadership and decision-making required to drive the programme forward and resourcing has been a challenge.

Refreshed governance

Mental health improvement and transformation in Surrey is a broad agenda with many activities and plans in need of prioritisation and phasing. The scope of mental health improvement and transformation covers:

- a) The 19 recommendations underpinning the Mental Health Improvement Programme;
- b) 'Priority 2' of Surrey's Health and Wellbeing Strategy (HWBS);
- c) 10 year plan for Mental Health (currently being prepared by NHS England);
- d) Sustainability and financial recovery requirements of the health systems in Surrey;
- e) Delivery of the NHS Long Term Plan; and

- f) System ambitions around place, in line with local priorities and the Fuller Stocktake¹.

The Health and Wellbeing Strategy is a key element of this work and Early Intervention and Prevention, aligned with Priority 2, is a particular focus. People with serious mental illness are one of the priority populations identified in the HWBS. There are other areas of overlap, for example regarding wider determinants of health. Until now, however, governance for the different areas set out below has not been effectively aligned.

We have now refreshed our governance, creating a new Mental Health System Delivery Board for Surrey, to be established jointly by the Health and Wellbeing Board and the Integrated Care Board (ICB) with the remit and membership to take the necessary decisions to deliver this work. The ICB had its first meeting in August 2022. Jonathan Perkins, formerly Deputy Chair of NHS Surrey Heartlands CCG, serves as Independent Chair with Clare Burgess, CEO of Surrey Coalition of Disabled People as Vice-Chair. Liz Bruce, Joint Executive Director – Adult Social Care & Integrated Commissioning continues as Executive SRO for mental health and Graham Wareham, CEO of Surrey and Borders Partnership NHS Foundation Trust (SaBP) is the ICB representative.

We have also maintained the best of the previous governance arrangements. A key feature of this was the engagement of a wide range of stakeholders – including service users, carers, schools, police, ambulance services and others – and the ability for that wide group to influence the direction of travel. This invaluable contribution will now be brought through the Co-Production and Insight Group, co-chaired by Tim Bates, Surrey Heartlands ICS Clinical Director, Integrated Services, and Helen Rostill, Deputy CEO and Director of Therapies, SaBP.

A summary of the governance arrangements is provided at Appendix 1 and the draft terms of reference for the Mental Health System Delivery Board – as discussed at the Board’s August meeting – are provided at Appendix 2. The Health and Wellbeing Board is asked to approve these terms of reference, as one of the two bodies (alongside the ICB) establishing it.

Within this wider governance reset, we have also agreed to bring together the leadership of the Early Intervention and Prevention work in the MHIP and Priority 2 of the HWBS, which have until recently been operating separately and with a different focus.

Phasing our priorities

The broad range of activities, plans and priorities we have cannot all be delivered at once, and a lack of system focus on the most critical issues will hold us back.

Our system priorities need to be clearly phased. We are therefore conducting a phasing exercise, to form the foundation of a plan which will set out:

- When interventions are able to be delivered
- What resources are required to deliver and where they will be drawn from

¹ Next steps for integrating primary care: Fuller stocktake report, NHS England May 2022

- The impact and reach of our choices

Appendix 3 is our workplan setting out how we intend to do this. At the time of writing, this phasing exercise is currently underway.

Key milestones already concluded include two workshops:

- Initial workshop with a number of senior leaders from across the system, representing NHS, local authority and voluntary sectors for both adults' and children's. This workshop tested and developed our approach to the overall phasing exercise.
- A workshop with the Co-Production and Insight Group, which includes representation from a wide range of stakeholders including service users and people with lived experience, Healthwatch, police, ambulance services, elected representatives, public health and others. This workshop provided an opportunity for this diverse group to contribute their views and insight on the areas which are most important to them and those they represent.

The Mental Health System Delivery Board is due to discuss recommendations at its meeting on 29 September 2022. It is anticipated that further work will be required to further develop our programme of work, as outlined in the workplan in Appendix 3.

The HWB Board should note that, while this phasing exercise is key to effective delivery of our work, a number of activities, plans and projects are already being delivered. Work has not been paused and we continue to deliver improvements to mental health support and services while we review the areas we need to focus on going forwards.

6. Challenges

Resourcing continues to be a challenge for this programme. We considered accelerating the pace of the phasing exercise by commissioning support from external health consultants. We have, however, decided to proceed using existing and internal resource. Two factors have been key to this decision: use of public money and the desire to align our work with wider system prioritisation, including the wider exercise being conducted by ICSs to respond to the Fuller Stocktake and how our services will be delivered at home, at neighbourhood, at place and at system.

When the Mental Health System Delivery Board has considered phasing recommendations, we will then need to determine the extent and timing of resource which can be allocated to deliver our priorities.

7. Timescale and delivery plan

Timescales for delivery will follow the phasing exercise and establishing the available resource.

8. What communications and engagement has happened/needs to happen?

A wide stakeholder group is being engaged in our phasing work, in particular using members of the Co-Production and Insight Group. Service users and people with lived experience are a key part of this. We are also engaging closely with the Adults and Health Select Committee.

Further assessment of our communications and engagement needs will be required following the phasing exercise.

7

9. Next steps

Key next steps are:

- Conclusion of the phasing exercise
- Meeting of the Mental Health System Delivery Board on 29 September
- Securing resource to deliver system priorities in line with the agreed phasing

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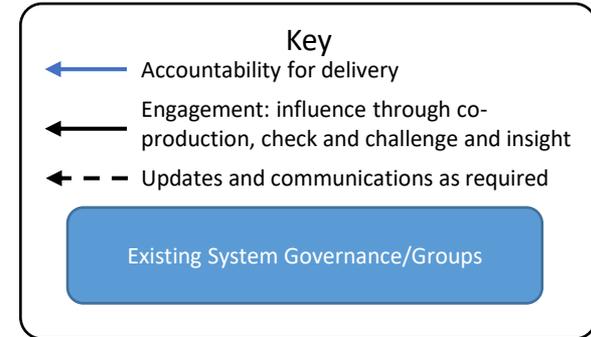
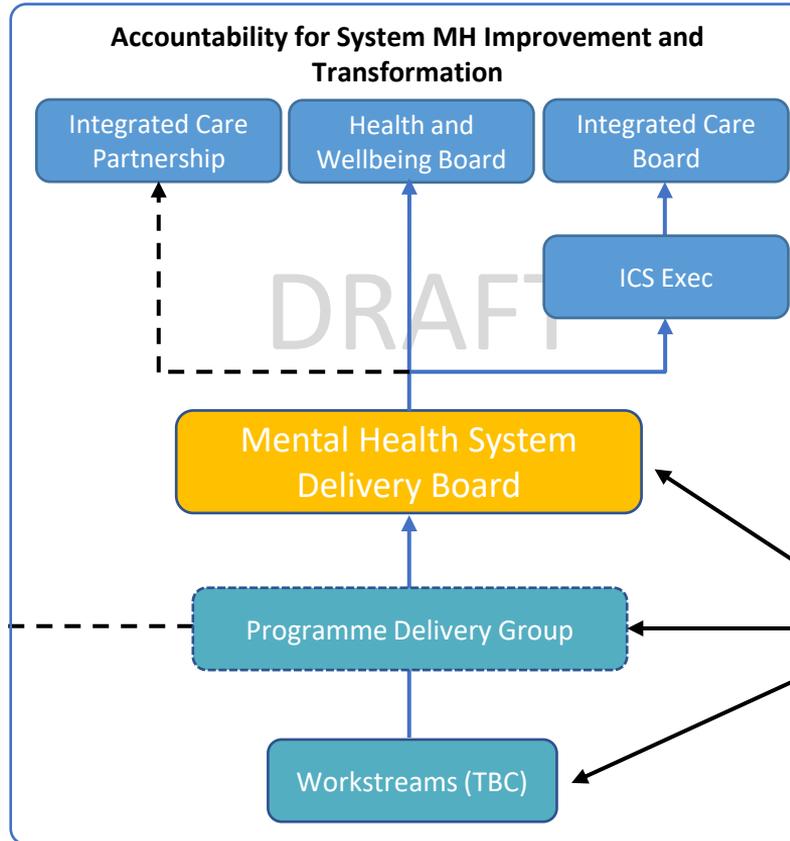
- Clear mandate to set system priorities and conditions for success (delivering our coproduced vision)
 - Board to be system decision-maker on priorities and resources
- Refresh system governance for mental health improvement and transformation
 - Keep what was working in existing governance and address what wasn't
 - Strong voice and influence for third sector, lived experience and carers
- Stronger link into system leadership; Health and Well Being Board/ ICB structures
 - To ensure direction setting, decision making and funding flow is clear
 - Escalation and support
 - Ensuring delivery plan covers the scope of the system statutory functions as a single version of the truth as a single MH all age delivery plan that covers the breadth of our citizens needs and delivers them in line with the coproduced vision

DRAFT

Streamline and clarify system accountability

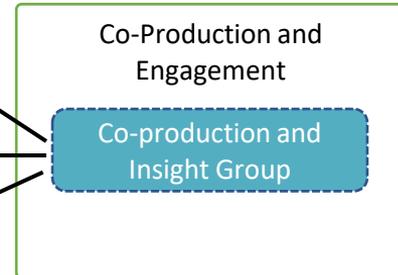
- Scope
 - Cover all improvement and transformation work: all age, current MHIP, HWBB P2, sustainability/financial recovery, LTP, ambition around place (in line with Fuller Stocktake)
 - Whole of Surrey
 - Broad agenda required prioritisation and focus –priorities agreed by all system partners and overseen by the empowered MH System Delivery board
 - Excludes BAU performance management/assurance

Proposed governance



Page 118

Wider ICS structures



Meeting	Proposed Chair	Proposed membership	Proposed Purpose
Mental Health System Delivery Board	Jonathan Perkins	<ol style="list-style-type: none"> 1. Chair - Jonathan Perkins 2. Deputy Chair – Clare Burgess 3. System SRO MH – Liz Bruce 4. DCS – Rachael Wardell 5. ICB partner rep – Graham Wareham 6. Non-exec – Lynette Nusbacher 7. Elected Member – Sinead Mooney 8. CIG Chair – Dr Tim Bates 9. MH Convenor 10. Neighbourhood Rep (TBC) 11. Frimley Rep – Helen Rostill 12. Third Sector Rep, Adults – Sue Murphy/Patrick Wolter 13. Third Sector Rep, CYP – Cate Newnes-Smith/Frank Sims 14. DPH – Ruth Hutchinson 	<ul style="list-style-type: none"> • Set system priorities for mental health improvement and transformation, to identify the areas which should be the focus of system improvement, in the short, medium and long term • Champion the System Priorities and encourage all partners to work together to ensure that conditions are in place for the System Priorities to be delivered • Encourage all partners to work together to seek to identify funding and resources required to deliver agreed System Priorities. Where sufficient such funding and resources cannot be identified the Board will report this to the ICB and HWB and work with partners to determine what can be done within the sustainable limits • Oversee progress on delivery – supported by Programme Delivery Group • Receive continuous feedback from key stakeholders – supported by Co-production and Insight Group • Commission engagement and insight work – supported by Co-production and Insight Group • Accountable to both HWB and ICB (via ICS Exec) • Forward plan - rhythm of system reporting with relevant attendees To be reviewed in six months
Co-production and Insight Group	Tim Bates and Helen Rostill – MHIP SROs	To be extended to existing membership of Partnership Board and MHDB, including carer and user voice, lived experience	<ul style="list-style-type: none"> • Broad membership representing all key stakeholders, bringing a range of perspectives • Key forum for third sector and lived experience to influence system priorities and actions and feedback on progress • Check and challenge – to both System Delivery Board and workstreams: Is this working? Are we engaging the right people in the right way? Are we taking a system approach to system priorities/achieving the outcomes we set out to? • Co-production with workstreams • Open line of communication into System Delivery Board: provide feedback, raise concerns, etc. • May be commissioned by Delivery Board to undertake specific pieces of engagement and insight work to support strategic objectives
Programme Delivery Group	Tim Beasley – Programme Director	<ul style="list-style-type: none"> • Programme Director Tim Beasley • Workstream Leads (to be refreshed based on new prioritisation) • MH System Convenor • Others TBC once DLs refreshed 	<ul style="list-style-type: none"> • Informal group to co-ordinate workstreams/priorities • Share learning, peer-to-peer accountability and support • Individual Workstreams hold responsibility for delivering priorities set by Delivery Board • Co-ordinate links to wider ICS governance/processes as required, e.g. where priorities support BAU assurance • Enabling agile flexible meeting for problem solving/ barrier checking
Workstreams	Workstream Leads	TBC but will vary by workstream	<ul style="list-style-type: none"> • Deliver priorities set by Delivery Board, underpinning workstream Leads • Engage with and get input from Co-production and Insight Group

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Mental Health System Delivery Board

Terms of Reference

1. Introduction

- 1.1. The Mental Health System Delivery Board (the 'Board') oversees the improvement and transformation of mental health and emotional wellbeing in Surrey.
- 1.2. The Board has been jointly established by Surrey Health and Wellbeing Board (the 'HWB') and Surrey Heartlands Integrated Care Board (the 'ICB') to bring together system partners with responsibility for delivering improvements in mental health and emotional wellbeing for our residents and service users.

2. Purpose & Objectives

- 2.1. The Board's overall purpose is to oversee the delivery of improvement of mental health and emotional wellbeing services in Surrey.
- 2.2. The scope of this work covers the full range of these services for all ages in Surrey. In particular, it includes the following existing and sometimes overlapping areas of work:
 - 2.2.1. The 19 recommendations underpinning the Mental Health Improvement Programme published in 2021 ('MHIP');
 - 2.2.2. 'Priority 2' of Surrey's Health and Wellbeing Strategy;
 - 2.2.3. 10 year plan for Mental Health (currently being prepared by NHS England)
 - 2.2.4. Sustainability and financial recovery requirements of the health systems in Surrey;
 - 2.2.5. Delivery of the NHS Long Term Plan; and
 - 2.2.6. System ambitions around place, in line with local priorities and the recommendations of "Next steps for integrating primary care: Fuller stocktake report" published in 2022.
- 2.3. The Board will focus this broad agenda by agreeing, from time to time, the system priorities for improving mental health and emotional wellbeing of Surrey residents (the 'System Priorities').
- 2.4. For the avoidance of doubt, the remit of the Board includes all ages and covers the whole of the county of Surrey.
- 2.5. The Board does not have a role in assuring 'business as usual' delivery of mental health services or the awarding or management of contracts for these services. These functions are performed elsewhere in Surrey's health and care governance.

3. Accountability/Delegated Authority

- 3.1. The Board is accountable to both the HWB and the ICB and will provide assurance to both bodies on the improvement of mental health and emotional wellbeing in Surrey. A number of members of the Board are also members of the HWB and/or the ICB.
- 3.2. The Board will provide regular reports to the HWB and the Chair will attend the HWB as and when invited to do so.
- 3.3. The Board will report to the ICB via the Surrey Heartlands ICS Exec, which is a committee of the ICB.

4. Sub Committees & Delegation

- 4.1. The Board will establish Workstreams and delegate responsibility for delivering the System Priorities to those Workstreams.
- 4.2. The Board will also establish a Co-Production and Insight Group (the “CPI Group”). The CPI Group:
 - 4.2.1. Will have a broad membership representing all key stakeholders, bringing a diverse range of perspectives, experience and expertise, including lived experience;
 - 4.2.2. Will influence the work of the Board and Workstreams through an open line of communication and by providing ‘check and challenge’. Members of the Co-Production and Insight Group will also be drawn upon for co-production and the group may be commissioned by the Board to undertake specific pieces of engagement and insight work to support strategic objectives; and
 - 4.2.3. Will not be accountable or responsible for delivery of the System Priorities: these will remain with the Board and Workstreams.
- 4.3. A Programme Delivery Group will be established to co-ordinate the work of Workstreams. This will be primarily formed of key leaders from each Workstream and the MHIP Programme Director, to share learning and to enable peer-to-peer support and challenge.

5. Responsibilities

- 5.1. The Board is responsible for setting the System Priorities, to identify the areas which should be the focus of system improvement, in the short, medium and long term.
- 5.2. The Board will champion the System Priorities and encourage all partners to work together to ensure that conditions are in place for the System Priorities to be delivered.
- 5.3. The Board will encourage all partners to work together to seek to identify funding and resources required to deliver agreed System Priorities. Where sufficient such funding

and resources cannot be identified the Board will report this to the ICB and HWB and work with partners to determine what can be done within the sustainable limits.

- 5.4. The Board is responsible for overseeing delivery of the System Priorities by the Workstreams. The Board will be supported in this role by the Programme Delivery Group.
- 5.5. The Board will seek and receive continuous feedback from stakeholders. The Board will be supported in this role by the Co-Production and Insight Group.

6. Membership

- 6.1. The Board will have an Independent Chair appointed by the HWB and the ICB.
- 6.2. The members of the Board are:

Role	Name
1. Independent Chair	<i>Jonathan Perkins</i>
2. Deputy Chair	<i>Clare Burgess</i>
3. System Senior Responsible Officer – Mental Health	<i>Liz Bruce</i>
4. Director of Children’s Services	<i>Rachael Wardell</i>
5. ICB partner representative	<i>Graham Wareham</i>
6. ICB Non-executive member	<i>Lynette Nusbacher</i>
7. Elected Member	<i>Sinead Mooney</i>
8. Co-Production and Insight Group Chair	<i>Dr Tim Bates</i>
9. Mental Health Convenor	<i>Vacant – covered by Liz Williams and Kate Barker (system convenors)</i>
10. Neighbourhood Representative	<i>TBC</i>
11. Frimley ICS Representative	<i>Helen Rostill</i>
12. Third sector representative, adults: Adult Mental Health Alliance / Community Connections	<i>Sue Murphy / Patrick Wolter</i>
13. Third sector representative, children: Surrey Youth Focus / Surrey Wellbeing Partnership	<i>Cate Newnes-Smith / Frank Sims</i>
14. Director of Public Health	<i>Ruth Hutchinson</i>

- 6.3. Members of the Board will be appointed by the group/system partner(s) they represent, in consultation with the Independent Chair.
- 6.4. The membership of the Board will be reviewed after 3-6 months and then annually.

7. Attendees

- 7.1. The Board will invite attendees from time to time, including members of the Workstreams and Co-Production and Insight Group.
- 7.2. The Board will be supported by the MHIP Programme Director and administrative support from the Integrated Strategic Commissioning team.

8. Quorum

- 8.1. Meetings of the Board will be quorate when at least 6 members are present, including at least the following:
 - 8.1.1. Independent Chair or Deputy Chair, or another nominated deputy;
 - 8.1.2. The System Senior Responsible Officer – Mental Health, or nominated deputy;
 - 8.1.3. One member from Surrey County Council, or nominated deputy; and
 - 8.1.4. One member from the third sector or the Co-Production and Insight Group, or nominated deputy.
- 8.2. If a meeting is not quorate, then the meeting may proceed if those attending agree but no decisions may be taken.

9. Meetings

- 9.1. The Board will meet monthly for the first six months and quarterly thereafter, to be reviewed after six months. Extraordinary meetings of the Board may be called where required, for example to agree the System Priorities.
- 9.2. Meetings may be held in person or by electronic means. Members attending by electronic means will count towards quorum.

10. Managing Conflicts of Interest

- 10.1. The members of the Board must comply fully with guidance relevant to them regarding Conflicts of Interest, e.g. NHS England Guidance, the Surrey Heartlands ICB Policy¹, or other applicable guidance from participating organisations.
- 10.2. Any conflicts or potential conflicts and mitigating actions should be identified in advance of the meeting, with advice from the ICS Governance Team. The MHIP

¹ The Management of Conflicts of Interest is included in the Standards of Business Conduct Policy.

Programme Director and/or administrative support will liaise with the ICS Governance Team as required.

11. Decision-making

- 11.1. The aim of the Board is to achieve consensus decision-making wherever possible. Where this is not possible (if the Chair determines that there is no consensus or one member disputes that consensus has been achieved) the Chair may call a vote.
- 11.2. Only members of the Board may vote, and each member shall have one vote. Any decisions put to a vote at a Board meeting shall be determined by a simple majority the votes of members present.
- 11.3. In the event of an equal vote, the Chair shall have a second and casting vote. The Chair will declare the result of the vote.

12. Emergency/Chair's action

- 12.1. In the event of an urgent decision being required, which cannot wait for the next scheduled meeting, the Chair may conduct business on a virtual basis through the use of telephone, email or other electronic communication.
- 12.2. Urgent decisions must be reported to the next Board meeting for ratification, together with a report detailing the grounds on which it was decided to take the decision on an urgent basis and the efforts made to contact the relevant other members of the Board prior to taking the decision.

13. Meeting Administration

- 13.1. The meeting will be supported by the MHIP Programme Director and administrative support from the Strategic Commissioning Team. They will liaise with and receive support from the ICS Governance Team as required.

14. Review of Terms of Reference

- 14.1. The Board will also self-assess its performance on an annual basis.
- 14.2. The Terms of Reference will be reviewed after 6 months and thereafter annually by the Board membership.

Committee Chair approval

Reviewed by _____ **Date**

Lead Director approval _____ **Date**

Review History

Date	Version no.	Reviewed by (Job Title or Committee Name)	Status (Draft or Final)	Comments/ Changes since last version
22.07.22	0.1	Tim Beasley, Programme Director	Draft	Initial draft for review by Board
04.08.22	0.2	Tim Beasley, Programme Director	Draft	Updated for feedback from Board members on v0.1. Includes changes to membership re third sector children's representation
07.08.22	0.3	Tim Beasley, Programme Director	Draft	Update administrative support being provided to Board

DRAFT

Prioritisation and phasing of mental health improvement and transformation in Surrey

Workplan

This is a potentially complex exercise...

- In order to prioritise a diverse range of programmes/interventions we will need to consider:
 - **Reach** – what cohort of residents have this need, and how many of them will be impacted? Where does this arise (e.g. priority populations)?
 - **Impact** – what improvement in outcomes will we see for the affected residents? Are there wider impacts, e.g. operational savings?
 - **Resourcing** – financial and non-financial, and where it may be available
 - **Ethical considerations** – what is the ethical approach to take for our citizens? What is the balance between different needs where resources are limited? How does the principle of non-Maleficence (not doing harm) affect what we might do?
 - **Interdependencies** – where do programmes/actions intersect? How does the partnership of providers for MH best work together?
- It must be developed with users, people with lived experience and carers – both to get it right and to ensure buy-in from across the system

... and requires a clear, straightforward and timely output

- Clearly linked to ICS priorities, including the Fuller Stocktake
- Set out a manageable number of system priorities and phasing of our overall programme
- Describe how these will achieve our co-produced vision and delivery of the overall MH improvement and transformation agenda
- Enable us to quickly focus on delivery

Our initial approach will be based around interviews and workshops

- There is much existing knowledge in the system. We believe that the key gap is not a lack of evidence or support for existing plans, but a lack of comparable, joined up information to enable decision-making across the breadth of the agenda
- Interviews and workshops provide an effective and time-efficient way of drawing this information together

A simple prioritisation framework will structure our decision-making

- This is to enable comparison across the range of plans and projects and will use existing information, as provided by interviewees

Engagement with users and people with lived experience and carers will happen throughout

Page 129

The voice of users and those with lived experience is embedded in our decision-making, i.e. through membership of MHSDDB

Interviews and workshops will include a range of people who bring this input, as a result of their existing participation in the MHIP, e.g. as workstream leads or members of the Co-Production and Insight Group

Groups such as the Independent Mental Health Network, Healthwatch and our third sector partners provide insight and evidence which will be incorporated alongside information from other sources. We also plan additional session(s) with these groups to get their input into our proposals as they develop

Data analysis at this stage will be limited

- We do not anticipate conducting detailed data analysis or a ‘deep-dive’ into the evidence base at this stage, as readily available information is expected to be sufficient to prioritise and phase our work. We will assess the need for further analysis when this is complete.
- Evaluation of delivery will depend on good data – measuring the right thing in the right way. This may require further attention after the initial prioritisation.

We will explain what we are doing, why and what the impact of those choices is

- A smaller number of immediate, focused priorities which can be demonstrably delivered
- Phasing of the whole programme
- Set out the reach and impact we expect our interventions to have, the cohorts/populations we are targeting and the potential consequences of actions deferred
- Expected resourcing requirements, and the extent to which resourcing is already secured

Page 130

Link our mental health priorities to wider system work

Set out how our work dovetails in to:

- Fuller stocktake
- Critical 5
- Financial sustainability plans

Further work will be needed to support effective implementation

- Further discussions are likely to be required on resource/funding
- Clear link to data and information to monitor progress and measure success
- Dock in to other areas, e.g. Frimley, children's structures

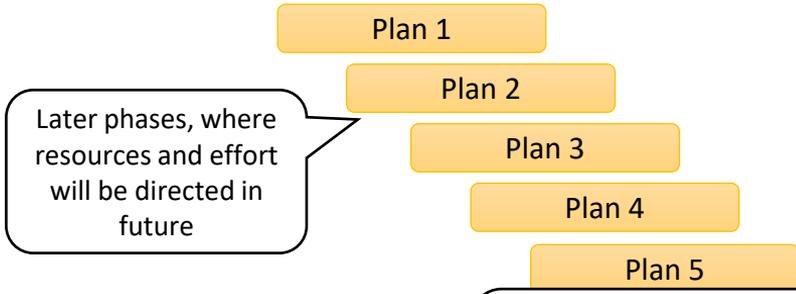
Phasing of priorities

System priorities

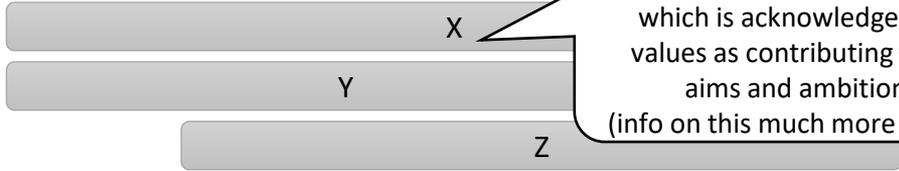
- Priority 1
- Priority 2
- Priority 3
- Priority 4

The initial focus of our system resources and effort

Future prioritised



Other work



Which elements of our overall vision does this contribute to?

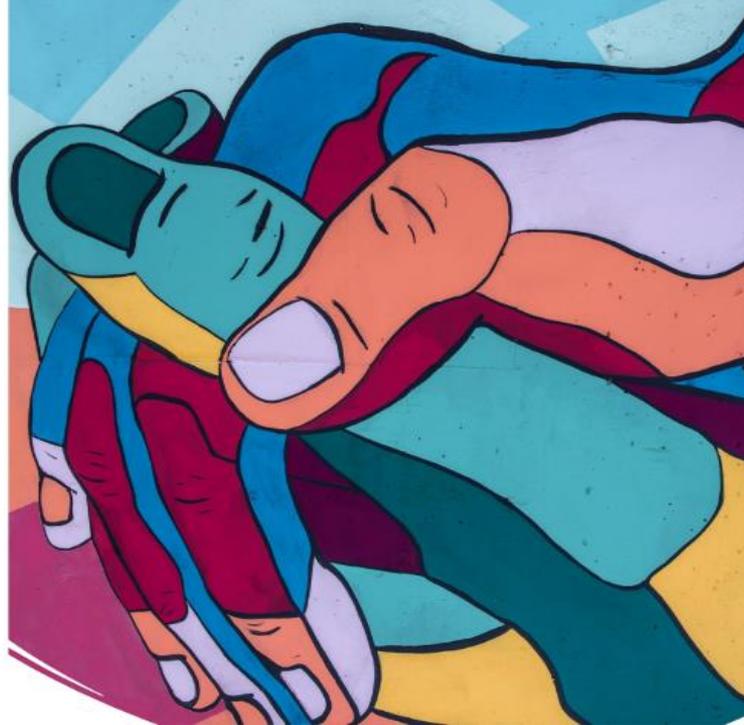
Critical 5	MHIP 19 recs	Fuller stocktake
Critical 1	Rec 1	Neighbourhood
Critical 2	Recs 1, 3 & 8	Place
Critical 5	Recs 4, 7 & 10	System
Etc.	Etc.	Etc.
Critical 1	Rec 1	Neighbourhood
Critical 2	Recs 1, 3 & 8	Place
Critical 5	Recs 4, 7 & 10	System
Critical 1	Recs 1, 3 & 8	Neighbourhood
Etc.	Etc.	Etc.
Critical 2	Recs 1, 3 & 8	Place
Critical 5	Recs 4, 7 & 10	System
Etc.	Etc.	Etc.

Appendix



The re-worked draft vision

“Together, we build and nurture good mental health and emotional wellbeing for all. If anyone needs help, they will find services on offer for themselves, their family and carers, which are welcoming, simple to access and timely. No-one is turned away from a service without being given support to get the help they need”



Mental health improvement and transformation in Surrey is a broad agenda with many activities and plans in need of prioritisation and phasing

- The scope of mental health improvement and transformation covers:
 - i. The 19 recommendations underpinning the Mental Health Improvement Programme ('MHIP');
 - ii. 'Priority 2' of Surrey's Health and Wellbeing Strategy;
 - iii. 10 year plan for Mental Health (currently being prepared by NHS England);
 - iv. Sustainability and financial recovery requirements of the health systems in Surrey;
 - v. Delivery of the NHS Long Term Plan; and
 - vi. System ambitions around place, in line with local priorities and the Fuller Stocktake

This broad range of activities, plans and priorities cannot all be delivered at once, and a lack of system focus on the most critical issues will hold us back

The Mental Health System Delivery Board has commissioned an exercise to prioritise and phasing system work

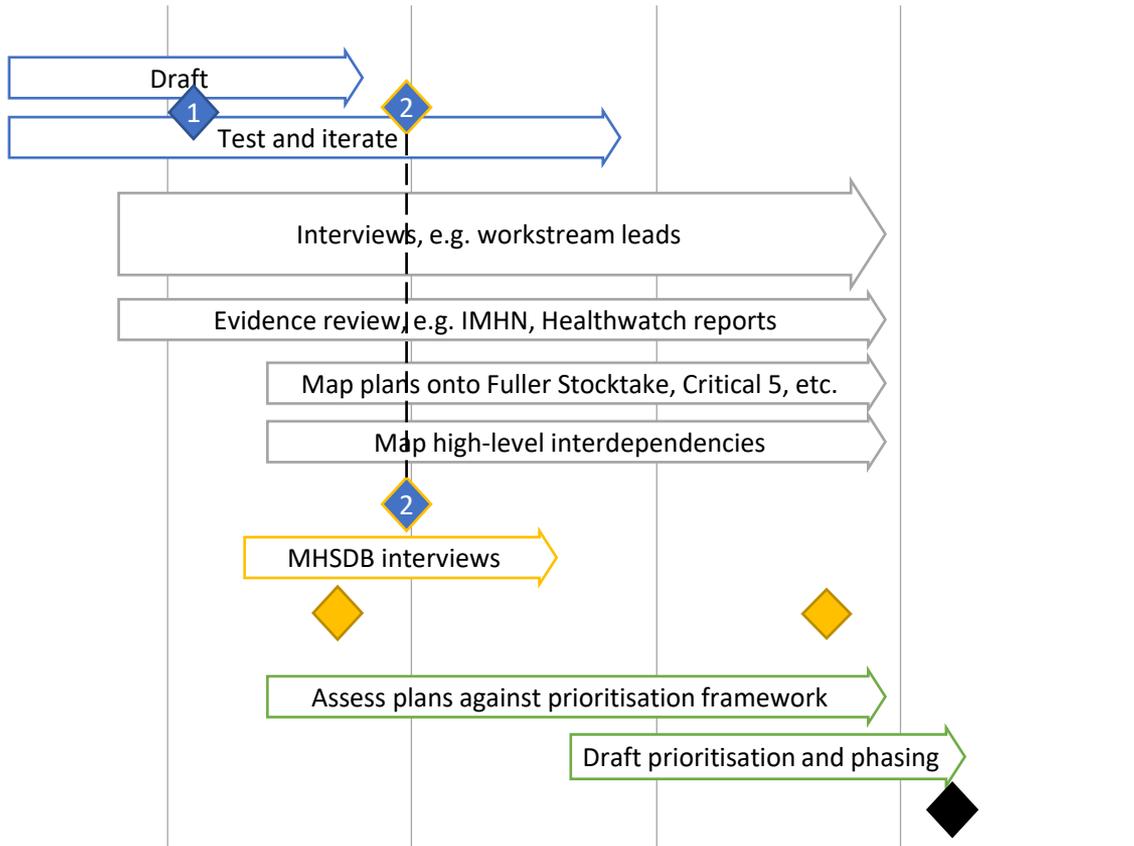
- This will restate our commitment to delivering the full agenda for our users and residents, while making clear the most critical areas which will be the focus of our effort and resources.
- This will form the foundation of a plan which will set out:
 - a) When interventions are able to be delivered
 - b) What resources are required to deliver and where they will be drawn from
 - c) The impact and reach of our choices
- This exercise is being led by the System Convenors (Liz Williams and Kate Barker) and MHIP Programme Director (Tim Beasley)

Prioritisation framework

'Fieldwork'
Page 135

Engagement

Prioritisation and phasing



-  Initial workshop
-  CPIG
-  User voice, lived experience sessions
-  MHSDB for decision

1) Workstream leads (or equivalent) from MHIP, LTP and HWB strategy and children's

- To collate consistent, comparable information for decision-making
- Includes 10 MHIP workstreams (although some overlap between areas)

2) MH System Delivery Board members

To capture input of those members not represented via workstreams, etc.

3) User voice, people with lived experience and carers

- Additional, dedicated session(s) planned to reinforce the voice of these groups throughout
- User voice, lived experience and carers are also represented in workstreams, CPIG, etc. and will be engaged in the same way as other stakeholders

1) Initial workshop

- Small number of MHSDB members or deputies representing a range of system partners
- To test initial and develop initial ideas prior to wider circulation
- Focus on prioritisation framework and high level priorities

2) Co-Production and Insight Group

Opportunity for wide stakeholder group to provide input and influence development

- Potential to explore specific areas with different sub-groups

3) Potential further sessions

- If required as work develops

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Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	A County-wide strategy for Housing, Accommodation and Homes: Baseline Assessment
HWBS Priority - 1, 2 and/or 3:	Priority 1 and Priority 3 (wider determinants)
Outcome(s)/System Capability:	The needs of those experiencing multiple disadvantage are met; People are supported to live well independently for as long as possible; People's basic need are met (poverty incl. fuel poverty/housing strategy) / Estates Management.
Priority populations:	All
Civic level, service based and/or community led interventions:	All
Author(s):	Michael Coughlin, Executive Director - Partnerships, Prosperity and Growth, Surrey County Council; Michael.coughlin@surreycc.gov.uk , 07974 212290
Board Sponsor(s):	Tim Oliver - Leader of Surrey County Council and HWB Chairman
HWB meeting date:	28 September 2022
Related HWB papers:	N/A
Annexes/Appendices:	Annex 1 - Summary of Contextual Factors Annex 2 - Baseline Assessment: Key Findings Annex 3 - Summary Deliberative Engagement Programme

8

2. Executive summary

This report outlines the background to and drivers for the initiation of a county-wide housing, accommodation and homes strategy and sets out the initial findings of a baseline assessment exercise, upon which key priorities and action will be derived, through a partnership-based, collaborative deliberation programme.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Endorse the consultative research work undertaken in partnership, to establish a strategic baseline assessment of accommodation and housing across the county.

2. Approve the proposed deliberative engagement approach to secure the views and buy-in of partner bodies to the identification of strategic priorities for accommodation and housing in Surrey.
3. Agree to a further report, confirming the Accommodation and Housing Strategic needs and priorities, coming to Health and Wellbeing Board in February 2023.

4. Reason for Recommendations

The housing circumstances and conditions in which one lives have a profound effect on health and wellbeing and if health inequalities are to be reduced, a number of aspects of housing must be improved. Housing, accommodation, and homes across Surrey reflect a complex mix of tenures, provision, quality, quantity and affordability and accessibility and in a number of these respects presents serious challenges.

The recommendations seek to secure endorsement at this stage of the engagement, assessment and analysis of the current position and proposed next steps, to provide a common platform of awareness and understanding of the key issues, in order to drive strategic priorities for action and improved delivery and outcomes, over time, so that more residents in Surrey live in secure, affordable housing, accommodation and homes.

5. Detail

1. The Adult Social Care Reform White Paper 'People at the Heart of Care' (Dec 2021) states that Integrated Care Partnerships (ICPs) would play a 'critical role' in driving the necessary integration of housing within health and care, both through the development of local strategies and in the delivery of services. The White Paper confirmed investment to embed the strategic commitment in all local places to connect housing with health and care and drive the stock of new supported housing.
2. The White Paper also set out the ambition to 'make every decision about care a decision about housing' and to give more people the choice to live independently and healthily in their own homes for longer, by allowing local authorities to integrate housing into local health and care strategies, with a focus on boosting the supply of specialist housing and funding improved services for residents.
3. In parallel, as part of the development of the County's Economic Strategy statement during 2021, the One Surrey Growth Board raised the critically important issue of housing and its impact on Surrey's economy. In addition, at their meeting in April 2022 the Surrey Delivery Board (comprising Council Leaders and Chief Executives from across Surrey) agreed to commission research and analysis to create a 'baseline assessment' in order to better understand the challenges and opportunities experienced with housing and accommodation, that could be used to identify shared priorities and the basis of a future Accommodation, Housing, and Homes Strategy.
4. Arising from these discussions and identification of the need for a more strategic approach, advisors (ICC - Inner Circle Consulting) have been commissioned to i)

undertake an initial broad baseline assessment of a wide range of housing, accommodation and homes matters, to support a better understanding of the accommodation and housing environment and the resources available, ii) conduct an engagement and deliberation programme, to establish where greater collaboration and partnership working may be most fruitful and iii) to derive a common set of strategic priorities for action.

Introduction

5. Housing is a fundamental determinant of individuals' wellbeing, along with employment, health and quality relationships. Housing conditions, accessibility and mix are key determinants of a thriving and sustainable workforce and economy, with consequent links into health and wellbeing. Housing also links strongly to poverty/fuel poverty and the cost of living and climate change and net zero ambitions.
6. It is apparent that a significant number of Surrey's residents, businesses, authorities and the economy face contextual and strategic challenges around accommodation and housing, as set out at Annex 1. Across these areas of activity and issues, there is not currently an evidenced and joined-up county-wide strategy or ambition that directs focus and alignment across the whole housing system. This is a gap that the baseline assessment and proposed strategy is intended to address.

Scope of the baseline assessment

7. In order to prioritise and address the above, a partnership approach to developing a collaborative strategy across Surrey has been initiated, the first stage of which is to establish a shared baseline assessment of the current position in respect of a wide number of elements of housing and accommodation, as follows:
 - a strategic housing market assessment
 - Social Housing provision and the experience of tenants
 - Essential Worker Housing
 - Increasing the positive contribution of accommodation and housing to wider determinants of health, including enabling more older people to continue to live safely and independently in their own home
 - Social Care provision, for older people (e.g. Sheltered Housing, Extra Care, residential care)
 - Increasing the contribution that accommodation and housing is able to make to addressing deprivation and promoting greater social mobility
 - Those with special housing needs, e.g. young people in care
 - The key role of and inter-relationship between housing and health
 - Homelessness and rough sleeping
 - The private rented market
 - Affordability, accessibility and demand within the housing market, aligned with labour market and economic factors
 - The contribution of housing in Surrey to the Climate Change agenda, either through new builds or retrofit programmes

- The requisite and desirable community infrastructure to support housing, homes and communities
- Increasing the scope to deliver the concept of 20 minute neighbourhoods in more areas, with the significant quality of life and climate change benefits that this brings.
- Innovative approaches to the identification of key opportunity sites across the county, investment strategies, unlocking land and funding, speeding up delivery of affordable housing, supporting the vulnerable etc.
- Increasing the opportunities to secure inward investment from Government, Homes England, and attract inward investment from businesses
- Approaches to increasing the overall supply of accommodation and housing

8

Baseline assessment

8. Inner Circle Consulting have been appointed as advisors for this work and have since July 2022, been undertaking an extensive research and engagement programme to build a 'Baseline Assessment' of housing, accommodation, and homes in Surrey. A summary of the baseline assessment key findings is attached at Annex 2.

Deliberative engagement programme

9. The next stage in the preparation of the strategy is to engage with a wide range of partners on the Baseline Assessment to build as far as possible a consensus around the strategic priorities for action. Annex 3 summarises the workshops and timescales being put in place, with a final step being a Housing, Accommodation and Homes Summit to be held on 8 December, prior to a final draft strategy being brought forward in January 2023.

6. Challenges

There are multiple sovereign agencies involved in this multi-faceted and complex area of work, as well as various (and sometimes conflicting) agendas, accountabilities and priorities. Convening partners and building a common understanding of the issues, barriers and opportunities will be key to securing delivery-oriented action.

7. Timescale and delivery plan

Following the deliberative engagement programme, it is planned to bring a draft strategy forward for consideration by partners in January 2023, to guide the actions each will take in securing delivery.

8. What communications and engagement has happened/needs to happen?

Extensive engagement with partners has been undertaken to date through ICC, who will continue to support the engagement work in the coming weeks and months, in accordance with the broad structure set out at Annex 3.

9. Next steps

- Presenting the baseline assessment to a range of agencies for their consideration and comment
- Initiating and managing the deliberative engagement programme
- Drafting a set of strategic priorities arising from the deliberative engagement
- Bringing forward a draft strategy for consideration and adoption in January 2023

Annex 1

SUMMARY OF CONTEXTUAL CHALLENGES

- *Contextual* - an aging population, areas of economic decline, congestion, cost inflation, health inequalities and increasing demand for services
- *Affordability* - despite positive average wage rates, high land values, property prices, and rents, translates into some of the worst affordability rates in the country
- *Supply* - the extent of Green Belt and other protected land designations places significant constraints on the availability of land for housing and specialist accommodation
- *Inequality, social inclusion and social mobility* - despite relatively high levels of affluence across the county, there are still areas of significant comparative deprivation where life expectancy, health, child poverty, employment, skills, educational attainment and housing etc, are significantly behind what is being achieved by communities living just a few miles away
- *Maximising the positive impact of available accommodation and homes* - making best use of the housing allocation system only addresses part of the issue, with a continued requirement to find even better ways to align the total supply of accommodation and housing with the most pressing social and economic needs of the area,
- *Securing inward investment* – increasingly Government investment is away from the relatively affluent South East, into more traditionally deprived parts of the country
- *Climate change, net zero and 20-minute neighbourhoods* – and the positive contribution that housing can make to these policy objectives.

Annex 2

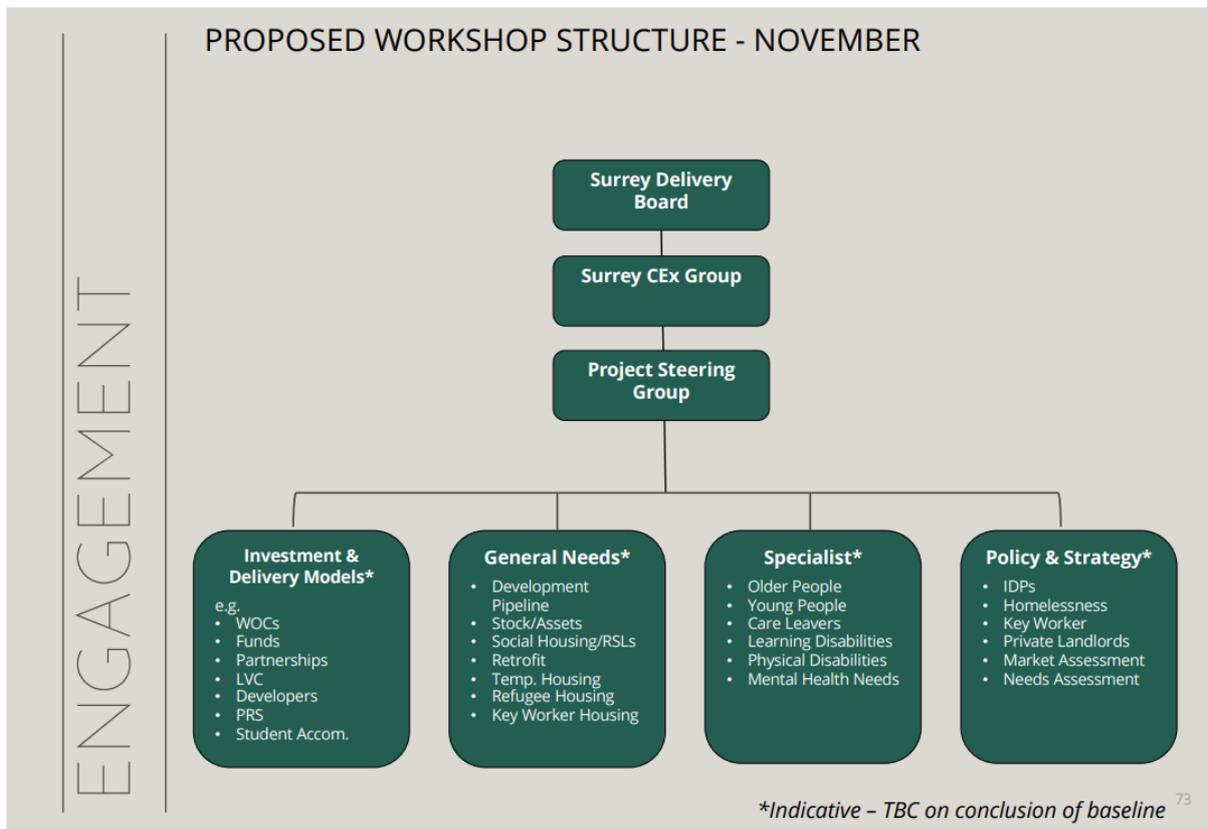
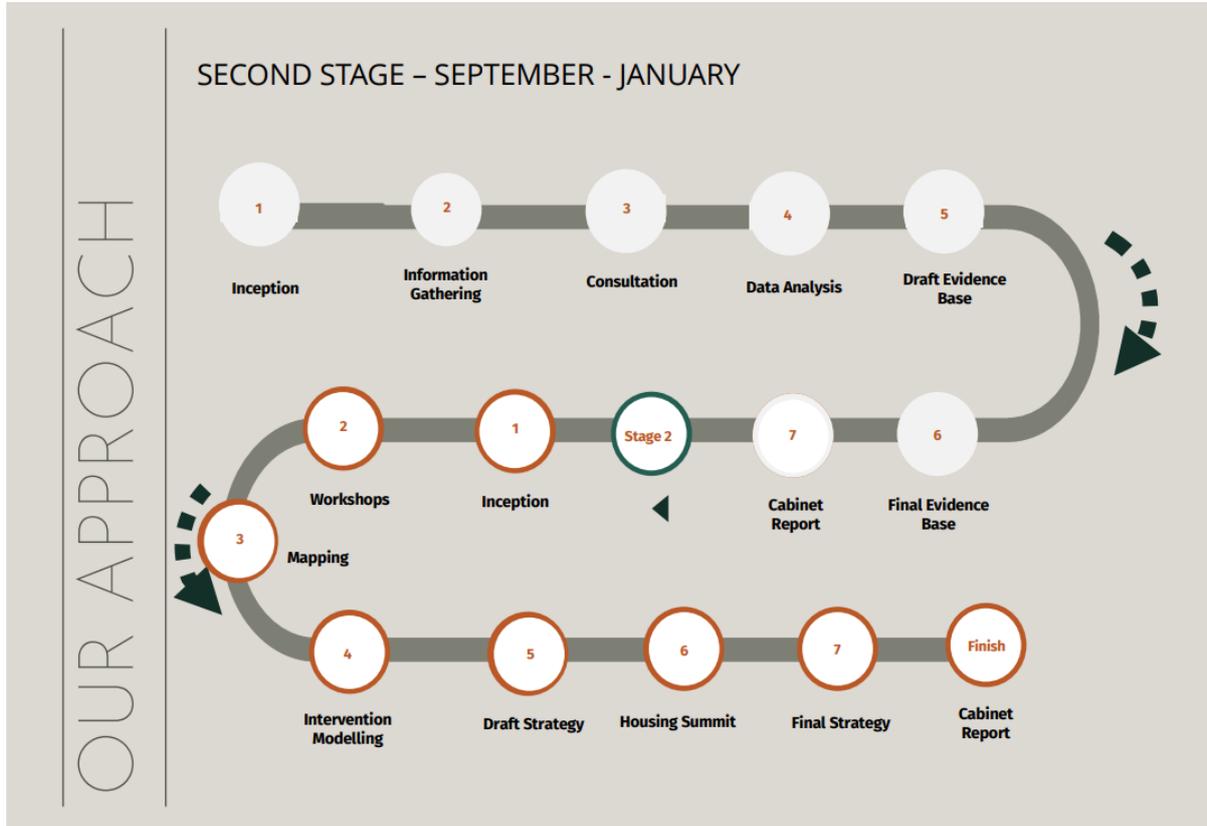
BASELINE ASSESSMENT: KEY COUNTY-WIDE ISSUES

- Despite isolated examples, partnership discussions and common aspirations, genuine partnership working that delivers can be improved
- Due to immediacy and crisis response, less attention is being given to longer term strategies especially for vulnerable residents
- Opportunity to work better together on making public land available for housing
- Capacity to deliver is severely constrained, set against other priorities
- Under-occupation exacerbating the housing supply problems and reducing the stock available to house families.
- Affordability a key factor in reducing inward migration, comparative to other parts of SE.
- Gap in provision of appropriate specialist/extra care/supported housing units that would enable older residents to move out of their family home as well as a lack of suitable/affordable accommodation for those looking to downsize.
- Ageing population and a rate of growth exceeding the national picture in some areas.
- Net zero meaning a greater focus on improving existing stock as opposed to new build, slowing delivery
- Concern that climate crisis would become a focal point for opposition to new homes
- Question over '20-minute towns' in practice, esp. in low-density suburbs across

Annex 3

PROPOSED DELIBERATIVE ENGAGEMENT PROGRAMME

8



Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	Evaluation Report from the Community Safety Assembly
HWBS Priority - 1, 2 and/or 3:	Priority 3
Outcome(s)/System Capability:	People are safe and feel safe / Empowered and Thriving Communities
Priority populations:	All
Civic level, service based and/or community led interventions:	All
Author(s):	Sarah Haywood, Partnership and Community Safety Lead, Office of the Police and Crime Commissioner for Surrey (OPCC)
Board Sponsor(s):	Lisa Townsend - Surrey Police and Crime Commissioner
HWB meeting date:	28 September 2022
Related HWB papers:	N/A
Annexes/Appendices:	Annex 1 - Surrey Community Safety Assembly Evaluation Report

9

2. Executive summary

In March 2020, the then Community Safety Board merged with the Health and Wellbeing Board. The overriding aim of the merger was to create a whole systems approach and develop a sense of shared priorities through collaborative working. In March 2022 the Board agreed a proposal to hold a biannual meeting bringing the wider community safety community together with health and social care colleagues.

The first meeting took place in May 2022. The conference style format was developed to encourage and develop wider collaboration and innovation and to ask what barriers there are in taking the Community Safety Agreement forward.

3. Recommendations

Following a detailed evaluation report and analysis of the feedback from the Community Safety Assembly, the Health and Wellbeing Board is being asked for agreement to explore some initial areas of focus:

- Explore the information sharing culture in Surrey and seek to promote a clear set of principles.

- Develop the Healthy Surrey website further as a portal for professionals to access resources in supporting individuals and communities.
- Increase the representation at the Health and Wellbeing Communications Group to include more community safety members to ensure campaigns and key messages are programmed in and are distributed across the systems.
- Work with the priority populations including the Key Neighbourhoods to ensure community safety partners are well represented and there is a broader understanding of available interventions.

4. Reason for Recommendations

The recommendations have been drawn from the feedback from the Community Safety Assembly and detail positive steps forward to begin to work closer together and break down the barriers between systems.

9

5. Detail

The first Community Safety Assembly took place in Dorking Halls and 82 people attended from 18 partner agencies. Partners that were in attendance included all 11 District and Boroughs, Surrey County Council, Surrey Police, Probation, Health representatives and representatives from the voluntary sector.

The agenda was formed around the Community Safety Agreement with the afternoon comprising three sessions: protecting our most vulnerable, protecting our communities from harm and empowering our communities to feel safe.

The full evaluation is detailed in Annex 1. but the discussion led to several areas or themes that could become areas for the Health and Wellbeing Board to include in the implementation plans under Priority three 'Supporting people to reach their potential by addressing the wider determinants of health' and - Outcome 'People are safe and feel safe.

Areas of focus -

Information sharing – many of the comments, particularly in the first and second session highlight the need to improve information sharing. Sharing information on our vulnerable people and communities should ensure effective delivery of targeted resources and provide all agencies the complete picture of what interventions are taking place.

'Information sharing and data analytics to focus and join up activity'

'Working together to fix the plumbing on data and insight systems'

'Join up systems to identify low level but persistent behaviour, as well as the most serious'

Knowledge – throughout the Assembly the theme of knowledge came up. Particularly being aware of what other partners responsibilities are and what is available locally to ensure our service users receive the best care.

Recommendations include directory of services, joining up teams and cross organisational briefings.

'Knowledge of available services and other relevant organisations'

'Knowing who to approach in an organisation'

'Knowing what partners can offer and when it is right to offer the service'

Leadership / Strategic prioritisation – many of the comments related back to having a clear direction from the centre. It links to knowledge, but all partners being aware of the Health and Wellbeing Boards priorities, its work around priority places and the population groups and signing up to the 4 Cs would create a more joined up system.

'Clear strategic and aligned direction across all agencies'

'Alignment with health'

'Enable and facilitate local delivery'

Communication and Engagement – the communication and engagement theme was picked up throughout the table discussions. Having targeted, engaging communications enables communities to understand what partners are delivering in their area, how they can access support and particularly in the second session increase reporting.

'Engage and listen to the community'

'Genuine engagement with communities'

'Give confidence in reporting'

'Make information more available about reporting'

Listen and hearing – under the Empowered Communities section, listening and truly taking on board what communities want was central and links to the delivery of resilient and local problem solving. The Assembly picked up that communities need to be part of the local delivery, that we need to work with communities trusted groups in community facilities and ensure there is a listening loop.

'Facilitate communities to identify solutions and opportunities for themselves and then deliver'

'Give the communities a real say in issues'

'Understand local need, priorities and how partners can contribute'

Unseen communities – a prominent theme in the final session was around inclusion and diversity. Many comments centred on the need for a work force that represented the community but also wanted statutory partners to ensure they identify, listen and hear our unseen communities. Key for community safety colleagues is to make sure they are linked into the priority place work. Time should

be given as to how this involvement can take place and the role community safety partners can play.

'Engage with protected characteristics groups to ensure diversity and inclusion'

'Engage with the hardest to reach and give them a voice'

Recommendations

The Community Safety Assembly provided a wealth of information and feedback from community safety partners, focusing on improving the relationships at a local and strategic level.

It is recommended that the Board focus on some initial areas

- Explore the information sharing culture in Surrey and seek to promote a clear set of principles.
- Develop the Healthy Surrey website further as a portal for professionals to access resources in supporting individuals and communities
- Increase the representation at the Health and Wellbeing Communications Group to include more community safety members to ensure campaigns and key messages are programmed in and are distributed across the systems. And
- Work with the priority communities to ensure community safety partners are well represented and there is a broader understanding of available interventions.

It is also recommended that the Health and Wellbeing Board receive detailed updates on some thematic areas such as Domestic Abuse, Serious Violence and Fraud to begin to consider positive actions to reduce the risk to our most vulnerable people and communities.

6. Challenges

The evaluation report identified several obstacles to embedding the merger and seeing the Community Safety Agreement is implemented. Working with key partners and as part of the work around the implementation plans, steps will be taken to support positive change.

7. Timescale and delivery plan

If these early recommendations are endorsed then they will be developed into the Health and Wellbeing Board Implementation Plans to be brought back to the Board in December.

8. What communications and engagement has happened/needs to happen?

Future engagement will take place through the Community Safety Assembly and the Prevention and Wider Determinants Board. Continued communication will take place with Community Safety Partnerships.

9. Next steps

- Incorporate the recommendations into the implementation plans.
- Communicate the November Community Safety Assembly agenda, focusing on the feedback from the May Assembly.
- Work with the Prevention and Wider Determinants to consider closer alignment between Health, Social Care and Community Safety.

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Annex 1



Evaluation Report

Introduction

In March 2020, the then Community Safety Board merged with the Health and Wellbeing Board. The overriding aim of the merger was to create a whole systems approach and develop a sense of shared priorities through collaborative working.

The scoping work prior to the merger recognised the statutory responsibilities of the partners and associated boards but was also mindful of the 2018 Policing, Health and Social Care Consensus that set health, social care and police partners a challenge of considering how we work together and to move beyond a single service response to prevention and commissioning. In March 2020, all agreed the merger created an exciting opportunity.

The Consensus also laid the foundation for the Community Safety Agreement which followed the merger, and which set the partnership's aspirations.

The Agreement set out how the HWBB would strive to work together to use our shared capabilities and resource to enhance the response to the lives of those with the most complex needs. It also described how, as a partnership, we would become better at identifying and supporting vulnerable people, making every contact count. And finally, it set out how we would look to improve our support to victims of crime and anti-social behaviour, making sure that we fully consider harm, and risk when we are commissioning and delivering support and preventative services.

In the last two years, as a partnership we have learnt a lot from each other in this new arrangement. However, the Health and Wellbeing Board is complex and is dealing with the aftermath of the pandemic and the national changes to public health. The Board has extremely full agendas, and it has become clear that a gap was emerging between the workings of countywide boards, and local delivery through the Community Safety Partnership resulting in concerns that the PCC and community safety partners might not be fulfilling their statutory duties.

In March 2022, the Police & Crime Commissioner proposed that a biannual meeting should be held to bring Community Safety Partners together to discuss countywide threats and opportunities and agree an approach to making Surrey's communities safer. This approach was supported and the first Community Safety Assembly took place on 15th May 2022.

The objectives would be to –

- Meet the statutory duty to cooperate across community safety partners
- Share data and trends to enable a collective response to countywide and local threats

- Enable the development of shared priorities across community safety, criminal justice and health and social care through the Community Safety Agreement
- Create opportunities to explore co-commissioning and project delivery
- Provide a forum to respond to the Health and Wellbeing Board's forward plan and performance framework
- Create a space for community safety partners to share best practise and areas of challenge
- Create a more cohesive approach to community safety

The plan to reinstate a community safety-focused meeting was not to distract from or duplicate the partnership work taking place within the Health and Wellbeing Board, but is ultimately to provide a place for community safety partners to meet, network and agree focused priorities which recommend areas to feed into the Health and Wellbeing Board implementation plans.

Community Safety Assembly Event Overview

The event took place in Dorking Halls and 82 people attended from 18 partner agencies. Partners that were in attendance included all 11 District and Boroughs, Surrey County Council, Surrey Police, Probation, Health representatives and representatives from the voluntary sector.

The agenda was formed around the Community Safety Agreement with the afternoon comprising three sessions: protecting our most vulnerable, protecting our communities from harm and empowering our communities to feel safe.

Protecting our most vulnerable –

The chapter in the Community Safety Agreement focusing on protecting our most vulnerable considers how as a partnership we first need to understand what makes someone more at risk and then how to identify those people and groups that may need additional support within our communities. The chapter looks at themes such as child exploitation and domestic abuse, these people or groups are often more invisible and perhaps do not consider they are victims.

The session was opened by Detective Superintendent Becky Molyneux who leads on child vulnerability, the High Harm Perpetrator Unit (HHPU), Paedophile Online Investigation Team (POLIT) and Police Single Point of Assess for Surrey Police. She presented on children exploitation, county lines, cuckooing, domestic abuse, fraud and modern slavery, closing that it is vital that, as partners, we share intelligence to identify those most at risk and seek opportunities to work together on innovative approaches to catching those that seek to do harm.

Attendees were asked to identify what are the common factors which make someone vulnerable. This exercise was to encourage participants to recognise that we are all supporting people with complex needs and identifying the same factors that make people more at risk of being a victim or perpetrator of crime.

Covid backdrop still causing inefficiency within organisations

Recruitment and retention of invested personnel

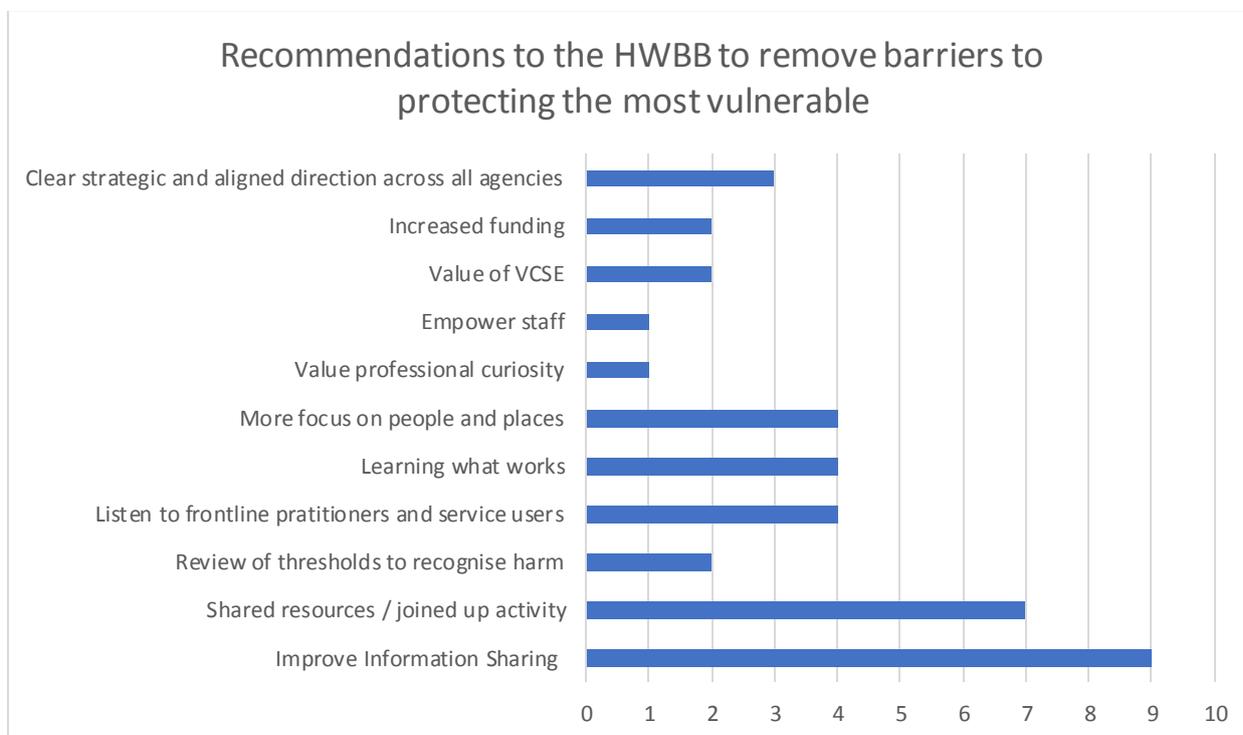
Knowledge of available services and other relevant organisations

Recommendations from session

At the close of each session the participants were asked to feed back what their recommendation(s) would be to the HWBB to remove the barriers and improve our response to protecting those vulnerable people or groups within our communities.

Similar to the barriers preventing us from working together, the feedback can be divided into common themes: improved information sharing, sharing of resources and joined up activity, review of thresholds to recognise the harm, listening to the service users and frontline practitioners, learning what works, more focus on people and places, value professional curiosity and empower staff, value the work of our voluntary and charity partners, increase funding, develop a clear strategy and aligned direction across all agencies.

9



Protecting our communities from harm –

The second session focused on the Community Safety Agreement chapter of protecting our communities from harm and was led by Jo Grimshaw, Head of Partnerships and ASB at Surrey Police. The Agreement chapter focuses on our duty to listen and support the communities that make up Surrey. By listening and focusing on those issues that cause people to feel unsafe and by working alongside residents on issues such as anti-social behaviour, road safety and drug related harm we can create stronger communities and long-term solutions.

The Assembly was asked to consider putting themselves in the place of the victim of anti-social behaviour and how it would feel. This exercise's aim was to make the audience think about the harm and lasting consequences of what we sometimes consider as low-level crime and ASB.



The second part of the session, having looked at the impact, considered how we raise the status of the victim and how we create an environment where harmful behaviour is not tolerated. The debate on the tables considered the need to listen to victims and to truly understand the harm caused. There was a focus on funding and supporting those dedicated services that coach and care for victims while the system works on enforcement or removal of the issues.

Below is a snapshot of the comments made around how we raise the status of victims –



How do we encourage communities to create an environment where harmful behaviour is not tolerated? The feedback centred around providing more local resources, particularly around opportunities to refer people into specialist services and then resources for communities to become empowered. There were comments about making better access to information such as phone numbers and defining what community harm is. Finally, several comments focused on increasing confidence in reporting and making it easier, safer and improving outcomes.

Recommendations from session

Again, participants were asked to feed back what their recommendation(s) would be to the HWBB to remove the barriers and improve community safety. The discussions created the most varied feedback across the afternoon and there were 43 responses ranging from increased funding to working with communities.

- *Manage expectations of the Surrey public*
- *Youth activity funding*
- *Identify where multiple agencies are involved*
- *Looking at how we can encourage communities to work together*
- *Empowering communities to help themselves*
- *Develop a pan Surrey data sharing portal where multi agencies can entre information attached to a UPRN at point of collection. Allow all agencies to extract data to enable joint action*
- *More focus on the wider determinants of health*
- *Empower communities to act: report and resolve*
- *More restorative justice*
- *Knowledge on non-violent communication*
- *Support local associations and hyper local democracy*
- *Provisions of youth services*
- *Clearer approach to mental health challenges that do not meet thresholds*
- *Join District and Borough's Community Safety teams into a central resource so it is not a postcode lottery for service*
- *Enable and facilitate local delivery*
- *Understand local need, priorities and how partners can contribute*
- *Funding services like Alliance Support Coaching and Mediation*
- *Keeping the built environment looking safe*
- *Pride in the community*
- *Ensure all helplines and contact details are up to date*
- *Join up systems to identify low level but persistent behaviour, as well as more serious ASB*
- *Accessible mental health services*
- *Linking to wider preventative programmes and directing to areas where need is not necessarily where the voices are the loudest*
- *Improve youth services/activities*
- *Issue with judicial thresholds*
- *Online safety awareness rising and funding initiatives*
- *Invest more funding in living streets for children to play*
- *Community development workers*
- *Regular community surveys and feedback from residents on concerns*
- *Improve access to shared social environments – youth clubs, day centres, social clubs etc*
- *Help communities to help themselves*
- *CCTV strategy*
- *Evidence led interventions*
- *More CCTV*
- *Improving community safety partnerships – continuity and outcomes*
- *Better enforcement of anti-social behaviour*
- *Turn streetlights back on*
- *Cross agency working*
- *Switch streetlights back on – still a big factor for Surrey residents in helping to reduce the fear of crime*
- *Have the right people in the room*
- *More money and resources*
- *Keep it local*
- *Put more money into it*
- *Clearer initial points of contact on ASB*

There is a great deal the Health and Wellbeing Board could consider, but similar to the first sessions, there are a number of themes being identified – joining up systems and partnerships to understand each other’s remit and work, sharing data around our communities to ensure resources are targeted for maximum effect and working alongside communities and listening to their experiences and concerns.

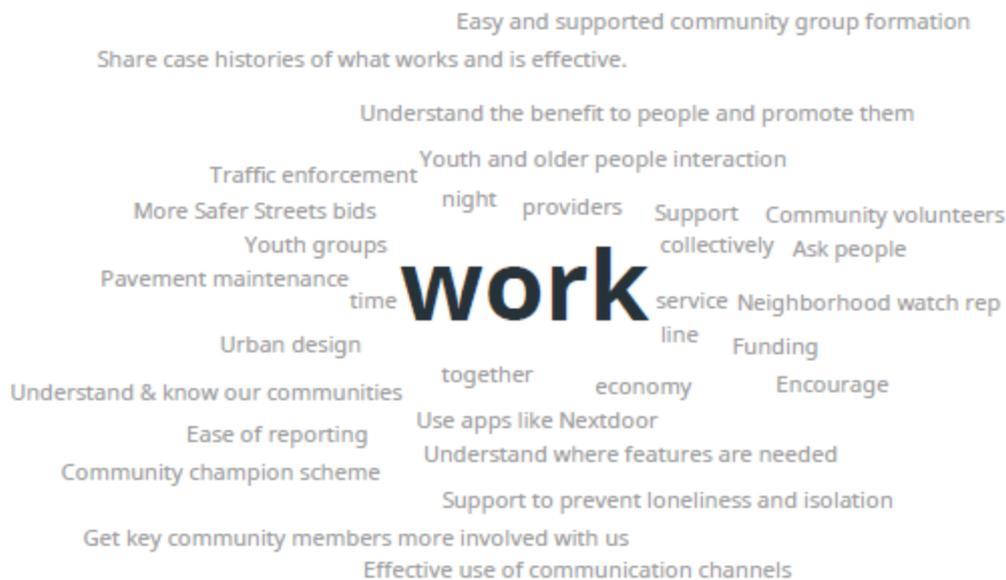
Empowering our communities to feel safe

The final focus of the Assembly was the third priority in the Community Safety Agreement – empowering our communities to feel safe. Led by Borough Commander Alick James and Dan Sherlock, Design Lead for Empowering and Thriving Communities at Surrey County Council, the session concentrated on the Priority Places work of the Health and Wellbeing Board and how as a partnership we can support the 4 Cs – community capacity building, co-designing, co-producing and community led action.

To get the participants talking, the first question considered what are the key features of our communities that help them to feel and be safe -

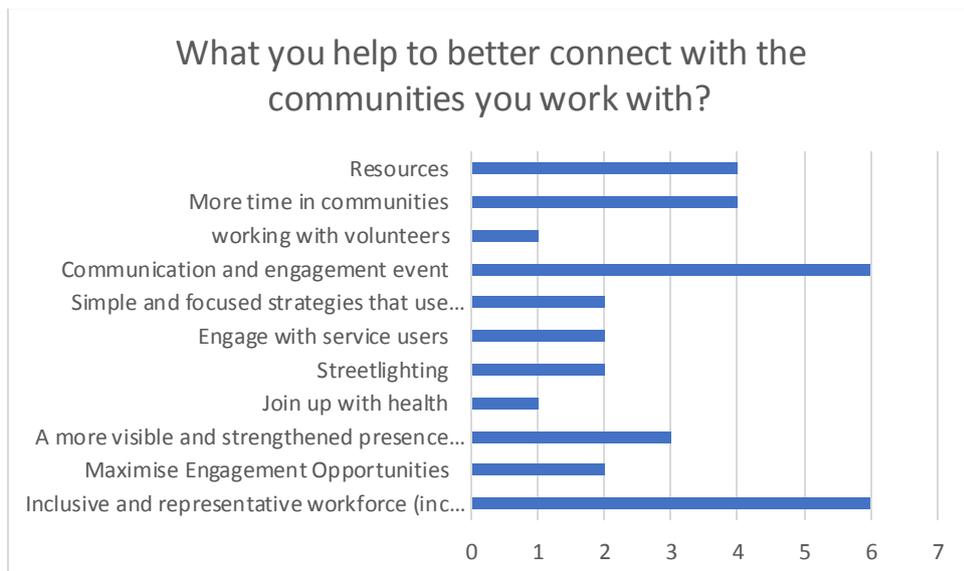


Thinking how we might support or enhance more of the things detailed above, the group suggested the following in a word cloud –



Key points are working together, particularly with volunteers and community groups, communications and more practical things like pavement maintenance and traffic enforcement.

In asking the group what would help them to better connect with the communities they work with, the standout responses were improving communication and engagement and having an inclusive and representative workforce. It is worth noting that there were significant comments on spending more time in communities and protecting that time in the diary.



Recommendations

Finally, the group was asked what its recommendations would be to the Health and Wellbeing Board to improve community empowerment.

- *Keep actions targeted and do not over commit*
- *Funding support for community groups*
- *Link with trusted community services*
- *Investing in staff well-being as community members*
- *Facilitate communities to identify solutions and opportunities for themselves then deliver*
- *Engage with the hardest to reach and give them a voice*
- *To find what will activate each community to work together*
- *Not expect individual agencies to solve the problem it is for the whole community*
- *Engage with protected characteristics groups to ensure diversity and inclusion*
- *Work with communities to develop a sense of pride*
- *Give the community a real say in issues*
- *Invest more in existing community group*
- *Funding local initiatives*
- *Ensure feedback is provided back to the community*
- *Ask the community*
- *Listen to the local voice*
- *Localism*
- *Public engagement*
- *Common approach to share engagement and what is being learnt to prevent multiple asks*
- *Engage with Neighbourhood Watch*
- *Be willing to experiment with community led approaches*
- *Involve the community and communicate the actions that have been taken*
- *Community Champions in as many streets as possible*
- *Genuine engagement with sections of the community*
- *Invest in our development to work better alongside communities*
- *Less strategies and more local action*
- *Engage and listen to the community.*
- *Be realistic with communities about time it takes to effect change*
- *Seek views and take action*
- *Ask the community*
- *Ensure strong community listening and responses*
- *Understand harder to reach groups*
- *Work with local NHS groups and local delivery arms and enable them to work together to respond to local needs in their area*
- *Working together*

The comments show a number of similarities: listening and engaging with our unseen communities and ensuring they are part of the community problem solving processes. Communication is key as well as making sure you work with local community leaders and community groups.

Future focus Area

In conclusion there are several areas or themes that were put forward at each session of the Assembly that could become areas for the Health and Wellbeing Board to include in the implementation plans under Priority three – Supporting People to reach their potential by addressing the wider determinants of health - outcome people are safe and feel safe

At the top of this paper it was noted that the momentum behind the merger was disrupted with the pandemic, the themes that have been highlighted link back to completing and embedding this merger and to see a successful future.

Information sharing – many of the comments, particularly in the first and second session highlight the need to improve information sharing. Sharing information on our vulnerable people and communities should ensure effective delivery of targeted resources and provide all agencies the complete picture of what interventions are taking place.

‘Information sharing and data analytics to focus and join up activity’

‘Working together to fix the plumbing on data and insight systems’

‘Join up systems to identify low level but persistent behaviour, as well as the most serious’

Knowledge – throughout the Assembly the theme of knowledge came up. We need to know what other partners remits are and what is available locally to ensure our service users receive the best care. Recommendations include directory of services, joining up teams and cross organisational briefings.

‘Knowledge of available services and other relevant organisations’

‘Knowing who to approach in an organisation’

‘Knowing what partners can offer and when it is right to offer the service’

Leadership / Strategic prioritisation – many of the comments related back to having a clear direction from the centre. It links to knowledge, but all partners being aware of the Health and Wellbeing Boards priorities, its work around priority places and people and signing up to the 4 Cs would create a more joined up system.

‘Clear strategic and aligned direction across all agencies’

‘Alignment with health’

‘Enable and facilitate local delivery’

Communication and Engagement – the communication and engagement theme was picked up throughout the discussions and links to the next theme. Having targeted, engaging communication enables communities to understand what partners are delivering in their area, how they can access support and particularly in the second session increase reporting.

‘Engage and listen to the community’

‘Genuine engagement with communities’

‘Give confidence in reporting’

‘Make information more available about reporting’

Listen and hearing – under the empowering communities section, listening and truly taking on board what communities want was central and links to the delivery of resilient and local

problem solving. The Assembly picked up that communities need to be part of the local delivery, that we need to work with community trusted groups in community facilities and ensure there is a listening loop.

'Facilitate communities to identify solutions and opportunities for themselves and then deliver'

'Give the communities a real say in issues'

Understand local need, priorities and how partners can contribute'

Unseen communities – a prominent theme in the final session was around inclusion and diversity. Many comments centred on the need for a work force that represented the community but also wanted statutory partners to ensure they identify, listen and hear our unseen communities. Key for community safety colleagues is to make sure they are linked into the priority place work. Time should be given as to how this involvement can take place and the role community safety partners can play.

'Engage with protected characteristics groups to ensure diversity and inclusion'

'Engage with the hardest to reach and give them a voice'

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Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	Surrey Pharmaceutical Needs Assessment (PNA) 2022
HWBS Priority - 1, 2 and/or 3:	Priority 1, 2 and 3
Outcome(s)/System Capability:	Outcomes across the priorities. System capabilities: Integrated Care; Data, insights and evidence; Empowered and Thriving communities
Priority populations:	Potential to support outcomes for all priority populations
Civic level, service based and/or community led interventions:	Service-based
Author(s):	<ul style="list-style-type: none"> Ruth Hutchinson, Director of Public Health, Surrey County Council; ruth.hutchinson@surreycc.gov.uk Tom Bourne, Public Health Analyst Team Lead, Surrey County Council; tom.bourne@surreycc.gov.uk Cassandra Ranatunga, Advanced Public Health Intelligence Specialist, Surrey County Council; cassandra.ranatunga@surreycc.gov.uk
Board Sponsor(s):	Ruth Hutchinson - Director of Public Health (Surrey County Council)
HWB meeting date:	28 September 2022
Related HWB papers:	N/A
Annexes/Appendices:	Annex 1 - Surrey Health and Wellbeing Board Pharmaceutical Needs Assessment October 2022 Annex 2 - Appendices: Surrey Health and Wellbeing Board Pharmaceutical Needs Assessment October 2022

2. Executive summary

Every Health and Wellbeing Board (HWB) in England has a statutory responsibility to assess the need for pharmaceutical services in its area and to publish (and keep up to date) a statement of its assessment; this is termed a pharmaceutical needs assessment (PNA) (as per Section 128A of the National Health Service Act 2006 (NHS Act 2006), amended by the Health and Social Care Act 2012¹). The PNA then forms an essential part of the decision making about market entry for new service providers of pharmaceutical services.

National regulations ([The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Regulations 2013](#)) require PNAs to be revised at least once every three years or more frequently if changes to the local population or services are sufficient to require a supplementary statement. Surrey HWB published its last PNA in April 2018. Due to the impact of responding to the COVID-19 pandemic, the Department of Health and Social Care (DHSC) extended the usual three-year deadline stating that HWBs must publish a revised PNA by 1 October 2022².

Surrey HWB delegated responsibility for overseeing the production of the Surrey PNA 2022 to a Steering Group (PNA SG) consisting of key professionals from the Surrey Local Pharmaceutical Committee, Surrey Local Medical Committee, Integrated Care Boards, NHSE regional representatives, Public Health, the Surrey County Council communications team and Healthwatch. This group has met regularly since October 2021.

The purpose of this paper is to **present** key aspects of the Surrey PNA 2022, including its recommendations, to the HWB for **final approval** and to **seek agreement** to its publication no later than 1 October 2022.

When making an overall PNA conclusion, schedule 1 to the NHS Regulations (2013), as amended, require the PNA to make assessments against specific set criteria:

- The conclusion of this PNA is that there are no gaps in **necessary services** in Surrey. The number, distribution and choice of pharmaceutical services meets the current needs of Surrey's population and future needs foreseen within the lifetime of this PNA (three years from 1 October 2022 until 30 September 2025).
- There are no identified needs for **additional pharmaceutical services**, or enhancements to current arrangements across the county that would secure **improvements or better access to services**.
- The PNA noted that current **locally commissioned services** (provided by Surrey public health and the ICBs) provide an improvement to pharmaceutical provision for the population of Surrey.

Findings and recommendations supporting these conclusions are enclosed within this paper.

¹ [Health and Social Care Act 2012 \(legislation.gov.uk\)](#)

² [Pharmaceutical needs assessments: information pack - GOV.UK \(www.gov.uk\)](#)

3. Recommendations

Health and Wellbeing Board members were provided a copy of the PNA for comment during the four-week period Friday 5 August 2022 to Friday 2 September 2022. All comments received were addressed and incorporated.

1. In order to give final approval of the PNA for publication, it is suggested that the HWB consider:
 - a. Whether the process followed to produce the PNA (set out in section 5 of this paper) was robust and met related regulations?
 - b. Whether the findings are appropriate to the evidence found?
2. It is recommended that the Health and Wellbeing Board approves the final draft of the Surrey PNA 2022 (Annex 1) including its Appendices (Annex 2) and agrees to its immediate publication.

4. Reason for Recommendations

Development of Surrey's 2022 PNA has met all requirements of [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Regulations 2013](#). Its production has been led by a skilled steering group (PNA SG) of relevant professionals. The PNA has been signed off by the PNA SG as a compliant and accurate assessment and has received their recommendation.

The final PNA is a HWB product and, as such, requires formal sign-off by the HWB prior to publication. PNA legislation requires the signed-off assessment to be published on Surrey County Council's Local Authority website by 1 October 2022³.

5. Detail

What is the PNA, and what is its purpose?

From 1 April 2013, HWBs have a statutory responsibility as set out in the Health and Social Care Act 2012 to publish and keep up to date the PNA which provides a statement of need for pharmaceutical services for the population of its area.

Under the [National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Regulations 2013](#), a person (a pharmacist, a dispenser of appliances, or in some circumstances and normally in rural areas, a GP) who wishes to provide NHS pharmaceutical services must apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA. The PNA is therefore also an essential part of the process of making decisions about market entry for new service providers.

More widely, a PNA gives an opportunity for the HWB to understand how pharmacies might better contribute to addressing the health needs of the local population through identifying gaps in access or the potential to improve the health of the local population through more targeted interventions.

³ [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Regulations 2013 \(legislation.gov.uk\)](#)

National regulations require PNAs to be revised at least once every three years or more frequently if changes to the local population or services are sufficient to require a supplementary statement. This PNA replaces the assessment undertaken by Surrey County Council Public Health in 2018. The lifetime of this PNA will be three years from 1 October 2022 until 30 September 2025.⁴

Process for developing the PNA

The Surrey HWB delegated responsibility for overseeing the production of the Surrey PNA 2022 to the PNA SG consisting of key professionals from the Surrey Local Pharmaceutical Committee (LPC), Surrey Local Medical Committee (LMC), Integrated Care Board (ICB), NHSE regional representative, Public Health, the Surrey County Council communications team and Healthwatch. This group has met since October 2021 to provide guidance, support, and oversee production.

The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013⁵, were used to inform the production process along with guidance documentation published by the DHSC in October 2021⁶.

The key steps in production included:

- Review of Surrey's 2018 PNA⁷ and any supplementary statements, the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013⁸, and subsequent amendments.
- Consideration of pharmaceutical service provision against local health needs, local pharmaceutical service changes and any recent or future planning for housing developments.
- Assessment of pharmaceutical services and activity provided (essential, advanced, enhanced and other NHS services (locally commissioned) to enable comparison nationally and locally, and mapping of service provision including travel time to identify any service gaps.
- A survey of the Surrey citizen's panel, as well as targeted circulation of the questionnaire to assist in reaching seldom heard groups and populations across Surrey that may experience health inequalities, in a targeted effort to seek views from these groups (see section 8 on 'engagement' below for further details).
- A survey to contracted pharmaceutical services, and dispensing GPs.
- Publication of a draft PNA for a minimum 60-day formal consultation between the period of May to July 2022 to seek views of the public and other stakeholders to ensure the PNA is reflective of the needs of the Surrey population. This consultation complied fully with regulatory requirements. Good engagement was received. A report on the consultation can be found at section 9 of the PNA.

⁴ [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Regulations 2013 \(legislation.gov.uk\)](https://www.legislation.gov.uk)

⁵ [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Legislation](#)

⁶ [Pharmaceutical needs assessments: information pack](#)

⁷ [Surrey Pharmaceutical Needs Assessment 2018](#)

⁸ [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Legislation](#)

- The final PNA report was presented to the Surrey HWB for a four-week review period, Friday 5 August 2022 to Friday 2 September 2022.

Public Health within the PNA SG sought further assurance on the production of the PNA via:

- ensuring to keep the HWB updated on progress, presenting twice on the development of the PNA. Updates were provided at informal meetings on 9 Feb 2022 and on 1 June 2022; and
- monitoring and reviewing neighbouring HWB's PNAs and incorporating relevant findings to the Surrey PNA.

Key findings and recommendations of the Surrey PNA 2022

Changing policy context

This PNA recognises the ongoing important role of community pharmacies and the changes to their way of working throughout the COVID-19 pandemic.

The PNA acknowledges the report on the 'Next steps for integrating primary care: Fuller stocktake report' (Fuller report). The Fuller report calls for integrated neighbourhood 'teams of teams' to evolve from primary care networks and highlights the importance of community pharmacy teams in urgent care and prevention, including early diagnosis of cancers. The Fuller report points out that pharmacists could play 'a more active role in signposting eligible people to screening and supporting early diagnosis, building on a number of successful pilots such as those from the Accelerate, Coordinate, Evaluate programme'.⁹

Finding - Local health needs

Population growth and the number of proposed housing developments in each locality (district and borough) across Surrey is not expected to exceed the needs that can be managed by existing providers during the life time of this PNA, however recognising the potential for change due to proposed large scale housing developments in Surrey, it is recommended that the PNA Steering Group should review actual increases in population and housing and the implications of any increases on an annual basis, publishing their findings in a PNA supplementary statement.

Finding - Current pharmaceutical service provision

Review of the necessary pharmaceutical services in Surrey has found no gaps in current or future provision. Across Surrey, there is good access to community pharmacy or dispensing general practice within a reasonable travel time by car during weekdays and Saturdays.

All Surrey residents are within a five-mile radius of an open pharmacy on a weekday, however for some residents, such as those living in more rural areas, or with limited

⁹ <https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/>

access to transport (public transport or their own car), or with limited mobility the access to community pharmacy may be less good but is complex to quantify. In these cases, access to essential services may be ameliorated by the growing availability of internet pharmacies and the willingness of some pharmacies to deliver prescription medications.

Finding - Feedback from public and providers

Most of the public and provider responses received indicated that the provision of pharmaceutical services and access is sufficient overall in Surrey.

Overall conclusion

The conclusion of this PNA is that there are no gaps in necessary services in Surrey. The number, distribution and choice of pharmaceutical services meets the current needs of Surrey's population and future needs foreseen within the lifetime of this PNA.

There are no identified needs for additional pharmaceutical services, or enhancements to current arrangements across the county that would secure improvements or better access to services.

The PNA noted that current locally commissioned services (provided by Surrey public health and the ICBs) provide an improvement to pharmaceutical provision for the population of Surrey.

The PNA recognises the ongoing important role of community pharmacies in improving the health and wellbeing of local communities as highlighted in the Fuller Report.

6. Challenges

Recognising the potential for change in local populations due to proposed large scale housing developments in Surrey, the PNA SG should review actual increases in population and the implications of any increases on an annual basis and publish their findings in a PNA supplementary statement.

7. Timescale and delivery plan

This final PNA for 2022 requires sign-off by the HWB ahead of publication no later than 1 October 2022.

8. What communications and engagement has happened/needs to happen?

Throughout the process of developing the Surrey PNA, key stakeholders have been engaged.

PNA Steering group (PNA SG)

The PNA SG was established with representation from key professionals (see section 5 of this paper).

The primary role of the PNA SG was to advise as well as to develop structures and processes to support the preparation of a comprehensive, well researched, well considered, and robust PNA, building on expertise from across the local healthcare community. The group ensured that the views of the main stakeholders were considered.

Formal consultation

As stipulated in [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Regulations 2013](#), the PNA SG ensured that a draft of the PNA was available for public consultation for 60 days between 13 May 2022 until 12 July 2022 (see section 5 of this paper).

The consultation was sent to the list of stakeholders as stipulated in regulation 8 of the 2013 regulations. The consultation was also circulated for comment and further onward circulation to several other relevant stakeholders including the place-based leads within Surrey Heartlands and Frimley ICSs, the director of pharmacy across Surrey Heartlands ICS and known chief pharmacists. The consultation was also promoted through the PNA SG's wider networks, including the LPCs in Hampshire, Kent and Medway and South London.

Questionnaires with the public and contractors

Surveys were completed with the public (via the Surrey Citizen's panel), community pharmacists and dispensing doctor contractors.

In addition to surveying the Surrey Citizen's panel, the PNA SG requested that an extended version of the panel questionnaire should be circulated more widely, in a targeted effort to seek views from population groups that may experience health inequalities across Surrey. This adapted version of the survey was published online using Surrey-says and was publicised via targeted posts to residents of the wards which have areas with the most deprived small areas across Surrey (as outlined in Surrey's Health and Wellbeing Strategy which is available online at the following webpage: [Surrey Health and Well-being Strategy update 2022 - Priority Populations](#)).

9. Next steps

Legislation requires the PNA to be published on Surrey County Council's Local Authority website by 1 October 2022. This is a national requirement for every HWB across the country. As a HWB product, the final PNA requires formal sign-off by the HWB prior to publication.

1. Following sign off, the PNA will be published online on Surrey-i, no later than Friday 30 September 2022 (last working day before deadline).

2. PNA regulations state each HWB must publish a statement of its revised assessment within three years of its previous publication of a PNA. The Surrey PNA should therefore be revised by 1 October 2025. In the interim, the PNA SG will review annually the need for a revised statement or a supplementary statement to keep the PNA up to date as required by legislation.

Surrey Health and Wellbeing Board Pharmaceutical Needs Assessment October 2022

Contents

Glossary	6
Executive summary	8
Purpose	8
Process.....	8
Context	9
Key findings and recommendations.....	10
1.0 Introduction	12
1.1 Purpose of the pharmaceutical needs assessment	12
1.2 Pharmaceutical services	13
1.2.1 Pharmaceutical services provided by pharmacy and dispensing appliance contractors ..	13
1.3 Surrey’s PNA	16
1.3.1 Current context	17
1.3.2 Methodology	19
1.3.3 Production of the PNA.....	20
1.3.4 Structure of the PNA	21
2.0 Surrey people and place	22
2.1 Protected characteristics and population groups	23
2.1.1 Population – age and sex.....	23
2.1.2 Ethnicity and Race	24
2.1.3 Languages spoken.....	26
2.1.4 Religion or belief	27
2.1.5 Disability.....	27
2.1.6 Gender reassignment.....	27
2.1.7 Marriage and civil partnership	27
2.1.8 Sexual orientation	27
2.2 Demography	28
2.2.1 Population density.....	28
2.2.2 Rural and urban population	29
2.2.3 Population projections.....	31
2.2.4 Housing constrained population projections.....	32
2.2.5 Households in Surrey	34
2.3 Planned housing growth	34
2.3.1 Elmbridge.....	35
2.3.2 Epsom & Ewell	35
2.3.3 Guildford	35

2.3.4 Mole Valley	35
2.3.5 Reigate & Banstead	36
2.3.6 Runnymede.....	36
2.3.7 Spelthorne.....	36
2.3.8 Surrey Heath.....	36
2.3.9 Tandridge.....	36
2.3.10 Waverley	37
2.3.11 Woking.....	37
2.4 Key findings & recommendations	37
3.0 Local health needs.....	39
3.1 Health in Surrey.....	39
3.1.1 Life expectancy and good health	39
3.1.2 Mortality	39
3.1.3 Long term conditions.....	39
3.1.4 Asthma.....	40
3.1.5 Chronic obstructive pulmonary disease	40
3.1.6 Diabetes.....	41
3.1.7 Stroke.....	41
3.1.8 Hypertension.....	41
3.1.9 Multiple morbidity and population aged 75 years and older	41
3.2 Wider determinants of health in Surrey.....	44
3.2.1 Obesity.....	44
3.2.2 Physical activity.....	44
3.2.3 Index of multiple deprivation	44
3.3 Key findings and recommendations.....	46
4.0 Current pharmaceutical service provision	47
4.1 Service providers.....	49
4.1.1 Community pharmacies	49
4.1.2 Dispensing activity	50
4.1.3 Dispensing doctors.....	51
4.1.4 Internet and distance selling pharmacies	52
4.1.5 Dispensing appliance contractors (DACs).....	52
4.2 Access to pharmacies.....	52
4.2.1 Opening hours	52
4.3 Distance and travel times	61
4.3.1 Neighbouring Health and Wellbeing Boards	61
4.3.2 Car ownership in Surrey.....	67

4.4 Necessary services: current provision	72
4.4.1 Essential service provision	72
4.4.2 Advanced service provision	74
4.4.3 Enhanced service provision	80
4.5 Other Relevant services: current provision	82
4.5.1 Public Health local services	82
4.5.2 ICB commissioned services	89
4.5.3 Other NHS providers	90
4.6 Key findings and recommendations	94
5.0 Surveys of public and patient views	95
6.0 Survey of Surrey community pharmacies	111
7.0 Survey of Surrey dispensing practices	119
8.0 Conclusions and recommendations	120
8.1 Surrey people and place	120
8.1.1 Conclusion	120
8.2 Local health needs	121
8.2.1 Conclusion	121
8.3 Current pharmaceutical service provision	122
8.3.1 Conclusion	122
8.4 Public and provider surveys	123
8.4.1 Conclusion	123
8.5 Overall recommendation	124
9.0 Consultation results	125
10.0 Acknowledgements	154

If you would like this information in large print, Braille, in another language or an alternative format please contact us on

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Glossary

AUR	Appliance Use Review
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CPCF	Community Pharmacy Contractual Framework
DAC	Dispensing Appliance Contractor
DCLG	Department for Communities and Local Government
DHSC	Department for Health and Social Care
DPS	Dynamic Purchasing System
EHC	Emergency Hormonal Contraception
FP10	NHS standard prescribing form
GP	General Practitioner
GRT	Gypsy, Roma and Traveller
HLP	Healthy Living Pharmacy
HWB	Health and Wellbeing Board
ICB	Integrated Care Board
ICS	Integrated Care System
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LCS	Locally Commissioned Service
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual and other identities
LMC	Local Medical Committee
LP	'LP services' is a legal term. If NHS England includes services relating to the provision of education and training in LPS contracts it turns those services into 'LP services' but it does not turn them into 'local pharmaceutical services'.

LPC	Local Pharmaceutical Committee
LPS	Local Pharmaceutical Services
LSOA	Lower Super Output Area
MDS	Monitored Dosage System
MUR	Medicine Use Review
NHS	National Health Service
NHSE	NHS England
NHSCB	National Health Service Commissioning Board, now known as NHS England
NICE	National Institute for Health and Care Excellence
NMS	New Medicine Service
NSP	Needle and Syringe Programme
NUMSAS	NHS Urgent Medicine Supply Advanced Service
OHID	The Office for Health Improvement and Disparities, formerly PHE
ONS	Office for National Statistics
PCT	Primary Care Trust
PHA	Public Health Agreements – contracts between providers and SCC
PHE	Public Health England
PNA	Pharmaceutical Needs Assessment
PSNC	Pharmaceutical Services Negotiating Committee
PURM	Pharmacy Urgent Medicines
SAC	Stoma Appliance Customisation Service
SCC	Surrey County Council
SLA	Service Level Agreement
UKHSA	UK Health Security Agency
UTI	Urinary Tract Infection

Executive summary

Purpose

From the 1 April 2013 Health and Wellbeing Boards (HWBs) in England have had a statutory responsibility to publish and keep up to date a pharmaceutical needs assessment (PNA).

The PNA provides a statement of need for pharmaceutical services for the population of the area covered by that HWB.

The PNA should describe services provided. It should also describe the access, in terms of time and place, that local residents have to those services. The PNA must relate to all the pharmaceutical services that may be provided under arrangements made by NHS England (NHSE).

The PNA provides useful information about how pharmacies might be better used to contribute to addressing the health needs of the local population.

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The PNA is also an essential part of the process of making decisions about market entry for new service providers. Under [The National Health Service \(NHS\) Pharmaceutical and Local Pharmaceutical Services Regulations 2013](#)¹, a person who wishes to provide NHS pharmaceutical services must apply to NHSE to be included on an NHS pharmaceutical list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA.

The PNA is required to be robust and of a sufficiently high standard to withstand any legal challenges that may occur on the commissioning decisions made on pharmaceutical services in reference to this document.

The PNA is not intended to describe the quality of services provided.

The legislation, The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, Section 6, as amended, states that any HWB that has published a pharmaceutical needs assessment before 1 July 2020 must publish a revised assessment by October 2022. This was amended due to the impacts of the COVID-19 pandemic. The lifetime of this PNA will be three years from the 1 October 2022 until the 30 September 2025.

Process

The Surrey HWB delegated responsibility for overseeing the production of the Surrey PNA to the Surrey PNA steering group consisting of key professionals from the Surrey Local Pharmaceutical Committee (LPC), Surrey Local Medical Committee (LMC), Integrated Care Board (ICB), NHSE regional representative, Surrey public health leads, communications team and Healthwatch.

The previous PNA was reviewed and any required changes to content and structure were determined. An assessment of the coverage of pharmaceutical services was made. Analysis of data was conducted to identify gaps in service provision and opportunities to secure improvements or better access to pharmaceutical services. Pharmacies were also mapped to see where they might be able to impact on local health need. Data is presented for the 11 local authorities (districts and

¹ [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Legislation](#)

boroughs) within Surrey, each represented on the HWB. Surveys were carried out to seek views on pharmaceutical service provision from those delivering services as well as consulting with the public on their experience of provision.

The PNA draft was published for a minimum 60-day formal consultation between the period of 13 May to 12 July 2022 to seek views of the public and other stakeholders to ensure the PNA is reflective of the needs of the Surrey population. The report on the consultation is included in Section 9.0 of this document. The final PNA report was presented to the Surrey Health and Wellbeing Board for sign off and published by the 1 October 2022.

Context

This PNA recognises the important role of community pharmacies and the changes to their way of working throughout the pandemic. This PNA acknowledges that the next three years will be a period of changing policy context for community pharmacies.

At a local level, from April 2022, new pharmacy contracts were rolled out in Surrey through the dynamic purchasing system (DPS) contracting system.

Nationally, the 2022 Health and Care Act² was passed in April 2022. The Act introduced legislative measures that aim to make it easier for health and care organisations to deliver joined-up care for people who rely on multiple different services³. Following changes brought about by the 2022 Health and Care Act, Integrated Care Systems (ICSs) have been formalised as statutory bodies. ICSs are partnerships of NHS bodies and local authorities, working with other relevant local organisations, that come together to plan and deliver joined up health and care services to improve the lives of people in their area. Each ICS has an integrated care board (ICB), which is a statutory NHS organisation responsible for developing a plan in collaboration with NHS trusts/foundation trusts and other system partners for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the defined area⁴.

Clinical commissioning groups (CCGs) were formally closed on 1 July 2022 when ICBs were established on a statutory basis. ICBs will take on delegated responsibility for pharmaceutical services. Throughout the document, this PNA has adopted the term ICB to replace CCG in line with this change, however it is important to note that the PNA has been written based on services commissioned by the CCGs within Surrey that were still in existence during the production period of this PNA. Some services that were commissioned from pharmacies by CCGs in Surrey will move to the two ICBs that now cover Surrey (Surrey Heartlands Integrated Care Board and Frimley Integrated Care Board) and those services will therefore fall within the definition of 'enhanced services' in future. Such services are currently summarised under 'other NHS services' in this PNA.

During the period of public consultation on the draft of this PNA report, NHSE published the '[Next steps for integrating primary care: Fuller stocktake report](#)', looking at what is working well, why it's working well and how, in the face of current challenges in primary care, we can accelerate the implementation of integrated primary care by working with partners across health and care, to best meet the needs of their local communities. The report was undertaken by Dr Claire Fuller (Chief Executive-designate Surrey Heartlands ICS and GP on integrated primary care) and lays emphasis

² [Health and Care Act 2022](#)

³ [The Health and Care Act 2022: our work to inform and make sense of the legislation, The King's Fund](#)

⁴ [NHS England - Integrated care in your area](#)

on the essential role of primary care and the potential of integrated neighbourhood teams in reducing the burden of ill health and tackling health inequities.

It commends community pharmacy for keeping 'its doors open to the public throughout' the pandemic whilst being 'among the most recognizable of a multitude of dedicated staff delivering care around the clock in every neighbourhood in the country'. The report highlights 'recruitment and retention challenges across the wider primary care workforce' including in community pharmacies.

The report calls for integrated neighbourhood 'teams of teams' to evolve from primary care networks and highlights the importance of community pharmacy teams in urgent care and prevention, including early diagnosis of cancers. The NHS Community Pharmacist Consultation Service (CPCS) was launched in October 2019 and is an example of the changing roles of pharmacies. The service takes referrals to community pharmacies from the NHS 111 call service, 111 online and GP practices. The CPCS is intended to relieve pressure on the wider NHS by connecting patients with NHS 111, as their first resort for repeat medications where the patient has run out of medication and for health consultations NHS 111 and GP surgeries.

The Fuller Report points out that pharmacists could play 'a more active role in signposting eligible people to screening and supporting early diagnosis, building on a number of successful pilots such as those from the Accelerate, Coordinate, Evaluate programme'⁵.

Key findings and recommendations

Schedule 1 to the NHS Regulations (2013) as amended, require the PNA to make statements in relation to identifying:

- gaps in current provision (Paragraphs 2(a) and 4(a)), and,
- future provision (Paragraphs 2(b) and 4 (b)),

of services that are either necessary or would provide improvements and better access for Surrey residents.

This PNA has assessed whether the current and future pharmacy provision meets the health and wellbeing needs of Surrey's population. It has also determined whether there may be gaps, needs for improvements, or better access in the provision of pharmaceutical services within the lifetime of this PNA (three years from 1 October 2022 until 30 September 2025).

There are 195 community pharmacies located within Surrey's HWB area and 87 pharmacies located within a one-mile radius of the Surrey border.

The conclusion of this PNA is that there are no gaps in **necessary services** in Surrey. The number, distribution and choice of pharmaceutical services meets the current needs of Surrey's population and future needs foreseen within the lifetime of this PNA.

There are no identified needs for **additional pharmaceutical services**, or enhancements to current arrangements across the county that would secure **improvements or better access to services**.

⁵ [Next steps for integrating primary care: Fuller stocktake report](#)

The PNA noted that current **locally commissioned services** (provided by Surrey public health and the ICBs) provide an improvement to pharmaceutical provision for the population of Surrey.

Population growth and the proposed housing developments in each locality (district and borough) across Surrey is not expected to exceed the needs that can be managed by existing providers during the life time of this PNA, however recognising the potential for change due to proposed large scale housing developments in Surrey, it is recommended that the PNA Steering Group should review actual increases in population and housing and the implications of any increases on an annual basis, publishing their findings in a PNA supplementary statement.

1.0 Introduction

Every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to assess the need for pharmaceutical services in its area and to publish (and keep up to date) a statement of its assessment; this is termed a pharmaceutical needs assessment (PNA) (as per Section 128A of the National Health Service Act 2006 (NHS Act 2006), amended by the Health and Social Care Act 2012).

From 1 April 2013 the Health and Social Care Act 2012 transferred responsibility for developing and maintaining PNAs from primary care trusts (PCTs) to HWBs. The National Health Service (NHS) Pharmaceutical Services and Local Pharmaceutical Services Regulations 2013⁶ set out the legislative basis for developing and updating PNAs. The PNA must contain the information set out in Schedule 1 of The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, this relates to all of the pharmaceutical services that may be provided under arrangements made by NHSE for:

1. the provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list.
2. the provision of local pharmaceutical services under a Local Pharmaceutical Services (LPS) scheme (but not LP services⁷ which are not local pharmaceutical services); or
3. the dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NHS services that may be provided under arrangements made by the National Health Service Commissioning Board (NHSCB) with a dispensing doctor).

1.1 Purpose of the pharmaceutical needs assessment

If a person (a pharmacist, a dispenser of appliances, or in some circumstances (and normally in rural areas) a GP) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and held by NHS England (NHSE). This is commonly known as the NHS 'market entry' system⁸.

Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHSE from 1 April 2013. Under the NHS Regulations (2013), a person who wishes to provide NHS pharmaceutical services must generally apply to NHSE to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA. There are exceptions to this, such as applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance-selling (internet or mail order only) basis. The PNA is therefore required to be robust and of a high standard to withstand legal challenges that may occur to the decisions made on commissioning pharmaceutical services.

⁶ [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Legislation](#)

⁷ 'LP services' is a legal term. NHS England has powers to include in LPS contracts other NHS services or other wider services, such as services relating to the provision of education and training. However, including those other services in an LPS contract turns those services into 'LP services' but it does not turn them into 'local pharmaceutical services'.

⁸ Regulations and regulatory matters. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. PSNC. Available from: <http://psnc.org.uk/contract-it/pharmacy-regulation/>

The PNA also gives an opportunity for the HWB to understand how pharmacies might better contribute to the health needs of the local population through identifying gaps in access or the potential to improve the health of the local population through more targeted interventions.

1.2 Pharmaceutical services

The services that a PNA must include are defined within both the National Health Service Act 2006 and the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended. Pharmaceutical services may be provided by:

- A pharmacy contractor who is included in the pharmaceutical list for the area of the HWB
- A pharmacy contractor who is included in the LPS list for the area of the HWB
- A dispensing appliance contractor who is included in the pharmaceutical list held for the area of the HWB and
- A doctor or GP practice that is included in the dispensing doctor list held for the area of the HWB

NHSE is responsible for preparing, maintaining and publishing these lists. In Surrey, there are 195 community pharmacies, plus three internet/ distance selling pharmacies, two dispensing appliance contractors, and 15 dispensing GP practices (this figure includes branch practices) as at December 2021.

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Pharmacy contractors may operate as either a sole trader, partnership, or a body corporate and The Medicines Act 1968 governs who can be a pharmacy contractor.

1.2.1 Pharmaceutical services provided by pharmacy and dispensing appliance contractors

Unlike for GPs, dentists, and optometrists, NHSE does not hold contracts with the majority of pharmacy and dispensing appliance contractors. Instead, pharmacy providers provide services under a contractual framework, sometimes referred to as the Community Pharmacy Contractual Framework (CPCF), details of which (the terms of service) are set out in schedule 4 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended, and also in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013. The dispensing appliance contractors' terms of service are set out in schedule 5 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulation 2012, as amended and the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013.

The CPCF for 2019/20 to 2023/24 (published in July 2019) is NHSEs latest statement of what is expected of pharmacists providing NHS services. This framework has been designed to support delivery of the [NHS Long Term Plan](#). Under the CPCF pharmacy contractors can provide three main types of services that fall within the definition of NHS pharmaceutical services and are all commissioned by NHSE: essential, advanced, and enhanced. These services can be complemented by services commissioned locally.

1.2.1.1 Essential services

All pharmacies, including distance selling premises, are required to provide 'essential services'. As of October 2021, there are eight essential services, these services are outlined below and described in more detail in section 4.

(i) dispensing of prescriptions i.e., medicines and appliances.

(ii) dispensing of repeat prescriptions i.e., prescriptions which contain more than one month's supply of drugs on them. For example, an electronic repeatable prescription may say that the prescription interval is every 28 days, and it can be repeated six times. This would give a patient approximately six months' supply of medication, dispensed every 28 days with the prescriber only needing to authorise them once.

(iii) disposal of unwanted medicines returned to the pharmacy by someone living at home, in a children's home, or in a residential care home.

(iv) promotion of healthy lifestyles, which includes providing advice to people who appear to have diabetes, be at risk of coronary heart disease (especially those with high blood pressure), or smoke, or are overweight, and participating in up to six health campaigns were requested to do so by NHSE.

(v) signposting people, who require advice, treatment or support that the pharmacy cannot provide, to another provider of health or social care services, where the pharmacy has that information.

(vi) support for self-care which may include advising on over the counter medicines or changes to the person's lifestyle.

(vii) discharge medicines service, which was introduced from February 2021.

Dispensing appliance contractors have a narrower range of services that they must provide.

- Dispensing of prescriptions.
- Dispensing of repeat prescriptions.
- For certain appliances, offer to deliver them to the patient (delivering in unbranded packaging), provide a supply of wipes and bags, and provide access to expert clinical advice.
- Where the contractor cannot provide a particular appliance, signposting or referring a patient to another provider of appliances who can.

(viii) Healthy Living Pharmacy which was introduced from January 2021

The Healthy Living Pharmacy (HLP) framework is aimed at achieving consistent provision of a broad range of health promotion interventions through community pharmacies to meet local need, improving the health and wellbeing of the local population, and helping to reduce health inequalities.

1.2.1.2 Advanced services

Pharmacy and dispensing appliance contractors may choose whether they wish to provide 'advanced services' or not, although they receive remuneration from the NHS if they choose to provide them. If they choose to provide one or more of the advanced services, they must meet certain requirements and must be fully compliant with the essential services and clinical governance and promotion of healthy living requirements. As of October 2021, the following advanced services may be provided by pharmacies:

- Appliance Use Review (AUR)
- New Medicine Service (NMS)
- Stoma Appliance Customisation (SAC)
- Hepatitis C testing service (time limited, will currently end on 31 March 2023)
- Seasonal influenza adult vaccination service
- Hypertension case-finding service
- Community Pharmacist Consultation Service (CPCS)
- In 2021, COVID-19 lateral flow device distribution service and COVID-19 medicines delivery service were also delivered through some community pharmacies.
- Smoking Cessation Service – due to launch as an advanced service on 10 March 2022

There are two appliance advanced services that dispensing appliance contractors may choose to provide:

- Appliance Use Reviews (AUR), and
- Stoma Appliance Customisation (SAC).

1.2.1.3 Enhanced services

'Enhanced services' are the third tier of services that pharmacies may provide, and they can only be commissioned by NHS England. The services that may be commissioned are listed in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 (as amended) which can be found in the Drug Tariff. NHS England commission a bank holiday service across Surrey and COVID-19 vaccinations in selected pharmacies across Surrey.

1.2.1.4 Other NHS services

Other NHS services (often referred to as locally commissioned services when commissioned from pharmacies by local authorities and ICBs), are those services that are provided or arranged (for example the public health services commissioned from pharmacies), locally by NHSE, ICSs, an NHS trust or an NHS Foundation Trust as part of the health service. They are not enhanced services because they are not commissioned by NHSE.

From July 2022 CCGs were replaced by ICBs that will take on delegated responsibility for pharmaceutical services, and from April 2023 NHSE expects all ICBs to have done so. Some services that are commissioned from pharmacies by CCGs in Surrey (and are therefore defined as other NHS services in this section of this PNA document) will move to the ICBs and will fall within the definition of enhanced services in future.

At the time of publication, the current Locally Commissioned Services (LCSs) (Commissioned by Surrey County Council (SCC) Public health from pharmacies) are:

- Emergency Hormonal Contraception (EHC)
- Chlamydia Screening and Treatment
- Needle and Syringe Exchange Scheme
- Supervised Consumption of Prescribed Medicines
- NHS Health Checks
- Take Home Naloxone
- BP Plus programme

At the time of publication, the current LCSs (Commissioned by the ICB) include:

- H. Pylori Testing
- Palliative Care Scheme

Underpinning the provision of all these services is the requirement on each pharmacy contractor to participate in a system of clinical governance and promotion of healthy living. This system is set out within the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended and includes:

- A patient and public involvement programme
- An audit programme
- A risk management programme
- A clinical effectiveness programme
- A staffing and staff management programme
- An information governance programme and
- A premises standards programme

1.3 Surrey's PNA

The aim of this PNA is to review the current pharmaceutical services in Surrey and identify any gaps in provision through assessment, consultation, and analysis of local need. This PNA replaces the assessment undertaken by SCC Public Health in 2018. The lifetime of this PNA will be three years from 1 October 2022 until 30 September 2025.

Surrey Primary Care Trust (PCT) produced the first PNA for Surrey in 2011 and the last complete PNA was published in 2018⁹ by the Surrey HWB. The 2018 PNA (and subsequent supplementary statements) have concluded there were no gaps in nationally commissioned service provision and satisfactory provision of locally commissioned services to meet the needs of the population. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013¹⁰, Part 2, Regulation 6 state the HWB must publish a statement of its revised assessment within three years of its previous publication of a PNA, however, the COVID-19 pandemic has put pressure on the caring services and the cycle of PNA publication was interrupted in 2021. Surrey issued an additional supplementary statement in April 2021¹¹ due to the COVID-19 pandemic leading to delays in the publication of the full PNA. The supplementary statement did not highlight any additional needs created by changes in service provision as outlined in Table 1 below. The legislation, [The NHS \(Pharmaceutical and Local Pharmaceutical Services\) Regulations 2013](#), was amended due to the

⁹ [Surrey Pharmaceutical Needs Assessment 2018](#)

¹⁰ [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Legislation](#)

¹¹ Surrey [Pharmaceutical needs assessment supplementary statement 2021](#)

impacts of the pandemic; with the [new guidance](#) requiring that HWBs must publish a revised PNA by 1 October 2022.

Table 1: Community pharmacy changes January 2021 to December 2021

Year	New contracts issued	Pharmacy closure	Pharmacy change of hands	Pharmacy relocation	Pharmacy change in opening hours
2021	0	4	9	2	11

Source: Surrey [Pharmaceutical needs assessment supplementary statement 2021](#)

1.3.1 Current context

1.3.1.1 Impact of the COVID-19 pandemic

The current PNA has been undertaken following a period of two years impacted by the COVID-19 pandemic, which has had a considerable effect on pharmacies being able to deliver services in the usual way.

The multiple impacts of the pandemic on pharmacies have been summarised in a Debate Paper by Kulakiewicz and Macdonald¹² for the House of Commons Library. The paper sets out that community pharmacies have remained open to customers throughout the periods of national lockdown and restrictions, employing preventive measures, such as mask-wearing, social distancing, use of hand gel and protective Perspex screens to do so. However, the challenges of the pandemic have meant that pharmacies have been less able to implement new initiatives. As commercial businesses, pharmacies have also experienced financial pressures, and there is concern that many will not be able to pay back the loans provided by the government to them as a means of temporary support. There have also been challenges to pharmacies in maintaining staff-levels due to illness, in keeping the physical environment secure, and in dealing with an increase in abusive behaviour from customers.

Pharmacies have been more involved in providing remote consultations (by telephone or sometimes video link) and in supplying repeat prescriptions when GP services have also been suffering pressures. All pharmacy contractors have been asked by NHSE to support the delivery of medicines to vulnerable patients shielding at home, but this has been considered a temporary measure.

Community pharmacies have also been involved during the pandemic in supporting victims of domestic abuse. The 'Ask for ANI' (Action Needed Immediately) scheme was launched in January 2021. By asking for ANI, a trained pharmacy worker can be alerted to offer a private space where they can understand if the victim needs to speak to the police or would like help to access support services such as national or local domestic abuse helplines. This scheme has been run in many Boots pharmacies as well as other providers.

¹² Kulakiewicz A and Macdonald M, 'Pharmacy and the impact of COVID-19', House of Commons Library Debate Pack Number CDP-0028, 10 March 2021.

Throughout 2021, some pharmacies have been able to carry out vaccination against COVID-19 where a need was identified, and all pharmacies that are NHS contractors have been asked to supply rapid test (lateral flow) kits. As a profession, pharmacists have experienced increased pressures on their pharmacies during this time.

1.3.1.2 The NHS Long Term Plan

In January 2019, NHSE published the NHS Long Term Plan¹³ setting out its priorities for healthcare for the coming 10 years. For the year 2019-2020, every NHS Trust, NHS Foundation Trust and ICBs were required to agree organisation-level operational plans which combined to form a system-level operating plan. The five major practical advances in the NHS service model were described as follows:

- Boosting of hospital care to dissolve the divide between primary and community health services.
- Redesigning and so reducing pressure on emergency hospital services.
- More personalised care to help people gain greater control over their health when they need it.
- Digitally enabled primary and outpatient care.
- Increasing focus on population health and local partnerships through ICSs.

The rationale of an ICS is to create a local health and care community in which all health and care services in an area are working together in an integrated and harmonious way. The advent of ICSs will have far-reaching consequences for all aspects of health services including pharmaceutical services, though ICS plans across the country are still in gestation and will take time to implement. A number of implications for pharmaceutical services are highlighted in the NHS Long Term Plan, although it should be noted that these are still proposals at this stage:

- The NHS 111 helpline should book GP appointments and also refer callers to community pharmacies for support with self-care.
- The creation of Pharmacy Connection Schemes for patients who do not need primary medical services.
- More support to all care home residents in line with the Enhanced Health in Care Homes model with pharmacist-led reviews.
- The funding for the new primary care networks, clusters of GP practices working together as described in Chapter Two, will be used to expand substantially the number of pharmacists working in general practices and other environments, such as care homes.
- The NHS should work with government to make greater use of community pharmacists' skills and their opportunities to engage patients.
- Up to 10% of hospital admissions in the elderly are medicines-related, so pharmacists should routinely work in general practice helping to relieve pressure on GPs and supporting care homes.

¹³ [The NHS Long Term Plan](#)

- About 50% of patients are not taking medicines as intended and pharmacists should support patients to achieve the best from medicines.

In January 2019, NHSE also published a five-year framework for GP services which implements commitments in the NHS Long Term Plan for changes to GP contracts and services over five years.

1.3.1.3 New dynamic purchasing contracts in Surrey from April 2022

From April 2022, there will be new pharmacy contracts rolled out in Surrey through the dynamic purchasing system (DPS) contracting system. Currently (at the time of publishing) 60 pharmacies have signed up to the DPS in Surrey, and 128 pharmacies are not yet on the DPS, as such their public health agreements (PHAs) were extended. The DPS will be reopened again to allow new entrants, so it is likely that the number of pharmacies signed up to the new contracting system will change throughout 2022/2023 and the lifetime of this PNA.

1.3.2 Methodology

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The PNA has largely followed the same methodology as the previous iteration of the document in 2018¹⁴. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013¹⁵, were used to inform the process along with the guidance document published by the Department for Health and Social Care (DHSC) in October 2021¹⁶.

This PNA has drawn on primary sources of information which have been used to inform current and future population needs and the current provision of pharmaceutical services in meeting these needs. These sources include NHSE; NHS Digital; The Office for Health Improvement and Disparities (OHID); The Office for National Statistics (ONS); SCC; The Surrey Joint Strategic Needs Assessment (JSNA); public survey on pharmaceutical service provision; community pharmacy and dispensing doctor's surveys on pharmaceutical service provision.

¹⁴ [Surrey Pharmaceutical Needs Assessment 2018](#)

¹⁵ [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Legislation](#)

¹⁶ [Pharmaceutical needs assessments: information pack](#)

1.3.3 Production of the PNA

The Surrey HWB delegated responsibility for overseeing the production of the Surrey PNA to the Surrey PNA steering group consisting of key professionals. The PNA was produced through several key steps which are outlined below:

- Review of Surrey's 2018 PNA¹⁷ and any supplementary statements, the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013¹⁸, and subsequent amendments.
- Consideration of pharmaceutical service provision against local health needs, local pharmaceutical service changes and any recent or future planning for housing developments.
- Assessment of pharmaceutical services and activity provided (essential, advanced, enhanced and other NHS services (locally commissioned)) to enable comparison nationally and locally, and mapping of service provision including travel time to identify any service gaps.
- A survey of the Surrey Citizen's Panel, as well as targeted circulation of the questionnaires to assist in reaching seldom heard and more deprived audiences.
- A survey to contracted pharmaceutical services, and dispensing GPs.
- This PNA consultation draft was published for a minimum 60-day formal consultation between the period of May to July 2022 to seek views of the public and other stakeholders to ensure the PNA is reflective of the needs of the Surrey population.

1.3.3.1 Localities

The Surrey HWB area, which is coterminous with Surrey County, covers 11 district and borough councils (this PNA uses the term local authorities to refer to the 11 districts and boroughs in Surrey), one ICS in its entirety (Surrey Heartlands ICS) and part of one ICS (Frimley Health and Care). The Surrey ICS structures are complex and contain place-based partnerships or alliances within them. No ICS and no place-based alliance within Surrey is entirely coterminous with its local authority boundaries.

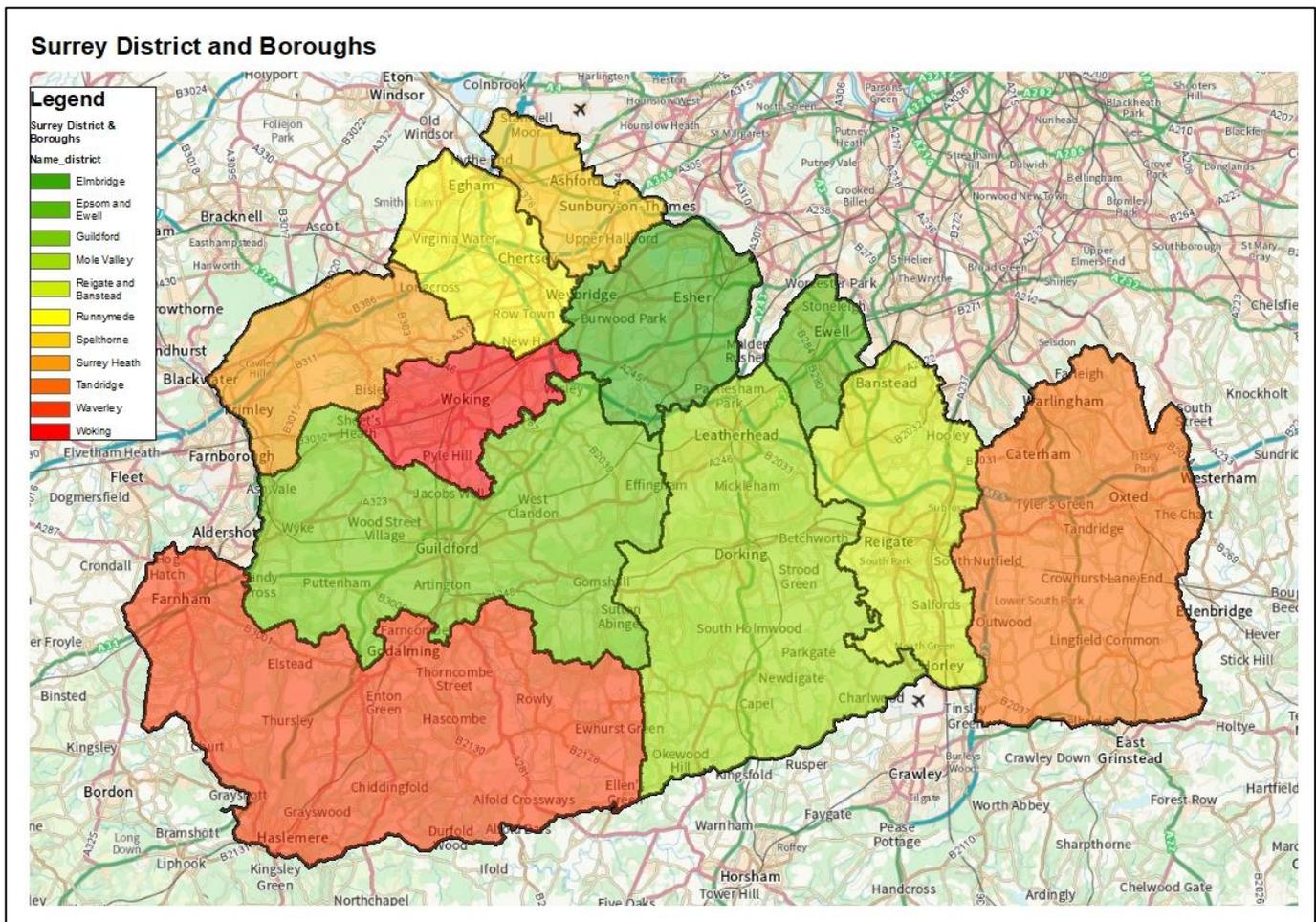
Regulation 9 of The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013¹⁹ and Paragraph 6 of Schedule 1, require the HWB to divide its area up into localities. Localities chosen should not be so large that they mask variations in need and the Regulations state that they must allow the PNA to have regard to the different needs of the different localities. The PNA steering group has chosen to use the 11 district and borough councils (referred to as local authorities) within Surrey as the localities in this PNA as there is an appropriate amount of data available at this level to allow an adequate assessment of the different needs of areas and the needs of relevant commissioning partners. These localities are shown in Figure 1.

¹⁷ [Surrey Pharmaceutical Needs Assessment 2018](#)

¹⁸ [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Legislation](#)

¹⁹ [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Legislation](#)

Figure 1: Surrey local authority councils



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1.3.4 Structure of the PNA

The first section of this document defines the purpose of a PNA and defines the different types of pharmaceutical services followed by an overview of the process of developing the PNA. This includes the establishment of a steering group and the governance of the document, data collection and analysis, collation of pharmaceutical services information and engagement with both contractors and the general public.

In Section 2.0 the need for pharmaceutical services across Surrey is then assessed using a summary of data about people and places in Surrey, including known housing development or regeneration projects that are current or will occur within the lifespan of the PNA. Further consideration of this data for each local authority is included in Appendix A. Section 3.0 considers local health needs in relation to pharmaceutical services and wider determinants of health. Section 4.0 details current pharmaceutical service provision, activity, and services across the county. Access is then considered in terms of opening hours and geographical access. Sections 5.0, 6.0, and 7.0 present the findings from surveys of the public, and community pharmacists and dispensing doctor contractors. Section 8.0 contains a summary of the conclusions and recommendations, and Section 9.0 contains the consultation report.

2.0 Surrey people and place

Surrey is one of the most prosperous counties in England with a mid-year 2020 resident population of 1,199,000, which has increased by 1.9% since 2018. The largest local authorities by population are Guildford (150,352) and Reigate and Banstead (149,243) and the smallest is Epsom and Ewell (81,003). Surrey residents generally have very good health, and the average healthy life expectancy is one of the longest in the country. Surrey residents also do well on aspects of life which we know contribute to health and wellbeing, such as employment and education.

The Index of Multiple Deprivation (IMD) 2019 is the official measure of relative deprivation for small areas in England. The majority (68.5%) of lower super output areas (LSOAs) in Surrey are in the least deprived deciles (eight, nine, and ten). LSOAs (Lower-layer Super Output Areas) are small areas designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. Although the majority of the population live in less deprived areas, there are still health inequalities within Surrey which mean that some areas are at risk of poor health outcomes. In some areas, people have poorer life chances, poorer health outcomes, and greater health care use. Existing health inequalities have been further highlighted and, in some cases, increased due to the impacts of COVID-19. Four (0.6%) areas are in decile two (with no areas in decile one). These are parts of Westborough and Stoke wards (in Guildford), Hooley, Merstham and Netherne ward (Reigate & Banstead) and Canalside ward (Woking). The IMD is considered in further detail in Section 3.

The demography of Surrey, along with planned housing and developments, and the needs of those sharing a protected characteristic as defined in the Equality Act 2010 are considered in this section. Further information including age, gender, ethnicity, and birth rates is provided in Appendix A for each of the 11 local authorities in Surrey. This section applies Census data from 2011 (the latest available) to the mid-year 2020 population estimates, to provide updated figures based on the more current population numbers. Surrey's future JSNA²⁰ work will include updated data once the 2021 Census data is published, and future supplementary statements will consider the 2021 census data once available.

²⁰ [Surrey JSNA](#)

2.1 Protected characteristics and population groups

The following sections consider the populations sharing protected characteristics in Surrey.

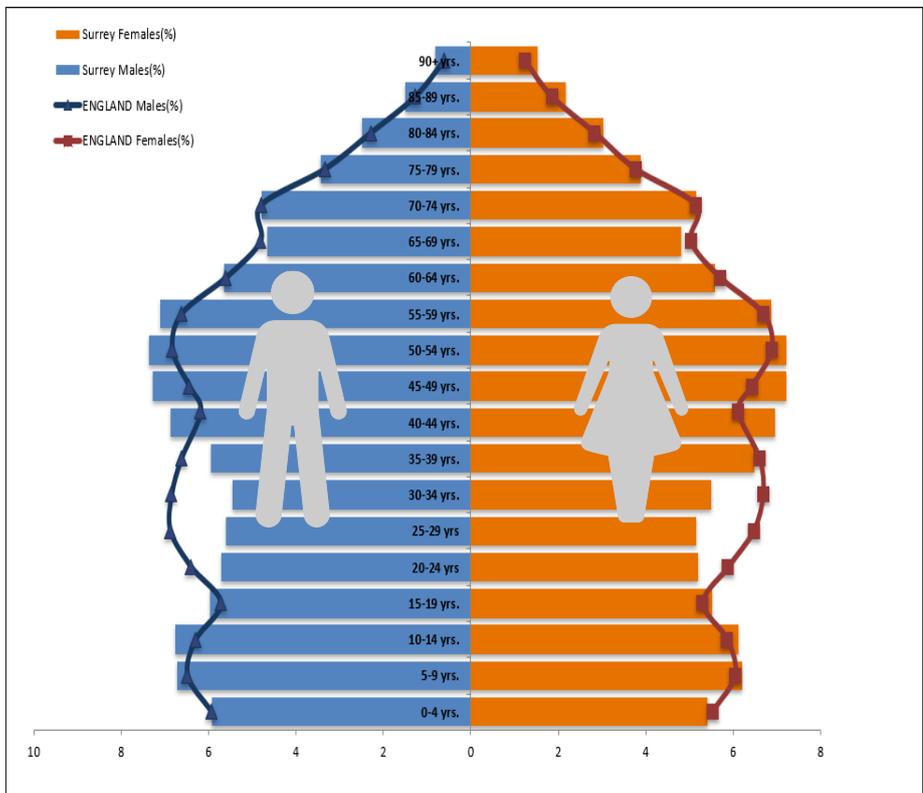
2.1.1 Population – age and sex

Figure 2 below, compares Surrey’s population with that of England. The proportion of males and females in Surrey is similar to the England average, with similar proportions of people aged 19 and under and 60 years and older. Surrey has a significantly lower proportion of males and females aged 20 to 39 and a slightly higher proportion of males and females aged 40 to 59 compared with the England average. Over half (61.1%) of the population of the 11 local authorities is of working age (16 to 64).

Older people use health and social care services more intensively than any other population groups. This means that the absolute number of older people in Surrey, as well as the percentage of the total population, has strong implications for the planning and need for pharmaceutical services.

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Figure 2: Surrey's population pyramid showing percentage breakdown of each gender by age group



Source: ONS Mid-year estimates, 2020

2.1.2 Ethnicity and Race

The most recent data on ethnicity uses 2011 census data applied to the mid-year 2020 population to estimate ethnicity by area. The table below shows that the Surrey population is predominantly white (90.4%), followed by 5.6% of the population reporting their ethnicity as Asian (within which more detailed ethnicity was reported as 'Indian' (1.8%) followed by 'Pakistani' (1.0%)), 2.1% reporting mixed ethnicity and 1.1% reporting their ethnicity as black. A small proportion (0.2%) of the population described themselves as Gypsy or Irish Traveller, making it the smallest reported ethnic category (with a tick box) in the 2011 Census. However, it is widely believed that the Gypsy, Roma, and Traveller community is under reported in the census. Surrey has a higher proportion of white population compared to England and the lowest proportion of black residents compared to the South East region and England.

Table 2: Percentage of population in Surrey, by broad ethnicity category, 2011 percentages to latest population estimates

Area	Population mid-year 2020	White %	White Number	Mixed %	Mixed Number	Asian %	Asian Number	Black %	Black Number	Other %	Other Number
England	56,550,138	85.4	48,293,818	2.3	1,300,653	7.8	4,410,911	3.5	1,979,255	1.0	565,501
South East	9,217,265	90.7	8,360,059	1.9	175,128	5.2	479,298	1.6	147,476	0.6	55,304
Surrey	1,199,870	90.4	1,084,682	2.1	25,197	5.6	67,193	1.1	13,199	0.8	9,599

Source: ONS 2020, Census 2011, Nomis

Table 3 shows that Woking is the most diverse local authority in Surrey with 16.5% of its population from Asian, black, mixed and other ethnic groups. Waverley is the least diverse with 96% of the population reporting their ethnicity as white. More people in Surrey (6.9%) were recorded in other white ethnic groups than in England (5.7%) with fewer (9.6% compared with 14.6%) in all other ethnic groups. Census data also shows that a larger majority of the population aged 65 and over in Surrey identified as white British compared to younger population groups in Surrey.

The older population is less diverse than the younger cohorts in Surrey; the majority of people aged 65 and older are white British with under 3% from other ethnic groups. The highest proportion of Asian ethnicities (other than Indian and Pakistani) are in young adults aged 16 to 24 and the proportion of mixed/multiple ethnic groups is highest among children under 16²¹.

²¹ [Surrey JSNA – Context chapter](#)

Table 3: Percentage of population in each local authority in Surrey, by broad ethnicity category, 2011

Area	Population mid-year 2020	White	White	Mixed	Mixed	Asian	Asian	Black	Black	Other	Other
		%	Number	%	Number	%	Number	%	Number	%	Number
Elmbridge	137,215	90.3	123,850	2.6	3,581	5.4	7,423	0.8	1,057	1.0	1,317
Epsom & Ewell	81,003	85.9	69,573	2.6	2,074	8.6	6,991	1.5	1,215	1.4	1,150
Guildford	150,352	90.9	136,685	1.8	2,736	4.8	7,247	1.2	1,819	1.2	1,864
Mole Valley	87,547	95.1	83,231	1.5	1,287	2.5	2,232	0.5	411	0.4	385
Reigate & Banstead	149,243	90.6	135,214	2.2	3,283	5.1	7,567	1.6	2,343	0.6	821
Runnymede	90,327	89.0	80,364	2.1	1,879	6.9	6,242	1.1	966	1.0	876
Spelthorne	99,873	87.3	87,189	2.5	2,487	7.6	7,620	1.6	1,618	1.0	959
Surrey Heath	89,204	90.2	80,453	1.9	1,686	6.3	5,584	1.0	892	0.7	598
Tandridge	88,542	93.8	83,079	2.2	1,913	2.6	2,311	1.1	939	0.3	301
Waverley	126,556	96.0	121,506	1.3	1,696	1.9	2,379	0.4	557	0.3	430
Woking	100,008	83.6	83,607	2.4	2,350	11.6	11,551	1.4	1,390	1.1	1,100

Source: ONS 2020, Census 2011, Nomis

Although the proportion of the population from black, Asian and minority ethnic groups is smaller in Surrey than in the country as a whole, it is essential to work across partner organisations to ensure that the needs of these small communities and individuals are appropriately met. Some minority ethnic groups may be seldom heard because of language or differences in culture which contribute to inequalities. The movement of Gypsy, Roma and Traveller community may also influence the ability of health services to reach and meet needs of this group. Levels of trust in different communities regarding healthcare and providers, different cultural patterns and behaviours may influence the experience of pharmaceutical services for residents from different ethnicity groups in Surrey.

2.1.3 Languages spoken

In the 2011 Census, nearly 65,000 Surrey residents reported that they speak a language other than English as their main language. The most common other languages spoken in Surrey were Polish (6,634 speakers) and Chinese languages (4,426 speakers). Most of those who spoke another main language, reported that they can speak English 'well' or 'very well', but nearly 6,500 people cannot speak English well and a further 1,000 reported that they cannot speak English at all in Surrey.

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Table 4 shows the proportion of Surrey's population whose main language is not English, broken down, by local authority. The highest number of people whose main language was not English live in Woking, and Woking also has the highest proportion of people who reported that they cannot speak English well (1.3%) or at all (0.6%), followed by Epsom and Ewell. Language is also very important in communicating health information, and may be a barrier to understanding, in populations where proficiency in English is not as high as others.

Table 4: Proficiency in English of the population in Surrey whose main language spoken is not English, by local authority

Area Name	Speak English very well (%)	Speak English well (%)	Do not speak English well (%)	Cannot speak English (%)
Elmbridge	3.73	2.12	0.60	0.10
Epsom & Ewell	3.81	2.64	0.83	0.15
Guildford	3.88	2.89	0.58	0.06
Mole Valley	1.78	1.17	0.33	0.04
Reigate & Banstead	2.76	1.60	0.52	0.09
Runnymede	4.34	2.88	0.76	0.08
Spelthorne	3.28	2.30	0.67	0.10
Surrey Heath	2.83	1.79	0.47	0.09
Tandridge	1.49	0.98	0.23	0.03
Waverley	1.85	1.21	0.27	0.05
Woking	4.90	3.64	1.33	0.24

Source: Census 2011

2.1.4 Religion or belief

Surrey's JSNA²² shows that the most common religion in Surrey is Christianity, with almost two thirds (62.8%) of the population, followed by almost a quarter of the population (24.8%) reporting no religion. Islam (2.2%) and Hinduism (1.3%) were the next most common religions in Surrey. Younger people are more likely to have no religion than older people in Surrey.

Religion and beliefs can influence attitudes towards medicine and health care. There can also be concerns about discrimination that affect trust about how people of different religions and beliefs would be treated in different health care settings.

2.1.5 Disability

The day-to-day activities of 13.5% of Surrey's population are limited by a long-term health problem or disability. The activities of 5.7% of people in Surrey are limited 'a lot' (Census 2011²³).

There are approximately 21,800 adults with learning disabilities and 9,086 autistic adults in Surrey, of whom 4,655 and 2,071 respectively are aged over 65. Approximately 4,500 adults will have both a learning disability and autism²⁴.

Disability (including physical, sensory, learning disability and long-term mental illness) has a significant impact on how people access health services. The NHS implemented the Accessible Information Standard in 2016 to ensure that communication needs of patients with a disability were met.

2.1.6 Gender reassignment

A published report on transgender experiences in 2018 highlights that a significant number of trans people face inequalities and discrimination when accessing healthcare services²⁵. This may impact on pharmaceutical services for people sharing this protected characteristic.

2.1.7 Marriage and civil partnership

In Surrey the majority of people aged 16 and older were living in a couple (63%) and 37% were not living in a couple. The term 'living in a couple' includes people who are living together in a couple and are either married, in a same-sex civil partnership, or are cohabiting with a partner of any sex.

2.1.8 Sexual orientation

In England 94.4% of people identified as heterosexual/straight (with 2.2% identifying as gay, lesbian or bisexual). The 2019 ONS annual population survey found 1.6% of people in the South East identified as gay or lesbian, 1.3% bisexual, 1.4% responded other and 2.8% answered don't know or declined to answer. This is a similar picture to what was seen nationally, although the data for

²² [Surrey JSNA – Context chapter](#)

²³ [Surrey JSNA – Context chapter](#)

²⁴ [Surrey JSNA – Context chapter](#)

²⁵ [Stonewall LGBT in Britain - Trans Report](#)

people in Surrey is not known. These surveys focused on sexuality rather than gender identify, in Surrey a survey is being developed to better understand the needs and experiences of LGBTQIA+ (lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual and other identities) people. Evidence suggests LGBTQIA+ people have disproportionately worse health outcomes and experiences of healthcare and can experience more health inequalities when accessing health services in England²⁶.

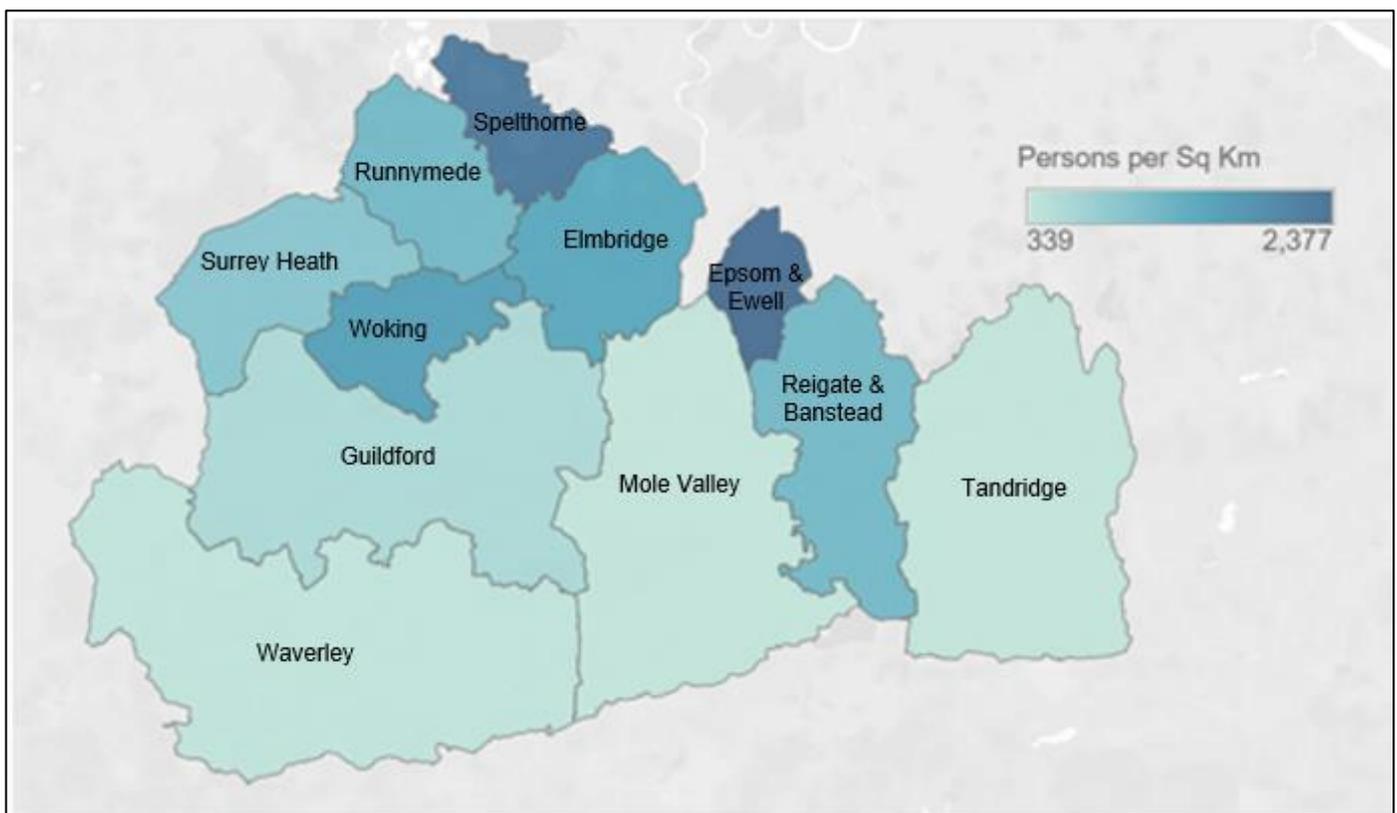
2.2 Demography

2.2.1 Population density

Surrey is one of the most densely populated shire counties in England with 721.7 people per square kilometre, significantly higher than the national average of 434.1. The most densely populated local authorities are Epsom & Ewell and Spelthorne, and the least are Mole Valley, Tandridge and Waverley (see Figure 3 below). Figure 4 shows further detail about the population density within the wards within each of the 11 localities; the most densely populated wards are within Epsom & Ewell and Spelthorne, but also within Guildford, Woking and Reigate and Banstead.

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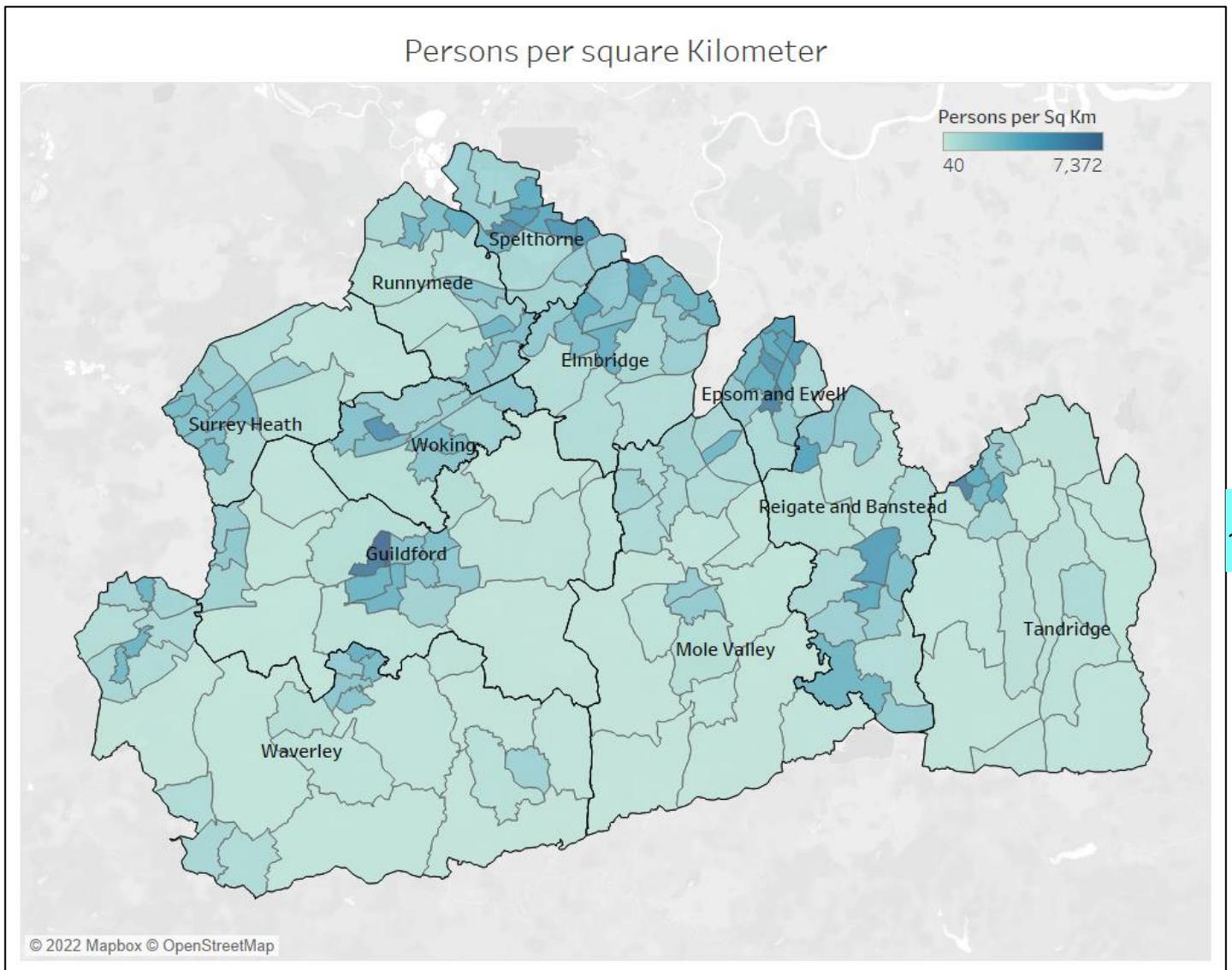
Figure 3: Population density by local authority (persons per square kilometre)



Source: ONS Census 2011

²⁶ [Sexual orientation health inequality: Evidence from Understanding Society, the UK Longitudinal Household Study](#)

Figure 4: Population density by ward (persons per square kilometre)

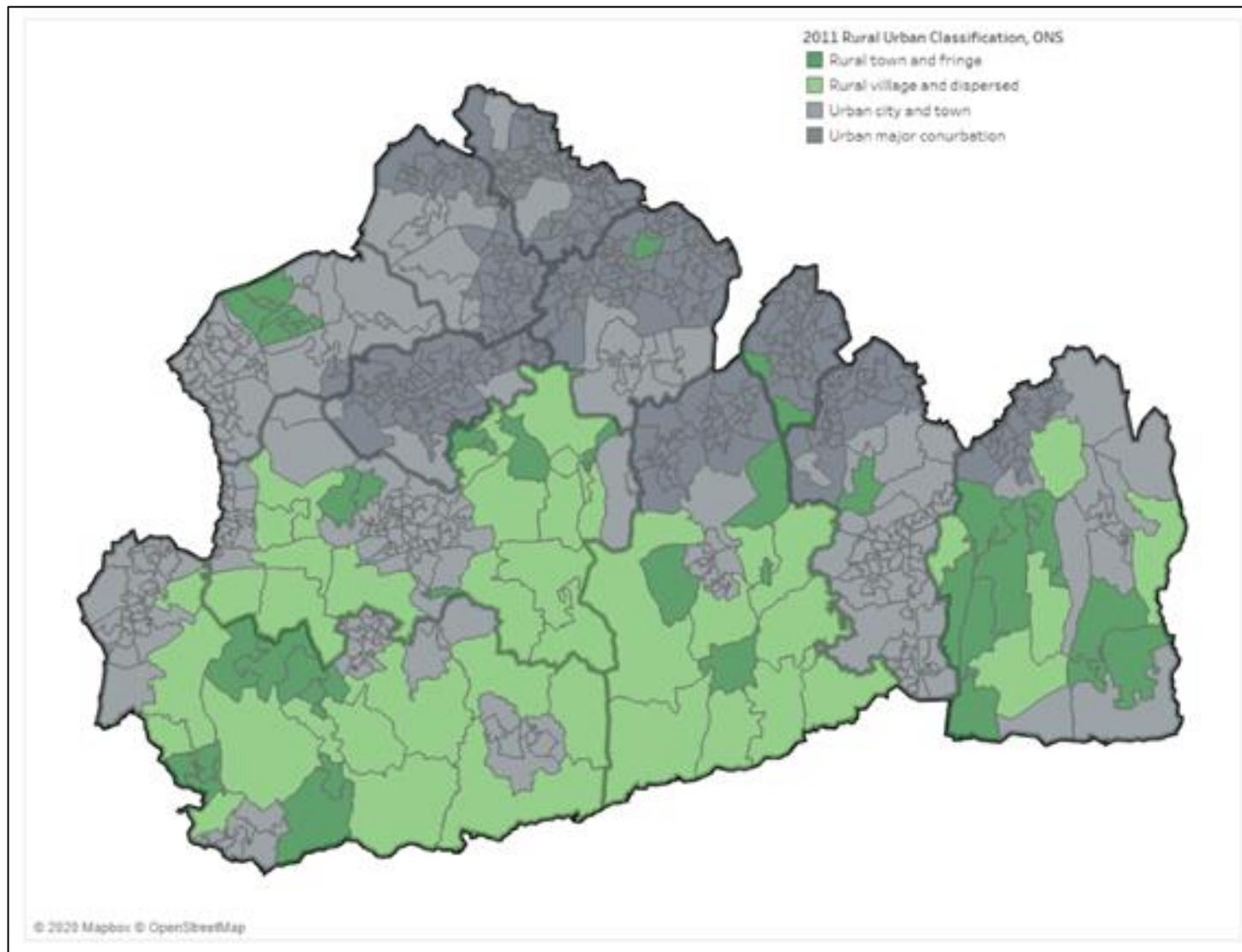


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2.2.2 Rural and urban population

Surrey has a complex geography with a mixture of rural, semi-rural and urban areas. Waverley is a largely rural local authority, Mole Valley and Tandridge are urban areas with significant rural areas, Surrey Heath, Reigate and Banstead and Guildford are urban areas with cities and towns, while Elmbridge, Epsom and Ewell, Woking, Runnymede, and Spelthorne are urban areas with major conurbations (see Figure 5 below).

Figure 5: Map of Surrey lower super output areas by urban/rural classification



Source: ONS Census 2011

2.2.3 Population projections

Over the next three years during the lifetime of this PNA, between 2022 and 2025, the population of Surrey is predicted to increase by 0.5%. The population aged 65 and over is expected to experience the biggest increase of 4.5%, while the 0 to 14 and 30 to 44 age cohorts are predicted to decrease in Surrey. The increase in the population groups aged 45 and over is likely to impact on healthcare services due to increased risks of developing long term conditions such as cardiovascular disease.

Table 5: Population projections for Surrey and England over the lifetime of this PNA (2022 to 2025)

Age band	2022	2025	Population Change in Surrey	Population Change in Surrey (%)	Population Change England (%)
0 to 14	220,256	213,986	-6,270	-2.8	-1.5
15 to 29	195,700	199,565	3,866	2.0	1.2
30 to 44	223,185	217,160	-6,026	-2.7	1.0
45 to 64	327,550	330,809	3,259	1.0	0.6
65 & Over	235,815	246,521	10,706	4.5	5.6
All ages	1,202,505	1,208,041	5,536	0.5	1.4

Source: ONS 2018 based subnational population projections

Looking over 10 years, the Surrey population is projected to increase by 1.3% between 2020 and 2030. The 65 and over age group continues to experience the largest increase in population with an estimated rise equating to an increase of around 40,300 people. The second largest increase will be among young people aged 15 to 29 years.

Table 6: Ten-year population projections for Surrey and England

Age band	2020	2030	Population Change in Surrey	Population Change in Surrey (%)	Population Change England (%)
0 to 14	222,078	201,776	-20,302	-9.1	-5.1
15 to 29	195,174	206,509	11,335	5.8	4.8
30 to 44	224,794	208,784	-16,009	-7.1	2.2
45 to 64	324,865	325,541	676	0.2	0.6
65 & Over	230,043	270,338	40,296	17.5	20.9
All ages	1,196,953	1,212,948	15,995	1.3	4.4

Source: ONS 2018 based subnational population projections

10

2.2.4 Housing constrained population projections

Housing constrained population projections give an estimate of population growth based on assumptions of fertility, mortality, migration and dwelling formation rates provided by ONS and Department for Communities and Local Government (DCLG) projections but constrained to expected housing development provided by local authorities. Therefore, it is considered to be a more realistic projection based on the accommodation of a projected population increase.

Numbers and percentages are presented in Table 7 by local authority. Housing constrained population growth is expected to be highest in Runnymede (7.7%) in 2025 and Epsom & Ewell (11.4%) in 2030. Among Surrey local authorities Runnymede is expected to grow the most by 2025 and Guildford by 2030 in terms of absolute numbers.

Table 7: Housing constrained population projections 2020 to 2030

Area name	2020	2025	2030	Number change 2020-25	% change 2020 to 25	Number change 2020 to 30	% change 2020 to 30
Elmbridge	135,590	138,260	140,360	2,670	2.0	4,770	3.5
Epsom & Ewell	83,810	88,870	93,330	5,060	6.0	9,520	11.4
Guildford	153,340	159,910	166,430	6,570	4.3	13,090	8.5
Mole Valley	86,920	88,070	89,330	1,150	1.3	2,410	2.8
Reigate & Banstead	149,820	154,580	158,740	4,760	3.2	8,920	6.0
Runnymede	89,180	96,060	97,450	6,880	7.7	8,270	9.3
Spelthorne	101,630	103,430	105,330	1,800	1.8	3,700	3.6
Surrey Heath	90,650	93,280	94,550	2,630	2.9	3,900	4.3
Tandridge	89,970	93,940	97,880	3,970	4.4	7,910	8.8
Waverley	132,160	137,470	139,500	5,310	4.0	7,340	5.6
Woking	102,350	104,850	106,800	2,500	2.4	4,450	4.3
Surrey	1,215,430	1,258,740	1,289,690	43,310	3.6	74,260	6.1

Forecasts created using POPGROUP population forecasting model July 2017 using 2016 Mid-Year Estimate as base. Based on assumptions of fertility, mortality, migration and dwelling formation from ONS/DCLG 2012 based projections. Constrained to expected housing development provided by local authorities as of May 2022

2.2.5 Households in Surrey

Household projections are based on a set of assumptions, the size and structure of the population and the population patterns of household information. These projections are based on the 2018-based subnational population projections, population estimates for England and Wales: mid-2001 to 2018 and Census 2021 data.

The number of dwellings since the 2018 PNA has increased by 2.1% (9,995) in Surrey. Woking has seen the largest percentage growth 4.9% (1,940), followed by Spelthorne 4.2% (1,667) and Surrey Heath 3.9% (1,352). Woking (1,940), Waverley (1,919) and Spelthorne (1,667) have grown the most in terms of absolute numbers.

Table 8: Change in the number of households, by local authorities, 2018 to Census 2021

Area Name	2018	Census 2021	Difference 2018 to 2021	% Change 2018 to 2021
Elmbridge	54,373	55,600	1,227	2.3
Epsom & Ewell	31,149	31,300	151	0.5
Guildford	56,064	55,800	- 264	-0.5
Mole Valley	36,979	37,100	121	0.3
Reigate & Banstead	58,598	59,800	1,202	2.1
Runnymede	34,591	34,800	209	0.6
Spelthorne	40,133	41,800	1,667	4.2
Surrey Heath	34,648	36,000	1,352	3.9
Tandridge	35,329	35,600	271	0.8
Waverley	50,481	52,400	1,919	3.8
Woking	39,460	41,400	1,940	4.9
Surrey	471,805	481,800	9,995	2.1

Source: ONS, 2018, Census 2021

2.3 Planned housing growth

In previous iterations of the Surrey PNA, the PNA Steering Group has agreed that a planned development of 4,000 to 5,000 population or around 2,000 homes is indicative of a need for additional pharmacy provision and should therefore be included in the PNA.

The steering group have been monitoring the proposed Deepcut redevelopment of the Princess Royal Barracks which straddles the boundaries of Surrey Heath and Guildford Borough Councils, the development at Meath Green Lane in Horley and other developments in Ash.

Below is a summary of the known housing plans in each of the local authorities, which may reach close to 2,000 new dwelling over the lifetime of this PNA.

2.3.1 Elmbridge

Elmbridge borough council have confirmed that there are no proposed or planned individual housing developments of over 2000 dwellings during the lifetime of this PNA.

2.3.2 Epsom & Ewell

Epsom & Ewell borough council have confirmed that there are no proposed or planned individual housing developments of over 2000 dwellings currently underway.

2.3.3 Guildford

Guildford Borough Council have confirmed there are no proposed or planned individual housing developments of over 2000 dwellings during the lifetime of this PNA. They have noted four sites which should be considered in future:

1. Blackwell Farm, Hogs back, to the West of Royal Surrey Hospital and Surrey Research Park – anticipated delivery of 1500 units 2026 to 27 to 2035 to 36
2. Gosden Hill in Burpham, center of the borough – anticipated delivery of 1600 units 2026 to 27 to 2037 to 38
3. Weyside Urban Village (formerly Slyfield Regeneration Project) – anticipated delivery of 1500 units 2023 to 24 to 2031 to 32
4. Wisley Airfield – anticipated delivery of 2000 units 2026 to 27 to 2035 to 36

Further detail on each of the sites can be found in Appendix 2 of the Guildford Borough Council Land Availability Assessment²⁷.

2.3.4 Mole Valley

Mole Valley District Council have confirmed that there are no proposed or planned individual housing developments of over 2000 dwellings. The Leatherhead/Ashted area, however, is projected to exceed the figure of 2,000 homes over the period of the new local Plan (2020 – 2037) through proposed allocations, planning consents and projected windfall.

Once the homes are built, review of this development should be undertaken through the mechanism of supplementary statements – to consider the number of homes likely to be built during the lifetime of this PNA.

²⁷ [Land Availability Assessment - Guildford Borough Council](#)

2.3.5 Reigate & Banstead

Reigate and Banstead Borough Council have confirmed that the largest development in Reigate and Banstead is at Westvale Park, within the Horley area, which has planning consent for a total of 1,510 residential units. The completions on site started in February 2017 and to date, there is a total of 976 completed dwellings, leaving 534 dwellings still to come forward.

2.3.6 Runnymede

Runnymede Borough Council have confirmed that there are no proposed or planned individual housing developments of over 2000 dwellings during the lifetime of this PNA. The Longcross Garden Village is due to have 1,778 units delivered over the next 10 years.

2.3.7 Spelthorne

10 Spelthorne council have confirmed that there are no proposed or planned individual housing developments of over 2000 dwellings during the lifetime of this PNA. The Steering Group should monitor whether the cumulative developments across Staines Town Centre may amount to over 2,000 new dwellings through the mechanism of supplementary statements and in future PNAs.

2.3.8 Surrey Heath

In the 2018 PNA the Deepcut re-development of the Princess Royal Barracks was noted, this site is now referred to as 'Mindenhurst'. There are approximately 340 new homes currently with planning permission on site that are being built-out. It is expected that these will be completed within the next three years. Surrey Heath's housing trajectory projects delivery of approximately 107 new homes per year going forward until the development is completed.

2.3.9 Tandridge

Tandridge does not currently have any applications for housing developments of over 2,000 dwellings. The Council has an emerging Local Plan²⁸ that is currently undergoing examination. The Plan sets out a new development strategy for the district to provide homes within the Plan period up to 2033, including the development of a new South Godstone Garden Community. Review of the Local Plan and further housing developments should be undertaken through the mechanism of supplementary statements and in future PNAs.

²⁸ [Our Local Plan 2013-2033](#)

2.3.10 Waverley

In Waverley, Policy SS7 of Waverley's Local Plan Part One allocated Dunsfold Aerodrome for 2,600 homes. The Dunsfold Park housing development site in Stovolds Hill Cranleigh already benefits from a hybrid planning permission which grants outline permission for 1,800 dwellings on site and 7,500 sqm of care accommodation. The delivery rates during the lifetime of this PNA indicate that by 2025 under 1,000 dwellings may be built, however development of up to 2,000 dwellings may be complete by 2032. Review of this development should be undertaken through the mechanism of supplementary statements and in future PNAs.

2.3.11 Woking

Woking Borough Council do not have any sites allocated in the borough for developments of 2,000 homes or above on a single site during the lifetime of this PNA. Taking into account cumulative planned development in the Town Centre and West Byfleet District Centre growth areas, projections sum to just above 1,000 dwellings.

However, Woking has been awarded Housing Infrastructure Funding to deliver additional homes in the Town Centre and is currently preparing a Town Centre Masterplan to guide this extra development which may enable the delivery of up to 3,304 extra town centre homes above existing Development Plan commitments, by 2030. This is across 13 sites in the Town Centre. If these plans are successful, then, cumulatively, this may trigger a need for a new pharmacy in the Town Centre of Woking. Review of this development should be undertaken through the mechanism of supplementary statements and in future PNAs.

Currently, none of the approved planning and development estimates exceeds the benchmark of 2,000 homes indicating a need for additional pharmacies during the lifetime of this PNA. However, the PNA steering group have agreed to review these developments once the homes are built through the mechanism of supplementary statements.

2.4 Key findings & recommendations

- Surrey has an ageing population with the 65 and over age cohort estimated to have the highest growth between 2020 and 2030 (17.5%). This increase ranges from 14.6% in Runnymede to 21.7% in Elmbridge. This is likely to impact on future healthcare demand.
- Surrey Heath is projected to see a 33.1% increase in the over 85 age cohort between 2020 and 2030.
- Mole Valley has a higher number of those aged over 65 living on their own (14.7%) in comparison to Surrey (12.6%) and England (12.4%) averages.
- Surrey has a greater proportion of people in the 40 to 59 age cohorts in comparison to England but a smaller proportion between 20 and 39.
- Surrey has a predominantly white population (90.4%) followed by Asian (5.6) and mixed ethnicities (2.1%). Woking has the highest proportion of Asian population (11.6%) and Elmbridge has the highest proportion of mixed (2.6%) population, which could impact on the prevalence of some long term health conditions in these areas

- A number of planned housing developments are underway across Surrey, varying in size but not exceeding 2,000 dwellings over the next three years. Cumulative developments in growth areas may start to reach over 2,000 dwellings in some areas in future years.

Recommendation: Recognising the potential for change in local populations due to proposed large scale housing developments in Surrey, the PNA Steering Group should review actual increases in the population and the implications of any increases on an annual basis and publish their findings in a PNA supplementary statement.

3.0 Local health needs

The following sections sets out local health needs relevant to local pharmaceutical provision.

3.1 Health in Surrey

3.1.1 Life expectancy and good health

Surrey has a higher proportion of people who report being in good or very good health compared with England at all ages. The lowest proportion is reported in those aged 65 and older (61.2%). In males across Surrey, life expectancy at birth ranges from 79.7 in Woking to 82.1 in Elmbridge (2020), in females it ranges from 83.0 in Woking to 85.6 in Waverley, and all areas have a higher life expectancy than England males (78.7) and females (82.6). The inequality in life expectancy at birth is highest in males in Tandridge (8.1 years) and in females in Waverley (8.0 years) – this measure represents the range in years of life expectancy across the social gradient from most to least deprived, based on a statistical analysis of the relationship between life expectancy and deprivation across all deprivation deciles.

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3.1.2 Mortality

The leading causes of mortality in Surrey (2020) were: dementia and Alzheimer's disease (13.79%), COVID-19 (11.46%), ischaemic heart diseases (7.97%), cerebrovascular diseases (4.71%) and malignant neoplasm of trachea, bronchus and lung (3.86%)²⁹. The under 75 mortality rate from causes considered preventable is 105.9 per 100,000 in Surrey. This ranges from 115.9 per 100,000 people in Woking to 95.0 per 100,000 people in Waverley, and is lower than England (140.5 per 100,000) and the South East region (120.7 per 100,000). The concept of 'preventable mortality' is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could mainly be avoided through effective public health and primary prevention interventions³⁰.

3.1.3 Long term conditions

Pharmacists have an important role in helping people manage their long-term conditions and medication in the community. The New Medicine Service (NMS) is an advanced service within the CPCF. Among other things, the aims of the NMS are to:

- improve patient adherence which will generally lead to better health outcomes;
- increase patient engagement with their condition and medicines, supporting patients in making decisions about their treatment and self-management;

²⁹ Office for national statistics (ONS) [Mortality statistics – underlying cause, sex and age](#)

³⁰ Public health outcomes framework indicator: [Under 75 mortality rate from causes considered preventable \(2019 definition\)](#) One year range

- reduce medicines wastage; and
- reduce hospital admissions due to adverse events from medicines³¹.

Specific medical conditions were initially selected to be included in the delivery of the NMS by a Reference Group which included the PSNC, NHS Employers, NICE and the DHSC. From 1 September 2021, the following conditions are covered by the NMS service:

- Acute coronary syndromes
- Antiplatelet/anticoagulant therapy
- Atrial fibrillation
- Asthma and chronic obstructive pulmonary disease(COPD)
- Diabetes (Type 2)
- Epilepsy
- Glaucoma
- Gout
- Heart failure
- Hypertension
- Hypercholesterolaemia
- Long term risks of venous thromboembolism/embolism
- Osteoporosis
- Parkinson's disease:
- Stroke / transient ischemic attack and coronary heart disease (CHD)
- Urinary incontinence/retention

3.1.4 Asthma

In Surrey, in people aged under 19 years there are 46.7 hospital admissions for asthma per 100,000 which compares with 54.7 per 100,000 people in the South East region and 74.2 per 100,000 in England.

The areas with higher asthma prevalence tend to be in the more rural parts of the county and may not have community pharmacies within their immediate area. Pharmacies can assist with inhaler technique and work with patients to successfully manage their condition in the community. There appears to be a mismatch between areas of greater need and availability of community pharmacies.

3.1.5 Chronic obstructive pulmonary disease

Chronic Obstructive Pulmonary Disease (COPD) is a common disabling condition with a high mortality. The most effective treatment is smoking cessation. Oxygen therapy has been shown to prolong life in the later stages of the disease and has also been shown to have a beneficial impact on exercise capacity and mental state. Some patients respond to inhaled steroids. Many patients

³¹ New Medicine Service (NMS). PSNC. Available from: [PSNC Commissioning Services - Advanced Services](#)

respond symptomatically to inhaled beta agonists and anti-cholinergics. Pulmonary rehabilitation has been shown to produce an improvement in quality of life.

The prevalence of COPD in Surrey Heartlands is 1.3% (14,325 people) (as recorded on practice disease registers 2020/21). In 2019/20 there were 243 per 100,000 emergency hospital admissions for COPD in Surrey, ranging from 172 per 100,000 in Elmbridge, to 278 per 100,000 in Guildford.

3.1.6 Diabetes

Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over three million people in the UK having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly patients with Type 2 diabetes is undertaken by the GP and members of the primary care team.

The prevalence of diabetes in Surrey Heartlands is 5.7% (51,164 people aged 17 and older) (as recorded on practice disease registers 2020/21).

3.1.7 Stroke

Stroke is the third most common cause of death in the developed world. One quarter of stroke deaths occur under the age of 65 years. There is evidence that appropriate diagnosis and management can improve outcomes.

The prevalence of stroke in Surrey Heartlands is 1.6% (18,268 people) (as recorded on practice disease registers 2020/21).

3.1.8 Hypertension

The prevalence of hypertension in Surrey Heartlands is 13% (144,624 people) (as recorded on practice disease registers 2020/21).

3.1.9 Multiple morbidity and population aged 75 years and older

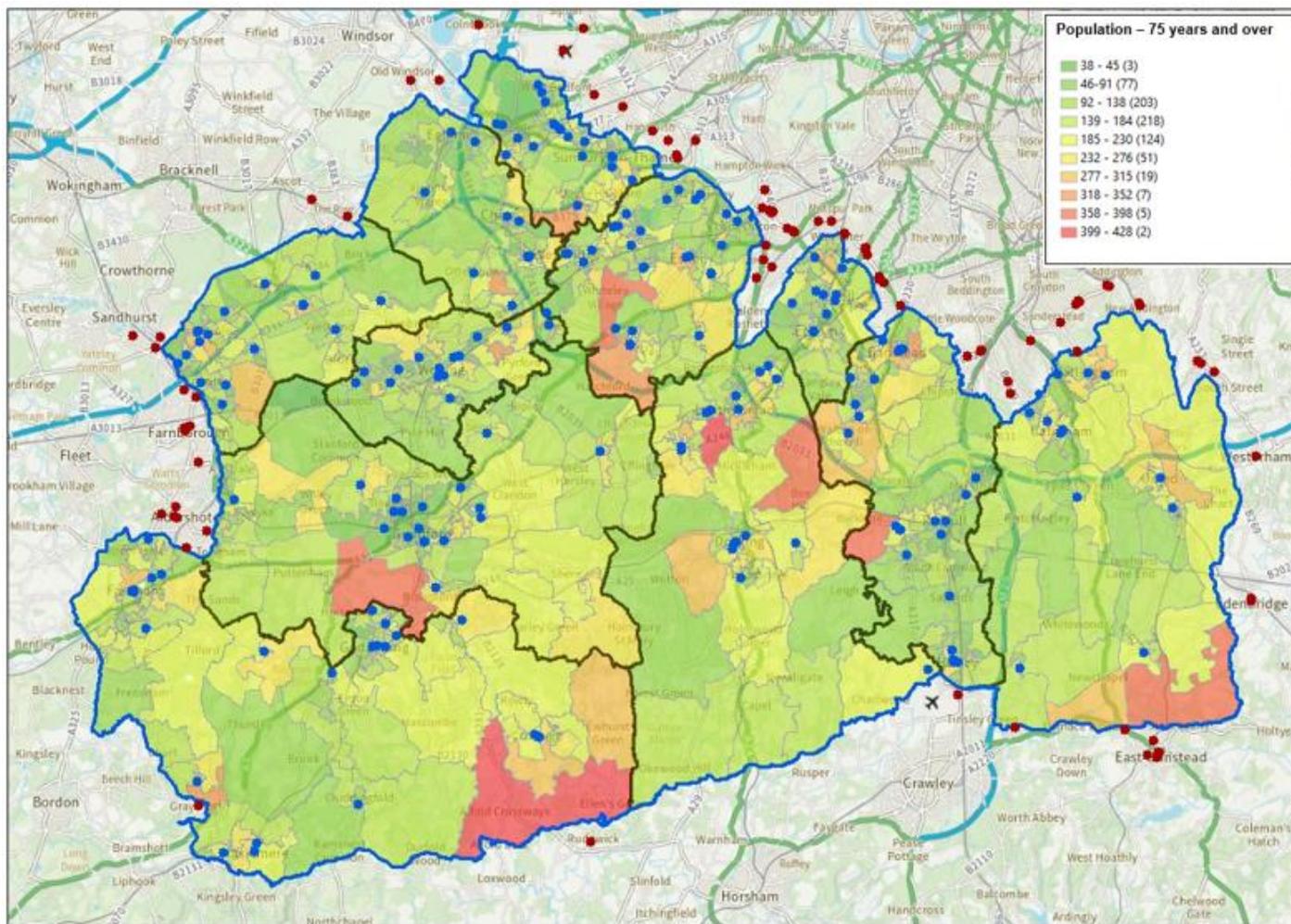
The proportion of the population aged 75 and over is shown as a proxy for multiple morbidity. The choice of the 75 and over age group as a proxy is based on evidence from the JSNA suggesting the prevalence of four morbidities is above 5% of all persons in that age group and are therefore likely to have at least four medicines³². Pharmacists can provide NMS and advice to help people manage their multiple morbidities.

³² JSNA Chapter: Multiple Morbidity and Frailty. Available from: [JSNA: Multiple Morbidity and Frailty](#)

Figure 6 highlights the number of people aged 75 and older, against where community pharmacies are located and where residents with multiple morbidity may find it more difficult to access services further afield.

The map shows that most of the areas with over 300 people aged 75 and over are located within reasonable distance of pharmacies in town centres or other areas. There are two areas with over 399 people in rural parts of Waverley and Tandridge that do not have as many pharmacies available to these populations. However, neighbouring area pharmacies shown on the map and dispensing appliance contractors may be able meet the needs of these populations.

Figure 6: Count of population aged 75+ by LSOA mapped against Surrey community pharmacies



Source: ONS and NHS England

3.2 Wider determinants of health in Surrey

3.2.1 Obesity

In 2019 to 2020 over half (57.8%) of the adult population of Surrey was overweight or obese, but this was a lower proportion than in England as a whole (62.8%) and the South East region (61.5%).

3.2.2 Physical activity

In 2019 to 2020, 70% of adults in Surrey were meeting the national physical activity guideline, while in England 66.4% of adults were attaining the recommended level (at least 150 minutes of moderate intensity activity each week or at least 75 minutes of vigorous intensity activity per week³³). The lowest proportion of physically active adults were in Woking and Reigate and Banstead (both 66%), followed by Runnymede (66.5%) and Spelthorne (66.9%).

In 2020 to 2021, 46.5% of children and young people in Surrey were physically active, which was slightly higher than the England (44.6%) and South East (45.4%) proportion³⁴. The lowest proportion of physically active children and young people were in Woking (40.5%), followed by Tandridge (43.4%) and Epsom and Ewell (43.8%).

3.2.3 Index of multiple deprivation

There is strong evidence of the link between poor health and areas of high material deprivation. The Marmot review 'Fair Society, Healthy lives' observed that health inequalities result from social inequalities. These inequalities result in reduced life expectancy and a greater proportion of life spent living with a disability³⁵. Marmot suggested a number of policy objectives to reduce health inequalities, among them creating and developing healthy and sustainable places and communities and strengthening the role and impact of ill health prevention, both of which pharmacies are well placed to do. Cardiovascular disease is one of the main contributors to health inequalities and pharmacies are contracted by public health to deliver NHS Health Checks and by the hypertension-case finding advanced service as a means of reducing health inequalities by detecting disease at an early stage.

The IMD 2019 measures relative deprivation by small area. It describes how relatively deprived an area is by saying whether it falls among the most deprived 10 percent, 20 percent or 30 percent of LSOAs in England. The LSOAs in Surrey have been ranked from most to least deprived and then split into 10 equal groups or deciles. The IMD is based on various different domains of deprivation to produce an overall index. Maps showing the overall index as well as the health and disability domain of deprivation are presented below.

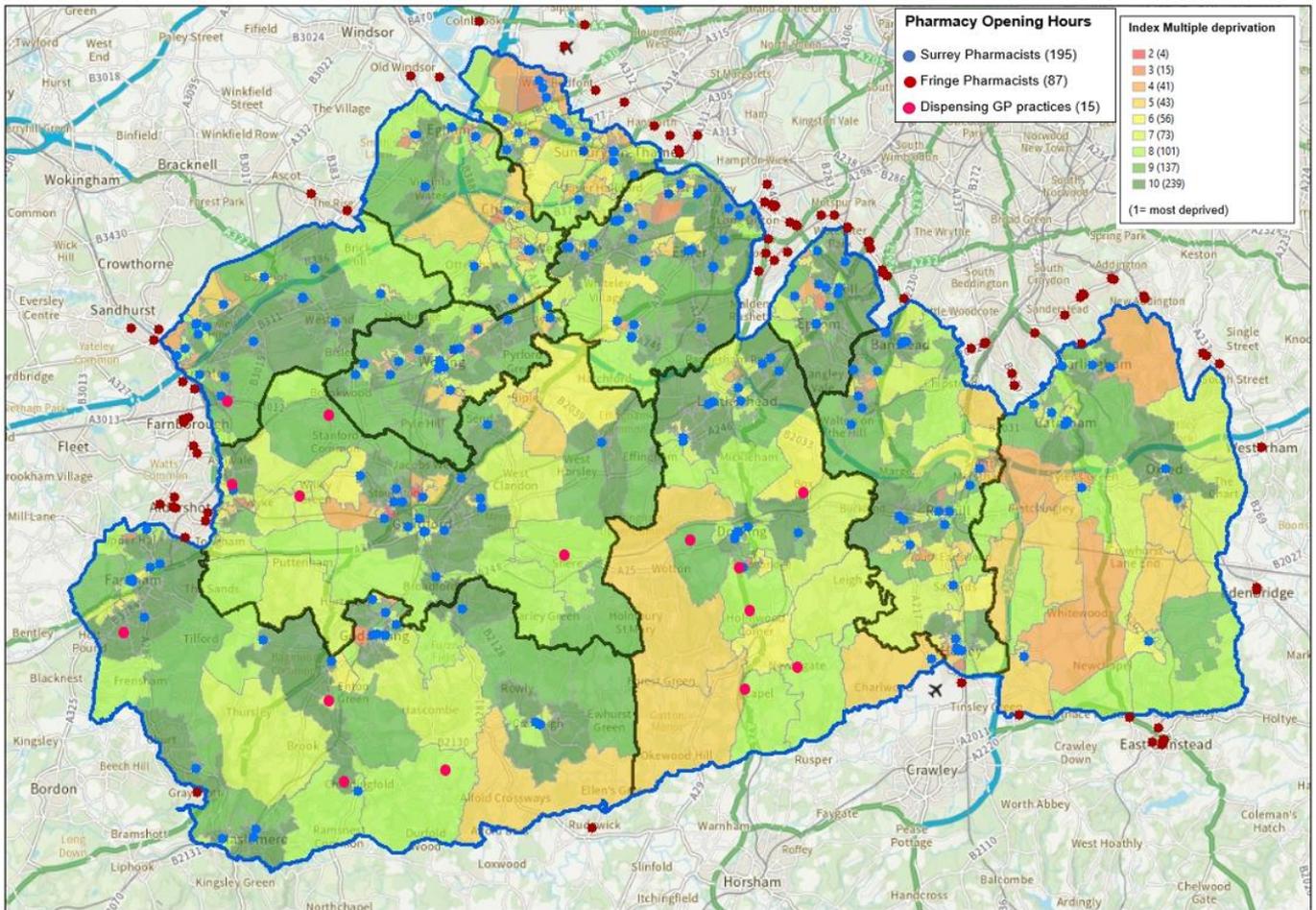
³³ Active Lives Adult Survey, Sport England

³⁴ Active Lives Children and Young People Survey, Sport England

³⁵ Marmot, M; Goldblatt, P; Allen, J et al. Fair Society, Healthy Lives (The Marmot Review). Institute of Health Equity. 2010. Available from: <http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review>

Figure 7 shows the overall index mapped against community pharmacies. There appears to be a mismatch between deprivation and available community pharmacy services particularly in the Southern and South Eastern areas of Surrey, while a few of the most deprived Surrey LSOAs are without a local pharmacy in East Surrey and North West Surrey.

Figure 7: Index of Multiple Deprivation (IMD) overall index decile 2019 by LSOA mapped against Surrey community pharmacies

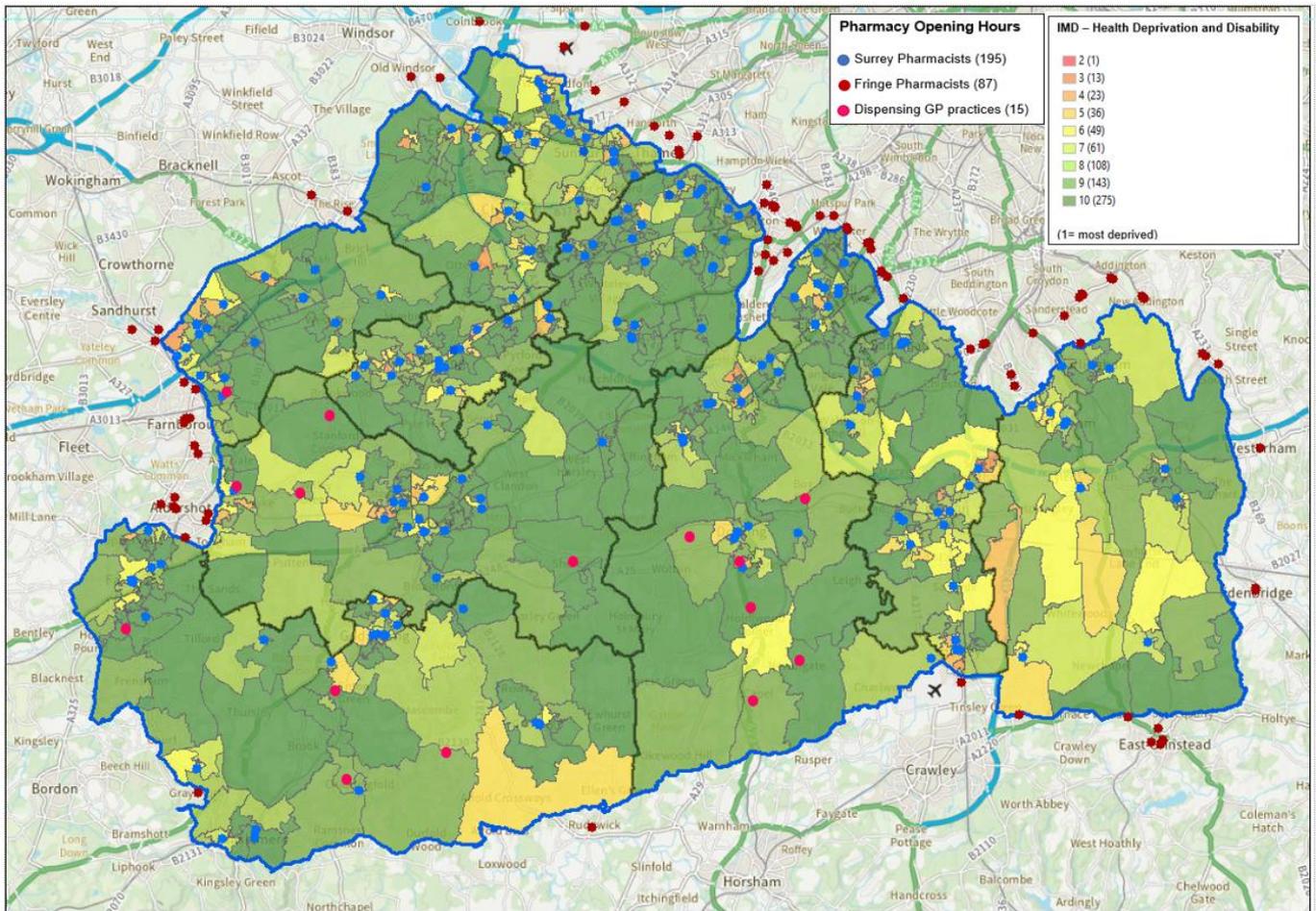


Source: DCLG and NHS England

Mapping the health and disability domain of the IMD also indicates a gap between community pharmacy provision and health deprivation, this time particularly in the South West of the County (Figure 8). Dispensing doctors (shown on both maps) are located in rural areas of the county.

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Figure 8: IMD 2019, Health Deprivation and Disability deciles by LSOA mapped against Surrey community pharmacies



Source: DCLG and NHS England

Additional data on local needs of health and wellbeing can be found in the [Surrey JSNA](#) which is currently undergoing a refresh.

3.3 Key findings and recommendations

Taking into account the locations of dispensing doctors across Surrey, all local health partners should consider how best to ameliorate the impact of poorer access to community pharmacies. This could help address health inequalities in areas of higher multiple deprivation, higher health and disability deprivation, and where there are higher numbers of people aged 75 and over (who are more likely to experience multiple morbidity) in some rural areas in Surrey.

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4.0 Current pharmaceutical service provision

This section covers the location of community pharmacies within the Surrey HWB area and in neighbouring HWB areas in terms of opening times, distance and travel times. It also considers the services provided within the Surrey HWB area. The NHS CPCF covers essential, advanced and other NHS services (and locally commissioned services) as listed in the pharmaceutical services section of the introduction. Pharmacy contractors must provide essential services but can choose to provide advanced, enhanced and locally commissioned services.

Table 9 provides a breakdown of pharmaceutical services provided in Surrey with Figure 9 showing the distribution across Surrey and Surrey local authorities. The map shows that community pharmacies are spread across most of the town centres, and urban areas (towards the north of Surrey and towards London). In more rural local authorities such as Waverley and Mole Valley and parts of Guildford, dispensing doctor practices fill gaps in community pharmacy provision. There are two dispensing appliance contractors (DACs) to the West of Waverley, and three distance selling pharmacies, one each located in Elmbridge, Spelthorne and Woking.

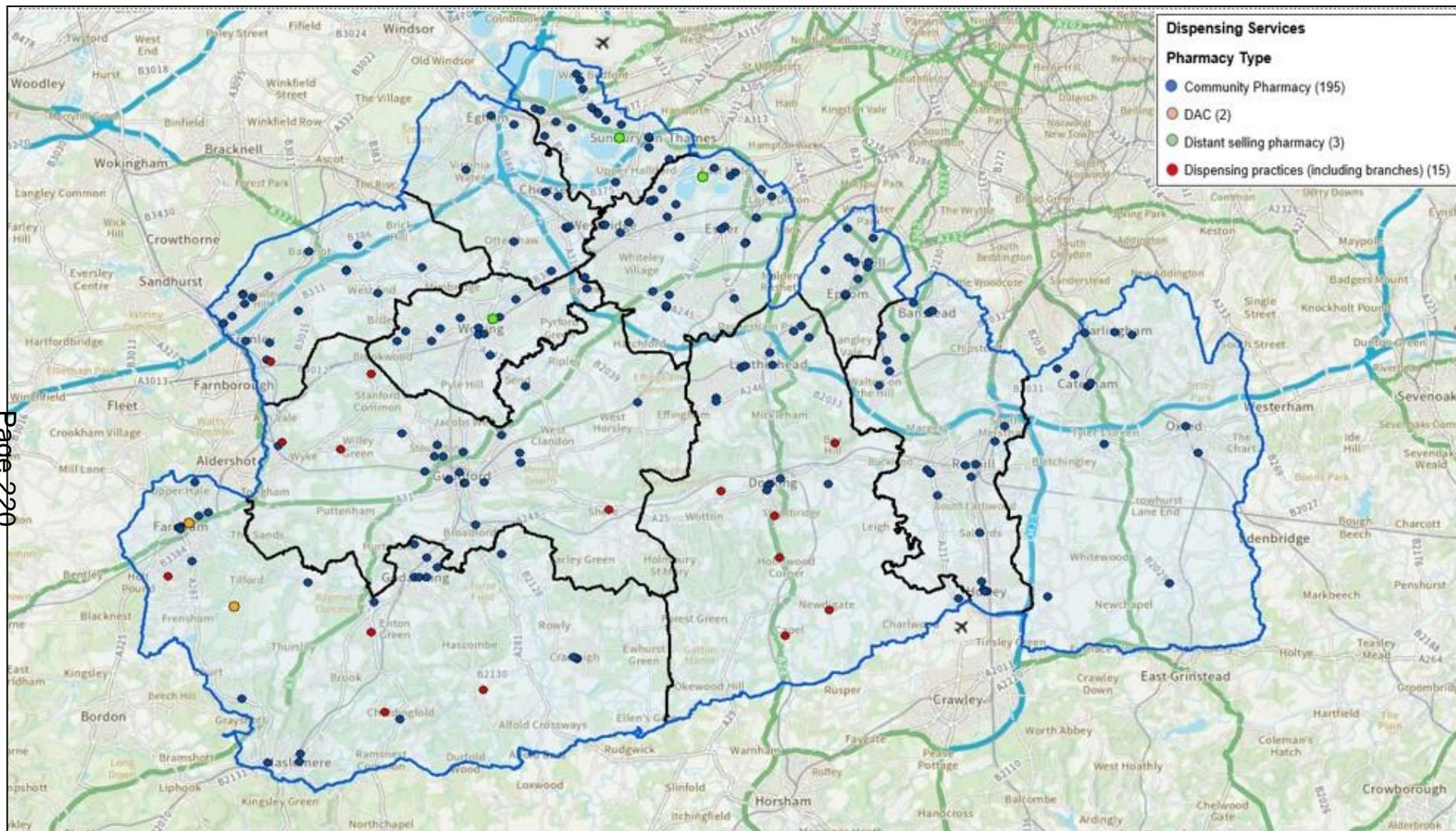
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Table 9: Number of pharmaceutical services in Surrey (December 2021)

Area Name	Community Pharmacies	Internet/ distance selling pharmacy	Dispensing Appliance Contractor (DAC)	Total	Dispensing GP practices (including branch)
Elmbridge	28	1	0	29	0
Epsom & Ewell	11	0	0	11	0
Guildford	18	0	0	18	4
Mole Valley	16	0	0	16	6
Reigate & Banstead	23	0	0	23	0
Runnymede	12	0	0	12	0
Spelthorne	20	1	0	21	0
Surrey Heath	17	0	0	17	1
Tandridge	14	0	0	14	0
Waverley	24	0	2	26	4
Woking	12	1	0	13	0
Surrey	195	3	2	200	15

Source: NHSE

Surrey Pharmaceutical Needs Assessment 2022
Figure 9: Pharmaceutical provision in Surrey (December 2021)



Page 220

Source: NHS England; Dispensing Doctors' Association

4.1 Service providers

4.1.1 Community pharmacies

There are 195 community pharmacies in Surrey County excluding internet pharmacies and DACs. A list of pharmacies by local authority is given in Appendix B. The distribution of pharmacies by local authority and the ratio per population is presented in Table 10. There is an average of 16 pharmacies per 100,000 population in Surrey, below the 21 per 100,000 in England. Elmbridge and Spelthorne have the highest ratio of pharmacies in Surrey at 20 per 100,000 population. Guildford and Woking have the lowest ratio of pharmacies in Surrey at 12 per 100,000 population. These crude rates do not account for pharmacies in neighbouring areas, nor the dispensing doctors within Surrey. It is important to note that these values are provided for information, but pharmacy business models and pharmacy sizes also impact on the service that each pharmacy provides. There is no set value or expectation set nationally on the ratio of pharmacies per 100,000 people because local geography, population and needs vary and crude rates should not be used as a measure in isolation to compare pharmaceutical provision across local authority areas. The rate of pharmacies per 100,000 should also be considered alongside the dispensing rates of pharmacies.

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Table 10: Pharmacies per 100,000 population

Area Name	Number of Community Pharmacies*	Population **	Ratio (pharmacies per 100,000) ***
England	11,636	56,550,138	21
Surrey	195	1,199,870	16
Elmbridge	28	137,215	20
Epsom & Ewell	11	81,003	14
Guildford	18	150,352	12
Mole Valley	16	87,547	18
Reigate & Banstead	23	149,243	15
Runnymede	11	90,327	13
Spelthorne	20	99,873	20
Surrey Heath	17	89,204	19
Tandridge	14	88,542	16
Waverley	24	126,556	19
Woking	13	100,008	12

Source: NHSE

* includes only those pharmacies in Surrey HWB area

** ONS Mid-year estimates, 2020

*** These crude rates are provided for information only and should not be used as a measure of comparison in isolation.

4.1.2 Dispensing activity

It is a requirement for pharmacies to maintain a record of all medicines dispensed and any significant interventions made. In 2020 to 21, more than 1.2 million items were dispensed per month in Surrey. Table 11 below shows the average number of items dispensed by community pharmacies (including DAC and distance selling pharmacies) within Surrey local authorities. The Surrey pharmacies on average dispensed fewer items per month than the national average in 2020 to 2021. Guildford dispensed the lowest number of items per person. It is important to note that contractors have different operating and staffing models and may use dispensing hubs in other locations across England. Dispensing activity should not be used as a measure in isolation to compare pharmaceutical provision across local authority areas.

Table 11: Average items dispensed per month per community pharmacy 2020 to 2021

Area Name	Number of pharmacies*	Number of Items Dispensed (000s)	Per month (000s)	Average per month per pharmacy	Population	Items dispensed per month per person
England	11,636	1,016,150	84,679	7,277	56,550,138	1.50
Surrey	216 **	14,382	1,199	5,549	1,199,870	1.00
Elmbridge	30	1,614	135	4,483	137,215	1.00
Epsom & Ewell	12	782	65	5,431	81,003	0.80
Guildford	19	1,269	106	5,566	150,352	0.70
Mole Valley	16	1,088	91	5,667	87,547	1.00
Reigate & Banstead	27	1,868	156	5,765	149,243	1.00
Runnymede	14	994	83	5,917	90,327	0.90
Spelthorne	21	1,423	119	5,647	99,873	1.20
Surrey Heath	19	1,273	106	5,583	89,204	1.20
Tandridge	14	1,080	90	6,429	88,542	1.00
Waverley	28	1,907	159	5,676	126,556	1.30
Woking	16	1,083	90	5,641	100,008	0.90

Source: NHSE, 2021, * The number of pharmacies shown includes community pharmacies and distance selling pharmacies that were open and dispensing in the time period shown.

**Number of pharmacies refers to time period 2020/21 so count differs from 2021 due to contract changes.

4.1.3 Dispensing doctors

Surrey has 8 dispensing practices (which increases to 15 when including branch surgeries) that have permission to dispense medicines. The distribution of dispensing doctors by local authority is outlined in Table 12. Appendix B provides a full list of dispensing doctors. These practices are located in Guildford, Mole Valley and Waverley (see Figure 9). Regulation 48 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 sets out the arrangements for provision of pharmaceutical services by doctors³⁶. Schedule 6 of the Regulations 2013 sets out the terms of service of dispensing doctors. A patient may at any time request in writing that a dispensing doctor provides them with pharmaceutical services. They must be on the doctor's patient list or the patient list of a provider of primary medical services by whom the doctor is employed or engaged. The patient must state if he or she would have serious difficulty in obtaining any necessary drugs or appliances from pharmacy premises by reason of distance or inadequacy of means of communication and/or is resident in a controlled locality at a distance of more than 1.6 kilometres from any pharmacy premises, other than distance selling premises.

Table 12: Dispensing doctors by local authority

Area Name	Number of dispensing GP practices (excluding branch)	Number of Dispensing doctors branch practices
Elmbridge	0	0
Epsom & Ewell	0	0
Guildford	3	1
Mole Valley	2	4
Reigate & Banstead	0	0
Runnymede	0	0
Spelthorne	0	0
Surrey Heath	0	1
Tandridge	0	0
Waverley	3	1
Woking	0	0
Surrey	8	7

Source: NHSE, 2021

³⁶ [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Legislation](#)

4.1.4 Internet and distance selling pharmacies

Distance selling pharmacies must also apply to NHSE for market entry. Currently there are three internet or distance selling pharmacies in the local authorities within Surrey. One in Elmbridge, Spelthorne and Woking (see Figure 9).

The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 Part 9 details a number of conditions for distance selling pharmacies to which they are required to conform.

Distance selling pharmacies may improve choice and must provide the full range of essential services, but regulations prevent them from providing services to persons face-to-face. As of 30 June 2021, each resident in England had the choice of using any of the 379 distance selling premises in England, all of which are required to provide all the essential services remotely to anyone anywhere in England who may request them. There are also distance selling pharmacies whose premises are located outside of Surrey who provide services to Surrey residents.

10 Determining the extent of use of internet pharmacies is not possible within local resources.

4.1.5 Dispensing appliance contractors (DACs)

DACs hold an NHS contract to dispense (on prescription) dressings and appliances as defined in the Drug Tariff³⁷. They are not permitted to dispense medicines or drugs and do not need a pharmacist to dispense their prescriptions. The terms of service of NHS appliance contractors can be found in Schedule 5 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013³⁸. DACs are required to comply with the Essential Services requirements in relation to appliances and only provide AURs and Stoma Customisation advanced services.

Surrey has two DACs, one located in Godalming and the other in Tilford in Farnham both in the borough of Waverley (see Figure 9).

4.2 Access to pharmacies

4.2.1 Opening hours

Pharmacies are formally contracted to deliver 40 hour or 100-hour contracts (these are known as core hours). Pharmacies may also provide supplementary hours above core hours (as part of their opening hours) which may be altered subject to giving three months of notice to NHSE.

³⁷ The Drug Tariff [NHS BSA Drug Tariff](#)

³⁸ [The National Health Service \(Pharmaceutical and Local Pharmaceutical Services\) Legislation](#)

Of the 198 pharmacies in Surrey (including internet pharmacies but excluding DACs), 185 or 93.4% have standard 40-hour contracts (Figure 10) while 13 or 6% have core hours of 100 hours. Opening hours across Surrey are similar to those presented in the previous 2018 PNA³⁹, where 92.6% of pharmacies held 40-hour contracts, and 7.4% held 100-hour contracts. Table 13 provides the numbers and percentage of pharmacies with 40 and 100-hour contracts by local authority. Elmbridge has the highest percentage of its pharmacies with 100-hour contracts, 14.3%, whilst Epsom & Ewell, Guildford, Runnymede and Tandridge have no 100 hour contracted pharmacies.

Evening and weekend out-of-hours services are no longer required as an enhanced service by NHSE. As Table 14 shows, many pharmacies opening hours include supplementary hours, beyond their 40 and 100 hour contracts (after 6.30pm and on weekends). Full details of opening times of pharmacies and dispensing doctors in Surrey are included in Appendix B. A bank holiday enhanced service is commissioned by NHSE for Christmas Day and Easter Sunday and in addition, they can direct pharmacies to open on Bank Holidays when needed to do so.

³⁹ [Surrey Pharmaceutical Needs Assessment 2018](#)

Surrey Pharmaceutical Needs Assessment 2022

Table 13: Number of pharmacies in Surrey by core contract type

Area Name	Number of Pharmacies*	40 Hour Contract Number	40 Hour Contract Percentage in each local authority (%)	40 Hour Contract Percentage in Surrey (%)	100 Hour Contract Number	100 Hour Contract Percentage in each local authority (%)	100 Hour Contract Percentage in Surrey (%)
Surrey	198	185	100.0	93.4	13	100.0	6.6
Elmbridge	29	25	86.2	12.6	4	13.8	2.0
Epsom & Ewell	11	11	100.0	5.6	0	0.0	0.0
Guildford	18	18	100.0	9.1	0	0.0	0.0
Mole Valley	16	14	87.5	7.1	2	12.5	1.0
Reigate & Banstead	23	22	95.7	11.1	1	4.3	0.5
Runnymede	11	11	100.0	5.6	0	0.0	0.0
Spelthorne	21	20	95.2	10.1	1	4.8	0.5
Surrey Heath	17	15	88.2	7.6	2	11.8	1.0
Tandridge	14	14	100.0	7.1	0	0.0	0.0
Waverley	24	22	91.7	11.1	2	8.3	1.0
Woking	14	13	92.9	6.6	1	7.1	0.5

Source: NHSE

* The number of pharmacies shown excludes dispensing appliance contractors, but includes community and distance selling pharmacies in Surrey's HWB area.

The majority (185, 93.4%) of community pharmacies within Surrey HWB are open on a Saturday for some part of the day. Fifty-one (25.8%) are open in the evening (after 18:30) and 44 (22.2%) are open on a Sunday (Table 14). These figures are slightly different to those shown in the table below because within the Surrey borders (Runnymede), there is a single pharmacy that is contracted to Windsor and Maidenhead HWB that is open on a Saturday for some part of the day and in the evening after 18:30 hours.

Table 14: Provision of core contract hours and opening times

Area Name	Number of pharmacies*	40-hour contract	100-hour contract	Opening Evening after 18:30	Opening Saturday	Opening Sunday
Surrey	198	185	13	52	186	44
Elmbridge	29	25	4	8	25	7
Epsom & Ewell	11	11	0	6	11	2
Guildford	18	18	0	4	18	4
Mole Valley	16	14	2	4	15	5
Reigate & Banstead	23	22	1	4	23	6
Runnymede	11	11	0	5	12	1
Spelthorne	21	20	1	5	19	4
Surrey Heath	17	15	2	2	16	3
Tandridge	14	14	0	3	13	2
Waverley	24	24	2	8	22	8
Woking	14	13	1	3	12	2

Source: NHSE, excludes dispensing appliance contractors

* The number of pharmacies shown excludes dispensing appliance contractors, but includes community and distance selling pharmacies.

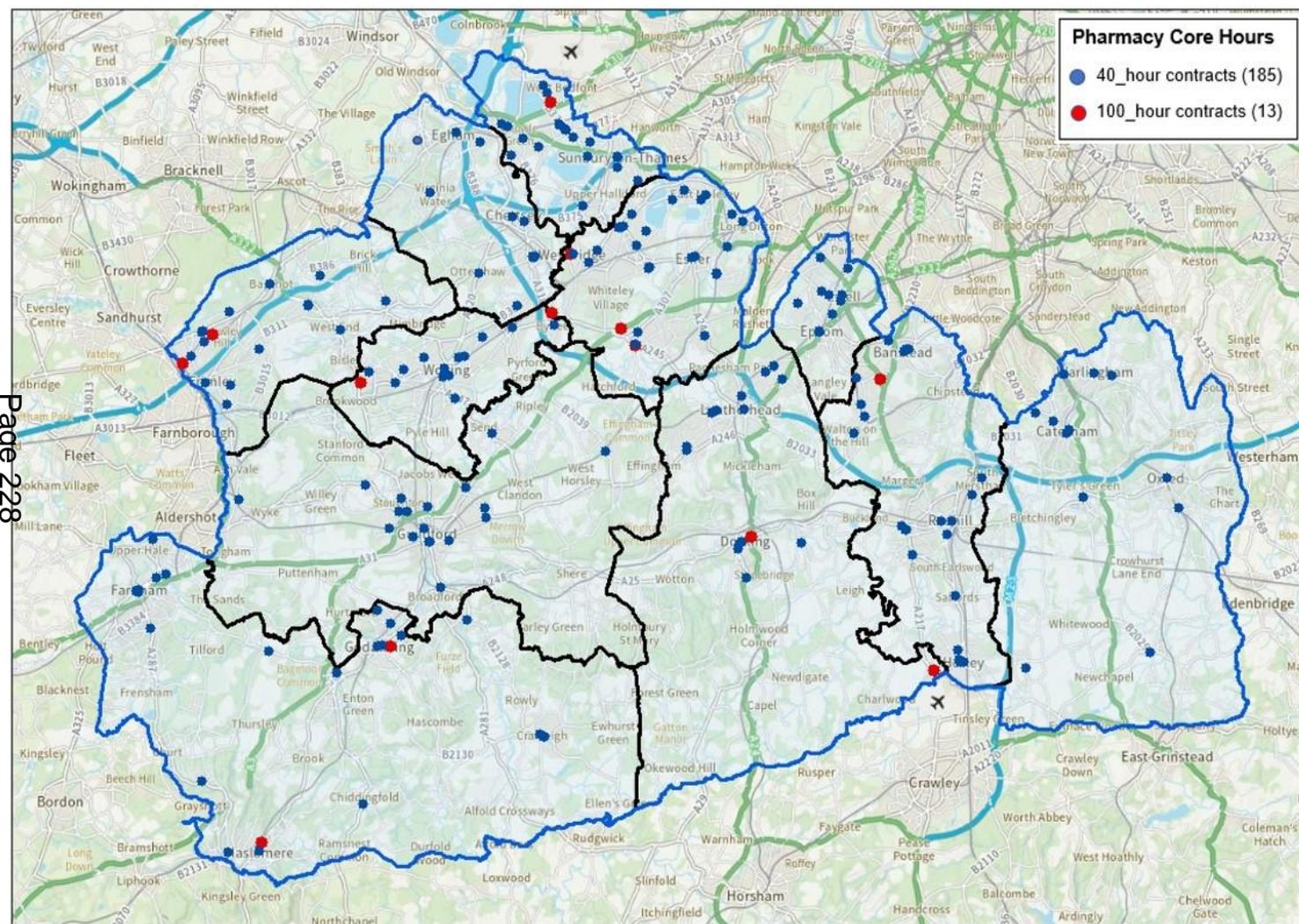
Note: This table includes a single pharmacy that is contracted to Windsor and Maidenhead HWB within the Surrey borders (Runnymede).

Figures below show the distribution of pharmacies, including those within one mile of the Surrey border, open weekdays, evenings, on Saturdays, and on Sundays.

Surrey Pharmaceutical Needs Assessment 2022

Core hour contracts

Figure 10: Location of Surrey community pharmacies in each local authority with 40 and 100 core-hour contract types

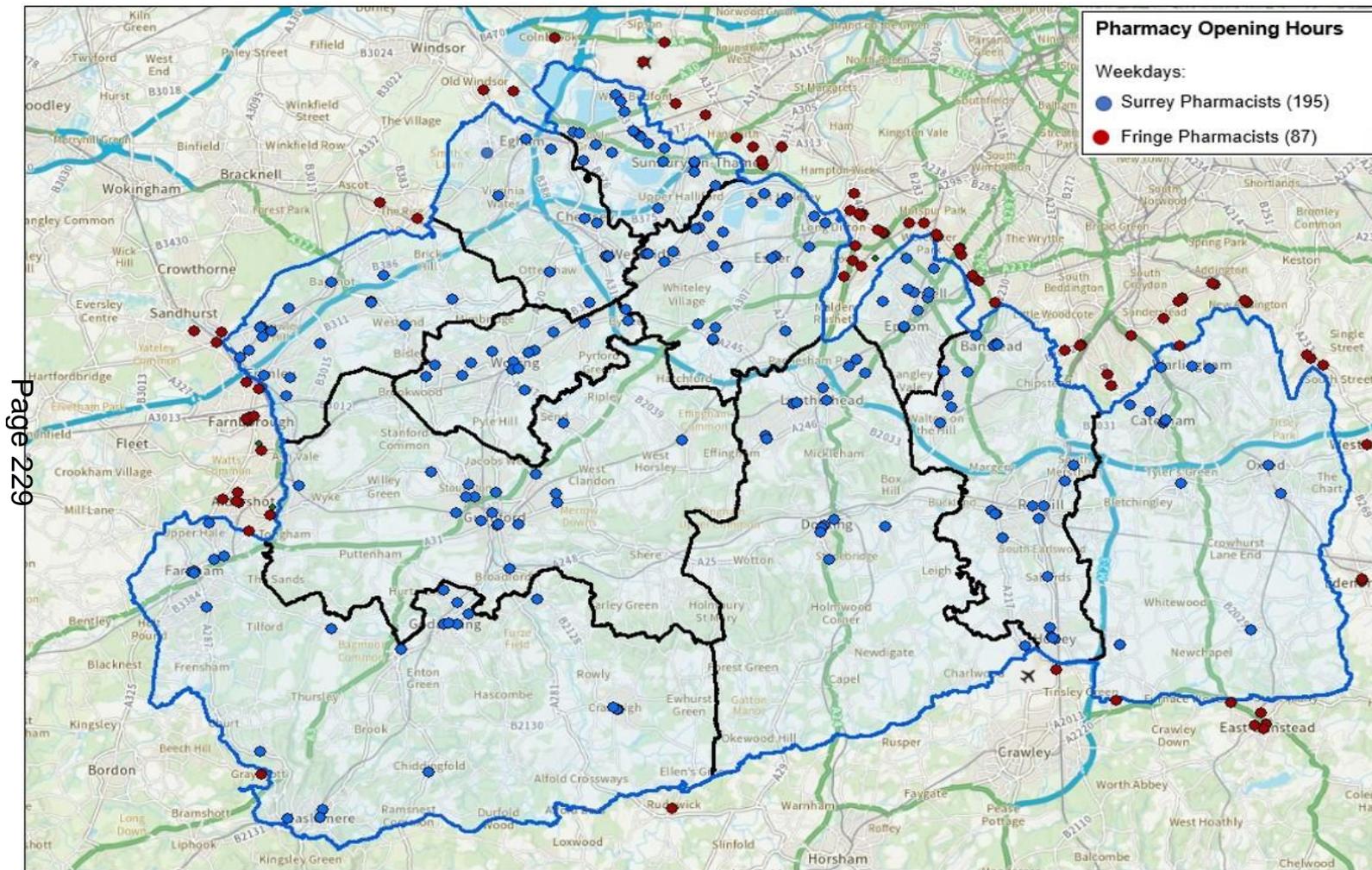


Source: NHSE

Note: The 2 DACs are not included in this map

Weekday opening hours

Figure 11: Pharmacies in Surrey and neighbouring HWB areas open during weekdays



Page 229

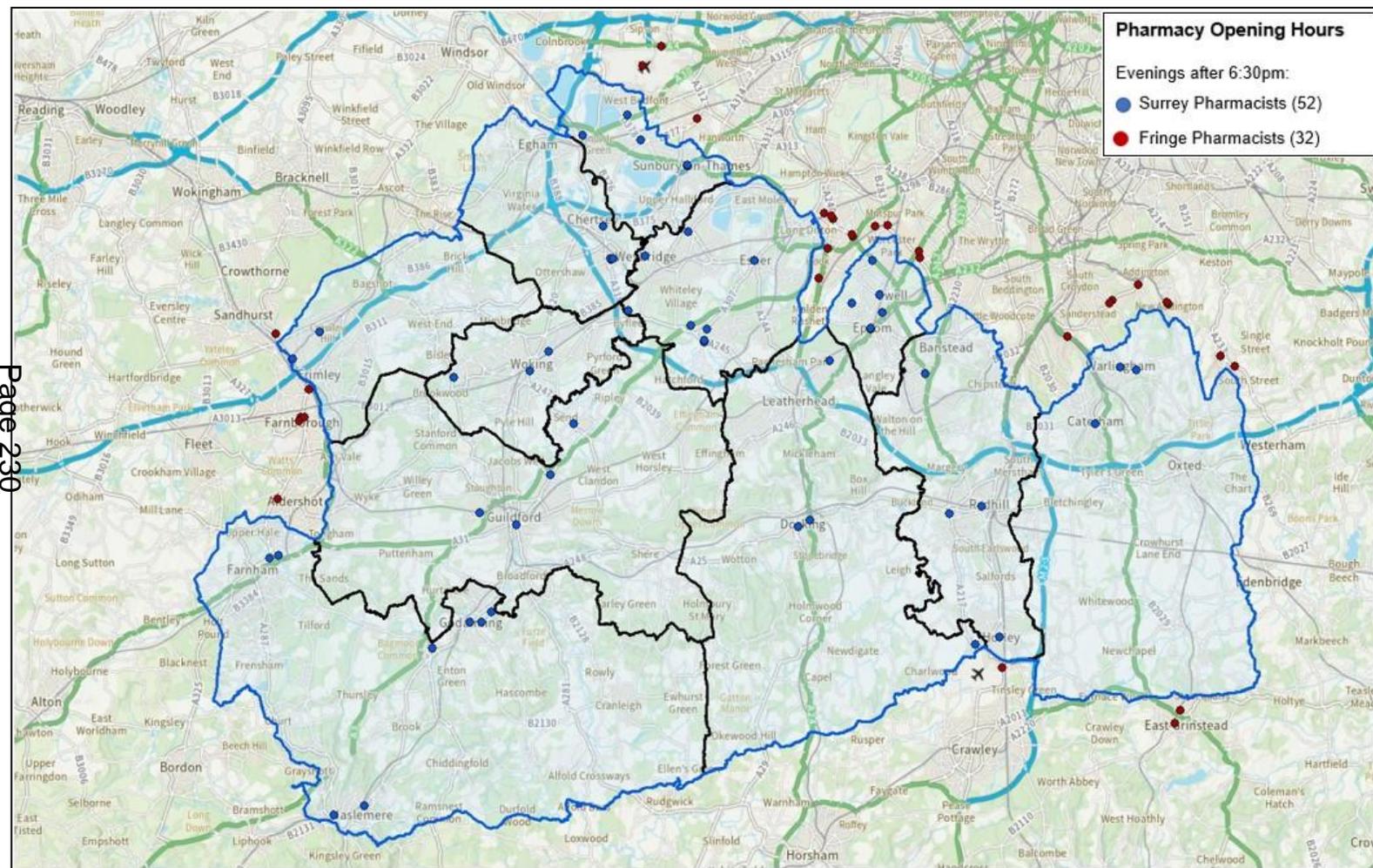
Source: NHSE

Note: The 2 DACs are not included in this map

Surrey Pharmaceutical Needs Assessment 2022

Evening opening hours

Figure 12: Pharmacies in Surrey and neighbouring HWB areas open during evenings (after 1830hrs)

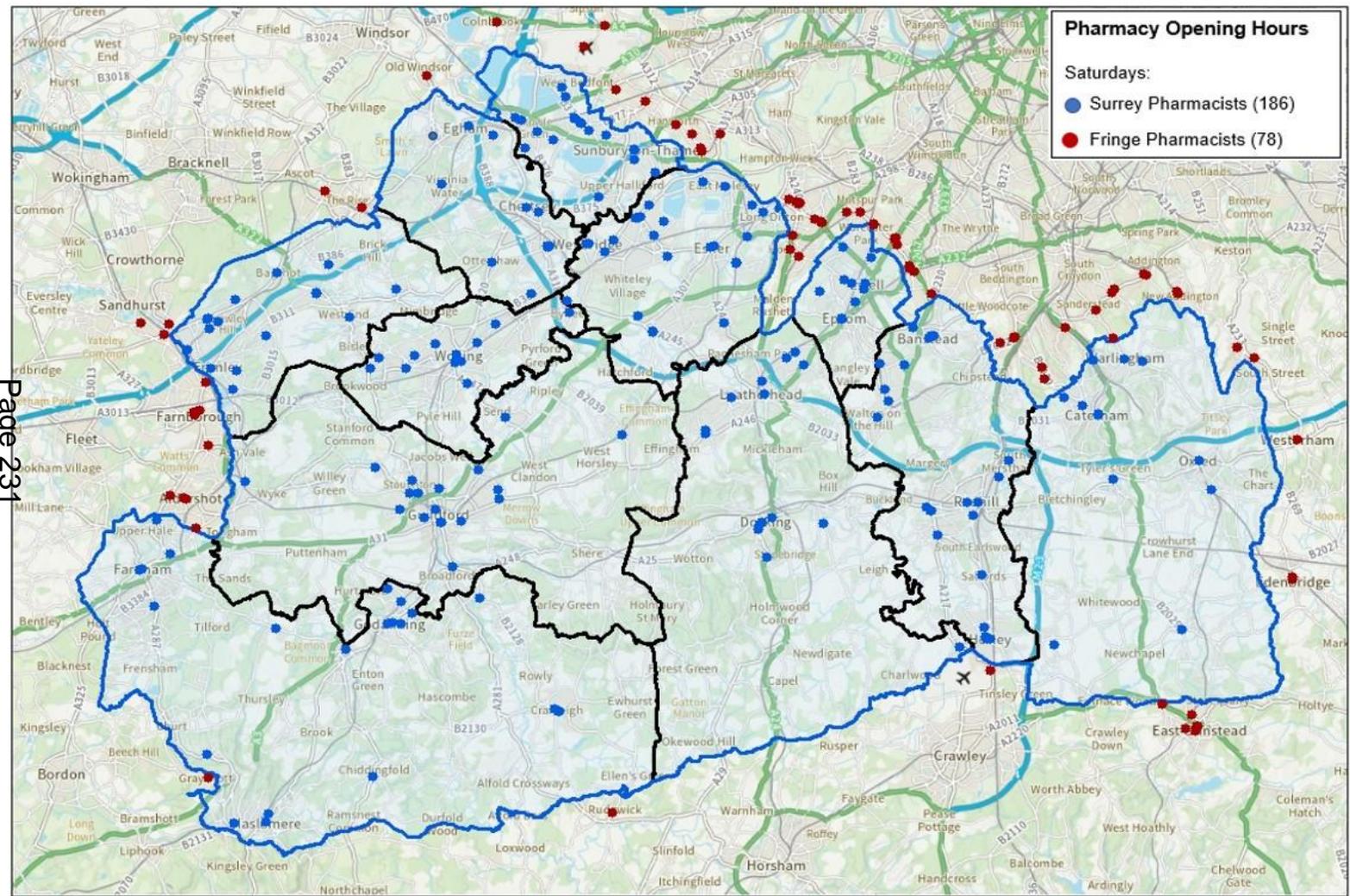


Source: NHSE

Note: The 2 DACs are not included in this map

Weekend opening hours - Saturday

Figure 13: Pharmacies in Surrey and neighbouring HWB areas open on Saturdays



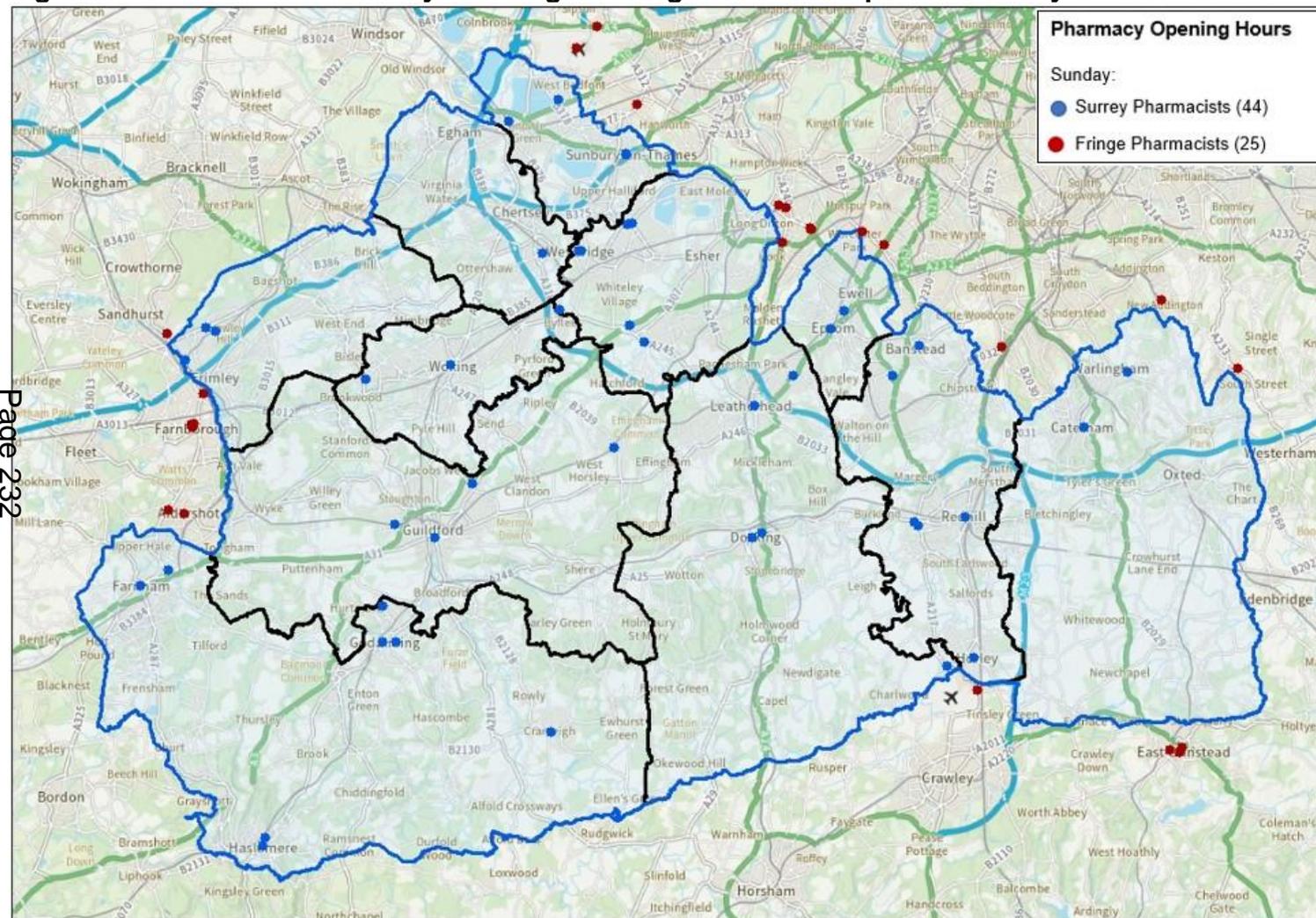
Source: NHSE

Note: The 2 DACs are not included in this map

Page 231

Weekend opening hours - Sunday

Figure 14: Pharmacies in Surrey and neighbouring HWB areas open on Sundays



Source: NHSE

Note: The 2 DACs are not included in this map

4.3 Distance and travel times

This PNA has considered one and -five-mile intervals from the pharmacy points as a measure of reasonable distance to travel to a pharmacy⁴⁰. In order to accurately reflect access to residents living on the borders of Surrey and other HWB areas, the distance and travel time maps have included pharmacies that sit outside Surrey. The maps use travel time catchments of 5, 10, 15 and 20 minutes (driving toward the pharmacy points, using available road speeds).

4.3.1 Neighbouring Health and Wellbeing Boards

Surrey borders 14 HWBs⁴¹, which have between them 87 community pharmacies within a one-mile radius of the Surrey border (Table 15). It is recognised that these pharmacies provide Surrey residents with the opportunity to access pharmaceutical services local and convenient to them. These pharmacy services need to be acknowledged when reviewing service provision within Surrey against the needs of the local population. Figures 15 to 23 show the locations of pharmacies in neighbouring HWB areas up to one mile outside the Surrey border.

10

⁴⁰ The maps were created using Esri's ArcGIS online (AGOL) tools. The road network speeds in AGOL are based on historic (previously measured) real time data as captured by commercial companies.

⁴¹ Bracknell Forest, Bromley, Croydon, East Sussex, Hampshire, Hillingdon, Hounslow, Kent, Kingston upon Thames, Richmond upon Thames, Slough, Sutton, West Sussex, Windsor and Maidenhead

Table 15: Community pharmacies within one mile radius of Surrey border

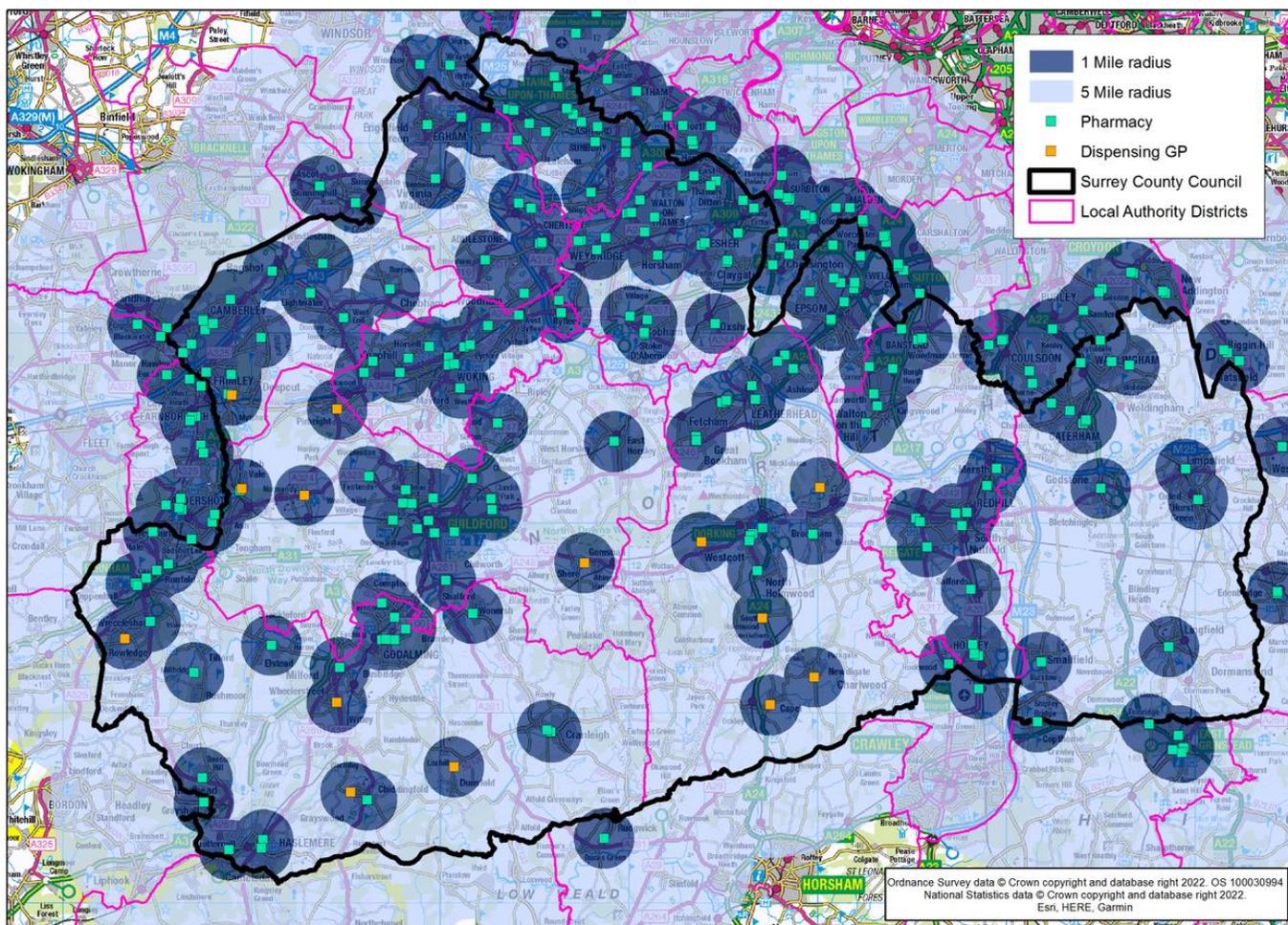
County	Number of pharmacies	Pharmacies Within 1 mile radius*
Bracknell Forest	19	1
Bromley	62	3
Croydon	74	15
East Sussex	103	0
Hampshire	234	19
Hillingdon	64	2
Hounslow	55	3
Kent	277	3
Kingston upon Thames	31	15
Richmond upon Thames	47	4
Slough	32	0
Sutton	44	9
West Sussex	168	9
Windsor and Maidenhead	29	4
Total	1,239	87

Source: NHSE, 2021

Surrey Pharmaceutical Needs Assessment 2022

Figure 15: Areas of Surrey within one and five-mile radius of a pharmacy open on weekday (including dispensing practices)

Page 235

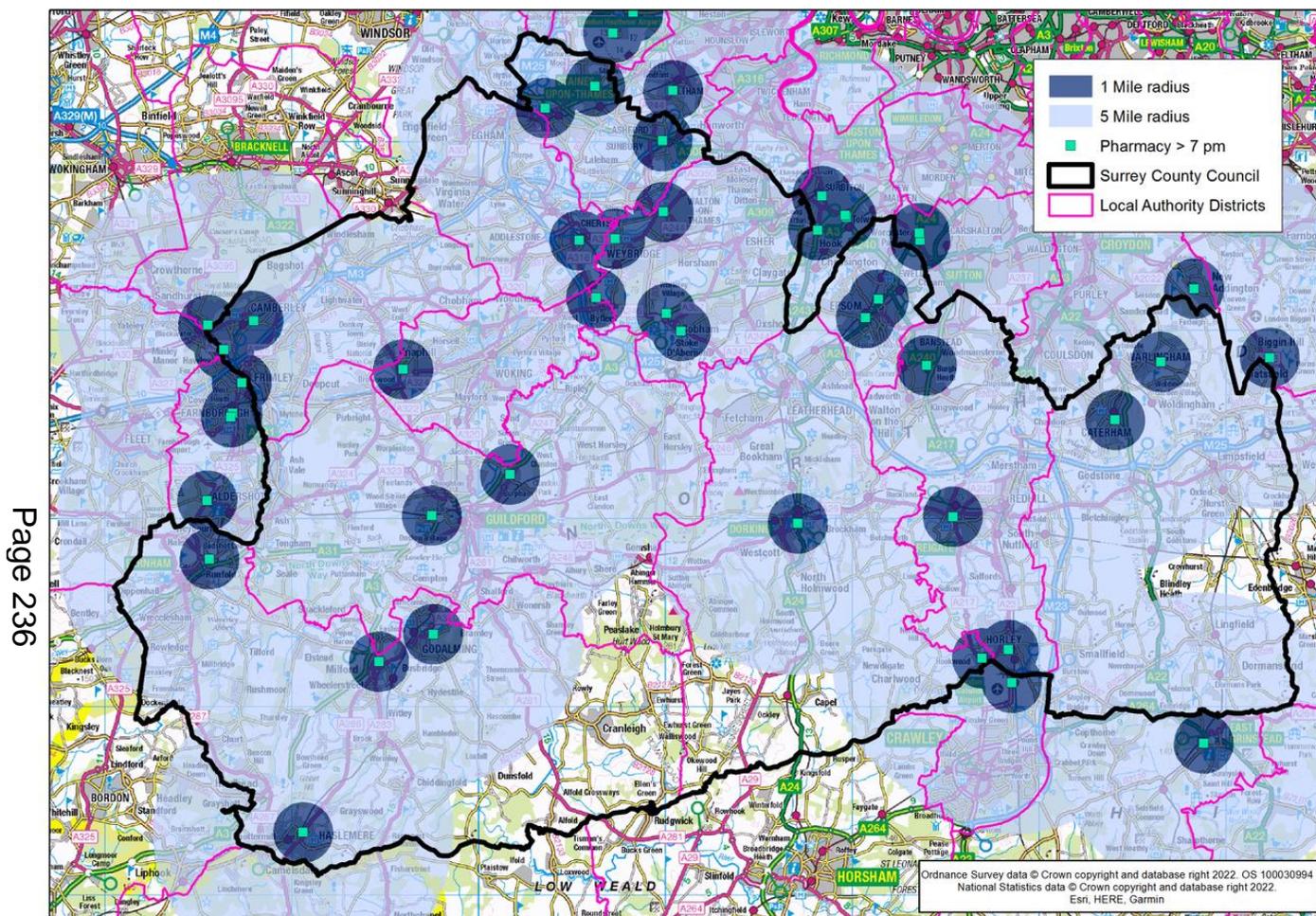


Source: NHSE; OHID, UKSHA

All Surrey residents are within a five-mile radius of an open pharmacy on a weekday.

Surrey Pharmaceutical Needs Assessment 2022

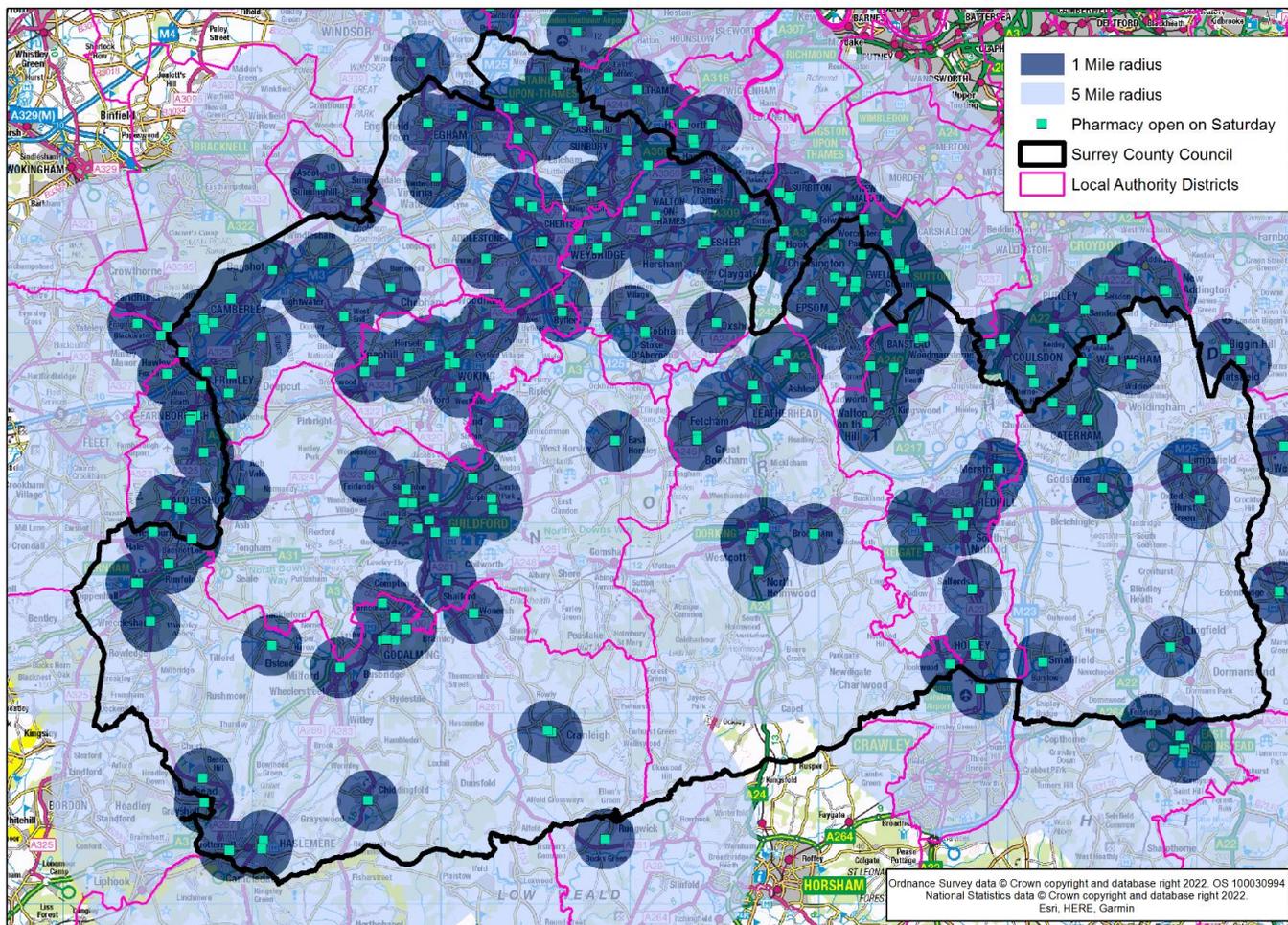
Figure 16: Areas of Surrey within one and five miles of a pharmacy open on weekday evenings (at 19:00hrs)



Source: NHSE; OHID, UKSHA

On weekday evenings (after 1900hrs) the majority of Surrey residents are able to access a pharmacy within a five-mile radius, however parts of Cranleigh in Waverley (a village with a population of about 11,000 people) and East of Tandridge are not within a five-mile radius of an open pharmacy (or dispensing practice) on a weekday evening.

Figure 17: Areas of Surrey within one and five miles of a pharmacy open on Saturday



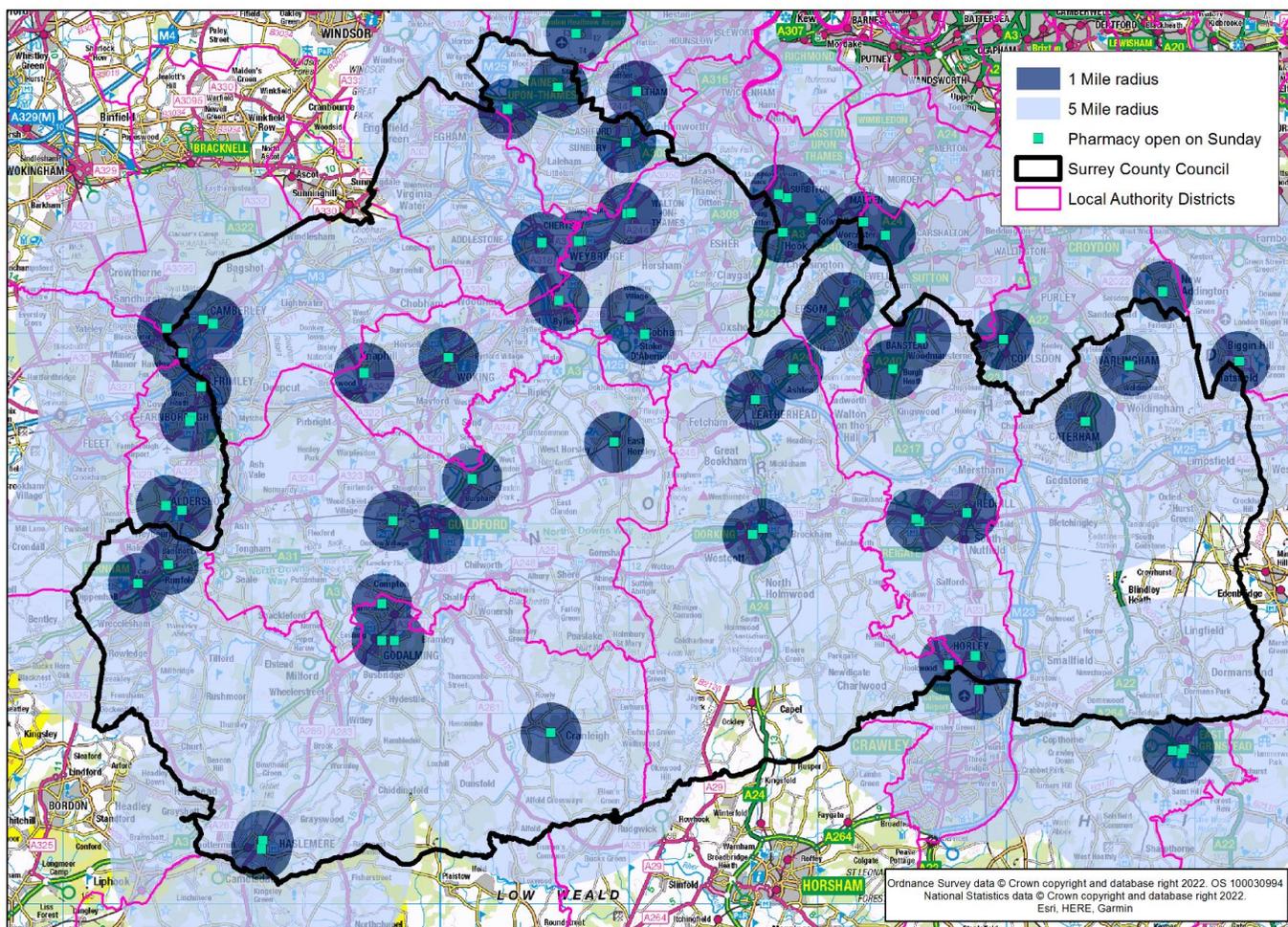
Page 237

Source: NHSE; OHID, UKSHA

On Saturdays, the majority of Surrey residents are able to access a pharmacy within a one to five-mile radius, however a small part of the South of Mole Valley (which is classified as a rural village) is not within a five-mile radius of an open pharmacy (or dispensing practice).

Surrey Pharmaceutical Needs Assessment 2022

Figure 18: Areas of Surrey within one and five miles of a pharmacy open on Sunday



Page 238

Source: NHSE; OHID, UKSHA

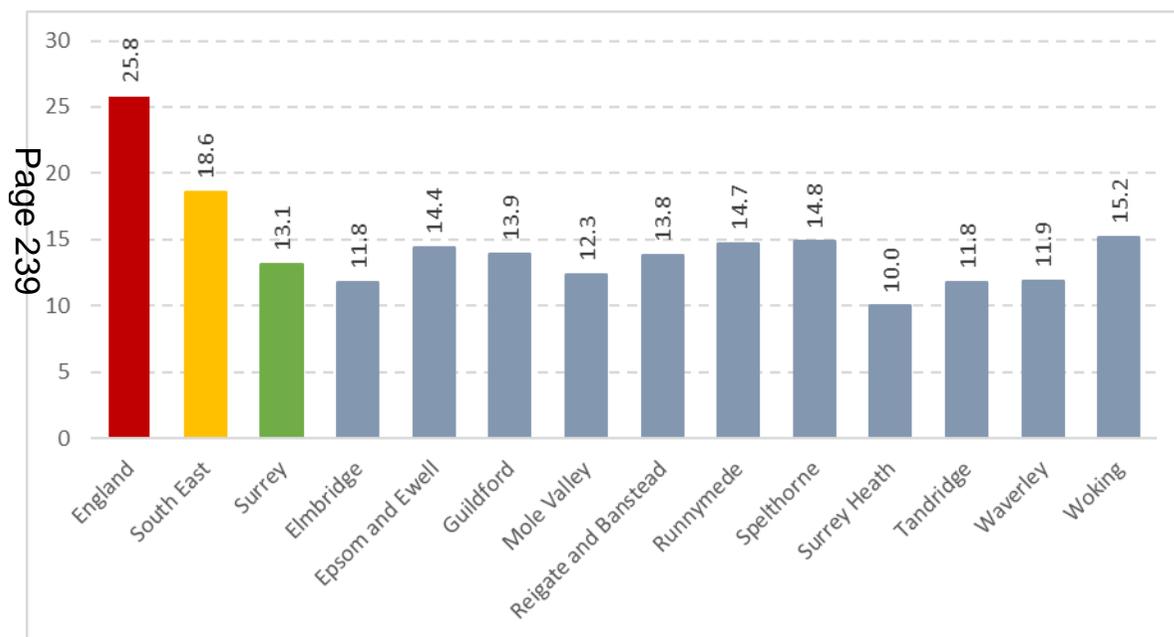
On Sundays, the majority of Surrey residents are able to access a pharmacy within a one-to-five mile-radius, however a small part of the South of Mole Valley and East of Tandridge (which is classified as a rural village) is not within a five mile radius of an open pharmacy (or dispensing practice).

4.3.2 Car ownership in Surrey

Distance and drive time maps (Figure 20 to Figure 23) show that during weekdays and on Saturdays a pharmacy or dispensing doctor is accessible to everyone in Surrey by car within a reasonable time. In the evening at (or after) 7pm and on Sundays, areas in the most rural Southerly and Eastern parts of Surrey County cannot be reached by car within a reasonable time.

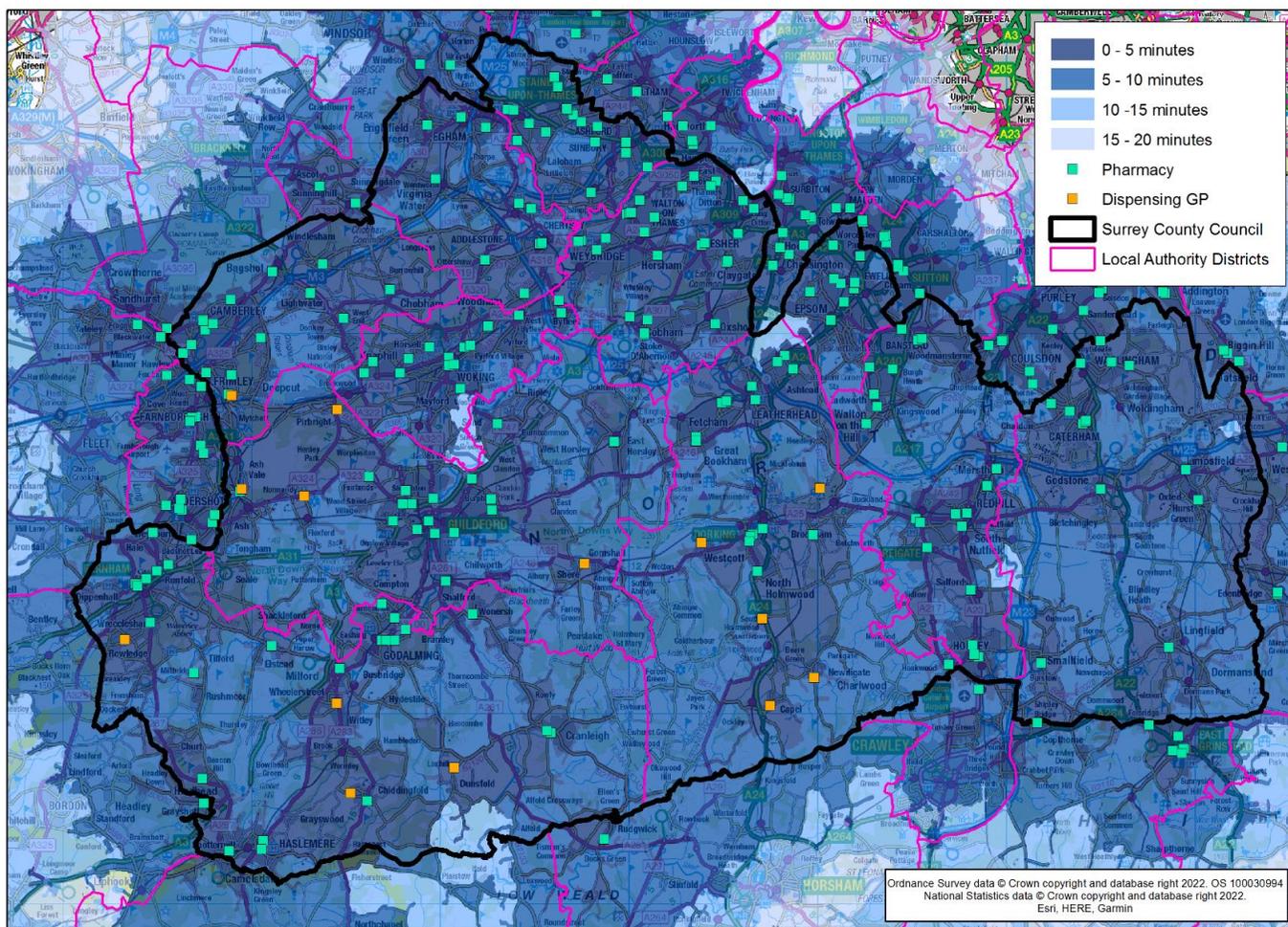
The 2011 Census indicates that 13.1% (59,865) of the residents in Surrey do not own a car. This is lower than the England (25.8%) and the South East (18.6%) rate. For those living in a rural area and without a car, access to a pharmacy may be limited. Figure 19 gives an indication of the scale of the problem.

Figure 19: The percentage of Surrey households that do not own a car by local authority



Source: Census 2011

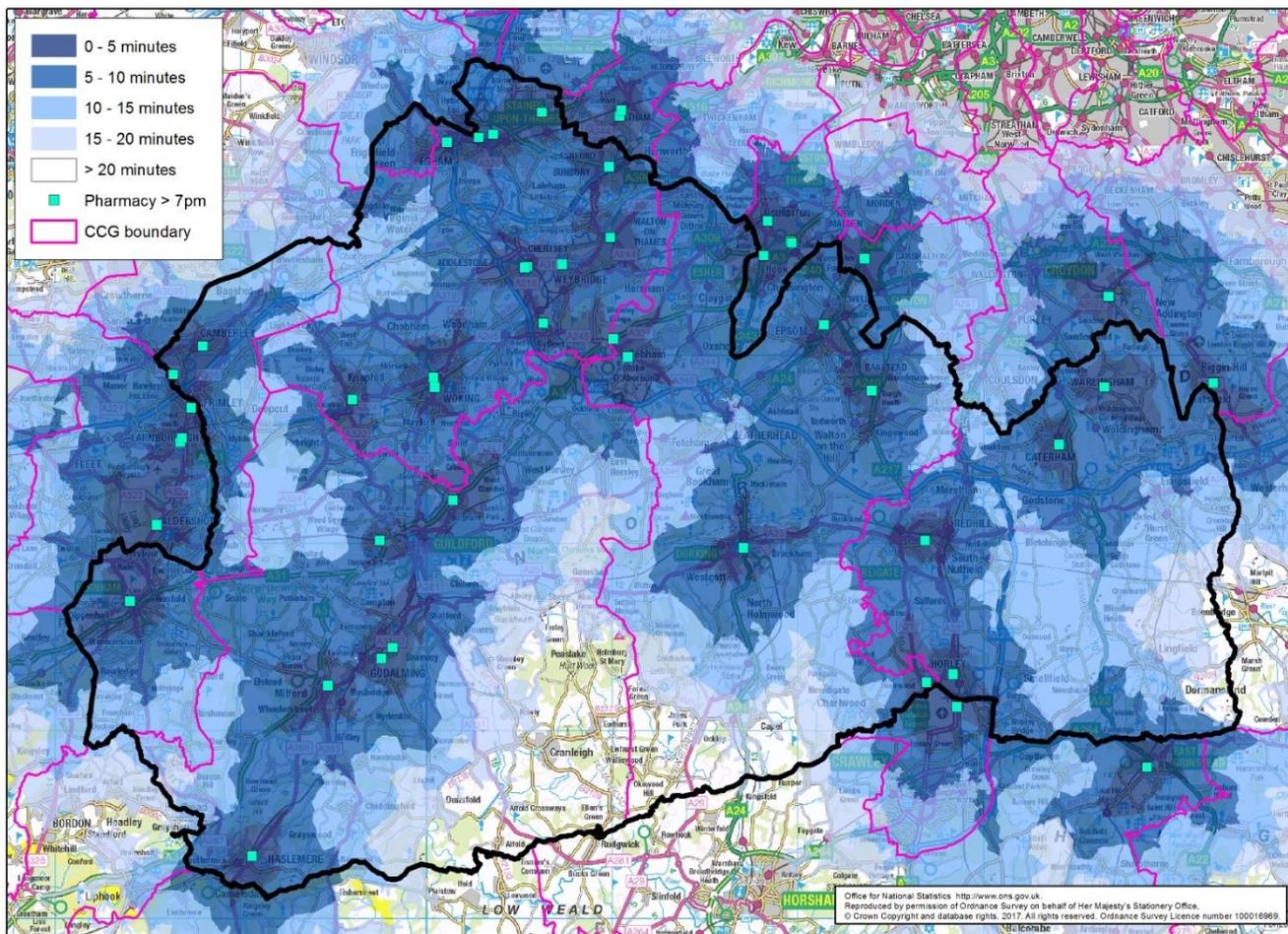
Surrey Pharmaceutical Needs Assessment 2022
Figure 20: Journey time by car during weekdays



Page 240

Source: NHSE; OHID, UKSHA

Figure 21: Journey time by car on weekday evenings (at 19:00hrs)

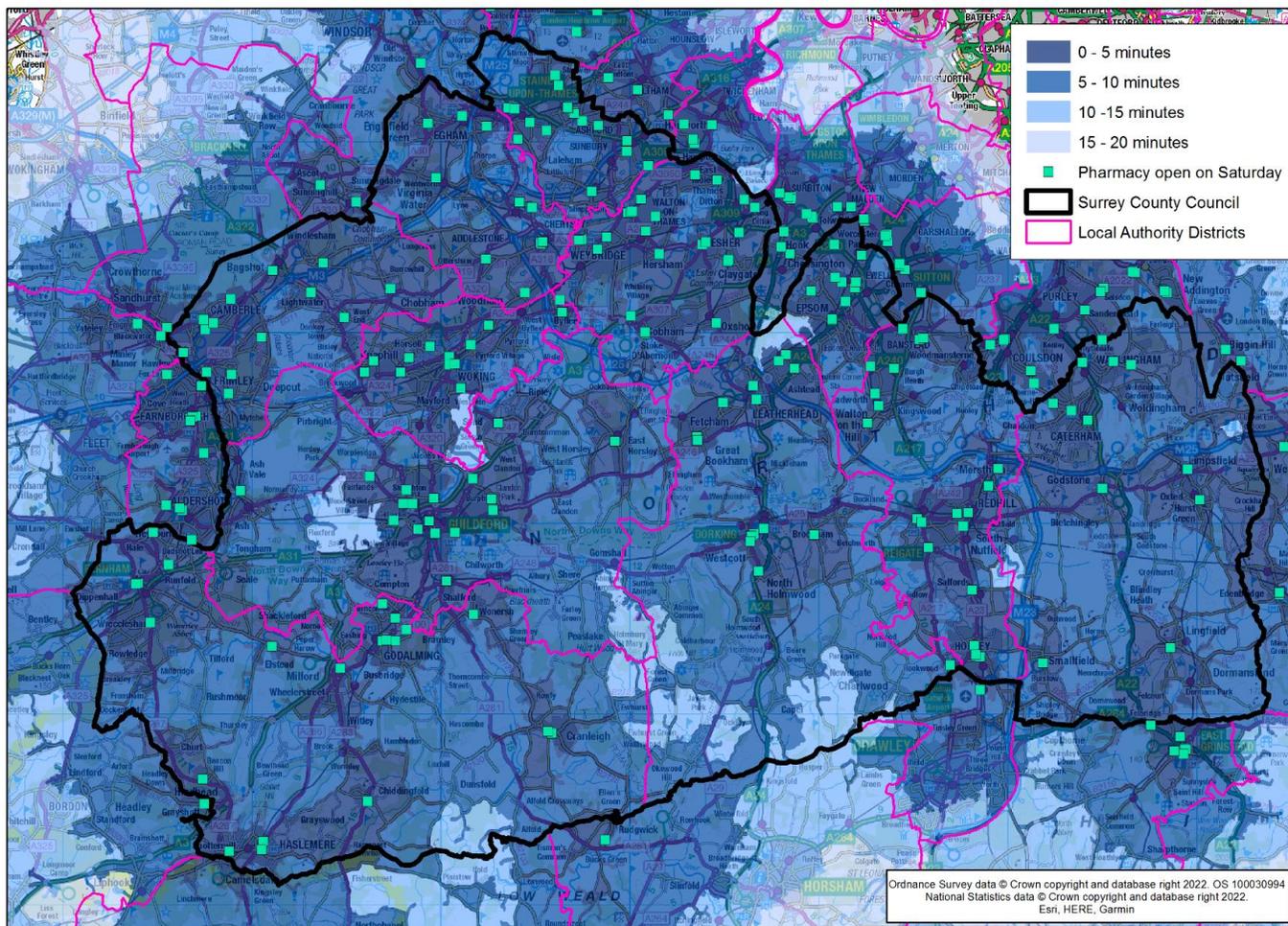


Page 241

Source: NHSE; OHID, UKSHA

Surrey Pharmaceutical Needs Assessment 2022

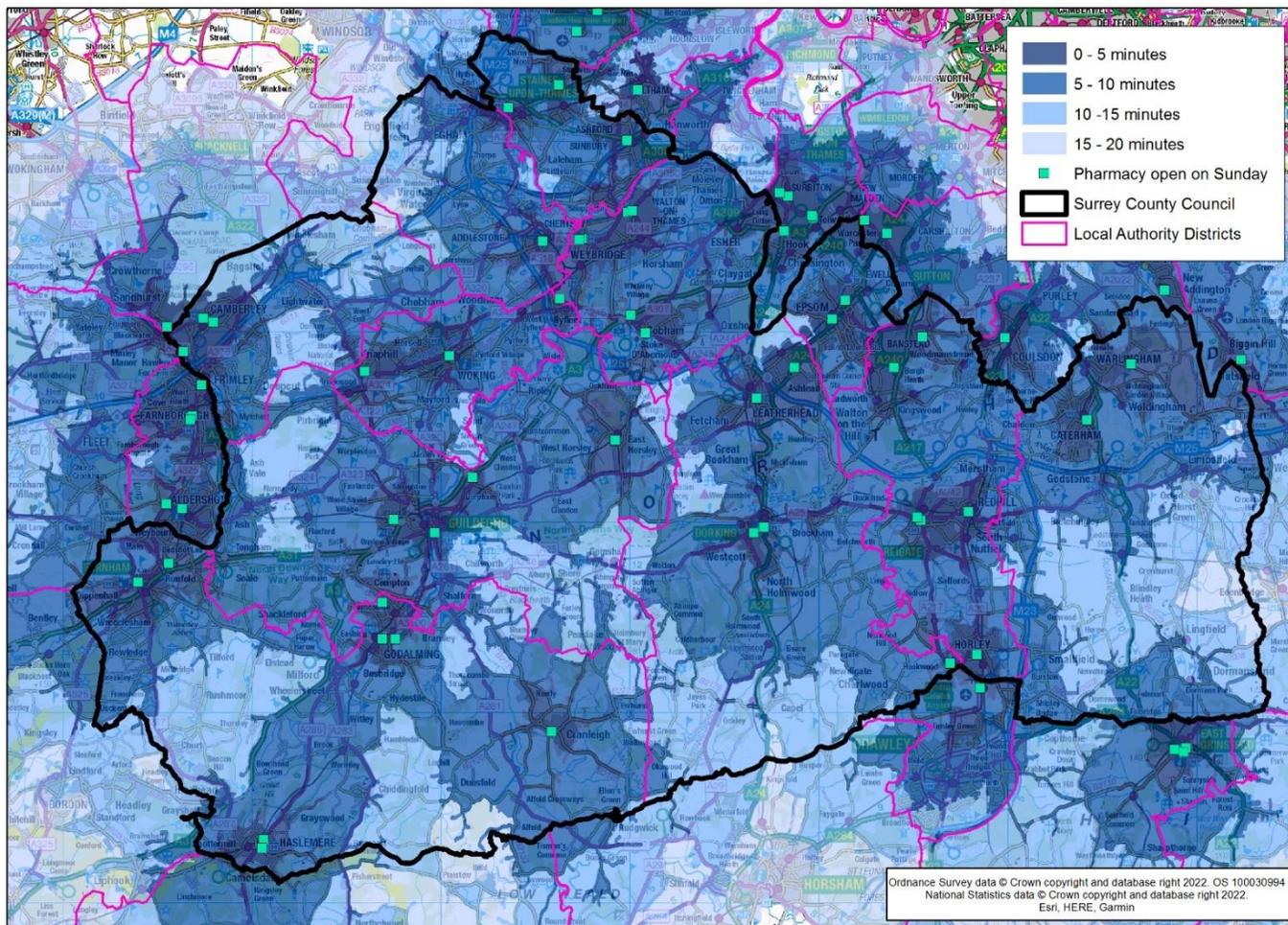
Figure 22: Journey time by car during Saturdays



Page 242

Source: NHSE; OHID, UKSHA

Surrey Pharmaceutical Needs Assessment 2022
Figure 23: Journey time by car on Sunday



Page 243

Source: NHSE; OHID, UKSHA

4.4 Necessary services: current provision

Necessary services are defined within the 2013 Regulations as those that are necessary to meet the need for pharmaceutical services and could be provided within or outside of the HWBs area. For the purpose of this PNA, they have been defined by the type of service as all essential and selected advanced services commissioned by NHSE.

4.4.1 Essential service provision

All community pharmacies are required to provide all essential services outlined in the CPCF. Provision of these services is overseen by NHSE. As listed in Section 2, there are seven essential services⁴², which are detailed below.

Dispensing of prescriptions (appliances and prescriptions)

Pharmacies must dispense appliances only if the pharmacy supplies such products in the normal course of their business.

Pharmacies are required to maintain a record of all medicines dispensed, and also keep records of any interventions made which they judge to be significant.

Dispensing of repeat prescriptions

Repeat dispensing and electronic repeat dispensing are processes that allow a patient to obtain repeated supplies of their medication or appliances without the need for the prescriber to sign authorised repeat prescriptions each time. The processes allow the prescriber to authorise and issue a batch of repeat prescriptions until the patient needs to be reviewed. When each supply is requested by the patient the pharmacist ensures each repeat supply is required and seeks to ascertain that there is no reason why the patient should be referred back to the GP.

Disposal of unwanted medicines

Pharmacies are obliged to accept back unwanted medicines from patients returned to the pharmacy by someone living at home, in a children's home, or in a residential care home. NHSE Regional Team will make arrangements for a waste contractor to collect the medicines from pharmacies at regular intervals.

⁴² Essential Services. PSNC. Available from: [PSNC Essential Services](#)

Public Health (promotion of healthy lifestyle)

This includes providing advice to people who appear to have diabetes, be at risk of coronary heart disease (especially those with high blood pressure), or smoke, or are overweight. Each year pharmacies are required to participate in up to six campaigns at the request of NHSE. This involves the display and distribution of leaflets provided by NHSE. In addition, pharmacies are required to undertake prescription-linked interventions on major areas of public health concern, such as encouraging smoking cessation.

Signposting

NHSE provides pharmacies with lists of sources of care and support in the area. Pharmacies are expected to help people who ask for assistance by directing them to the most appropriate source of help.

Supporting self-care

Pharmacies help manage minor ailments and common conditions, by the provision of advice and where appropriate, the sale of medicines, including dealing with referrals from NHS 111.

Discharge medicines service

The discharge medicines service was introduced in February 2021, and aims to reduce the risk of medication problems when a person is discharged from hospital. It is estimated that 60 percent of patients have three or more changes made to their medicines during a hospital stay. However, a lack of robust communication about these changes may result in errors being made once the person has left hospital. In summary, under this service a pharmacist will review a person's medicines on discharge and ensure that any changes are actioned accordingly.

Healthy Living Pharmacy

The Healthy Living Pharmacy (HLP) framework is aimed at achieving consistent provision of a broad range of health promotion interventions through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities.

Community pharmacy contractors will be required to become a HLP in 2020/21 as agreed in the five-year CPCF; this reflects the priority attached to public health and prevention work.

The NHS Terms of Service have been amended to include HLP requirements, with supplementary information on the details being included in guidance on the Regulations, which will be published by NHSE. Pharmacy contractors must ensure they are compliant with the HLP requirements from 1 January 2021, however the Distance Selling Pharmacy website requirements do not have to be complied with until 1 April 2021. More details can be found on the HLP page on the PSNC website.

4.4.2 Advanced service provision

Community pharmacies can choose to provide any of the advanced services as long as they meet the requirements set out in the Secretary of State Directions. Pharmacies are required to seek approval from NHSE before providing these services and are required to have an appropriate consultation area.

Activity data for the following advanced services reflects claims made to NHSE for provision of the service by the pharmacy contractors.

Appliance Use Reviews (AURs)

AURs aim to improve the patient's knowledge and use of a 'specified appliance' by:

- Establishing the way the patient uses the appliance and the patient's experience of such use;
- Identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient;
- Advising the patient on the safe and appropriate storage of the appliance; and
- Advising the patient on the safe and proper disposal of the appliances that are used or unwanted.

The service can be provided by pharmacies that normally provide the specified appliances in the normal course of their business as long as they meet the conditions of service.

Table 16 shows 32 AURs were done by Surrey pharmacies and appliance contractors in the latest available data (which is for 2018 to 19). These could have been done either on the pharmacy premises or at the patient's home.

Note that AUR and SAC prescriptions are processed centrally at the contractor's head office and sent out from that point to a site closest to the patient. Prescriptions for residents of Surrey HWB area may not therefore be handled by sites in Surrey HWB area. Therefore the numbers reflected in the data do not necessarily reflect the activity for Surrey residents.

Table 16: Appliance Use Reviews by local authority (2018 to 19)

Area Name	Number of pharmacies and appliance contractors ⁸	Number of pharmacies and appliance contractors providing service	% of pharmacies and appliance contractors providing service	Total Appliance Use Reviews	Average per pharmacy and appliance contractor claiming for service
Elmbridge	30	0	0.0	0	0.0
Epsom & Ewell	12	0	0.0	0	0.0
Guildford	19	0	0.0	0	0.0
Mole Valley	16	0	0.0	0	0.0
Reigate & Banstead	28	0	0.0	0	0.0
Runnymede	14	1	7.1	23	23.0
Spelthorne	22	0	0.0	0	0.0
Surrey Heath	18	1	5.6	5	5.0
Tandridge	14	0	0.0	0	0.0
Waverley	29	1	3.4	4	4.0
Woking	18	0	0.0	0	0.0
Surrey	220	3	1.4	32	10.7

Source: NHSE, *Note: Number of pharmacies shown in this table refers to time period 2018/19 due to contract changes so the count differs from 2021.

New Medicines Service (NMS)

The NMS was added to the NHS Community Pharmacy Contract in 2011. The service provides early support for people with long-term conditions who are newly prescribed a medicine. The aim is to improve medicines adherence and is initially focused on particular patient groups and conditions.

The NMS was implemented as a time-limited service commissioned until March 2013 but due to an overwhelmingly positive evaluation by the University of Nottingham in 2014 NHSE has made a firm decision to continue commissioning this service⁴³.

One hundred and sixty-seven (83.5%) of community pharmacies in Surrey carried out NMS in 2020/21 with an average of 86 NMS per pharmacy (Table 17).

⁴³ New Medicine Service (NMS). PSNC. Available from: <http://psnc.org.uk/services-commissioning/advanced-services/nms/>

Table 17: New Medicines Services (NMS) by local authority (2020 to 21)

Area Name	Number of pharmacies and appliance contractors*	Number of pharmacies claiming for service	% of pharmacies claiming for service	Number of New Med Services	Average per pharmacy claiming for service
Elmbridge	28	19	63.3	908	47.8
Epsom & Ewell	11	9	75.0	1,156	128.4
Guildford	18	16	84.2	1,053	65.8
Mole Valley	16	13	81.3	867	66.7
Reigate & Banstead	23	20	74.1	1,798	89.9
Runnymede	12	11	78.6	714	64.9
Spelthorne	21	17	81.0	1,502	88.4
Surrey Heath	17	16	84.2	1,852	115.8
Tandridge	14	11	78.6	1,198	108.9
Waverley	26	21	80.8	2,153	102.5
Woking	14	14	87.5	1,159	82.8
Surrey	200	167	83.5	14,360	86.0
England	11,636	9,401	80.8	932,341	99.2

Source: NHSE, * The number of pharmacies shown includes community pharmacies, distance selling pharmacies and dispensing appliance contractors.

Stoma Appliance Customisation (SAC) Service

Stoma Appliance Customisation (SAC) service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. The stoma appliances that can be customised are listed in Part IXC of the Drug Tariff⁴⁴.

SAC services can be provided by pharmacies that normally provide specified appliances in the normal course of their business as long as they meet the conditions of service.

⁴⁴ The Drug Tariff <http://www.nhsbsa.nhs.uk/924.aspx>

Table 18 shows the proportion of pharmacies providing this service in Surrey (12.5%) slightly higher than the England (10.9%) average. There is a great variation in the provision of SACs across Surrey local authorities with an average of one per pharmacy in Reigate & Banstead to 8.5 in Runnymede compared to 2,470.7 in Waverley. This difference in claims in Waverley is because the dispensing appliance contractors in Waverley are responsible for the vast majority of SACs in Surrey. The Surrey average is far lower than in the local NHS England local area team and England.

Table 18: Stoma Appliance Customisation Services (SACs) by local authority (2020 to 21)⁴⁵

Area Name	Number of pharmacies and appliance contractors*	Number of pharmacies and appliance contractors claiming for service	% of pharmacies and appliance contractors claiming for service	Total Stoma Appliance Customise Services	Average per pharmacy and appliance contractor claiming for service
Elmbridge	29	1	3.4	4	4
Epsom & Ewell	11	1	9.1	2	2
Guildford	18	3	16.7	17	5.7
Mole Valley	16	2	12.5	9	4.5
Reigate & Banstead	23	1	4.3	1	1
Runnymede	12	6	50.0	51	8.5
Spelthorne	21	2	9.5	7	3.5
Surrey Heath	17	2	11.8	5	2.5
Tandridge	14	2	14.3	13	6.5
Waverley	26	3	11.5	7,412	2,470.7
Woking	13	2	15.4	9	4.5
Surrey	200	25	12.5	7,530	301.2
England	11,636	1,271	10.9	1,529,708	1,203.50

Source: NHSE, * The number of pharmacies shown includes community pharmacies, distance selling pharmacies and dispensing appliance contractors.

⁴⁵ Most SACs will be provided by specialist companies, known generically as Appliance Contractors. There are two such contractors in Surrey; based in Godalming and Tilford. These companies can offer a SAC service to all their patients, many of which may not be in the Surrey area.

Community pharmacist consultation service (CPCS)

NHS Community Pharmacist Consultation Service (CPCS) was launched in October 2019 and the majority of community pharmacies have registered to provide the service. Initially the service took referrals to community pharmacies from the NHS 111 call service and subsequently the service was expanded to take referrals from 111 online. The latest development is for pharmacies to take referrals from GP practices; this is referred to as GP CPCS. The CPCS is intended to relieve pressure on the wider NHS by connecting patients with NHS 111, as their first resort for repeat medications where the patient has run out of medication and for health consultations NHS 111 and GP surgeries. NHS 111 by telephone and online is an important service in itself. It gives patients access to a team of fully trained call advisers, supported by experienced clinicians. They give healthcare advice or direct patients to the right local service, as needed. If they think an ambulance is required they will send one immediately.

Table 19: Community pharmacy consultation service by local authority (2020 to 2021)

Local Authority	Number of pharmacies *	Number of pharmacies claiming for service	% of pharmacies claiming for service	Community Pharmacist Consultation Service (CPCS)	Average per pharmacy claiming for CPCS
Elmbridge	28	22	78.6	406	18.5
Epsom & Ewell	11	11	100.0	304	27.6
Guildford	18	15	83.3	466	31.1
Mole Valley	16	12	75.0	386	32.2
Reigate & Banstead	23	20	87.0	630	31.5
Runnymede	12	9	75.0	267	29.7
Spelthorne	21	19	90.5	386	20.3
Surrey Heath	17	13	76.5	317	24.4
Tandridge	14	14	100.0	285	20.4
Waverley	26	21	80.8	608	29.0
Woking	14	11	78.6	318	28.9
Surrey	200	167	83.5	4,373	26.2
England	11,636	9,999	85.9	379,388	37.9

Source: NHSE, * The number of pharmacies shown includes community pharmacies, distance selling pharmacies and dispensing appliance contractors.

Seasonal influenza vaccination service

As part of the 2015/16 community pharmacy funding settlement NHSE agreed to commission community pharmacies in England to offer a seasonal influenza (flu) vaccination service for patients in at-risk groups. This service is the fifth Advanced Service in the English CPCS and provision of the service commenced from 16 September 2015.

Table 20 below shows that approximately 90% of all community pharmacies in Surrey were providing the flu vaccination service in 2020 to 21 and delivered an average of 293 vaccinations per pharmacy. The England average for the same time period was 282 (data for England is not shown in the table). The average by local authorities in Surrey varied from 202 in Woking to 588 in Epsom & Ewell.

Table 20: Seasonal influenza vaccination by local authority

Area Name	Number of pharmacies *	Number of pharmacies claiming for service	Percentage of pharmacies claiming for service	Number of Flu vaccinations	Average per pharmacy claiming for service
Elmbridge	28	22	78.6	6,599	300
Epsom & Ewell	11	11	100.0	6,471	588
Guildford	18	18	100.0	4,969	276
Mole Valley	16	12	75.0	3,817	318
Reigate & Banstead	23	22	95.7	8,193	372
Runnymede	12	10	83.3	2,036	204
Spelthorne	21	20	95.2	4,167	208
Surrey Heath	17	15	88.2	4,014	268
Tandridge	14	13	92.9	2,902	223
Waverley	26	22	84.6	6,481	295
Woking	14	14	100.0	2,829	202
Surrey	200	179	89.5	52,478	293
England	11,636	9,816	84.4	**	**

Source: NHSE, 2020/21, * The number of pharmacies shown includes community pharmacies, distance selling pharmacies and dispensing appliance contractors, **no data available at time of publication

NHS Urgent Medicine Supply Advanced Service (NUMSAS)

NUMSAS is a national service, now incorporated into the community pharmacy contract under the CPCS, and is no longer commissioned by NHSE, the pilot scheme ended on 28 October 2019.

Medicine Use Reviews (MURs) and Prescription Intervention Service

The MURs and Prescription Intervention Service consists of accredited pharmacists undertaking structured adherence-centred reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions. The MUR service was discontinued from the 31 March 2021 as it is no longer commissioned as an advanced service.

Hypertension case finding

Hypertension case finding was commissioned from October 2021 and is currently in the implementation phase with pharmacies signing up to the service.

- The service has two stages – the first is identifying people at risk of hypertension and offering them blood pressure measurement (a 'clinic check').
- The second stage, where clinically indicated, is offering 24-hour ambulatory blood pressure monitoring. The blood pressure test results will then be shared with the patient's GP to inform a potential diagnosis of hypertension.

Note: Pharmacies signing up to provide the service have to provide both stages.

Smoking cessation

Smoking cessation was commissioned from March 2022 and is currently in implementation phase with pharmacies signing up to the service.

4.4.3 Enhanced service provision

Enhanced services can only be commissioned by NHSE. Service specifications for this type of service are developed by NHSE and then commissioned to meet specific health needs. In Surrey, NHSE South East commissions a bank holiday enhanced service and COVID-19 vaccinations.

Bank holiday service

A Bank Holiday enhanced service is commissioned by NHSE for Christmas Day and Easter Sunday across Surrey, Sussex, Kent & Medway, Hampshire & Isle of Wight, and Berkshire, Oxfordshire & Buckinghamshire.

NHSE has a duty to ensure that residents of the HWBs area are able to access pharmaceutical services every day. Pharmacies and dispensing appliance contractors are not required to open on public and bank holidays, or Easter Sunday, although some choose to do so. NHSE asks each contractor to confirm their intentions regarding these days and where necessary will direct a contractor or contractors to open all or part of these days to ensure adequate access when needed⁴⁶.

⁴⁶ Opening Hours. PSNC. Available from: [PSNC Pharmacy Regulation - Opening Hours](#)

COVID-19 Vaccinations

During the pandemic the vital role of pharmacies as a community-based, front-line health service, interlocking with other services, has been brought very much into the spotlight, as community pharmacies have remained open to customers throughout the periods of restrictions and lockdown. In October 2021 pharmacies were commissioned to provide rapid (lateral flow) test kit distribution services through the pharmacy collect scheme and the community pharmacy COVID-19 medicines delivery service was also commissioned to be delivered from community pharmacies.

From January 2021, NHSE commissioned selected community pharmacists to deliver COVID-19 vaccines to accelerate the COVID-19 programme. A summary of the number of vaccinations provided is available in the table below.

Table 21: COVID-19 vaccination service provided (2020 to 2021)

Area Name	Number of community pharmacies*	Number of pharmacies claiming for service	% of pharmacies claiming for service	Number of COVID-19 Vaccinations	Average per pharmacy claiming for service
Elmbridge	28	1	3.6	2,548	2,548
Epsom & Ewell	11	0	0.0	0	0.0
Guildford	18	2	11.1	19,551	9,775.5
Mole Valley	16	2	12.5	2,192	1,096.0
Reigate & Banstead	23	1	4.3	3,385	3,385.0
Runnymede	12	0	0.0	0	0.0
Spelthorne	20	1	5.0	567	567.0
Surrey Heath	17	0	0.0	0	0.0
Tandridge	14	1	7.1	752	752.0
Waverley	24	0	0.0	0	0.0
Woking	12	1	8.3	7,169	7,169.0
Surrey	195	9	4.6	36,164	4,018.2
England	11,636	280	2.4	2,299,336.3	8,211.9

Source: NHSE, * The number of pharmacies shown includes community pharmacies, and excludes distance selling pharmacies and dispensing appliance contractors.

4.5 Other Relevant services: current provision

Other NHS services (often referred to as locally commissioned community pharmacy services) can be contracted via a number of different routes and by different commissioners, including local authorities, ICBs and local NHSE teams⁴⁷. Services commissioned by SCC Public Health Team through PHAs and by the ICBs (formerly CCGs) are described below.

4.5.1 Public Health local services

SCC Public Health Team commissions pharmacies to provide a range of public health services. These include: EHC, Chlamydia Screening and Treatment, Needle and Syringe Exchange, Supervised Consumption, Take Home Naloxone, BP Plus, and NHS Health Checks. These services have been commissioned according to local health needs as well as local and national initiatives. Any data in this section excludes internet pharmacies and DACs.

10 Sexual Health Services

Pharmacies play an important role in enabling Surrey residents to lead healthy sexual and reproductive lives. They help increase provision across the county, providing services in convenient locations in the heart of the community and they are often in contact with communities most at need.

SCC Public Health commission pharmacies to provide a package of community sexual health services for young people under 25 years old including STI prevention, screening and treatment, and services to reduce unintended teenage conceptions. Table 22 shows how many pharmacies provide each service. Further information on sexual health services in Surrey can be found on the Healthy Surrey website.

During 2022, a new name and logo is being rolled out to all venues (not just pharmacies) across Surrey which will enable residents to easily identify which venues are offering sexual health support and will facilitate better and easier access to services from our local pharmacies.

Emergency Hormonal Contraception (EHC) Service

Enabling pharmacies across Surrey to offer EHC 'free of charge' to young people has been a key factor in the reduction of unintended teenage conceptions. Young women (under 25 years of age) can visit their local pharmacy and be issued (under a patient group directive) the appropriate method of EHC or referred to another service if timescales suggest it is more appropriate. Table 22 shows that 96 pharmacies in Surrey have been commissioned to provide this service.

⁴⁷ Locally Commissioned Services. PSNC. Available from: [PSNC Locally Commissioned Services](#)

Chlamydia and Gonorrhoea screening and Chlamydia treatment service

The National Chlamydia Screening Programme is aimed at preventing onward transmission and the harms caused by chlamydia infection through early detection and treatment. Although the screening element of the service is aimed at 15 to 24year olds, treatment is available to them and their partners, irrespective of age. As with the EHC service, providing Chlamydia and Gonorrhoea screening and treatment in pharmacies increases access for young people.

In 2021, the National Chlamydia Screening Programme changed to focus on reducing reproductive harm of untreated infection in young women*. The prevalence of infection is highest in young sexually active women (15 to 24year olds). In practice, this means that chlamydia screening in pharmacies will only be proactively offered to young women. All young men and women can still be tested but men will not be proactively offered a test unless an indication of infection has been identified, such as being a partner of someone with chlamydia or having symptoms.

*(References to women includes cisgender women, transgender men, and non-binary (assigned female at birth) people who have not had a hysterectomy or bilateral oophorectomy).

In Surrey, 65 pharmacies are currently commissioned to provide chlamydia and gonorrhoea screening (Table 22). Information on the number of pharmacies offering Chlamydia and Gonorrhoea screening and Chlamydia treatment can be found on the [Healthy Surrey](#) website.

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Condom Distribution Scheme (CDS) C-card

A number of pharmacies across the country are part of the CDS. The C-Card scheme is managed by the sexual health service provider, not through PHAs, and training needs to take place before pharmacies can deliver the scheme. The introduction of a new IT platform in 2022 is making the process of distributing condoms to young people from pharmacies much simpler for both the individual and the pharmacies themselves. The new IT system provides assurance that appropriate safeguarding checks have been carried out and that the young person has received appropriate information and support before being able to access safer sex materials.

It is anticipated that the number of pharmacies providing this service will increase substantially during 2022 to improve access to this service even further.

Information on the C-Card scheme can also be found on the [Healthy Surrey](#) website.

Table 22: Pharmacies delivering Sexual Health Services in Surrey (September 2021/22)

Area name	Number of community pharmacies *	Emergency Hormonal Contraception (EHC)	EHC Percentage (%)	Chlamydia & Gonorrhoea screening	Chlamydia & Gonorrhoea screening Percentage (%)
Surrey	195	96	49.2	65	33.3
Elmbridge	28	9	32.1	4	14.3
Epsom & Ewell	11	8	72.7	7	63.6
Guildford	18	12	66.7	8	44.4
Mole Valley	16	10	62.5	5	31.3
Reigate & Banstead	23	15	65.2	11	47.8
Runnymede	12	6	50.0	6	50.0
Spelthorne	20	6	30.0	5	25.0
Surrey Heath	17	6	35.3	6	35.3
Tandridge	14	7	50.0	3	21.4
Waverley	24	10	41.7	6	25.0
Woking	12	7	58.3	4	33.3

Source: SCC Pharmaoutcomes, * The number of pharmacies shown includes community pharmacies, and excludes distance selling pharmacies and dispensing appliance contractors.

Substance misuse service

A range of substance misuse services are commissioned through community pharmacy. The Supervised Consumption service supports opiate users by enabling them to be supervised during Opiate Substitution Therapy when clinically appropriate in their treatment pathway.

The NSP (Needle & Syringe Programme) allows for county wide provision of clean injecting equipment for People Who Inject Drugs. In 2020, Hepatitis C antibody testing and the provision of Take-Home Naloxone services was introduced to pharmacies. Hepatitis C antibody testing was due to end 31 March 2022 and has been extended to 2023. Nationally the uptake of the service has been low, mainly due to the launch of the service during COVID-19 pandemic. Surrey pharmacies have had no uptake of this service. The Take-Home Naloxone service was introduced to reduce the number of drug-related deaths caused by opiate overdose. Naloxone is an opioid antagonist which rapidly reverses an opioid overdose.

Twenty-two pharmacies across Surrey provide the Take-Home Naloxone service.

The Public Health Team within SCC coordinate the local strategy for these services. Provision is deemed to be meeting the needs of the population throughout the county by commissioners.

Supervised consumption

The Supervised Consumption scheme through community pharmacy aims to reduce mortality and morbidity among high-risk opiate users by improving consistency and quality of care. Government recommendations acknowledge that patient compliance with the programme is an important issue in substance misuse treatment.

This service supports individuals in complying with their prescribed regime therefore reducing incidents of accidental deaths through overdose and pharmacists are able to keep to a minimum the misdirection of controlled drugs, which may help reduce drug related deaths in the community.

Pharmacies that have been commissioned to deliver the service, provide support and advice to the patient, including referral to specialist services when appropriate. Users of this services are able to nominate a pharmacy that they can easily access on a daily basis.

There are 104 accredited providers participating in the scheme (Table 23).

Needle and syringe exchange programme (NSP)

The aim of this service is to reduce the transmission of blood-borne viruses associated with injecting drug use by providing free, sterile injecting equipment and advice in line with NICE public health guideline PH52⁴⁸. In the UK, Hepatitis C is the most prevalent blood-borne virus among people who inject drugs (PHE, 2015).

NSPs are often the first contact individuals may have with services and key to engaging individuals into treatment.

The restrictions introduced in response to COVID-19 presented many challenges, particularly for vulnerable and marginalised populations. These included maintaining access to NSPs to reduce the harms associated with injecting drugs. NSPs effectiveness is coverage dependent, but lockdowns and social distancing limited NSP access and availability. Data collected through an established comprehensive regional monitoring system from five four-week periods, centred on the implementation of restrictions in the UK in mid-March 2020, were examined. The restrictions resulted in the number of NSP clients decreasing by 36%, visits by 36%, and needles distributed by 29%.

Though it is currently unclear if there has been a decline in injecting, the decline in NSP usage is so marked that it almost certainly reflects decreased utilisation among those in need, indicating increased equipment reuse and risk ([The impact of COVID-19 restrictions on needle and syringe programme provision and coverage in England - PMC \(nih.gov\)](#)).

The Public Health Team within SCC coordinate the local strategy for this service, and provision is deemed to be meeting the needs of the population throughout the county. Commissioners' actively monitor and respond to changes in patterns of drug use including provision of specific packs for an increasing prevalence of Steroid and Image and Performance Enhancing Drug Use. There are currently 46 pharmacies participating in the scheme (Table 23).

⁴⁸ [NICE Needle and Syringe Programmes](#)

Table 23: Number of pharmacies accredited to deliver Substance Misuse Services by Local Authority (September 2021/22)

Area name	Number of community pharmacies*	Supervised consumption of methadone	Percentage (%)	Needle and syringe exchange programme	Percentage (%)
Surrey	195	104	53.3	46	23.6
Elmbridge	28	10	35.7	4	14.3
Epsom & Ewell	11	8	72.7	2	18.2
Guildford	18	12	66.7	4	22.2
Mole Valley	16	6	37.5	5	31.3
Reigate & Banstead	23	11	47.8	6	26.1
Runnymede	12	6	50.0	3	25.0
Spelthorne	20	10	50.0	6	30.0
Surrey Heath	17	5	29.4	4	23.5
Tandridge	14	9	64.3	3	21.4
Waverley	24	16	66.7	6	25.0

Source: Pharmoutcomes, * The number of pharmacies shown includes community pharmacies, and excludes distance selling pharmacies and dispensing appliance contractors.

NHS Health Checks

The NHS Health Check is a free service aimed at adults in England aged 40 to 74. It is an assessment of the risk of developing vascular or circulatory disease. During the check, questions around lifestyle and family medical history and some routine tests are carried out. From these the healthcare professional is able to give the patient their risk of developing heart disease, kidney disease, and/or diabetes over the next ten years. For patients over 65, the signs and symptoms of dementia are also discussed⁴⁹. The NHS Health Check offers personalised advice and support to stay healthy and reduce risks if any results need improving upon.

There are 28 pharmacies trained and accredited to deliver NHS Health Checks in Surrey (Table 24).

⁴⁹ What is an NHS Health Check? NHS Choices. 2016. Available from: [NHS What is a NHS Health Check?](#)

Table 24: Pharmacies delivering NHS Health Checks in Surrey (October 2021/22)

Area name	Number of community pharmacies*	Number of pharmacies delivering Health Checks	Health Check Percentage (%)
Surrey	195	28	14.4
Elmbridge	28	1	3.6
Epsom & Ewell	11	1	9.1
Guildford	18	5	27.8
Mole Valley	16	8	50.0
Reigate & Banstead	23	6	26.1
Runnymede	12	1	8.3
Spelthorne	20	1	5.0
Surrey Heath	17	0	0.0
Tandridge	14	4	28.6
Waverley	24	1	4.2
Woking	12	0	0.0

Source: SCC PHA, * The number of pharmacies shown includes community pharmacies, and excludes distance selling pharmacies and dispensing appliance contractors.

Stop Smoking Services

The public health local stop smoking service ended in April 2020 in Surrey pharmacies.

A new smoking cessation service was commissioned by NHSE in March 2022 for hospital in-patients who start their smoking cessation treatment in hospital and can then be referred out into community pharmacy to continue their treatment. This is currently being rolled out across Surrey.

BP Plus service

The service aims to increase the number of opportunities for patients to have their blood pressure and pulse rhythm checked in community pharmacies. It has two main elements:

- checks for certain stroke and CVD risk factors (raised blood pressure and pulse rhythm) and appropriate onward referral; and
- community pharmacies offering blood pressure BP Plus to manage patients referred or signposted from any community pharmacy and voluntary organisation

Surrey Pharmaceutical Needs Assessment 2022

Depending on the results of the BP Plus, the healthcare professional/pharmacist will advise the appropriate action(s) from the following options:

- referral/signposting or advice about healthy lifestyle management
- depending on the results, encourage the patient to home monitor BP results for a month and bring it back to discuss with the pharmacist
- referred for a full NHS Health Check

As at October 2021, 27 out of the 195 pharmacies in Surrey have given an expression of interest for the BP Plus service in Surrey.

4.5.2 ICB commissioned services

Local authorities and CCGs were able to commission services to meet the needs of the local population. From 1 July 2022 the role of commissioning has moved from CCGs (which ceased to exist) to the ICBs. The following services are currently commissioned in Surrey.

Palliative care scheme

An integral part of End of Life Care is the provision of medicines to facilitate symptom control and enable patients to live and die in their place of choice whilst reducing unnecessary admissions in the last weeks of their life. The aim of this service is to provide immediate and consistent access to palliative care medication across Surrey. Out-of-hours access to medical help and drugs is therefore essential.

Table 25 shows there are 18 pharmacies that provide the palliative care scheme in Surrey.

Table 25: Number of pharmacies included in the on-demand availability of drugs for the palliative care scheme by local authority (July 2021)

Area name	Number of community pharmacies	Number of pharmacies on palliative care scheme	% per local authority
Surrey	195*	18	9%
Elmbridge	28	2	7%
Epsom & Ewell	11	1	9%
Guildford	18	1	6%
Mole Valley	16	1	6%
Reigate & Banstead	23	2	9%
Runnymede	12	1	8%
Spelthorne	20	1	5%
Surrey Heath	17	2	12%
Tandridge	14	2	14%
Waverley	24	3	13%
Woking	12	2	17%

Source: SCC PHA, * The number of pharmacies shown includes community pharmacies, and excludes distance selling pharmacies and dispensing appliance contractors.

H. Pylori test

In 2007, East Surrey commissioned community pharmacists to carry out H. Pylori testing using Pylobactell Tests. This is a simple breath test used to determine the presence of active bacterium known as Helicobacter Pylori in the gut. The service was developed to help prescribers confirm if the patient had helicobacter pylori infection in order to help diagnose and treat the condition. The service is still available, however the local contract for the H. Pylori service in East Surrey is due to end on 31 March 2022. This service is going to be re-commissioned across the whole of Surrey Heartlands by Surrey Heartlands ICS.

Pharmacy urgent medicines (PURM) service

The PURM service was a locally commissioned service which preceded the national NHS urgent medicine supply advanced service (NUMSAS). PURM reverted to NUMSAS on 1 April 2018. NUMSAS is now incorporated into the community pharmacy contract under the CPCS and is no longer commissioned in Surrey.

Online non-prescription ordering service

The online non-prescription ordering service is no longer a locally commissioned service, it ceased in December 2020.

Newly Commissioned Services – UTI treatment and Ondansetron

Two new locally enhanced services have been commissioned by NHS Frimley Health and Care recently, which includes only pharmacies in the Surrey Heath area. These are a urinary tract infection treatment service and a service across selected pharmacies to stock certain medications to support the Paediatric Urgent Care Gastroenterology Pathway.

4.5.3 Other NHS providers

The following are providers of pharmacy services in the Surrey HWB area but not defined as NHS Pharmaceutical Services within The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The 2013 Regulations require PNAs to include a statement of other NHS services that the HWB considers affect the need for pharmaceutical services.

The NHS services offered by hospital pharmacies in Acute Trusts, GP out-of-hours service (when it gives patients a course of treatment rather than a prescription), personal administration of items by GP practices and prison pharmacy services in Surrey are considered to contribute to a reduced need for pharmaceutical services, in particular the dispensing service. NHS services in Surrey that may increase the demand for pharmaceutical services include GP out-of-hours services (where a prescription is issued), walk-in centres and minor injury units (where a prescription is issued) and dental services. It should be noted that dentists will issue NHS prescriptions which are dispensed as part of pharmaceutical services, however the level of activity and number of items is not known.

Acute and Mental Health Trusts

Surrey's population has access to seven acute providers, with Epsom & St Helier University NHS Trust divided into two sites. There is a pharmacy on site at each acute provider which dispenses to hospital patients only and does not dispense prescriptions issued by other prescribers such as GPs.

Surrey Pharmaceutical Needs Assessment 2022

The table below shows the opening times of these dispensing services. Surrey and Sussex Healthcare NHS Trust Pharmacy at East Surrey Hospital is commissioned to deliver smoking cessation and NHS Health Checks through PHAs.

Surrey and Borders Partnership NHS Foundation Trust is the leading provider of health and social care services for people of all ages with mental ill-health and learning disabilities in Surrey and North East Hampshire. Surrey and Borders Partnership NHS Foundation Trust has an onsite pharmacy co-located with Farnham Road Hospital in Guildford. This pharmacy service is provided and managed directly by the Trust and provides clinical, supply and distribution services to the Trust wards and community teams across Surrey. The pharmacy is not contracted to dispense on behalf of other prescribers including GPs. The pharmacy is open Monday to Fridays 9am to 5pm and provides an emergency duty service outside of these hours. In addition Surrey and Borders Partnership NHS Foundation Trust have two pharmacy Service Level Agreement with acute Trusts. A significant proportion of dispensing activity is generated by the community teams using FP10 HP prescriptions which are dispensed by local community pharmacies.

Table 26: Acute Trusts that serve the Surrey Population

Trust	Local Authority	Opening hours
Epsom Hospital (Epsom and St Helier University Hospitals NHS Trust)	Epsom & Ewell	Monday – Friday: 08:30 - 17:30 Saturday: Closed Sunday: Closed
Frimley Park NHS Foundation Trust	Guildford	Monday – Friday: 09:00 - 19:00 Saturday: 09:30 - 16:00 Sunday: 09:30 - 16:00
The Royal Surrey County NHS Foundation Trust	Guildford	Monday – Friday: 09:00 - 17:45 Saturday: Closed Sunday: Closed
East Surrey Hospital	Reigate & Banstead	Monday – Friday: 08:00 - 20:30 Saturday: 08:00 - 20:30 Sunday: 10:00 - 16:00
Ashford & St Peters NHS Foundation Trust	Runnymede	Monday – Friday: 09:00 - 17:00 Saturday: 10:00 - 15:00 Sunday: 10:00 - 15:00
Kingston Hospital NHS Foundation Trust	Kingston (outside of Surrey)	Monday – Friday: 09:00 - 17:00 Saturday: 10:00 - 13:00 Sunday: 10:00 - 13:00
St Helier (Epsom and St Helier University Hospitals NHS Trust)	Sutton (outside of Surrey)	Monday – Friday: 09:00 - 17:30 Saturday: Closed Sunday: Closed
Surrey & Borders Partnership NHS Foundation Trust	Leatherhead	Monday – Sunday 24 hours

Walk-In-Centres (WIC), Minor Injury Units (MIU) and Urgent Treatment Centres (UTC)

There are now two walk-in-centres in Surrey, two minor injury units and one urgent treatment centre which offer a range of services to the public without the need for a prior appointment. The services are designed to typically deal with routine and urgent primary care for minor ailments and injury. The Weybridge walk-in-centre has closed indefinitely due to a fire in July 2017.

The dispensing arrangements are included in the service specification for pharmacy services from an acute trust. The Patient Group Directions that the walk-in-centres use in order to supply and administer the medication are produced by the Virgincare pharmacy team. Support for centres in East Surrey is provided by First Community Health and Care in partnership with the walk-in-centres.

Occasionally patients are prescribed medicines using an FP10 form to take to a pharmacy. The walk-in-centres are located in convenient locations and have a number of pharmacies located nearby.

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Table 27: Walk-In-Centres and Minor Injury Units

Walk-In-Centre (WIC)	Local Authority	Opening hours
Ashford WIC	Spelthorne	Monday - Friday: 08:00 - 20:00 Saturday - Sunday: 08:00 - 20:00
Woking Community Hospital WIC	Woking	Monday - Friday: 07:00 - 19:30 Saturday - Sunday: 09:00 - 19:00

Minor Injury Unit (MIU)	Local Authority	Opening hours
Caterham MIU Over 18's only	Tandridge	Monday - Friday: 08:00 - 17:00 Saturday - Sunday: Closed
Haslemere MIU	Waverley	Monday - Friday: 08:00 - 17:00 Saturday - Sunday: Closed

Urgent Treatment Centre (UTC)	Local Authority	Opening hours
St Peter's Hospital, UTC	Runnymede	Monday - Sunday: 08:00 - 23:59

Source: Surrey Heartlands, 2022

GP practices

There are 117 GP practices and 29 GP branch (i.e. not main) surgeries in Surrey which are outlined in the table below. GPs also offer a range of locally commissioned services that may be provided in a particular locality to tackle health inequalities. These include Homelessness service and Shared care/drug misuse service. There are a range of GPs signed up to provide locally commissioned services through a PHA.

Table 28: GP Practices within Surrey and locally commissioned services they provide (2020/21)

Local Authority	Number of GP practices	Number of branches	Number of GP practices providing NHS Health Checks	Number of GP practices providing Drug Misuse Service
Elmbridge	17	1	13	3
Epsom & Ewell	7	4	5	1
Guildford	11	5	7	2
Mole Valley	9	6	8	1
Reigate & Banstead	13	0	10	1
Runnymede	7	0	6	1
Spelthorne	10	1	10	4
Surrey Heath	8	0	6	3
Tandridge	8	2	4	0
Waverley	15	3	10	1
Woking	12	7	11	3
Surrey	117	29	90	20

Source: NHSE

GP out-of-hours

The out-of-hours period for the majority of General Medical Practices is from 18:30 to 08:00 on weekdays and all day at weekends and on bank holidays.

Prison Services

There are five prisons in Surrey (HMP Send, HMP High Down, HMP Coldingley, HMP Downview and HMP/YOI Bronzefield). Central and North West London NHS Foundation Trust provides a clinical and supply pharmacy service to HMP Send, HMP High Down, HMP Coldingley and HMP Downview. The Central and North West London NHS Foundation Trust pharmacy is based in-house at HMP High Down and a daily delivery of medicines is made to all sites. Sodexo provides a clinical and supply pharmacy service to HMP/YOI Bronzefield however this will change in April 2023 when Integrated Healthcare Services (which includes both clinical and supply pharmacy services (commissioned by NHSE, Health and Justice) will incorporate all 5 prisons in the Surrey region.

4.6 Key findings and recommendations

- There are 200 pharmacies in the Surrey HWB area. Three of these are internet / distance selling pharmacies and two are DACs
- There are 87 additional pharmacies in 14 neighbouring HWB areas within one mile of the Surrey County border
- There are 15 dispensing doctor practices including branch surgeries
- There are 16 pharmacies per 100,000 population in Surrey compared to 21 per 100,000 population in England
- Thirteen community pharmacies have 100 hour per week contracts
- 185 community pharmacies have 40-hour contracts. Pharmacies may also provide supplementary hours above core hours
- One hundred and eighty-five (94.9%) are open on Saturdays and 44 (22.6%) are open on Sundays
- Fifty-two pharmacies, over a quarter (26.7%), are still open in the evening at 18:30
- Across Surrey, there is good access to community pharmacy or dispensing general practices within a reasonable travel time by car during weekdays and Saturdays
- The population of Surrey is within a five-mile radius of a pharmacy during weekday opening hours giving a reasonable choice to residents
- For some residents living in more rural areas without access to their own car, the access to community pharmacy may be less good but cannot be quantified. Their access to essential services may be ameliorated by the growing availability of internet pharmacies and the willingness of some pharmacies to deliver prescription medications
- Surrey council commissions pharmacies to provide emergency hormonal contraception, Chlamydia and Gonorrhoea screening and treatment, supervised consumption, needle and syringe exchange programme, Take Home Naloxone, BP Plus and NHS Health Checks

5.0 Surveys of public and patient views

Surveys were distributed to the Surrey Citizen's Panel. The panel is a large group of residents from across Surrey who volunteer to take part in online engagement activities such as surveys, to help the council understand residents' views and ideas about a range of important issues. The panel is recruited to quotas based on Surrey demographics rather than residents being able to self-select themselves. The panel is currently made up of 2,177 residents, however not all of these residents will choose to respond to an engagement. We received 977 responses to the pharmaceutical needs survey from these residents.

The Citizens Panel survey data is weighted on age and gender to make the responses more representative of the population. The survey responses initially leaned towards females and people aged over 65 years old. The results presented in this section are based on the weighted data.

Survey table 1 - Age profile of Surrey Citizen's Panel participants (2021):

Age	Count	%
16 to 24	13	1%
25 to 34	60	6%
35 to 44	194	20%
45 to 54	160	17%
55 to 64	172	18%
65+	349	37%
Prefer not to say	3	0%
Total	951	100.0%

Survey table 2 - Surrey population age profile:

Age	Age breakdown of population as of Dec 2021
18 to 24	10%
25 to 34	14%
35 to 44	17%
45 to 54	19%
55 to 64	16%
65+	24%

Survey table 3 - Sex profile of Surrey Citizen’s Panel participants (2021):

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Gender	Count	%
Female	592	61%
Male	365	37%
N/A	19	2%
Prefer not to say	1	0%
Total	977	100%

Survey table 4 - Surrey population sex profile:

Gender	Population as of Dec 2021
Female	51%
Male	49%

In addition to the Surrey Citizen’s Panel, the PNA steering group requested that an extended version of the questionnaire should be circulated more widely, in a targeted effort to seek views from population groups that may experience health inequalities across Surrey.

This adapted version of the survey was published online using Surrey Says and was publicised via targeted ‘next door’ posts to residents of the wards which have areas with the most deprived small areas across Surrey (as outlined in Surrey’s Health and Wellbeing Strategy which is available online at the following webpage: [Surrey Health and Well-being Strategy update 2022 - Priority Populations](#)) via Healthwatch Twitter and Facebook accounts, in the Surrey Minority Ethnicity Forum newsletter, the Surrey Gypsy Traveller Communities Forum and the Surrey Coalition of Disabled People newsletter.

The results from the Surrey Citizen’s Panel and targeted circulation are summarised below along with responses from the extended online survey that was sent to targeted circulation.

Free text responses have been included in this section. The content of each response is unchanged, however some minor edits to grammar and spelling have been made for ease of understanding.

Choice of pharmacy

When asked about their choice of pharmacy, the majority of respondents said that they ‘always or almost always use the same pharmacy’, and location was the most commonly reported factor that influenced the choice of pharmacy. The large majority of participants reported that the pharmacy being close to where they lived was the most important reason for this. Fourteen percent of participants on the Citizens Panel, and eight percent of participants from the targeted circulation reported that the pharmacy being located close to another place they need or want to visit was the most important reason, while 12% of participants from the targeted circulation reported ‘something else’ compared with 4% from the Citizen’s Panel.

Survey table 5 – Use of a regular pharmacy

Thinking about your visits to a pharmacy, do you...	Citizens panel (Count)	Citizens panel (%)	Targeted circulation (Count)	Targeted circulation (%)
I always or almost always use the same pharmacy	677	74%	74	78%
I often use different pharmacies but have one that I typically or prefer to use	136	15%	14	15%
I use different pharmacies with no preference for one in particular	84	9%	5	5%
I don’t use pharmacies	17	2%	2	2%
Total	914	N/A	95	N/A

Survey table 6 – Factors influencing choice

What factor or factors influence your choice of pharmacy? (multiple selection) *	Citizens panel (Count)	Citizens panel (%)	Targeted circulation (Count)	Targeted circulation (%)
Familiarity	336	37%	44	47%
Location	780	85%	81	86%
Opening hours	244	27%	18	19%
Services on offer	192	21%	29	31%
None of these	26	3%	1	1%
Total	915	100%	94	100%

*Participants could select multiple options; percentages are reported out of the total number of respondents who answered the question, not the total number of responses received

Survey table 7 – Location of pharmacy as important factor

If location was selected as an important factor, respondents were asked:

What is it about the location of the pharmacy that is most important to you?	Citizens panel (Count)	Citizens panel (%)	Targeted circulation (Count)	Targeted circulation (%)
It is close to where I live	276	78%	67	72%
It is close to friends and / or family	1	0%	5	5%
It is close to where I work	10	3%	3	3%
It is located close to another place I need or want to visit	50	14%	7	8%
Something else	15	4%	11	12%
Total	352	100%	93	100%

Participants in the targeted circulation were asked 'In a few words, please describe if the factors that influence your choice of pharmacy have changed as a result of the COVID-19 pandemic, or government measures over the last 2 years?'. There were 79 responses to this question. The majority (45 people) said there was no change due to COVID-19, 10 described changes in their choice, seven described changes in pharmacies, and 17 commented on other factors. Ten respondents described changes in their choice, due to various factors, outlined below.

Factors relating to lockdown (which affected usual behaviour and travel patterns):

- *'During lockdown/restrictions I used local pharmacy within walking distance as we were not travelling into town.'*
- *'Location so I can walk there and the doctor surgery send my prescription there'*
- *'I have changed from using a 'high street' pharmacy with a shop to a deliver to the door service by [redacted]. This was due to inefficiencies and poor service when collecting repeat medications from my local chemist. The additional advantage of it being delivered to my home is even better. Your survey does not seem to cover the use of online pharmacies.'*
- *'Only one who could do blister packs as [pharmacy name redacted] stopped doing them. Also location as somehow to get them for me as I am wheelchair user'*

Surrey Pharmaceutical Needs Assessment 2022

- *'I did try online pharmacy in lock down but went back to local as my medication was never complete and too difficult to rectify.'*

Factors relating to accessibility and mask wearing

- *'I have avoided returning to pharmacies that disable me by not having a working Hearing Loop, or staff who have no knowledge of how it works, or even deny that one is available when signage at the door or counter says there is one. It is impossible to lipread staff who wear masks that are not transparent'*

Factors relating to service

- *'I changed pharmacy because the one I used consistently provided a poor service in failing to fill my prescriptions and failing to communicate according to my needs. The pharmacy I moved to was also nearby, was [recommended] by my GP after I explained the difficulties and has consistently filled prescription and has communicated well, [according] to my needs'*
- *'The pharmacy at my local GP ([redacted]) - was impractical with COVID 19 and stopped serving for a while). They were poor at getting drugs and inflexible and hard to park, cramped inside and unsafe for COVID and generally rubbish). I moved to [redacted] at another surgery ([redacted]) and they proved to be open for long hours, get medication quickly, very efficient and basically, I would never go back to [redacted] who were simply dreadful by comparison.'*

Factors that coincided with the pandemic, but may be unrelated

- *'Only because we changed GP just before the pandemic and the pharmacy is on site'*
- *'My health needs.'*

Seven respondents described changes at their pharmacy, although they did not clearly state if they changed their pharmacy as a result of these changes.

There were two positive changes highlighted:

- *'I have been managing to get my medication delivered, or I pick it up depends'*
- *'No change [in choice] but had a volunteer collect my scripts, as I am extremely vulnerable.'*

There were four negative changes highlighted:

- *Reduced hours and reduced services - delayed obtaining of goods*
- *I have been unable to arrange home delivery of regular prescriptions*
- *[pharmacy name redacted] all ways stock my medication but starting to change has brought another chemist.*
- *No change [in choice] but the service has deteriorated since covid*

There was one comment, which asked that changes not be used to reduce services

- *all services have been affected by the pandemic please do not use it to reduce services such as pharmacies*

Surrey Pharmaceutical Needs Assessment 2022

Seventeen respondents made general comments about their pharmacy.

Examples of positive feedback include:

- *Adherence and encouragement of mask-wearing and social distancing to keep everyone safe. Demonstrates they follow rules, so I can expect they are operating properly and safely with other aspects of pharmacy. My pharmacy served from the door at the beginning, rather than let anyone in, to maximise safety. Only when screens were in place and case numbers had dropped did they allow just 2 people in at a time.*
- *the pharmacist knows about my condition and i trust the advice they give.*
- *Mostly has what I need in stock for myself and son.*
- *They are very helpful with my husband complicated medication now do ordering and dosette box*
- *Fantastic team. They even deliver 'filled' scripts if I am unable to get to premises*

Examples of comments about service:

- *All our local pharmacies are under staffed. So customer service is sadly lacking. Convenient location to walk or park easily.*

Comments about location, transport and parking impacting on choice

- *Close to my health centre*
- *It's close to where I live also helpful for someone else to collect my medication*
- *It is convenient for my partner to collect my prescriptions and they always have any other medicines or supplies I need*
- *There are no pharmacies near me, so I use one where friends or family can help too.*
- *In the town, so I can access by bus.*
- *No way of getting to another pharmacy without more cost i.e. taxi*
- *Available parking at pharmacy*
- *I have it delivered because no chance parking outside*

Participants in the targeted circulation were also asked 'Is there a more convenient and/or closer pharmacy that you don't use? (please select one)'. All 95 participants responded, and the majority (58 people, 61%) said no, 35 people (37%) said yes and 2 people (2%) said they did not know.

Those who answered yes, were asked why they do not use the closer or more convenient pharmacy and the majority (46%) of participants said that the service is too slow, 36% said they have had a bad experience in the past and 31% said the pharmacy did not have what they needed in stock. Participants could select multiple options to this question.

Survey table 8 – Why don't use pharmacy

If you answered 'yes' to the above question, please could you tell us why you do not use that pharmacy? (please select all that apply)	Targeted circulation (Count)	Targeted circulation (%)
The service is too slow	18	46%
I have had a bad experience in the past	14	36%
They don't have what I need in stock	12	31%
It is not easy to park at the pharmacy	9	23%
The staff are always changing	8	21%
There is not enough privacy	7	18%
The staff don't know me	6	15%
The pharmacy doesn't deliver medicines	6	15%
I know the staff and would prefer them not to know what medicines I am taking	5	13%
It's not open when I need it	3	8%
It's not wheelchair/baby buggy friendly	2	5%
Other [please specify]	11	28%
Total	39	N/A

*Participants could select multiple options; percentages are reported out of the total number of respondents who answered the question, not the total number of responses received

Eleven participants selected other, and 15 participants listed reasons. These included service quality, issues, availability of certain items, accessibility and practical reasons.

Most comments about service reflected on negative experiences:

- *They are my only option but they can be rude and unhelpful*
- *Chaotic service*
- *Rude officious staff*
- *Pharmacist is rude and ignorant and no staff in the tiny shop*
- *They don't communicate in the manner I need and fail to fill prescriptions without much effort to correct this*
- *I would get the same medications every month, prescribed by my psychiatrist. Pharmacist would argue with me every single time that I shouldn't be taking multiple antidepressants. I would explain that I had been prescribed that combination by the psychiatrist to try to get the therapeutic benefit of a medication I had a serious allergic reaction to, He would refuse to dispense my medication until I begged, in a loud voice in front of the whole pharmacy full of people. I was always reduced to tears by this*

Surrey Pharmaceutical Needs Assessment 2022

experience, and it happened every single time I went there. After 6 months I started using a different pharmacy, in a far less convenient location, because they would just prescribe my meds without traumatising me.

Two comments described certain items not being available, however one reflected on positive experience of service influencing choice, despite not having certain items that were needed:

- *I have used the nearest one, they are a small independent and don't always have the additional items that I might want. However, they do provide an excellent pharmacy service and help especially with elderly customers.*
- *Don't do blister packs*

One comment was about accessibility:

- *'The only hearing loop is at the counter that staff never use, and won't go to because it is cluttered.'*

Two comments were about issues or difficulty in requesting/ receiving medications:

- *'Often I would not receive the correct prescription'*
- *'A long time, over 7 working days, to issue repeat prescriptions and then not fulfilled so a second visit required to collect all medications'*

A few comments also described practical reasons that they used a certain pharmacy and not another:

- *'The Pharmacy is in the Hospital where my Medical [practice] is situated.'*
- *'They don't manage repeat prescriptions for my GP surgery'*
- *GP surgery signed me up automatically'*

One comment described their preference, and noted no clear reason for using one pharmacy over another:

- *I am happy with my present one, will use the other one sometimes.*

Ease of using a pharmacy

The majority of participants from the Citizens Panel and targeted survey find it very easy or somewhat easy to visit a pharmacy. A higher percentage (16%) of participants from the targeted circulation find it somewhat or very difficult to visit a pharmacy, compared with 7% of participants from the Citizens Panel.

Survey table 9 – Ease of visiting a pharmacy

If you needed to visit a pharmacy on a typical day, how easy or difficult would that be for you?	Citizens panel (Count)	Citizens panel (%)	Targeted circulation (Count)	Targeted circulation (%)
Very easy	512	56%	39	41%
Somewhat easy	256	28%	26	27%
Neither easy or difficult	84	9%	15	16%
Somewhat difficult	52	6%	10	11%
Very difficult	11	1%	5	5%
Total	915	100%	95	100%

Of those who found it somewhat or very difficult to visit a pharmacy (7% of Citizens panel, and 16% of the targeted circulation) the main reasons given were limited mobility (67% of targeted circulation and 35% of the citizens panel) and 37% of the citizens panel respondents also selected opening times.

Survey table 10 – Factors that make visiting difficult

If 'somewhat difficult' or 'very difficult' was selected, respondents were asked:

In the previous question, you said that you can find it difficult to use the pharmacy. What is the factor or factors that make it difficult?	Citizens panel (Count)	Citizens panel (%)	Targeted circulation (Count)	Targeted circulation (%)
I have limited mobility and so find it hard to visit in person	25	35%	10	67%
The pharmacy is a long way from where I live	6	8%	1	7%
It is not open when I need it to be	26	37%	1	7%
Something else	14	20%	6	40%
Total	71	100%	15	100%

*Participants could select multiple options; percentages are reported out of the total number of respondents who answered the question, not the total number of responses received

Participants in the targeted circulation were also asked ‘Has there been a time recently when you weren’t able to use your normal pharmacy? (please select one)’. There were 94 responses to this question, and the majority (55 people, 58%) said no, 32 people (34%) said yes and 7 people (7%) said it was not applicable.

The majority of respondents who said ‘yes’ there had been a time they weren’t able to use their normal pharmacy, instead went to another pharmacy, 13% waited until the pharmacy was open and one person went to the general hospital. Participants could select multiple options to this question, although most only selected one.

Survey table 11 – What you did

If you answered ‘yes’ to the above question can you tell us what you did? (please select all statements that apply)	Targeted circulation (Count)	Targeted circulation (%)
I went to another pharmacy	17	53%
I waited until the pharmacy was open	4	13%
I went to the general hospital	1	3%
I went to my GP	0	0%
I went to a Walk In Centre	0	0%
I called 111	0	0%
Other [please specify]	11	34%
Total	32	100%

Eleven participants selected other, and 13 participants described the detail in comments. The majority of comments were about seeking help from a family member, friend or colleague:

*Friend had to collect for me
friend collected item*

I got a family member to go on my behalf.

I had to get my pa to help

Asked a carer to [phone] because they do not have SMS or other text communication for use by lipreaders who cannot use this skill on the phone

I got someone else to [go]

One person stated that they used online services instead:

No stock of my cream went online

One person waited:

I had to wait until another day (they had no staff)

Some comments were about changes or implications due to the pandemic:

Shielding, drugs delivered to me

Closed during pandemic when staff got covid

Surrey Pharmaceutical Needs Assessment 2022

Some comments were about the location, but not all specified what action they took when they weren't able to access their usual pharmacy:

Closure of usual pharmacy

In supermarket

I was staying with friends so my GP mailed me my prescription

Travel to pharmacy

The two main methods of travel to pharmacy were walking and driving, and the journey time is under 10 mins for the majority of respondents; however, this was a larger majority (66%) amongst respondents from the Citizens Panel compared with 49% of respondents from the targeted circulation, more closely followed by 40% of respondents taking between 10 and 20 minutes.

Survey table 12 – How typically travel to pharmacy

How would you typically travel to the pharmacy?	Citizens panel (Count)	Citizens panel (%)	Targeted circulation (Count)	Targeted circulation (%)
Walk	421	46%	44	46%
Cycle	18	2%	2	2%
Car or other motor vehicle (including taxis)	457	50%	45	47%
Public transport	11	1%	4	4%
Another way	9	1%	0	0%
Total	916	100%	95	100%

Survey table 13 – How long it takes to get to pharmacy

And thinking about a typical visit to the pharmacy, how long would you say it usually takes you to get there?	Citizens panel (Count)	Citizens panel (%)	Targeted circulation (Count)	Targeted circulation (%)
Under 10 minutes	606	66%	47	49%
Between 10 and 20 minutes	267	29%	38	40%
Over 20 minutes	41	4%	10	11%
Total	914	100%	95	100%

Approximately half of the respondents typically travel to the pharmacy by car or other motor vehicle (including taxis). These respondents were asked about parking, and the majority of the citizens panel (57%) stated they never or very occasionally have trouble parking and a third stated they sometimes have trouble parking. A smaller majority (38%) of respondents to the targeted survey sometimes have trouble parking, and 31% never or occasionally have trouble parking while 20% reported they frequently or always have trouble parking.

Survey table 14 – Parking experience

You said that you typically use a car or other motor vehicle when visiting the pharmacy. On these occasions, which of the following statements would best describe your parking experience?	Citizens panel (Count)	Citizens panel (%)	Targeted circulation (Count)	Targeted circulation (%)
I never or very occasionally have trouble parking	259	57%	14	31%
I sometimes have trouble parking	150	33%	17	38%
I frequently or always have trouble parking	43	9%	9	20%
Not applicable (e.g. you travel by taxi or are dropped off by someone else)	4	1%	5	11%
Total	456	100%	45	100%

Reasons for visiting pharmacy

The majority of people stated that picking up a prescription for themselves was a main reason for a visit to the pharmacy. Thirty-two percent of participants from the targeted circulation and 21% of participants from the citizens panel visit to seek information and/ or advice from the pharmacist.

Survey table 15 – Reason to visit pharmacy

Thinking again about a typical visit to a pharmacy, what would be your reasons to visit? (multiple selection)*	Citizens panel (Count)	Citizens panel (%)	Targeted circulation (Count)	Targeted circulation (%)
To pick up a prescription for myself	748	82%	83	87%
To pick up a prescription for someone I live with	418	46%	40	42%
To pick up a prescription for someone I don't live with (e.g. as an unpaid carer)	57	6%	11	12%
To seek information and / or advice from the pharmacist	190	21%	30	32%
To buy 'over the counter' medicines or products	452	49%	48	51%
Something else	26	3%	7	7%
Total	915	100%	95	100%

*Participants could select multiple options; percentages are reported out of the total number of respondents who answered the question, not the total number of responses received

Surrey Pharmaceutical Needs Assessment 2022

Participants could select multiple options to the above question about reasons to visit. Seven participants selected 'Something else', and 10 participants described the detail. Six of these included to buy or collect certain products, or tests or vaccinations:

Collect monthly blister packs

To buy other items

Collect covid tests

Tests such as hearing, blood tests (blood sugar) flu jab etc

Get flu jab

Get a flu jab

Four participants described reasons that they do not visit a pharmacy in person:

I use online pharmacies

As I am housebound I use the phone for contacting them which I have found satisfactory.

I am unable to visit pharmacy due to poor mobility

Over the phone via my doctor; to pharmacy; then delivered to me??

Meeting needs and expectations

Participants were asked about the typical experience when visiting a pharmacy. The majority of respondents said they always or almost always achieve the reason for their visit.

Survey table 16 – Typical experience

Thinking about visits to the pharmacy, which of the following statements best describes your typical experience?	Citizens panel (Count)	Citizens panel (%)
I always or almost always achieve the reason for my visit	682	74%
I frequently achieve the reason for my visit	194	21%
I sometimes achieve the reason for my visit	34	4%
I infrequently achieve the reason for my visit	4	0%
I never or almost never achieve the reason for my visit	2	0%
Total	916	100%

Participants who stated that their needs were not met, were also asked why. Participants could select multiple options to this question.

Survey table 17 – Reasons needs not met

You said that your needs are never, almost never or infrequently met for some visits to your pharmacy. What reason or reasons would you say make you feel this way	Citizens panel (Count)	Citizens panel (%)	Targeted circulation (Count)	Targeted circulation (%)
There are services I need or want which are not offered	1	11%	6	18%
The pharmacy is often closed when I want to use it	1	11%	2	6%
The medicines and / or products I want are not always in stock	3	33%	13	39%
I feel the staff are not knowledgeable	2	22%	3	9%
I am unable to make staff adequately understand the reason for my visit	0	0%	2	6%
Something else	2	22%	7	21%
Total	9	100%	33	100%

In addition to the reasons selected above, seven participants also listed ‘something else’ and gave details of why their needs were not met.

Two comments described problems with accessibility:

‘no braille on medications means I am unable to know what is in the [box] of medication as I am blind’

‘I need a Hearing Loop, BUT.... No effective communication in many pharmacies because they don't have, or deny having a working hearing loop.’

Two comments described issues with filling prescriptions, or items being in stock:

‘Takes too long, over 7 working days, to issue repeat prescription and then some items are out of stock’

‘my partner is with a different pharmacy and they often fail to fulfill her prescriptions or only partly provide what is needed or there are long delays’

One described opening hours that do not meet needs:

‘The pharmacy does not open outside of work hours and at weekends when I can go, they are shut for part of the time for staff breaks.’

One described difference in preferences:

‘Doctors like digital prescription and I don't like that, or digital to selected chemist, I don't like that either, that's why I do post. Easier, only problem is that if I go to chemist on a on[e] off prescription then it's a parking problem.’

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One person now uses online pharmacy, due to a previous very bad experience of needs not being met in person:

[...] I now use an online pharmacy and the reason for this change was that [redacted] Pharmacy on [redacted] High Street were really nasty to me: they abruptly decided to stop delivering my regular medications to me and left me without high blood pressure medications without any warning. This was because ‘you are young and fit and can collect from the pharmacy’, this is what the manager said. He was smug and it made me feel like I had been caught doing something wrong and was being punished for that. He ‘forgot’ to consider that I have a disabled 10 years old child (adopted) and I can't leave him at home neither I can take him with me easily. That was unbelievably inconsiderate and very embarrassing because I was made to explain my personal matters in front of other customers; this was completely unnecessary, as I am a registered carer and my child is registered disabled. I had told them before and the GP would have been able to confirm that anyway. The whole experience was traumatic and I then started using an online pharmacy.’

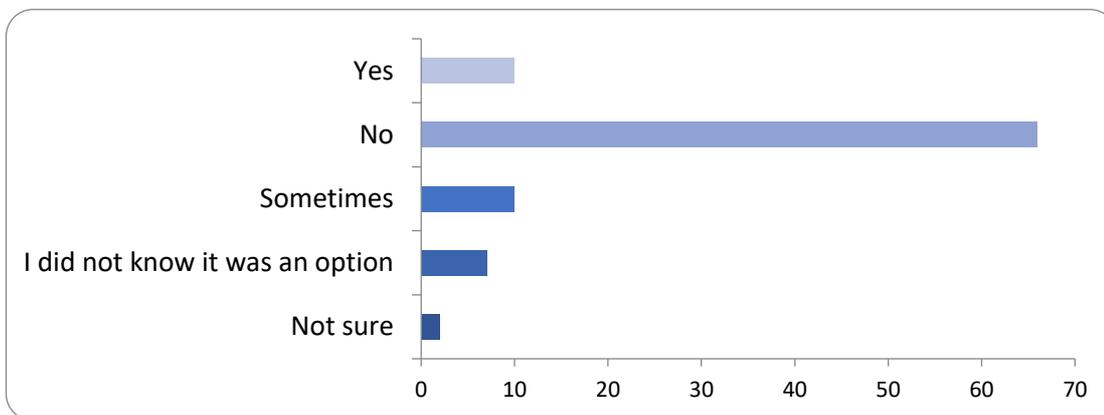
Three further questions were asked of respondents from the targeted circulation to find out about online pharmacy use, and the prescription and delivery service.

10

When asked ‘Do you use online or distance selling pharmacies? (Please select one)’, the majority of respondents (66, 70%) selected no, they did not, and 20 respondents said yes (10, 11%) or sometimes (10, 11%). Seven people (7%) did not know this was an option.

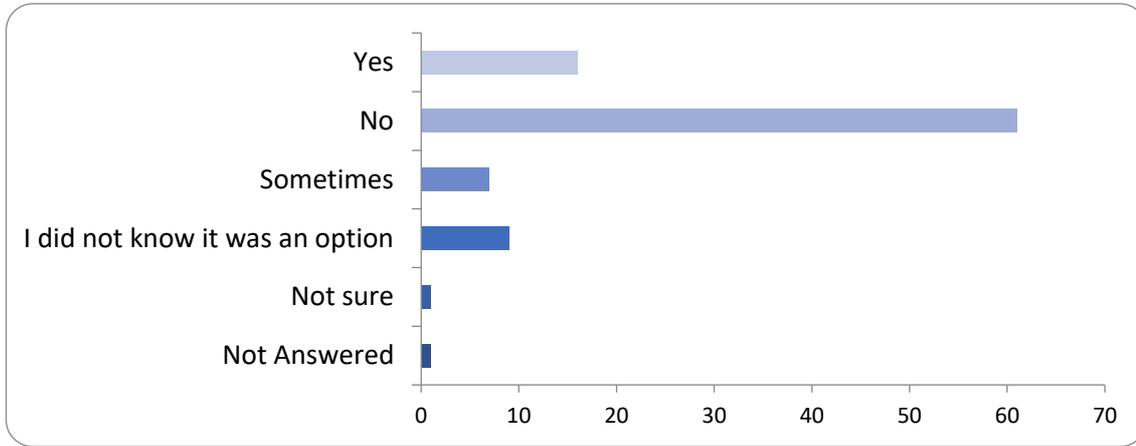
Note that the delivery of prescriptions is not part of the CPCF and is not an NHS service.

Survey figure 1 – Do you use online or distance selling pharmacies?



When asked ‘Do you use the prescription delivery service where the pharmacy delivers your prescription items to you? (Please select one)’, the majority of respondents (61, 94%) said no and 16 participants (16%) said yes, 7 participants (7%) said sometimes and 9 (9%) did not know it was an option.

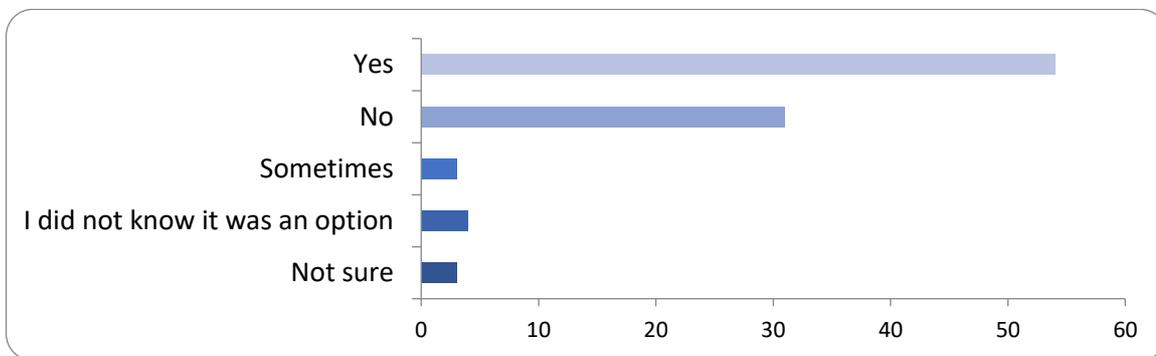
Survey figure 2 – Do you use the prescription delivery service where the pharmacy delivers your prescription items to you?



10

Survey figure 3 – Do you use the prescription collection service where the pharmacy picks up your prescription (usually from your GP) for you?

When asked ‘Do you use the prescription collection service where the pharmacy picks up your prescription (usually from your GP) for you? (Please select one)’ just over half of the respondents (54, 57%) said yes they do, and 31 people (33%) said no.



6.0 Survey of Surrey community pharmacies

The provider surveys were developed with the Surrey PNA steering group. Surveys were published online using Surrey Says and on the 11 April 2022 a targeted email was specifically sent to Surrey pharmacy contractors, as well advertised in the Local Pharmaceutical Committee newsletter, which is circulated to all pharmacies across Surrey and Sussex. The survey closing date was the 1 May 2022.

There were 47 responses received in total, 45 from Surrey community pharmacists, 23% of the 195 community pharmacies in Surrey, and a further two responses received from bordering pharmacies. The response rate was highest amongst pharmacies in Runnymede (58%) and lowest from pharmacies in Spelthorne. The table below summarises the number of responses by local authority, but where there were less than five responses, values have been suppressed. The number of surveys received from pharmacists within each place based partnership have also been summarised below.

Survey table 18 – Number of responses by district and borough

Area name	Number of community pharmacies	Number of responses	% per local authority*
Surrey	195	45	23%
Elmbridge	28	5	18%
Epsom & Ewell	11	<5	S
Guildford	18	<5	S
Mole Valley	16	<5	S
Reigate & Banstead	23	6	26%
Runnymede	12	7	58%
Spelthorne	20	<5	S
Surrey Heath	17	<5	S
Tandridge	14	6	43%
Waverley	24	5	21%
Woking	12	<5	S

*S' indicates where a percentage has been suppressed to prevent data disclosure of small values

Survey table 19 – Number of responses by Place based partnership

Place based partnership	Number of respondents
North West Surrey	13
Surrey Downs	11
East Surrey	9
Guildford and Waverley	8
Frimley	4

Responses from the survey are summarised below.

Dispensing of appliances

Participants were asked 'Does the pharmacy dispense appliances from the premises?'. The majority of respondents dispense all types of appliances.

Survey table 20 – Whether pharmacy dispenses appliances from premises

Option	Total	Percent
No, appliances are not dispensed	6	13%
Yes – All types	35	74%
Yes, excluding stoma appliances, or	0	0%
Yes, excluding incontinence appliances, or	0	0%
Yes, excluding stoma and incontinence appliances, or	0	0%
Yes, just dressings, or	3	6%
Other [please specify]	2	4%
Not Answered	1	2%

Two participants selected other, and 1 participant did not select a response, all three of these respondents outlined the following details:

Catheters and dressings often sent via NWOS

Most appliances are sent directly from North West Ostomy Supplies

Yes - all types except truss fitting due to lack of space

Need for locally commissioned services

When asked 'Is there a particular need for a locally commissioned service in your area?' just over half (26, 55%) of the respondents said yes, and 21 (45%) said no.

When asked 'If yes, what is the service requirement and why? If no, please leave blank', 25 of those who said yes listed the following service types:

Survey table 21 – Type of locally commissioned service mentioned

Locally commissioned services mentioned	Number of responses	% Responses
CPCS	10	40%
Minor ailments	9	36%
Appliances	3	12%
Sexual health services	2	8%
Easier access for patients	1	4%

10

Some respondents gave further details about the services.

Ten of the respondents made comments about the CPCS as a service that improves overall health outcomes, an example of the comments reflecting this is provided below:

'We are aware that in other parts of the country the local NHS has commissioned a walk-in Community Pharmacist Consultation Service (CPCS) which means that members of the public with low acuity minor illnesses can refer themselves directly to a pharmacy and receive a structured intervention and advice. Whilst this service is not being commissioned by local authorities it is a service that hugely impacts on the overall health and wellbeing of the local population and improves overall health outcomes without putting unnecessary burden on other part of primary care.'

Nine respondents listed minor ailment service but did not provide further comment.

Three respondents made a comment about appliance dispensing. Two stated that 'We do dispense appliances, but the majority of these items are dispensed via an appliance contractor which we work with. Local surgeries and nurses in the area tend to refer their patients to external appliance contactors which tend to have delays in deliveries and patients have problems getting through to these contractors, so we have seen an increase in patients asking us to supply their appliances.' And the third said 'Yes we provide appliances to go alongside prescription medication'.

Two respondents mentioned sexual health services (emergency hormonal contraception and Chlamydia). One of these commented that 'Under 16 EHC not supplied at the moment. Free EHC not supplied at the moment both are frequently requested'.

There was no clarification regarding whether Chlamydia screening or treatment, or both was intended.

Delivery of medicines

Note delivery of medication is not part of the Community Pharmacy Contractual Framework or commissioned locally, but maybe provided by pharmacies as a private service.

Participants were asked 'Does the premises provide any of the following:'

Survey table 22 – Services provided

Option	Total	Percent
Collection of prescriptions from GP practices	42	89%
Delivery of dispensed medicines to selected patient groups or to selected areas	22	47%
Delivery of dispensed medicines – Free of charge on request	20	43%
Delivery of dispensed medicines – With charge	27	57%
Not Answered	3	6%

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Note that participants could select multiple responses, and there were 44 respondents to this question. The majority (42, 89%) collect prescriptions from GP practices and more than half (27, 57%) provide delivery of dispensed medicines service, with a charge.

If participants selected the 'Delivery of dispensed medicines to selected patient groups or to selected areas' they were asked to 'please list criteria'. Twenty-three participants provided multiple responses and these criteria have been thematically coded into the following categories listed in the table below.

Survey table 23 – Patient criteria listed

Criteria listed	Number of responses	Proportion of the 23 respondents to this question (%)
Housebound/ unable to collect	9	39%
Patients who pay for delivery charge	8	35%
Elderly patients	7	30%
Patients who are COVID-19 positive	7	30%
Specified surrounding/local areas	3	13%
Care home/ nursing home patients	2	9%
Patients with full time carers	1	4%
Incontinence appliances	1	4%
Hospital contract	1	4%
Yes, delivery of dispensed medicines	1	4%
Total	23	100%

Service not currently commissioned

Participants were asked 'Are there any services you would like to provide that are not currently commissioned in your area?'. The majority (28, 59%) said no, and the remaining 19 (40%) said yes. The most commonly listed service was the CPCS, followed by various sexual health services (Chlamydia screening and treatment, emergency hormonal contraception). One respondent did not specify a service, but stated 'Willing to consider provision of any services proposed if there is a need'

Survey table 24 - Locally commissioned services mentioned

Locally commissioned services mentioned	Number of responses	Proportion of the 19 respondents to this question (%)
CPCS	10	53%
Sexual health services	4	21%
Weight management	2	11%
INR monitoring	2	11%
Smoking cessation	2	11%
Funding for MDS (Monitored Dosage Systems for blister packs)	1	5%
Healthy Start Vitamins	1	5%
NHS Health Check (Vascular risk assessment and management service)	1	5%
Seasonal Influenza Vaccination	1	5%
Minor ailments	1	5%

Languages spoken

Participants were asked 'Apart from English which other languages, if any, are available to patients from staff at the premises every day – please list main languages spoken'. There were 27 responses to this question and languages, other than English listed were: Afrikaans, Albanian, Arabic, Bengali, Chinese, Dutch, Farsi/ Pharsi, Filipino, French, German, Greek, Gujarati, Hindi, Nepalese, Persian, Polish, Portuguese, Punjabi, Russian, Romanian, Spanish, Swahili, Urdu.

COVID-19 pandemic

Participants were asked 'We recognise that you will have made a number of changes to how pharmaceutical services are provided as a result of COVID-19.

Please can you give us information on changes to the delivery of your service that have been beneficial and that you plan to retain?'

Surrey Pharmaceutical Needs Assessment 2022

Three respondents stated none or no changes. Thirty-one other participants responded to this question and the most common themes were changes to delivery services, use of digital technologies, non-pharmaceutical interventions, and more general changes.

Delivery

We continue to provide free delivery to the most vulnerable patients and have increased our delivery service from once a week to four times a week

deliveries are still contactless where possible. delivery driver will check patient is able to get to the door to collect prescription and will not hand directly to patient where possible. deliver driver is still currently wearing appropriate PPE

we have now an official delivery system in place twice a week since covid.

[...] delivering to people identified as terminally ill or isolating

Provision of free delivery to shielding patients was beneficial during the lockdown period. This has now stopped as the shielding requirement has ended.

Technology

Requesting scripts from surgeries by email,[...]

taking prescription request over the phone, so patient don't need to visit GP surgery

All NMS completed remotely works as much better for patients to be called at a time that's convenient and also works better at scheduling work in store

All stores have now embraced digital technology and are now able to utilise ways of communication that previously didn't happen

Prescription requests only by email.

Non-pharmaceutical interventions

Regular cleaning (sanitising surfaces), wearing PPE, and regular hand washing.

Use of PPE, Social distancing to reduce risk to our staff and customers from Covid-19.

Face masks for all staff, Perspex screen at public facing counter, Distance between people queuing, One way flow, as far as possible

Masks, PPE, temp checks

We will still be using PPE for vulnerable staff. Limit the number of customers that can wait in the pharmacy

Use of masks when interacting with patients, sanitising hands after dealing with each delivery.

General changes

Higher levels of pre-planning leading to improved organisation.

Appointments for vaccinations and all other services we provide like BP testing so we have cleaning time in between

Patients have now got used to coming to pharmacists for advice first, something we now want to build on

Also awareness of local networks of volunteers to help our most vulnerable patients by making the initial between the 2

Demand for services

Participants were asked ‘We recognise that the demand for services may or may not be increasing in your area, and the pharmaceutical needs assessment will need to identify whether the needs of Surrey residents can be met by the existing spread of pharmacies and dispensing appliance contractor premises. With this in mind, please select the option that best reflects your situation at the moment: (please select one)’

Survey table 25 – Assessment of premises and staffing capacity

Option	Total	Percent
We have sufficient capacity within our existing premises and staffing levels to manage the increase in demand in our area	28	60%
We don't have sufficient premises and staffing capacity at present but could make adjustments to manage the increase in demand in our area	10	21%
We don't have sufficient premises and staffing capacity and would have difficulty in managing an increase in demand	9	19%
Not Answered	0	0%

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7.0 Survey of Surrey dispensing practices

Surveys were distributed via the LMC to the 8 dispensing practices (plus their 7 branch surgeries) in Surrey. The survey was sent on Friday 8 April 2022. Following a low initial response rate, the survey closing date was extended and was promoted twice via direct email, and the closing date was extended until the 1 May 2022.

There was a fifty percent response rate received from the dispensing practice doctors, however because less than five responses were received and in line with data disclosure and information governance, only the general findings have been summarised to inform this PNA. The survey questions have been listed below for completeness.

Dispensing of appliances

Participants were asked 'Does the dispensary dispense appliances from the premises?'

Delivery of medicines

Participants were asked 'Does the premises provide any of the following:

Delivery of dispensed medicines to selected patient groups or to selected areas

Delivery of dispensed medicines - Free of charge on request

Delivery of dispensed medicines – With charge'

Languages spoken

Participants were asked 'Apart from English which other languages, if any, are available to patients from staff at the premises every day – please list main languages spoken'.

COVID-19 pandemic

Participants were asked 'We recognise that you will have made a number of changes to how pharmaceutical services are provided as a result of Covid-19.

Please can you give us information on changes to the delivery of your service that have been beneficial and that you plan to retain?' The following services were mentioned by some respondents:

SMS system to inform patients when their medication was ready to collect

Ability for patients to collect medication from branch site all day (not only during specified hours).

Demand for services

Participants were asked 'We recognise that the demand for services may or may not be increasing in your area, and the pharmaceutical needs assessment will need to identify whether the needs of Surrey residents can be met by the existing spread of pharmacies and dispensing appliance contractor premises. With this in mind, please select the option that best reflects your situation at the moment: (please select one)'

All participants responded that '*We have sufficient capacity within our existing premises and staffing levels to manage the increase in demand in our area*'.

8.0 Conclusions and recommendations

8.1 Surrey people and place

Surrey is one of the most prosperous counties in England. Over half (61.1%) of the population is of working age (16 to 64), although the working age group is older; with a lower proportion of people aged 20 to 39 and a higher proportion of people aged 40 to 59 compared to the England average. The mid-year 2020 resident population of Surrey was 1,199,000, which has increased by 1.9% since 2018. Over the next three years during the lifetime of this PNA, between 2022 and 2025, the population of Surrey is predicted to increase by 0.5%. Surrey has an ageing population with the 65 and over age cohort estimated to have the highest increase of 4.5%, while the 0 to 14 and 30 to 44 age cohorts are predicted to decrease by 2025. The increase in the proportion of the population aged 45 and over is likely to impact on future healthcare demand in the longer term.

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Surrey has a predominantly white population (90.4%) followed by Asian (5.6) and mixed (2.1%) ethnicities. Woking has the highest proportion of Asian population (11.6%) and Elmbridge has the highest proportion of people from mixed ethnicity (2.6%), which could impact on the prevalence of some long term conditions in these areas.

A number of planned housing developments are underway across Surrey, varying in size but not exceeding 2,000 dwellings over the next three years. Cumulative developments in growth areas may start to reach over 2,000 dwellings in some areas in future years beyond this lifetime of this PNA.

8.1.1 Conclusion

Surrey has an ageing population, and the population is predicted to increase slightly over the next three years. Currently, none of the approved planning and development estimates received from districts and boroughs exceed the benchmark of 2,000 homes indicating a need for additional pharmacies during the lifetime of this PNA (2022 to 2025).

Recognising the potential for change in local population predictions due to proposed large scale housing developments in Surrey, the PNA Steering Group should review actual increases in population and the implications of any increases on an annual basis and publish their findings in a PNA supplementary statement.

8.2 Local health needs

Surrey has a higher proportion of people who report being in good or very good health than England at all ages. In males across Surrey, life expectancy at birth (2020) ranges from 79.7 in Woking to 82.1 in Elmbridge, in females it ranges from 83.0 in Woking to 85.6 in Waverley, and all areas have a higher life expectancy than England males (78.7) and females (82.6).

There is strong evidence of the link between poor health and areas of high material deprivation. Cardiovascular disease is one of the main contributors to health inequalities and pharmacies are contracted by public health to deliver NHS Health Checks and the hypertension-case finding advanced service. These services are used as a means of reducing health inequalities by detecting disease at an early stage. Pharmacies are well placed to implement changes that can work towards reducing health inequalities, and this has been highlighted in the Fuller Report⁵⁰.

8.2.1 Conclusion

Taking into account the locations of dispensing doctors across Surrey, all local health partners should consider how best to ameliorate the impact of poorer access to community pharmacies and help address health inequalities in areas of higher multiple deprivation, higher health and disability deprivation, and where there are higher numbers of people aged 75 and over (who are more likely to experience multiple morbidity) in some rural areas in Surrey.

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⁵⁰ [Next steps for integrating primary care: Fuller stocktake report](#)

8.3 Current pharmaceutical service provision

There are 200 pharmacies in Surrey; 195 are community pharmacies and these are spread across most of the town centres, and urban areas (towards the north of Surrey and towards London). There are also two dispensing appliance contractors (DACs) to the west of Waverley, and three distance selling pharmacies, one each located in Elmbridge, Spelthorne and Woking. In more rural local authorities such as Waverley and Mole Valley and parts of Guildford, dispensing doctor practices fill gaps in community pharmacy provision. Surrey has 8 dispensing practices (which increases to 15 when including branch surgeries) that have permission to dispense medicines. There are 87 additional pharmacies which serve Surrey residents in 14 neighbouring HWB areas within one mile of the Surrey County border.

Necessary services are defined within the 2013 Regulations as those that are necessary to meet the need for pharmaceutical services and could be provided within or outside of the HWBs area. For the purpose of this PNA, they have been defined by the type of service as all essential and selected advanced services commissioned by NHSE.

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Of the 198 pharmacies in Surrey (including internet pharmacies but excluding DACs), the majority (185, 93.4%) have standard 40-hour contracts (Table 13) while 13 (6%) have core hours of 100 hours. Supplementary hours are additional hours to the core hours, and most pharmacies are open for supplementary hours in addition to their core hours. Across Surrey the opening hours are similar to those presented in the previous 2018 PNA. The population of Surrey is within a five-mile radius of a pharmacy during weekday opening hours giving a reasonable choice to residents.

8.3.1 Conclusion

Review of the necessary pharmaceutical services in Surrey has found no gaps in current or future provision. Across Surrey, there is good access to community pharmacy or dispensing general practice within a reasonable travel time by car during weekdays and Saturdays.

All Surrey residents are within a five-mile radius of an open pharmacy on a weekday, however for some residents, such as those living in more rural areas, or with limited access to transport (public transport or their own car), or with limited mobility the access to community pharmacy may be less good but cannot be quantified. In these cases, access to essential services may be ameliorated by the growing availability of internet pharmacies and the willingness of some pharmacies to deliver prescription medications.

This PNA recognises the ongoing important role of community pharmacies and the changes to their way of working throughout the pandemic. The 'Next steps for integrating primary care: Fuller stocktake report' (Fuller report) calls for integrated neighbourhood 'teams of teams' to evolve from primary care networks and highlights the importance of community pharmacy teams in urgent care and prevention, including early diagnosis of cancers. The Fuller report points out that pharmacists could play 'a more active role in signposting eligible people to screening and supporting early diagnosis, building on a number of successful pilots such as those from the Accelerate, Coordinate, Evaluate programme'.

8.4 Public and provider surveys

The surveys were publicised widely and were also targeted to try and increase participation from a diverse range of residents. The majority of the public and provider responses indicated that the provision of pharmaceutical services and access is sufficient overall in Surrey.

Community pharmacies and dispensing practices were asked to reflect on whether the needs of Surrey residents can be met by the existing spread of pharmacies and dispensing appliance contractor premises. All the dispensing practices (although sample size was small) and the majority of community pharmacies (60%) answered that they believe they have sufficient capacity within existing premises and staffing levels to manage a potential increase in demand in their area. A further 21% of community pharmacists answered that they could make adjustments to manage an increase in demand in their area, while 19% answered that they don't have sufficient premises and staffing capacity and would have difficulty in managing an increase in demand.

Community pharmacies also noted the CPCS as a service that improves overall health outcomes, and some respondents noted the importance of sexual health services.

For residents, location (primarily proximity to home) was the key factor that influenced choice of pharmacy, followed by familiarity. The majority of participants from the citizens panel and targeted survey found it very easy or somewhat easy to visit a pharmacy. In the targeted survey circulation, 37% of respondents said that there was a more convenient and/or closer pharmacy that they did not use and the main reasons were that service was too slow, a bad experience in the past, and the pharmacy did not have what they needed in stock.

In terms of access and travel to a pharmacy, the two main methods of travel to pharmacies were walking and driving. The journey time was noted as under 10 mins, or between 10 to 20 mins for the majority of respondents. Less than 5% said they use public transport and less than 5% selected cycling or other methods of transport.

8.4.1 Conclusion

The majority of the public responses received indicated that the provision of pharmaceutical services and access is sufficient overall in Surrey.

The majority of provider responses received indicated that they have sufficient capacity within existing premises and staffing levels (or they could make adjustments) to manage any increase in demand at present.

Survey results suggested the majority of respondents access a pharmacy by walking or driving. This PNA has considered one and five-mile intervals from the pharmacy points as a measure of reasonable distance to travel to a pharmacy. This PNA also uses travel time catchments of 5, 10, 15 and 20 minutes (driving toward the pharmacy points, using available road speeds).

8.5 Overall recommendation

This PNA has assessed whether the current and future pharmacy provision meets the health and wellbeing needs of the Surrey's population. It has also determined whether there may be gaps or needs for improvements or better access in the provision of pharmaceutical services within the lifetime of this PNA (three years from 1 October 2022 until 30 September 2025).

There are 200 pharmacies in Surrey; 195 are community pharmacies and these are spread across most of the town centres, and urban areas (towards the north of Surrey and towards London). There are two dispensing appliance contractors (DACs) to the west of Waverley, and three distance selling pharmacies, one each located in Elmbridge, Spelthorne and Woking. In more rural local authorities such as Waverley and Mole Valley and parts of Guildford, dispensing doctor practices fill gaps in community pharmacy provision. Surrey has 8 dispensing practices (which increases to 15 when including branch surgeries) that have permission to dispense medicines. There are 87 additional pharmacies which serve Surrey residents in 14 neighbouring HWB areas within one mile of the Surrey County border.

The conclusion of this PNA is that there are no gaps in necessary services in Surrey. The number, distribution and choice of pharmaceutical services meets the current needs of Surrey's population and future needs foreseen within the lifetime of this PNA.

There are no identified needs for additional pharmaceutical services, or enhancements to current arrangements across the county that would secure improvements or better access to services.

The PNA noted that current locally commissioned services (provided by Surrey public health and the ICBs) provide an improvement to pharmaceutical provision for the population of Surrey.

The conclusion is based on assessment of Surrey's people and place (demographics, projected population and housing growth) (summarised in 8.1 above), an assessment of local health needs and wider determinants (summarised in 8.2 above), an assessment of current pharmaceutical service provision (summarised in 8.3 above), and surveys of the public and providers views (summarised in 8.4 above).

9.0 Consultation results

9.1 Background and process

The Regulations (2013) require the HWB to consult on their draft PNA for a minimum 60-day period. Surrey's consultation period ran from the 13 May 2022 until the 12 July 2022. Responses to the consultation were sought through widespread publicity about the PNA and targeted emails to key contacts.

The consultation questions were developed based on suggestions outlined in the DHSC PNA guidance. The questionnaire was available on Surrey-Says, the Surrey consultation hub, at the following web address: <https://www.surreysays.co.uk/adult-social-care-and-public-health/surrey-draft-pna-consultation/>

The draft PNA was linked to the consultation and was available for downloading together with the appendices on Surrey-I at the following web address:

<https://www.surreyi.gov.uk/dataset/24mnz/pharmaceutical-needs-assessment-2022-draft>

The consultation and draft PNA stated that printed copies and accessible or alternative formats of the draft documents and the questionnaire could be requested via phone call, email or SMS text. No requests were received by the team.

The consultation was sent to the list of stakeholders as stipulated in Regulation 8 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. The consultation was also circulated to several other relevant stakeholders including the newly nominated place-based leads within Surrey Heartlands and Frimley ICS, the director of pharmacy across Surrey Heartlands ICS and known chief pharmacists. The consultation was also promoted through the Steering Group's wider networks, including the LPCs in Hampshire, Kent and Medway and South London.

The consultation was publicised more broadly to the general public through social media, newsletters and other websites (please see consultation table 1, below which lists these).

Consultation table 1 - Additional promotion of the PNA public consultation

Media	Promotion
Facebook pages	SCC (boosted) (May) Healthy Surrey (May) Local authority pages (May) Healthwatch Surrey (3 posts in June) Surrey Comms partners (NHS, Police, Voluntary Organisations) including Surrey Care Association (care workers), Surrey Coalition of Disabled People, Surrey Coalition of Carers and Action for Carers
Twitter	Surrey News (May) Healthy Surrey (May) Local authority pages (May) Healthwatch Surrey (3 posts in June) Surrey Comms partners (NHS, Police, Voluntary Organisations), including Surrey Care Association (care workers), Surrey Coalition of Disabled People, Surrey Coalition of Carers and Action for Carers
Healthwatch Surrey consultation page	<u>Healthwatch Surrey - Shaping Pharmacy Services in Surrey</u>
Newsletters	Community champions briefing (May) Surrey Matters e-newsletter (May) Primary care Newsletter (May) CPSS (Community Pharmacy Surrey and Sussex) newsletter (May) Public Health bulletin (June) Editorial provided to Surrey Comms Partners (NHS, Police, Voluntary Organisations), including Surrey Care Association (care workers), Surrey Coalition of Disabled People, Surrey Coalition of Carers and Action for Carers

Responses were shared with the Steering Group for consideration in mid-July 2022. The responses were collectively reviewed and discussed at the Steering Group meeting on the 29 July 2022.

Where there were responses or comments related to the need to make corrections or clarifications to the text or data within the draft PNA, these changes would be made directly to the PNA without referring them back to the group. A list of suggested corrections or clarifications can be found alongside the comments in consultation table 4. Minor grammatical, punctuation or spelling errors are not listed.

9.2 Consultation responses

In total thirteen responses were received via the online Surrey-says questionnaire

- 5 as a member of the public
- 3 health and social care professionals
- 3 on behalf of an organisation
- 2 on behalf of a business or sole trader

9.2.1 Demographics and protected characteristics

Eight of the 13 participants responded to the questions requesting demographic information, therefore much of the breakdown of demographic data related to numbers under 5 and cannot be provided in compliance with data disclosure and privacy laws. The general findings from the demographic questions have been summarised where possible in the table below.

Consultation table 2 - Demographic summary of consultation respondents

Category	Summary
Local authority	Responses to the consultation came from people from Mole Valley, Reigate and Banstead, Spelthorne and Woking.
Gender	The breakdown of data on gender cannot be provided due to numbers under 5, in line with data disclosure and privacy laws.
Age	Respondents were aged between 25 and 74 years old.
Ethnicity	The majority of respondents were from white ethnicity groups
Religion	The majority of respondents were Christian, followed by 'no religion'.
Disability	The majority of respondents answered 'no, they do not consider themselves to have a disability'. There were less than 5 responses relating to the sub question about the type of disability, so this data has not been summarised here.
Sexual orientation	The breakdown of data on sexual orientation cannot be provided due to numbers under 5, in line with data disclosure and privacy laws.
Employment status	The majority of respondents said they were in full-time employment, followed by volunteers.
Carers	The majority of respondents were not currently a carer

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9.2.2 Responses to questions

The consultation questions were developed based on the suggested questions outlined in the DHSC PNA guidance which focus on whether the PNA has met its purposes. The majority of responses to all the questions (except question 8) were positive and in agreement with the draft PNA. Six respondents to question 8 said there were services which could be provided in future that had not been highlighted and five provided further detail (see consultation table 4, rows 27 to 31).

Of respondents who gave a positive or negative response, over 90% of respondents said that the PNA clearly explains its purpose (question 1) and provides information on how pharmaceutical services may be commissioned in the future (question 6). Over 80% said the information contained in the PNA was accurate (question 9) and over 70% said the PNA reflects the current pharmaceutical service provision (question 2).

Surrey Pharmaceutical Needs Assessment 2022

Two thirds of respondents said there were no gaps in service provision that had been unidentified (question 3), that the PNA reflects the pharmaceutical needs of the population (question 4), provides information to inform market entry decisions (question 5) and has provided enough information to inform future pharmaceutical provision and plans (question 7). Over 60% agreed with the conclusions of the PNA (question 10). Question 11 was an open-ended question requesting further comments, and 5 comments were received.

Numbers of responses received to the consultation questions are summarised in consultation table 3. The responses are reported together with the Steering Group's comments or agreed actions in consultation table 4.

Consultation table 3 - Number of responses received via the consultation questionnaire

Question	Yes	No	No response
1. Does the draft PNA clearly explain its purpose and background?	12	1	0
2. Does the draft PNA reflect the current pharmaceutical service provision within Surrey?	8	3	2
3. Are there any unidentified gaps in service provision i.e. when, where and which services are available?	4	8	1
4. Does the draft PNA reflect the pharmaceutical needs of the Surrey population?	8	4	1
5. Does the PNA provide information to inform market entry decisions i.e. decisions on applications for new pharmacies and dispensing appliance contractor premises?	8	4	1
6. Does the PNA provide information to inform how pharmaceutical services may be commissioned in the future?	11	1	1
7. Has the PNA provided enough information to inform future pharmaceutical services provision and plans for pharmacies and dispensing appliance contractors?	8	4	1
8. Are there any services which could be provided in a community pharmacy setting in the future, that have not been highlighted?	6	6	1
9. Is the information contained in Surrey's draft PNA accurate?	9	2	2
10. Do you agree with the conclusions of the PNA?	7	4	2

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Consultation table 4 - Comments received through the consultation questionnaire in response to the draft PNA consultation

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
1	2. Does the draft PNA reflect the current pharmaceutical service provision within Surrey? - If no, please explain:	It seems to assume that there is no delay between a doctor writing a prescription and the medicine being available. The dispensing chemist I use packs all medicines it can offsite, and that adds a delay. In addition its stocks of some medicines can be (erratically) inadequate. Add in delays by the GP and it is necessary to hold a stock of medicines at home and also to order well in advance of need. Thus the provision is not as good as it appears.	<p>This is beyond the scope of the PNA and was shared with the LPC and LMC.</p> <p>Under the Community Pharmacy Contractual Framework the pharmacy is required to dispense medication on NHS prescriptions in a timely manner. Pharmacies are currently dealing with significant issues in the supply of medicines from wholesalers and manufacturers. The information that they receive on out of stock situations and when medication will be available again is often only an estimate from the manufacturer and not an exact date of supply.</p> <p>The Pharmaceutical Services Negotiating Committee (PSNC) acknowledge the known issue that manufacturers can be out of stock nationally. The PSNC states that ‘shortages of medicines are becoming an increasingly frequent issue that can hinder pharmacy teams’ efforts to dispense medicines in a timely manner.’</p>	This feedback was shared with the LPC and LMC and will be shared at a public meeting of the HWB in September 2022.

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
			Further information, including the option to report new medicine shortages can be found on the PSNC Medicine Shortage page https://psnc.org.uk/dispensing-and-supply/supply-chain/medicine-shortages/	
2	2. Does the draft PNA reflect the current pharmaceutical service provision within Surrey? - If no, please explain:	It is difficult to answer this question, as I could find no maps showing the location of community pharmacies and/or dispensing general practices.	A map showing community pharmacies and dispensing practices is shown in Figure 9: Pharmaceutical provision in Surrey (December 2021), Section 4.0: Current pharmaceutical service provision. In addition, Figures 11 to 15 show maps of pharmacies open at various times across Surrey, Figure 15: Areas of Surrey within one and five-mile radius of a pharmacy open on weekday (including dispensing practices) to 19 show areas within Surrey within a one and five mile radius of an open pharmacy for various days and times, and Figures 20 to 24 show the journey times by car for various days and times.	N/A
3	2. Does the draft PNA reflect the current pharmaceutical service	There is no rationale to explain the disparity of pharmaceutical provision across the county. For example there is almost double the number of pharmacies per	The crude rate of pharmacies per 100,000 is shown in Section 4.1.1 however as noted in text, crude rates should not be used as a measure in isolation to compare pharmaceutical	An additional note has been included under Table 10, Section 4.1.1 about the

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
	provision within Surrey? - If no, please explain:	100,000 in Waverley compared with Woking, despite the number of dispensing doctors in Waverley	provision across local authority areas. Other factors that must also be considered are addressed throughout this PNA and include <ul style="list-style-type: none"> •Rurality •Presence of dispensing doctors •Population density and the locations of town centres •Age (as a proxy for health need) •Access to transport •Travel times to nearest pharmacy 	appropriate use of crude rates. Further explanation was included in text to expand on the use of crude rates and other factors in consideration of pharmaceutical need. An additional map has been included in Section 2.2.1 to show the differences in population density at <i>ward</i> level within each local authority (the draft only contained a figure of population density at local authority level).
4	2. Does the draft PNA reflect the current	The draft does not show the area in Ashvale (Guildford) where major	The PNA draft lists planned developments that come close to the	The PNA Steering group has agreed that

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
	<p>pharmaceutical service provision within Surrey? - If no, please explain:</p>	<p>development of nearly 1500 homes being built. The area comprises of just a pharmacy within the local area without serving a growing population.</p>	<p>threshold of 2000 dwellings. These figures have been supplied by local authority planning teams.</p> <p>Ashvale borders Hampshire. We have reviewed Hampshire's PNA to understand the impact of housing developments in the neighbouring Rushmoor council and deemed that no additional bordering developments have a current impact on the area raised in this comment.</p> <p>Further confirmation was sought from Guildford Borough Council regarding the number of dwellings built between 2018 to 2022, and the plan for 2022 to 2025 in the Ashvale area mentioned. The response confirmed that there have been no individual development proposals in Guildford Borough that have delivered over 1000 dwellings in Guildford since the last PNA (2018).</p> <p>The four sites highlighted in the PNA consultation draft (Blackwell Farm, Gosden Hill, Weyside Urban Village and Wisley Airfield) will each provide in excess of one thousand dwellings but are all yet to deliver any units.</p>	<p>supplementary statements will be used to reflect changes in pharmaceutical provision throughout the term of the current PNA.</p>

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
			<p>The site allocation A31: Land to the south and east of Ash and Tongham is a broad allocation composed of several land parcels and is allocated for approximately 1,750 homes. Construction has commenced on 1,460 homes of which 657 had been completed by 31/12/2021.</p> <p>There have been approvals for dwellings in the Ash and Tongham area that sit outside the A31 allocation; however, these are generally of a smaller quantity and below the threshold.</p>	
5	<p>3. Are there any unidentified gaps in service provision i.e. when, where and which services are available? - If yes, please explain:</p>	<p>There is no communication between the manufacturer and the user. In the past few years there have been two occasions when a drug was not available but no-one was able to say if it were a temporary manufacturing issue or a decision to stop manufacture.</p> <p>This is in addition to the two occasions when I had to phone around to find a pharmacist who could get a drug we needed.</p>	<p>Please see further detail outlined in the response in Row 1.</p>	<p>This feedback was shared with the LPC and LMC and will be shared at a public meeting of the HWB in September 2022.</p>

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
		I believe that the service should provide the requested medicine on request, or explain properly why it can't.		
6	3. Are there any unidentified gaps in service provision i.e. when, where and which services are available? - If yes, please explain:	I'm uncertain whether issues of physical disabilities has sufficiently been taken into consideration when looking at someone's ability to reach a pharmacy and use their services. This also applies to disabilities which prevent someone from driving - all references to access to pharmacies refer to 'driving distance from' and 'parking', etc.	<p>We acknowledge that disabled people (for example, including those with physical disabilities and those who are blind or partially sighted, or on certain medications) may be unable to drive due to their disability, which may impact on a person's ability to reach a pharmacy and use their services.</p> <p>It would be difficult to measure travel times for the population with a disability as mobility and needs may be different for each individual. The PNA also considers health in Surrey (Section 3.1), wider determinants (Section 3.2), online and distance selling pharmacies (Section 4.1) in addition to driving distance from nearest pharmacy and parking when assessing pharmacy service provision.</p> <p>There are also online distance selling NHS pharmacies who provide a delivery service as part of their contractual requirement and the NHS volunteers service continues to assist</p>	<p>This comment has been shared with the Surrey Coalition for Disabled People.</p> <p>Following review of this comment, the PNA Steering Group will review the measures and mapping used in future PNAs, regarding access for people with physical disabilities.</p> <p>The LPC will also add a reminder in their community pharmacy weekly newsletter about the Accessible Information Standard.</p>

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
			<p>people who are unable to reach their pharmacy to collect prescriptions etc.</p> <p>All pharmacies must meet The Accessible Information Standard . Any AIS issues should be directed to the pharmacy, or NHSE as commissioners. Further information on the Equality Act and AIS summarised by the PSNC here: https://psnc.org.uk/quality-and-regulations/pharmacy-regulation/equality-act/</p>	
7	3. Are there any unidentified gaps in service provision i.e. when, where and which services are available? - If yes, please explain:	Furthermore, the issuing of 'repeat prescriptions' as described in the PNA simply does not work in the manner set out in the document - I have been trying for 40 years to have repeat prescriptions issued in this way but I spend ages chasing both my doctor and pharmacist every month for my medication (I am on 6 medicines) as the system never works.	<p>This is beyond the scope of the PNA.</p> <p>There is a complaints procedure in place for both GP surgeries and pharmacies and any issues can be raised with the individual organisation initially and if resolution is not obtained issues can be escalated via the NHS England complaints procedure.</p>	This feedback has been shared with the LPC and LMC in Surrey.
8	3. Are there any unidentified gaps in service provision i.e. when, where and which	No gap has been identified in central Woking. Of the 12 pharmacies in the Borough 6 are in the same ownership. Only one is in the town centre and three on	Ownership and competition law is beyond the scope of the PNA. Competition law is considered when	N/A

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
	services are available? - If yes, please explain:	the periphery; all in the same ownership. There is a conspicuous absence of choice.	<p>there are large acquisitions of pharmacies.</p> <p>However, we note that while there are 6 pharmacies under the same ownership, there are also 6 pharmacies all under different ownership; 5 independent pharmacies and 1 branch of a large pharmacy multiple in Woking (further detail is available in Appendix B).</p>	
9	3. Are there any unidentified gaps in service provision i.e. when, where and which services are available? - If yes, please explain:	It is too general. I live in Woking Borough. There needs to be a more factually detailed breakdown as to availability of services and precise location where they are available. Who provides what.	<p>The PNA process provides a high-level summary of services available across the HWB area and is not able to provide detailed service availability by pharmacy. Section 4 of the PNA includes maps and data showing current pharmaceutical service provision.</p> <p>Lists of services by pharmacy are available on the NHS Service Finder.</p>	N/A
10	4. Does the draft PNA reflect the pharmaceutical needs of the Surrey population? - If no, please explain:	I cannot see that any conclusion was reached?	The process for producing the PNA and reaching a conclusion is outlined in the Executive summary followed by key findings and recommendations outlined at the end of the Executive summary and in sections 2.4, 3.3, 4.6.	A more detailed conclusions and recommendations section has been added to the final PNA in response to this

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
			However, the PNA acknowledges this comment.	comment (please see Section 8).
11	4. Does the draft PNA reflect the pharmaceutical needs of the Surrey population? - If no, please explain:	In my experience, the service currently available is inadequate	We acknowledge this comment but without further detail cannot provide any further comment.	N/A
12	4. Does the draft PNA reflect the pharmaceutical needs of the Surrey population? - If no, please explain:	The Guildford area shows a major development with no confirmation of whether a pharmacy is required or not.	Please refer to the response outlined in Row 4.	The PNA Steering Group has agreed that supplementary statements will be used to reflect changes in pharmaceutical provision throughout the term of the current PNA.
13	4. Does the draft PNA reflect the pharmaceutical needs of the Surrey population? - If no, please explain:	Although we must be vigilant to the changing landscape of delivery of health care and how the development of neighbourhood teams will impact the role of community pharmacies	We acknowledge the importance of this comment.	N/A

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
14	4. Does the draft PNA reflect the pharmaceutical needs of the Surrey population? - If no, please explain:	Far too general and complacent. Given what is now expected of Pharmacies there is inadequate availability and insufficient skill. If Pharmacies are to provide the services expected of them, they need to be far less retail and far more professional. They are not viewed as a source of medical advice	<p>This is beyond the scope of the PNA.</p> <p>The LPC would like to note that pharmacists are highly qualified healthcare professionals who have undergone a four-year Master degree course and a foundation trainee year before registration as a pharmacist. In addition, on an annual basis they complete a revalidation process with the General Pharmaceutical Committee.</p> <p>Pharmacists complete additional ongoing training to provide various clinical services including Independent Prescribing Qualifications.</p> <p>Pharmacists make a difference to the lives of their patients through an expert knowledge of medicines and health. Helping people live longer and healthier lives depends on the safe use of medicines and excellent healthcare advice. Pharmacists' unique expertise and knowledge makes them essential members of the healthcare team.</p>	This comment has been shared with the LPC and will be shared at a public meeting of the HWB in September 2022.

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
15	5. Does the PNA provide information to inform market entry decisions i.e. decisions on applications for new pharmacies and dispensing appliance contractor premises? - If no, please explain:	But there is no obligation on them to take these comments on board.	Under the NHS Regulations (2013), a person who wishes to provide NHS pharmaceutical services must apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA. The PNA is therefore an essential part of the process of making decisions about market entry for new service providers.	N/A
16	5. Does the PNA provide information to inform market entry decisions i.e. decisions on applications for new pharmacies and dispensing appliance contractor premises? - If no, please explain:	There is a statement no gaps have been identified. It is a simple statement and lacks detail as to how it was arrived at. I question if this is sufficient for NHSE to make decisions on.	Please refer to the response outlined in Row 10.	A more detailed conclusions and recommendations section has been added to the final PNA in response to this comment (please see Section 8).
17	5. Does the PNA provide information to inform market entry decisions i.e. decisions on applications for new pharmacies and dispensing appliance contractor premises? - If no, please explain:	If it were to do so there would be a rash [rush] of applications. The draft PNA looks only at the situation as it is at the moment without regard to future development, even when it is fairly advanced. Working as a case in point.	The timeframe that this PNA must cover is from 2022 to 2025. This PNA includes housing projections and population projections among other factors in order to consider future needs. The housing data included in this draft PNA shows that no single development has exceeded the criteria of 2,000 developments, that would	N/A

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
			create a need for an additional pharmacy.	
18	5. Does the PNA provide information to inform market entry decisions i.e. decisions on applications for new pharmacies and dispensing appliance contractor premises? - If no, please explain:	For example applications in Cranleigh or east of Tandridge or Mole Valley should be accommodated	Under the NHS Regulations (2013), a person who wishes to provide NHS pharmaceutical services must apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA. It is not within the scope of the PNA to grant market entry, applications will be judged by NHSE.	N/A
19	5. Does the PNA provide information to inform market entry decisions i.e. decisions on applications for new pharmacies and dispensing appliance contractor premises? - If no, please explain:	Nothing to explain - it does not do that	In line with national NHS Regulations (2013), this PNA describes services provided and the access, in terms of time and place, that local residents have to those services in Section 4.	N/A
20	6. Does the PNA provide information to inform how pharmaceutical services may be commissioned in the future? - If no, please explain:	Again, nothing is binding.	Under the NHS Regulations (2013), a person who wishes to provide NHS pharmaceutical services must apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA. The PNA is an	N/A

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
			essential part of the process of making decisions about market entry for new service providers.	
21	6. Does the PNA provide information to inform how pharmaceutical services may be commissioned in the future? - If no, please explain:	Increasing provision is a long and tortuous process. The absence of information in the PNA is, by accident, helpful in Reg 18 - unforeseen benefit - applications	The PNA follows the statutory legislation and describes services provided. It provides information on demographics, health needs and various other factors. It also describes the access, in terms of time and place, that local residents have to those services.	N/A
22	6. Does the PNA provide information to inform how pharmaceutical services may be commissioned in the future? - If no, please explain:	We should look at better modelling what the JSNA tells us to target services delivered by pharmacies better eg availability of sexual health services in areas with high teenage pregnancy rates or high STI rates -at the moment we are not targeting that resource or encouraging new business in those areas with higher need eg Spelthorne and sexual health services	Pharmacies are key to providing a range of sexual health services to reduce both unintended conceptions and STI's and help to expand service coverage across the county. Pharmacies can express interest in delivering additional services (such as sexual health) or not, which sometimes results in uneven coverage. We acknowledge this feedback and agree that services should be in targeted locations based on what the data tells us. The public health team at Surrey Council have already begun to approach pharmacies where there are gaps in provision or where delivery is low to improve availability. The public health team will continue to support	This comment has been shared with public health commissioners at SCC.

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
			<p>pharmacies and train pharmacy staff to deliver services and are in the process of updating promotional materials for pharmacies to improve promotion of additional in-house services.</p>	
23	<p>7. Has the PNA provided enough information to inform future pharmaceutical services provision and plans for pharmacies and dispensing appliance contractors? - If no, please explain:</p>	<p>I fail to see how simply informing them of the results of a survey is considered enough to ensure that new pharmacies and contractors set up the correct services.</p>	<p>All pharmacies, including distance selling premises, are required to provide 'essential services'. As of October 2021, there are eight essential services, these services are outlined in more detail in section 4. Advanced services and public health commissioned services are optional.</p> <p>All community pharmacies are subject to a yearly assurance programme – the Community Pharmacy Assurance Framework. This is part of NHSE contract monitoring process to ensure that community pharmacies are complying with the terms of service as outlined in the NHS Regulations (2013) as amended. This includes assessment of the quality of the services provided, both essential and advanced services. The activity levels for each are monitored through</p>	N/A

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
			<p>monthly returns to NHS Business Services Authority.</p> <p>When a new pharmacy applies for a contract, they must state the services they will be delivering and NHSE will consider this.</p>	
24	7. Has the PNA provided enough information to inform future pharmaceutical services provision and plans for pharmacies and dispensing appliance contractors? - If no, please explain:	More detailed information, such as maps showing planned developments, deprivation and travel times to pharmacies/dispensing practices, would assist.	Maps showing community pharmacies and dispensing practices mapped against the IMD overall index and the health deprivation and disability deciles are shown in Figure 7 and Figure 8, Section 3. In addition, Figure 10 to Figure 14 show maps of pharmacies open at various times across Surrey, Figure 15 to Figure 18 show areas within Surrey within a one and five mile radius of an open pharmacy for various days and times, and Figure 19 to Figure 23 show the travel times by car for various days and times.	We will consider the inclusion of maps showing planned developments in future PNAs
25	7. Has the PNA provided enough information to inform future	As above (in reference to 'Increasing provision is a long and tortuous process. The absence of	Please refer to the response outlined in Row 21 above.	N/A

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
	pharmaceutical services provision and plans for pharmacies and dispensing appliance contractors? - If no, please explain:	information in the PNA is, by accident, helpful in Reg 18 - unforeseen benefit – applications')		
26	7. Has the PNA provided enough information to inform future pharmaceutical services provision and plans for pharmacies and dispensing appliance contractors? - If no, please explain:	Is there a confirmation statement showing [showing] that major developments happening with no preparation of pharmacy contracts in place to serve the growing population? In addition, the covid has shown us major cities population reducing to move out of London and enter Surrey as people can now work from home and the house prices in Surrey are more affordable.	<p>We note that some developments in the planning phase have boards which review new developments and recommend which, if any, health services are needed.</p> <p>Population growth has been considered in Section 2 of this PNA using ONS projected population statistics.</p>	N/A
27	8. Are there any services which could be provided in a community pharmacy setting in the future, that have not been highlighted? - If yes, please explain:	Possibility of blood tests to be taken in the pharmacy as well?	<p>This is not currently a commissioned service. NHSE review all PNAs and is open to future review and development if required.</p> <p>There is an annual review of the Community Pharmacy Contractual Framework, with an emphasis on the</p>	N/A

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
			<p>provision of further clinical services from community pharmacy.</p> <p>NHS Health checks are commissioned by Surrey Public Health including cholesterol and glucose level blood checks.</p>	
28	8. Are there any services which could be provided in a community pharmacy setting in the future, that have not been highlighted? - If yes, please explain:	Something needs to be done to ensure that more GPs provide dispensing services, so these are more accessible to people.	<p>The ability for a GP practice to dispense to its registered patients depends on certain circumstances which are summarised in the NHS Regulations (2013); the patient must live in a 'controlled locality' or must pass the 'serious difficult test'.</p> <p>Controlled localities are areas that have been determined to be 'rural in character', at least 1.6km from a community pharmacy, has limited local services, limited local population and appreciable distances between settlements/housing by NHSE(or a preceding organisation) or on an appeal by NHS Resolution.</p>	N/A
29	8. Are there any services which could be provided in a community pharmacy	Pain Management	This is not currently a commissioned service. NHSE review all PNAs and is	N/A

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
	setting in the future, that have not been highlighted? - If yes, please explain:		open to future review and development if required.	
30	8. Are there any services which could be provided in a community pharmacy setting in the future, that have not been highlighted? - If yes, please explain:	Pharmacies struggle to defuse patient irritation about the paucity of GP availability. Sadly pharmacists, by and large, do not have clinical skills and are hampered by the small range of medical products they can provide. They are also constrained in what 'first-aid' they can offer	<p>This is beyond the scope of the PNA.</p> <p>The LPC would like to note that pharmacists are highly qualified healthcare professionals who have undergone a four-year Masters degree course and a foundation trainee year before registration as a pharmacist. In addition, on an annual basis they complete a revalidation process.</p> <p>Pharmacists complete additional ongoing training to provide various clinical services including Independent Prescribing Qualifications.</p> <p>There is also future development of clinical services and Independent Prescribing qualifications on all newly qualified pharmacists from 2026.</p>	This comment has been shared with the LPC and will be shared at a public meeting of the HWB in September 2022.
31	8. Are there any services which could be provided in a community pharmacy setting in the future, that have not been	See above-I think the role of community pharmacies is about to really grow as part of an integrated	We acknowledge the role of community pharmacies, particularly in the roll out of the GP CPCS.	N/A

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
	highlighted? - If yes, please explain:	urgent care system eg roll out of GP CPCS		
32	9. Is the information contained in Surrey's draft PNA accurate? - If no, please explain:	See my comments at no.3 above (Row 6)	Please see the response provided to the comment referred to as no. 3, in Row 6.	N/A
33	9. Is the information contained in Surrey's draft PNA accurate? - If no, please explain:	Although accurate it is wordy, over illustrated and much of it irrelevant	The format of the PNA follows national legislation and guidance.	N/A
34	9. Is the information contained in Surrey's draft PNA accurate? - If no, please explain:	Recently areas have shown major development with no instructions in PNA showing the need of a pharmacy. Presently or in the future.	The PNA draft lists planned developments that come close to the threshold set by the steering group of 2000 dwellings. These figures have been supplied by local authority planning teams. Further confirmation has been sought from selected councils that have been mentioned in the consultation process (Guildford, Woking, Surrey Heath), regarding confirming the number of	N/A

Page 319

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
			<p> dwellings built between 2018-2022, and the plan for 2022 to.</p> <p>The response received thus far confirm that at present the number of dwellings built does not meet the threshold for further pharmacies but have identified key areas to monitor in future supplementary statements.</p>	
35	9. Is the information contained in Surrey's draft PNA accurate? - If no, please explain:	I have no idea. Where I live there is one chemist open five days a week which is understaffed with no privacy and at times difficulty in sourcing prescription drugs.	<p>This is beyond the scope of this PNA. However, we note that there is a complaints procedure in place at each pharmacy or patients may contact NHS national complaints to share issues.</p> <p>Please refer to further detail in relation to medicines shortages outlined the response in Row 1.</p> <p>Also note that as a result of the Healthy Living Pharmacy Level 1 (HLP) criteria becoming Terms of Service requirements, almost all pharmacies are now required to have a consultation room. The details are specified in the NHSE&I regulations guidance and summarised in an article</p>	This comment has been shared with the LPC and will be shared at a public meeting of the HWB in September 2022.

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
			by the PSNC <u>Regs reminder #14: consultation rooms and remote consultations.</u>	
36	10. Do you agree with the conclusions of the PNA? - If no, please explain:	I could not see any conclusions.	Please refer to the response outlined in Row 10.	A more detailed conclusions and recommendations section has been added to the final PNA in response to this comment (please see Section 8).
37	10. Do you agree with the conclusions of the PNA? - If no, please explain:	The conclusion that current provision is adequate is, in my opinion, wrong. I fail to see any value added to NHS pharmacy provision by publication of this document.	The development and content of this report follows the legislation set out by the DHSC.	N/A
38	10. Do you agree with the conclusions of the PNA? - If no, please explain:	Didn't really see any clear conclusions	Please refer to the response outlined in Row 10.	A more detailed conclusions and recommendations section has been added to the final PNA in response to this comment (please see Section 8).

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
39	10. Do you agree with the conclusions of the PNA? - If no, please explain:	<p>What Surrey commissions pharmacies to provide and what is provided are rather different.</p> <p>I worry that to some extent it does not reflect reality.</p>	<p>All pharmacies, including distance selling premises, are required to provide 'essential services'. As of October 2021, there are seven essential services, these services are outlined in more detail in section 4. Pharmacies may provide enhanced and advanced services if they choose.</p> <p>Unlike for GPs, dentists and optometrists, NHSE does not hold contracts with the majority of pharmacy and dispensing appliance contractors. Instead, pharmacy providers provide services under a contractual framework, sometimes referred to as the Community Pharmacy Contractual Framework, details of which (the terms of service) are set out in schedule 4 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended, and also in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013.</p> <p>In addition to the Community Pharmacy Contractual Framework, SCC enables pharmacies (through PHAs) to offer additional services such</p>	N/A

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
			<p>as smoking cessation, chlamydia screening and treatment and needle exchange. These services are funded through either a payment by results or activity-based arrangement which is monitored on monthly basis. This enables commissioners to understand what services are being delivered and to offer additional support and training to pharmacies who are not achieving the projected levels of activity.</p> <p>The general pharmaceutical council (GPHC) monitors the standards that apply to all pharmacy professionals (https://www.pharmacyregulation.org/standards/standards-for-pharmacy-professionals).</p>	
40	<p>11. If you have any further comments about the content of Surrey's draft PNA, please write them below: - If you have any further comments about the content of the draft PNA, please write them below:</p>	<p>The information, particularly the demographic information in the main section and the locality sections is clearly presented. Great job.</p> <p>I have been critical in my feed with the aim of assisting those that will use the PNA.</p>	<p>We acknowledge the feedback.</p>	<p>N/A</p>

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
41	11. If you have any further comments about the content of Surrey's draft PNA, please write them below: - If you have any further comments about the content of the draft PNA, please write them below:	Well, as I have just said, a total waste of effort. The multitude of maps are very pretty!	The development and content of this report follows the legislation set out by the DHSC.	N/A
42	11. If you have any further comments about the content of Surrey's draft PNA, please write them below: - If you have any further comments about the content of the draft PNA, please write them below:	The area of Ashvale is showing major development with only a pharmacy within the local area. How is it possible that the surveyors have not managed to have further research of this area? Considering this development was also mentioned in the previous PNA, this has not been mentioned in the current PNA. The population has been struggling and this has previously been mentioned in the Surrey live. I will highly appreciate if further investigation is done within this local area and this needs to be published and shared to the local council and health and wellbeing surrey council.	Please see the details outlined in response to the comment in Row 4.	The PNA Steering group has agreed that supplementary statements will be used to reflect changes in pharmaceutical provision throughout the term of the current PNA.

Surrey Pharmaceutical Needs Assessment 2022

Row	Consultation Question	Comment from Respondent	HWB Response	Actions taken and/or amendments to PNA
43	11. If you have any further comments about the content of Surrey's draft PNA, please write them below: - If you have any further comments about the content of the draft PNA, please write them below:	It appears that possibly due to the timing of production of this draft, the recent changes in the opening hours of a number of Boots pharmacies may not have been reflected in the draft PNA.	As advised in the DHSC PNA guidance document the Steering Group in Surrey agreed to a cut of date for data of 31/12/2021. Changes to opening hours will be considered in supplementary statements.	A summary of changes to the pharmaceutical list has been added to the appendices of the final PNA (please see Appendix D). Detail of opening hour changes will be reflected in supplementary statements.
44	11. If you have any further comments about the content of Surrey's draft PNA, please write them below: - If you have any further comments about the content of the draft PNA, please write them below:	Woking has a shockingly low number of pharmacies per 100,00 of population. In West Byfleet over the next five years we expect a population increase of around 40% many of whom will be elderly and we have a totally inadequate pharmacy availability.	Please see the details outlined in response to the comment in Row 3.	Please see the details outlined in response to the comment in Row 3.

10.0 Acknowledgements

All the Surrey PNA Steering Group members

The Local Medical Committee

The Local Pharmaceutical Committee

NHS Surrey Heartlands CCG/ ICS colleagues

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Surrey Pharmaceutical Needs Assessment 2022

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Appendices: Surrey Health and Wellbeing Board Pharmaceutical Needs Assessment October 2022

Contents

Appendix A: Locality profiles	5
Elmbridge borough	5
Elmbridge Population	5
Rural and Urban composition of Elmbridge borough	8
Elmbridge Population Density	9
Elmbridge Population Projections	9
Older People living alone	11
General Birth Rate	12
Epsom & Ewell borough	14
Epsom & Ewell Population	14
Rural and Urban composition of Epsom & Ewell borough	16
Epsom & Ewell Population Density	17
Epsom & Ewell Population Projections	17
Older People living alone	19
General Birth Rate	20
Guildford borough	22
Guildford Population	22
Rural and Urban composition of Guildford borough	24
Guildford Population Density	25
Guildford Population Projections	25
Older People living alone	27
General Birth Rate	28
Mole Valley district	30
Mole Valley Population	30
Rural and Urban composition of Mole Valley district	32
Population Density	33
Mole Valley Population Projections	33
Older People living alone	35
General Birth Rate	36
Reigate & Banstead borough	38
Reigate & Banstead Population	38
Rural and Urban composition of Reigate & Banstead borough	40
Population Density	41
Reigate & Banstead Population Projections	41
Older People living alone	43
General Birth Rate	44

Runnymede borough	46
Runnymede Population	46
Rural and Urban composition of Runnymede borough	48
Population Density	48
Runnymede Population Projections	49
Older People living alone	50
General Birth Rate	51
Spelthorne borough	53
Spelthorne Population	53
Rural and Urban composition of Spelthorne borough	55
Population Density	56
Spelthorne Population Projections	56
Older People living alone in Spelthorne	58
General Birth Rate	59
Surrey Heath borough	61
Surrey Heath Population	61
Rural and Urban composition of Surrey Heath borough	63
Population Density	64
Surrey Heath Population Projections	65
Older People living alone	66
General Birth Rate	67
Tandridge district	69
Tandridge Population	69
Rural and Urban composition of Tandridge district	71
Population Density	71
Tandridge Population Projections	72
Older People living alone	73
General Birth Rate	74
Waverley Borough.....	76
Waverley Population	76
Rural and urban composition of Waverley borough	78
Population Density	78
Waverley Population Projections	79
Older People living alone	80
General Birth Rate	81
Woking Borough.....	83
Woking Population	83
Rural and Urban composition of Woking borough.....	85
Population Density	86

Woking Population Projections	87
Older People living alone	88
General Birth Rate	89
Appendix B: Pharmacies and Dispensing Doctors opening times.....	91
B. 1. 1 Elmbridge borough.....	91
B. 1. 2 Epsom & Ewell borough.....	94
B. 1. 3 Guildford borough.....	95
B. 1. 4 Mole Valley district	97
B. 1. 5 Reigate & Banstead borough	99
B. 1. 6 Runnymede borough.....	101
B. 1. 7 Spelthorne borough.....	102
B. 1. 8 Surrey Heath borough	104
B. 1. 9 Tandridge district.....	106
B. 1. 10 Waverley borough	107
B. 1. 11 Woking borough	109
B. 2.0 List of Dispensing Doctors.....	111
Appendix C: Pharmacies qualifying for Pharmacy Access Scheme payments	112
Appendix D: Changes to the pharmaceutical list.....	114

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Appendix A: Locality profiles

Elmbridge borough

Elmbridge Population

The population of Elmbridge is 48.4% males and 51.6% females (Table 1). Half (54.8%) of the population is aged between 20 to 64, and children and young people make up over a quarter (26.6%) of the population and the proportion aged between 5 and 14 years is higher than in England (Table 2). Table 2 shows the percentage of the population aged 85 and over as well as the percentage aged 65 and over (which includes the 85+ cohort), these have both been included as these populations have a higher need for prescriptions and healthcare. The percentage of the population aged 85 and older overall is 3.1%, and this 85+ group makes up 16.8% of the population aged 65 and over. The population pyramid for Elmbridge (

Figure 1) shows that the largest 5-year population groups are children aged 0 to 14 and adults aged 40 to 59 years. Overall, the working-age population living in Elmbridge is older than in England. The proportion of males and females in the 40 to 59 age groups is higher when compared to the England average, while the proportion of males and females aged 20 to 39 are significantly lower than the England average.

Table 1: Population by sex in Elmbridge

Sex	Number	Percentage
Persons	137,215	100.0
Males	66,477	48.4
Females	70,738	51.6

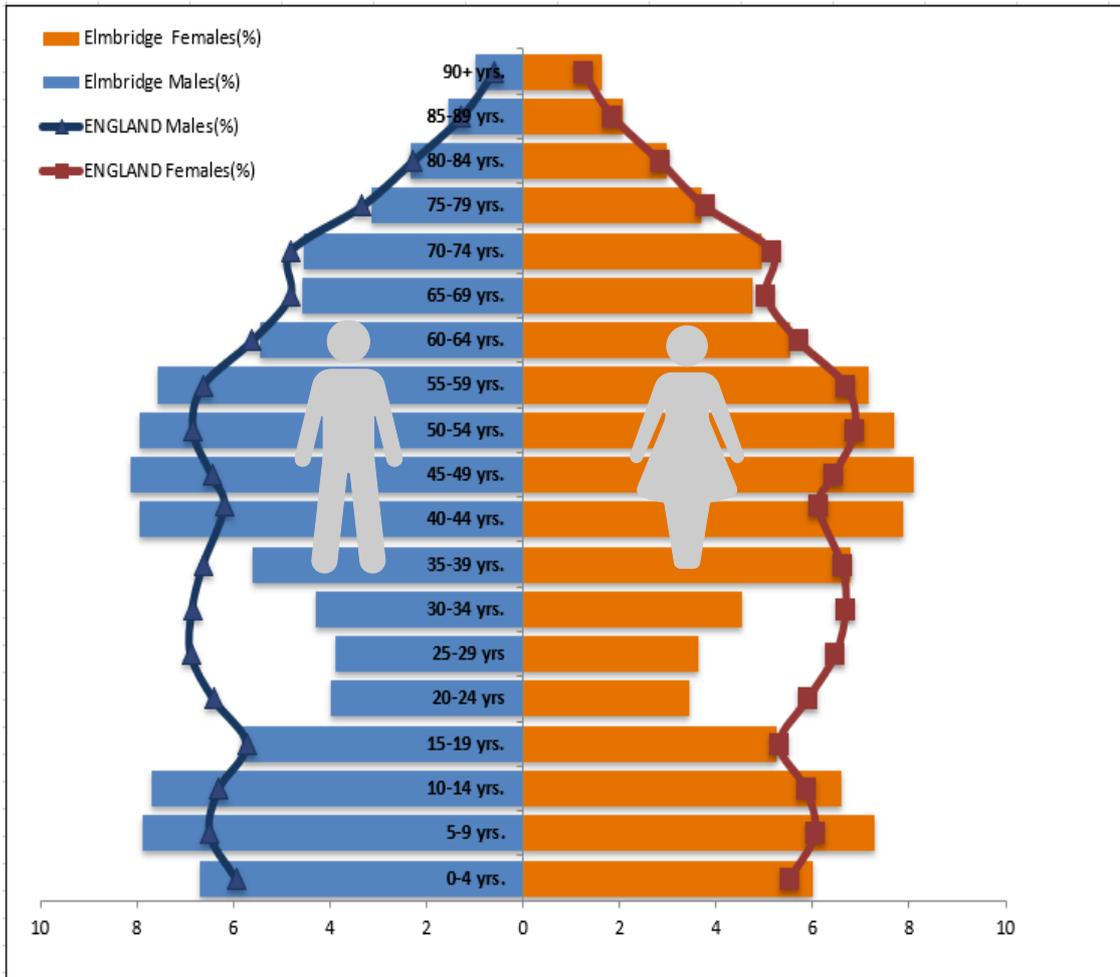
Source: ONS, Mid-year estimates, 2020

Table 2: Percentage of population by age & sex in Elmbridge 2020

Sex	0 to 19	20 to 64	65 and over	85 and over
Persons	26.6	54.8	18.6	3.1
Males	28.1	54.8	17.1	2.5
Females	25.1	54.8	20.1	3.7

Source: ONS, Mid-year estimates, 2020

Figure 1: Elmbridge Population Pyramid



Source: ONS, Mid-year estimates, 2020

The majority of the population in Elmbridge are white (90.3%), followed by Asian (5.4%) and Mixed ethnicities (2.6%). This is similar to the population across Surrey and the South East, but less diverse than the whole population of England.

Table 3: Percentage of population by ethnicity, 2011

Ethnicity	Number	Percentage
Population 2020	137,215	100.0
White	123,850	90.3
Mixed	3,581	2.6
Asian	7,423	5.4
Black	1,057	0.8
Other	1,317	1.0

Source: Census 2011, QS201EW, Nomis 2020

Rural and Urban composition of Elmbridge borough

The majority of people living in Elmbridge live in urban areas (and this is a higher proportion of households than across Surrey, the South East and England), while only a small proportion of the population live in an area classified as rural.

Table 4: Rural and urban composition of Elmbridge borough

Area name	Total	Urban (total)	Urban (%)	Rural (total)	Rural (%)
England	52,059,931	42,935,229	82.5	9,124,702	17.5
Southeast	8,446,500	6,735,465	79.7	1,711,035	20.3
Surrey	1,105,800	958,798	86.7	147,002	13.3
Elmbridge	129,483	126,765	97.9	2,718	2.1

Source: Nomis,2022

*Local Authority Districts and Output Areas may cover a large area of open countryside and yet be urban if most of the population lives in an urban settlement. Rural is a matter of settlement form and dwelling density rather than the economic function or the character or use of the land. Most local authorities classed as rural will include urban populations and vice versa - indeed 'urban' authorities may have sizeable rural populations.

Type of urban settings

- urban major conurbation (83.0%)
- city and town (14.8%)

Type of rural settings

- rural town and fringe (1.0%)
- rural hamlet and isolated dwellings (0.9%)
- rural village (0.2%)

Elmbridge Population Density

Elmbridge has double the number of people per square kilometre than Surrey overall.

Table 5: The projected change in population density of Elmbridge in 2020 compared to 2030

Area name	Area (sq km)	2022 people per sq. km	2025 people per sq. km	2030 people per sq. km
Surrey	1,663	723	727	730
Elmbridge	95	1,446	1,448	1,443

Source: Surrey, 2020,

Note: numbers may not add up due to rounding

Elmbridge Population Projections

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Looking over a 10-year period, Elmbridge is expected to have a smaller population growth of 0.1% compared to the growth expected across Surrey (1.3%). People aged 65 and over are projected to have the largest growth (21.7%), and of those, one third (27.4%) are estimated to be 85 and over (Table 6) – this growth is higher than in Surrey overall.

Over the lifetime of this PNA, the population of Elmbridge is expected to grow by 0.1% over the next 3 years. The number of children 0 to 14 years and the 30 to 44 age cohorts are expected decrease, while the 15 to 29 and 45 to 64 age cohorts will see a small growth. People aged 65 and over are projected to have the largest growth (5.7%) (Table 7), of those 19.4% are estimated to be aged 85 and over by 2025.

Table 6: Projected population change in Elmbridge, 2020 to 2030

Age band	2020	2030	Difference	% Change	Population Change Surrey %
0 to 14	28,762	24,725	-4,037	-14.0	-9.1
15 to 29	17,335	18,269	934	5.4	5.8
30 to 44	25,904	22,140	-3,764	-14.5	-7.1
45 to 64	39,290	40,714	1,424	3.6	0.2
65 & Over	25,736	31,316	5,580	21.7	17.5
All ages	137,027	137,164	137	0.1	1.3

Source: Sub-national Population LA Projections, 2018

Table 7: Projected population change in Elmbridge borough 2022 to 2025

Age band	2022	2025	Difference	% Change	Population Change Surrey %
0 to 14	28,368	27,144	-1,225	-4.3	-2.8
15 to 29	17,360	17,706	346	2.0	2.0
30 to 44	24,989	23,667	-1,322	-5.3	-2.7
45 to 64	40,243	41,135	892	2.2	1.0
65 & Over	26,491	27,994	1,503	5.7	4.5
All ages	137,452	137,645	194	0.1	0.5

Source: Sub-national Population LA Projections, 2018

Older People living alone

Approximately 5.2% of those aged 65 and over are living on their own in Elmbridge; this is consistent with the Surrey (5.2%) average and lower than the national average (6.9%).

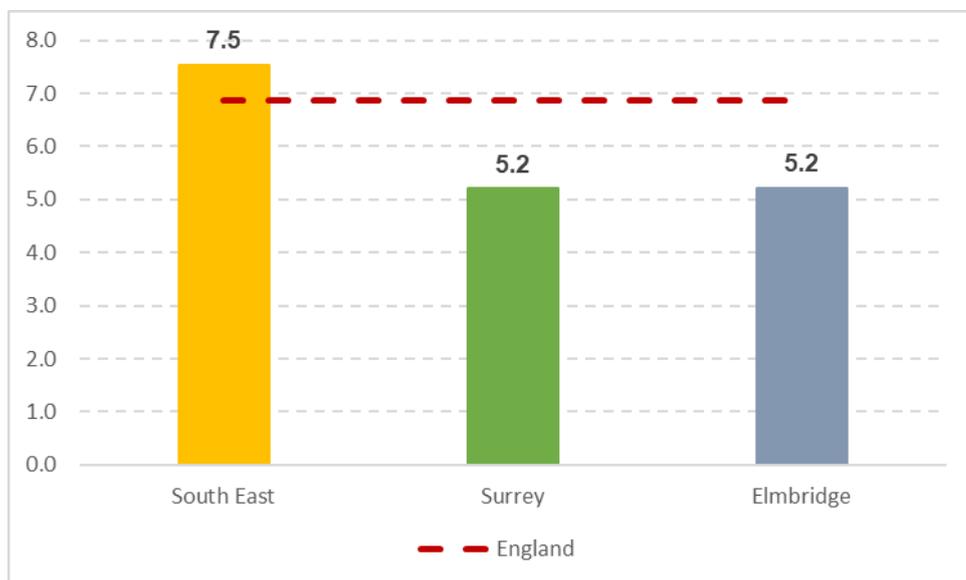
Table 8: Percentage of households occupied by older people (aged 65 & over) living alone in Elmbridge, 2011

Area name	All households	One person household: Aged 65+	% One person household: Aged 65+
England	52,059,931	3,579,698	6.9
South East	8,446,500	637,330	7.5
Surrey	1,105,800	57,543	5.2
Elmbridge	129,483	6,743	5.2

Source: Census, 2011, QS112EW – Nomis, 2020

10

Figure 2: Percentage of households occupied by older people (aged 65 & over) living alone in Elmbridge, 2011



Source: Census, 2011, QS112EW – Nomis, 2020

General Birth Rate

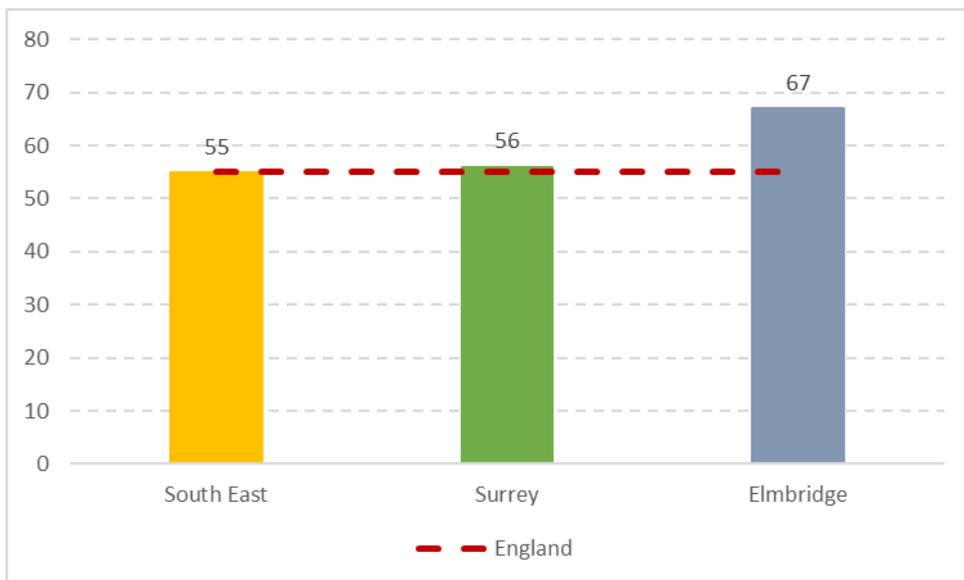
Elmbridge borough birth rate for women aged 15 to 44 years (67/1,000) is significantly higher than the England average (55/1,000) (Table 9).

Table 9: Live births, per 1,000 women aged 15 to 44 years in Elmbridge, 2020

Area name	Female population 15 to 44 years	Births	Rate per 1,000 female population
England	10,581,832	585,195	55
Southeast	1,642,566	90,864	55
Surrey	212,519	11,880	56
Elmbridge	22,320	1,496	67

10 Source: Office for National Statistics (ONS), Nomis, 2020

Figure 3: Live births, per 1,000 women in Elmbridge, aged 15 to 44 years, 2020



Source: Office for National Statistics (ONS), Nomis, 2020

Table 10: Live birth numbers, General Fertility Rates (GFR) and Total Fertility Rates (TFR) in Elmbridge, 2020

Area of usual residence	Live births	GFR ²	TFR ³
England	585,195	55	1.59
Southeast	90,864	55	1.65
Surrey	13,423	56	1.70
Elmbridge	1,496	67	2.07

Source: Office for National Statistics (ONS), Nomis, 2020

¹ Rates for 2020 have been calculated using the mid-2020 population estimates based on 2011 census

² The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15 to 44. The GFRs have been calculated using mid-2020 population estimates.

³ The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

Epsom & Ewell borough

Epsom & Ewell Population

The population of Epsom & Ewell is approximately 48.6% males and 51.4% female (Table 11). Half (56.0%) of the population is aged between 20 to 64, children and young people make up a quarter (25.6%) of the population. Table 12 shows the percentage of the population aged 85 and over as well as the percentage aged 65 and over (which includes the 85+ cohort), these have both been included as these populations have a higher need for prescription and healthcare; 18.3% of the population is aged 65 and over, of whom 14.3% are aged 85 and over.

The population pyramid for Epsom & Ewell (Figure 4) shows the proportions for both males and females aged 20 to 34 are lower than the England average whereas the proportions for males 40 to 59 and females aged 35 to 49 are slightly higher than the England average. The proportion of the population in the aged 60 to 90 in both males and females are similar to that of the England average.

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Table 11: Population by sex in Epsom & Ewell

Sex	Number	Percentage
Persons	81,003	100.0
Males	39,360	48.6
Females	41,643	51.4

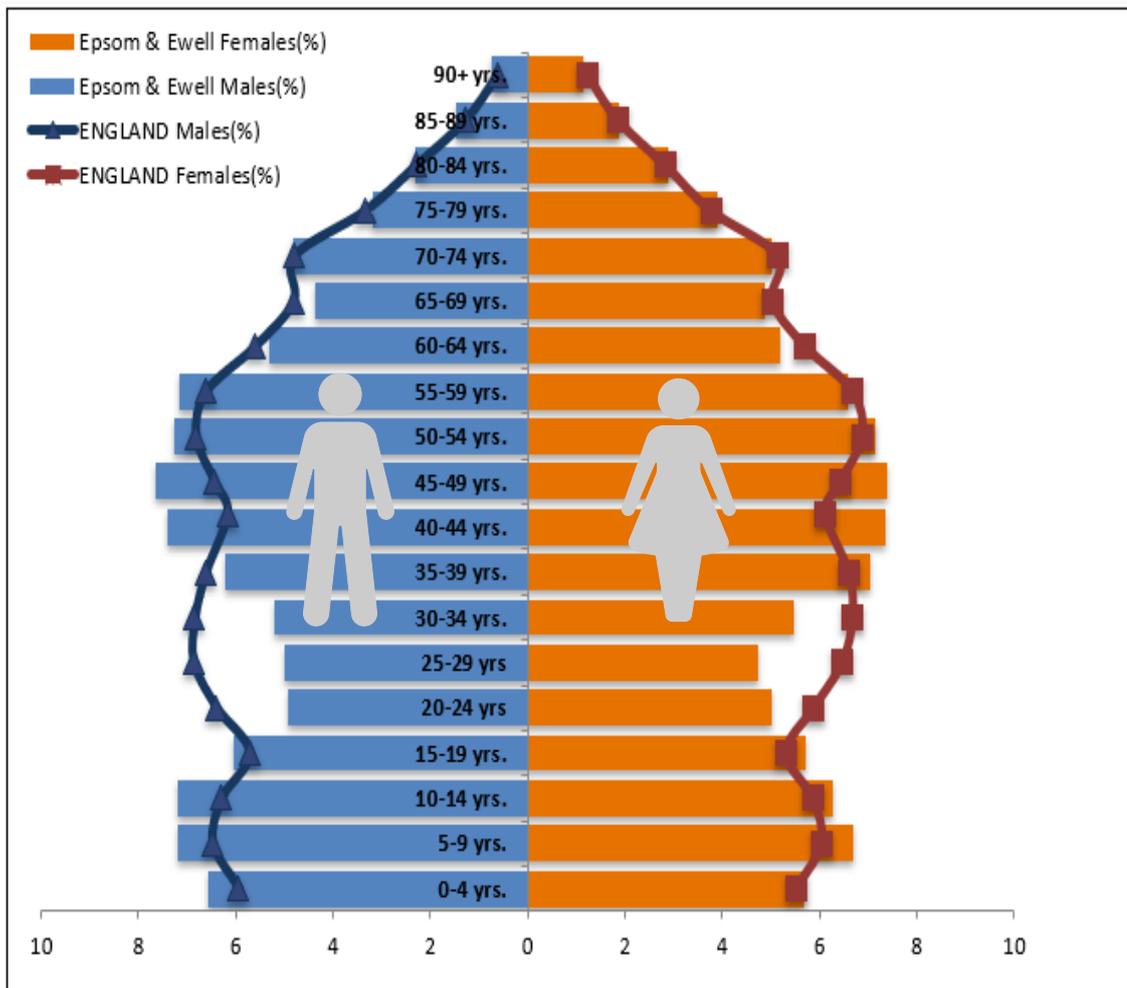
Source: ONS, Mid-year estimates, 2020

Table 12: Percentage of age & sex breakdown, in Epsom & Ewell, 2020

Sex	0 to 19	20 to 64	65 and over	85 and over
Persons	25.6	56.0	18.3	2.6
Males	27.0	56.2	16.9	2.2
Females	24.3	55.9	19.7	3.0

Source: ONS, Mid-year estimates, 2020

Figure 4: Epsom & Ewell Population Pyramid



Source: ONS, Mid-year estimates, 2020

The majority of the population in Epsom & Ewell are white (85.9%), followed by Asian (8.6%) and mixed (2.6%).

Table 13: Percentage of population, by ethnicity, 2011

Ethnicity	Number	Percentage
Population 2020	1,003	100.0
White	69,573	85.9
Mixed	2,074	2.6
Asian	6,991	8.6
Black	1,215	1.5
Other	1,150	1.4

Source: Census 2011, QS201EW, Nomis 2020

Rural and Urban composition of Epsom & Ewell borough

The majority of people living in Epsom & Ewell live in urban areas (and this is a higher proportion of households than across Surrey, the South East and England), while only a small proportion of the population live in an area classified as rural.

Table 14: Rural and urban composition of Epsom & Ewell Borough

Area name	Total	Urban (total)	Urban (%)	Rural (total)	Rural (%)
England	52,059,931	42,935,229	82.5	9,124,702	17.5
South East	8,446,500	6,735,465	79.7	1,711,035	20.3
Surrey	1,105,800	958,798	86.7	147,002	13.3
Epsom and Ewell	74,026	71,225	96.2	2,801	3.8

Source: Nomis, 2020

*Local Authority Districts and Output Areas may cover a large area of open countryside and yet be urban if most of the population lives in an urban settlement. Rural is a matter of settlement form and dwelling density rather than the economic function or the character or use of the land. Most local authorities classed as rural will include urban populations and vice versa - indeed 'urban' authorities may have sizeable rural populations.

Type of urban settings

- urban major conurbation (96.2%)

Type of rural settings

- rural town and fringe (3.8%)

Epsom & Ewell Population Density

Epsom & Ewell is the most densely populated local authority in Surrey. Epsom & Ewell is approximately seven times more densely populated than Mole Valley.

Table 15: The projected change in population density of Epsom & Ewell in 2020 compared to 2030

Area name	Area (sq km)	2022 people per sq. km	2025 people per sq. km	2030 people per sq. km
Surrey	1,663	723	727	730
Epsom & Ewell	34	2,382	2,405	2,428

Source: Surrey, 2020

10

Epsom & Ewell Population Projections

Epsom & Ewell is expected to grow by 2.7% in the next 10 years, higher than Surrey (1.3%). The population aged 30 to 44 is projected to have the largest decrease (-8.8%), while the 65 and over age group is estimated to have the largest increase (15.7%), of which a 25% are 85 and over (Table 16).

Over the lifetime of this PNA, the population of Epsom & Ewell is expected to grow by 1.0% over the next three years. The number of children 0 to 14 years and adults 30 to 44 age cohorts are expected to decrease. 15 to 29 and 45 to 64 age cohorts will see a small growth, 2.5% and 2.6% respectively. People aged 65 and over are projected to have the largest growth (4.0%) (Table 17) of which 22.1% are 85 and older.

Table 16: Projected population change in Epsom & Ewell, 2020 to 2030

Age band	2020	2030	Number	%	Population Change Surrey %
0 to 14	15,889	15,087	-802	-5.0	-9.1
15 to 29	12,446	13,451	1,005	8.1	5.8
30 to 44	15,661	14,281	-1,380	-8.8	-7.1
45 to 64	21,645	22,687	1,042	4.8	0.2
65 & Over	14,915	17,251	2,336	15.7	17.5
All ages	80,555	82,756	2,201	2.7	1.3

Source: Sub-national Population LA Projections, 2018

Table 17: Projected population change in Epsom & Ewell, 2022 to 2025

Age band	2022	2025	Number	%	Population Change Surrey %
0 to 14	16,031	15,852	-179	-1.1	-2.8
15 to 29	12,395	12,709	315	2.5	2.0
30 to 44	15,602	15,058	-545	-3.5	-2.7
45 to 64	21,961	22,539	577	2.6	1.0
65 & Over	15,205	15,809	604	4.0	4.5
All ages	81,193	81,967	773	1.0	0.5

Source: Sub-national Population LA Projections, 2018

Older People living alone

Approximately 5.1% of those aged 65 and over are living on their own in Epsom & Ewell this is similar to Surrey average (5.2%) and lower than the national average (6.9%).

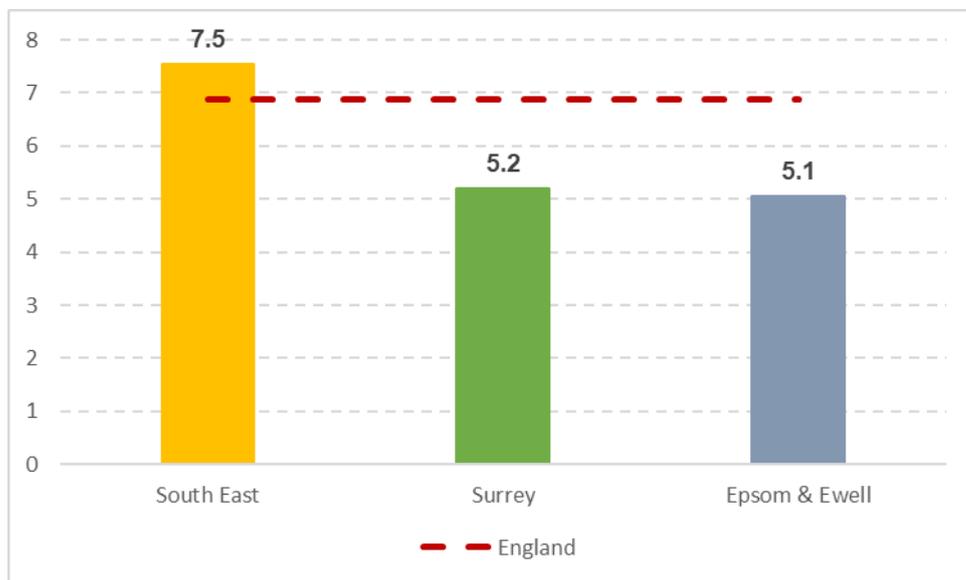
Table 18: Percentage of households occupied by older people (aged 65 & over) living alone in Epsom & Ewell, 2011

Area name	All households	One person household: Aged 65+	% One person household: Aged 65+
England	52,059,931	3,579,698	6.9
South East	8,446,500	637,330	7.5
Surrey	1,105,800	57,543	5.2
Epsom & Ewell	74,026	3,746	5.1

Source: Census, 2011, QS112EW – Nomis, 2020

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Figure 5: Percentage of households occupied by older people (aged 65 & over) living alone in Epsom & Ewell, 2011



Source: Census, 2011, QS112EW – Nomis, 2020

General Birth Rate

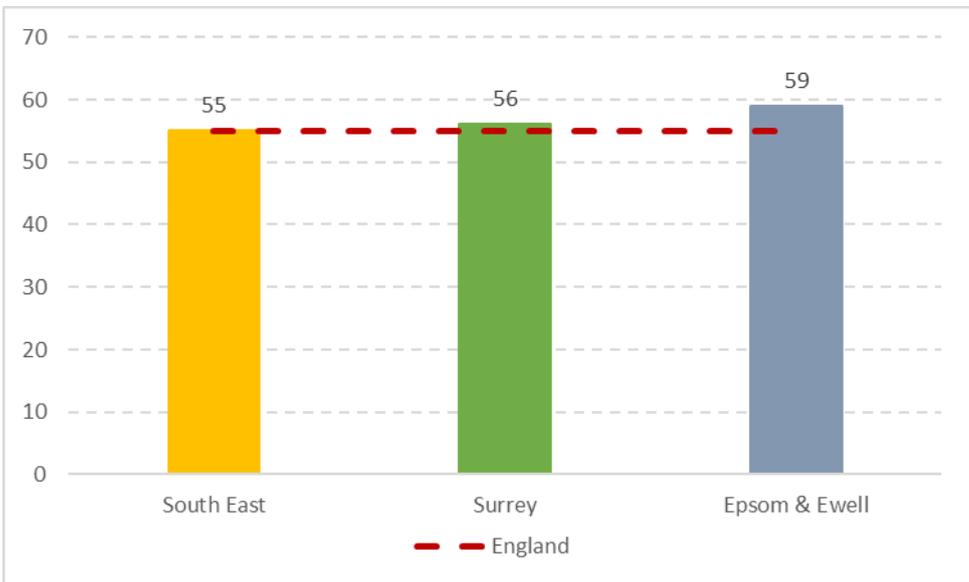
Epsom & Ewell birth rate for women aged 15 to 44 years (59/1,000) is higher than the England average (55/1,000) (Table 19).

Table 19: Live births, per 1,000 women aged 15 to 44 years in Epsom & Ewell, 2020

Area name	Female population 15 to 44 years	Births	Rate per 1,000 female population
England	10,581,832	585,195	55
South East	1,642,566	90,864	55
Surrey	212,519	11,880	56
Epsom & Ewell	14,712	864	59

Source: Office for National Statistics (ONS), Nomis, 2020

Figure 6: Live births, per 1,000 women in Epsom & Ewell aged 15 to 44 years, 2020



Source: Office for National Statistics (ONS), Nomis, 2020

Table 20: Live birth numbers, General Fertility Rates (GFR) and Total Fertility Rates (TFR) in Epsom & Ewell, 2020

Area of usual residence	Live births	GFR ²	TFR ³
England	585,195	55	1.59
South East	90,864	55	1.65
Surrey	13,423	56	1.70
Epsom & Ewell	864	59	1.80

Source: Office for National Statistics (ONS), Nomis, 2020

¹ Rates for 2020 have been calculated using the mid-2020 population estimates based on 2011 census

² The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15-44. The GFRs have been calculated using mid-2020 population estimates.

³ The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

Guildford borough

Guildford Population

The population of Guildford is 50.2% males and 49.8% females (Table 21). A slightly higher proportion of the population is aged between 20 to 64 compared to most other local authorities in Surrey, but this is entirely driven by the high proportion of the population aged 20 to 29 years specifically. This is mainly attributed to the high numbers of students residing in Guildford (Table 22). The proportion of all other population groups are broadly similar to the England average, unlike most of the other local authorities in Surrey. Table 22 shows the percentage of the population aged 85 and over as well as the percentage aged 65 and over (which includes the 85+ cohort), these have both been included as these populations have a higher need for prescription and healthcare. The percentage of the population aged 85 and older overall is 3.2%, and this 85+ group makes up 15% of the population aged 65 and over.

The population pyramid shows the proportion of males and females in Guildford is similar to the England average in all age bands except 20 to 29 years, where the proportion of males and females is significantly higher.

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Table 21: Population by sex in Guildford

Sex	Number	Percentage
Persons	150,352	100.0
Males	75,512	50.2
Females	74,840	49.8

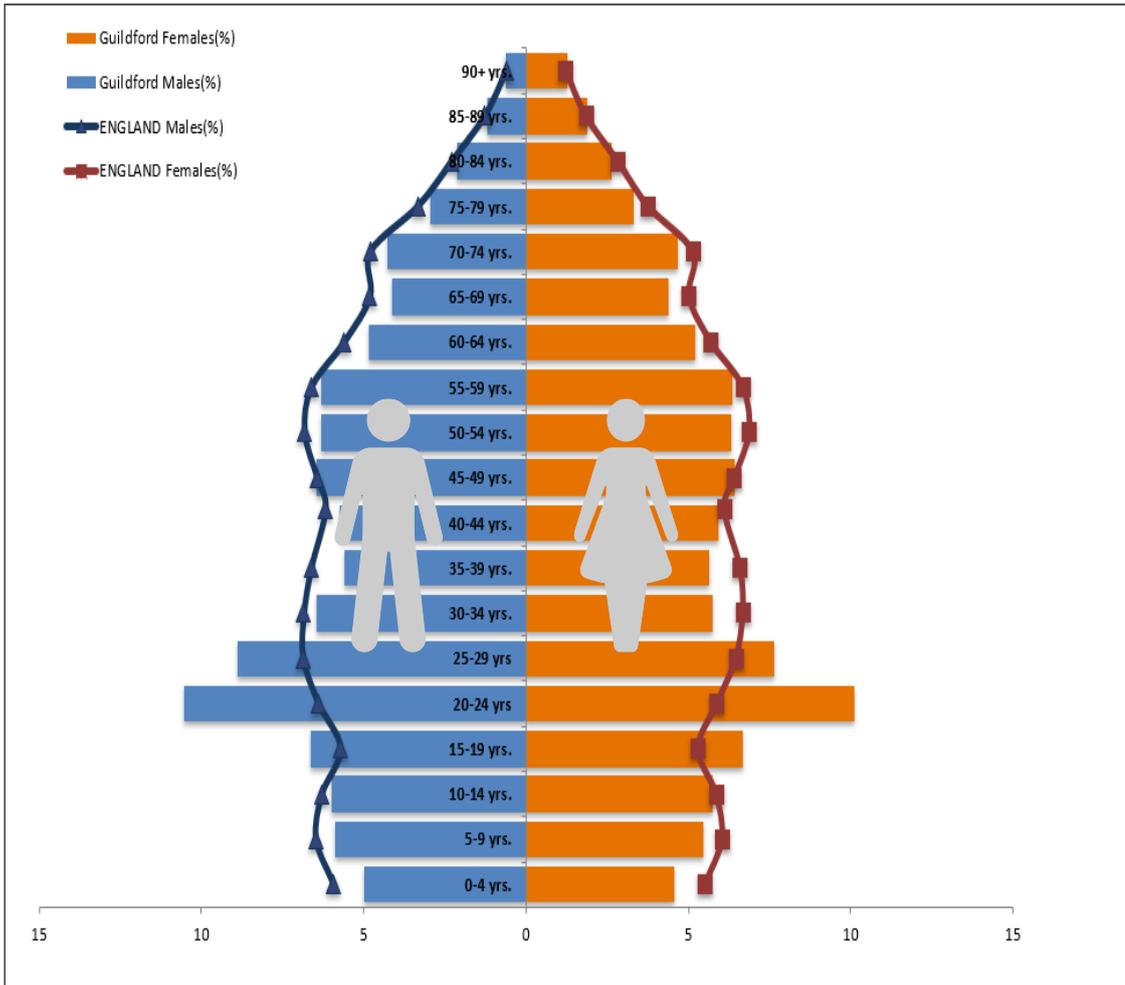
Source: ONS, Mid-year estimates, 2020

Table 22: Percentage of population by age & sex breakdown in Guildford, 2020

Sex	0 to 19	20 to 64	65 and over	85 and over
Persons	23.0	60.3	16.7	2.5
Males	23.5	61.2	15.3	1.8
Females	22.5	59.4	18.2	3.2

Source: ONS, Mid-year estimates, 2020

Figure 7: Guildford Population Pyramid



Source: ONS, Mid-year estimates, 2020

The majority of the population in Guildford are White (90.9%), followed by Asian (4.8%) and mixed ethnicities (1.8%). This is similar to the population across Surrey and the South East, but less diverse than the whole population of England.

Table 23: Percentage of population by ethnicity, 2011

Ethnicity	Number	Percentage
Population 2020	150,352	100.0
White	136,685	90.9
Mixed	2,736	1.8
Asian	7,247	4.8
Black	1,819	1.2
Other	1,864	1.2

Source: Census 2011, QS201EW, Nomis 2020

Rural and Urban composition of Guildford borough

The majority of the people living in Guildford live in urban areas (but the proportion is lower than across Surrey, the South East and England). A quarter of the population in Guildford live in an area classified as rural.

Table 24: Rural and urban composition of Guildford Borough

Area name	Total	Urban (total)	Urban (%)	Rural (total)	Rural (%)
England	52,059,931	42,935,229	82.5	9,124,702	17.5
South East	8,446,500	6,735,465	79.7	1,711,035	20.3
Surrey	1,105,800	958,798	86.7	147,002	13.3
Guildford	137,183	103,194	75.2	33,989	24.8

Source: Nomis,2020

*Local Authority Districts and Output Areas may cover a large area of open countryside and yet be urban if most of the population lives in an urban settlement. Rural is a matter of settlement form and dwelling density rather than the economic function or the character or use of the land. Most local authorities classed as rural will include urban populations and vice versa - indeed 'urban' authorities may have sizeable rural populations.

Type of urban settings

- urban city and town (75.2%)

Type of rural settings

- rural villages (12.0%)
- rural town and fringe (6.9%)
- rural hamlet and isolated dwellings (5.9%)

Guildford Population Density

Guildford has 550 people per square kilometre, lower than the Surrey average (723).

Table 25: The projected change in population density of Guildford in 2020 compared to 2030

Area name	Area (sq km)	2022 people per sq. km	2025 people per sq. km	2030 people per sq. km
Surrey	1,663	723	727	730
Guildford	271	550	550	551

Source: Surrey, 2020

Guildford Population Projections

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Over the next 10 year period Guildford is expected to have a smaller population growth of 0.2% compared to the growth across Surrey (1.3%). Children and young people 0 to 14 years and people aged 30 to 64 age cohorts will decrease. People aged 65 and over is projected to have the largest growth (15.4%) (Table 26), and of those a fifth will be aged 85 and over.

Over the lifetime of this PNA, the overall population of Guildford is not expected to grow over the next 3 years. Children and young people 0 to 14 years and 30 to 64 age cohorts are expected to see a negative growth while 15 to 29 age cohorts will see a small growth similar to Surrey. People aged 65 and over are projected to have the largest growth (Table 27), with 18.4% of this group aged 85 and over.

Table 26: Projected population changes in Guildford, 2020 to 2030

Age band	2020	2030	Number	%	Population Change Surrey %
0 to 14	24,420	21,643	-2,778	-11.4	-9.1
15 to 29	36,903	39,232	2,329	6.3	5.8
30 to 44	26,482	25,353	-1,128	-4.3	-7.1
45 to 64	36,084	34,089	-1,995	-5.5	0.2
65 & Over	25,052	28,916	3,864	15.4	17.5
All ages	148,940	149,232	292	0.2	1.3

Source: Sub-national Population LA Projections, 2018

Table 27: Population changes in Guildford, all persons, 2022 to 2025

Age band	2022	2025	Number	%	Population Change Surrey %
0 to 14	23,932	22,991	-942	-3.9	-2.8
15 to 29	37,098	37,721	623	1.7	2.0
30 to 44	26,450	25,976	-474	-1.8	-2.7
45 to 64	35,955	35,735	-221	-0.6	1.0
65 & Over	25,657	26,598	941	3.7	4.5
All ages	149,092	149,020	-72	0.0	0.5

Source: Sub-national Population LA Projections, 2018

Older People living alone

Guildford has a lower proportion of households occupied by an older person 65 and over living alone (4.7%) compared to England (6.9%).

Table 28: Percentage of households occupied by older people (aged 65 & over) living alone, 2011

Area name	All households	One person household: Aged 65+	% One person household: Aged 65+
England	52,059,931	3,579,698	6.9
South East	8,446,500	637,330	7.5
Surrey	1,105,800	57,543	5.2
Guildford	130,920	6,160	4.7

Source: Census, 2011, QS112EW – Nomis, 2020

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Figure 8: Guildford percentage of households occupied by older people (aged 65 & over) living alone, 2011



Source: Census, 2011, QS112EW – Nomis, 2020

General Birth Rate

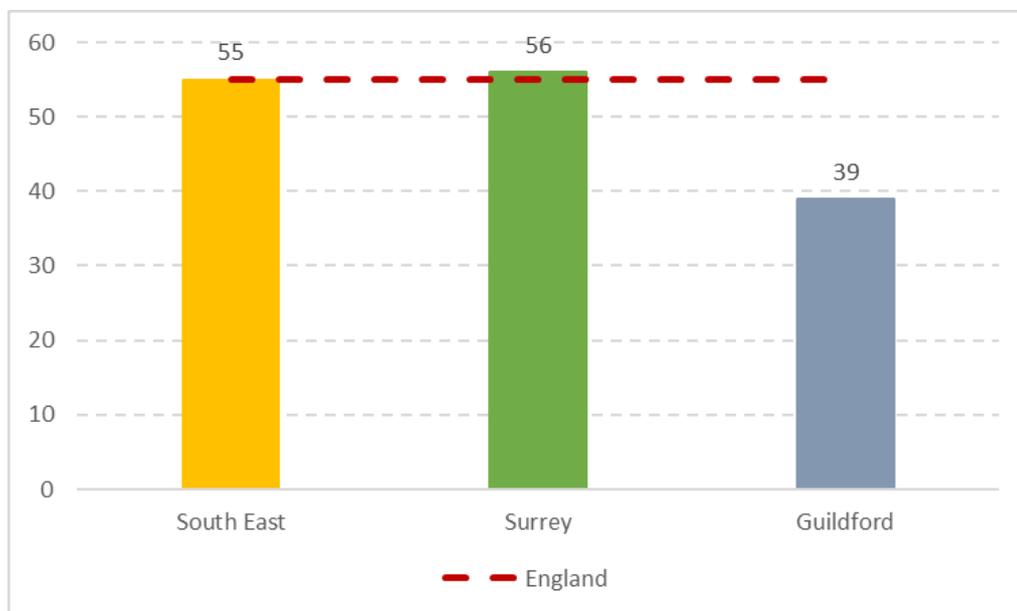
Guildford birth rate for women aged 15 to 44 years (39/1,000) is lower than the England average (55/1,000).

Table 29: Live births, per 1,000 women aged 15 to 44 years in Guildford, 2020

Area name	Female population 15 to 44 years	Births	Rate per 1,000 female population
England	10,581,832	585,195	55
South East	1,642,566	90,864	55
Surrey	212,519	11,880	56
Guildford	31,269	1,219	39

Source: Office for National Statistics (ONS), Nomis, 2020

Figure 9: Live births, per 1,000 women in Guildford, aged 15 to 44 years, 2020



Source: Office for National Statistics (ONS), Nomis, 2020

Table 30: Live births numbers, General Fertility Rates and Total Fertility Rates in Guildford, 2020

Area of usual residence	Live births	GFR ²	TFR ³
England	585,195	55	1.59
South East	90,864	55	1.65
Surrey	13,423	56	1.7
Guildford	1,219	39	1.3

Source: Office for National Statistics (ONS), Nomis, 2020

¹ Rates for 2020 have been calculated using the mid-2020 population estimates based on 2011 census

² The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15 to 44. The GFRs have been calculated using mid-2020 population estimates.

³ The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

Mole Valley district

Mole Valley Population

The population of Mole Valley is 48.9% males and 51.1% females (Table 31). Half the population is aged between 20 to 64, people aged 65 and over make up almost a quarter (23.9%). Table 32 shows the percentage of the population aged 85 and over as well as the percentage aged 65 and over (which includes the 85+ cohort), these have both been included as these populations have a higher need for prescription and healthcare. The percentage of the population aged 85 and older overall is 3.8%, and this 85+ group makes up 16.1% of the population aged 65 and over.

The population pyramid for Mole Valley (Figure 10) shows the largest 5-year population groups are adults aged 50 to 54 and 55 to 59 years. Overall, the working-age population living in Mole Valley is older than the England average. The proportions of males and females aged 10 to 19 years is similar to the England average, the proportion of males and females aged 20 to 39 years is significantly lower than the England average, and 45 to 90 year old males and females is slightly higher than the England average.

10 **Table 31: Population by sex and locality**

Sex	Number	Percentage
Persons	87,547	100.0
Males	42,796	48.9
Females	44,751	51.1

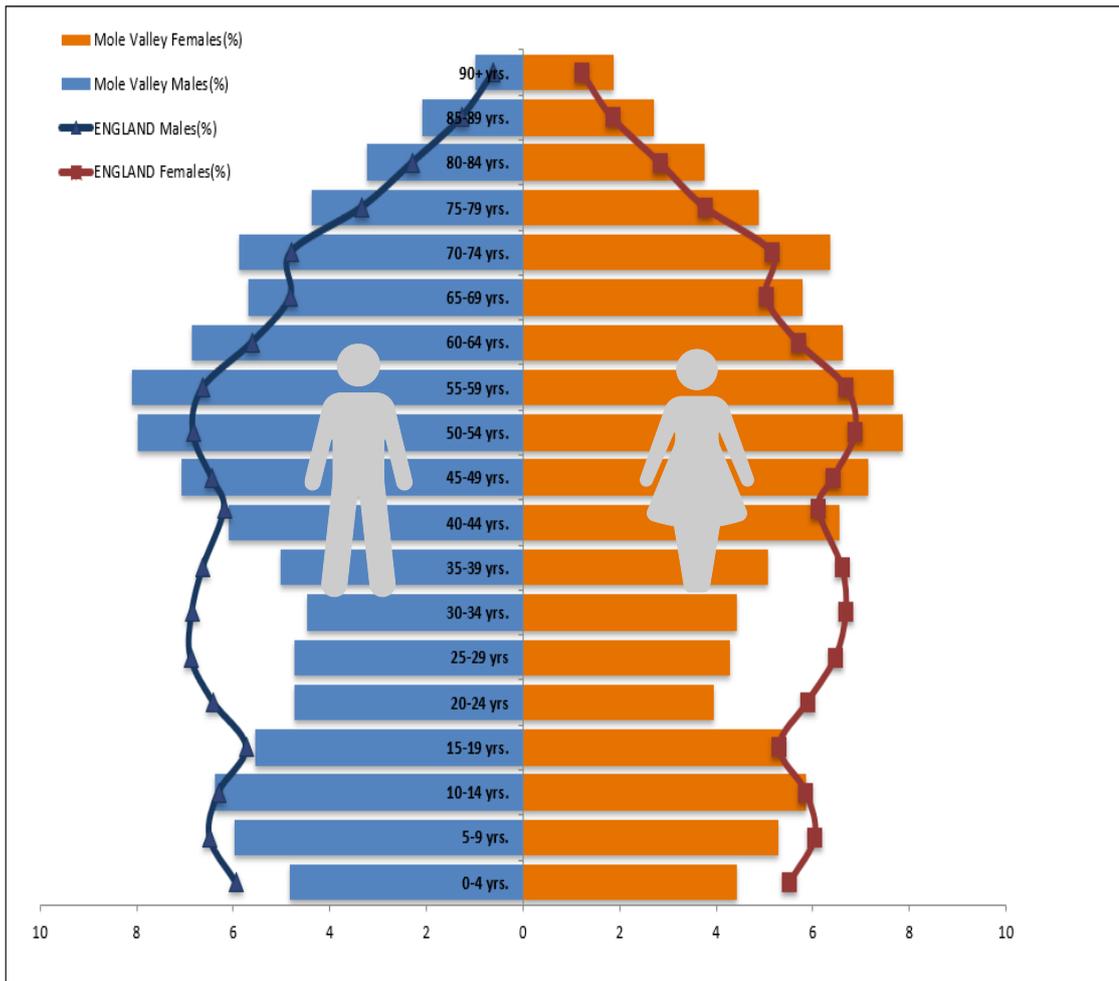
Source: ONS, Mid-year estimates, 2020

Table 32: Percentage of age & sex breakdown in Mole Valley, 2020

Sex	0 to 19	20 to 64	65 and over	85 and over
Persons	21.8	54.3	23.9	3.8
Males	22.7	55.0	22.3	3.1
Females	21.0	53.6	25.4	4.6

Source: ONS, Mid-year estimates, 2020

Figure 10: Mole Valley Population Pyramid



Source: ONS, Mid-year estimates, 2020

The majority of the population in Mole Valley area white (95.1%) followed Asian (2.5%) Asian and mixed ethnicities (1.5%). Mole Valley population is not as diverse compared across Surrey and the South East and England.

Table 33: Percentage of population, by ethnicity, 2011

Ethnicity	Number	Percentage
Population 2020	87,547	100.0
White	83,231	95.1
Mixed	1,287	1.5
Asian	2,232	2.5
Black	411	0.5
Other	385	0.4

Source: Census 2011, QS201EW, Nomis 2020

Rural and Urban composition of Mole Valley district

The majority of people living in Mole Valley live in urban areas (and this is a lower proportion of households than across Surrey and the South East England), while a quarter of the population live in an area classified as rural.

Table 34: Rural and urban composition of Mole Valley district

Area name	Total	Urban (total)	Urban (%)	Rural (total)	Rural (%)
England	52,059,931	42,935,229	82.5	9,124,702	17.5
South East	8,446,500	6,735,465	79.7	1,711,035	20.3
Surrey	1,105,800	958,798	86.7	147,002	13.3
Mole Valley	85,375	63,410	74.3	21,542	25.7

Source: Nomis, 2020

*Local Authority Districts and Output Areas may cover a large area of open countryside and yet be urban if most of the population lives in an urban settlement. Rural is a matter of settlement form and dwelling density rather than the economic function or the character or use of the land. Most local authorities classed as rural will include urban populations and vice versa - indeed 'urban' authorities may have sizeable rural populations.

Type of urban settings

- urban major conurbation (50.9%)
- urban city and town (23.3%)

Type of rural settings

- rural town and fringe (6.2%)
- rural village (9.2%)
- rural hamlet and isolated dwellings (10.3%)

Population Density

Mole Valley district is the least densely populated area in Surrey, 337 people per square kilometre. Projections show that there will be no change in the number of people per square kilometre over the next 10 years.

Table 35: The projected change in population density of Mole Valley in 2020 compared to 2030

Area name	Area (sq km)	2022 people per sq. km	2025 people per sq. km	2030 people per sq. km
Surrey	1,663	723	727	730
Mole Valley	258	337	337	337

Source: Surrey, 2020

Mole Valley Population Projections

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Looking over a 10-year period, Mole Valley is not expected to experience population growth overall, which compares with 1.3% growth in Surrey. However the age structure of the population is projected to change; people aged 65 and over are projected to have the largest growth (18.8%) (Table 36), of those a quarter are estimated to be 85 and over.

Over the 3-year lifetime of this PNA, overall Mole Valley population is not expected to grow compared to Surrey (0.5%). Children aged 0 to 14 years and 45 to 64 age cohorts are expected to have the largest negative growth (-4.3% and -3.5%, respectively). People aged 65 and over are projected to the largest growth (4.9%), slightly higher than across Surrey (4.5%) (Table 37).

Table 36: Projected population changes, 2020 to 2030

Age band	2020	2030	Number	%	Population Change Surrey %
0 to 14	14,362	12,613	-1,749	-12.2	-9.1
15 to 29	11,891	11,716	-175	-1.5	5.8
30 to 44	13,960	12,902	-1,058	-7.6	-7.1
45 to 64	26,062	25,139	-923	-3.5	0.2
65 & Over	20,820	24,731	3,911	18.8	17.5
All ages	87,095	87,101	7	0.0	1.3

Source: Sub-national Population LA Projections, 2018

Table 37: Projected population changes by locality, all persons, 2022 to 2025

Age band	2022	2025	Number	%	Population Change Surrey %
0 to 14	14,072	13,469	-603	-4.3	-2.8
15 to 29	11,751	11,745	-7	-0.1	2.0
30 to 44	13,769	13,318	-451	-3.3	-2.7
45 to 64	26,105	26,081	-23	-0.1	1.0
65 & Over	21,436	22,489	1,052	4.9	4.5
All ages	87,133	87,101	-31	0.0	0.5

Source: Sub-national Population LA Projections, 2018

Older People living alone

Mole Valley district has a higher proportion of those aged 65 and over living on their own (6.3%) in comparison to Surrey average (5.2%). (Table 38, Figure 11).

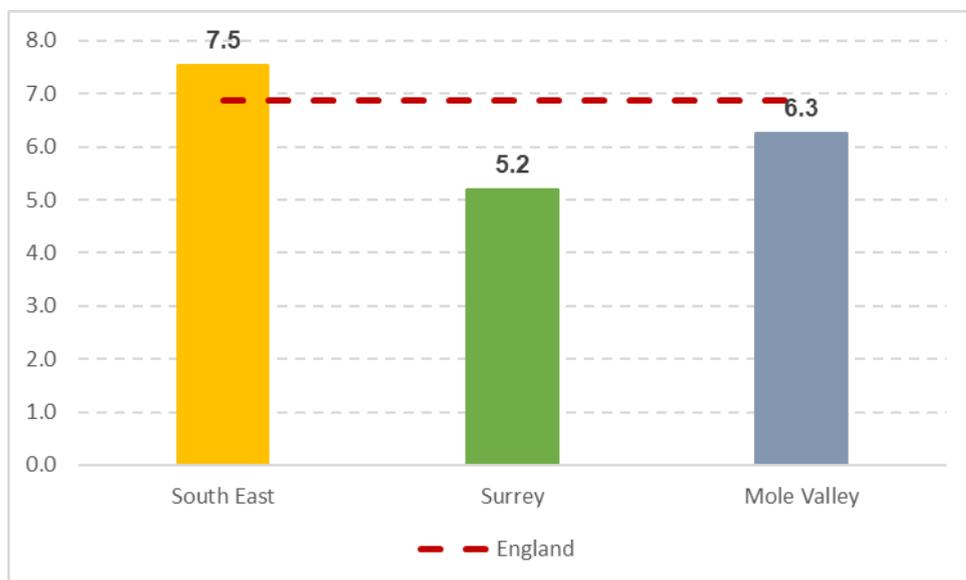
Table 38: Percentage of households occupied by older people (aged 65 & over) living alone, 2011

Area name	All households	One person household: Aged 65+	% One person household: Aged 65+
England	52,059,931	3,579,698	6.9
South East	8,446,500	637,330	7.5
Surrey	1,105,800	57,543	5.2
Mole Valley	83,985	5,252	6.3

Source: Census, 2011, QS112EW – Nomis, 2020

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Figure 11: Percentage of households occupied by older people (aged 65 & over) living alone, 2011



Source: Census, 2011, QS112EW – Nomis, 2020

General Birth Rate

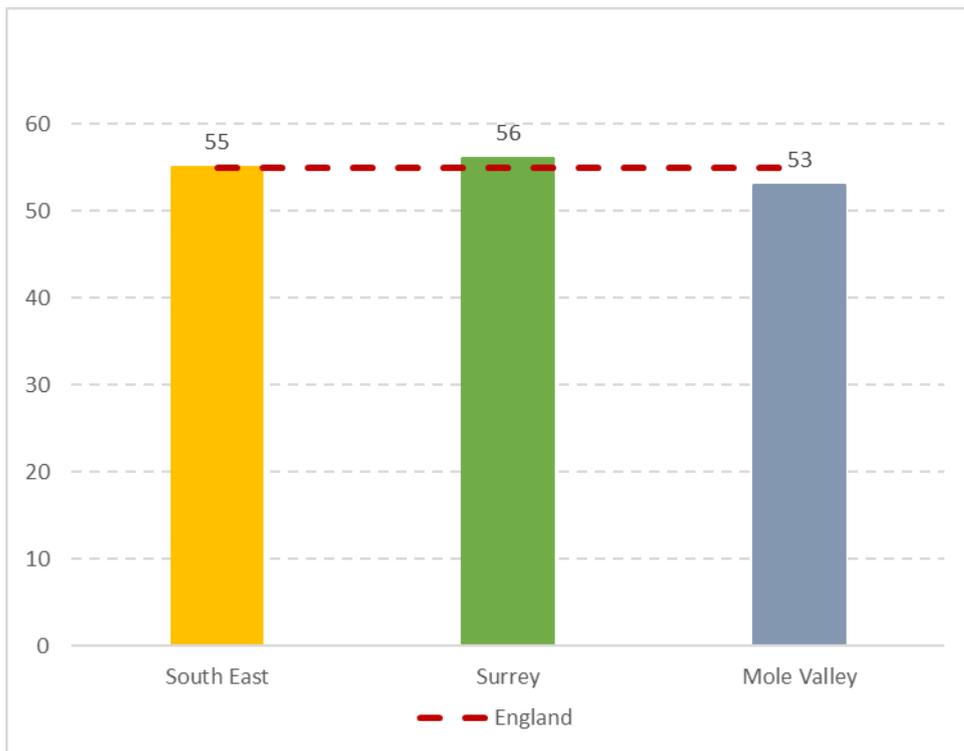
Mole Valley district birth rate for women aged 15 to 44 years (53/1,000) is lower than the England average (55/1000). (Figure 12).

Table 39: Live births, per 1,000 women aged 15 to 44 years by locality, 2020

Area name	Female population 15 to 44 years	Births	Rate per 1,000 female population
England	10,581,832	585,195	55
South East	1,642,566	90,864	55
Surrey	212,519	11,880	56
Mole Valley	13,301	703	53

Source: Office for National Statistics (ONS), Nomis, 2020

Figure 12: Live births, per 1,000 women aged 15 to 44 years in Mole Valley, 2020



Source: Office for National Statistics (ONS), Nomis, 2020

Table 40: Live births numbers, General Fertility Rates and Total Fertility Rates in Mole Valley, 2020

Area of usual residence	Live births	GFR ²	TFR ³
England	585,195	55	1.59
Southeast	90,864	55	1.65
Surrey	13,423	56	1.7
Mole Valley	703	53	1.7

Source: Office for National Statistics (ONS), 2020

¹ Rates for 2020 have been calculated using the mid-2020 population estimates based on 2011 census

² The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15 to 44. The GFRs have been calculated using mid-2020 population estimates.

³ The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

Reigate & Banstead borough

Reigate & Banstead Population

The population of Reigate & Banstead consists of proximately 48.8% males and 51.2% females (Table 41). A quarter of the population is between 0 to 19 years, more than half (56.9%) of the population (20 to 64 years) is of working age, and one sixth of the population is 65 and over, 18.3% of those 16.2% are aged 85 and over (Table 42).

The population pyramid for Reigate & Banstead (Figure 13) shows similar proportions of both males and females aged 0 to 4 and 60 to 90 age cohorts to that of the England average. The proportion of males and females aged 15 to 34 are significantly lower compared to that of the England average, whereas both males and females aged 40 to 54 are slightly higher.

Table 41: Population by sex in Reigate & Banstead

Sex	Number	Percentage
Persons	149,243	100
Males	72,837	48.8
Females	76,406	51.2

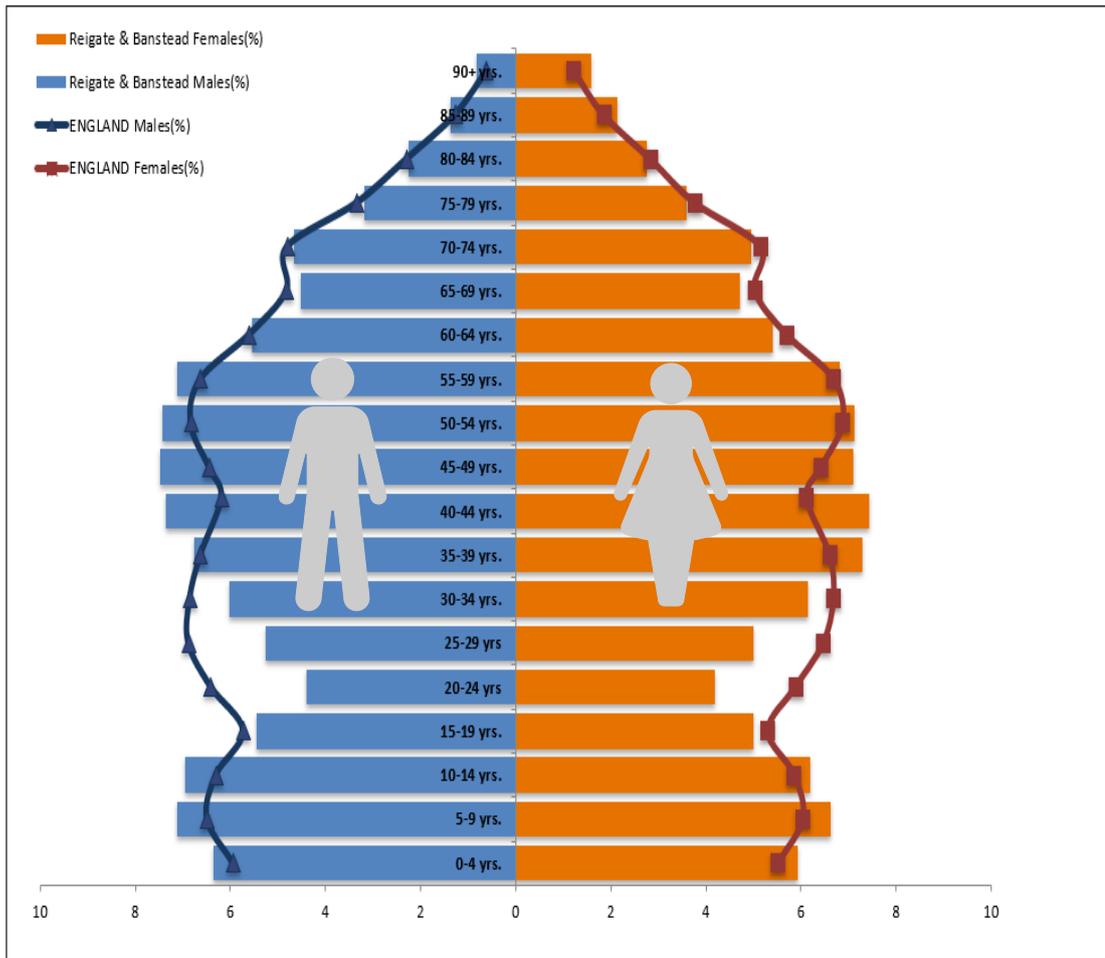
Source: ONS, Mid-year estimates, 2020

Table 42: Percentage of age & sex breakdown, by locality, 2020

Sex	0 to 19	20 to 64	65 and over	85 and over
Persons	24.8	56.9	18.3	3.0
Males	25.8	57.4	16.8	2.2
Females	23.8	56.5	19.7	3.7

Source: ONS, Mid-year estimates, 2020

Figure 13: Reigate & Banstead Population Pyramid



Source: ONS, Mid-year estimates, 2020

The majority of the population in Reigate & Banstead are white (90.6%), followed by Asian (5.1%) and mixed ethnicities (2.2%). This is similar to the population across Surrey and the South East, but less diverse than the whole population of England.

Table 43: Percentage of population, by ethnicity, 2011

Ethnicity	Number	Percentage
Population 2020	149,243	100.0
White	135,214	90.6
Mixed	3,283	2.2
Asian	7,567	5.1
Black	2,343	1.6
Other	821	0.6

Source: Census 2011, QS201EW, Nomis 2020

Rural and Urban composition of Reigate & Banstead borough

The majority of people living in Reigate & Banstead live in urban areas, 95.1% (and this is a higher proportion of households than across Surrey, the South East and England), about 5% of the population live in an area classified as rural.

Table 44: Rural and urban composition of Reigate & Banstead borough

Area name	Total	Urban (total)	Urban (%)	Rural (total)	Rural (%)
England	52,059,931	42,935,229	82.5	9,124,702	17.5
Southeast	8,446,500	6,735,465	79.7	1,711,035	20.3
Surrey	1,105,800	958,798	86.7	147,002	13.3
Reigate & Banstead	137,835	130,810	94.9	7,025	5.1

Source: Nomis, 2020

*Local Authority Districts and Output Areas may cover a large area of open countryside and yet be urban if most of the population lives in an urban settlement. Rural is a matter of settlement form and dwelling density rather than the economic function or the character or use of the land. Most local authorities classed as rural will include urban populations and vice versa - indeed 'urban' authorities may have sizeable rural populations.

Type of urban settings

- urban major conurbation (27.8%)
- city and town (67.1%)

Type of rural settings

- rural town and fringe (2.1%)
- rural hamlet and isolated dwellings (1.2%)
- rural village (1.8%)

Population Density

Reigate & Banstead has the highest increase in population density (9.0%) in Surrey.

Table 45: The projected change in population density of Reigate & Banstead in 2020 compared to 2030

Area name	Area (sq km)	2022 people per sq. km	2025 people per sq. km	2030 people per sq. km
Surrey	1,663	723	727	730
Reigate & Banstead	129	1,176	1,195	1,216

Source: Surrey, 2020

Reigate & Banstead Population Projections

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Looking over a 10-year period Reigate & Banstead population is expected to have a higher population growth of 4.7% compared to the growth across Surrey (1.3%). People aged 65 and over are projected to have the largest growth (20.1%) (Table 46), of whom 16.2% will be aged 85 and over, higher than the Surrey (17.5%) average.

Over the lifetime of the PNA, the population of Reigate & Banstead is expected to have a population growth 1.6% over the next three years. The number of children 0 to 14 years and the 30 to 44 age cohort are expected to decrease, while the 15 to 29 and 45 to 64 age cohorts will see a small growth. People aged 65 and over will see the largest growth (5.2%), of those 13.5% will be 85 and over by 2025 (Table 47).

Table 46: Reigate & Banstead borough projected population changes, 2020 to 2030

Age band	2020	2030	Number	%	Population Change Surrey %
0 to 14	29,315	27,713	-1,602	-5.5	-9.1
15 to 29	21,923	23,968	2,045	9.3	5.8
30 to 44	30,935	29,531	-1,404	-4.5	-7.1
45 to 64	40,326	42,873	2,546	6.3	0.2
65 & Over	27,437	32,965	5,528	20.1	17.5
All ages	149,936	157,050	7,114	4.7	1.3

Source: Sub-national Population LA Projections, 2018

Table 47: Reigate & Banstead projected population changes, 2022 to 2025

Age band	2022	2025	Number	%	Population Change Surrey %
0 to 14	29,448	29,012	-436	-1.5	-2.8
15 to 29	22,216	22,969	753	3.4	2.0
30 to 44	31,003	30,389	-614	-2.0	-2.7
45 to 64	41,066	42,296	1,230	3.0	1.0
65 & Over	28,177	29,655	1,477	5.2	4.5
All ages	151,910	154,320	2,410	1.6	0.5

Source: Sub-national Population LA Projections, 2018

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Older People living alone

Table 48 shows that approximately 5.0% of those aged 65 and over are living on their own in Reigate & Banstead, this is similar compared to Surrey (5.2%) and lower than the England average (6.9%).

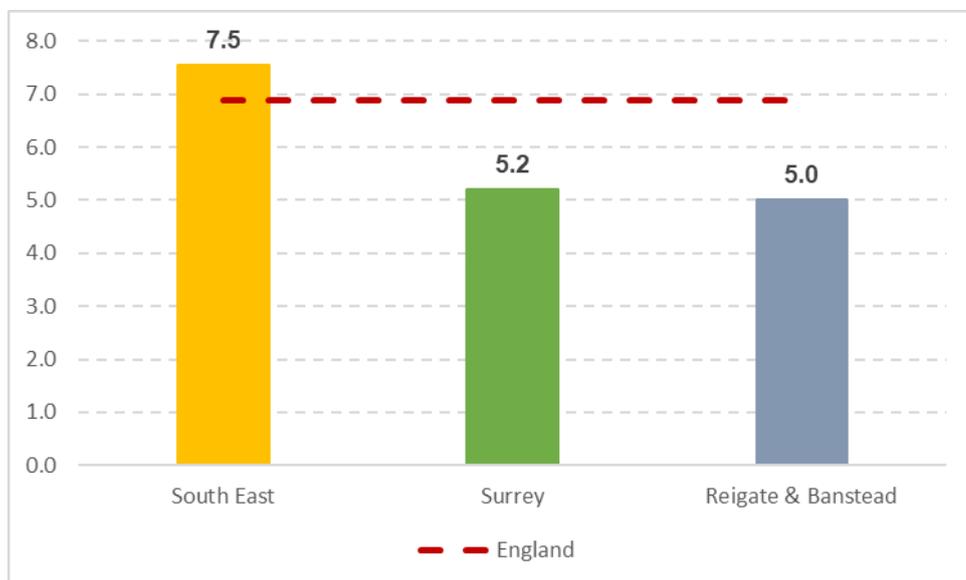
Table 48: Percentage of households occupied by older people (aged 65 & over) living alone, 2011

Area name	All households	One person household: Aged 65+	% One person household: Aged 65+
England	52,059,931	3,579,698	6.9
South East	8,446,500	637,330	7.5
Surrey	1,105,800	57,543	5.2
Reigate & Banstead	134,346	6,723	5.0

Source: Census, 2011, QS112EW – Nomis, 2020

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Figure 14: Percentage of households occupied by older people (aged 65 & over) living alone, 2011



Source: Census, 2011, QS112EW – Nomis, 2020

General Birth Rate

Reigate & Banstead birth rate for women aged 15 to 44 years (63/1,000) is significantly higher than the England average. (Table 49).

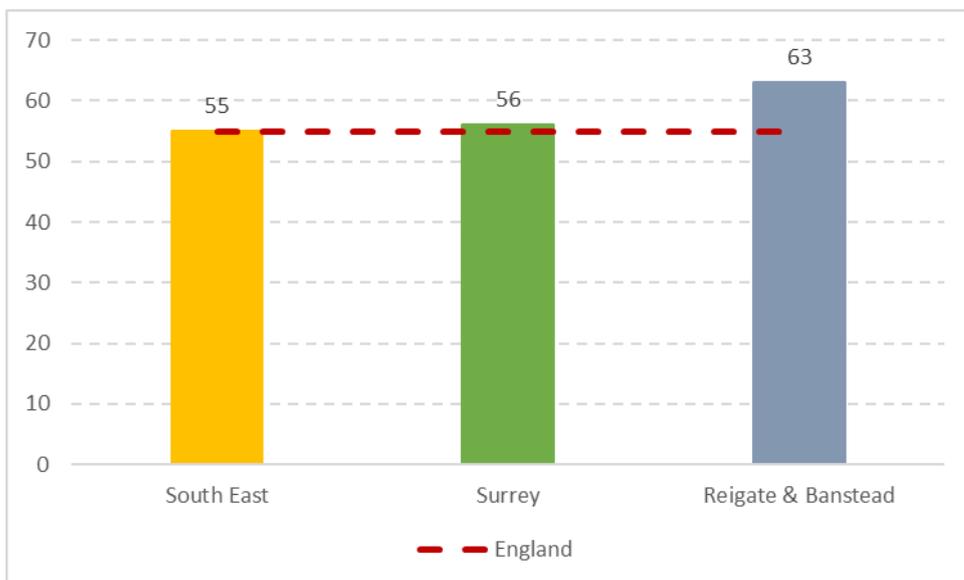
Table 49: Live births, per 1,000 women aged 15 to 44 years by locality, 2020

Area name	Female population 15 to 44 years	Births	Rate per 1,000 female population
England	10,581,832	585,195	55
South East	1,642,566	90,864	55
Surrey	212,519	11,880	56
Reigate & Banstead	26,785	1,677	63

Source: Office for National Statistics (ONS), 2020

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Figure 15: Live births, per 1,000 women aged 15 to 44 years by locality, 2020



Source: Office for National Statistics (ONS), Nomis, 2020

Table 50: Live births numbers, General Fertility Rates (GFR) and Total Fertility Rates (TFR) in Reigate & Banstead, 2020

Area of usual residence	Live births	GFR ²	TFR ³
England	585,195	55	1.59
South East	90,864	55	1.65
Surrey	13,423	56	1.7
Reigate & Banstead	1,677	63	1.85

Source: Office for National Statistics (ONS), 2020

¹ Rates for 2020 have been calculated using the mid-2020 population estimates based on 2011 census

² The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15 to 44. The GFRs have been calculated using mid-2020 population estimates.

³ The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

Runnymede borough

Runnymede Population

The population of Runnymede is 48.8% males and 51.2% females (Table 51). Sixty percent of the population is aged between 20 to 64, which is slightly higher than other local authorities in Surrey. Females 15 to 19, 20 to 24, and 25 to 29 are significantly higher compared to the national average, this is attributed to the high number of students residing in Runnymede. Children and young people make up approximately a quarter 23% of the population, while one sixth of the population is made up of people aged 65 and over, of whom 16.4% makes up the 85 and over age cohort.

The population pyramid for Runnymede borough (Figure 16) shows that the largest 5-year population groups are 20 to 24 and 25 to 29 years. The proportion of both males and females in all age groups are similar to the England average with the exception of 20 to 29 years where the proportion of males and females are significantly higher.

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Table 51: Population by sex and locality

Sex	Number	Percentage
Persons	90,327	100.0
Males	44,091	48.8
Females	46,236	51.2

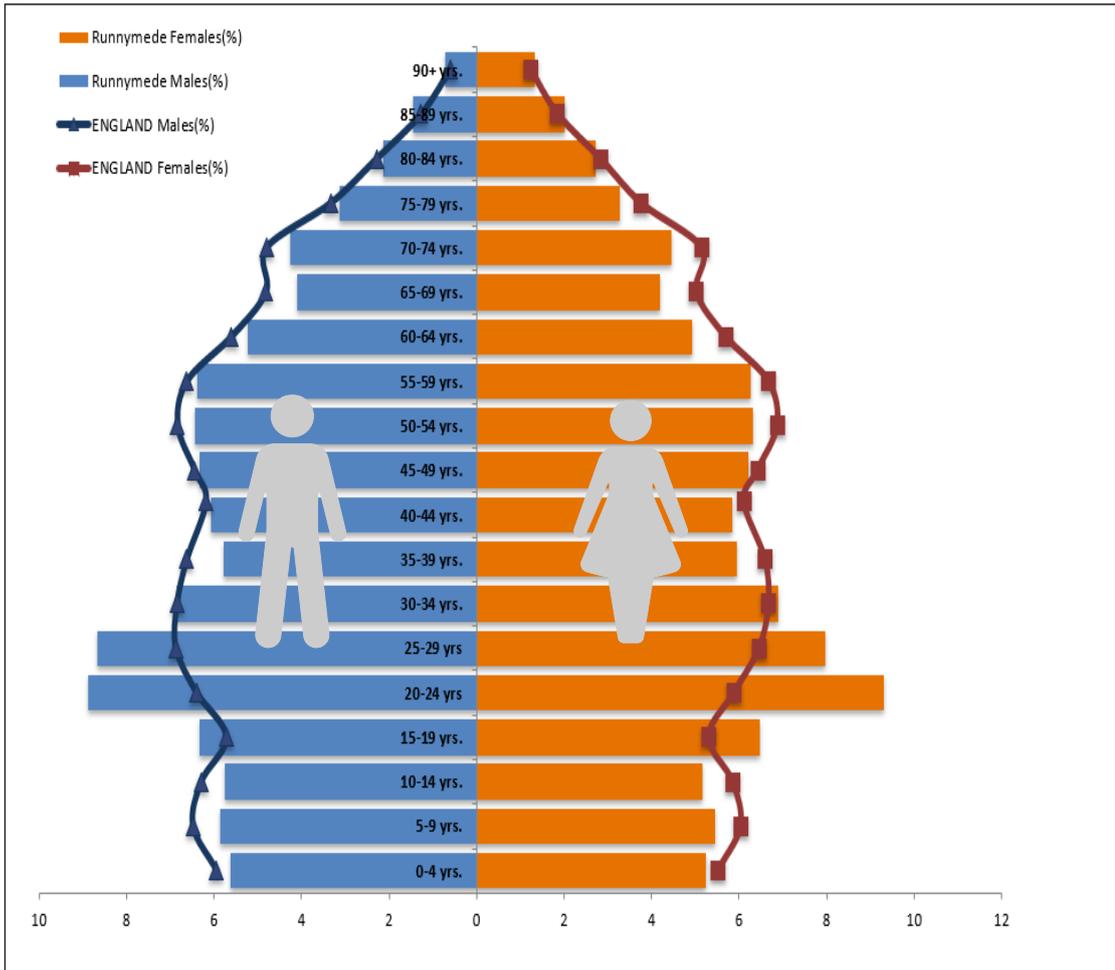
Source: ONS, Mid-year estimates, 2020

Table 52: Percentage of age & sex breakdown, by locality, 2020

Sex	0 to 19	20 to 64	65 and over	85 and over
Persons	22.9	60.1	16.9	2.8
Males	23.6	60.6	15.8	2.2
Females	22.3	59.7	18	3.3

Source: ONS, Mid-year estimates, 2020

Figure 16: Runnymede Population Pyramid, 2020



Source: ONS, Mid-year estimates, 2020

The majority of the population in Runnymede are white (89.0%), followed by Asian (6.9%) and mixed (2.1%), this is similar to Surrey, and the South East.

Table 53: Percentage of population, by ethnicity, 2011

Ethnicity	Number	Percentage
Population 2020	90,327	100.0
White	80,364	89.0
Mixed	1,879	2.1
Asian	6,242	6.9
Black	966	1.1
Other	876	1.0

Source: Census 2011, QS201EW, Nomis 2020

Rural and Urban composition of Runnymede borough

The majority of people living in Runnymede live in urban areas (and this is a higher proportion of households than across Surrey and the South East and England), while only a small proportion of the population live in an area classified as rural.

Table 54: Rural and urban composition of Runnymede borough

Area name	Total	Urban (total)	Urban (%)	Rural (total)	Rural (%)
England	52,059,931	42,935,229	82.5	9,124,702	17.5
Southeast	8,446,500	6,735,465	79.7	1,711,035	20.3
Surrey	1,105,800	958,798	86.7	147,002	13.3
Runnymede	80,510	78,861	98.0	1,649	2.0

Source: Nomis, 2020

Type of urban settings

- urban major conurbation (84.8%)
- urban city and town (13.4%)

Type of rural settings

- rural town and fringe (0.2%)
- rural village (0.5%)
- rural hamlet and isolated dwellings (1.4%)

Population Density

Runnymede has approximately 40% higher population density than Surrey (723).

Table 55: The projected change in population density of Runnymede in 2020 compared to 2030

Area name	Area (sq km)	2022 people per sq. km	2025 people per sq. km	2030 people per sq. km
Surrey	1,663	723	727	730
Runnymede	78	1,150	1,161	1,179

Source: Surrey, 2020

Runnymede Population Projections

Looking over a 10-year period, Runnymede is expected to have a higher population growth of 3.2%, projected to be higher than the Surrey (1.3%) growth overall. People aged 65 and over are projected to have the largest growth (14.6%), lower than the Surrey average (17.3%). A sixth of the 65 and over (16.4%) age cohort will be people aged 85 and over.

Over the lifetime of this PNA, the population of Runnymede is expected to grow by 1.0%, twice the growth of Surrey (0.5%) overall. The number of children 0 to 14 years and the 40 to 64 age cohorts are expected to have a negative growth, while the 15 to 29 and 30 to 44 age cohorts will see a small growth above the Surrey average. People aged 65 and over are projected to have the largest growth (4.0%) (Table 57) of those 11.3% are estimated to be aged 85 and over by 2025.

Table 56: Runnymede projected population changes, 2020 to 2030

Age band	2020	2030	Number	%	Population Change Surrey %
0 to 14	14,812	14,653	-159	-1.1	-9.1
15 to 29	20,934	22,193	1,260	6.0	5.8
30 to 44	16,664	16,895	231	1.4	-7.1
45 to 64	21,594	20,936	-657	-3.0	0.2
65 & Over	15,092	17,302	2,209	14.6	17.5
All ages	89,096	91,980	2,884	3.2	1.3

Source: Sub-national Population LA Projections, 2018

Table 57: Runnymede projected population changes, 2022 to 2025

Age band	2022	2025	Number	%	Population Change Surrey %
0 to 14	14,949	14,941	-8	-0.1	-2.8
15 to 29	20,688	21,008	320	1.5	2.0
30 to 44	17,141	17,256	115	0.7	-2.7
45 to 64	21,638	21,506	-133	-0.6	1.0
65 & Over	15,295	15,900	605	4.0	4.5
All ages	89,711	90,611	900	1.0	0.5

Source: Sub-national Population LA Projections, 2018

Older People living alone

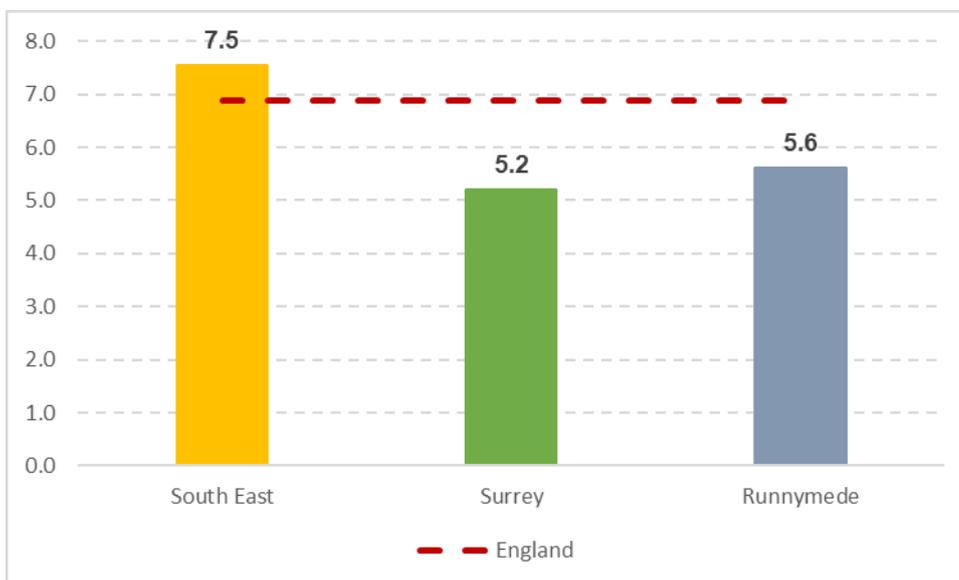
Approximately 5.6% of those aged 65 and over are living on their own in Runnymede; this is slightly higher than Surrey (5.2%). (Table 58, Figure 17).

Table 58: Percentage of households occupied by older people (aged 65 & over) living alone, 2011

Area name	All households	One person household: Aged 65+	% One person household: Aged 65+
England	52,059,931	3,579,698	6.9
Southeast	8,446,500	637,330	7.5
Surrey	1,105,800	57,543	5.2
Runnymede	77,346	4,345	5.6

Source: Census, 2011, QS112EW – Nomis, 2020

Figure 17: Percentage of households occupied by older people (aged 65 & over) living alone, 2011



Source: Census, 2011, QS112EW – Nomis, 2020

General Birth Rate

Runnymede birth rate for women aged 15 to 44 years (45/1,000) is lower than the England average (55/1,000).

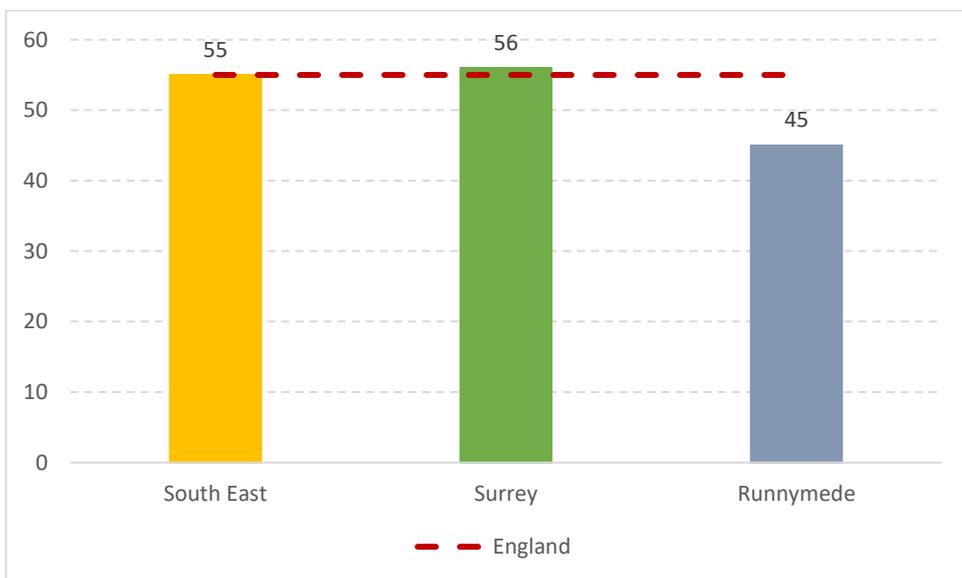
Table 59: Live births, per 1,000 women aged 15 to 44 years by locality, 2020

Area name	Female population 15 to 44 years	Births	Rate per 1,000 female population
England	10,581,832	585,195	55
Southeast	1,642,566	90,864	55
Surrey	212,519	11,880	56
Runnymede	19,630	883	45

Source: Office for National Statistics (ONS), 2020

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Figure 18: Live births, per 1,000 women aged 15 to 44 years by locality, 2020



Source: Office for National Statistics (ONS), 2020, Mid-year estimates, 2020

Table 60: Live birth numbers, General Fertility Rates (GFR) and Total Fertility Rates (TFR) in Runnymede. 2020

Area of usual residence	Live births	GFR ²	TFR ³
England	585,195	55	1.59
South East	90,864	55	1.65
Surrey	13,423	56	1.7
Runnymede	883	45	1.38

Source: Office for National Statistics (ONS), 2020

¹ Rates for 2020 have been calculated using the mid-2020 population estimates based on 2011 census

² The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15 to 44. The GFRs have been calculated using mid-2020 population estimates.

³ The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

Spelthorne borough

Spelthorne Population

The population pyramid of Spelthorne is 49.2% males and 50.8% females (Table 61). Over half (57.4%) of the population is aged 20 to 64, children and young people 0 to 19 years make up a quarter of the population. A fifth of the population is 65 and over, whom 14% are aged 85 and over.

The population pyramid for Spelthorne (Figure 19) shows the largest 5-year population groups are females 35 to 39 years, all adults aged 40 to 44 years and males 55 to 59. Spelthorne has a significantly lower proportion of males and females aged 20 to 34 and a slightly higher proportion of males and females aged 35 to 59 compared to the England average.

Table 61: Population by sex and locality

Sex	Number	Percentage
Persons	99,873	100.0
Males	49,178	49.2
Females	50,695	50.8

Source: ONS, Mid-year estimates, 2020

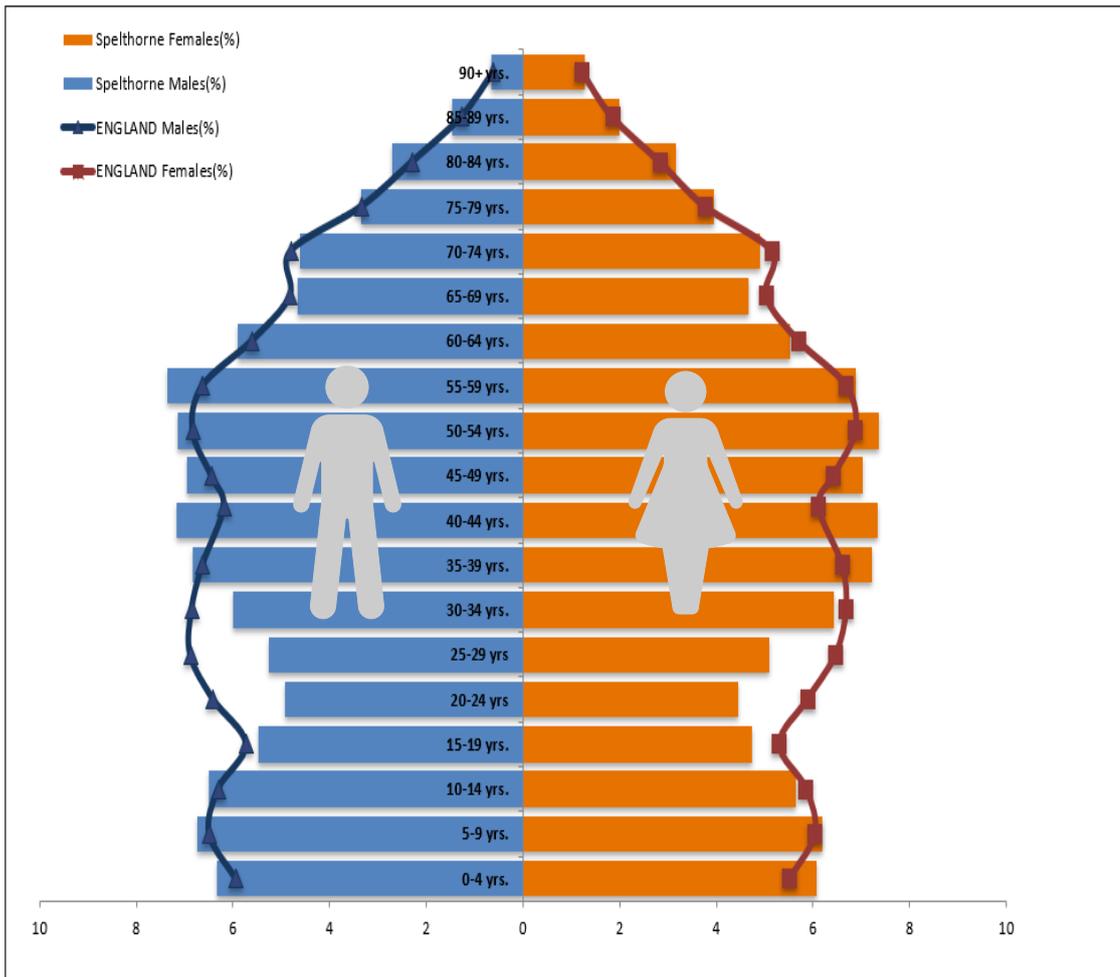
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Table 62: Percentage of age & sex breakdown, by locality, 2020

Sex	0 to 19	20 to 64	65 and over	85 and over
Persons	23.8	57.4	18.7	2.7
Males	25.0	57.5	17.4	2.1
Females	22.6	57.4	20	3.3

Source: ONS, Mid-year estimates, 2020

Figure 19: Spelthorne Population Pyramid



Source: ONS, Mid-year estimates, 2020

The majority of the population in Spelthorne are white (87.3%), followed by Asian (7.6%) and mixed (2.5%). This similar to the population across Surrey and the South East, but less diverse than the whole population of England.

Table 63: Percentage of population by ethnicity, 2011

Ethnicity	Number	Percentage
Population 2020	90,873	100.0
White	87,189	87.3
Mixed	2,487	2.5
Asian	7,620	7.6
Black	1,618	1.6
Other	959	1.0

Source: Census 2011, QS201EW, Nomis 2020

Rural and Urban composition of Spelthorne borough

The majority of people living in Spelthorne live in urban areas (and this is a higher proportion of households than across Surrey and the South East and England), while only a small proportion of the population live in an area classified as rural.

Table 64: Rural and urban composition of Spelthorne borough

Area name	Total	Urban (total)	Urban (%)	Rural (total)	Rural (%)
England	52,059,931	42,935,229	82.5	9,124,702	17.5
Southeast	8,446,500	6,735,465	79.7	1,711,035	20.3
Surrey	1,105,800	958,798	86.7	147,002	13.3
Spelthorne	94,837	93,477	98.6	1,360	1.4

Source: Nomis, 2020

Type of urban settings

- urban major conurbation (95.5%)
- urban city and town (3.1%)

Type of rural settings

- rural town and fringe (0.8%)
- rural hamlet and isolated dwellings (0.7%)

Population Density

Spelthorne has three times more people per square kilometre than the Surrey average. Spelthorne is the second most densely populated area in Surrey.

Table 65: The projected change in population density of Spelthorne in 2020 compared to 2030

Area name	Area (sq km)	2022 people per sq. km	2025 people per sq. km	2030 people per sq. km
Surrey	1,663	723	727	730
Spelthorne	45	2,233	2,241	2,246

Source: Surrey, 2020

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Spelthorne Population Projections

Looking over a 10-year period, Spelthorne is expected to have a slightly lower population growth of 1.0% compared to the growth expected across Surrey (1.3%) (Table 66). People aged 65 and over are projected to have the largest growth (15.7%), of those a fifth (18.8%) will be aged 85 and over, lower than Surrey (17.5%).

Over the lifetime of this PNA, the population of Spelthorne is expected to grow by 0.4% (Table 67). The number of children and young people 0 to 14 years and the 30 to 44 age cohort age cohorts are expected to decrease, while 15 to 29 and 45 to 64 age cohorts will see a small growth. People aged 65 and over are projected to have the largest growth (4.1%), of those 14.4% will be aged 85 and over by 2025.

Table 66: Spelthorne projected population changes, 2020 to 2030

Age band	2020	2030	Number	%	Population Change Surrey %
0 to 14	18,680	17,073	-1,607	-8.6	-9.1
15 to 29	14,934	16,279	1,345	9.0	5.8
30 to 44	20,483	18,343	-2,140	-10.4	-7.1
45 to 64	27,012	27,472	460	1.7	0.2
65 & Over	18,705	21,644	2,939	15.7	17.5
All ages	99,813	100,809	996	1.0	1.3

Source: Sub-national Population LA Projections, 2018

Table 67: Projected population changes in Spelthorne, 2022 to 2025

Age band	2022	2025	Number	%	Population Change Surrey %
0 to 14	18,605	18,219	-386	-2.1	-2.8
15 to 29	15,059	15,410	350	2.3	2.0
30 to 44	20,319	19,583	-735	-3.6	-2.7
45 to 64	27,207	27,559	351	1.3	1.0
65 & Over	19,047	19,835	788	4.1	4.5
All ages	100,237	100,605	368	0.4	0.5

Source: Sub-national Population LA Projections, 2018

Older People living alone in Spelthorne

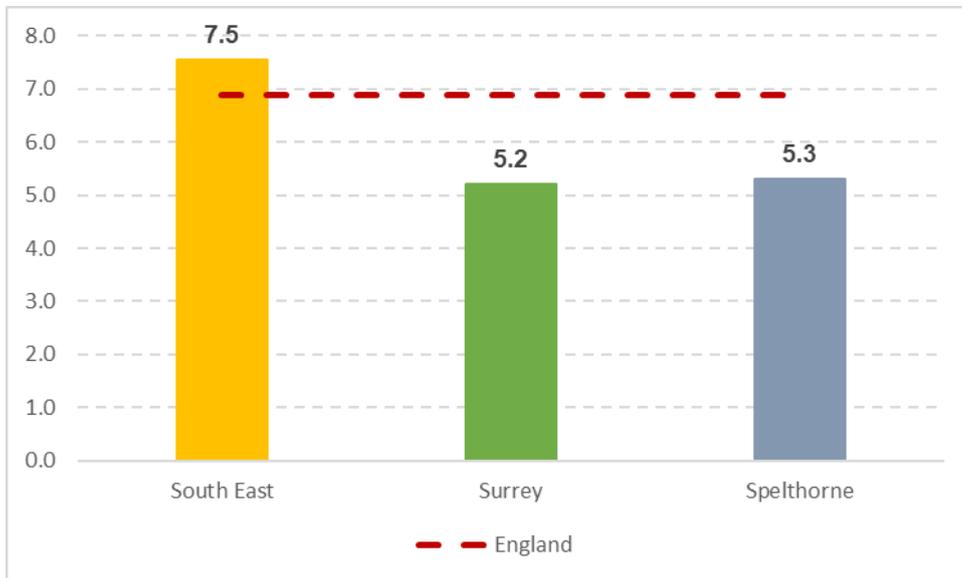
Approximately 5.3% of those aged 65 and over living on their own in Spelthorne, this is consistent with the Surrey (5.2%) average and lower than the national average (6.9%) (Table 68, Figure 20).

Table 68: Percentage of households occupied by older people (aged 65 & over) living alone, 2011

Area name	All households	One person household: Aged 65+	% One person household: Aged 65+
England	52,059,931	3,579,698	6.9
South East	8,446,500	637,330	7.5
Surrey	1,105,800	57,543	5.2
Spelthorne	94,837	5,031	5.3

Source: Census, 2011, QS112EW – Nomis, 2020

Figure 20: Percentage of households occupied by older people (aged 65 & over) living alone, in Spelthorne, 2011



Source: Census, 2011, QS112EW – Nomis, 2020

General Birth Rate

Spelthorne borough birth rate for women aged 15 to 44 years (63/1,000) is significantly higher than the England average (55/1,000). (Table 69)

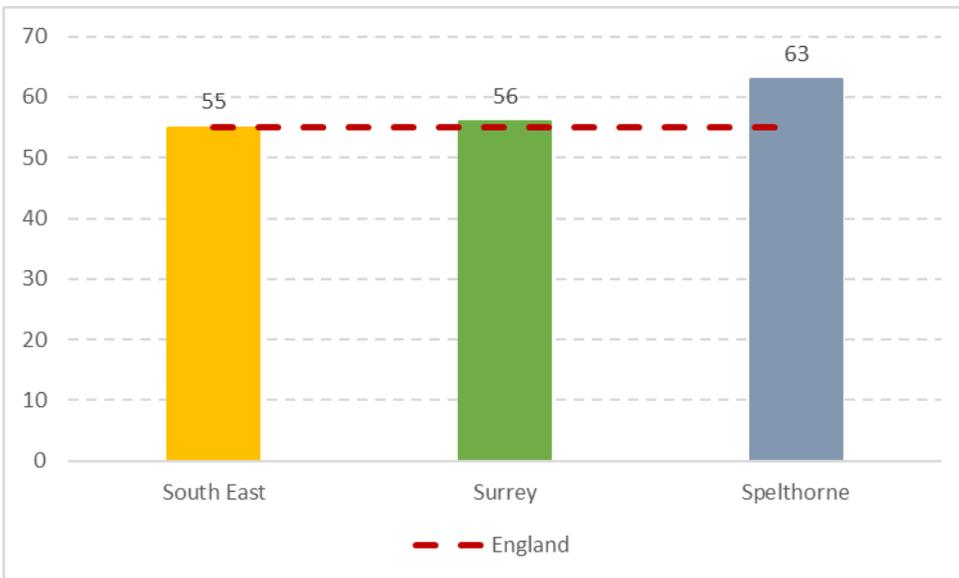
Table 69: Live births, per 1,000 women aged 15 to 44 years in Spelthorne, 2020

Area name	Female population 15 to 44 years	Births	Rate per 1,000 female population
England	10,581,832	585,195	55
Southeast	1,642,566	90,864	55
Surrey	212,519	11,880	56
Spelthorne	17,889	1,119	63

Source: Office for National Statistics (ONS), 2020

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Figure 21: Live births, per 1,000 women in Spelthorne aged 15 to 44 years, 2020



Source: Office for National Statistics (ONS), 2020

Table 70: Live birth numbers by General Fertility Rates (GFR) and Total Fertility Rates (TFR) in Spelthorne, 2020

Area of usual residence	Live births	GFR ²	TFR ³
England	585,195	55	1.59
Southeast	90,864	55	1.65
Surrey	13,423	56	1.7
Spelthorne	1,119	63	1.84

Source: Office for National Statistics (ONS), 2020

¹ Rates for 2020 have been calculated using the mid-2020 population estimates based on 2011 census

² The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15 to 44. The GFRs have been calculated using mid-2020 population estimates.

³ The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

Surrey Heath borough

Surrey Heath Population

The population of Surrey Heath is 49.4% of males and 50.6% females (Table 71). Over half the population is aged between 20 to 64. Children and young people make up to just under a quarter (23.4%) of the population. One fifth (19.9%) of the population is aged 65 and over, whom 15.0% are aged 85 and over.

The population pyramid for Surrey Heath (Figure 22) shows the largest 5-year population groups are children and young people aged 10 to 14 years and adults aged 44 to 59 years. Overall, the working-age population living in Surrey Heath is older than in England.

Table 71: Population by gender and locality

Sex	Number	Percentage
Persons	89,204	100.0
Males	44,062	49.4
Females	45,142	50.6

Source: ONS, Mid-year estimates, 2020

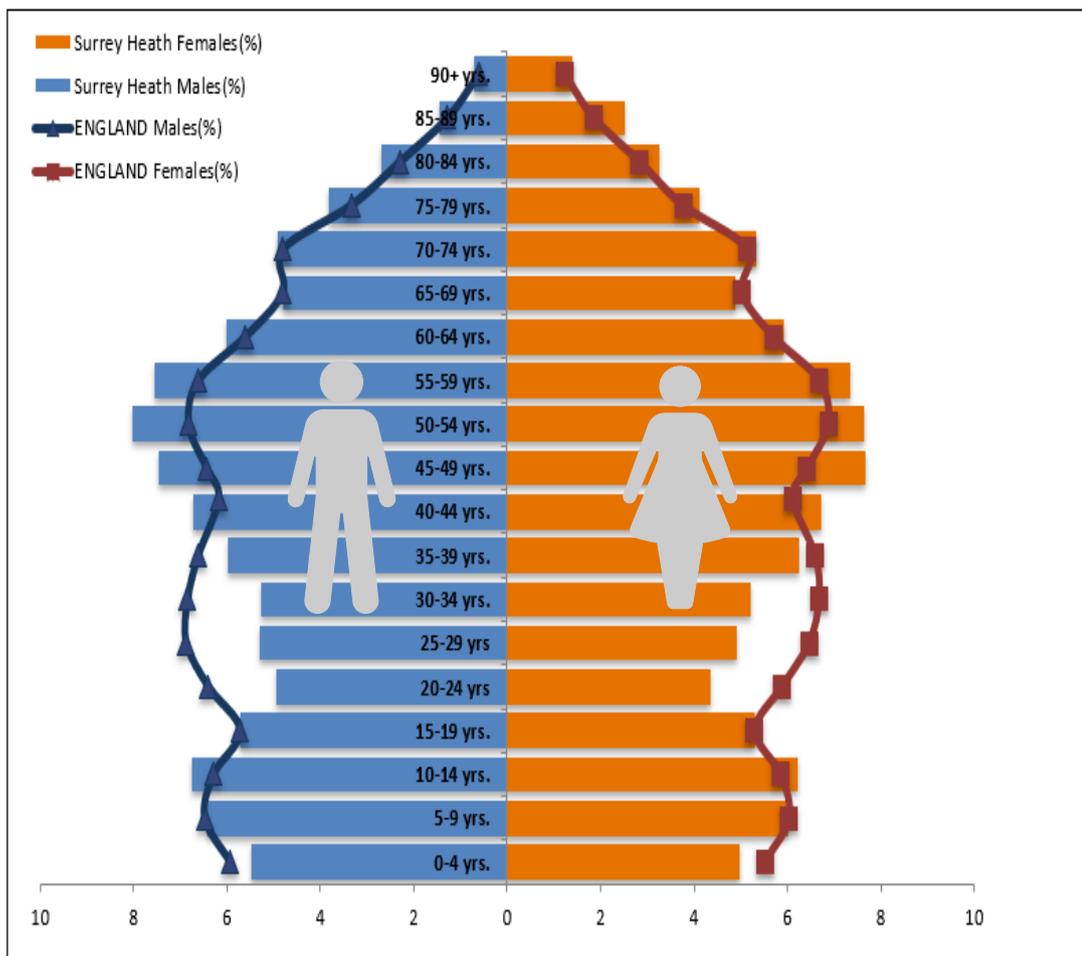
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Table 72: Percentage of age & sex breakdown, by locality, 2020

Sex	0 to 19	20 to 64	65 and over	85 and over
Persons	23.4	56.6	19.9	3.0
Males	24.4	57.3	18.4	2.2
Females	22.5	56.0	21.5	3.9

Source: ONS, Mid-year estimates, 2020

Figure 22 : Surrey Heath Population Pyramid



Source: ONS, Mid-year estimates, 2020

The majority of the population in Surrey Heath are white (90.2%), followed by Asian (6.3%) and mixed ethnicities (1.9%)

Table 73: Percentage of population, by ethnicity, 2011

Ethnicity	Number	Percentage
Population 2020	89,204	0
White	80,453	90.2
Mixed	1,686	1.9
Asian	5,584	6.3
Black	892	1.0
Other	598	0.7

Source: Census 2011, QS201EW, Nomis 2020

Rural and Urban composition of Surrey Heath borough

The majority of people living in Surrey Heath live in urban areas (83.9%) (however, the proportion is lower than of households across Surrey and England), while only a small proportion (16.4%) of the population live in an area classified as rural.

Table 74: Rural and urban composition of Surrey Heath borough

Area name	Total	Urban (total)	Urban (%)	Rural (total)	Rural (%)
England	52,059,931	42,935,229	82.5	9,124,702	17.5
Southeast	8,446,500	6,735,465	79.7	1,711,035	20.3
Surrey	1,105,800	958,798	86.7	147,002	13.3
Surrey Heath	86,144	72,325	84.0	13,819	16.0

Source: Nomis, 2020

*Local Authority Districts and Output Areas may cover a large area of open countryside and yet be urban if most of the population lives in an urban settlement. Rural is a matter of settlement form and dwelling density rather than the economic function or the character or use of the land. Most local authorities classed as rural will include urban populations and vice versa - indeed 'urban' authorities may have sizeable rural populations.

Type of urban settings

- urban major conurbation (4.0%)
- urban city and town (80.0%)

Type of rural settings

- rural town and fringe (13.8%)
- rural village (0.7%)
- rural hamlet and isolated dwellings (1.5%)

Population Density

Surrey Heath has 22.7% more people (938) per square kilometre, than Surrey overall.

Table 75: The projected change in population density of Surrey Heath in 2020 compared to 2030

Area name	Area (sq km)	2022 people per sq. km	2025 people per sq. km	2030 people per sq. km
Surrey	1,663	723	727	730
Surrey Heath	95	936	934	929

Source: Surrey, 2020

Surrey Heath Population Projections

Looking over a 10-year period, Surrey Heath is expected to experience a negative growth of -0.7%, a smaller growth compared to the growth expected across Surrey (1.3%). People aged 65 and over are projected to have the largest growth (17.2%), slightly lower than Surrey (17.5%). (Table 76).

Over the lifetime of the PNA the population of Surrey Heath is expected to decrease by -0.2%. The children and young people 0 to 14, and adults 30 to 44 and 45 to 64 age cohorts are expected to see a decrease, while 15 to 29 age cohorts will see a small growth. People aged 65 and over are projected to have the largest growth of 4.6%, similar to the Surrey growth. (Table 77)

Table 76: Surrey Heath projected population changes, 2020 to 2030

Age band	2020	2030	Number	%	Population Change Surrey %
0 to 14	15,905	14,192	-1,713	-10.8	-9.1
15 to 29	13,593	13,868	275	2.0	5.8
30 to 44	16,009	14,952	-1,057	-6.6	-7.1
45 to 64	25,621	24,439	-1,182	-4.6	0.2
65 & Over	17,855	20,932	3,077	17.2	17.5
All ages	88,983	88,384	-599	-0.7	1.3

Source: Sub-national Population LA Projections, 2018

Table 77: Projected population changes by locality, all persons, 2022 to 2025

Age band	2022	2025	Number	%	Population Change Surrey %
0 to 14	15,655	15,166	-490	-3.1	-2.8
15 to 29	13,597	13,635	37	0.3	2.0
30 to 44	15,845	15,489	-355	-2.2	-2.7
45 to 64	25,572	25,358	-214	-0.8	1.0
65 & Over	18,337	19,186	849	4.6	4.5
All ages	89,006	88,833	-173	-0.2	0.5

Source: Sub-national Population LA Projections, 2018

Older People living alone

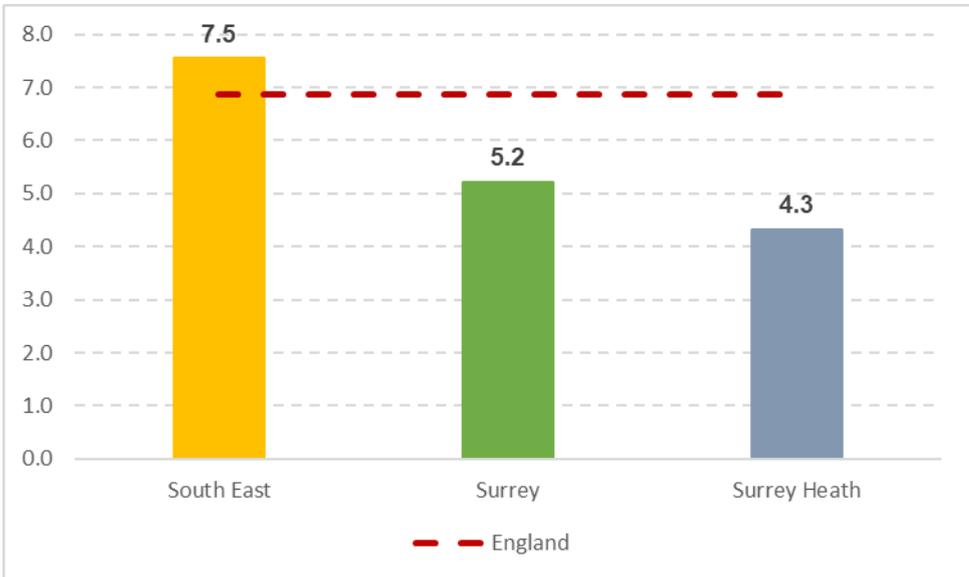
Approximately 4.3% of those aged 65 and over are living on their own in Surrey Heath this is lower than the Surrey average (6.9%).

Table 78: Percentage of households occupied by older people (aged 65 & over) living alone, in Surrey Heath, 2011

Area	All households	One person household: Aged 65+	% One person household: Aged 65+
England	52,059,931	3,579,698	6.9
Southeast	8,446,500	637,330	7.5
Surrey	1,105,800	57,543	5.2
Surrey Heath	84,440	3,648	4.3

Source: Census, 2011, QS112EW – Nomis, 2020

Figure 23: Percentage of households occupied by older people (aged 65 & over) living alone, in Surrey Heath, 2011



Source: Census, 2011, QS112EW – Nomis, 2020

General Birth Rate

Surrey Heath birth rate for women aged 15 to 44 years (54/1,000) is similar to that of the England average (55/1,000). (Table 79).

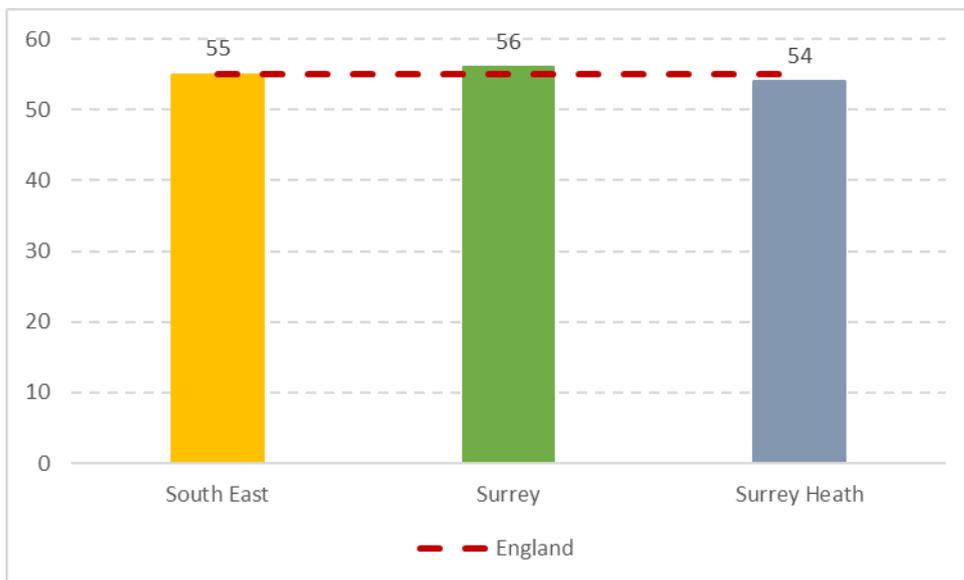
Table 79: Live births, per 1,000 women aged 15 to 44 years by locality, 2020

Area name	Female population 15 to 44 years	Births	Rate per 1,000 female population
England	10,581,832	585,195	55
Southeast	1,642,566	90,864	55
Surrey	212,519	11,880	56
Surrey Heath	14,784	798	54

Source: Office for National Statistics (ONS), 2020

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Figure 24: Live births, per 1,000 women aged 15 to 44 years in Surrey Heath, 2020



Source: Office for National Statistics (ONS), 2020

Table 80: Live births numbers, General Fertility Rates (GFR) and Total Fertility Rates (TFR) in Surrey Heath, 2020

Area of usual residence	Live births	GFR ²	TFR ³
England	585,195	55	1.59
South East	90,864	55	1.65
Surrey	13,423	56	1.7
Surrey Heath	798	54	1.65

Source: Office for National Statistics (ONS), 2020

¹ Rates for 2020 have been calculated using the mid-2020 population estimates based on 2011 census

² The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15 to 44. The GFRs have been calculated using mid-2020 population estimates.

³ The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

Tandridge district

Tandridge Population

The population of Tandridge is 48.6% males and 51.3% females. Over half (56.0%) of the population is aged between 20 to 64. Children and young people make up a quarter (24%) of the population. Over one fifth of the population is aged 65 and over, Table 82 shows the percentage of the population aged 85 and over as well as the percentage aged 65 and over (which includes the 85+ cohort), these have both been included as these populations have a higher need for prescription and healthcare. The percentage of the population aged 85 and older overall is 3.2%, and this 85+ group makes up 15.5% of the population aged 65 and over.

The population pyramid for Tandridge (Figure 25) shows the largest 5-year population groups are adults aged 50 to 54 and 55 to 59 years. Tandridge has similar proportions of both males and females aged 0 to 19 and 40 to 49 to that of the England average. The proportion of males and females in the 20 to 39 age groups are significantly lower compared to that of the England average.

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Table 81: Population by gender and locality

Sex	Number	Percentage
Persons	88,542	100.0
Males	43,086	48.6
Females	45,456	51.3

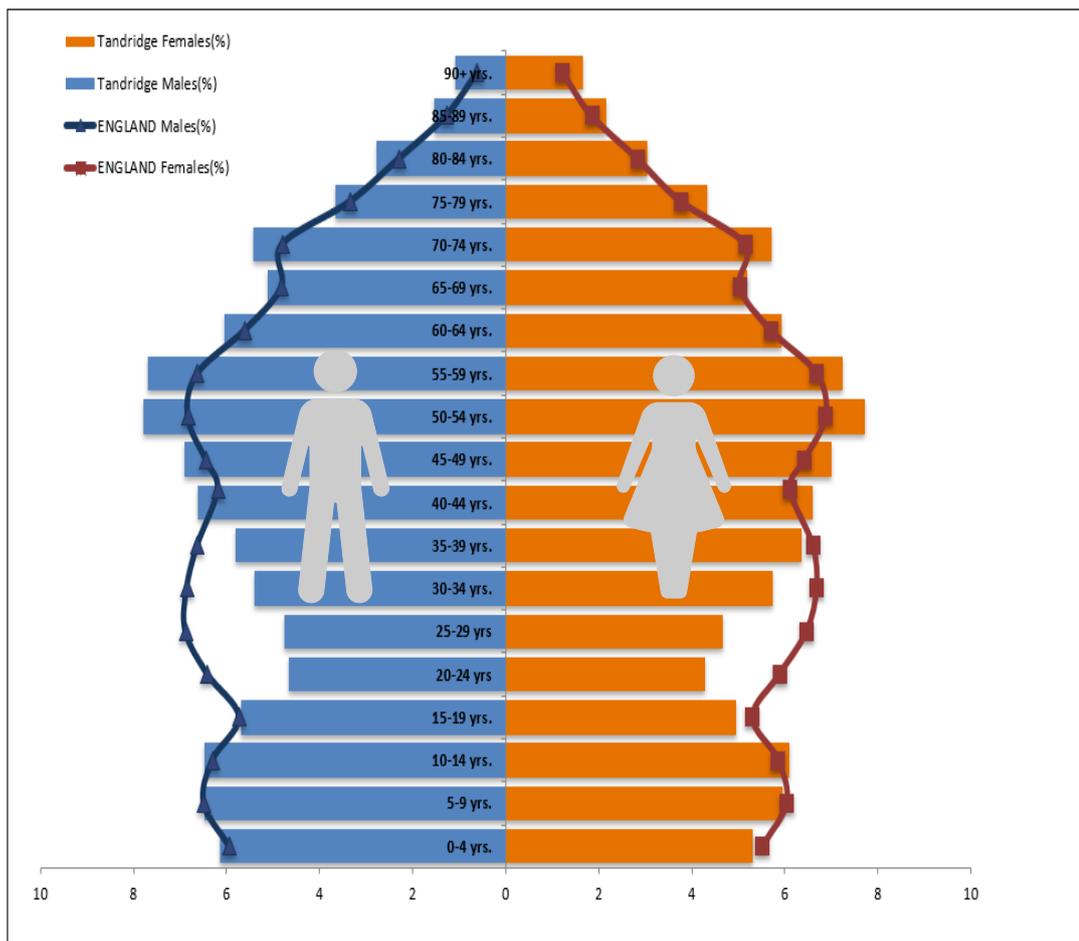
Source: ONS, Mid-year estimates, 2020

Table 82: Percentage of age & sex breakdown, by locality, 2020

Sex	0 to 19	20 to 64	65 and over	85 and over
Persons	23.5	55.6	20.9	3.2
Males	24.8	55.6	19.6	2.6
Females	22.3	55.6	22.1	3.8

Source: ONS, Mid-year estimates, 2020

Figure 25: Tandridge Population Pyramid



Source: ONS, Mid-year estimates, 2020

The majority of the population in Tandridge are white (93.8%), followed by Asian (2.6%) and mixed ethnicities (2.2%) This population is less diverse than the populations of Surrey, South East and England.

Table 83: Percentage of population, by ethnicity, 2011

Ethnicity	Number	Percentage
Population 2020	88,542	100.0
White	83,079	93.8
Mixed	1,913	2.2
Asian	2,311	2.6
Black	939	1.1
Other	301	0.3

Source: Census 2011, QS201EW, Nomis 2020

Rural and Urban composition of Tandridge district

The majority of people living in Tandridge live in urban areas (and this is a lower proportion of households across Surrey, South East and England), while a smaller proportion of the population live in an area classified as rural (and this is a higher proportion of households across Surrey, South East and England).

Table 84: Rural and urban composition of Tandridge district

Area name	Total	Urban (total)	Urban (%)	Rural (total)	Rural (%)
England	52,059,931	42,935,229	82.5	9,124,702	17.5
South East	8,446,500	6,735,465	79.7	1,711,035	20.3
Surrey	1,105,800	958,798	86.7	147,002	13.3
Tandridge	82,998	52,307	63.1	30,691	37.0

Source: Nomis, 2020

Types of urban settings

- urban major conurbation (38.8%)
- urban city and town (24.3%)

Types of rural settings

- rural town and fringe (19.2%)
- rural village (11.5%)
- rural hamlet and isolated dwellings (6.3%)

Population Density

Tandridge has a smaller proportion, half (359) of the number of people per square kilometre, compared to Surrey overall. This is significantly lower than the Surrey population per square kilometre, 723.

Table 85: The projected change in population density of Tandridge in 2020 compared to 2030

Area name	Area (sq km)	2022 people per sq. km	2025 people per sq. km	2030 people per sq. km
Surrey	1,663	723	727	730
Tandridge	248	359	363	368

Source: Surrey, 2020

Tandridge Population Projections

Looking over a 10-year period, Tandridge is expected to have population growth three times higher 3.6%, compared to the growth expected across Surrey (1.3%). People aged 65 and over are projected to have the largest growth (18.0%), this growth is similar to Surrey overall.

Over the lifetime of this PNA, the population of Tandridge is expected to grow by 1.2% over the next 3 years. The number of children 0 to 14 years and the adult 30 to 44 age cohorts are expected decrease, while the 15 to 29 and 45 to 64 age cohorts will see a small growth. People aged 65 and over are projected to have the largest growth (4.3%) (Table 87), of those 27.0% are estimated to be aged 85 and over by 2025.

Table 86: Tandridge projected population changes, 2020 to 2030

Age band	2020	2030	Number	%	Population Change Surrey %
0 to 14	16,104	15,589	-515	-3.2	-9.1
15 to 29	12,408	12,881	472	3.8	5.8
30 to 44	16,256	15,995	-261	-1.6	-7.1
45 to 64	24,923	25,029	106	0.4	0.2
65 & Over	18,594	21,934	3,340	18.0	17.5
All ages	88,285	91,427	3,142	3.6	1.3

Source: Sub-national Population LA Projections, 2018

Table 87: Projected population changes by locality, all persons, 2022 to 2025

Age band	2022	2025	Number	%	Population Change Surrey %
0 to 14	16,194	16,029	-165	-1.0	-2.8
15 to 29	12,390	12,614	224	1.8	2.0
30 to 44	16,480	16,286	-194	-1.2	-2.7
45 to 64	24,923	25,285	362	1.5	1.0
65 & Over	19,119	19,933	814	4.3	4.5
All ages	89,105	90,145	1,040	1.2	0.5

Source: Sub-national Population LA Projections, 2018

Older People living alone

Approximately 5.4% of those aged 65 and over are living on their own in Tandridge, this is consistent with the Surrey (5.2%) average and lower than the national average (6.9%).

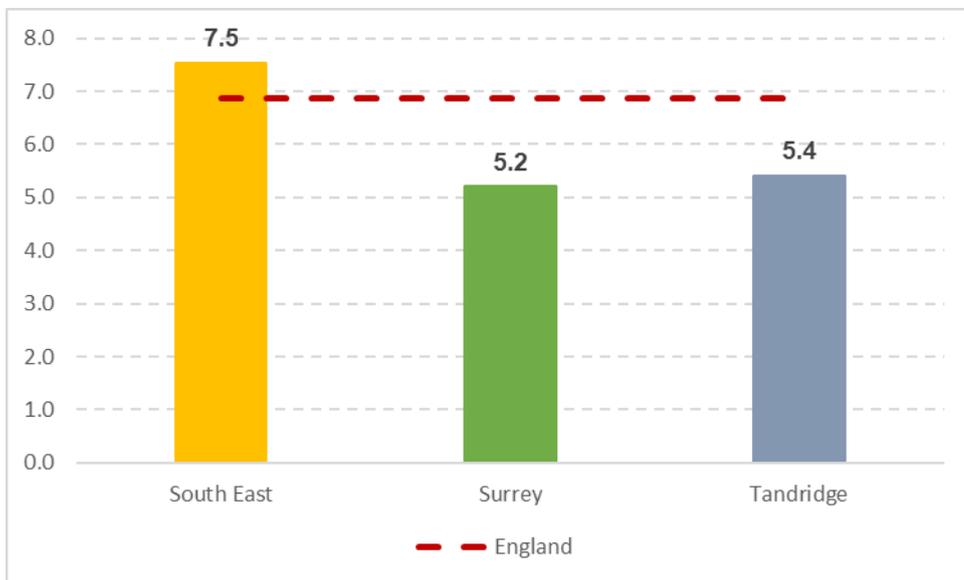
Table 88: Percentage of households occupied by older people (aged 65 & over) living alone, 2011

Area name	All households	One person household: Aged 65+	% One person household: Aged 65+
England	52,059,931	3,579,698	6.9
South East	8,446,500	637,330	7.5
Surrey	1,105,800	57,543	5.2
Tandridge	80,916	4,376	5.4

Source: Census, 2011, QS112EW – Nomis, 2020

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Figure 26: Percentage of households occupied by older people (aged 65 & over) living alone, 2011



Source: Census, 2011, QS112EW – Nomis, 2020

General Birth Rate

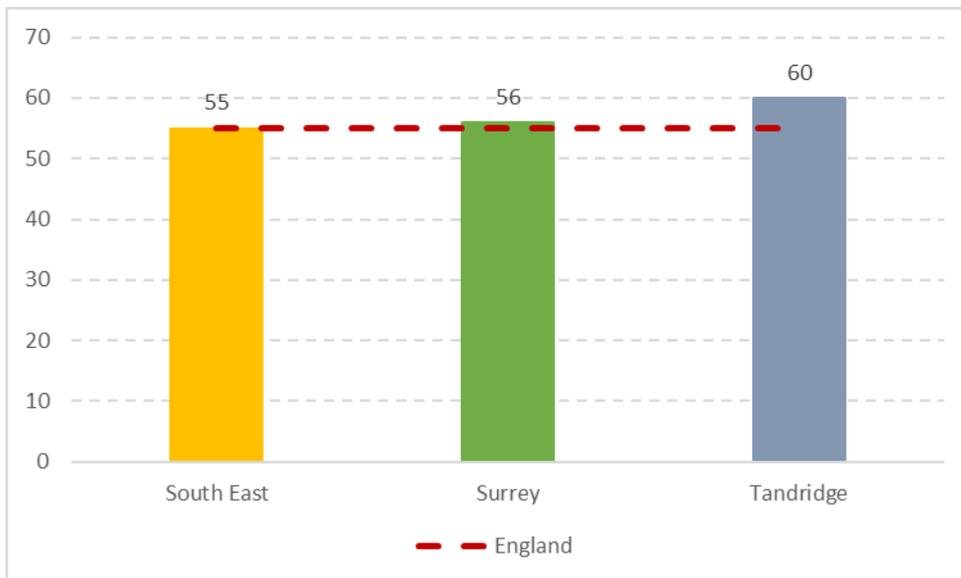
Tandridge birth rate for women aged 15 to 44 years (60/1,000) is higher than the England average (55/1,000). (Table 89)

Table 89: Live births, per 1,000 women aged 15 to 44 years, 2020

Area name	Female population 15 to 44 years	Births	Rate per 1,000 female population
England	10,581,832	585,195	55
South East	1,642,566	90,864	55
Surrey	212,519	11,880	56
Tandridge	14,826	896	60

Source: Office for National Statistics (ONS), 2020

Figure 27: Live births, per 1,000 women in Tandridge, aged 15 to 44 years, 2020



Source: Office for National Statistics (ONS), 2020

Table 90: Live birth numbers, General Fertility Rates (GFR) and Total Fertility Rates (TFR) in Tandridge, 2020

Area of usual residence	Live births	GFR ²	TFR ³
England	585,195	55	1.59
South East	90,864	55	1.65
Surrey	13,423	56	1.7
Tandridge	896	60	1.78

Source: Office for National Statistics (ONS), 2020

¹ Rates for 2020 have been calculated using the mid-2020 population estimates based on 2011 census

² The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15 to 44. The GFRs have been calculated using mid-2020 population estimates.

³ The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

Waverley Borough

Waverley Population

The population of Waverley is 48.9% males and 51.1% females (Table 91). Half of the population is aged between 20 to 64 and children and young people make up a quarter (25.0%) of the population (Table 92). Table 92 shows the percentage of the population aged 85 and over as well as the percentage aged 65 and over (which includes the 85+ cohort), these have both been included as these populations have a higher need for prescription and healthcare. The percentage of the population aged 85 and older overall is 3.8%, and this 85+ group makes up 24.6% of the population aged 65 and over.

The population pyramid for Waverley (Figure 28) shows that the largest 5-year population groups are adults aged 50 to 59 years. The proportion of males and females in the 70 to 74-year age group is higher when compared to the England average, while the proportion of males and females aged 20 to 39 are significantly lower than the England average.

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Table 91: Population by sex in Waverley

Sex	Number	Percentage
Persons	126,556	100.0
Males	61,858	48.9
Females	98,646	51.1

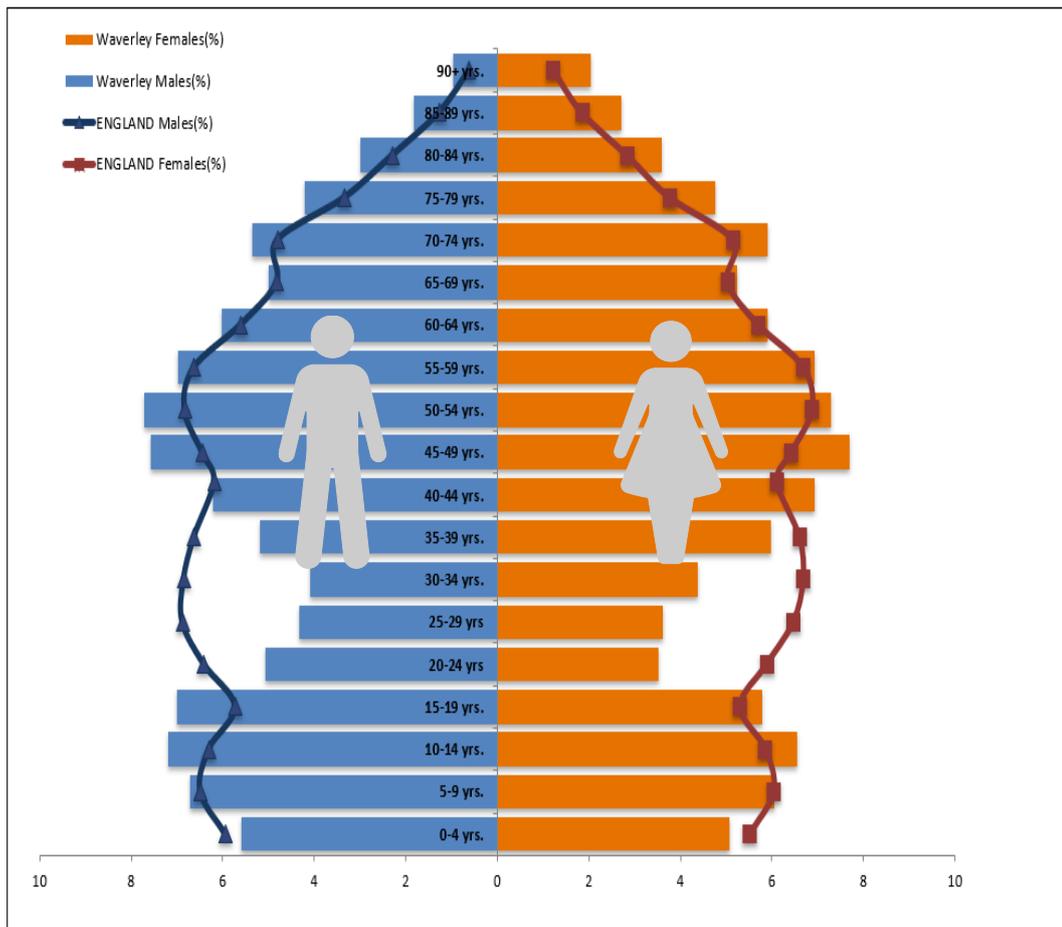
Source: ONS, Mid-year estimates, 2020

Table 92: Percentage of age & sex breakdown, in Waverley, 2020

Sex	0 to 19	20 to 64	65 and over	85 and over
Persons	24.9	52.7	22.4	3.8
Males	26.5	53.2	20.4	2.8
Females	23.5	52.3	24.3	4.8

Source: ONS, Mid-year estimates, 2020

Figure 28: Waverley Population Pyramid



Source: ONS, Mid-year estimates, 2020

The majority of the population in Waverley are white (95.8%), followed by Asian (1.9%) and mixed ethnicities (1.3%). Waverley has a less diverse population across Surrey, South East, and the whole population of England.

Table 93: Percentage of population, by ethnicity, 2011

Ethnicity	Number	Percentage
Population 2020	126,556	100.0
White	121,506	96.0
Mixed	1,696	1.3
Asian	2,379	1.9
Black	557	0.4
Other	430	0.3

Source: Census 2011, QS201EW, Nomis 2020

Rural and urban composition of Waverley borough

The majority of people living in Waverley live in urban areas (and this is a lower proportion of households than across Surrey, the South East and England), while a small proportion of the population live in rural areas

Table 94: Rural and urban composition of Waverley borough

Area name	Total	Urban (total)	Urban (%)	Rural (total)	Rural (%)
England	52,059,931	42,935,229	82.5	9,124,702	17.5
South East	8,446,500	6,735,465	79.7	1,711,035	20.3
Surrey	1,105,800	958,798	86.7	147,002	13.3
Waverley	117,219	84,862	72.0	32,357	28.0

Source: Nomis, 2020

Type of urban settings

- urban city and town (72.0%)

Type of rural settings

- rural town and fringe (11.5%)
- rural village (8.5%)
- rural hamlet and isolated dwellings (8.0%)

Population Density

Waverley has a smaller proportion, approximately half (367), of the number of people per square kilometre compared to Surrey overall. This is significantly lower than the Surrey population per square kilometre (723).

Table 95: The projected change in population density of Waverley in 2020 compared to 2030

Area name	Area (sq km)	2022 people per sq. km	2025 people per sq. km	2030 people per sq. km
Surrey	1,663	723	727	730
Waverley	345	367	369	370

Source: Surrey, 2020

Waverley Population Projections

Looking over a 10-year period Waverley population is expected to have a similar growth compared to the Surrey (1.3%). People aged 65 and over are projected to have the largest growth (16.0%) and of those (21.3%) are estimated to be 85 and over

Over the lifetime of this PNA, the population of Waverley is expected to grow by 0.5% over the next three years. The number of children in 0 to 14 and adults in 30 to 44 age cohorts are expected to decrease, while 15 to 29 and 45 to 64 age cohorts will see a small growth. People aged 65 and over are projected to have the largest growth (4.2%). (Table 97)

Table 96: Waverley projected population changes, 2020 to 2030

Age band	2020	2030	Number	%	Population Change Surrey %
0 to 14	23,524	21,316	-2,208	-9.4	-9.1
15 to 29	18,205	19,247	1,042	5.7	5.8
30 to 44	20,966	19,710	-1,257	-6.0	-7.1
45 to 64	35,253	34,767	-486	-1.4	0.2
65 & Over	28,189	32,710	4,520	16.0	17.5
All ages	126,137	127,749	1,612	1.3	1.3

Source: Sub-national Population LA Projections, 2018

Table 97: Projected population changes by locality, all persons, 2022 to 2025

Age band	2022	2025	Number	%	Population Change Surrey %
0 to 14	23,301	22,528	-774	-3.3	-2.8
15 to 29	18,291	18,819	528	2.9	2.0
30 to 44	20,746	20,305	-441	-2.1	-2.7
45 to 64	35,483	35,615	132	0.4	1.0
65 & Over	28,926	30,135	1,209	4.2	4.5
All ages	126,747	127,401	654	0.5	0.5

Source: Sub-national Population LA Projections, 2018

Older People living alone

Approximately 6.0% of those aged 65 and over are living on their own in Waverley, this is a higher proportion (6.0%) compared to Surrey average (5.0%). (Table 98, Figure 29).

Table 98: Percentage of households occupied by older people (aged 65 & over) living alone in Waverley, 2011

Area name	All households	One person household: Aged 65+	% One person household: Aged 65+
England	52,059,931	3,579,698	6.9
South East	8,446,500	637,330	7.5
Surrey	1,105,800	57,543	5.2
Waverley	117,219	7,018	6.0

Source: Census, 2011, QS112EW – Nomis, 2020

10

Figure 29: Percentage of households occupied by older people (aged 65 & over) living alone in Waverley, 2011



Source: Census, 2011, QS112EW – Nomis, 2020

General Birth Rate

Waverley birth rate for women aged 15 to 44 years (53/1,000) is similar to that of the England average (55/1,000). (Table 99)

Table 99: Live births, per 1,000 women aged 15 to 44 years in Waverly, 2020

Area name	Female population 15 to 44 years	Births	Rate per 1,000 female population
England	10,581,832	585,195	55
Southeast	1,642,566	90,864	55
Surrey	212,519	11,880	56
Waverley	19,545	1,040	53

Source: Office for National Statistics (ONS), 2020

10

Figure 30: Live births, per 1,000 women aged 15 to 44 years in Waverley, 2020



Source: Office for National Statistics (ONS), 2020

Table 100: Live birth numbers, General Fertility Rates (GFR) and Total Fertility Rates (TFR) in Waverley, 2020

Area of usual residence	Live births	GFR ²	TFR ³
England	585,195	55	1.59
South East	90,864	55	1.65
Surrey	13,423	56	1.7
Waverley	1,040	53	1.74

Source: Office for National Statistics (ONS), 2020

¹ Rates for 2020 have been calculated using the mid-2020 population estimates based on 2011 census

² The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15 to 44. The GFRs have been calculated using mid-2020 population estimates.

³ The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

Woking Borough

Woking Population

The population of Woking is 50.1% males and 49.9% females (Table 101). More than half (56.7%) of the population is aged between 20 to 64; children and young people make up over a quarter (25.7%) of the population (Table 102). Table 102 shows the percentage of the population aged 85 and over as well as the percentage aged 65 and over (which includes the 85+ cohort), these have both been included as these populations have a higher need for prescription and healthcare. The percentage of the population aged 85 and older overall is 2.8%, and this 85+ group makes up 15.7% of the population aged 65 and over.

The population pyramid for Woking (Figure 31) shows that the largest 5-year population groups are children aged 5 to 14 and adults aged 40 to 49 years. The proportion of females in the 35 to 39 age cohort is slightly higher than the England average., while the proportion of males and females aged 15 to 34 are significantly lower than the England average.

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Table 101: Population by sex in Woking

Sex	Number	Percentage
Persons	100,008	100.0
Males	50,089	50.1
Females	49,919	49.9

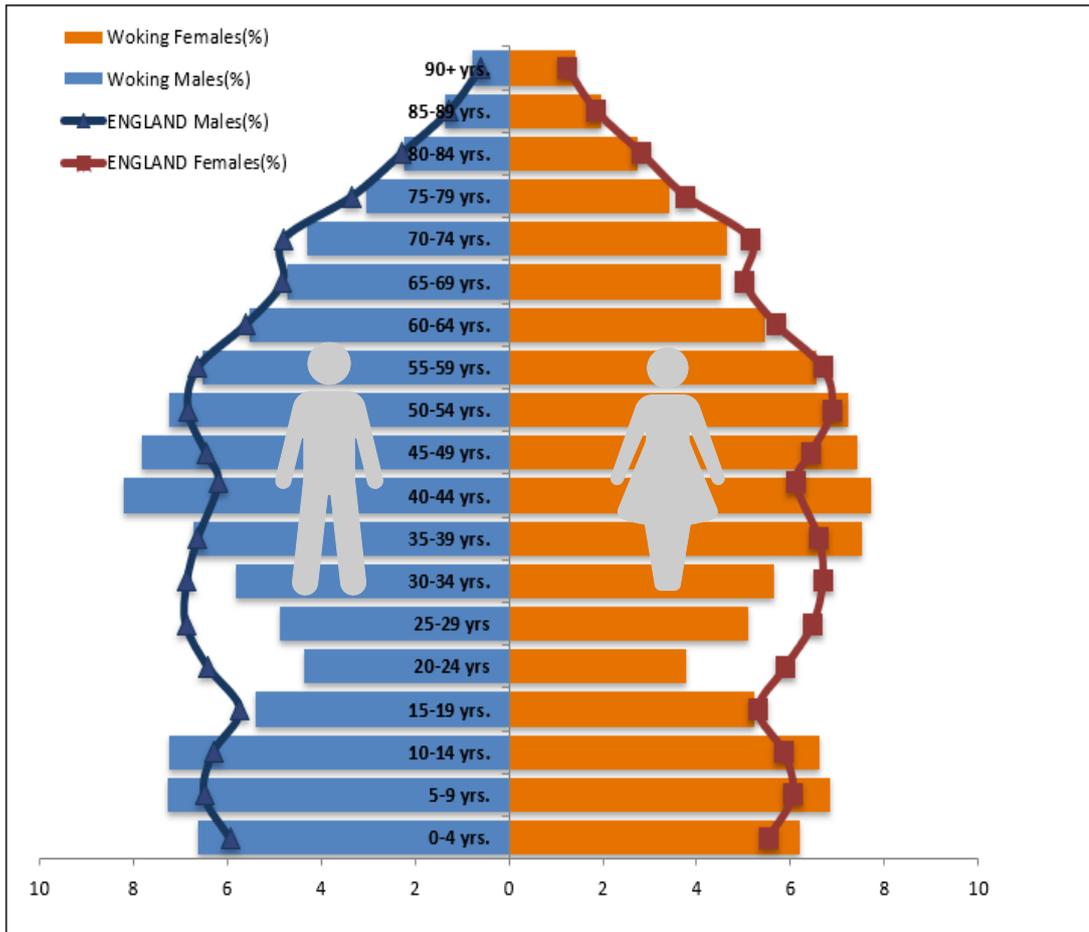
Source: ONS, Mid-year estimates, 2020

Table 102: Percentage of age & sex breakdown, in Woking, 2020

Sex	0 to 19	20 to 64	65 and over	85 and over
Persons	25.7	56.7	17.6	2.8
Males	26.5	57.0	16.4	2.1
Females	24.9	56.4	18.7	3.4

Source: ONS, Mid-year estimates,2020

Figure 31: Woking Population Pyramid



Source: ONS, Mid-year estimates, 2020

The majority of the population in Woking are white (83.6%), followed by Asian (11.6%) and mixed ethnicities (2.4%).

Table 103: Percentage of population, by ethnicity, 2011

Ethnicity	Number	Percentage
Population 2020	100,008	100.0
white	83,607	83.6
Mixed	2,350	2.4
Asian	11,551	11.6
Black	1,390	1.4
Other	1,100	1.1

Source: Census 2011, QS201EW, Nomis 2020

Rural and Urban composition of Woking borough

The majority of people living in Woking live in urban areas (and this is a higher proportion of households than across Surrey, South East and England), while only a small proportion of the population live in an area classified as rural.

Table 104: Rural and urban composition of Woking borough

Area Name	Total	Urban (total)	Urban (%)	Rural (total)	Rural (%)
England	52,059,931	42,935,229	82.5	9,124,702	17.5
Southeast	8,446,500	6,735,465	79.7	1,711,035	20.3
Surrey	1,105,800	958,798	86.7	147,002	13.3
Woking	98,282	96,351	98.0	1,931	2.0

Source: Nomis, 2020

*Local Authority Districts and Output Areas may cover a large area of open countryside and yet be urban if most of the population lives in an urban settlement. Rural is a matter of settlement form and dwelling density rather than the economic function or the character or use of the land. Most local authorities classed as rural will include urban populations and vice versa - indeed 'urban' authorities may have sizeable rural populations.

Type of urban settings

- urban major conurbation (94.5%)
- urban city and town (3.5%)

Type of rural settings

- rural town and fringe (0.3%)
- rural village (0.6%)
- rural hamlet and isolated dwellings (1.1%)

Population Density

Woking has double the number of people (1,587) per square kilometre, compared to Surrey (723).

Table 105: The projected change in population density of Woking in 2020 compared to 2030

Area name	Area (sq km)	2022 people per sq. km	2025 people per sq. km	2030 people per sq. km
Surrey	1,663	723	727	730
Woking	64	1,587	1,578	1,561

Source: Surrey, 2020

Woking Population Projections

Looking over a 10-year period, Woking is expected to have a decrease in population growth of (-1.8%) compared to the growth expected across Surrey (1.3%). People aged 65 and over are projected to have the largest growth (16.9%), and of those one fifth (21.3%) are estimated to be 85 and over (Table 106) – this growth is lower than in Surrey overall.

Over the lifetime of this PNA, the population of Woking is expected to decrease by 0.5% over the next 3 years. The number of children aged 0 to 14 years and adults aged 30 to 44 are expected decrease, while the 15 to 29 and 45 to 64 age cohorts will see a small growth. People aged 65 and over are projected to have the largest growth (4.8%) (Table 107), of those 15.1% are estimated to be aged 85 and over by 2025.

Table 106: Woking projected population changes, 2020 to 2030

Age band	2020	2030	Number	%	Population Change Surrey %
0 to 14	20,306	17,173	-3,132	-15.4	-9.1
15 to 29	14,603	15,404	801	5.5	5.8
30 to 44	21,474	18,683	-2,791	-13.0	-7.1
45 to 64	27,056	27,397	342	1.3	0.2
65 & Over	17,649	20,639	2,990	16.9	17.5
All ages	101,087	99,297	-1,790	-1.8	1.3

Source: Sub-national Population LA Projections, 2018

Table 107: Projected population changes by locality, all persons, 2022 to 2025

Age band	2022	2025	Number	%	Population Change Surrey %
0 to 14	19,701	18,637	-1,064	-5.4	-2.8
15 to 29	14,854	15,231	377	2.5	2.0
30 to 44	20,842	19,833	-1,009	-4.8	-2.7
45 to 64	27,396	27,703	307	1.1	1.0
65 & Over	18,126	18,990	863	4.8	4.5
All ages	100,920	100,393	-527	-0.5	0.5

Source: Sub-national Population LA Projections, 2018

Older People living alone

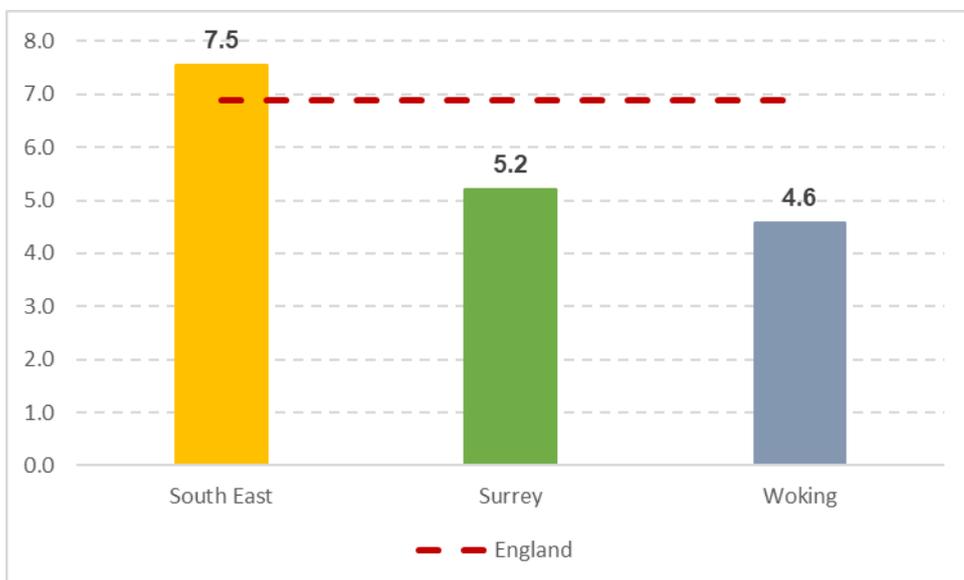
Approximately 4.6% of those aged 65 and over are living on their own in Woking, this is lower than the Surrey average (5.2%) and significantly lower than the national average (6.9%). (Table 108, Figure 32).

Table 108: Percentage of households occupied by older people (aged 65 & over) living alone, 2011

Area name	All households	One person household: Aged 65+	% One person household: Aged 65+
England	52,059,931	3,579,698	6.9
Southeast	8,446,500	637,330	7.5
Surrey	1,105,800	57,543	5.2
Woking	98,282	4,501	4.6

Source: Census, 2011, QS112EW – Nomis, 2020

Figure 32: Percentage of households occupied by older people (aged 65 & over) living alone, in Woking, 2011



Source: Census, 2011, QS112EW – Nomis, 2020

General Birth Rate

Woking borough birth rate for women aged 15 to 44 years (68/1,000) is significantly higher than Surrey, South East and England. (Table 109)

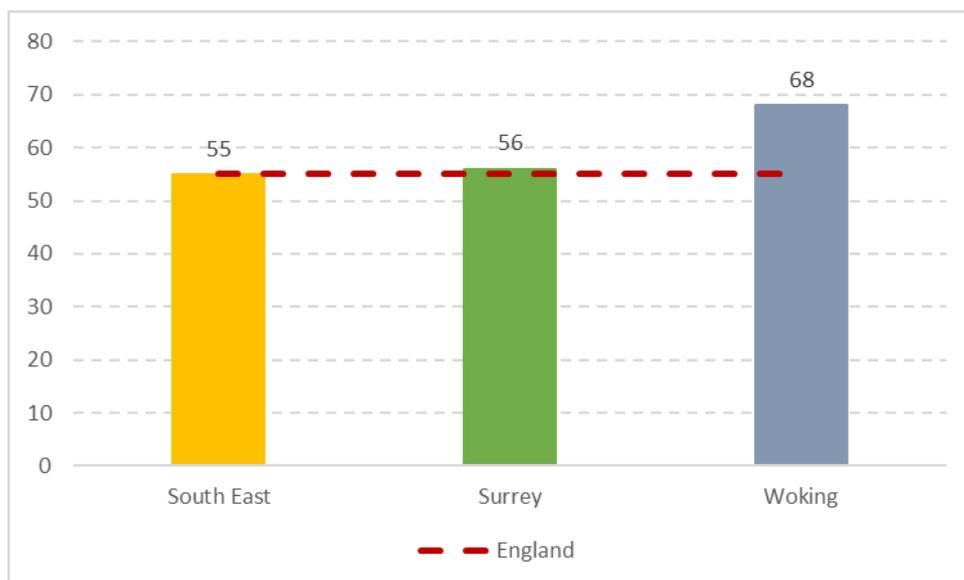
Table 109 : Live births, per 1,000 women aged 15 to 44 years by locality, 2020

Area name	Female population 15 to 44 years	Births	Rate per 1,000 female population
England	10,581,832	585,195	55
Southeast	1,642,566	90,864	55
Surrey	212,519	11,880	56
Woking	17,458	1,185	68

Source: Office for National Statistics (ONS), 2020

10

Figure 33: Live births, per 1,000 women in Woking aged 15 to 44 years, 2020



Source: Office for National Statistics (ONS), 2020

Table 110: Live birth numbers, General Fertility Rates (GFR) and Total Fertility Rates (TFR) in Woking, 2020

Area of usual residence	Live births	GFR ²	TFR ³
England	585,195	55	1.59
South East	90,864	55	1.65
Surrey	13,423	56	1.7
Woking	1,185	68	2.05

Source: Office for National Statistics (ONS), 2020

¹ Rates for 2020 have been calculated using the mid-2020 population estimates based on 2011 census

² The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15 to 44. The GFRs have been calculated using mid-2020 population estimates.

³ The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

Appendix B: Pharmacies and Dispensing Doctors opening times

B. 1. 1 Elmbridge borough

Opening Times

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A Amin	KT12 1GH	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	11:00-17:00	Closed
Boots UK Ltd	KT10 0QX	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-17:30	Closed
Boots UK Ltd	KT11 3EB	08:00-24:00	08:00-24:00	08:00-24:00	08:00-24:00	08:00-24:00	08:00-24:00	10:00-16:00
Boots UK Ltd	KT10 9RL	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	Closed
Boots UK Ltd	KT7 0RY	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00	Closed
Boots UK Ltd	KT12 1DG	08:30-13:30; 14:30-18:00	08:30-13:30; 14:30-18:00	08:30-13:30; 14:30-18:00	08:30-13:30; 14:30-18:00	08:30-13:30; 14:30-18:00	08:30-13:30; 14:30-18:00	11:00-17:00
Boots UK Ltd	KT13 8AX	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	09:00-17:30	10:00-16:00
C&H Esher	KT10 9QS	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-18:00	Closed
Dev & Kalher Associate Ltd	KT22 0JP	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-13:00	Closed

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Goulds UK Ltd	KT12 2SA	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-14:00	Closed
H. A. McParland Ltd	KT12 1RJ	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:30	Closed
Herisse Ltd	KT12 4HL	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:30	Closed
Herisse Ltd	KT12 4HW	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	Closed	Closed
JCL Cobham and NS Limited	KT11 1HT	08:30-13:00; 13:20-19:00	08:30-13:00; 13:20-19:00	08:30-13:00; 13:20-19:00	08:30-13:00; 13:20-19:00	08:30-13:00; 13:20-19:00	Closed	Closed
JCL(UK) Ltd	KT8 2NA	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-14:00	Closed
JSKR Pharma Ltd	KT10 0SH	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-13:00	Closed
KICO Ltd	KT10 0PD	09:00-13:30; 14:00-18:15	09:00-13:30; 14:00-18:15	09:00-13:30; 14:00-18:15	09:00-13:30; 14:00-18:15	09:00-13:30; 14:00-18:15	09:00-13:00	Closed
Laldas Ltd	KT7 0UQ	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00	Closed
Lloyds Pharmacy Ltd	KT11 1HW	07:00-23:00	07:00-23:00	07:00-23:00	07:00-23:00	07:00-23:00	07:00-22:00	10:00-16:00
Lloyds Pharmacy Ltd	KT11 3DY	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-17:30	Closed
Lloyds Pharmacy Ltd	KT12 1AD	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	11:00-17:00
Mrs O Udueni	KT13 9UQ	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-13:00	Closed
Nicklevale Ltd	KT8 0DL	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-16:00	Closed
Nicklevale Ltd	KT8 0JX	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	Closed	Closed

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
P&U Mangal Ltd	KT13 9HL	09:00-13:00; 14:00-17:30	09:00-13:00; 14:00-17:30	09:00-13:00; 14:00-17:30	09:00-13:00; 14:00-17:30	09:00-13:00; 14:00-17:30	09:00-12:00	Closed
Pharmacy 4 You Limited	KT13 8DX	07:00-23:00	07:00-23:00	07:00-23:00	07:00-23:00	07:00-23:00	07:00-21:00	10:00-16:00
Tesco Stores Ltd	KT13 0XF	08:00-22:30	06:30-22:30	06:30-22:30	06:30-22:30	06:30-22:30	06:30-22:00	10:00-16:00
Vertical Pharma Resources Ltd	KT8 2QZ	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	Closed	Closed
Y Dhir	KT12 3LJ	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-16:00	Closed

B. 1. 2 Epsom & Ewell borough

Opening Times

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Anna Healthcare Ltd	KT17 2HS	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:30	Closed
Anna Healthcare Ltd	KT17 2HS	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:00	09:00-18:30	09:00-17:00	Closed
Boots UK Ltd	KT18 5DB	08:30-19:00	08:30-19:00	08:30-19:00	08:00-20:00	08:00-19:00	08:30-18:00	10:30-16:30
Celticpharm Ltd	KT19 9UR	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-16:00	Closed
Dev & Kalher Associates Ltd	KT19 8HJ	08:45-19:00	08:45-19:00	08:45-19:00	08:45-19:00	08:45-19:00	09:00-14:00	Closed
Kasmwa Ltd	KT17 1NP	08:45-18:00	08:45-18:00	08:45-18:00	08:45-18:00	08:45-18:00	09:00-13:00	Closed
Lloyds Pharmacy Ltd	KT17 1EQ	08:00-22:00	08:00-22:00	08:00-22:00	08:00-22:00	08:00-22:00	08:00-22:00	10:00-16:00
Lloyds Pharmacy Ltd	KT19 8EF	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	08:30-17:30	Closed
Mitrose Ltd	KT19 0JA	09:00-13:00; 14:00-19:00	09:00-13:00; 14:00-19:00	09:00-13:00; 14:00-19:00	09:00-13:00; 14:00-19:00	09:00-13:00; 14:00-19:00	09:00-13:00	Closed
P&U Mangal Ltd	KT19 9XA	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-12:00	Closed
Ricky's (Ewell) Ltd	KT17 1SL	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-14:00	Closed

B. 1. 3 Guildford borough

Opening Times

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Boots UK Ltd	GU1 1LL	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	14:00-18:00	14:00-18:00	14:00-18:00	09:00-17:00	Closed
Boots UK Ltd	GU1 2RE	09:00-13:00; 13:30-17:30	09:00-13:00; 13:30-17:30	13:30-17:30	13:30-17:30	13:30-17:30	09:00-13:00; 14:00-17:30	Closed
Boots UK Ltd	GU1 3DS	08:30-18:00	08:30-18:00	08:30-18:00	08:30-19:00	08:30-18:00	08:30-18:00	11:00-17:00
Boots UK Ltd	GU1 3JH	08:30-13:30; 14:00-18:30	08:30-13:30; 14:00-18:30	14:00-18:30	14:00-18:30	14:00-18:30	09:00-13:00	Closed
Boots UK Ltd	GU2 8AF	08:30-18:00	08:30-18:00	08:30-18:30	08:00-18:00	08:30-18:00	09:00-13:00	Closed
Boots UK Ltd	GU4 7EW	09:00-13:00; 13:30-18:30	09:00-13:00; 13:30-18:30	09:00-13:00; 13:30-18:30	09:00-13:00; 13:30-18:30	09:00-13:00; 13:30-18:30	09:00-17:00	Closed
Boots UK Ltd	GU23 7BP	08:30-12:30; 13:30-19:00	08:30-12:30; 13:30-18:15	13:30-18:15	08:30-12:30; 13:30-18:15	13:30-18:15	09:00-13:00	Closed
Boots UK Ltd	GU4 8JU	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	14:00-18:00	14:00-18:00	14:00-18:00	14:00-17:00	Closed
Jeneesapharmacy Ltd	GU2 9XA	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-13:00	Closed
L Rowland & Co (Retail) Ltd	GU3 3NA	08:30-13:30; 13:50-18:30	08:30-13:30; 13:50-18:30	08:30-13:30; 13:50-18:30	08:30-13:30; 13:50-18:30	08:30-13:30; 13:50-18:30	09:00-13:00	Closed
Lloyds Pharmacy Ltd	GU12 5AZ	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:30	Closed

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Lloyds Pharmacy Ltd	GU4 7JU	08:30-21:00	08:30-21:00	08:30-21:00	08:30-21:00	08:30-21:00	08:00-20:00	10:00-16:00
Lloyds Pharmacy Ltd	KT24 6QN	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:00	10:00-13:00
Needsuper Ltd	GU1 4RP	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00	Closed
Needsuper Ltd	GU2 7NT	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00	Closed
Primary Care Chemists Ltd	GU2 8BE	08:30-18:30	08:30-18:30	08:30-18:30	08:30-18:30	08:30-18:30	09:00-17:30	Closed
Superdrug Stores PLC	GU1 3DP	09:00-14:00; 14:30-18:00	09:00-14:00; 14:30-18:00	09:00-14:00; 14:30-18:00	09:00-14:00; 14:30-19:00	09:00-14:00; 14:30-18:00	14:00-17:30	Closed
Tesco Stores Ltd	GU2 7UN	08:00-21:00	08:00-21:00	08:00-21:00	08:00-21:00	08:00-21:00	08:00-21:00	10:00-16:00

B. 1. 4 Mole Valley district

Opening Times

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Boots UK Ltd	KT23 4AA	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-17:30	Closed
Boots UK Ltd	RH4 1AW	08:30-17:30	08:30-17:30	08:30-17:30	08:30-17:30	08:30-17:30	08:30-17:30	10:00-16:00
Boots UK Ltd	KT22 9HX	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-17:30	Closed
Boots UK Ltd	KT22 8AH	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	10:00-16:00
Brockwood Healthcare Ltd	RH5 4HY	08:00-18:30	08:00-18:30	08:00-18:30	08:00-17:00	08:00-18:30	09:00-13:00	Closed
Frith Brothers Ltd	RH4 2HQ	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-17:00	Closed
Geruda Ltd	RH4 2EU	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-12:00	Closed
Herisse Ltd	KT22 9LG	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-18:00	Closed	Closed
L Rowland & Co (Retail) Ltd	RH3 7JR	9:00-13:00; 14:00-17:30	9:00-13:00; 14:00-17:30	9:00-13:00; 14:00-17:30	9:00-13:00; 14:00-17:30	9:00-13:00; 14:00-17:30	09:00-13:00	Closed
Lloyds Pharmacy Ltd	KT21 1QL	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-17:30	Closed
Mauripharm Ltd	KT21 1AW	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-14:00	10:00-12:00
Mauripharm Ltd	KT21 2DB	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-18:00	9:00-13:00; 14:00-18:00	09:00-13:00	Closed

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Mauripharm Ltd	KT22 7SR	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-12:00	Closed
Quincewood Ltd	KT23 4LP	9:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-17:30	Closed
Richard Woodroffe	RH4 1SD	08:00-23:00	08:00-23:00	08:00-23:00	08:00-23:00	08:00-23:00	08:00-23:00	10:00-20:00

B. 1. 5 Reigate & Banstead borough

Opening Times

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Asda Stores Ltd	KT20 5NZ	08:00-23:00	07:00-23:00	07:00-23:00	07:00-23:00	07:00-23:00	07:00-22:00	10:00-16:00
B B Madhvani	SM7 1PB	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-13:00	Closed
Boots UK Ltd	SM7 2NL	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-17:30	10:00-16:00
Boots UK Ltd	RH6 7AY	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	Closed
Boots UK Ltd	RH1 1RD	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	10:30-16:30
Boots UK Ltd	RH2 9AT	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	10:30-16:30
Day Lewis Chemist	KT20 5SR	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-13:00	Closed
Day Lewis Chemist Limited	RH1 3HU	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-13:00	Closed
Day Lewis Chemist Ltd	RH2 7AQ	09:00-18:00	09:00-18:00	09:00-17:30	09:00-18:00	09:00-18:00	09:00-13:00	Closed
Genesis Enterprise	RH6 7JQ	9:00-13:30; 14:00-19:00	9:00-13:30; 14:00-19:00	9:00-13:30; 14:00-19:00	9:00-13:30; 14:00-19:00	9:00-13:30; 14:00-19:00	09:00-13:30	Closed
Guidebrook Ltd	RH2 8AU	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-13:00	Closed
Iceline Trading	RH1 6NZ	9:00-13:00; 14:00-18:30	9:00-13:00; 14:00-18:30	9:00-13:00; 14:00-18:30	9:00-13:00; 14:00-18:30	9:00-13:00; 14:00-18:30	09:00-13:00	Closed
Jubichem Ltd	KT20 5PU	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-13:00	Closed
Lloyds Pharmacy Ltd	RH6 7DG	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-13:00	Closed

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Paydens Ltd	KT18 5QJ	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-16:00	Closed
Pearl Chemist Ltd	SM7 2LS	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-17:30	Closed
Pennywell Healthcare Limited	RH1 5BX	09:30-18:00	09:30-18:00	09:30-18:00	09:30-18:00	09:30-17:30	10:00-14:00	Closed
R & B Amin	SM7 2NN	09:30-18:30	09:30-18:30	09:30-18:30	09:30-18:30	09:30-18:30	09:30-17:30	Closed
TH Dolman Ltd	RH1 1BD	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-13:00	Closed
Vibikas Ltd	KT20 7RT	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-14:00	Closed
Waremass Ltd	RH1 2NP	08:30-18:30	08:30-18:30	08:30-18:30	08:30-18:30	08:30-18:30	09:00-13:00	Closed
WM Morrison Supermarkets PLC	RH2 7BA	08:30-13:30; 14:00-20:00	08:30-13:30; 14:00-20:00	08:30-13:30; 14:00-20:00	08:30-13:30; 14:00-20:00	08:30-13:30; 14:00-20:00	08:00-13:30; 14:00-19:00	10:00-16:00
Zein Health Ltd	RH6 7AS	08:00-22:00	08:00-22:00	08:00-22:00	08:00-22:00	08:00-23:59	00:00-19:30	09:00-17:30

B. 1. 6 Runnymede borough

Opening Times

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Boots UK Ltd	TW20 9EX	08:00-18:00	08:00-18:00	08:00-18:00	08:00-18:00	08:00-18:00	08:00-18:00	Closed
Jays Pharmacy Ltd	TW20 8AS	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-13:00	Closed
Jays Plus Limited	TW20 9EX	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-13:00	Closed
Lloyds Pharmacy Ltd	KT15 2AD	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-17:30	Closed
Lloyds Pharmacy Ltd	KT15 2AR	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-13:00	Closed
Lloyds Pharmacy Ltd	KT16 8NF	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-17:00	Closed
Lloyds Pharmacy Ltd	KT16 0HL	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:00	Closed
Lloyds Pharmacy Ltd	GU25 4DW	08:30-18:30	08:30-18:30	08:30-18:30	08:30-18:30	08:30-18:30	08:30-17:30	Closed
Lloyds Pharmacy Ltd	KT15 3NT	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-17:30	Closed
Tesco Stores Limited	KT15 2AS	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	11:00-17:00
Wedgeglan Ltd	KT16 9AD	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-15:00	Closed

B. 1. 7 Spelthorne borough

Opening Times

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A O Akodu	TW15 2BX	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	Closed
Archana Biologics (UK) Ltd	TW16 6LG	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	10:00-12:00	Closed
Boots UK Ltd	TW15 1QD	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	Closed
Boots UK Ltd	TW15 2TS	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-17:30	Closed
Boots UK Ltd	TW17 9AJ	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:30	Closed
Boots UK Ltd	TW18 4WB	08:30-18:30	08:30-18:30	08:30-18:30	08:30-19:30	08:30-18:30	08:30-18:30	10:00-16:00
Boots UK Ltd	TW16 7AZ	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	10:00-16:00
Easy Care Services Limited	TW15 1UU	09:00-13:00, 14:00-18:00	09:00-13:00, 14:00-18:00	09:00-13:00, 14:00-18:00	09:00-13:00, 14:00-18:00	09:00-13:00, 14:00-18:00	Closed	Closed
Herman Trading Ltd	TW19 7HT	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	Closed	Closed
Julie Chuna Li	TW18 1AT	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	Closed
KV Chouhan	TW19 7QU	08:30-17:30	08:30-17:30	08:30-17:30	08:30-17:30	08:30-17:30	09:00-13:00	Closed
Lloyds Pharmacy Ltd	TW15 2PH	08:30-19:00	08:30-19:00	08:30-19:00	08:30-19:00	08:30-19:00	09:00-17:30	Closed
Lloyds Pharmacy Ltd	TW16 5HS	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-17:30	Closed
Mr Sachin Patel	TW18 1PJ	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-14:00	Closed

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Pillbox Chemist Ltd	TW15 2UN	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:00	Closed
Pillbox Chemist Ltd	TW18 2PG	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:00	Closed
S P Pharm Ltd	TW18 4PA	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-13:00	Closed
Superdrug Stores PLC	TW15 2UP	08:30-17:30	08:30-17:30	08:30-17:30	08:30-17:30	08:30-17:30	09:00-17:30	Closed
Tesco Stores Ltd	TW19 7PZ	08:00-22:30	06:30-22:30	06:30-22:30	06:30-22:30	06:30-22:30	06:30-22:00	11:00-17:00
Tesco Stores Ltd	TW16 7BB	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	08:00-20:00	10:00-16:00
Trio Pharma Ltd	TW17 9AJ	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-16:00	Closed

B. 1. 8 Surrey Heath borough

Opening Times

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Balchem Ltd	GU18 5SD	08:45-18:00	08:45-18:00	08:45-18:00	08:45-18:00	08:45-18:00	08:45-14:00	Closed
Boots UK Ltd	GU15 2NN	8:30-13:00; 13:30-18:00	8:30-13:00; 13:30-18:00	8:30-13:00; 13:30-18:00	8:30-13:00; 13:30-18:00	8:30-13:00; 13:30-18:00	09:00-12:30	Closed
Boots UK Ltd	GU15 3SD	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	10:30-16:30
Boots UK Ltd	GU16 6LD	08:45-18:00	08:45-18:00	08:45-18:30	08:45-18:30	08:45-18:00	08:45-17:30	Closed
Boots UK Ltd	GU18 5SA	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-17:30	Closed
Camberley Healthcare LLP	GU15 2HJ	08:00-23:00	08:00-23:00	08:00-23:00	08:00-23:00	08:00-23:00	08:00-23:00	08:00-18:00
Enimed Ltd	GU16 7JF	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:30	Closed
H P Hindocha	GU16 8UR	09:30-13:00; 14:00-18:00	09:30-13:00; 14:00-18:00	14:00-18:00	09:30-13:00; 14:00-18:00	14:00-18:00	09:30-13:00	Closed
Hazel Hope Limited	GU15 2QN	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	Closed	Closed
L Rowland & Co (Retail) Ltd	GU24 9LH	09:00-13:00; 14:00-17:30	09:00-13:00; 14:00-17:30	09:00-13:00; 14:00-17:30	09:00-13:00; 14:00-17:30	09:00-13:00; 14:00-17:30	09:00-13:00	Closed
Lloyds Pharmacy Ltd	GU19 5AZ	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:30	Closed
Lloyds Pharmacy Ltd	GU15 3YN	07:00-23:00	07:00-23:00	07:00-23:00	07:00-23:00	07:00-23:00	07:00-22:00	10:00-16:00
Pillbox Chemist Ltd	GU15 1AX	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:00	Closed

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Roshban Ltd	GU24 8LA	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00	Closed
RSA & Co. Ltd	GU20 6AF	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-13:00	Closed
Superdrug Stores PLC	GU15 3SJ	08:30-17:30	08:30-17:30	08:30-17:30	08:30-17:30	08:30-17:30	14:00-17:30	Closed
X-Pharm Ltd	GU15 4HE	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-12:30	Closed

B. 1. 9 Tandridge district

Opening Times

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Boots UK Ltd	CR3 6JU	08:30-18:30	08:30-20:00	08:30-18:30	08:30-18:30	08:30-18:30	Closed	Closed
Boots UK Ltd	CR3 6RT	08:30-14:00; 15:00-17:30	08:30-14:00; 15:00-17:30	08:30-14:00; 15:00-17:30	08:30-14:00; 15:00-17:30	08:30-14:00; 15:00-17:30	08:30-14:00; 15:00-17:30	10:00-16:00
Boots UK Ltd	RH7 6EP	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:00	Closed
Boots UK Ltd	RH8 0PG	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	Closed
Butt & Hobbs Ltd	CR3 0EL	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-13:00	Closed
Chemitex Ltd	CR3 5UA	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-13:00	Closed
Hogarth Pharmacy Ltd	RH6 9QL	09:00-18:00	09:00-18:00	09:00-18:00	09:00-17:30	09:00-18:00	09:00-12:00	Closed
Lloyds Pharmacy Ltd	RH9 8LW	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-13:00	Closed
Lloyds Pharmacy Ltd	CR6 9DY	08:00-22:00	08:00-22:00	08:00-22:00	08:00-22:00	08:00-22:00	07:00-22:00	10:00-16:00
Paydens Ltd	CR3 5XL	08:30-13:00; 14:00-18:30	08:30-13:00; 14:00-18:30	08:30-13:00; 14:00-18:30	08:30-13:00; 14:00-18:30	08:30-13:00; 14:00-18:30	09:00-13:00	Closed
Paydens Ltd	RH8 0PG	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:30	Closed
Sutton Chase Ltd	CR6 9NA	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-17:30	Closed
VCKP Limited	RH8 0JP	09:00-13:00; 14:15-17:30	09:00-13:00; 14:15-17:30	Wed: 09:00- 13:00	09:00-13:00; 14:15-17:30	09:00-13:00; 14:15-17:30	09:00-13:00	Closed
Vitaltone Ltd	CR3 6QA	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-17:30	Closed

B. 1. 10 Waverley borough

Opening Times

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A D & A I Gohill	GU8 5DR	08:30-19:30	08:30-19:30	08:30-19:30	08:30-19:30	08:30-19:30	08:30-16:00	Closed
A D Gohill	GU8 6HR	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	14:00-18:00	14:00-17:30	14:00-18:00	09:00-13:00	Closed
AMG Healthcare Ltd	GU10 3PX	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-13:00	Closed
Boots UK Ltd	GU8 4TU	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	Wed: 09:00- 13:00	09:00-13:00; 14:00-18:00	09:00-13:00; 14:00-18:00	09:00-13:00	Closed
Boots UK Ltd	GU6 8AF	13:00-18:30	13:00-18:30	09:00-12:00; 13:00-18:30	09:00-12:00; 13:00-18:30	09:00-12:00; 13:00-18:30	09:00-17:00	Closed
Boots UK Ltd	GU6 8AT	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-17:30	11:00-17:00
Boots UK Ltd	GU7 3AZ	09:00-13:30; 14:30-18:00	09:00-13:30; 14:30-18:00	09:00-13:30; 14:30-18:00	09:00-13:30; 14:30-18:00	09:00-13:30; 14:30-18:00	09:00-13:30; 14:30-17:00	Closed
Boots UK Ltd	GU9 7NW	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	10:30-16:30
Boots UK Ltd	GU7 1DW	08:30-14:00; 15:00-18:00	08:30-14:00; 15:00-18:00	08:30-14:00; 15:00-18:00	08:30-14:00; 15:00-19:00	08:30-14:00; 15:00-18:00	08:30-14:00; 15:00-18:00	11:00-17:00
Boots UK Ltd	GU27 2HJ	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-17:30	10:00-16:00
Borg Pharma Ltd	GU7 3PR	08:30-18:30	08:30-18:30	08:30-18:30	08:30-18:30	08:30-18:30	09:00-13:00	10:00-13:00
Bushra Mansoor Khan	GU9 7HH	09:00-18.00	09:00-18.00	09:00-18.00	09:00-18.00	09:00-18.00	09:00-12:00	Closed

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Charles s Bullen Stomacare Ltd	GU9 7UP	09:00-17:00	09:00-17:00	09:00-17:00	09:00-17:00	09:00-17:00	Closed	Closed
DSM Pharma Ltd	GU7 1DZ	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-13:30	
Fittleworth Medical Ltd	GU10 2DY	09:00-17:00	09:00-17:00	09:00-17:00	09:00-17:00	09:00-17:00	Closed	Closed
Haslemere Healthcare LLP	GU27 2BQ	07:00-22:30	07:00-22:30	07:00-22:30	07:00-22:30	07:00-22:30	07:00-22:30	10:00-17:00
Heath End Pharmacy Ltd	GU9 9AW	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-13:00	Closed
L Rowland & Co Ltd	GU9 9QL	08:30-13:00; 13:20-19:00	08:30-13:00; 13:20-19:00	08:30-13:00; 13:20-19:00	08:30-13:00; 13:20-19:00	08:30-13:00; 13:20-19:00	Closed	Closed
Lalys Chemist	GU9 7PB	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	Closed	Closed
Lloyds Pharmacy Ltd	GU9 9NJ	08:00-14:00; 15:00-21:00	08:00-14:00; 15:00-21:00	08:00-14:00; 15:00-21:00	08:00-14:00; 15:00-21:00	08:00-14:00; 15:00-21:00	08:00-14:00; 15:00-20:00	10:00-16:00
Lloyds Pharmacy Ltd	GU7 1LQ	08:00-23:00	07:00-23:00	07:00-23:00	07:00-23:00	07:00-23:00	07:00-22:00	10:00-16:00
Lloyds Pharmacy Ltd	GU27 1LE	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-17:30	Closed
Lloyds Pharmacy Ltd	GU26 6NL	09:00-13:00; 14:15-18:30	09:00-13:00; 14:15-18:30	09:00-13:00; 14:15-18:30	09:00-13:00; 14:15-18:30	09:00-13:00; 14:15-18:30	09:00-13:00	Closed
Paydens Pharmacy Ltd	GU5 0PE	08:00-18:00	08:00-18:00	08:00-18:00	08:00-18:00	08:00-18:00	09:00-13:00	Closed
Surrey H/C Solutions Ltd	GU6 8RF	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:00	Closed
Waremass Ltd	GU7 1NJ	08:30-19:00	08:30-19:00	08:30-19:00	08:30-19:00	08:30-19:00	08:30-17:00	Closed

B. 1. 11 Woking borough

Opening Times

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Assan Pharmacy Ltd	KT14 6DH	08:30-18:30	08:30-18:30	08:30-18:30	08:30-18:30	08:30-18:30	Closed	Closed
Boots UK Ltd	KT14 7QX	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	Closed
Boots UK Ltd	GU21 2DR	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-17:30	Closed
Boots UK Ltd	GU21 3LG	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-17:30	Closed
Boots UK Ltd	GU21 6XU	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	11:00-17:00
Boots UK Ltd	GU22 7QQ	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-18:00	Closed
Boots UK Ltd	GU22 7XL	08:30-13:00; 13:30-18:30	08:30-13:00; 13:30-18:30	08:30-13:00; 13:30-18:30	08:30-13:00; 13:30-18:30	08:30-13:00; 13:30-18:30	09:00-12:30	Closed
Easihealth LTD	GU21 5DU	09:00-13:00, 14:00-18:00	09:00-13:00, 14:00-18:00	09:00-13:00, 14:00-18:00	09:00-13:00, 14:00-18:00	09:00-13:00, 14:00-18:00	Closed	Closed
Enimed Ltd	GU21 4SY	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-14:00	Closed
Heath End Pharmacy Ltd	GU21 5JR	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-19:00	09:00-13:00	Closed
L Rowland & Co Ltd	GU21 8TB	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00; 14:00-18:30	09:00-13:00	Closed
Lloyds Pharmacy Ltd	GU21 2QT	07:00-23:00	07:00-23:00	07:00-23:00	07:00-23:00	07:00-23:00	07:00-22:00	10:00-16:00

Pharmacy Name	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Lloyds Pharmacy Ltd	GU22 9EH	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:00	Closed
May & Thomson Ltd	GU21 5PE	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-13:00	Closed

B. 2.0 List of Dispensing Doctors

Local Authority	Practice Code	Dispensing Practice	Main Practice	Branch Surgery	Postcode
Guildford	H81013	Frimley Green Medical Centre	Frimley Green Medical Centre	Y	GU16 6QQ
Guildford	H81064	Normandy Surgery	Fairlands Medical Centre	Y	GU3 2DD
Guildford	H81077	Shere Surgery/Dispensary	Shere Surgery/Dispensary	N	GU5 9DR
Guildford	H81129	Pirbright Surgery	Old Vicarage	N	GU240JE
Mole Valley	H81028	Hillside Surgery	Dorking Medical Practice	Y	KT20 7JG
Mole Valley	H81028	Riverbank Surgery	Dorking Medical Practice	Y	RH4 3PA
Mole Valley	H81068	North Holmwood	Brockwood Medical Practice	Y	RH5 4HY
Mole Valley	H81068	Newdigate Surgery	Brockwood Medical Practice	Y	RH5 5BE
Mole Valley	H81113	Leith Hill Practice	Leith Hill Practice	N	RH5 5EN
Mole Valley	H81113	Northbrook Surgery	Leith Hill Practice	Y	RH5 4NP
Surrey Heath	H81013	Ash Vale Health Centre	Frimley Green Medical Centre	N	GU12 5BA
Waverley	H81022	Chiddingfold Surgery	Chiddingfold Surgery	N	GU8 4QP
Waverley	H81022	Dunsfold Surgery	Chiddingfold Surgery	Y	GU8 4ND
Waverley	H81031	Witley Surgery	Witley Surgery	N	GU8 5QR
Waverley	H81110	Holly Tree Surgery	Holly Tree Surgery	N	GU10 4TG

Source: KHUB

Note: Branch Surgery, Y = Yes, N = No

Appendix C: Pharmacies qualifying for Pharmacy Access Scheme payments

District & Borough	Pharmacy	Address	Town	County	Postcode
Elmbridge	Wallis Jones Pharmacy	6 Manor Road North, Hinchley Wood	Esher	Surrey	KT10 0SH
Elmbridge	Lloyds pharmacy	Bridge Way,	Cobham	Surrey	KT11 1HW
Epsom & Ewell	Horton Pharmacy	Horton Retail Park , Pelman Way	Epsom	Surrey	KT19 8HJ
Epsom & Ewell	Ruxley Pharmacy	2 Ruxley Lane,	Ewell	Surrey	KT19 0JA
Guildford	Boots the Chemist	12 Stoughton Road,	Guildford	Surrey	GU1 1LL
Guildford	Boots the Chemist	Villages Medical Centre, Send Barnes Lane	Send	Surrey	GU23 7BP
Guildford	Boots the Chemist	8 Kings Road,	Shalford	Surrey	GU4 8JU
Guildford	Lloyds pharmacy	Sainsburys Superstore, Clay Lane, London Road	Burpham	Surrey	GU4 7JU
Guildford	Lloyds pharmacy	7 Station Parade, Ockham	East Horsley; Leatherhead	Surrey	KT24 6QN
Mole Valley	Brockwood Pharmacy	North Holmwood Surgery, Bentsbrook Close	Dorking	Surrey	RH5 4HY
Mole Valley	Rowlands Pharmacy	The Pharmacy, Brockham Green	Betchworth	Surrey	RH3 7JR
Reigate & Banstead	ASDA Pharmacy	Reigate Road,	Burgh Heath	Surrey	KT20 5NZ
Reigate & Banstead	Mediwise Pharmacy	32 Brighton Road,	Salfords	Surrey	RH1 5BX
Reigate & Banstead	Tesco Pharmacy	Reigate Road, Hookwood	Horley	Surrey	RH6 0AT
Runnymede	Lloyds pharmacy	6 Brox Road,	Ottershaw	Surrey	KT16 0HL
Runnymede	Lloyds pharmacy	17 Station Approach,	Virginia Water	Surrey	GU25 4DW
Runnymede	Lloyds pharmacy	98 St .Jude's Road, Englefield Green	Egham	Surrey	TW20 0DF
Spelthorne	Lloyds pharmacy	8 Avenue Parade,	Sunbury	Middlesex	TW16 5HS
Spelthorne	Westlake Pharmacy	63 Wheatsheaf Lane,	Staines	Middlesex	TW18 2PG

District & Borough	Pharmacy	Address	Town	County	Postcode
Surrey Heath	Boots the Chemist	261 Frimley Green Road,	Frimley Green	Surrey	GU16 6LD
Surrey Heath	Ram Chemist	4 Beaumaris Parade, Balmoral Road	Frimley	Surrey	GU16 8UR
Surrey Heath	Lloyds pharmacy	36 High Street,	Bagshot	Surrey	GU19 5AZ
Surrey Heath	Chobham Pharmacy	18 Windsor Road,	Chobham	Surrey	GU24 8LA
Surrey Heath	Windlesham Village Pharmacy	20 Updown Hill,	Windlesham	Surrey	GU20 6AF
Surrey Heath	Touchwood Pharmacy	199 Upper College Ride,	Camberley	Surrey	GU15 4HE
Tandridge	Boots the Chemist	8 East Grinstead Road,	Lingfield	Surrey	RH7 6EP
Tandridge	Hobbs Pharmacy	197 Godstone Road,	Whyteleafe	Surrey	CR3 0EL
Tandridge	Lloyds pharmacy	72 High Street,	Godstone	Surrey	RH9 8LW
Tandridge	Hurst Green Pharmacy	224 Pollards Oak Road, Hurst Green	Oxted	Surrey	RH8 0JP
Waverley	Milford Pharmacy	Portsmouth Road, Milford	Godalming	Surrey	GU8 5DR
Waverley	Elstead Pharmacy	2 Carlton House,, Milford Road	Elstead	Surrey	GU8 6HR
Waverley	Avicenna Pharmacy	46 Frensham Road, Lower Bourne	Farnham	Surrey	GU10 3PX
Waverley	Boots the Chemist	The Green,	Chiddingfold	Surrey	GU8 4TU
Waverley	Heath End Pharmacy	103 Farnborough Road, Heath End	Farnham	Surrey	GU9 9AW
Waverley	Lloyds pharmacy	5/7 Junction Place, Shottermill	Haslemere	Surrey	GU27 1LE
Waverley	Lloyds pharmacy	Churt Road,	Hindhead	Surrey	GU26 6NL
Woking	Horsell Pharmacy	91 High Street,	Horsell	Surrey	GU21 4SY
Woking	Rowlands Pharmacy	3 Gosden Road, West End	Woking	Surrey	GU24 9LH
Woking	Lloyds pharmacy	Kingfield Road, Kingfield	Woking	Surrey	GU22 9EH
Woking	May & Thomson	51 Dartmouth Avenue,	Sheerwater	Surrey	GU21 5PE

Appendix D: Changes to the pharmaceutical list

The PNA steering group agreed that December 2021 was an appropriate date to consider data for the purposes of this PNA.

The table below summarise changes to pharmaceutical contracts in Surrey since quarter 3, 2021/2022.

The PNA document data and tables do not include the below changes as they were notified after the data cut-off period; the below changes will be reviewed as part of the supplementary statement process in 2023.

Type of Change	Pharmacies affected by change
Change of Core hours	1
Change of Ownership	3
Change of Supplementary hours	37
New Pharmacy Contract (Distant-Selling)	1
Pharmacy Closures (community)	0
Pharmacy Merger (resulting in one closure)	1

10

Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	Better Care Fund Plan 2022-2023: Narrative and Financial Plan
HWBS Priority - 1, 2 and/or 3:	Priority 1, 2 and 3
Outcome(s)/System Capability:	Programme Management
Priority populations:	All including some Key Neighbourhoods
Civic level, service based and/or community led intervention:	All
Author(s):	Jude Middleton - Project Manager, Health Integration, Surrey County Council; Jude.Middleton@surreycc.gov.uk
Board Sponsor(s):	Liz Bruce - Joint Executive Director Adult Social Care and Integrated Commissioning, Surrey County Council and Surrey Heartlands ICS
HWB meeting date:	28 September 2022
Related HWB papers:	N/A
Annexes/Appendices:	Annex 1 - BCF Plan Narrative Annex 2 - BCF Financial Plan

11

2. Executive summary

This report is the Better Care Fund (BCF) Plan for 2022-2023.

Guidance for the plan was published by NHS England in August 2022 and, following consultation with the Local Joint Commissioning Groups and data managers across Surrey, this plan has been developed.

Surrey's two strategic priorities for the Better Care Fund align with the national priorities, which are:

- Priority one: Enable people to stay well, safe and independent at home for longer
- Priority two: Provide the right care in the right place at the right time

This plan demonstrates how the use of BCF schemes in 2022/23 are supporting the strategic priorities of the BCF and targeting priority populations identified in line with the Health and Wellbeing Strategy's priorities.

The BCF has enabled Integrated Care Boards and Local Authorities to enter into pooled budget arrangements and develop an integrated spending plan. This is demonstrated through the Local Joint Commissioning Groups who are comprised of, and supported by, members from Surrey County Council, ICBs, District and Borough Councils, NHS providers and other third sector organisations.

3. Recommendations

The Health and Wellbeing Board is asked to approve the Better Care Fund (BCF) Plan for 2022-2023 (Annex 1 and 2).

4. Reason for Recommendations

The plan has been compiled through extensive consultation with the local joint commissioning groups, data managers and finance. It is a comprehensive plan for 2022/23, developed by partners and based on local knowledge of Place needs. The plan addresses the strategic priorities of the BCF and supports the ambitions of the Surrey-wide Health and Wellbeing Strategy.

5. Detail

Surrey's two strategic priorities for the Better Care Fund are:

- Priority one: Enable people to stay well, safe and independent at home for longer
- Priority two: Provide the right care in the right place at the right time

Investment in schemes for 2022/23 supports these strategic priorities as demonstrated by the following examples of BCF Surrey-wide and local place-based funded activity for 2022-2023:

- Across Surrey £650k Discharge to Assess schemes
- Further local area-based investment in:
 - Autism Friendly Communities - providing support to communities in Surrey to be inclusive of people with Autism
 - Falls Prevention Packs supporting people to stay well at home
 - GP based in A&E to help reduce avoidable admissions
 - Safe and Settled service – supporting discharge from Hospital where low-level support is required
 - Community Discharge Nurse – planning discharge to community settings
 - In East Surrey, the Growing Health Together programme will aim to engage local communities with over 15 social and health projects and additional GP support jointly funded by each PCN. Each PCN will be working on different initiatives that reflect the needs and priorities of their individual communities
 - Community capacity to support referrals from social prescribers and health and wellbeing coaches in Surrey Heath

- New roles supporting hospital discharge and flow in Guildford and Waverley
- Commitment to support homelessness case worker in Surrey Heath
- Tech to Connect, training to residents to enable social inclusion through the use of technology

In Surrey, as nationally, the effects of Covid-19 are still being felt, not only in exposing health inequalities, but the labour shortage in Health and Social Care. Surrey, again as nationally, is also preparing to help residents through a 'cost of living crisis', the effects of which will be felt particularly harshly this winter. Surrey's Health and Wellbeing Strategy previous refresh included a strengthened focus on health inequalities. This continues to be reflected in work developing across system partners to better target and reduce health inequalities. Surrey's Better Care Fund Plan for 2022-2023 contains a number of schemes that focus on addressing health inequalities and, through regular review, we will continue to develop its support for the ambitions and priorities of the Health and Wellbeing Board.

Many of the schemes invested in for 2022/23 are continuations of schemes in operation in 2021/22. Previous schemes have been allowed to continue and be given time to 'bed in', particularly after the disruption of COVID and as a result of many years of short-term planning, enabling KPIs to be effectively measured.

A Governance Review of the BCF fund is currently in progress with the outcomes expected towards the end of 22/23. A decision to continue 'as is' while this review is carried out is shown in the continuation of schemes already commissioned. It is acknowledged that there are areas where strategy and targeting of schemes should be updated and these will be identified through the review, with a particular focus on preventative spend. Additionally, a new management structure for the BCF is being embedded to support and implement the review and its findings.

The detail of the plan itself can be found in the appendices.

6. Challenges

The workforce challenges seen across the health and care setting and the projected cost of living crisis may make implementation difficult, or result in a need to redistribute resources at short notice.

7. Timescale and delivery plan

The plan covers the financial year 2022-2023. A Governance Review of the BCF fund is currently in progress with the outcomes expected towards the end of 22/23. The recommendations from this review will inform how the BCF is managed and planned for 2023/24.

8. What communications and engagement has happened/needs to happen?

The local joint commissioning groups, data managers and finance colleagues have all been associated with the preparation of this plan. Once approved by the HWB, it will be socialised via the commissioning group to the district and boroughs and other local stakeholders, including 3rd sector organisations and provider organisations.

Recommendations from the Governance Review are expected to support a more proactive approach to planning of the BCF. This will minimise the impact of the short-notice timeframes set by NHSE for planning submissions which have been seen in recent years.

9. Next steps

The plan will go to BCF assurance, once approved. Assurance processes will confirm that national conditions and planning requirements are met, ambitions are agreed for all national metrics and that all funding is pooled, with relevant spend agreed. Where plans are not initially approved, the BCF team may implement a programme of support, with partners, to help areas achieve approval as soon as possible.

BCF Context and Governance Review

The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. The BCF encourages integration by requiring ICBs (previously CCGs) and local authorities to enter into pooled budget arrangements and agree an integrated spending plan.

The Better Care Fund in Surrey has local commissioning arrangements. Seven Local Joint Commissioning Groups (LJCGs) provide a joint commissioning framework for the delivery and implementation of the BCF Plan enabling locally relevant placed-based decisions. There are Terms of Reference for the LJCG that are updated on a regular basis to ensure strategic overview with ensure robust budget management.

A system-wide review of how the BCF operates across Surrey is in progress and due to be reported on towards the end of 2022/23. Initial engagement with Surrey partners as part of this review suggests there is broad consensus that the current approach to allocation for the scheme is working well to allow for local innovation and to develop solutions tailored to local need. Going forward, there are potential changes that could be made to support local initiatives:

- Setting system-wide expectations and ambitions relating to outcomes
- Providing support to evidence impact and outcomes of schemes.
- Providing formal mechanisms to support sharing of good practice and reporting impacts and outcomes.

It is recognised within the review, that linking the BCF to prevention spend mapping has the potential to encourage a new way of allocating resources, using a robust evidence base to target resources and to drive prevention far more than it has to date. Whilst maintaining opportunities for local innovation, there is the opportunity for Surrey BCF to lead the way on redistributing resources to drive prevention, aligned to the Public Health grant and its key role in the prevention agenda.

This work is being taken forward by an integrated team of Surrey Heartlands and Frimley Health and Care ICS' colleagues and Council individuals and will be shared with partners towards the end of the year.

Health and Wellbeing Board:

Surrey

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

Surrey County Council, Local Joint Commissioning Groups made up of reps from Surrey County Council, ICS, District and Borough Councils as follows:

Surrey Heath

Surrey Downs

North West Surrey

East Surrey

North East Hants and Farnham

East Berkshire

Guildford and Waverley

How have you gone about involving these stakeholders?

Local Partnerships are the key element to ensuring involvement and on-going stakeholder engagement. District and borough council representatives regularly attend local joint commissioning group meetings and are actively leading on communities and prevention work. East Surrey, in particular, has established the East Surrey Prevention and Communities Board, which has facilitated strong, effective place-based partnerships including engagement with local residents, VCS, and other local service providers. Surrey Downs ran an innovation fund at the end of 2021-2022 to support local groups.

In addition, as part of a separate Surrey-wide review, a series of meetings was held with individual LJCG chairs to gain insight to their operations.

Executive Summary

Surrey's two strategic priorities for the Better Care Fund align with the national priorities, which are:

- Priority one: Enable people to stay well, safe and independent at home for longer
- Priority two: Provide the right care in the right place at the right time

Surrey BCF is working towards these priorities by:

- mapping spending against prevention strategies, in order to maximise value and efficiency

- 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
- 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
- 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

Alongside ongoing investment in existing BCF Schemes, examples of BCF Surrey-wide and local place-based funded activity which support these strategic priorities for 2022-2023 include:

- Across Surrey £650k Discharge to Assess schemes
- Further local area-based investment in:
 - Autism Friendly Communities - providing support to communities in Surrey to be inclusive of people with Autism
 - Falls Prevention Packs supporting people to stay well at home
 - GP based in A&E to help reduce avoidable admissions
 - Safe and Settled service – supporting discharge from Hospital where low-level support is required
 - Community Discharge Nurse – planning discharge to community settings
 - In East Surrey, the Growing Health Together programme will aim to engage local communities with over 15 social and health projects and additional GP support jointly funded by each PCN. Each PCN will be working on different initiatives that reflect the needs and priorities of their individual communities
 - Community capacity to support referrals from social prescribers and health and wellbeing coaches in Surrey Heath
 - New roles supporting hospital discharge and flow in Guildford and Waverley
 - Commitment to support homelessness case worker in Surrey Heath
 - Tech to Connect, training to residents to enable social inclusion through the use of technology

In Surrey, as nationally, the effects of Covid-19 are still being felt, not only in exposing health inequalities, but the labour shortage in Health and Social Care. Surrey, again as nationally, is also gearing up to help residents through a 'cost of living crisis', the effects of which will be felt particularly harshly this winter. Surrey's Health and Wellbeing Strategy previous refresh included a strengthened focus on health inequalities. This continues to be reflected in work developing across system partners to better target and reduce health inequalities. Surrey's Better Care Fund Plan for 2022-2023 contains a number of schemes that focus on addressing health inequalities and, through regular review, we will continue to develop its support for the ambitions and priorities of the Health and Wellbeing Board.

The BCF operation throughout Surrey is also under strategic review as a whole. Previous schemes have been allowed to continue and be given time to 'bed in', particularly after the disruption of COVID and as a result of many years of short-term planning, so that KPIs can be effectively measured. A decision to continue 'as is', while this review is carried out thoroughly is shown in the continuation of schemes already commissioned. It is acknowledged that there are areas where strategy and targeting should be updated and these will be identified through the review. Additionally, a new management structure for the BCF is being embedded to support and implement the review and its findings. It is expected that the process of implementation will begin Q3 22/23.

Governance

The Better Care Fund in Surrey has local commissioning arrangements. Seven Local Joint Commissioning Groups (LJCGs) provide a joint commissioning framework for the delivery and implementation of the BCF Plan enabling locally relevant placed-based decisions. There are Terms of Reference for the LJCG that are updated on a regular basis to ensure strategic overview with ensure robust budget management.

Each LJCG meets and oversees the delivery of Surrey-wide initiatives such as the Handyperson Scheme, Community Equipment and Carers services to ensure that they are tailored appropriately for their Place and uses the BCF to fund a programme of local initiatives. The remit of LJCGs includes overseeing the performance of these initiatives, with representatives invited to present progress, outputs and outcomes and future plans. In Surrey Downs, for example, representatives from D&B Councils attend every other meeting (six each year) to provide essential local knowledge.

The Surrey-wide Strategic Health and Care Commissioning Collaborative maintains oversight of the quarterly reporting submissions and Better Care Fund plans to NHS England and can request deep dives into BCF performance as required, particularly with regard to countywide commissioned schemes.

The Surrey Commissioning Committee-in-Common (which includes necessary delegated authority) oversees the development of the Surrey-wide integrated commissioning governance between Surrey County Council and the Clinical Commissioning Group Governing Bodies meaning this also has the local Better Care Fund within its scope.

Additional audits are undertaken through SCC's Internal Audit Team with recommendations complementing the above. Previous audits have looked at governance, performance reporting and monitoring arrangements.

As set out within planning requirements, Surrey's Health and Wellbeing Board signs off the final plan as it aligns to, and is an important contributor for, achieving the priorities within the Health and Wellbeing Strategy. This is a ten-year strategy first published in 2019 and was the result of extensive collaboration between the NHS, Surrey County Council, District and Borough Councils and wider partners, including the Voluntary and Community Sector and the Police. This engagement has been used for and continues to be considered in the shaping of local BCF programmes.

Similarly, the development of area and care group specific strategies informs and is shaped by Place based strategy.

The Health and Wellbeing Strategy now sets out how different partners across Surrey work together with local communities to commission services to achieve these aims, focused around two key priorities:

- Priority one: Enable people to stay well, safe and independent at home for longer
- Priority two: Provide the right care in the right place at the right time

To support this renewed focus, a strong link is also forming locally with the growing 'Empowered and Thriving Communities' agenda. This is due to the aspiration agreed in the refreshed strategy for the Health and Wellbeing Board to enable more community-led interventions to reduce health inequalities. BCF governance and forums will be essential in taking forward this renewed focus and the work to narrow the gap in health outcomes within the county.

Overall BCF plan and approach to integration

Approach to Integration

The Surrey healthcare system recognises it will only deliver its health ambitions for the population of Surrey by working in partnership and integrating services. The system architecture in place following the Health and Care Act supports this, with the Integrated Care Partnership as the key space for Partnership working within the ICS.

The role of the Surrey Heartlands ICP in delivering system ambitions is:

- Coordinating a system approach to support delivery
- Maintaining a system focus on health inequalities (priority groups incl core 20+5)
- Alignment with system strategic objectives via Health and Wellbeing Board & Surrey Forum

The role of the Frimley Health and Care ICP is:

- Consider and set the strategic intent of the partnership; act as final approver of the ICS Strategy, including the proposed programmes of work, outcomes and intended benefits;
- Act as an objective "guardian" of the ICS vision and values, putting the population's needs and the successful operation of the ICS ahead of any sector or organisation specific areas of focus;
- Provide a forum for the consideration of Wider Determinants of Health and Health Inequalities, taking fullest advantage of the opportunities arising to hear the views and perspectives of the broadest range of local stakeholders and democratic representatives.

Surrey's ambition to create a truly integrated system has been operationalised within Surrey Heartlands by the creation of joint roles which span both the County Council and ICS. There are two Executive Directors: The Joint Executive Director for Public Services Reform and the Joint Executive Director of Adult Social Care & Integrated Commissioning who have been appointed jointly across both Surrey County Council and Surrey Heartlands ICS. Their remit as Executive Directors is to lead their services across the two organisations and support the population of Surrey to receive services which are integrated and operating in partnership. In addition to these structural changes, within the Public Services Reform Directorate there is the Health Integration Team which is led by another joint appointment between Surrey County Council and Surrey Heartlands ICS.

Within the Frimley Health and Care ICS, integration is happening structurally through jointly commissioned convenor posts in Learning Disabilities, Mental Health and Children's services as well as the Place based lead for Surrey Heath having a whole system relationship co-ordination role. In addition to this, Frimley Health and Care ICS has two Director roles who work across NHS and Local Government, supporting and enabling integration:

- Locality Director of Health and Social Care, Surrey Heath Adult Social Care, Surrey County Council and NHS Frimley.
- Director of Operations (NHS Frimley and Surrey Heath Borough Council)

Many services commissioned through BCF are made up of multi-agency staff working together from health, social care and VCS organisations to deliver a joined up, person-centred pathway of care in line with the Critical five, which are as follows:

Keeping people well – doing more to promote prevention and stepping in earlier to prevent people's health deteriorating; and, when people do deteriorate, making sure they understand how and where to get the urgent help they need.

Safe and effective discharge – helping patients, their carers and families understand and safely navigate the options available to them from a much more joined up and improved community care environment

High-risk care management – making sure those who are most vulnerable receive the care they need in a coordinated and planned way

Effective hospital management – making best use of hospital resources to support patients safely and efficiently from the point of admission to discharge; this is also about delivering high quality care based on the 'Get it Right First Time' principles (a national programme designed to improve patient treatment and care through in-depth reviews of services and analysis of data/evidence)

Surrey-wide efficiencies – system-wide programmes that ensure we are working in the most efficient way - whilst maintaining high quality care - across areas such as diagnostics, clinical networks, more efficient use of our workforce, digital innovation, corporate and clinical support services, financial management and how we use our estates and facilities

Overall Plan

Surrey's Better Care Fund continues to drive organisations to work across boundaries to deliver outcomes for Surrey residents. All Surrey BCF partners are fully engaged with delivering joint objectives across all service delivery systems and within all partner contract management processes. A strategic approach to service delivery is promoted via Local joint Commissioning Groups and reflected within local plans, including local and regional Health and Wellbeing Boards. Individual BCF service contracts ensure patient choice is at the heart of service delivery and contract reviews ensure KPIs reflect patient engagement with services.

In Surrey we have an established structure which partners in community health, social care, voluntary organisations and primary care. These approaches and schemes are based on the principles of: people receiving person-centred care based on their needs; users only telling their story once and care coordinated around the person. Teams such as our Integrated Discharge Team and Homefirst Team continue to work together to deliver services to keep people out of hospital and to return them home with all the appropriate support they require as quickly as possible following an acute admission with the aim of avoiding further admissions.

Examples of successful Joint Commissioning and Integration in Surrey:

- Integrated Intermediate Care between the NHS community services and Local Authority Reablement service as a component of community-based care models, with additional partnership with VCS services to further meet the needs of service users.
- Implementing effective Information and Advice Service to help residents to navigate the health and care system.
- Creating multi-agency boards in place, in line with shared priorities, so that partners can join up to tackle the wider determinants of health (for example Housing Associations are members on East Surrey's Prevention and Communities Board).
- Primary Care Mental Health services are strengthening local clinical networks between GPs, social care professionals and Mental Health professionals.
- Providers are working together across the system to develop person-centred workforce plans and relevant training, supported by appropriate technology in care and multi-agency roles.
- Risk stratification tools are in place to identify residents at high risk of emergency admission to allow preventative interventions.
- Countywide commissioned carers services are being supported by years of established (and award-winning) joint commissioning, a committed Surrey-wide multi-partnership group, Surrey-wide providers and the desire for a consistent approach across the geography
- Frailty programmes are being successfully linked to other admission avoidance schemes, including falls prevention work through regular MDTs that bring together all areas of health, social care and other statutory services.

The ambition is to enable residents to be as independent as possible for as long as possible and so avoid or delay dependence on Statutory services. We are supporting people to be in their own homes, providing reablement/rehabilitation and short-term services to maximise independence – this will support the delivery of the reablement measure and help to reduce the number of new residential and nursing home admissions.

Surrey's Joint Strategic Needs Assessment (JSNA) and local health profiles tell us that Surrey has an ageing and growing population. The population of Surrey was estimated to be 1.19 million people in mid-2018, projected to rise to 1.3 million people by 2039, with the largest rise anticipated in people aged over 65 years. An increased and ageing population inevitably results in an increase in the number of people living with complex needs such as long-term conditions, dementia, falls, depression and loneliness. For example, the number of people with dementia in Surrey is predicted to rise to 21,075 by 2025. Therefore many of the schemes currently in place will work to support Surrey's aging population. The services being commissioned are not fundamentally different in 22/23 compared to 21/22 due to the strategic review which is underway (see above). Previous schemes have been allowed to continue and be given time to 'bed in', particularly after the disruption of COVID and as a result of many years of short-term planning, so that KPIs can be effectively measured. It is expected that the effects of the review and a new management structure for BCF will begin to be seen from Q1 2023/24.

Implementing the BCF Policy Objectives

Supporting people home from hospital is a key feature of Surrey's BCF plan and has been a feature of integrated working in Surrey since before the introduction of the Better Care Fund. Surrey is committed to continuous improvement in managing transfers of care and has built local plans to address areas for development.

We have been strengthening our approach to supporting patients to be discharged from hospital successfully and to achieve good outcomes with many different initiatives in Surrey. Across the county, prevention and self-management is taking place using a strengths-based approach which recognises the assets of the individual. We continue to place emphasis on personalised care across the system. This is being complemented by our strong personal budget offer in Surrey.

Within this year's BCF there are a number of programmes and schemes in place and being implemented with the aim of reducing delays and supporting timely discharge, without increasing admissions:

- Investment into Health and Wellbeing packs & a Falls prevention programme all help to support our local population to live healthier, independent lives and remain at home for longer. This is additionally supported via investment into the Reconnections pilot which helps reduce social isolation.
- The BCF funded Anticipatory Care Community Matron roles drive the delivery of the Anticipatory care LCS, playing a central role in the development of PCN-wide MDTs, ensuring co-ordinated anticipatory care in the community for complex patients, helping them to better manage their own conditions and

reduce avoidable hospital admissions. The matrons take a holistic approach to patient care, working closely with colleagues across health & social care and the voluntary sector.

- The implementation & subsequent expansion of the Phyllis Tuckwell Integrated Community Model has ensured that the team is now able to provide more families with high quality palliative and end of life care, increasing accessibility to all its services. Making timely interventions, tailored to the personal needs and wishes of patients, their families, and carers.
- Timely and safe discharge of patients following an episode of inpatient hospital care is supported via the BCF in multiple ways. There is funding for patient transport via the HOPPA Bus, additional reablement and therapy provision. Significant investment into our community nursing teams and in particular into In-Reach community nursing roles within the acute hospital have helped to ensure that more patients, and in particular those already known to our community teams, can be discharged quickly and safely to their usual place of residence.
- Organisations commissioned using the BCF to address the support needs of Carers in Surrey undertook a specific piece of work to look at Carers' experiences of discharge. This had led to action plans in each of the six acute trusts to improve Carers' experience and thereby facilitate successful discharge planning.

BCF funding actively supports individuals across all discharge pathways through increased investment in the British Red Cross Independent Living Service - take home and settle service, which works in partnership with the handypersons service to help patients remain safe at home, preventing admission and supporting post discharge. The British Red Cross take home and settle services is available for pathway 1 and pathway 0 hospital patients. Volunteers contact all discharged patients 3 days post discharge and assist to link patients to local services and support networks including Wellbeing prescription services to signpost and/or refer people to community social and health services. This programme has been extended over the last 2 years to provide an additional 20% capacity providing support for over 100 individuals per month.

- BCF funded Community Equipment Services also enable timely and effective discharge to home and enables people to remain in their homes for longer, supporting independence.
- BCF funded schemes also support Occupational Therapy provision within acute and community settings to facilitate effective discharge.
- Integrated multi-disciplinary teams support early discharge planning and wraparound out of hospital
- Enhanced Reablement programmes to pool capacity and reduce delays. For example, the colocation of Reablement and Rapid Response colleagues in East Surrey is firmly established

- Discharge to Assess and Recover pilot – BCF has agreed to support a new rapid response discharge scheme to support pathway 1. The aim is to grow and develop an integrated health and care workforce that provides short term and intensive support to recover post-hospital discharge. schemes,
- Virtual wards are being established utilising technology-enabled monitoring at home with a dedicated clinical team providing an MDT approach to ensure each patient continues to receive the appropriate clinical and social care. This will allow patients to return home sooner, thus reducing the demand on hospital beds whilst encouraging independence and supporting patients' mental wellbeing.

With recent high demand on acute and domiciliary services, recruitment pressures and an anticipated energy cost crisis, the system is expecting to experience significant pressures over the winter period. Planning to support this demand and complex discharges is underway. The BCF has dedicated investment in the Discharge to Assess and Recover, Community Health Providers delivering the Virtual Ward models and additional bed capacity. This investment aims to enable assessments to be undertaken outside of an acute hospital bed to increase patient flow through the hospital and support reduction in unnecessary Length of Stay.

Supporting Unpaid Carers

A ringfenced budget has been created within the BCF specifically to address the support needs of Carers, implementing the Surrey-wide Strategy for Carers 2022-2025.

The BCF Carers Budget makes provision for a range of externally commissioned services that are Surrey wide but are required to be appropriately tailored to local need:

- Carers Hubs: these are located in Surrey's 'Places' to increase visibility and encourage carers to access preventative support and early intervention
- Carer Breaks: through the provision of care for the cared-for individual
- End of Life Care and Carer Breaks
- Supporting Carers in Hospital Settings
- Carers Personal Health Budgets
- Carers Emergency Planning and Carer Passports
- Moving and Handling
- Young Carers
- Independent Giving Carers a Voice
- There is currently a review of the particular support needed by carers of someone using mental health services, expected to report by end September 2022.

There is also an innovation fund to address issues that arise and that are not otherwise addressed in the specifications for the commissioning services which may be Place-based.

The budget also enables the establishment, and during 2021-2022 the development of, the long-standing Integrated Carers team. This comprises SCC and ICB employed staff and is hosted within Surrey County Council within the new Surrey Heartlands ICB and works in partnership with North Hants and Farnham ICB.

The Carers Partnership Board has been refreshed and there are representatives of each of the newly established Place-based Carers Action Groups, which report into the Surrey Heartlands Carers Partnership board. These will interface directly with the LJCGs. The initial priority of East Surrey's Carers Steering group is to develop an action plan in response to the needs of carers in East Surrey.

Additionally, resources placed into expanding our Community Nursing & Hospice teams via BCF funding help to provide support in the community to our population and help reduce the burden placed upon unpaid carers.

Disabled Facilities Grant (DFG) and Wider Services

The DFG is paid to Borough and District Councils as set out in the grant conditions. Local Joint Commissioning Groups work at place to determine how best to spend this grant in their areas. This can be through specific forums bringing together Health and Social Care colleagues with Housing colleagues (East Surrey) or with OT's being involved in ensuring provision is reasonable and appropriate (Guildford and Waverley). Boroughs and Districts across Surrey work to ensure consistency and best use of resources. It is recognised that a DFG will need to be used to meet strategic housing needs in the future, this is where specific forums that are being set up can have the most impact.

As described earlier, the remit of LJCGs includes overseeing the performance of these initiatives, with representatives invited to present progress, outputs and outcomes and future plans. In Surrey Downs, for example, representatives from D&B Councils attend every other meeting (six each year) to provide essential local knowledge.

In addition, ICPs will be a delivery forum for issues which require a co-ordinated approach – in attendance will be D&B, health, VCSE, enabling health, social care and housing/environmental issues to be addressed and strategy set in one place. Further, the integrated commissioning function allows all these aspects to be considered by an integrated team.

Equality and Health Inequalities

BCF continues to address inequalities through its strategic alignment to Surrey Heartlands Critical Five, with the additional contribution of the Core20PLUS5 and Fuller Stocktake further localising health and care around communities and priority populations. This provides opportunities to assess demographics and wider determinants of health that impact on social and health inequalities allowing more accurate assessments of need to take place at a community level. The evolving structure of the health and care partnership alongside the continued incorporation of population health data through Graphnet assists LJCGs and BCF partners to target populations with the most appropriate services to achieve equity in access to health

and social care. In doing so, promoting independence at home, reducing admissions to hospital, and reducing the reliance on social care.

Surrey Downs LJCG set aside underspend from 21-22 to fund innovative services focusing on reducing health inequalities.

BCF funding continues to be allocated to projects/services directly addressing health inequalities:

- Tech 2 Community Connect, Growing Health Together and Wellbeing Prescription Service.
- Tech2 Connect provide free access to digital services for isolated individuals by providing free equipment, data and digital literacy support in the form of Tech Angels.
- Growing Health Together focuses on developing the health creation agenda in local communities across East Surrey. Growing Health Together Programme has picked up considerable momentum across all five Primary Care Networks with dedicated GP leads and committed engagement from local organisations, businesses, residents, schools, and places of worship. As a result, many projects have already been successful in reducing social isolation, improving mental health through multi-generational activities, increasing physical activity, facilitating green social prescribing, overcoming cultural barriers to health education, promoting healthy eating and many other outcomes, all of which are recognised to have a positive effect on individuals' health.
- The well-established East Surrey Wellbeing Prescription Service are working closely with PCNs, social care and community networks to understand inequalities and seek to address and reduce them. Wellbeing advisors utilise population health and primary care data to proactively identify priority cohorts within their local population and work with these groups to seek and develop services that meet their personal needs. By taking a targeted approach and assessing individual cases, the Wellbeing Prescription Service is able to efficiently navigate the system and tailor the offer to meet the demand.

These services strive to development stronger local communities to support local residents to lead more active, socially engaged lives. Addressing the wider, non-medical needs of individuals with the provision of asset-based community programmes - Growing Health Together, and personal development services such as Wellbeing Prescription enabling individuals to valuable parts of their community networks thus creating a sense of resilience.

Partners within the LJCG work closely with local groups and organisations representing seldom heard groups to ensure services are available, appropriate and co-produced to provide the right intervention at the right time.

East Surrey BCF will be using population health management pooled data (via Graphnet and resident's engagement) to assist with the identification, and

development of suitable provision of services to address health inequalities with identified population groups.

Surrey Downs supported a variety of organisations, key priorities being to encourage connectivity and reduce isolation (particularly following Covid), development of skills among young people; bereavement support (given the greater demand as a result of covid-related deaths).

It is also recognised that more can be done, particularly with regards to the use of data to target priorities and act. This is part of the review currently being carried out and we expect to see changes take place from Q1 23/24 onwards.

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BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue 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 sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. 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. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution.
4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.
5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.
6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these 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 NHS 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. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text 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. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. 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 in tab 5b.

- 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. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.

- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:

- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.

- Please note that where 'Social Care' is selected and the source of funding is "NHS 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 scheme types where possible.

6. Commissioner:

- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.

- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.

- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:

- Please select the type of 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.

8. 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. This includes additional, voluntarily pooled contributions from either the ICB or Local authority

- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:

- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme

- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:

- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:

- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
<https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704>
- Technical definitions for the guidance can be found here:
<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions>

2. Discharge to normal place of residence.

- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:

- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:

- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements [\(click to go to sheet\)](#)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board:

Income & Expenditure

[Income >>](#)

Funding Sources	Income	Expenditure	Difference
DFG	£10,155,847	£10,155,847	£0
Minimum NHS Contribution	£85,191,031	£85,191,031	£0
iBCF	£11,408,352	£11,408,352	£0
Additional LA Contribution	£3,164,726	£3,164,726	£0
Additional ICB Contribution	£23,271,880	£23,271,880	£0
Total	£133,191,836	£133,191,836	£0

[Expenditure >>](#)

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£24,211,667
Planned spend	£35,399,302

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£50,187,500
Planned spend	£50,794,546

Scheme Types

Assistive Technologies and Equipment	£6,340,984	(4.8%)
Care Act Implementation Related Duties	£2,610,001	(2.0%)
Carers Services	£9,352,448	(7.0%)
Community Based Schemes	£51,042,729	(38.3%)
DFG Related Schemes	£10,155,847	(7.6%)
Enablers for Integration	£638,321	(0.5%)
High Impact Change Model for Managing Transfer o	£10,508,281	(7.9%)
Home Care or Domiciliary Care	£13,161,482	(9.9%)
Housing Related Schemes	£335,040	(0.3%)
Integrated Care Planning and Navigation	£1,620,592	(1.2%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£8,362,350	(6.3%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£698,644	(0.5%)
Prevention / Early Intervention	£4,735,764	(3.6%)
Residential Placements	£11,408,352	(8.6%)
Other	£2,221,000	(1.7%)
Total	£133,191,835	

[Metrics >>](#)

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)				

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	8.0%	8.9%	9.6%	10.3%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	464	233

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	67.9%

[Planning Requirements >>](#)

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board:

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Surrey	£10,155,847
DFG breakdown 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	£11,408,352
Total iBCF Contribution	£11,408,352

Are any additional LA Contributions being made in 2022-23? 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	£492,844	Mental Health Community Connections
Surrey	£2,671,882	Carry forward
Total Additional Local Authority Contribution	£3,164,726	

NHS Minimum Contribution	Contribution
NHS Frimley ICB	£10,943,335
NHS Surrey Heartlands ICB	£74,247,696
Total NHS Minimum Contribution	£85,191,031

Checklist Complete:

Yes

Yes

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	Yes
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Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Surrey Heartlands ICB	£21,140,920	Carry forward from 2021-22
NHS Frimley ICB	£2,130,960	Carry forward from 2021-22
Total Additional NHS Contribution	£23,271,880	
Total NHS Contribution	£108,462,911	

Yes

Yes

	2021-22
Total BCF Pooled Budget	£133,191,836

Funding Contributions Comments Optional for any useful detail e.g. Carry over	
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See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2022-23 Template
5. Expenditure

Selected Health and Wellbeing Board:

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£10,155,847	£10,155,847	£0
Minimum NHS Contribution	£85,191,031	£85,191,031	£0
iBCF	£11,408,352	£11,408,352	£0
Additional LA Contribution	£3,164,726	£3,164,726	£0
Additional NHS Contribution	£23,271,880	£23,271,880	£0
Total	£133,191,836	£133,191,836	£0

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£24,211,667	£35,399,302	£0
Adult Social Care services spend from the minimum ICB allocations	£50,187,500	£50,794,546	£0

>> Link to further guidance

Checklist

Column complete:

Yes													
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Sheet complete

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	Planned Expenditure		Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
									% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)				
1	ES 1a - Responsibilities under the Care	Homecare Service Provision	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£373,696	Existing
2	ES 1b - Responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	Minimum NHS Contribution	£4,552	Existing
3	ES 1c - Responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum NHS Contribution	£17,752	Existing
4	ES 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£380,000	Existing
5	ES 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£4,164,172	Existing
6	ES 4 - Prescription Schemes	Social Prescription	Prevention / Early Intervention	Social Prescribing		Social Care		CCG			Local Authority	Minimum NHS Contribution	£518,004	Existing
7	ES 5 - Community Grants	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£143,650	Existing
8	ES 6 - Supported Employment	Mental Health Employment Support	Prevention / Early Intervention	Other	Employment Sup	Social Care		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£120,341	Existing
9	ES 7 - FCHC Discharge to Assess	D2A	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£210,655	Existing
10	ES 8 - Tech to Connect	Training to residents to enable social inclusion through the use of	Assistive Technologies and Equipment	Digital participation services		Other	Wellbeing services	CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£65,000	New

11	ES 9 - Independent Living Service -	Help at home to enable people to stay at home or return home from	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£134,000	New
12	ES 10 - Growing Health Together	Co-creating conditions for peoples health and wellbeing to thrive	Prevention / Early Intervention	Other	Local PCN led scheme to promote	Primary Care		CCG			NHS Community Provider	Minimum NHS Contribution	£147,658	New
13	ES 11 - Discharge to Recover	Development of the workforce to support Pathway 1	Home Care or Domiciliary Care	Domiciliary care workforce development		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£122,000	New
14	ES 12 - D2A funding	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Community Health		CCG			Private Sector	Minimum NHS Contribution	£228,567	Existing
15	ES 13 - Home from Hospital	Home First	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£137,623	Existing
16	ES 14 - Stroke Support	Contribution to Stroke Support contract	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£17,901	Existing
17	ES 15 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£120,000	Existing
18	ES 16 - Information & Advice	Information and advice for the public to navigate the care sector	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£37,890	Existing
19	ES 17a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£235,449	Existing
20	ES 17b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£75,709	Existing
21	ES 18 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes			Social Care		LA			Local Authority	Minimum NHS Contribution	£41,247	Existing
22	ES 19 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	£495,139	Existing
23	ES - 20 Autism Friendly Communities	Providing support to communities in Surrey to be inclusive of	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum NHS Contribution	£3,500	New
24	ES - 21 All Age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£68,241	Existing
25	ES - 22 D2A funding - ASC	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Private Sector	Minimum NHS Contribution	£57,019	New
27	ES 23 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£1,268,237	Existing
28	ES 24 - Improve BCF 22/23	Support to D2A process through Care Home packages	Residential Placements	Discharge from hospital (with reablement) to		Social Care		LA			Local Authority	iBCF	£1,729,976	Existing
29	ES 25 - CCG Carry Forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Community Health		CCG			CCG	Additional NHS Contribution	£7,581,862	Existing
30	ES 26 SCC Carry Forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Social Care		LA			Local Authority	Additional LA Contribution	£281,862	Existing

31	GW 1a - Responsibilities under the Care	Homecare Service Provision	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£427,399	Existing
32	GW 1b - Responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	Minimum NHS Contribution	£5,207	Existing
33	GW 1c - Responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum NHS Contribution	£20,394	Existing
34	GW 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£435,000	Existing
35	GW 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£3,971,932	Existing
36	GW 4 - Supported Employment	Mental Health Employment Support	Prevention / Early Intervention	Other	Employment Support for Mental Health	Social Care		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£141,927	Existing
37	GW 5 - End of Life Care - Contract	End of Life Contract	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£172,545	Existing
38	GW 6 - Psychiatric Liaison Services	Mental Health Support	Prevention / Early Intervention	Other	Psychiatric Liaison	Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£179,183	Existing
39	GW 7 - Mental Health wards	Mental Health Support	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Mental Health		LA			Local Authority	Minimum NHS Contribution	£166,646	Existing
40	GW 8 - Funding for NEA in acute	Contributions to Acute contracts	Other		Acute contracts	Acute		CCG			NHS Acute Provider	Minimum NHS Contribution	£200,000	Existing
41	GW 9 - Blue Box	Discharge to Care Homes	High Impact Change Model for Managing	Improved discharge to Care Homes		Community Health		CCG			CCG	Minimum NHS Contribution	£6,054	Existing
42	GW 10 - Falls Co-ordinator	Falls Prevention	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			Local Authority	Minimum NHS Contribution	£54,590	Existing
43	GW 11 - Care Home Matrons	Discharge to Care Homes	High Impact Change Model for Managing	Improved discharge to Care Homes		Community Health		CCG			Private Sector	Minimum NHS Contribution	£129,669	Existing
44	GW 12 - Hoppa Bus	Relieving pressure in A&E/reduce admissions	High Impact Change Model for Managing	Monitoring and responding to system demand		Social Care		CCG			Local Authority	Minimum NHS Contribution	£160,363	Existing
45	GW 13 - Let's get steady, Fall prevention	Falls Prevention	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			Local Authority	Minimum NHS Contribution	£26,000	Existing
46	GW 14 - Very High Intensity Users Programme	Focused support for High Intensity Users	Integrated Care Planning and Navigation	Support for implementation of anticipatory		Community Health		CCG			CCG	Minimum NHS Contribution	£56,067	Existing
47	GW 15 - Reconnections matched funding	Match funding for Reconnections contract	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			CCG	Minimum NHS Contribution	£50,000	Existing
48	GW 16 - Carers Partnership Manager shortfall	Staffing costs	Enablers for Integration	Joint commissioning infrastructure		Community Health		CCG			CCG	Minimum NHS Contribution	£18,128	Existing
49	GW 17 - D2A funding	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Community Health		CCG			Private Sector	Minimum NHS Contribution	£179,142	Existing
50	GW 18 - Falls Prevention Packs	Falls Prevention	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			Local Authority	Minimum NHS Contribution	£10,136	New

51	GW 19 - GP in A&E	GP based in A&E	Community Based Schemes	Low level support for simple hospital		Primary Care		CCG			NHS Community Provider	Minimum NHS Contribution	£86,065	New
52	GW 20 - Social Prescribing Administrator	Social Prescription	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£33,000	New
53	GW 21 - Discharge Nurse	Discharge Nurse to support flow from Acute	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£22,919	New
54	GW 22 - PTH Responsive Pilot	Phyllis Tuckwell Hospice Pilot project	Personalised Care at Home	Other	EOL Care	Community Health		CCG			NHS Acute Provider	Minimum NHS Contribution	£54,668	New
55	GW 23 - Independence and Prevention	Independence and prevention lead	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			CCG	Minimum NHS Contribution	£77,819	New
56	GW 24 - Palliative Care Lead	Palliative Care Lead	Personalised Care at Home	Other	EOL Care	Community Health		CCG			CCG	Minimum NHS Contribution	£25,905	New
57	GW 25 - Community Discharge Nurses	Community Discharge Nurses	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£83,721	New
58	GW 26 - MH Caseworker	MH Caseworker	Personalised Care at Home	Mental health /wellbeing		Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£40,000	New
59	GW 27 - Tech to Connect	Training to residents to enable social inclusion through the use of	Assistive Technologies and Equipment	Digital participation services		Other	Wellbeing services	CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£92,625	New
60	GW 28 - Outline Grant	Outline Grant	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£276	Existing
61	GW 29 - Art Therapy	Art Therapy	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£25,000	New
62	GW 30 - Home from Hospital	Home First	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£23,010	Existing
63	GW 31 - Stroke Support	Contribution to Stroke Support contract	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£21,060	Existing
64	GW 32 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£107,000	Existing
65	GW 33 - Information and Advice	Information and advice for the public to navigate the care sector	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£44,361	Existing
66	GW 34a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£268,452	Existing
67	GW 34b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£86,320	Existing
68	GW 35 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes			Social Care		LA			Local Authority	Minimum NHS Contribution	£47,925	Existing
69	GW 36 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	£586,216	Existing
70	GW 37 - Social Prescribing	Social Prescription	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£64,444	Existing

71	GW 38 - Safe & Settled	Discharge from Hospital - low level support required	Community Based Schemes	Low level support for simple hospital		Social Care		LA			Local Authority	Minimum NHS Contribution	£65,443	New
72	GW 39- All Age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£73,347	Existing
73	GW40 - D2A funding - ASC	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Private Sector	Minimum NHS Contribution	£120,969	New
74	GW 42 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£1,253,448	Existing
75	GW 43 - Improve BCF 22/23	Support to D2A process through Care Home packages	Residential Placements	Discharge from hospital (with reablement) to		Social Care		LA			Local Authority	iBCF	£1,981,153	Existing
76	GW 44 - CCG Carry Forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Community Health		CCG			CCG	Additional NHS Contribution	£4,370,133	Existing
77	GW 45 - SCC Carry Forward 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Social Care		LA			Local Authority	Additional LA Contribution	£370,133	Existing
78	NW 1a - Responsibilities under the Care	Homecare Service Provision	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£734,033	Existing
79	NW 1b - Responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	Minimum NHS Contribution	£8,943	Existing
80	NW 1c - Responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum NHS Contribution	£35,025	Existing
81	NW 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£747,000	Existing
82	NW 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£7,291,546	Existing
83	NW 4 - Supported Employment	Mental Health Employment Support	Prevention / Early Intervention	Other	Employment Support for Mental Health	Social Care		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£237,148	Existing
84	NW 5 - Mental Health Virtual Wards	Mental Health Support	Personalised Care at Home	Mental health /wellbeing		Primary Care		CCG			NHS Community Provider	Minimum NHS Contribution	£424,071	Existing
85	NW 6 - Acute Contributions	Contributions to Acute contracts	Other		Acute contracts	Acute		CCG			NHS Acute Provider	Minimum NHS Contribution	£1,687,000	Existing
86	NW 7 - D2A funding	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Community Health		CCG			Private Sector	Minimum NHS Contribution	£942,668	Existing
87	NW 8 - Home from Hospital	Home First	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	Minimum NHS Contribution	£90,527	Existing
88	NW 9 - Stroke Support	Contribution to Stroke Support contract	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£34,749	Existing
89	NW 10 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£210,000	Existing
90	NW 11 - Information & Advice	Information and advice for the public to navigate the care sector	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£73,049	Existing

91	NW 12a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£458,827	Existing
92	NW 12b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£147,537	Existing
93	NW 13 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes			Social Care		LA			Local Authority	Minimum NHS Contribution	£97,938	Existing
94	NW 14 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	£810,538	Existing
95	NW 15 All age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£154,879	Existing
96	NW 16 - D2A funding - ASC	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Private Sector	Minimum NHS Contribution	£49,940	Existing
97	NW 17 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£3,622,770	Existing
98	NW 18 - Improve BCF 22/23	Support to D2A process through Care Home packages	Residential Placements	Discharge from hospital (with reablement) to		Social Care		LA			Local Authority	iBCF	£3,400,298	Existing
99	NW 19 - SCC Carry forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Social Care		LA			Local Authority	Additional LA Contribution	£505,706	Existing
100	NW 20 - CCG Carry forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Community Health		CCG			CCG	Additional NHS Contribution	£4,505,705	Existing
101	SD 1a - New responsibilities under the Care	Homecare Service Provision	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£610,436	Existing
102	SD 1b - New responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	Minimum NHS Contribution	£7,437	Existing
103	SD 1c - New responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum NHS Contribution	£29,127	Existing
104	SD 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£621,000	Existing
105	SD 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£5,944,914	Existing
106	SD 4 - Supported Employment	Mental Health Employment Support	Prevention / Early Intervention	Other	Employment Support for Mental Health	Social Care		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£173,715	Existing
107	SD 5 - End of Life Care Contract	End of Life Contract	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£326,227	Existing
108	SD 6 - Integrated Teams	Integrated Community Health Team	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£502,685	Existing
109	SD 7 - Care Home support post	Support to Care Homes	Integrated Care Planning and Navigation	Care navigation and planning		Continuing Care		CCG			CCG	Minimum NHS Contribution	£37,000	Existing
110	SD 8 - Mental Health - Psychiatric Liaison	Mental Health Support	Prevention / Early Intervention	Other	Psychiatric Liaison	Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£440,133	Existing

111	SD 9 - Local CCG Schemes mapped to BCF projects	Various small contracts	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			CCG	Minimum NHS Contribution	£83,899	Existing
112	SD 10 - Funding for NEA in acute	Contributions to Acute contracts	Other		Acute contracts	Acute		CCG			NHS Acute Provider	Minimum NHS Contribution	£334,000	Existing
113	SD 11 - D2A funding	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Community Health		CCG			Private Sector	Minimum NHS Contribution	£784,590	Existing
114	SD 12 - Tech to Connect	Training to residents to enable social inclusion through the use of	Assistive Technologies and Equipment	Digital participation services		Other	Wellbeing services	CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£54,000	Existing
115	SD 13 - Care Home Improvement and	Care Home improvement including workforce training	High Impact Change Model for Managing	Improved discharge to Care Homes		Other	Workforce Development	CCG			CCG	Minimum NHS Contribution	£37,000	Existing
116	SD 14 - Falls Prevention Packs	Falls Prevention	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			CCG	Minimum NHS Contribution	£10,782	Existing
117	SD 15 - Hospital to Home Support Service	Home First	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£82,198	Existing
118	SD 16 - Stroke Support	Contribution to Stroke Support contract	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£32,643	Existing
119	SD 17 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£225,000	Existing
120	SD 18 - Information & Advice	Information and advice for the public to navigate the care sector	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£65,090	Existing
121	SD 19a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£365,931	Existing
122	SD 19b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£117,666	Existing
123	SD 20 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes			Social Care		LA			Local Authority	Minimum NHS Contribution	£74,412	Existing
124	SD 21 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	£840,202	Existing
125	SD 22 - Social Prescribing	Social Prescription	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum NHS Contribution	£110,649	Existing
126	SD 23 - All Age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£133,308	Existing
128	SD 25 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£2,763,648	Existing
129	SD 26 - Improve BCF 22/23	Support to D2A process through Care Home packages	Residential Placements	Discharge from hospital (with reablement) to		Social Care		LA			Local Authority	iBCF	£2,827,261	Existing
130	SD 27 - CCG Carry Forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Community Health		CCG			CCG	Additional NHS Contribution	£4,683,220	Existing

131	SD 28 - SCC Carry Forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Social Care		LA			Local Authority	Additional LA Contribution	£683,220	Existing
132	NEHF 1a - Responsibilities under the Care	Homecare Service Provision	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£92,462	Existing
133	NEHF 1b - Responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,126	Existing
134	NEHF 1c - Responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum NHS Contribution	£4,412	Existing
135	NEHF 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£94,000	Existing
136	NEHF 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,068,377	Existing
137	NEHF 4 - Supported Employment	Mental Health Employment Support	Prevention / Early Intervention	Other	Employment Support for Mental Health	Social Care		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£31,396	Existing
138	NEHF 5 - End of Life Care - Contract	End of Life Contract	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£37,500	Existing
139	NEHF 6 - Integrated Team Management	Staffing costs	Enablers for Integration	Integrated models of provision		Social Care		CCG			Local Authority	Minimum NHS Contribution	£60,000	Existing
140	NEHF 7 - Discharge to Assess	D2A	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Community Health		CCG			CCG	Minimum NHS Contribution	£40,000	Existing
141	NEHF 7a - Community Schemes	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			CCG	Minimum NHS Contribution	£56,685	Existing
142	NEHF 8 - Home from Hospital	Home First	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£141,077	New
143	NEHF 9 - Home from Hospital	Home First	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£5,070	Existing
144	NEHF 10 - Stroke Support	Contribution to Stroke Support contract	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£5,265	Existing
145	NEHF 11 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£24,000	Existing
146	NEHF 12 - Information & Advice	Information and advice for the public to navigate the care sector	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£9,827	Existing
147	NEHF 13a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£54,698	Existing
148	NEHF 13b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£17,589	Existing
149	NEHF 14 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes			Social Care		LA			Local Authority	Minimum NHS Contribution	£11,051	Existing
150	NEHF 15 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	£188,141	Existing

151	NEHF 16 - All Age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£14,694	Existing
152	NEHF 17 - ASC Community Scheme	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£12,027	New
153	NEHF 18 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£282,969	Existing
154	NEHF 19 - Improve BCF 22/23	Support to D2A process through Care Home packages	Residential Placements	Discharge from hospital (with reablement) to		Social Care		LA			Local Authority	iBCF	£428,574	Existing
155	NEHF 20 - CCG Carry Forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Community Health		CCG			CCG	Additional NHS Contribution	£508,189	Existing
156	NEHF 21 - SCC Carry Forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Social Care		LA			Local Authority	Additional LA Contribution	£228,189	Existing
157	EB 1a - New Responsibilities under the Care	Homecare Service Provision	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£24,531	Existing
158	EB 1b - New Responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	Minimum NHS Contribution	£299	Existing
159	EB 1c - New Responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum NHS Contribution	£1,170	Existing
160	EB 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£25,000	Existing
161	EB 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£239,733	Existing
162	EB 4 - Podiatry - Frimley NHS	Podiatry Service	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£22,911	Existing
163	EB 5 - D2A Risk Contingency Pool	D2A	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Community Health		CCG			CCG	Minimum NHS Contribution	£10,600	Existing
164	EB 6 - End Of Life - TVHC	End of Life Contract	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£25,000	Existing
165	EB 7 - Commissioning Reserve	Support to Commissioning	Enablers for Integration	Joint commissioning infrastructure		Community Health		CCG			CCG	Minimum NHS Contribution	£48,905	Existing
166	EB 8 - Community Schemes	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			CCG	Minimum NHS Contribution	£51,071	Existing
167	EB 9 - Stroke Support	Contribution to Stroke Support contract	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£1,053	Existing
168	EB 10 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£8,000	Existing
169	EB 11 - Information & Advice	Information and advice for the public to navigate the care sector	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£2,147	Existing
170	EB 12a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£17,877	Existing

171	EB 12b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£5,748	Existing
172	EB 13 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes			Social Care		LA			Local Authority	Minimum NHS Contribution	£2,842	Existing
173	EB 14 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	£45,450	Existing
174	EB 15 - All Age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£3,768	New
175	EB 16 - ASC Community Schemes	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£35,208	Existing
176	EB 17 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£82,287	Existing
177	EB 18 - Improve BCF 22/23	Support to D2A process through Care Home packages	Residential Placements	Discharge from hospital (with reablement) to		Social Care		LA			Local Authority	iBCF	£113,781	Existing
178	EB 19 - CCG Carry Forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Community Health		CCG			CCG	Additional NHS Contribution	£290,318	Existing
179	EB 20 - SCC Carry Forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Social Care		LA			Local Authority	Additional LA Contribution	£210,319	Existing
180	SH 1a - New responsibilities under the Care	Homecare Service Provision	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£200,019	Existing
181	SH 1b - New responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	Minimum NHS Contribution	£2,437	Existing
182	SH 1c - New responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board	Social Care		LA			Local Authority	Minimum NHS Contribution	£9,544	Existing
183	SH 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£204,000	Existing
184	SH 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,512,132	Existing
185	SH 4 - Supported Employment	Mental Health Employment Support	Prevention / Early Intervention	Other	Employment Support for Mental Health	Social Care		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£85,036	Existing
186	SH 5 - End of Life Care Contract	End of Life Contract	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£78,946	Existing
187	SH 6 - End of Life Care Clinical Lead	Staffing costs	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£11,093	Existing
188	SH 7 - Mental Health - Psychiatric Liaison	Mental Health Support	Prevention / Early Intervention	Other	Psychiatric Liaison	Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£201,366	Existing
189	SH 8 - Integrated Care Team	Staffing costs	Enablers for Integration	Integrated models of provision		Social Care		CCG			CCG	Minimum NHS Contribution	£406,632	Existing
190	SH 9 - Out of Hospital	D2A	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		CCG			CCG	Minimum NHS Contribution	£210,617	Existing

191	SH 10 - Occupational Therapist (SHBC)	Occupational Therapist (SHBC)	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			Local Authority	Minimum NHS Contribution	£70,000	New
192	SH 11 UCR Reablement	UCR Reablement	Reablement in a persons own home	Rapid/Crisis Response - step up (2 hr		Community Health		CCG			CCG	Minimum NHS Contribution	£50,000	Existing
193	SH12a - Social Prescribing post SHBC	Social Prescription	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			CCG	Minimum NHS Contribution	£40,000	New
194	SH 12b - Social Prescribing Post	Social Prescription	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			CCG	Minimum NHS Contribution	£39,000	Existing
195	SH 12c - Social Prescribing Post	Social Prescription	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			CCG	Minimum NHS Contribution	£34,122	Existing
196	SH 13a - Time to Talk	Mental Health Support	Personalised Care at Home	Mental health /wellbeing		Mental Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£10,000	Existing
197	SH 13b - Time to Talk	Mental Health Support	Personalised Care at Home	Mental health /wellbeing		Mental Health		CCG			CCG	Minimum NHS Contribution	£10,000	Existing
198	SH 14a - Neighbourhood resilience Social	Social Prescription	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			CCG	Minimum NHS Contribution	£5,000	Existing
199	SH 14b - Neighbourhood resilience Social	Social Prescription	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			CCG	Minimum NHS Contribution	£5,000	Existing
200	SH 15a - Locality Director	Staffing costs	Enablers for Integration	Integrated models of provision		Social Care		CCG			CCG	Minimum NHS Contribution	£30,128	Existing
201	SH 15b - Locality Director	Staffing costs	Enablers for Integration	Integrated models of provision		Social Care		CCG			CCG	Minimum NHS Contribution	£30,128	Existing
202	SH 16a - MH Case Worker (Homelessness)	Homelessness	Housing Related Schemes			Social Care		CCG			CCG	Minimum NHS Contribution	£12,500	Existing
203	SH 16b - MH Case Worker (Homelessness)	Homelessness	Housing Related Schemes			Social Care		CCG			CCG	Minimum NHS Contribution	£12,500	Existing
204	SH 16c - Community Schemes	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			CCG	Minimum NHS Contribution	£124,195	Existing
205	SH 17 - Home from Hospital Scheme	Home First	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£40,869	New
206	SH 18 - Home from Hospital	Home First	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£10,920	Existing
207	SH 19 - Stroke Support	Contribution to Stroke Support contract	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£9,954	Existing
208	SH 20 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£55,000	Existing
209	SH 21 - Information & Advice	Information and advice for the public to navigate the care sector	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£21,225	Existing
210	SH 22a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£131,469	Existing

211	SH 22b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£42,275	Existing
212	SH 23 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes			Social Care		LA			Local Authority	Minimum NHS Contribution	£34,625	Existing
213	SH 24 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	£314,673	Existing
214	SH 25 - All Age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£51,763	Existing
215	SH 26 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£882,488	Existing
216	SH 27 - Improve BCF 22/23	Support to D2A process through Care Home packages	Residential Placements	Discharge from hospital (with reablement) to		Social Care		LA			Local Authority	iBCF	£927,309	Existing
217	SH 28 - CCG Carry forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Community Health		CCG			CCG	Additional NHS Contribution	£1,332,453	Existing
218	SH 29 - SCC Carry Forward from 21/22	This is the carryforward from the previous year, bids are made against	Community Based Schemes	Other	Carry forward	Social Care		LA			Local Authority	Additional LA Contribution	£392,453	Existing
219	CW 1 - Integrated Multi Disciplinary Teams - Social	Hospital, Reablement and Occupational Therapy Staffing	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£3,911,239	Existing
220	CW 2 - Integrated Multi Disciplinary Teams - Mental	Integrated Mental Health Teams	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Mental Health		LA			Local Authority	Minimum NHS Contribution	£480,152	Existing
221	CW 3 - Protection of Carers Service	Contribution to Carers Contracts	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£6,846,448	Existing
222	CW 4 - Protection of Community Equipment	Contribution to ASC Community Equipment Costs	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	Minimum NHS Contribution	£2,100,000	Existing
223	CW 5 - Protection of Reablement Staffing	Contribution to ASC reablement costs	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Minimum NHS Contribution	£7,243,131	Existing
224	CW 6 - Protection of Hospital ASC Teams	Contribution to ASC Hospital Staffing	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£3,081,740	Existing
225	CW 7 - Protection of OP HBC	Contribution to Homecare Service Provision	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum NHS Contribution	£10,676,587	Existing
226	CW 8 - Protection of Collaborative Reablement	Reablement partnerships	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,069,219	Existing
227	CW 9 - D2A Staffing	Contribution to ASC D2A Staffing costs	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£922,927	Existing
229	CW 11 - BCF Administration	Staffing costs	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum NHS Contribution	£44,400	Existing

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	<ol style="list-style-type: none"> 1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other 	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	<ol style="list-style-type: none"> 1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other 	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	<ol style="list-style-type: none"> 1. Respite Services 2. Other 	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	<ol style="list-style-type: none"> 1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other 	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/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	<ol style="list-style-type: none"> 1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other 	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. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	<ol style="list-style-type: none"> 1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other 	Schemes that build and develop the enabling foundations of health, social care and housing 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 commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	<ol style="list-style-type: none"> 1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other 	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, is included in this section.

8	Home Care or Domiciliary Care	<ol style="list-style-type: none"> 1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other 	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.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	<ol style="list-style-type: none"> 1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other 	<p>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 such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals.</p> <p>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.</p> <p>Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, 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 appropriate sub-type alongside.</p>
11	Bed based intermediate Care Services	<ol style="list-style-type: none"> 1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other 	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 sub-types.
12	Reablement in a persons own home	<ol style="list-style-type: none"> 1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other 	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	<ol style="list-style-type: none"> 1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other 	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.
15	Prevention / Early Intervention	<ol style="list-style-type: none"> 1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other 	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.
16	Residential Placements	<ol style="list-style-type: none"> 1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other 	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.
18	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.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board:

8.1 Avoidable admissions

		2021-22 Q1	2021-22 Q2	2021-22 Q3	2021-22 Q4	Rationale for how ambition was set	Local plan to meet ambition
		Actual	Actual	Actual	Actual		
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	169.1	150.3	166.0	145.1	We have followed the trends shown by our data and set ambitions from there. As outlined in the narrative, we are allowing our current schemes time to bed in after so much disruption.	We are working closely with data managers to monitor this metric against commissioned services and will work with local joint commissioning groups to adjust where necessary.
	Indicator value	100	99	79	60		

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1	2021-22 Q2	2021-22 Q3	2021-22 Q4	Rationale for how ambition was set	Local plan to meet ambition
		Actual	Actual	Actual	Actual		
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	91.1%	91.2%	90.3%	90.0%	We have followed the trends shown by our data and set ambitions from there. As outlined in the narrative, we are allowing our current schemes time to bed in after so much disruption.	We are working closely with data managers to monitor this metric against commissioned services and will work with local joint commissioning groups to adjust where necessary.
	Numerator	22,071	22,560	21,782	19,883		
	Denominator	24,224	24,727	24,130	22,084		
	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan			
	Quarter (%)	8.0%	8.9%	9.6%	10.3%		
	Numerator	1,264	1,399	1,509	1,619		
	Denominator	15,722	15,722	15,722	15,722		

8.4 Residential Admissions

		2020-21	2021-22	2021-22	2022-23	Rationale for how ambition was set	Local plan to meet ambition
		Actual	Plan	estimated	Plan		
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	464.1	462.2	236.2	233.2	We have followed the trends shown by our data and set ambitions from there. As outlined in the narrative, we are allowing our current schemes time to bed in after so much disruption.	We are working closely with data managers to monitor this metric against commissioned services and will work with local joint commissioning groups to adjust where necessary.
	Numerator	1,067	1,076	550	550		
	Denominator	229,900	232,820	232,820	235,815		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
<https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based>

8.5 Reablement

		2020-21	2021-22	2021-22	2022-23	Rationale for how ambition was set	Local plan to meet ambition
		Actual	Plan	estimated	Plan		
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	69.7%	69.7%	67.9%	67.9%	We have followed the trends shown by our data and set ambitions from there. As outlined in the narrative, we are allowing our current schemes time to bed in after so much disruption.	We are working closely with data managers to monitor this metric against commissioned services and will work with local joint commissioning groups to adjust where necessary.
	Numerator	405	405	434	434		
	Denominator	581	581	639	639		

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:

- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for **North Northamptonshire** and **West Northamptonshire** are using the **Northamptonshire** combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Checklist

Complete:

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board:

Surrey

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	A jointly developed and agreed plan that all parties sign up to	<p>Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted?</p> <p>Has the HWB approved the plan/delegated approval?</p> <p>Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan?</p> <p>Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?</p>	<p>Cover sheet</p> <p>Cover sheet</p> <p>Narrative plan</p> <p>Validation of submitted plans</p>	Yes			
	PR2	A clear narrative for the integration of health and social care	<p>Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:</p> <ul style="list-style-type: none"> • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include <ul style="list-style-type: none"> - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. <p>The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.</p>	Narrative plan	Yes			
	PR3	A strategic, joined up plan for Disabled Facilities Grant (DFG) spending	<p>Is there confirmation that use of DFG has been agreed with housing authorities?</p> <ul style="list-style-type: none"> • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: <ul style="list-style-type: none"> - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? 	<p>Narrative plan</p> <p>Confirmation sheet</p>	Yes			

Checklist

Complete:

Yes

Yes

Yes

NC2: Social Care Maintenance	PR4	A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				
NC3: NHS commissioned Out of Hospital Services	PR5	Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				
NC4: Implementing the BCF policy objectives	PR6	Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes				
Agreed expenditure plan for all elements of the BCF	PR7	Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes				
Metrics	PR8	Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes				

Yes

INTEGRATED CARE SYSTEMS (ICS) UPDATE

Health and Wellbeing Board – Formal public meeting

28 September 2022

Healthy Surrey

DELIVERING THE
COMMUNITY VISION FOR SURREY

Item 12

12

Surrey Heartlands ICB update

September's Integrated Care Board was held on 7th September 2022. The following items were discussed:

- MOU of understanding between Surrey Heartlands ICB and NHSE – this was agreed and is a standard national approach.
- A powerful carers presentation was given by Sue Tresman, independent carer's lead.
- Place updates were given – there was a focus this month on Surrey downs, and reports from other place leads / chairs. A common theme was response to the Fuller Report and preparation for strengthening integrated health and social care capacity at neighbourhood level.
- A very powerful pair of videos was shown regarding asylum seekers and their health needs.
- The departing equality and diversity lead gave a very positive overview of her work over the last two years before she leaves to take up another post in Kent,.
- A range of assurance reports and reports from committees were given that identified some significant operational and financial challenges, which would continue over the forthcoming winter period. Despite a strong base for performance.

Surrey Safe care

- Work continues to embed the new electronic patient record system (Surrey Safe Care) at Ashford and St Peter's and the Royal Surrey NHS Foundation Trusts launched in May.
- The system comprises a series of software applications that bring together and digitalise clinical and administrative data to replace paper-based records that will improve processes and increase safety, efficiency, and experience for patients.
- Cancer treatment has been prioritised throughout implementation, with performance across both Trusts remaining above the national average for the new 28-day diagnosis standard, 62 day and Two-Week Referral performance.
- Teams continue to work hard to mitigate initial difficulties particularly in outpatients where implementation, added to an increase in demand and seasonal capacity patterns, resulted in some impact on appointment waiting times.
- Positive progress is being made to rebuild clinic templates to mitigate this alongside improvements in discharge summaries to primary care.
- Both Trusts have set out clear action plans, with additional resources to include external specialist expertise in a number of fields, to continue to mitigate remaining issues, with appropriately increased risk ratings to ensure focus remains on recovery as a priority.
- Data quality is taking some time to settle, which has a short-term impact on our ability to provide accurate reporting data for elective activities and timely urgent and emergency care activity for the system; additional expert resources are helping improve the situation.
- We continue to work closely with the two Trusts and with colleagues across and beyond our system to ensure learning is applied nationally to any future roll-out.

Surrey Heartlands ICP update

Agenda items and brief summary from the last meeting (July)

- **Terms of Reference review and approval.** Terms of Reference were agreed in principle, and members acknowledged would be an ongoing discussion of the purpose and function, and membership of the Integrated Care partnership ('ICP').
- **Local Partnership Fora.** Paper proposed the setting up of Local Partnership Forums (LPF), being initially piloted in a small number of Districts and Boroughs. The Local Partnership Forums are intended to fill that gap in the translation of county-wide activity, into community-based activity at the local level. Discussion centered around how the LPFs could link to the new health structures being established, and the links between the LPF and recommendations of the Fuller Stocktake report.
- **Review of ICP Priorities and Forward plan.** Priorities and forward plan were reviewed to ensure right items are coming to the ICP.

Agenda items for next Integrated Care Partnership (28th September 2022)

The September formal public meeting will discuss the following topics in more depth:

- Health and Care Academy
- Local Partnership Fora update
- Fuller Stocktake implementation
- VCSE alliance
- Integrated Care Strategy headlines



Establishment of NHS Frimley

- Following Royal Assent being given and the establishment of the Health and Care Act (2022) in law, our new legal structures were established on 1st July 2022, in common with other health and care systems around the country. We are retaining the “Frimley Health and Care” title for our partnership as an Integrated Care System and have now formalised two new key parts of local architecture (further detail below).
- We have now established the Frimley Integrated Care Board (to be known as “NHS Frimley”) on the 1st July. Recruitment to all our Executive, Director and Non-Executive Member positions is complete, with colleagues taking having up their posts between 1st July and 8th September 2022.
- All our Board Partner Members were also formally appointed on the 1st July and these eight seats have been filled with members who are working in the Local Authority, Primary Care and NHS Provider sectors. The Board of NHS Frimley has now met twice and will ensure we bring a true system partnership approach to how the ICB takes decisions for the benefit of our population.

Establishment of Frimley Public Service Partnership

- Our other major point of establishment is the Frimley Integrated Care Partnership (to be known as “the Frimley Public Services Partnership”) which also came into existence on 1st July 2022. The first meeting of the ICP Assembly will take place at the end of September, with over 50 invites issued to Assembly members from across the Partnership to attend an introductory development session which will launch the ICP formally.



- One of the first responsibilities of the ICP will be to refresh the Frimley system strategy and over the course of the rest of the year we will be progressing this work to ensure that we understand where our greatest challenges are for the 800,000 people who live in our system.

Planning and Delivering for Winter 2022 / 23

- In April we submitted our system plan for 2022/23 which sets out our approach to meeting the main challenges of the year ahead. As a partnership we have submitted an ambitious plan which will ensure we can improve patient care and access throughout the year whilst living within the financial allocation which has been made available to us. The Frimley system partnership is currently focusing on the production of its immediate Winter Plan to ensure that have the best chance of meeting our residents' needs during challenging periods in the winter months.
- Further to this, we have recently concluded a significant piece of work to refresh the Frimley ICS Urgent and Emergency Care Strategy which we will be bringing through to a future meeting in further detail.

Working across ICS boundaries for the benefit of the Surrey population

- We continue to participate in further work on the Surrey Commissioning Memorandum of Understanding which will enable us to work more seamlessly with partners organisations in the Surrey geography to meet local need.